Rejecting Privatization: Case Study Analysis of Local Government Decision-Making

Anna A. Amirkhanyan
American University

Recent years were marked with a large number of privatization initiatives in the field of nursing home care. The objective of this study is to understand the determinants and the process of these initiatives using qualitative methodology. Four categories of antecedents are hypothesized to influence governments' divestment decisions: (1) financial motives, (2) market failure, (3) government failure, and (4) institutional motives. Two case studies of counties that formally considered but eventually rejected the privatization option are conducted using semi-structured interviews and document analysis. While organizational performance, financial considerations, and political pressures are significant, decision-making is primarily determined by community needs, governments' safety net role in the local market, and access to high-quality care. The cases demonstrate that government agencies not only critically analyze *various alternatives, but also* valuate *them using as their ultimate criterion the ability to ensure more enhanced and financially sustainable services for community residents.*

Recent years were marked with a considerable number of local government divestments[1] in the field of nursing home care. The Online Survey, Certification, and Reporting (OSCAR) data indicates that 75 county-owned nursing homes have changed their ownership status to nonprofit or forprofit and 30 county-owned homes were terminated between March 2000 and December 2003[2] (Amirkhanyan 2007). Considering the fact that 1.5 million Americans currently reside in nursing homes (Cubanski and Kline 2002), the majority of which are forprofit and, generally, of inferior quality,[3] this trend may have serious long-term implications for the chronic care supply available to the aging cohort of baby-boomers. Among the many interesting questions raised by these reforms, is the question about the factors explaining these privatization initiatives. The main objective of this research is to understand the determinants and the process of privatization decisions in the field of nursing home care through the means of qualitative analysis. While approaching the topic uncon-

ventionally – by focusing on the government agencies that formally considered, but eventually rejected the privatization option – this study attends to decision-makers' perceptions of political, economic, and institutional forces driving their decisions.

This research is motivated by the need to examine the role of public providers of nursing home care in the face of impending demographic and fiscal challenges affecting the industry. Increasing longevity and decreasing fertility in the U.S. are expected to produce substantial changes in the population age structure (Kinsella and Velkoff 2001). As kinship resources for unpaid care become more constrained and as the number of elderly people residing alone grows, more people may be facing the risk of institutionalization (Dwyer and Vogel 1994). Parallel to the increasing demand for chronic care, nursing home care expenditures in the U.S. grew considerably during the last decade, representing the major spending category within the Medicaid program[4] (The AARP Public Policy Institute 1999; The Government Performance Project 2004). While federal and state governments have continued to pursue cost-containment strategies with respect to Medicare, Medicaid, and other programs (Pear 2006; NYAHSA 2002a, 2002b, 2004; Korb et al. 2003; Ku and Broaddus 2003), nursing homes increasingly report losing money on operations (Dobson, DaVanzo, and Sen 2003; NYAHSA 2003; Young 2004). This trend can seriously undermine their ability to provide affordable and high-quality long-term care (Cubanski and Kline, 2002). County-owned homes may be especially vulnerable to these fiscal pressures: in addition to having to find ways to operate facilities with declining reimbursement levels, in some states the county governments must also cover a portion of the non-federal share of Medicaid reimbursement to other local facilities (NYAHSA 2002a, 2003). Thus, many local governments face a choice between increasing the taxpayers' support and scaling down services. To date, many counties are reassessing their participation in the direct delivery of nursing home care through privatization (Amirkhanyan 2007). The identification of the main factors that drive these reforms is the focus of this study.

The analysis presented in this study reinforces the argument about the complexity of the privatization decision (Hefetz and Warner 2004; Heilman and Johnson 1991, 1992; Johnson and Heilman 1987; Ferris and Graddy 1986: 337; Boyne 1998). Various policy alternatives, political interests, and criteria gain significance at different stages of the decision-making process. While financial considerations, organizational performance, and political interests play a role, decision-makers are primarily guided by their perception of a county's safety-net function, community needs, and access to high-quality care. For public managers interviewed in this study, the value of enhanced and sustainable nursing home care available to community residents outweighs other considerations, especially in the absence of rigorous private markets.

Theoretical Framework

While being prevalent in the U.S. for many decades, privatization gained momentum upon becoming a central feature of the New Federalism-era efforts to promote devolution and small government (Heilman and Johnson 1991), and, later, during the National Performance Review attempts to create results-oriented, customer-centered and efficient public sector (Osborne and Gaebler 1992). The privatization promise rests on the wilsonian assumption that public tasks can be performed more efficiently and effectively when they are freed from politics and performed by the "neutral" private providers operating in free markets. Re-

flecting the reduction in the role of government and increasing involvement of private entities in the administration of public tasks, privatization embraces a range of interorganizational arrangements, including contracting out and divestment (Savas 2000, Heilman and Johnson 1992; Leavitt, and Morris 1999, 2007). While many privatization studies are concerned with the outcomes and the design of providers' oversight, a small body of literature focuses on the "make or buy" decisions. Some authors provide recommendations on various considerations that *should* be determining the decisions to privatize (Donahue 1989, Savas 2000; Moe 1987; Cohen 2001); while others offer a descriptive account of such decisions (O'Toole and Meier 2004; Ferris and Graddy 1986; Ya Ni and Bretschneider 2007; Morris 2007; Heilman and Johnson 1992; Amirkhanyan 2007).

Two main themes can be separated in this literature. First, researchers point to the complexity of the privatization decision which is determined by the interplay of many factors, including a combination of government failure, market failure, and political interests (Hefetz and Warner 2004; Johnson and Heilman 1987; Morris 2007). Little evidence has consistently pointed to one specific determinant, and each predictor has traditionally had low explanatory power (Boyne 1998; Heilman and Johnson 1991; Ferris and Graddy 1986). Furthermore, multiple goals, insufficient information, and uncertainty result in a decision process that is not rational, but informal, unstructured, and discretionary (DeHoog 1984; Cooper 2002; Heilman and Johnson 1992). Second, in the decision-making process, governments' capacity and the prominence of various determinants can change over time. At the onset of the privatization movement authors were concerned with the instances of unwise privatization (Donahue 1989), exaggerated by political pressures and the lack of procedural support:

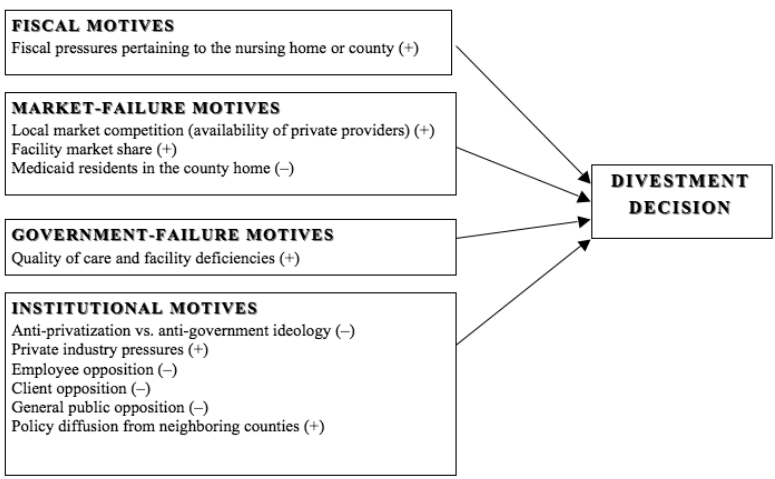
> *"They did not know or had not thought about what it was, how it worked, what its advantages and pitfalls might be, who was able to do it, what was needed to make it happen, how it related to other possible financing options, how it related to state law, or what strategies and policies they might develop to regulate it. In other words, at the point privatization was introduced, in about 1983, state agencies were a blank slate with respect to it"* (Heilman and Johnson 1991: 53).

Entering the mature cycle of privatization reforms, today's decision-makers appear to be more "pragmatic" paying less attention to ideology and more attention to citizens' needs and efficiency (Hefetz and Warner 2004, 2007; Brudney, Fernandez, Eungha Ryu, and Wright 2005). In addition, rushed decisions, poor incentive and monitoring structures, accountability concerns, providers' inability to deal with hard-to-serve clients, and failure to deliver the expected financial benefits have forced some governments to recapture the privatized services (Breaux, Duncan, Keller, Morris 2000, Froschauer 2005, Hefetz and Warner 2007; Heilman and Johnson 1992). The proportions of new contracting and contracting back-in in the U.S. almost precisely flipped from 18 and 11 percent respectively in 1992, to 12 and 18 percent in 1997 (Hefetz and Warner 2007). While these numbers do not show the proportion of governments considering but rejecting privatization, earlier studies indicate that this number is nontrivial (Johnson and Heilman 1987).

This study examines the determinants and the process of decision-making in the context of nursing home care. In this industry, divestment, conducted through termination of a government-owned enterprise or change of ownership from public to nonprofit or forprofit, has been the primary form of privatization. Using the consumption and excludability criteria[5] (Savas 2000), the economic nature of nursing home care makes it an ideal candidate for privatization, especially since local governments are under no legal mandate to provide nursing home care. Divestment of nursing homes is also relieved of transaction costs traditionally associated with contracting out (Brown and Potoski 2003): upon divestment, counties do not engage in performance oversight and leave the task of monitoring service quality to the state nursing home inspectors.

The first attempt to examine the determinants of nursing home divestments involved analysis of national quantitative data to determine the effects of various fiscal, market-related, performance-related, and institutional factors on the likelihood of divestment (Amirkhanyan 2007). The findings suggested that counties generally acted as "smart-sellers" by divesting smaller facilities with lower occupancy and lower quality of the physical plant. Privatizations were also more common in counties with competitive private markets, smaller elderly populations, and states where other privatizations were widespread (Amirkhanyan 2007). Nonetheless, the study is subject to the problems associated with the use of secondary data in the analysis of managerial decision-making: absence of direct measures and use of proxies to capture the effect of ideology, employee opposition, interest groups, general public, neighboring counties, and the private industry. Building upon this research, the current study attempts to develop a deeper understanding of the determinants and the context of privatization decisions and to help qualitatively validate the theoretical framework proposed by Amirkhanyan (2007). Specially, four categories of antecedents are hypothesized to influence local governments' propensity to divest a nursing facility (see Figure 1).

Figure 1. Determinants of Divestment Decision



Fiscal Motives. While critical evaluations of privatization still force us to question the economic benefits of private-sector provision (Boyne 1998; Sclar 2000; Wallin 1997), economic incentives play an important role in the privatization decisions (Ya Ni and Bretschneider 2007; Ferris and Graddy 1986; Hirsch 1995; Hefetz and Warner 2007; Johnson and Heilman 1987). Privatization is viewed as a way to solve fiscal problems and improve managerial efficiency and productivity (Greene 1996; Sclar 2000; Wessel 1995). Empirical research examining economic determinants of various forms of privatization shows mixed results. Boyne (1998), and Price and Riccucci (2005), find no evidence of the relationship between financial stress and the likelihood of contracting. Other studies find that revenue capacity and surpluses are in fact positively associated with privatization (as a way to acquire non-core "extra" services when slack resources are available), while fiscal stress prevents managers from privatizing by motivating higher standards for savings and more rigid scrutiny (Brudney, Fernandez, Eungha Ryu, and Wright 2005; Hefetz and Warner 2004; O'Toole and Meier 2004; Ya Ni and Bretschneider 2007). Finally, some studies of contracting determinants report observing a positive association between fiscal stress and privatization (Savas 2000; DeHoog 1984).

As opposed to contracting, which may or may not generate economic benefits through more efficient use of public funds, divestment promises immediate cost-savings. Empirical studies focusing on divestment, mostly conducted abroad, report productivity improvements, and increased profits in the privatized entities (Hinds 1995; Hodge 2000; Moore 1998; Sampson 1995; Vacha 1995). For governments, divestment of nursing homes is a way to eliminate operating expenses such as staffing, utilities, maintenance, pharmaceutical and other care-related costs and, in the case of a sale, a chance to collect revenues. It may also help resolve facilities' financial problems resulting from decreased occupancy or high Medicaid mix[6]. Thus, the decision to privatize a nursing facility may be explained by the need to reduce county expenses and dispose of a costly and unprofitable enterprise.

Market Failure. The structure of the private market is another important condition of effective privatization reforms (Cohen 2001; Donahue 1989; Hefetz and Warner 2004; Sclar 2000). Availability of private providers can influence public managers' perceptions of the need for government's presence in the market, the expectation of sufficient bargaining power and the choice available to privatizing agencies (Ferris and Grady 1986; Ya Ni and Bretschneider 2007). Empirical studies show that social service markets commonly lack competition (Van Slyke 2003). The latter has been shown to produce less new contracting and more contracting back-in (Hefetz and Warner 2004). The abundance of private supplies may encourage governments to privatize their nursing homes, while small or concentrated markets raise concerns about buyer availability and sale price, when divesting through sale, and service accessibility, when divesting through termination. In addition to the number of private providers, the public facility's market share prior to privatization also reflects market's ability to sustain the demand. Counties that operate facilities with high market share are more likely to regard their role as significant and either refrain from privatization or impose stricter criteria when selecting potential buyers.

While ensuring the general access to services is a major consideration, ability to

achieve distributional goals can be just as important. Governments often target groups that are politically "worthy", while private entities find other ways to optimize service distribution (Ferris and Graddy 1986; Savas 2000). In cases when private sector is not willing to serve the deserving groups, privatization can be counterproductive. On one hand, it can result in a loss of control over service content, delivery, and target groups (Ferris and Graddy 1986), and, eventually, have an impact on responsiveness, and democratic accountability (Heilman and Johnson 1992; Cooper 2002; Gilmore and Jensen 1998). This has been shown to result in intolerable conditions prompting reverse privatization (Breaux, Duncan, Keller, & Morris 2000). On the other hand, obligating private providers to operate like a government eliminates the advantages of free markets (Morris 2007). While the proponents of privatization claim that that "privatization can be at least as compassionate as the welfare state" (Savas, 2000: 4), empirical studies indicate that divestments can produce massive winners and losers (Dilger, Moffer & Struyk 1997; Hodge 2000). Reviewing the evidence on divestment outcomes, Hodge maintains that "the social contours of inequality appear unfortunately to have been deepened by privatizations" (Hodge 2000: 227). When political and managerial interests are in conflict, and the redistribution objective is valued more than efficiency, public provision may be preferred (Heilman and Johnson 1992).

These arguments are especially applicable to nursing home care. Public and private nursing homes serve a variety of clients. Some pay out-of-pocket fees, or use private long term care insurance benefits. The elderly undergoing short-term post-hospitalization treatment rely on Medicare, while impoverished clients, who often spend down their savings on other long-term care options, receive services that are reimbursed by Medicaid. The latter program pays less than a private insurances or Medicare. Hence, while private markets in some communities may be abundant, the providers may still be reluctant to admit Medicaid clients. In fact, private homes have the right to deny admission to residents if admitting them will result in monetary losses. Not being able to control access for the Medicaid clients upon divestment[7], counties may have access-related concerns that would prevent them from divesting the facility. Hence, in the communities where private homes serve a smaller share of Medicaid recipients, governments address market failure by serving those who might otherwise have limited access.

Government Failure. Proposing a framework for the privatization decisions, Cohen (2001) suggests that one of the most important questions that must to be considered is whether the government has the capacity to perform the task in-house. Government failure, which refers to "potential shortcomings in the process and administration of government," can be used as a valid justification for privatization (Morris 2007). Public services can lack responsiveness, efficiency or quality; they may also suffer from corruption, obsolete practices and products, oversupply and lack of need (Downs 1957, 1967; Niskanen 1971; Stigler 1971, Savas 2000). Some studies cite "better services" as a major reason for privatization (DeHoog 1984). Nursing home divestment may be triggered by poor quality of care, which has been shown to lower occupancy (Angelelli et al. 2003) and result in voluntary and involuntary termination (Castle 2005). While performance problems may be associated with poor quality of care or administration, others can be due to poor conditions of the outdated buildings constructed under different safety and sanitary guidelines. The need of costly ren-

ovations might trigger the discussion of divestment before government chooses to invest more money to sustain public operation.

Institutional Motives. Finally, divestment decisions may be influenced by a variety of institutional pressures coming from internal and external political actors, private industry, employees, other county governments, and the general public. Decision-makers' ideological preferences and values can be particularly important. Heilman and Johnson (1992: 82) provide an account of a privatization experience in Texas where, according to a manager, city officials "just feel like wastewater treatment is a basic public service and they shouldn't give it up." Privatization decisions can be ideologically charged, being based on certain assumptions about the role of government, spending considerations and political tradeoffs between the priorities of efficiency, economy, equity, and redistribution (Cohen 2001; Donahue 1989; Heilman and Johnson 1992; Savas 2000; Sclar 2000). Being the central feature of both Reagan and Clinton-era reforms and used by political candidates across both parties in the U.S., privatization hasn't become a partisan issue (Heilman and Johnson 1992). However, the idea of privatization has traditionally been associated with the so-called antigovernment or conservative ideology involving some mistrust towards government and faith in free markets (Ballard and Warner 2000; Ya Ni and Bretschneider 2007). The anti-privatization perspective is the contrary outlook determined by officials' concern that reduction of government services may affect service quality and access.

Findings pertaining to the effect of ideology on privatization decisions are unclear. In some studies, the political climate emphasizing the decreasing role of government predicts privatization (Hefetz and Warner 2004). Other studies cite examples of privatization promoted by conservative leadership and implemented in the individualistic-traditionalistic culture (Breaux, Duncan, Keller, and Morris, 2002). Three studies show no association or mixed findings (Brudney, Fernandez, Eungha Ryu, and Wright 2005; Price and Riccucci 2005; Ya Ni and Bretschneider 2007). Ya Ni and Bretschneider comment on these findings:

> *"The discrepancy somehow reflects the controversy of contracting out both as a method of reducing government size and for increasing private employment opportunities. The mixed finding blur the ideological discrepancy regarding contracting and reveals the rhetorical value of contracting as a strategy used by both parties to win popular support"* (Ya Ni and Bretschneider 2007: 541)

The present study will explore the effect of political views on the likelihood of supporting the option of privatizing public nursing homes.

Institutional Motives. Several other factors in public organizations' institutional environment can affect privatization decisions. First, private industry can and does influence government spending decisions using various strategies (Donahue 1989). Nonprofit and forprofit providers' position on privatization may be mixed. On one hand, private nursing homes may be threatened by the competition with public facilities. On the other hand, public and private providers may target different populations of clients, and hence, private homes may value their public counterparts who relieve private industry of the least desired

patients. This may be especially true in smaller markets with few providers and higher share of Medicaid clients served by the public facility.

Second, privatization savings often come from reducing the number of employees in overstaffed and inefficiently organized systems. Divestment through liquidation results in the elimination of staff working in the privatized unit, while divestment through sale results in considerable changes in staffing unless special arrangements are made to preserve the current employees (Lopez 1998; Kengor 1998). Privatization has also been found to have distributional consequences particularly in terms of employee wages (Heilman and Johnson 1992). Threatened by the prospects of staff reduction, public workers can attempt to defend their rights by exerting political pressures to prevent privatization, organizing boycotts and strikes, as well as by bribing and blackmailing the primary decision-makers (Donahue 1989, Savas 2000). Other sources of political influence include client interest groups and the general public who may be concerned with the possible effect of divestment on availability of care in their communities.

Finally, past experiences with similar decisions in the neighboring counties can inform and sway decision-makers' perceptions of the viability of certain options. A county operating in a state where other counties have divested their facilities will be more likely to consider and eventually adopt this alternative, than a county in a state where no divestments took place. The mechanism for such influence may involve coercive isomorphism (resulting from political influences in the institutional environment), mimetic isomorphism (arising from an intention to copy other entities), and normative isomorphism (affected by professional norms) (DiMaggio and Powell 1991).

Methods

I use a multiple case study design preferred when "why" and "how" questions are asked to reveal the richness of the context (Yin 1984). Two case studies were conducted in two New York State (NYS) counties. Upon developing a theory, the research proceeded to (a) selecting cases, (b) designing data collection protocol, (c) collecting data, and (d) writing individual case reports and drawing cross-case conclusions. Three primary case selection criteria were used. First, counties had to be located in NYS for easier access to the interviewees, as well as for keeping constant the state-level factors. Second, county governments had to own and operate a nursing home at the time of data collection. Third, the counties had to *formally*[8] explore the divestment option, but choose to reject it. Descriptive statistics on both cases are presented in the next section. Semi-structured[9] interviews with open-ended questions, commonly employed in other studies of privatization (Heilman and Johnson 1991), were used as a primary data collection strategy, supplemented by documentation from various sources[10]. The primary contact persons in the two counties (referred henceforth, as County A and County B), were asked to identify up to five persons who were part of the county-based decision-making body that directly considered the privatization option and made a decision. The 23-question interview guide (shown in Appendix A) incorporates several broad questions asking the respondents to describe the decision-making process, explain when, why and how the issue of privatization was raised and how it was eventually resolved (Questions 3, 8, 9, 21, and 23). Additional open-ended questions were

used to reveal the significance of various determinants of the privatization decision discussed in the theory section. Table 1 links Figure 1 and the instrument shown in Appendix A by indicating which questions were used to examine the significance of each determinant. As the table indicates, in addition to the interviews, the primary contact persons were asked for a copy or a temporary access to various documentation produced during the decision-making process. In County A, respondents demonstrated and reviewed the internal reports pertaining to the facility and the county, as well as various reports generated by consultants hired to assist in the process. I also used the elaborate web site of the nursing facility in County A for additional documentation. County B provided copies of all meeting minutes and a final report produced by the task force designated to examine the privatization issue. Respondents provided further clarifications on the documentation. Furthermore, information on other nursing homes in the county, facility, and client characteristics, were obtained by the publicly available Nursing Home Compare database[11].

Findings

State-wide context. Privatization decisions are rarely made in a vacuum: they are influenced by the history of the field and experiences in their environment. This section will begin with a discussion of the broader context of the two cases analyzed below. In the late 1700s, almshouses were the first prototypes of nursing homes established when communities first took responsibility for their indigent and elderly residents (Pepper 1982). As the heath care system developed, some states legislatively reaffirmed their ownership of such poorhouses serving both the domiciliary and medical needs of patients. In 1824, NYS passed The County Poorhouse Act calling to erect at least one poorhouse in each county (Trattner 1999). These facilities were the sole providers of institutional care until the 20th century, when the federal government's willingness to finance chronic care became an incentive for private providers to enter the market (Pepper 1982). At the time of this study, fifty out of six hundred fifty-six nursing homes in NYS were publicly owned. Thirty-nine of these homes were county-owned (Nursing Home Compare, n.d.)[12]. All providers operate under Certificate of Need/Construction Moratorium, and counties in the state are required to pay the local portion of Medicaid expenditures.

The option of nursing home privatization has been under consideration by NYS counties for almost a decade. In 1999, Ballard, Sherper, and Warner (1999), found that one fourth of all surveyed counties in NYS were considering at least one form of external restructuring of their nursing home. Similar to other fields (Johnson, and Heilman 1987), the field of nursing home care lacks a national policy to guide local government privatization decisions. Thus, it is what Johnson and Heilman (1987) would call a fluid context of policy implementation in which local governments have much flexibility. Ample media reports illuminate the uncertainty, multiple decision options, tradeoffs and changing conditions faced by the county decision-makers (Kengor 1998; Strauss 2004; Prohaska 2005; Terreri 2005; Genovese 2004). Below, are three recent examples that provide context for the decisions-making in two counties analyzed in this study[13].

The decision-making process in Niagara County, NY, is a good illustration of challenges relevant to this study (Prohaska 2005). For many years, the county used over $2 mil-

lion of surpluses from operating the Mount View home in order to balance the general budget and avoid tax increases. The facility has been renovated, but the employees were paid relatively high salaries. Gradually, the Mount View home experienced increasing inadequacy of Medicaid reimbursement and the unwillingness of its 205 employees to consider concessions on their salary and benefits. The union's claim was that high salaries accounted for excellent quality inspection results. After years of "bitter wrangling," the county solicited bids twice over the period of two years, but received one bid which was not pursued. Currently, additional construction and improvements in the amount of $13 million are being considered. The option of termination is still viable, despite its costs ($5 million) and the burden of relocating 140 patients.

Deliberations on selling, closing or renovating county homes can be quite contentious. In Montgomery County, NY, the employee association actively protested the sale of Montgomery Meadows. Similar to Mount View, employees contend that access will diminish, quality will be compromised, and costs will eventually increase as a result of the sale. While, the county Board of Supervisors voted to sell the facility, the employee groups claim that the labor union was not allowed to make its case, and that a legal action would be taken (Strauss, 2004).

The proposal to privatize the Foley Nursing Facility in Suffolk County has also been met with stiff opposition (Pirraglia, 2006). In 2006, the facility has been operating at a deficit of approximately $11.9 million. While the county executive supported privatization in light of financial looses, county legislators claimed that privatization was not something they would personally support. If privatized, the nursing home "becomes a forprofit [establishment], and that's when poor people go out the window," argued former legislator of Suffolk County, John Foley, adding "[w]hy should the poor be the first ones hit because someone wants to make a reputation for himself as a cost-cutter?" (Pirraglia 2006).

Cross-case introduction. In 2002, County A and County B had similar population size (64,721 and 61,934), income per capita ($23,512 and $23,240) and poverty rates (10.0 and 11.9 percent). County A operates a 268-bed nursing facility. Two other smaller forprofit nursing homes operate in the county. In County B, a 174-bed public facility operates along with one nonprofit and one forprofit nursing home. In both counties, public homes have a significant market share (75 % in County A, and 45 % in County B). Three in-depth interviews were conducted in County A with the Director of Long-Term Care, County Administrator and the Chairman of the Board of the Legislature. The interviewees provided temporary access to several extensive reports generated during the decision-making process. In addition, the county maintains a separate web site devoted to the county's nursing facility, used as a secondary source of data for this study. In County B, I interviewed the Planning Director, County Clerk, the Director of the Office for the Aging, and two members of the Board of Legislature. The county also provided minutes from all meetings of the task force charged with the decision to restructure the facility and the final report presented to the legislature. As mentioned in the methodology section, both counties considered and rejected the option of divestment, choosing internal restructuring (i.e., construction of new facilities). Counties A and B were governed by a board of representatives and a board of supervisors which included both conservative and liberal members.[14]

County A case study report. In County A, creation of the nursing facility dates back to 1824, after the NYS legislation established county-owned poor farms. In 1826, County A began operating a poor farm serving individuals suffering from alcoholism, mental illness and frailty. In response to the growth of elderly population, the county constructed a new 3-building structure and created an infirmary staffed with trained medical personnel to tend to the infirmed. It was subsequently expanded and renovated in the 1960s, 1970s, and 1980s. The capacity peaked at 340 beds in the late nineties, but was downsized to 268 beds. In the absence of nongovernmental operators for almost 150 years, the county home's role was to be the sole provider of nursing care for the indigent and other county residents. Before the establishment of Medicaid and Medicare programs in 1965, the county covered 100 percent of the local care costs. Afterwards, the county continued to care for the vulnerable clients, serving most of the Medicaid residents in the county. In recent years, the share of Medicaid residents has been around 80 percent.

In the late 1990s, similar to its private counterparts, the facility experienced declining occupancy, and aggressively competed for admissions. Its marketing activities, however, were hampered by a critical newspaper editorial which claimed that, being a non-taxable operation, the county was "pushing the envelope" by competing with proprietary providers. Consumer expectations have also changed significantly: rather than looking for a place to die, clients were interested in a long-term home. A new nursing home administrator, experienced in managing proprietary homes, was hired and pursued the image of a progressive facility by actively expanding services, changing the staffing mix, and reforming the admissions process.

Pointing out the differences between county home and proprietary facilities in County A, respondents argued that, being located in a small rural community, the county had a certain sense of ownership operating a nursing home in a smaller community, where most people view the facility as a community asset. The non-governmental facilities are smaller, serve fewer acute care patients, and, importantly, have a lower proportion of Medicaid patients.

The chronology of the decision-making process. The issue of restructuring in County A was formally raised at least twice. In the early 1990s, mainly due to growing operating and fiscal concerns, based on the recommendation of a consulting group, the county released an RFP to sell the facility. Two proposals were received and rejected by the board: they were not regarded "financially sound" to ensure viable operation of the nursing home in the future, including provision of continuous employment for the workforce and access for the Medicaid residents.

In 1995, the issue of restructuring was revisited. In particular, decision-makers questioned if they should be in the nursing home business. Among the reasons for these questions were declining occupancy, worsening financial performance (e.g., inefficiency of service provision in two separate buildings), and obsolescence of the physical plant (i.e., multiple maintenance problems and associated worker's compensation incidents due to injuries). These issues were brought to the attention of the county board, which authorized an engineering study. At the same time, a Steering Committee[15] was appointed to oversee the process. The committee monitored several feasibility studies conducted by various consulting firms. The first engineering study concluded that if the county decided to continue public provision of services, a new construction, rather than a renovation was in order. Next,

the Committee commissioned a second study of various restructuring options including (1) downsizing the facility, particularly eliminating one of the two buildings and renovating the other facility (2) building a new facility, (3) selling the facility, and (4) terminating it. The committee also examined service utilization projections, construction costs, and similar experiences in other counties. The findings predicted a growing need for long-term services, including institutional and community-based care. The county also conducted citizen focus groups and mailed surveys to community organizations and residents.

In 1999, the county released an RFP to explore the possibility of sale. Local forprofit homes and hospitals were contacted, but it was determined that no entity in the county had the financial capacity to "fully" pick up the county service. After the 20 months of research involving external architects, engineers, CPAs, planners and other consultants, the committee recommended retention of public ownership, consolidation of the two buildings into one and the construction of a new facility. The proposal was approved by the county board of legislature and later, by the state officials. The decision-makers chose the so-called "neighborhood model" design which allowed enhanced opportunities for resident socialization and staff monitoring. The construction process began in 2003 and was completed in 2006.

Determinants of rejecting divestment. Market-failure considerations played a major role in the decision-making process in county A. Respondents argued that the major reason for abandoning the sale was the absence of qualified[16] buyers and the fact that the private providers operating in the county were unable to fully take over the county operation. The option of closing the facility was eliminated early on, because of the nursing home's significant market share. The residents would have to seek care in other counties, which would result in a reduction of familial involvement in the post-institutionalization period. The unmet need could also overburden the local home health care program. In addition, the county home is an important employer in the community, and divestment would result in a loss of local jobs. All respondents were concerned that in the case of divestment the responsibility for providing care would eventually revert back to the government. The county administrator noted that the management was willing to make an investment to have some control over chronic care in the community. Importantly, rather than focusing on access to care for Medicaid recipients, decision-makers were concerned with access for the general population. Analysis presented in internal reports corroborates this interest.

Respondents argued that *financial concerns* played a role in the early stages of the process, but were not the primary force in their decision-making. The facility had operating losses of $1.5 million in 1999 and doubled the loss in 2000. Increased fiscal pressures were expected in the future "in the face of inadequate Medicaid reimbursement and lost IGT revenues." However, the county had non-operating revenues from the Intergovernmental Transfer Program[17], as well as from the interest earned by the fund balance accumulated during the years of surplus. Respondents noted that their facility performed "as well as any public facility could perform." While not breaking even, the county home allowed the local residents to receive care in the communities. Reiterating the market-failure concerns, respondents also noted that the county had "little choice", being the largest provider in the community. The county's overall financial stability was cited as a necessary (but not sufficient) condition for the final decision.

Government performance and specifically, the quality of nursing care was a significant factor in the decision-making process. Respondents reported excellent performance outcomes identified during the last state inspection: the county homes had no citations implying actual harm[18]. While choosing between the privatization, termination, and reconstruction, respondents prioritized the opportunity to significantly improve the access to high-quality care by creating a contemporary, technologically enhanced environment that would minimize boredom and isolation.

Respondents in county A noted that partisan politics and *ideological preferences* did not matter in the decision-making process. One of them argued that the members of both parties on the board of legislature "used common sense and understood the costs and the needs of the community, and based their final decision strictly on that." Another respondent agreed that, like any decision which needs to get the approval of an elected body, this decision was inherently political, and often triggered passionate discourse about board members' positions on the issue. However, he argued that all decision-makers shared a consensus that "something needed to be done", and due to the ample number of studies and good communication between the board and the administration, the process was not perceived as politicized or ideologically motivated.

County documentation and respondent interviews indicate that many *institutional players* were involved in the decision-making. Local hospitals, physicians, clergy, and citizen groups were interviewed, and their opinions were actively sought. The county held three community meetings and mailed out the "Letter for the Community from the County Board of Supervisors," also posted on the facility web site. Accompanied by a detailed history of the county home, service overviews, and a question-and-answer section, the letter explained the county's decision options and directed residents to the web site to explore the characteristics of the proposed new facility design. While facility residents and their families were not surveyed separately, they were made aware of the process. After the decision was made, the county received and documented positive feedback from the community members and nursing home residents. Interviewees did not actively involve any professional associations in the decision-making process: The NY Association for Homes and Services for the Aging and The NYS Association of Counties were aware of the process and, reportedly, "saw it as progressive," but did not take part in the decision.

Employee opposition was not cited as a decisive factor in county A. While the mission of the facility historically included employment for community residents, decision-makers pointed out that they could not be concerned about employment more than service quality or financial viability. "We are employers but only because we need to achieve our mission," one respondent said. In fact, the county's final decision involved some reduction of the facility staff. Respondents uniformly noted that employees were "informed about" or made "aware of" the county's decision, but no evidence of organized opposition was found.

The county documentation and interviews indicated that the decision-makers had thoroughly reviewed similar experiences in other counties. Nonetheless, the decision was made despite, rather than due to other experiences. One respondent noted that many counties chose the "privatization" model or the status quo without looking at the long-term consequences. He named private consultants who consistently recommended divestment, and

discussed the examples of other counties that had privatized but continued bearing substantial financial responsibilities. One respondent suggested that County A's experience must be a model for other counties.

Most other factors in Figure 1 were not perceived as important. Thus, respondents reported no private industry influence. They also appeared to be less influenced by access to care for the indigent clients, as opposed to the access for the general population. Overall, County A appeared to be optimistic about its final decision. The pride that the county takes in the newly constructed home is obvious from the county's web site. In 2004 and 2005, the title page of the county's web site depicted the design of the new facility and directed the visitors to a live web cam of the construction, a virtual tour of the new rooms, multiple progress photos, and other materials.

County B case study report. The contemporary nursing home in County B was built in 1956 to replace an old poor farm operating in the community for many decades. Further renovations and new constructions took place in 1972 and 1983. In 1998, the committee charged with the restructuring research began its research by developing the mission statement: the facility was established for the benefit of county residents and provide in a fiscally responsible manner the best possible care to the residents regardless of race, religion, color, national origin, marital status, sex, age, sexual preference and infirmity. Interview respondents stressed an additional aspect of their mission. One respondent noted: "[p]eople still refer to our nursing home as a poor farm. I still don't believe there is a competition for the type of patients that we serve. I don't want to refer to other homes as cherry-pickers, but most homes certainly take the most affluent. We take people who can't afford private homes." "We are the last-resort type of a nursing home, and we are proud of it," added another respondent.

The chronology of the decision-making process. In 1994, the old facility building had significant regulatory violations, including 4 beds in one room, inadequate toilets, corridor congestion, heating and ventilation problems, and lack of wheelchair accessible units. The legislative board raised the question of county's role in service delivery and authorized creation of a review committee to examine the available options. The work of the committee is documented in meeting minutes from 18 meetings held for over a year, as well as in a report outlining the committee's findings, analysis, and recommendations. Similar to county A, the committee studied the facility performance, invited specialists to provide estimates for various scenarios, forecasted the community long-term care needs' and analyzed the corresponding availability of community resources. It was determined that while the demand would continue to grow, the county had a lower bed-to-population ratio compared to its neighbors. Several alternatives were proposed: (1) do nothing, (2) privatization of the existing facility, (3) renovation of the existing facility, (4) construction and public operation of the nursing home, (5) construction and privatization.

The final report used a rational policy analysis scheme: it defined the problem, proposed the evaluation criteria, outlined the options and presented a grid with each option evaluated with respect to each criterion. The "do nothing" alternative was infeasible due to the condition of the physical plant. The privatization alternative promised savings, but required significant management capacity associated with the difficulty of findings buyers,

and ensuring that availability of care for the Medicaid groups in a privatized facility is not compromised. Finally, decreased access for Medicaid residents could have financial consequences by creating a backlog of Medicaid residents in county hospitals. Under NYS law, County B shares Medicaid expenditures with the state, and its share of hospital costs for Medicaid recipients is higher than that in a nursing home. Thus, the county might have to pay $75,000 more due to Medicaid recipients' reduced access to nursing care. Further study determined that the renovation option would cost less than a new construction, but would leave a lot of regulatory violations unsolved. Finally, the committee considered the option of constructing a new facility and privatizing it, which would ensure access to high quality care with no operational burden for the county.

The committee's report, presented to the legislature in 1995, recommended construction of a new facility and its immediate privatization conditional on the new owner's ability to ensure access to Medicaid clients, sustainability for current residents, and continuous employment for the staff. The committee argued that privatization was "the quickest and the cleanest way" of getting the best return on the funds. In 1998, upon deliberation the legislators rejected the committee's recommendation and decided to construct a new facility but maintain county-ownership.

Decision Determinants. Interviewees describing the board's refusal to approve the committee's recommendation argued that personal ideological preferences played a crucial role in the decision-making process. Thus, some legislators adamantly rejected the privatization option, no matter how good the conditions were. Describing these legislators' party affiliation, one respondent claimed that it was "almost a role reversal": while Democrats supported privatization to a nonprofit provider, Republicans, who eventually prevailed, were proud of county's nursing care capacity and resented gaining a bad reputation for not sustaining their obligation to the communities' seniors. These concerns were motivated by the perceived inability of private markets to absorb the county clientele due to their low capacity, and the county's current scale of service provision. Thus, county homes' safety-net role and *market-failure considerations* were not only important, but were also moderated by respondents' ideological preferences. One respondent claimed that those who may have been interested in purchasing the facility simply did not believe that the board was serious about privatization and, hence, did not bother to respond to the RFP. Reportedly, the many elderly board members were concerned about their own long-term care options in the community and made its opposition to privatization clear to the public.

The documents and the interviews pointed to the role of the *employees' opposition*. Facility staff was actively involved in the legislative meetings. Working overtime, providing care for their friends, neighbors, and other community residents, employees claimed that a private institution would be unable to provide the same level of care. Referring to the union involvement, one respondent noted: "They were smart, you know. They framed it as a quality of care issue." Another respondent claimed that while the union pressure was evident, he thought, "they didn't even need to carry it out. The board was really not serious about it [privatization – A.A.]." Remarkably, while acknowledging union involvement, one respondent denied the political nature of decision-making. She argued that the process was "humanistic" and quite "technical." The concern about the public needs, and the "safety-net"

rationale (particularly, a consideration that the nursing home served most of the county's Medicaid residents) was stressed by all respondents.

Respondents agreed that the impending *fiscal pressures* (including increasing health care expenditures, competition, and phase-out of the Intergovernmental Transfer Program) was one of the two reasons the issue of privatization was originally raised. Nonetheless, as one respondent noted, "fiscal considerations were never the major determinant of our decision." The nursing home has been financially stable for many years. Similar to County A, County B was in good financial standing and, if necessary, was willing to subsidize[19] the facility. "It didn't matter whether we were in the black or in the red," one respondent said.

While all respondents argued that the *quality of care* delivered in their home was "quite good" or "excellent," they agreed that the idea of constructing a new neighborhood-model facility was attractive for its ability to further improve residents' living conditions and quality of life. Concern about the past inspection results, which highlighted the shortcomings of the old buildings, was paramount in triggering the reforms. Most other factors shown in Figure 1 were insignificant or played a minor role. Respondents in County B denied any involvement of private providers in the decision-making process. Documentation indicates the committee's awareness of other divestments in the state: a manager from a neighboring county has been invited to discuss his experience with nursing home privatization, and the review committee visited the counties that had undergone privatization and consulted with them. Facility residents and the general public gave some feedback on their expectations and desires, but respondents were not certain that their involvement played any role in the final stages of the decision-making process.

Discussion

The objective of this paper is to examine the determinants, the process, and the context of nursing home divestment decisions made by county governments. The findings show striking similarities in approaches used in the two counties intensified by their similar size, the size of their long-term care markets, as well as the common historical, regulatory, and fiscal context. Both counties are located in NYS, where local governments have traditionally played prominent roles in nursing home care as well as other non-mandatory social services. It is also no surprise that both counties considered privatizing their facilities around the same time: both governments share a long history of running facilities which originated as poor farms and needed renovations to meet the regulatory guidelines. Both counties had witnessed debates on privatization in neighboring counties. Finally, both counties showed dedication to well-documented research including, a thorough analysis of trends in supply and demand and the use of external professional advice.

Several factors appear to determine the decisions in these counties. First, considerations related to *market failure and unmet community needs* appeared to be of primary importance. Privatization research reviewed earlier indicated that the need for services and the risks of dealing with private providers could influence governments' choice (Johnson and Heilman 1987). Often, public agencies recognize that privatization is likely to create additional pathologies (Morris 2007). Decision-makers in the examined cases were fully aware of these considerations. Their concerns were rooted in the lack of private market capacity

to fully pick up the county service in the face of increasing long-term care demand, the lack of eligible buyers, and the associated concerns about access to care for the general and, specifically, the Medicaid population (more evident in County B than in County A). Both counties were dominant providers with a significant market share in the community. Whether it was due to the fear that private homes would not be able to meet the growing demand, or due to the ideologically motivated skepticism towards the long term benefits of privatization, both counties were willing to maintain control over service delivery. While service to the low-income groups was carefully considered, the access to contemporary and high-quality services for the general population determined counties' decisions to stay in the nursing home business. Decision-makers perceived their facilities as important community assets and expressed their commitment to subsidize public care in the future.

Government-failure considerations were quite pronounced, but more complex than originally presumed. Both homes performed well, and there was no evidence of counties attempting to divest themselves of an enterprise with operating performance concerns. However, the building conditions motivated the privatization inquiry. While acknowledging the capacity to deliver excellent care, both counties admitted the inadequacy of the current buildings and were not willing to continue to provide substandard services, even if that meant investing more money in reconstruction. The promise of the new "neighborhood model" design and its perceived benefits explained both counties' willingness to invest in the costly reconstruction projects.

The role of *fiscal considerations* was a necessary but insufficient condition in county decision-making. Both counties were in good financial standing which gave them the opportunity to consider variety of options. At the same time, decision-makers shared anxiety related to possible fiscal pressures associated with continued operation of the facilities. They have engaged in a thorough analysis of fiscal consequences of different options and evaluated fiscal capacities of prospective buyers. While doing their best to be prudent, respondents repeatedly indicated that monetary considerations weren't the first priority: they were willing to make investments to stay in control of chronic care in their communities. In both counties, nursing home care was certainly considered a *worthy* or a *symbolic* good (Starr 1987; Hebdon and Gunn 1995; Savas 2000).

The importance of ideology was mixed across two cases. Decision-makers' ideological outlooks and party affiliation played an unusual role in one county: conservative decision-makers were more likely to share anti-privatization views and managed to effectively oppose the privatization option. Conservatives' opposition towards privatization may have been determined by the dedication to community residents, as well as by the general distrust towards "reinventing the government" reforms articulated by the Clinton-Gore administration. In the second county, political and ideological preferences did not seem to play a major role.

Analysis provided little evidence of other institutional pressures to privatize. Decision-makers in both counties argued that their final decisions were not affected by the private industry pressures. On the contrary, counties were seeking private partners, but few appeared to be interested or fit the established criteria. While both counties communicated with various constituencies on the issue of restructuring, there is not enough evidence that

community input was significant, or that these activities were not carried out to build political support. County A kept its employees and residents "informed" about the process, while in County B, it is unclear whether employees' concerns articulated to the board indeed played a significant role, or whether they served as a justification for dismissing the privatization option. Had the likelihood of privatization been articulated to the stakeholders as a viable option, the community and employee feedback could have been stronger. Finally, the findings indicate that decision-makers made their decisions independently of experiences in the neighboring counties. Interviews and document analysis unequivocally indicate that county officials critically approached similar experiences by collecting data and surveying other decision-makers. They did not, however, rush into solutions pursued by their neighbors and were eager to point out the distinctiveness of their approaches.

Limitations. Several limitations of this analysis can be pointed out. The sample examined in this study did not include the sites that considered and in fact pursued privatization. Incorporating these sites would allow us to conduct comparative analysis and determine if the findings were similar across two groups. This line of inquiry ought to be pursued in the future empirical research on privatization decisions.

Both case studies are limited to two NYS counties which restricts the generalizability of the findings. A common data collection protocol with the consent form and a standard interview guide were used to increase study reliability. The findings may apply more readily to states with a significant number of counties with unionized workforce and a shared perception of government's safety-net role, delivering public nursing home care in the context of limited private markets. The future replications of this study in other states and counties may help enhance reliability and external validity of this study. While this paper has been under review, the author has been contacted by the nursing home administrator who considered privatizing the Nathaniel Witherell municipal home in Greenwich, CT and sought relevant research on nursing home privatizations. Currently, Greenwich is renovating the old home and planning a $40-million construction of a new in-patient rehabilitation facility. This evidence suggests that our findings can be applicable to other states.

Clearly, high incidence of privatizations, cited in the earlier national study of nursing home privatizations (Amirkhanyan 2007), and multiple other media accounts suggest that restructuring decisions are becoming more prevalent. A recent New York Times article (Duhigg 2007) indicates that, since 2000, over 1,200 nursing homes of different ownership status have been purchased nationwide by large private investment groups, which may compromise quality and use complex corporate structures to dissuade consumer lawsuits in cases of neglect. While research on world-wide nursing home privatizations is limited, reforms are prevalent in other countries, including U.K., Australia, and Israel (Stevenson 2000; Wynne n.d.). The problem of comparing these trends lies in the difference between legal frameworks, definitions, scale, technology, financing and the baseline availability of public nursing home care (Day and Klein, 1987).

Generalizability concerns may also be determined by the limited number of interviews. However, according to the interviewees in both counties, the number of decision-makers directly involved in the restructuring process was small to begin with. In county A, potential subjects contacted by the author referred her to three primary decision-makers

who were most knowledgeable and played central role in the decision-making process and who were interviewed in this study. In addition to the interview data, this study relied on document analysis and retrieved information from the Nursing Home Compare web site. Other privatization studies relied on limited number of interviews for similar reasons (e.g., only a few persons in charge were able and willing to address the matter with outside interviews, and personnel turnover was significant and limited the number of qualified subjects) (Heilman and Johnson 1991).

Conclusion

The findings of this research suggest important implications for practitioners and scholars concerned with the issue of privatization. This study confirms the main findings presented in Amirkhanyan (2007): while organizational performance, financial constraints, and political pressures are important, decisions are ultimately driven by the perceptions of unmet needs and government's safety net role in the "failing" local markets. The cases demonstrate that the counties not only thoroughly and critically *analyzed* various decision options, but also *valuated* them using the benefits of the enhanced and sustainable service available to the community residents as the decisive guideline for their decision. Importantly, while some privatization theorists argue that it is critical to resist bias in assumptions while making the privatization decisions (Cohen 2001), this study show that this may be hard to achieve. Decision-makers' value-systems, their assumptions of government responsibility in addressing market failure, and willingness to make financial investments to maintain control and reduce risk, were inseparable from more pragmatic considerations of financial prudence and political optimization.

Supporting the evidence in the past empirical studies (Breaux, Duncan, Keller, Morris 2000; Johnson and Heilman, 1987; Heilman and Johnson 1992; Morris 2007, DeHoog 1984; Cooper 2002;), this research provides an illustration of the complexity of the privatization decisions that raise the fundamental public administration question of boundaries in public service provision (Kettl 2003, 2006). What begins as a rational schema of policy-making (e.g., "what options do we have and what criteria should we consider?") may turn into a political or ideological process where individual preferences and political interests of employee groups may effectively override other decision-making criteria. Some determining factors may merely trigger the decision-making process – such as operational difficulties and impending financial losses – but become less significant at the end. While some studies find that the decision to privatize is conceptually separate from the choice of providers (Ferris and Graddy 1986), cases considered in this study indicate that both questions are asked and explored in tandem. In addition, while past empirical research describes cases of haphazard decisions and early choices (Breaux, Duncan, Keller, and Morris 2000, 2002), in the present cases the counties take time to evaluate various options and criteria, and hence the process is longer and more elaborate. However, confirming the findings by Heilman and Johnson (1991) and DeHoog (1984), this study indicates that 20 years after privatization emerged as a central feature of the New Federalism era reforms, governments still lack objective decision schema or procedures to guide their inquiry about the status of state-owned enterprises. The process is, indeed, reflexive and informal (Heilman and Johnson 1991).

Practitioners embarking upon the restructuring task should be ready to question their

involvement in service provision and be mindful of possible organizational conflicts and turbulence. They should also acknowledge the complexity of decision-making and take into consideration various structural, cultural, political and analytical frames of analysis. Managers who disregard political aspects of decision-making (e.g., legislators' opposition towards privatization) and who invest their staff time and resources in cost-benefit analysis or other rational decision-making schema, may face conflicts and staff frustration. Decision-makers should specifically be aware of possible opposition of the union and be mindful of party-line differences in openness towards these decisions. Practitioners should also be aware of the existing frameworks of decision-making: while not providing the standard operating procedures for this process, they offer useful questions that can help guide the inquiry (Cohen 2001). Finally, managers should consider a wider scope of reform options, including franchises, grants, vouchers, contracting, intergovernmental agreement (Morris 1999), as well as governmental and quasi-governmental arrangements, such as public authorities (Leavitt, and Morris, 2004).

Several recommendations for the privatization research can be made based on this study. First, this research reinforces the need to study organizational decision-making that results in internal restructuring, service enhancement, status quo, or reverse privatization. Such instances may be as prevalent as external privatizations. Second, this study underscores the importance of qualitative research methodology while studying complex organizational decisions. Interviews and document analysis may be more effective tools for revealing the richness and the complexity that would not be captured in a more structured quantitative study. Finally, this research reinforced the existing proposition that public service mission, community needs and context, as well as political considerations are significant, and hence, researchers should employ multiple frames of analysis while examining the privatization decisions. Approaches focusing exclusively on financial or service-quality aspects of privatization are too narrow.

Anna A. Amirkhanyan is an assistant professor of public administration at American University, where she teaches and conducts research in the fields of organizational theory, public and nonprofit management, and research methodology. She received her PhD from the Maxwell School of Citizenship and Public Affairs at Syracuse University. Her research has been published in numerous journals, including *Public Administration Review, Journal of Public Administration Research and Theory*, and *Journal of Policy Analysis and Management*. She can be contacted at amirkhan@american.edu.

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Table 1. Predictors of the privatization decision, measurements and data sources (used in addition to the open-ended questions Q3, Q8, Q9, Q21, and Q23).

Variables (from Figure 1)	Interview Questions (Appendix A)	Other data sources
Fiscal pressures pertaining to the county government	Q10	County Documentation
Fiscal pressures pertaining to the nursing home	Q6 and Q11	County Documentation
Local market competition (availability of private providers)	Q2, Q4, and Q5	County Documentation, CMS Nursing Home Compare data
Facility market share	Q2, Q4, and Q5	County Documentation, CMS Nursing Home Compare data
Medicaid residents served in the county home	Q2, Q4, and Q5	County Documentation, CMS Nursing Home Compare data
Quality of care/care deficiencies	Q7 and Q12	County Documentation, CMS Nursing Home Compare data
Private industry pressures	Q14	
Anti-privatization vs. anti-government ideology (political pressures)	Q13	
Employee opposition	Q18	County Documentation
Client or general public opposition	Q15	
Policy diffusion from neighboring counties	Q19 and Q20	

Note: The interviews were semi-structured: the interviewer followed the order of the questions, but permitted respondents to deviate from the subject and to ask clarifying questions.

Appendix A. Interview Guide

Thank you for participating in this study. Let me reiterate again that you should feel free to say "Don't know" or withdraw from answering a particular question or all questions at any time. Let's proceed to the questions.

1. First, I would like to ask you a few questions about the history of _____ (name of nursing facility (NONF)). Please, tell me when did this facility begin operating as a county-owned nursing home?

2. I would like you to describe the role that _____ (NONF) played in this community at the time it was first opened. Please, tell me what was the mission of _____ (NONF) at the time it was first opened?

Probe: Was _____ (NONF) any different from an average nongovernmental nursing home (if any) at the time?

If yes, ask: In what way?

Probe: Did this nursing home serve a larger proportion of financially disadvantaged individuals in comparison to an average non-governmental facility during the first years of operation?

Probe: Can you please describe the long-term care (LTC) system in this county at the

time when _____ (NONF) began operating? By LTC system I mean a range of providers of chronic care (e.g., nursing home care, home health care, hospice care, respite care, etc.) in this county.

Probe: Who were the major providers of LTC in this county?

Probe: Approximately how many other nursing homes were operating in this county?

3. As you know we are here to discuss recent restructuring or reorganization of _____ (NONF). I was advised by your colleague that during the past several years _____ (name of the county (NOC)) County has considered several restructuring options for _____ (NONF) and has made a decision to pursue one particular option. Let's begin by talking about how this process began. Please, tell me when the issue of restructuring _____ (NONF) was first raised and how it was raised.

4. You talked about the LTC system in this community at the time the home was originally opened. In your opinion how had the LTC market changed by the time the issue of restructuring was recently raised?

Probe: Who were the major providers of LTC in this county?

Probe: Would you say there was a lot of market competition among nursing homes in this county at the time the issue of restructuring was raised?

5. At the time when the issue of restructuring _____ (NONF) was raised was its mission and its role in this community any different from an average nonprofit or forprofit nursing home?

Probe: Did _____ (NONF) serve a larger proportion of individuals with Medicaid than an average nonprofit facility at that time?

Probe: Did _____ (NONF) serve a larger proportion of individuals with Medicaid than an average forprofit facility at that time?

6. Would you please characterize very generally the financial performance of _____ (NONF) at the time the issue of restructuring was raised? (You do not need to provide specific figures).

7. Would you describe very generally the performance of the _____ (NONF) in terms of quality of care at the time the issue of restructuring was raised?

8. Why do you think the issue of restructuring was originally raised?

9. Would you please describe the administrative process that was initiated after the question of restructuring _____ (NONF) was on the agenda?

Probe: Was there a special task force designated to examine the issue of restructuring?

Probe: Did you hire an outside consultant (or consultants)?

Probe: What was the question that the task force had to consider and find the answer to?

Probe: What were the major policy alternatives (solutions, strategies) that were examined?

Probe: How long did it take before the final decision was made and one policy was chosen?

Probe: What policy was recommended?

Probe: Can you explain why in your opinion this policy was chosen over other options?

Probe: Did you consider the option of privatizing the facility through sale to a nongovernmental entity or creation of a new nongovernmental entity?

If yes, ask: Can you explain why this policy was not chosen?

Probe: Did you consider the option of closing the facility?

If yes, ask: Can you explain why this policy was not chosen?

10. Now let's talk about some specific factors that may have influenced your choice of the policy. In your opinion what role did the budgetary or fiscal health of _____ (NOC) County play in choosing this option?

11. How important was the financial performance of _____ (NONF) in your final choice of the policy?

12. What role did the quality of care at _____ (NONF) play in the decision-making process?

13. Would you say the process of decision-making was a political process?

Probe: Please, explain. Or, in what way?

14. Did other LTC providers in this county influence the decision-making process directly or indirectly?

If yes, ask: In what way?

If yes, ask: For example, acute care hospitals?

15. Did _____ (NONF) residents or their families influence the decision-making process directly or indirectly?

If yes, ask: In what way?

16. Have the decision-makers relied on their past experience with similar decisions in _____ (NOC)?

If yes, ask: In what way?

17. Do you know whether in the past 5-7 years _____ (NOC) has ever terminated, sold or contracted out a service or a business that it was previously operating?

18. Did considerations about the employees of the _____ (NONF) play any role in the decision-making process?

If yes, ask: In what way?

19. Have the decision-makers relied on the past experience of other county governments with similar issues?

If yes, ask: In what way?

20. Did you seek any help or information from professional associations such as NYAHSA (New York State Associated for Homes and Services for the Aging), or NYSAC (New York State Associated of Counties)?

21. Suppose that the _____ (NOC) County today existed without _____ (NONF). What would that be like in your opinion?

22. Could you tell me on what is going on with the _____ (NONF) now?

23. Is there anything else you would like to tell me about your decision to restructure the (NONF) or about its future?

Notes

[1] As explained later, divestment is one of several forms of privatization.
[2] This period lies between two quarterly waves of the OSCAR data. The first wave is dated March 2000 and contains information on all U.S. Medicaid and/or Medicare certified facilities surveyed during the period of up to 15 months prior to 03/2000. The second wave is dates December 2003, and contains information on the same cohort nursing homes surveyed up to 15 months prior to December 2003.
[3] As shown in Harrington et al. 2000; Harrington et al. 2001; O'Neill et al. 2003; Amirkhanyan, Kim, and Lambright (forthcoming).
[4] 56.6% in 2002.
[5] Savas (2000) suggests that services appropriate for individual consumption and excludability (i.e., possibility of restricting service access to paying customers only) are more appropriate for private provision of services.
[6] These factors have been found to predict nursing home terminations (Angelelli et al. 2003; Castle 2005)
[7] A private divested facility is nonetheless subject to government regulations and inspections.
[8] Documentation of this policy alternative by a county-based decision-making body in a formal document, or a request for proposals constituted formal consideration of the privatization option.
[9] The interviews were semi-structured in the sense that the interviewer followed the order of the questions, but permitted respondents to deviate from the subject and to ask clarifying questions.
[10] Such documentation included materials provided by county respondents, as well as the Nursing Home Compare Online database publicly available on the Centers for Medicare and Medicaid Services web site.
[11] generated by the Centers for Medicare and Medicaid Services and available at http://www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteria.asp?version=default&browser=IE%7C7%7CWinXP&language=English&defaultstatus=0&pagelist=Home&CookiesEnabledStatus=True.
[12] These numbers are similar to the nationwide distribution: 65.5% forprofit, 28.3% nonprofit, and 6.2% public homes (Amirkhanyan 2007).
[13] Counties mentioned in these three examples are not the subjects of this study.
[14] New York is a state with democratic legislature and a republican governor, and with individualistic-moralistic political culture (Mead 2004).
[15] The task force included the county administrator, the chairman of the board of the legislature, other members of the board of legislature, county public health director, individuals from non-county LTC organizations, as well as an individual from the county buildings and grounds department.
[16] Importantly, one respondent argued that bureaucratic procedures might have deterred potential buyers.
[17] Intergovernmental transfer program allows the states to transfer funds to and from local government facilities (including nursing homes) in order to finance the state share of Medicaid; the program has been argued to be carried out to inflate state share of Medicaid costs and maximize the federal Medicaid funding.
[18] These findings were corroborated by the author using the Nursing Home Compare data base.
[19] One respondent claimed that it was quite frustrating for the review committee members to be unable to find out exactly how much subsidy the nursing home was getting throughout these years.