Payments to Informal versus Formal Home Care Providers: Policy Divergence Affecting the Elderly and Their Families in Michigan and Illinois

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State policies vary widely on paying friends and family rather than home care agencies to care for the elderly. We explore two state programs that exemplify different payment options: Michigan, which pays clients' informal caregivers, and Illinois, which generally pays agencies to provide services. We ask how different payment policies affect clients, specifically exploring program structure (division of labor and bases for need determination) and financing incentives created by Medicaid (centralization, means testing, and quality assurance). These factors shape provider and client preferences, well-being, and assessment of care quality. Comparatively, Illinois's approach favors professionalism, high cost/quality, documentation, and an orientation toward medical and physical needs. It has experienced high worker turnover and less regard for caregiver-client relationships. Michigan's approach favors informality, casual accountability, long-term stability of helping relationships, and respect for client preferences and autonomy. Both approaches offer important client benefits, but state precedents and incentives to administering agencies have shaped their overall directions. The recent rapid growth of the home care industry in Illinois could proscribe a fuller range of provider options. We recommend greater flexibility in considering states' payment.

Medicaid coverage of home care services has grown dramatically since 1982, when waivers for home- and community-based care (under

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Section 2176) first permitted states to use federal matching funds to divert care from institutions (Weissert, 1986). States' choices to contract with formal agencies, as opposed to informal care providers, particularly family members and friends, present an interesting basis on which to analyze comparatively their Medicaid home care services.

A number of recent studies have explored state programs to pay informal caregivers, generally friends and relatives. Burwell (1986) examined 13 such state programs and found variance in size, funding source, and relationship to other programs. Linsk, Keigher, Osterbusch, and Simon-Rusinowitz (in press) found key differences in provisions for payments to family members, including outright prohibition against relatives receiving payment, provision of a "family or attendant allowance," and reliance on home care agency employees with de facto exclusion of informal caregivers (family or friends) from employment or eligibility for reimbursement. Despite the prevalence of agency-provided care in the United States, 32 of the 45 states responding reported having at least *some* provision for paying family members to care for an elderly dependent member.

Biegel (1986) and associates identified 23 states providing significant economic incentives (both tax incentives and direct payment programs) to family caregivers. Observing great variation in eligibility requirements, level of benefits, and payments, as well as program administration and structure, he notes that "direct payment programs tend to be targeted at the lower income, high risk elderly to a greater degree than tax benefit programs" (p. 48). A related analysis by Osterbusch, Keigher, Miller, and Linsk (1987) frames reimbursement of family care, which is largely provided by women, as an issue of gender justice. These studies lack thorough analysis of individual state programs and thus reveal little about how different payment policies affect older clients. Our study does this in examining only two quite similar states that take contrasting approaches to informal care.

Programs in Michigan and Illinois are ideal for thorough analysis. Both are large, industrial states somewhat similar in size, ethnic composition, and extent of urbanization. The key programs providing

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home care to the elderly in Michigan are based on payment of informal caregivers, while in Illinois this option is only occasionally exercised.

The Illinois Community Care Program, operated by the state's Department on Aging (IDOA), represents a prototypic agency-based model reliant on agencies to determine eligibility and provide direct services. The Michigan Adult Home Help program, operated by the state welfare agency, the Department of Social Services (DSS), represents a prototypic client-based model in that it relies on the client to suggest appropriate caregivers who then provide the direct service. Each is described below.

Michigan's Home Help program relies heavily on family and friends as the paid providers of choice and closely resembles a family-, or attendant-, allowance model such as that of the Veteran's Administration. The program provides a cash transfer to the client, who pays the caregiver of his or her own choice, who may be a relative. Illinois contracts community care services to outside agencies and neither prohibits nor encourages these agencies regarding the hiring of relatives. The contract agencies are permitted to make their own policies. This almost always results in some de facto exclusion of informal providers because of agencies' preferences for full-time, flexible employees.

While Michigan also provides personal care service, both states provide homemaker and chore or housekeeping services. Both programs pay for similar assistance with activities of daily living to deter or preclude nursing home placement. The main difference is in who receives payment and in who selects and pays the caregiver.

Two dimensions of state policy choice appear to create the incentives that have resulted in program divergence: the states' program structure and the means of financing (Linsk, Keigher et al., in press). Program structure includes reliance on formal contract agencies to provide services to Illinois clients and reliance on state employees to contract with informal caregivers in Michigan. Financing includes each state's use of Medicaid and the incentives created by the home- and community-based care waivers. This study contrasts how the incentives created by structure and financing appear to differentially affect providers' and clients' preferences, well-being, and assessment of care quality.

Methods and Findings

We interviewed key state officials, case managers, and contract agency staff from both states to explore the procedures and values operating in each state's program. We gathered program performance,

financing, and expenditure data from published agency reports. We reviewed a survey of Illinois home care agencies (Linsk, Osterbusch, Simon-Rusinowitz, & Keigher, in press) and conducted exploratory interviews with a small number of clients and their caregivers in Michigan. We analyzed program data to delineate the structure and financing of each state program and the key effects clients felt. The interview and survey findings provide salient statements that highlight respondents' policy perspectives.

The main features found in each state's basic home care program are summarized in Table 1. The salient contrasting elements include how the program developed, the structure of service delivery, mechanisms for financing, and impacts on clients.

Program Origins and Context

Long-term care services in Michigan have been characterized by a gradual and steady growth of home care services over a long period, while Illinois has experienced more recent and rapid growth. In the past decade Michigan has constrained nursing home construction and use by Medicaid recipients while it gradually developed a broad array of supervised living arrangements (alternatives to nursing homes). In 1976 Michigan had 47.7 nursing home beds per 1,000 elderly, while Illinois had 50.0 (Vladeck, 1980), only very slightly more; but by 1981 the Michigan rate was 49.3, while in Illinois it was 68.3 (Aging Health Policy Center nursing home supply data for 1985 in Harrington, Newcomer, & Estes et al., 1985). Michigan imposed tight controls on nursing home construction through certificates of need. Nursing home use by Medicaid patients declined from 32,000 in 1975 to 29,000 in 1985. Michigan also made extensive use of board-and-care homes and adult foster care homes, expanding adult foster care beds from 13,000 to 18,500 in this period.

The most substantial growth, however, occurred in the two home-based care programs of the Department of Social Services (DSS), Adult Home Help and Medicaid Home Health. Home Help provides personal care and chore housekeeping services, while Home Health, in the Medicaid budget, provides nursing care services.

Between 1975 and 1985, Home Help grew from 9,800 to 22,700 clients, and Home Health grew from 2,810 to 7,925 clients. Clients over age 60 compose a growing share of Home Help—currently 72% of the program's 22,700 users, up from 67.2% just four years before (Michigan Department of Social Services, 1985; Nye, 1982). About half of the

Table 1. Program and Policy Analysis Model

Program Aspects	Michigan Adult Home Help Client-Based Care	Illinois Community Care Agency-Based Care
Historical	Longer term commitment to home and personal care. Began 1970. Slow but steady growth.	Program emerged as a governor's initiative 1980.
Basic Program/ Policy Model	More entitlement oriented. Categorical up to 133% of poverty. No sliding scale.	More residual—need based with copayments based on income/assets; restrictive. Sliding fee scale.
Objectives	Maintain recipient in own home and support natural support system. No nursing home preadmission screening.	Maintain recipient in own home to keep elderly people out of nursing homes. Nursing home preadmission screening to divert admissions.
Target of Benefits	Strengthening ecosystem as a whole.	Elderly client only, also contract agencies.
Provider Agencies	90% informal caregivers family or friends; 10% served by formal agencies.	Home care contract.
Program Size in FY86	17,280 elderly Home Help clients (72% of total). About half of providers are relatives.	22,000 CCP clients. Only a small number of providers are relatives (most contract agencies do not hire relatives).
Financing	Medicaid Personal Care, state funds, and Social Service block grants (formerly).	State funds, Medicaid (2176 waiver) and Social Service block grants (formerly).

7,925 Home Health users are over age 60. Deinstitutionalization of the mentally ill, which also occurred during this period, was facilitated by a shift of Department of Mental Health funding and responsibility to local mental health centers.

In Michigan the private home health care industry is less developed than in Illinois, at least partly because, in providing directly for the dependent population through the Home Help program and adult foster care, Michigan has created few market incentives for private

nursing home corporations or home health agencies to expand or move into the state. According to information from the DSS Medical Services Administration Office of Policy, total institutional beds (nursing homes and state institutions) increased by only 10.2% from 1975 to 1985 (from 44,000 to 48,513), while the elderly population grew by 22%. Over time state alternatives to nursing homes have facilitated a significant diversion of the growing poor elderly population from more expensive nursing home settings, while reimbursement for alternatives is received generally by individual informal caregivers and small homes.

Illinois's commitment to community-based long-term care was more recent and dramatic. With the closure of three state psychiatric institutions in 1982, large numbers of disabled clients were transferred to community nursing homes, reducing access to nursing homes for other Medicaid patients and necessitating development of less expensive alternatives for the poor elderly in the community. Adult foster care, which cannot be developed quickly, remains underdeveloped.

To absorb this pressure, Illinois dramatically expanded its home care service in the early 1980s. Community Care Program use expanded from 14,200 clients in FY84 to 22,085 served in FY86. The home care industry responded to this stimulus with hundreds of home care agencies bidding for contracts to implement state-funded community services. The state delivery system's turn to contract agencies was followed by very rapid growth of the home care industry.

Structure of Service Delivery and Payment System

Dispersion of Care Planning

The Illinois Community Care Program (CCP) contracts with local agencies to serve as Case Coordination Units (CCUs) for a given region for a given period. The CCU assesses the client, authorizes hours of care and payment, and monitors the provision of care. The CCU also acts as a nursing home preadmission screening authority.

In Michigan, staff in the DSS district offices act as case managers, doing the assessment, authorization, and monitoring of care. There is no nursing home preadmission screening. The department delegates all case management work "in house" to its local offices. Michigan's arrangement lacks a formal "check and balance" on the client assessment process in that the same worker who assesses client need also "hires" the

caregiver. Theoretically (and legally), the client actually employs the caregiver.

In contrast, the Illinois program separates assessment and delivery between two distinct agencies, the CCU and the provider. Selection of the contractor is a matter in which local agencies have the contracts and have space available. The client and CCU worker are constrained in their choice of provider by the contracting system.

Determining Need

The local CCU in Illinois determines the number of hours of care a client needs, that is, care to supplement the amount already being provided by family or friends. Only care in addition to that being provided by the informal system can be authorized. This determination then authorizes the local contract (not-for-profit or proprietary) agency to begin service delivery. Contract agencies hire employees (usually full time) to provide direct service. In contrast, the Michigan DSS caseworker determines the total number of hours of care required and negotiates a three-way contract with the client and the service provider to provide actual care. Care already provided by friends or relatives (except spouses or parents of a minor who are financially responsible) is compensated, as is any additional service needed.

Hiring Relatives and Friends

In Illinois there is no policy prohibiting the hiring of relatives. A survey of 76 provider agencies in Illinois conducted in June 1985 found that 39% of Illinois contract agencies would permit hiring of relatives under certain circumstances, including situations in which regular employees are unavailable, an agency employee would have difficulty meeting particular client needs, or the staff capacity is overextended (Linsk, Osterbusch et al., in press). The state neither encourages nor discourages the hiring of relatives, nor would it gain economically by either policy. The state reimbursement rate, which includes overhead/supervision costs, is the same whether the provider agency hires its own staff or a relative or friend. Employment of a relative provider is sometimes recommended by a CCU.

The Michigan DSS, on the other hand, prefers to hire relatives and friends, and does so directly. About 90% of worker wages are paid to informal providers rather than to agencies, and about half of these are relatives of the client. Caseworkers go through agencies "only in the more difficult cases" or when no informal caregivers can be found.

Agencies command a higher rate of payment, typically $7 per hour versus approximately $3.65 per hour paid to informal providers. The state can serve more clients or maximize the amount of time purchased per client by hiring mostly informal care providers, partly because they are untrained and only minimally supervised.

To summarize, in Michigan the state exercises program authority, sets reimbursement on the basis of total client needs without discounting for care already provided, and systematically encourages paying informal caregivers. In Illinois the state contracts program authority to private agencies, discounts for care already provided, and systematically encourages professional care by relying on formal agencies.

Program Background, Financing, and Flow of Funds

Centralization of Program Finances

The Illinois Department on Aging (IDOA) is a unified service system providing an entitlement to *all* persons over age 60 in need of home care. Those with incomes above poverty and not Medicaid eligible may also use the CCP, paying according to a sliding fee scale.

Michigan's is a means-tested welfare system. Only poor persons are served and local DSS offices are the main source of available state assistance. Provisions for noncategorical clients come through the limited state agency for the aging or private sources. They are underdeveloped when compared to those in Illinois, as can be seen in the expenditures (in thousands) and proportions from different funding sources compared in Table 2. Michigan's is a bifurcated system of service for the elderly with priority for categorical services.

Categorical Financing and Its History

By FY85 Michigan used Medicaid financing for fully 75% of the Adult Home Help program, and 72% of all state-provided home care. State general funds support 66% of total home care funding between DSS and the state agency for the aging. In Illinois Medicaid finances only 29% of the total CCP program, and 85% of the program is supported with state funds. Michigan's reliance on categorical Medicaid funding has apparently stimulated little expansion of services for income eligibles, whereas the greatly expanded Illinois CCP is available for all elderly persons, including high-income clients through fees. The

Table 2. Home Care Program Costs in FY1985 and Revenue Sources ($ thousands)

Sources of Revenue	Michigan DSS Home Help[a]	Michigan Aging Agency	Illinois Department of Aging Community Care Program
State General Fund	15,600.0		36,000.0
Medicaid	47,100.0		15,000.0
federal	23,550.0		7,500.0
state	23,550.0		7,500.0
Total	62,700.0	2,500.0	51,000.0[b]

a. Counts clients of *all* ages. Actually 72% of clients are aged.
SOURCE: Michigan Department of Social Services.
b. SOURCE: Illinois Department of Aging.

explanation for these priorities lies in the reasons Medicaid was included in each program.

Michigan altered its Medicaid program in 1981, when severe economic pressure threatened the very survival of the Adult Home Help Program. Previously funded with Title XX, the Home Help program already had 19,800 categorical clients. By adding personal care as a benefit to its Medicaid plan, most of the Home Help program clients became eligible for Medicaid reimbursement, thus sustaining the program.[1]

Illinois, on the other hand, added Medicaid funding in 1983, when the state was experiencing growing demand for nursing home beds because of closure of three state institutions. The courts declared the IDOA CCP to be an "entitlement" and standardized services had to be designed for statewide delivery, so the IDOA acquired a Medicaid 2176 waiver.[2] Thus in Illinois the federal Medicaid match facilitated expansion of services, while in Michigan it largely supplanted state money.[3]

Program Utilization and Unit Costs

Program use and annual expenditures in Illinois grew very quickly after the Community Care Program began in 1979, but especially after the Medicaid waiver was obtained in 1983 (see Table 3). Use in Michigan grew much more gradually since Home Help began in the early 1970s and did not increase with the infusion of Medicaid funding. The Illinois rapid growth reflects a pattern typical of states receiving Medicaid waivers in the early 1980s (Linsk, Osterbusch, Keigher, & Simon-Rusinowitz, 1986) and purchasing care from formal agencies.

Table 3. Annual Program Cost and Use

	Michigan Home Help Only		Illinois	
		% change		% change
FY84				
No. served/mo.	14,910	N.A.	14,240	N.A.
$ annual	$40.3 million		$36.6 million	
Avg. monthly cost	$225		N.A.	
FY85				
No. served/mo.	16,344	9.6%	19,524	37.1%
$ annual	$45.1 million		$51 million	
Avg. monthly cost	$230		$213	
FY86				
No. served/mo.	16,792	2.7%	22,085	13.1%
$ annual	$16.1 million		$62 million	
Avg. monthly cost	$270		$221	
Maximum allowable per mo.	$333		$980	
FY87				
No. served/mo.	17,220	2.5%	23,871*	8.1%
$ annual	$51.2 million		$79 million	
Avg. monthly cost	$248		$243	

SOURCES: Estimates for Illinois, Department of Aging; for Michigan, Department of Social Services, Adult Home Help Program. AHH Program use and expenditures are adjusted here to reflect only the use made by the elderly: 70% of total in FY87, 71% in FY86, 72% in FY85, and 71% in FY84.

While average monthly costs appear to be similar in the two states, in FY86 the maximum allowable payment in Michigan was $333 per month while in Illinois it was $980 per month. The Michigan maximum payment was kept just low enough to avoid including worker's compensation costs in the payments. The average payment, however, was about $170. Michigan also has an exception policy for some higher-cost clients. The Illinois maximum is the cost limit set relative to the cost of institutional care as required by the home- and community-based care waiver and the program's nursing home screening function. While average clients cost about the same in both states, the basis for this cost is entirely different.

To summarize, Michigan retained a categorical program tied to the welfare system to sustain clients, their families, and the state through difficult economic times by maximizing federal aid through a direct limit on per client costs. Illinois created an entitlement to service for all

elderly persons through a more discretionary limit on per client costs and indirect controls on agency costs, which supports agency interests at much greater state cost.

Client Impacts

Determination of Eligibility and Functional Assessment

In both states eligibility is determined by meeting guidelines for income, assets, a physician's certification of medical need, and a functional assessment performed by a DSS worker in Michigan and a CCU contract agency worker in Illinois.

Both states' eligibility and functional assessment forms weigh the same factors, but the eligibility criteria start from different basic assumptions. The Michigan DDS worker asks the client what services are needed, identifying appropriate individuals in the client's ecosystem who can help with each need. Some of these persons are already helping, and contracting with them is seen simply as a way to assure their continued involvement. Whether or not services are currently being provided for free is of little consequence to DDS, and the availability of informal providers is considered to be an asset. Notes one DSS worker we interviewed:

> Some of the best chore providers are friends who the client found. Many already are helping anyway. This just formalizes it. Our first approach is to have the client identify who could be a provider. We feel it works best when the client already knows the worker. Some take the money reluctantly, but they take it just the same.

The Home Help payment (or stipend) is seen as a way to keep helpers in the picture, and to help caregivers purchase what might be necessary to facilitate appropriate care. The DSS worker draws up a client service plan, which is reviewed by a nurse in the central office, then negotiates a contract with the client *and* the provider (both client and provider names appear on the monthly reimbursement checks) and monitors the time sheets submitted monthly by the provider.

In Illinois the CCU, which is reimbursed by the Department of Aging on a per unit basis, assesses what the client needs that is not currently being provided. Assessment is directed at "filling gaps" and identifying only currently unmet needs. The CCU authorizes the contract agency to provide a certain amount of care by deploying its employee, and then monitors care periodically.

Basically, then, the Illinois program "discounts" for work already being provided and assumes that it will continue without compensation. The Michigan program sees this caregiving work as sufficiently vital to the client to compensate it. The Michigan program stimulates provision of uncompensated time, simply because a closer bond exists between informal caregivers and their clients.

Caregiver Consistency and Turnover, Client Preferences and Efficacy

A 1985 evaluation of the Michigan program provides evidence that informal caregivers provide clients more regular, consistent, and reliable care (Michigan Department of Social Services, 1985; Nye, 1985).[4] In initiating competitive bidding among contractors, Illinois stimulated a significant turnover in agency contracts in fiscal years 1984 and 1985, affecting a substantial proportion of the program's clients. Stabiliy of the caregiving relation was more assured by the Michigan program's contracting with informal caregivers.

Consistent informal care can have shortcomings: It may promote dependence, may not always be in the best interest of the client (or the caregiver, who is at risk of burnout), or preclude use of better trained and consistently productive workers. Yet, formal care providers, hired to do specific tasks, cannot be permanently depended upon.

Offering the client a choice of provider respects his or her preferences in general, and may lead to more individualized attention. The continuity of an agreeable provider further allows the client to assert preferences in little choices of daily living. Allergies to household products, food tastes, and preferences in over-the-counter medications, daily routines, or favorite TV shows might constitute basic reasons an older person wants to remain at home. These preferences may in fact reinforce positive behavior and therefore promote activities that decrease depression and social isolation (Laret, 1980; Pinkston & Linsk, 1984). Knowing these "reinforcers," regular providers can be less intrusive and more respectful.

One Michigan DDS worker noted:

> There is continuity of care in getting the same person every day, but you get no such guarantee with a home health agency. With the same person the client gets security, the same things and the same routines. Some clients get less paranoid.

In allowing the client and his or her family to select the caregiver, the client's preference is paramount, but when a contract agency chooses the

caregiver, bureaucratic imperatives delimit the choice of client helpers. Agencies are constrained by formal procedures and legal sanctions; for example, they "must not discriminate in any way. If the clients don't like it, they go without service."[5] Home care aides are often assigned at random without regard to client characteristics. Client preferences are difficult to honor.

Finally, Michigan workers feel that contracts with informal care providers enhance client feelings of efficacy, dignity, and reciprocity with their caregivers. The check written to clients eligible for welfare and highly dependent on others gives persons some, albeit limited, control over the care they receive. This control helps preserve personal dignity, especially when the care is provided by a relative or friend. As another DSS worker observed:

> The client is happy that the helper is getting something for their effort, some benefit. This allows them a more secure feeling. Also this assures them that care will continue. The worker is answerable to the state, to someone else besides the client, so they are expected now to do certain things.
>
> The client also feels like less of a burden, like they are "paying their own way," and are less of an imposition on the helper.

The Illinois program requires the client to accept whatever is given from whomever gives it. The client is relieved of being the "employer" of the provider, but typically is still reliant to some extent on unpaid informal caregivers, anyway.

Professionalism, Quality Assurance, and Service Linkages

What the Michigan program offers in consistency and client satisfaction, the Illinois program compensates for in professionalism and appropriateness. In Illinois the professional medical orientation of most provider agencies assures that medical needs are monitored for a larger number of clients. Neither program is "supposed" to provide medically oriented care, though both do provide medication monitoring, dressing changes, exercise, and other medically related care to some extent. Contract agencies have direct access to medical backup.

Neither state provides much monitoring of quality of care. In Illinois there are annual client reassessments by the CCU and, of course, workers are supervised by their agency. The Michigan DSS caseworker reviews the case within 90 days after eligibility and then every 6 months, only providing ongoing supervision if a problem arises. The division of

labor in the Illinois arrangement theoretically provides more quality assurance.

As the medical needs of the elderly grow in the future, and increasingly skilled health care intervention is required, the need for low-skill caregivers will not decrease, but state monitoring staffs are not likely ever to increase sufficiently to guarantee quality care. The director of the Michigan program noted in an interview that in 17 years, "We've never had a major disaster or a scandal in all this time." The goodwill and diligence of a family support network will probably remain the best oversight upon which a client can rely in the future.

Being separated from the "aging network" of the state aging agency, the Michigan program limits client access to knowledge of other services. On this dimension the Illinois program seems stronger, although oversight by the case managers as well as networking are significantly limited by large caseloads and narrowness of functions.

Respite for Informal Caregivers

Neither state funds respite care of informal caregivers directly, although both home care services facilitate it. While Michigan allows paid informal caregivers to spend the money received as they choose, the actual number of hours provided are only loosely accounted for, and caregivers are free to "subcontract" care in order to get time off. This flexibility is more difficult to arrange in Illinois, since the agency worker is not to substitute for the care informal caregivers already provide. In providing direct care for the client, however, the CCP does allow the informal caregiver time off also.

To summarize, the differences in client impacts include the implications of the state's practices of using professional versus nonprofessional caregivers, "discounting" of informal caregiver time and effort, consistency of care, tendency to support and honor the client's preferences, support of client control, extent of external monitoring, and extent of caregiver respite.

Discussion and Implications

This examination has shown that a state's choice to reimburse formal as opposed to informal caregivers has powerful implications for client care and that it creates further incentives for the administering agencies. While both agencies and informal caregivers have proven to be effective

paid providers, neither care delivery strategy is unequivocally "better" for states or clients. Each has its strengths.

In the policy development stage in both states there was heated debate about the "morality" of paying family members to do what is perceived by some as "already their duty." Interestingly, this question received little attention after a choice was made. In Michigan one DSS Adult Services social worker noted in an interview:

> Back in 1969 there was a lot of controversy about paying parents or relatives. Now we just take it for granted. There is no question about it [now], that's the rule.

Indeed, questions of "who to reimburse for what" *are* heavily value-laden, not simple issues of efficiency or even effectiveness. Policy decisions made on the basis of political pressures or assumptions about the services of a network of agencies are rationalized as a response to client needs. Yet what is truly best for elderly persons and their support systems is not easily discovered in systems that are overly proscribed. Client needs can be easily obscured by suggestions of "immorality" in paying families. And once precedents are set, state policies gain a directional momentum.

As increasing numbers of families acquire an interest in home care, making it a highly charged issue, community-based and posthospital services grow and home care agencies are emerging as a significant political force in the state houses. The formal home care industry that has developed rapidly in Illinois now has a vital stake in future discussions of family involvement. If poor families are to remain an acknowledged part of client support systems, rather than simply a lower cost alternative to agencies, they will probably need a lobbying capacity, too. The formal care system has developed in lieu of a system that could have reimbursed informal caregivers—an alternative that Michigan's experience indicates is still a reasonable one for serving a significant portion of poor elderly clients.

Medically oriented provider organizations typically strive to maintain their discretion, generating revenue, operating efficiently, and (especially in highly competitive markets) satisfying their consumers. While hiring informal caregivers might enhance patient satisfaction, this alternative can be accepted by an industry *only* if its survival is assured first. The home health industry in Illinois now lobbies toward that end.

No such organized lobby has developed in Michigan, where the state Home Help beneficiaries are low-income citizens receiving small grants (and home health agencies serve mainly non-Medicaid clients). These

individuals are not organized, and could not be organized easily. Low-income, elderly, frail, and disabled clients and their caregivers (children and friends) have little basis for even knowing each other, much less organizing. The interests of the Home Help family caregivers are disparate and not strong ones for lobbying. Advocacy groups, such as the Alzheimer's and Related Disorders Association, nursing home reform groups, and professional societies only recently have begun to focus public attention on informal care.

Professional bias, organizational imperatives, and political pressures all too often shape policymakers' perceptions of family and informal care, encouraging reimbursement incentives that either exploit informal caregivers or undervalue them. Professionals and government employees (who are, one hopes, insulated from interest group bias) should be sensitive to appropriate informal caregiving, dispassionately weigh the strengths and weaknesses of reimbursing informal caregivers, and advocate for consideration of this policy option.

For example, in Illinois, where state workers have little discretion at the direct service level, policy and organizational changes are still possible. The state could adopt policy guidelines for contract agencies about when to "hire" informal caregivers, or the CCU could arrange care directly with informal caregivers in concert with client choice, bypassing the contract agency. Sending in an agency "stranger" could, indeed, be made the option of last resort, rather than the first choice. In Michigan more options, orientation, and training opportunities could be offered to paid informal caregivers. DSS could encourage development of special purpose agencies, cooperatives, and respite care. The alternatives suggested by each of these states are worth consideration by the other, in order to expand the choices open to clients and those who care for them.

The development of the Michigan and Illinois programs show how home care program structure and financing can incrementally become two distinct models of service delivery, one client-centered and one agency-centered, with very different implications for clients. While this analysis could not, of course, account for variation in practices throughout each state, evidence has highlighted the implicit values and impacts of client policies.

Under American laissez-faire federalism, values and precedents that are quickly reified into a program in one state are sometimes thoroughly overlooked by a neighboring state.[6] Since policymakers can be persuaded by good experience as well as by political pressure, we believe more attention to client and caregiver satisfaction would serve to make

payment to informal caregivers a more widely acknowledged policy option.

Notes

1. To avoid the Medicaid prohibition on provision of personal care by relatives, the state narrowed its definition of *family* to include *only* relatives who were financially responsible, thus allowing most relatives caring for the elderly (about half of all Home Help providers) to continue to be eligible for Home Help payments.

2. Section 2176 of the 1981 Omnibus Budget Reconciliation Act authorized waivers for home- and community-based care to states that could show that this would not increase overall Medicaid expenditures. Illinois has such a waiver to provide services to the aged; Michigan does not.

3. Michigan's choice to use a regular Medicaid service (personal care) rather than a waiver may have precluded the close scrutiny by the federal Health Care Finance Administration that Illinois and other waiver states have since experienced. Michigan complies with the Medicaid requirement for nurse supervision of personal care by having a nurse in the central state office do a "paper review." This can be variously perceived as an administrative efficiency (DSS avoids significant state quality assurance costs) or a weakness (lack of federal oversight permits poor care).

4. These two evaluations, four years apart, showed that the mean age for clients and caregivers had each increased by four years. (This may also be evidence that few new [younger] clients are being admitted to the program.) Increasingly, caregivers tend to coreside with the clients.

5. Interview with staff of a Michigan home care agency, October 1986.

6. While the evidence presented in this study may seem subjective, it has yielded salient questions about client benefits in the two states. In qualitative research such exploration has been called "perspectival." For a description of such generative methods and their value, see Lincoln (1986), and for their value to aging research, see Borgatta and Montgomery (1987).

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