Parenti, M.
1977 Democracy for the Few. 2nd Edition. New York: St. Martin's Press.

1978 Power and the Powerless. New York: St. Martin's Press.

Piccone, P.
1978 "The Crisis of One-Dimensionality." Telos 35:43-54.

Schiller, H.
1971 Mass Communications and American Empire. Boston: Beacon Press.

1973 The Mind Managers. Boston: Beacon Press.

1978 Communication and Cultural Domination. New York: Pantheon.

Sorel, G.
1950 Reflections on Violence. Chicago: Free Press.

Thomas, M.
1970 The Luddites. New York: Schocken.

Weber, M.
1979 Economy and Society: An Outline of Interpretive Sociology. Berkeley, CA: University of California Press.

HOME-AND COMMUNITY-BASED SERVICES: ADMINISTRATIVE ORGANIZATION AND PROGRAM ADEQUACY*

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Mid-American Review of Sociology, 1985,
Vol. X, No. 2:29-54

Considering the adequacy of federally authorized and state implemented community-based long-term care programs, this research examines the characteristics of these programs most conducive to elderly persons living in the least restrictive environment that their health will allow. Results suggest that service availability and population explain a significant proportion of the adequacy of the Home- and Community-Based Services program in Kansas.

This study investigates the relationship of governmental decentralization to state-implemented and administrated health and social service programs and furnishes a detailed analysis of such a program. The decentralization of Medicaid has occurred in response to two factors, the rising costs of health care and the increase in the elderly population. The result was the creation of the Home- and

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*This paper earned the author a SRPP Student Paper Award presented by the Gerontological Society of America at the annual meeting in New Orleans in November, 1985.

Community-Based Services (HCBS) Program to provide non-institutional, long-term care for financially elgible elderly. The HCBS Program operates under a centralized set of guidelines and a decentralized administration. This study provides an account of how the program operates in different settings and the relative impact of the decentralized and centralized components upon the program adequacy. Program adequacy is defined as the ability of HCBS, under its current organizational structure, to provide a sufficient level of care and quality of services to its elderly clients to enable them to live in the least restrictive environment possible.

Decentralization of Health and Social Service Programs

In response to the growth of the elderly population of the United States and the increase in long-term care costs, the federal government has responded by altering health and social service programs affecting the elderly, including Medicaid. These changes include cutbacks in federal allocations, cancellation of various service requirements and the shift of decision-making responsibilities concerning program administration to the state level. This shift of decision-making involves the devolution of the state bureaucracy or decentralization, defined as the:

> division of an organization into autonomous or semi-autonomous decision units where performance responsibilities and controls are vested in subordinate organizational units. In human terms, decentralization maximizes the amount of individual judgment discretion exercised by an administration (Scott and Mitchell, 1972:150).

Under decentralization the decision units are organized in a horizontal structure wherein authority is exercised in all directions according to the functional requirements of the structure (Olsen, 1968:303). Authority is vested in role incumbents on the basis of technical

knowledge, experience and ability rather than on formally designed offices of centralized unions. The structure is sectioned into a number of semi-autonomous units, each performing specific activities for the whole organization. The horizontal system operates with all units exercising relatively equal power, including those units charged with policy-making and those performing the duties of administration (Tobin, Davidson and Sack, 1976:84-87).

Theoretically, decentralization works to the advantage of individuals by making it possible for them to participate in public decisions and counteract the imbalance of power found in centralized organization (Hart, 1976:606). No longer is the decision-making limited to the administrative elite, for the powers of authority are divided and more decisions are subject to local majorities (Zuckert, 1983:422).

Decentralized programs, some argue, may be beneficial to entire com- munities as well as to potential clients. The increase in local autonomy allows communities greater freedom to generate innovations to meet the specific needs of their locality and the clients within that community (Tobin, Davidson and Sack, 1976:86-87).

Others view the impact of decentralization as negative rather than positive, arguing that it is the current administration's intention to transfer many social welfare programs to the management of state and local governments in an effort to reduce the expenditures of the federal govern- ment. From this perspective the administrative decentralization of domestic social programs may be one route toward President Reagan's goal of rejuvenating American enterprise, making public policy an adjunct of his economic policy and reducing government support by increasing private expenditures. (Zuckert, 1983:421-422). Decentralization may also weaken the political power of the disadvantaged by moving the center of political action from the national level into state and local jurisdictions (Estes, 1979:194-195; Estes and Newcomer, 1983:255-259). Only the most well- organized, stable and well-funded interest groups are able to build and sustain the momentum needed for involvement in widespread social action efforts.

The placement of demands for program funding upon the most fiscally assailable levels of decision-making is another negative effect of decen- tralization. State and local governments are subject to many pressures which increase their financial vulnerability, including:

1. shrinking federal funding for social service programs,
2. diminishing state revenues due to the lowering of individual and corporate taxes, unemployment and recession,
3. restrictions upon state-imposed taxing and spending limitations, and
4. reductions in local tax revenues resulting from cuts in property taxes (Estes and Newcomer, 1983:257).

Decentralization may also cause the replacement of national policy goals and duties with more autonomous and variable objectives of state and local policies. Program variability affords little assurance of uniform policies or of equity for the politically powerless. State and local governmental levels are easily politicized, giving local interest groups a strong voice in the decision-making process.

Finally, because of the extreme variability in goal selection and processes of implementation, decentralization may make it nearly impossible to evaluate the effects of health and social service programs. The reduction of comparable program data and of uniform federal data leaves the divergence of programs and their inconsistent implementation unidentified and not available for challenging the dominant economic and political interests of the federal government.

Medicaid -- Long Term Care

Medicaid (PL 89-97, 42 USC 1396) was enacted in 1965 to provide federal financial assistance to states for payments of Medical Assistance on behalf of cash assistance recipients, the categorically needy, and, if the state chose, other medically needy persons whose health care costs would soon exceed personal income and resources (Directory of Federal Aid to the Aging, 1982:46). Program administration takes place at either

the state or local level, providing the state plan has been approved by the supervising federal agencies, the Department of Health and Human Services (HHS) and the Health Care Financial Administration (HCFA).

Long-term care, especially nursing home care, has long been the greatest cost for Medicaid. In FY 1980, 44.2% of the federal Medicaid expenditures were for the reimbursement of long-term care services, with 34.2% being spent for institutional care (Cohen, 1983:11).

During 1981 several amendments to Medicaid altered federal funding responsibilities, service availability and state discretion concerning the planning, implementation and provision of services. This federal legislation, the Omnibus Budget Reconciliation Act of 1981 (OBRA) - (PL 97-35), was presented as a measure to reduce the federal bureaucracy. OBRA was introduced to the states through an ideological commitment to decentralization while promising the elimination of any excessive decision-making junctures between the federal and state governments. Even when questioned about the ulterior motives of OBRA, the reduction of federal dollars to Medicaid, federal officials argued that state and local discretion in decision-making was the main objective of the program amendments. These amendments, however, called for federal Medicaid contributions to be reduced by a small, yet annually increasing, percentage: 1982-3%; 1983-4%; 1984-4.5% (Hovbjerg and Holahan, 1982:9; Cohen, 1983; PL 97-35, 1981).

OBRA-1981 also authorized the Secretary of the HHS to waive many of the federal requirements under Medicaid's home care program. This legislation created a long-term care waiver program under which individual states could offer various home- and community-based services to beneficiaries as an alternative to institutionalization. Section 2176 of PL 97-35 allows the Secretary, by waiver, to provide that a state plan may include as "medical assistance" under the plan Home- and Community-Based Services (HCBS). The waiver permits the use of Medicaid monies to reimburse non-institutional long-term care services to the Medicaid eligible who would otherwise require institutional care.

In order for a state waiver to be granted the state must provide assurances to HHS that per capita spending under the waiver will not exceed the per capita spending

had the waiver not been granted. The federal regulations for administering the HCBS program require strong proof by the states that the expanded in-home benefits are not heading toward an increase in long-term care spending (Sager, 1983:49).

Along with the guarantee to not increase total program expenditures, states must provide assurance that: 1) necessary safeguards, including adequate standards for provider participation, have been included to pro- tect the health and welfare of service recipients; 2) financial account- ability will be claimed for funds spent on home- and community-based services; 3) an evaluation be made of eligible persons' need for services and that persons likely to require institutional care be informed of the alternatives under the waiver and given the choice of institutional or HCBS care; and 4) the state provide annual, consistent information to HCFA (HHS) about the impact of the waiver program upon the type and amount of medical assistance provided under the state's Medicaid program [PL 97-35, Sec. 2176 (c) (2) (A-E)].

Federal regulations [PL 97-35, Sec. 2176 (c) (4) (B)] provide the following catalogue of service types which states may offer under the HCBS waiver: 1) case management; 2) homemaker/home health aid; 3) personal care; 4) adult day health; 5) habilitation; 6) respite care; and 7) other services requested by the state and federally approved.

This brief description of the origin and regulations of the HCBS program clearly illustrate that the program is the product of organiza- tional decentralization. The legislation permitting program waivers, defining the eligible population and regulating program spending is the result of federal decision-making. However, decisions about the implementation and administration of the program are made by state and local officials. Guidelines and standards remain centralized at the federal level while the actual operation of the HCBS program is decen- tralized at the state and, in most instances, the local level.

Methodology

A combination of factors makes the state of Kansas an excellent choice for the site of this study. First of

all, in 1980 the number of persons in Kansas aged 65 years and over equalled 306,262. This figure represents nearly 13% of the state's total population, while this age group only equals 11.2% of the nation's population. Because of this large elderly population Kansas ranks eighth among all states in percapita residents aged 65 and over (State of Kansas, 1983:111-112).

A second reason for choosing Kansas as the setting is the presence of a decentralized, state-implemented program offering non-institutional long-term care for Medicaid eligible clients. The HCBS program in Kansas was developed when the state was permitted the waiver and gained allowance for the provision of Medicaid reimbursable, in-home and community-based services to eligible clients in Kansas.

Much of the data presented in this paper was gathered during an eval- uation of the HCBS program in Kansas. This evaluation, conducted by the Long-Term Care Gerontology Center at the University of Kansas Medical Center in Kansas City, Kansas, began in the summer of 1984. In the fall of 1984 a descriptive and evaluative questionnaire concerning the program was distributed to the 185 personnel involved with the implementation and operation of the program. These persons, all employees of the program's administrative agency, the Kansas Department of Social and Rehabilitative Services (SRS), included administrators/supervisors, social workers, case managers and registered nurses. These positions may be held at the commu- nity, county, or SRS Management Area level. The final date for survey collection was January 31, 1985, with a total return of 116 or 62% of all potential respondents.

Analysis

The frequency of survey responses gathered from each employee position is shown in Table 1. Social workers comprised the largest proportion of respondents. Over 40% of the returned surveys were from those persons directly connected with the program's operation -- screening and assessing potential clients, locating service providers and interpreting administra- tive rules and regulations. Because of their intimate acquaintance with daily program management, social workers' responses

were helpful in deter- mining the true effects of the program's administrative organization.

Case managers returned 23% of the surveys. Case managers also interact directly with the program's clients, and the case managers' eva- luations of the quality of care received by these clients add important insights to the analysis. Like the social workers, their responses were largely confined to the specific program in which they participated. Area-wide and state-wide evaluations of HCBS were provided by those persons in the administrative/supervisory positions (34%), who are most likely to be well informed about past governmental legislation creating and affecting the program in Kansas. The staff members in other employee positions reported on the effects of this legislation on their specific programs throughout the state.

Implementation

In order to examine the implementation of a program lacking total federal authority and supervision, staff members were asked what resources were available that affected the implementation of the HCBS Program.

Some SRS staff members listed several responses while others listed only one. As Table 2 shows, the four most frequently mentioned resources, mentioned by respondents from both the community and the state level of administration, were competence of SRS staff, interagency cooperation, competence of service providers and services offered by HCBS. Those who mentioned the competence of the SRS staff as a factor affecting program implementation included persons employed at the state, county and community levels.

Another important factor was interagency cooperation, which is promoted by the federal and state governments, but is accomplished within the SRS Management Areas and within the county and community divisions throughout these areas. The third factor noted as significant in successful program implementation, the competence of the service providers, depends upon those persons and their skills within the counties and communities where the individual programs are in operation. Thus, even though the services offered in this long-term care program are the result of federal and

state legislation, the services available to clients depend upon resources at the local level as well as the funds available for program operation. Clearly, the success of HCBS depends upon the people and their skills available for program operation, especially at the very basic levels of program administration. Federal and state governments play a large part in the financial matters of the program, but the administration and provision of services are the result of decentralized authority and local support.

Respondents were also asked to name the factors that inhibited the successful implementation of the HCBS program within their areas. As Table 3 shows, the most frequent responses, difficulty in locating providers and the lack of available services, may result from county or community deficiencies, such as low population and lack of community support for the program. However, the other characteristics listed, low provider wages and difficulty interpreting the program's rules and regulations, are the effects of governmental decisions and practices at both the federal and state levels. Also, as discussed earlier, the services offered to clients are affected by governmental allocations to Medicaid and reimbursement rates for service providers.

The factors affecting a successful implementation as well as those inhibiting the process can be linked to the program's administrative organization. Nearly all of the factors associated with successful implementation result from the endeavors of the decentralized administration, the SRS staff and persons at the local level. Factors inhibiting implementation appear to be the direct effects of centralized authority. Low wages for providers, lack of resources to offer services, and vague program rules and regulations all point toward the federal government as the root of these problems.

Services

Several questions in the survey were employed to obtain data regarding what services were available to elderly persons in the HCBS Program and to test the following hypothesis: The availability of program services to elderly clients of HCBS is positively related to program adequacy.

Staff members were asked to describe the availability of the services permitted by the waiver approval as well as other long-term care services. The non-waiver services were included in the survey because of their role in assisting the HCBS Program in preventing the unnecessary institutionalization of its elderly clients.

Responses by SRS staff members about the services offered revealed a wide range of availability throughout the state. The frequency of services available are presented in rank-order in Table 4 which shows that many of the HCBS services are clustered at the bottom of the list of services available to the program's elderly clients. A possible explanation for this occurrence is the relative newness of the program compared to other programs offering long-term care. HCBS service packages offer few, if any, community-based services. However, it may also be that the infrequent availability of waiver services may be attributed to the fact that HCBS is a state-implemented program. This interpretation supports the notion that decentralization causes difficulties in program organization, in the attainment of service providers and in the provision of information about the program both to the public and to potential clients.

Program Adequacy

The dependent variable in this analysis, perceptions of program adequacy, was measured by staff responses to the following question: In your opinion, are there an adequate range and amount of resources currently available in your community to enable the majority of your elderly clients to live in the least restrictive environment that their health will allow?

Sixty percent of the respondents argued that the available resources were adequate. The remainder felt that not enough resources were available to support an adequate environment for the majority of their elderly clients. The staff members replying that available resources were inadequate were then asked to list impediments which made an adequate environment difficult to obtain. A large proportion (44%) cited the lack of services available to clients as the major hindrance. Other barriers listed were the lack of available service

providers (14%) and insufficient financial resources (14%).

Services:Program Adequacy

In order to test the hypothesis that the availability of program services is positively related to program adequacy a new variable, SERVICES, was computed. The variable SERVICES equals the sum of the positive responses for each service, divided by the total number of services in the survey.

In analyzing the relationship between thee availability of services and program adequacy, a cross-tabulation of the variables, SERVICES and LEAST RESTRICTIVE ENVIRONMENT, was performed. The results of this cross- tabulation are summarized in Table 5. An examination of these figures shows that once the SERVICES score reaches 1.29 the number of respondents claiming that HCBS is able to attain the least restrictive living environment for its clients becomes less frequent than the number replying that this environment is not attainable. This distribution indicates that the lack of services available to clients hampers their chances of remaining in their homes and communities rather than being institutionalized.

In continuing the investigation a binomial table was constructed using the data in Table 5. In Table 6, the sixteen values of SERVICES were collapsed into two values, one equal to or less than 1.24 and the second equal to or greater than 1.29. The yes:no ratios support the assumption that the number of services available determines the living environment of the elderly clients of HCBS since a large decrease in the ratio occurred as the service value rose from 1.24 to 1.29. Along with these figures the chi-square scores, significant at the .001 level, confirmed that the more services offered by the HCBS Program, the greater the client's chances of remaining in his or her own home and community rather than being institutionalized.

Population:Program Adequacy:

Service delivery to the rural and urban aged was examined by Gary Nelson in 1980. His work analyzed the

implications of "rural-urban differences in Area Agency (on Aging) organizational characteristics and capacities, success in resource mobilization, contextual environment influences, and service expenditure patterns" (Nelson, 1980:200).

Nelson's study found that rural Area Agencies provide fewer services than do urban agencies to their elderly populations. Rural agencies were deficient in the provision of services to the "at-risk" aged, including therapeutic or counseling services and self-care services (Nelson, 1980:205). The limited range of available services and the lack of services for the frail elderly provided proof, according to Nelson (1980:206), that rural Area Agencies have more difficulty implementing a continuum of care for the elderly than do urban agencies.

In this study the seventeen SRS Management Areas in Kansas were divided into two population-based categories, rural and nonrural, in order to test the following hypothesis: The population of an SRS Management Area is positively related to program adequacy.

The basic assumption of this is that SRS Management Areas of low population are not able to implement or operate the HCBS Program as well as those areas of higher population. The division into population categories was based upon the average county population per area, using 1980 census figures and the following formula: Total population of SRS Management Area / Number of Counties in SRS Management Area. The nonrural areas included those with a mean county population greater than 20,000. Those areas with less than 20,000 inhabitants per county were categorized as rural. Table 7 demonstrates the population categorization and the proportion over-65 population in each area.

A new variable was computed to allow a comparison to HCBS programs across the state in regard to population size. The variable, NEW AREA, was assigned a value of 1.0 when representing nonrural areas and 2.0 for rural.

Nonrural areas reported a 5:1 ratio in their programs' ability to attain the least restrictive living environment for their elderly clients. In rural areas, however, the ratio was only 1:1; that is, the least restrictive environment is attained only 50% of the time. To determine possible causes of this population

difference, the NEW AREA variable was cross-tabulated with SERVICES to discover if this variable also varied according to population size.

Chi-square scores for the association between these variables (Table 9), were great enough to confirm the relationship between the variables NEW AREA and SERVICES. Clearly, the adequacy of the HCBS Program in areas of higher population is greater than in the rural or low populated areas. Thus, although much of the Kansas population is located within rural, low populated counties, according to staff member reports, these persons have the fewest services available and are often not able to reside in the least restrictive environment that their health will allow.

Conclusion

The data from this analysis of the HCBS Program in Kansas may be used as empirical evidence to substantiate several of the arguments supporting the centralization of health and social service programs. Centralized programs have been favored by many because of the supposed nonexistence of geographical boundaries within the program area. Clients, according to this perspective, would not be excluded from services because they were fragmented or inconsistently available.

These arguments are supported by the research data. Throughout Kansas there is a wide variation in the services offered by HCBS. Variability is especially evident when comparing rural and nonrural management areas by their geographical area and population size. The lack of services was often reported as a barrier to the successful implementation of the program in various parts of the state. These findings indicate that geographical boundaries and inconsistent service availability exist in decentralized programs. They also suggest that a completely centralized program has the potential to reduce the fragmentation and inconsistencies existing between rural and nonrural management areas in Kansas by terminating the geographical boundaries in the current program and by operating the program through a single administration.

Proponents of centralization also claim that a centralized program would allow greater accountability

and uniformity of standards and would facilitate the performance of extensive tasks that smaller, fragmented administrations would find difficult, if not impossible, to accomplish (Tobin, Davidson and Sack, 1976:85-89). Within a single administration there are greater opportunities to maintain consistent standards and operate programs that meet total population needs.

The data provide support for these claims by revealing that the HCBS Program fails to maintain accountability and uniformity of one particular standard, the availability of waiver services. Further, the decentralized administration of the HCBS Program in Kansas has made assessment of total population needs and control over the services offered throughout the state difficult.

Estes and Newcomer (1983:257) hypothesize that the decentralization of health and social service programs places the service demands on the most "fiscally vulnerable" levels of government, the states, counties and communities. Federal policy-makers locate the responsibility of program operation where pressures to limit social service expenditures are the strongest.

Indications that this claim is valid are found in the analysis of the survey data. The inconsistency of services available to HCBS clients may be explained by difficulties in program administration and the lack of service providers, both of which result from restricted resources for program operation. Also, with less than two-thirds of the SRS staff members replying that adequate resources are available to enable program clients to live in the least restrictive environment possible, it is evident that state and local governments are unable to provide financial support for human service programs.

Estes and Newcomer (1983:258) also argue that placing program operation at the state and local levels provides little assurance of consistency or uniformity of programs or of equity for the eligible population throughout the state. The fragmentation produced by decentralization supposedly weakens the impact of a program on both the "personal lives" and the "aggregate social condition" of the eligible population.

The variation of service availability in Kansas supports this argument. When comparing population size

with service availability it was discovered that rural HCBS clients are able to reside in the least restrictive environment only 50% of the time. These program variations in relation to population size confirm the claim of Estes and Newcomer (1983:258) that decentralization of program operation weakens the impact of the program on both the personal lives and the overall social situation of the eligible population.

These findings indicate that, without the return of federal revenues to state and local governments, health and social service programs may not be successfully implemented or maintained. In order for the adequacy of the programs to be improved, the resources lost through federal cutbacks and tax dollars no longer reallocated to states must be returned. Davis and Shannon (1981:18) propose four alternatives for these dollar turnbacks: state and federal revenue sharing on a formula basis, tax sharing on an origin basis, conditional relinquishing of a federal tax ("pick-up" tax) or unconditional relinquishing of a federal tax.

With the return of financial resources, health and social service programs may be legislated, funded and operated at the state level. A smaller geographic area and lower population could be included in the operation of these programs than those centralized at the national level. This would make the tasks of assessing total population needs and provision of services easier to accomplish. Also, with program regulations and funding standards centralized at the state level, it would be possible to assure the uniformity and accountability of program standards and to guarantee the adequacy of the program itself.

However, state operated and funded programs have drawbacks along with the benefits listed above. Interstate comparisons of the programs may reveal differences in eligibility standards and services available. Even so, the current organization of these programs fails to produce consistency at the intrastate level. The state level administration with the dollar turnbacks from the federal government should allow for a congruent and equitable program statewide. After this task is accomplished a second problem may be addressed, finding a method to assure comparable health and social service programs throughout the nation, not only within individual states.

REFERENCES

Bellin, S.S. and Miller, S.M.
1983 Economic Policy is the Dominant Social Policy. American Behavioral Scientist, 26(6), 725-737.

Bovkjerg, R.R. and Holahan, J.
1982 Medicaid in the Reagan Era. Washington, DC: Urban Institute Press.

Brown, D.R.
1983 Administering aging programs in a federal system. In W.P. Browne & L.K. Olson (Eds.), Aging and Public Policy: The Politics of Growing Old in America. Westport, CT: Greenwood Press, 201-219.

Cohen, J.
1983 Public Programs Financing Long-term Care. The Urban Institute, National Governor's Association.

David, A.J. and Shannon, J.
1981 Stage Two: Revenue Turnbacks. Intergovernmental Perspective, 7(2), 18-25.

DeLoach, C.P., Wilkins, R.D. and Walker, G.W.
1983 Independent Living: Philosophy, Process and Services. Balitimore: University Park Press.

DiNitto, D.M. and Dye, T.R.
1983 Social Welfare: Politics and Public Policy. Englewood Cliffs, NJ: Prentice-Hall, Inc.

Directory of Federal Aid for the Aging.
1982 Santa Monica, CA: Ready Reference Press.

Estes, C.L.
1979 The Aging Enterprises. San Francisco: Jossey-Bass Publishers.

Estes, C.L.
1983 Austerity and Aging in the U.S.: 1980 and Beyond. In A.M. Guillemard (Ed.), Old Age and the Welfare State. Beverly Hills: Sage, 169-185.

Estes, C.L. and Newcomer, R.J.
1983 The future for aging and public policy: two perspectives. In C.L. Estes, R.J. Newcomer, et al. (Eds.), Fiscal Austerity and Aging. Beverly Hills: Sage, 249-270

Eustis, N., Greenberg, J. and Patten, S.
1984 Long-term Care for Older Persons: A Policy Perspective. Monterey, CA: Brooks/Cole Publishing Co.

Gibson, R.M., Waldo, D.R. and Levit, K.R.
1983 National health expenditures, 1982. Health Care Financing Review 5(1), 1-31.

Granneman, T.W. and Pauly, M.V.
1983 Controlling Medicaid Costs: Federalism, Competition and Choice. Washington, DC: American Enterprise for Public Policy Research.

Hart, D.K.
1972 Theories of government related to decentralization and citizen participation. Public Administration Review, 32, 603-621.

Lindeman, D. and Pardini, A.
1983 Social services: the impact of fiscal authority. In C.L. Estes, R.J. Newcomer, et al. (Eds.), Fiscal Austerity and Aging. Beverly Hills: Sage, 133-155.

Nelson, G.
1980 Social services to the urban and rural aged: the experience of area agencies on aging. The Gerontologist, 20(2), 200-207.

Olsen, M.E.
1968 The Process of Social Organization. NY: Holt, Rinehart and Winston.

Piven, F.F. and Cloward, R.A.
1982 The New Class War. NY: Pantheon Books.

Sager, A.P.
1983 Planning Home Care with the Elderly: Patient, Family and Professional Views on an Alternative to Institutionalization. Cambridge MA: Ballinger Publishing Co.

Scott, W.G. and Mitchell, T.C.
1972 Organizational Theory: A Structural and Behavioral Analysis. Homewood, IL: Irwin-Dorsey.

State of Kansas.
Statewide Health Coordinating Council and the Department of Health and Environment.
1983 The 1984 Plan for the Health of Kansas. Topeka, KS.

State of Kansas. Department of Social and Rehabilitative Services.
1982 Waiver Request to the Secretary of the U.S. Department of Health and Human Services. Topeka, KS.

Swoap, D.B.
1982 Federalism: new directions at the Dept. of HHS. In R.B. Hawkins, Jr. (Ed.), American Federalism: A New Partnership for the Republic. San Francisco: Institute for Contemporary Studies, 121-130.

Tobin, S.S, Davidson, S.M. and Sack, T.A.
1976 Effective Social Services for Older Americans. Detroit: University of Michigan - Wayne State University, Institute of Gerontology.

U.S. Public Law 97-35.
1981 Omnibus Budget Reconciliation Act of 1981. Washington, DC: U.S. Government Printing Office.

Yates, D.
1973 Neighborhood Democracy. Lexington, MA: D.C. Heath and Co.

Zuchert, C.H.
1983 Reagan and that unnamed Frenchman (De Tocqueville): on the rationale for the new (old) federalism. The Review of Politics, 45(3), 421-442.

Table 1: Employees Represented in Survey

EMPLOYEE POSITION	NUMBER	PERCENT
Administrative/Supervisory	39	34.0
Social Worker	48	41.0
Case Manager	27	23.0
Registered Nurse	1	1.0
Other	1	1.0
TOTAL	116	100.0

Table 2: Implementation

SUCCESSFUL	Percent of Total
Competence of SRS Staff	20.7
Interagency Cooperation	18.2
Competence of Service Providers	14.9
Services offered by HCBS	14.9

Table 3: Implementation

UNSUCCESSFUL	Percent of Total
Difficulty Finding Dependable Providers	17.7
Lack of Services Available	14.2
Low Wages/Reimbursement Rate for Providers	14.2
Difficulty Interpreting Program Rules and Regulations	10.6

Table 4: Frequency of Services Available

SERVICES	Number	Percent	Total Response
1. Homemaker Service*	114	99	115
2. Senior Center	112	98	114
3. Protective Services*	111	97	114
4. Nutrition Services	107	94	114
5. Professional Counseling	103	90	114
6. Adult Care Homes	99	89	111
7. Personal Care*	97	85	114
8. Recreation	96	84	114
9. Transportation	95	83	114
10. Advocacy Services	90	82	110
11. Home Maintenance*	88	79	112
12. Telephone Reassurance	82	73	112
13. Night Support*	82	72	114
14. Chore Services*	80	71	112
15. Medical Alert Services*	76	67	114
16. Employment Placement	73	66	111
17. Hospice Care*	72	63	114
18. Respite Care*	64	56	114
19. Adult Day Care*	53	48	111
20. Adult Family Homes*	45	41	111
21. Congregate Living Homes*	40	36	111

* services included in waiver program

Table 5: Service Availability and Program Adequacy

SERVICES	PROGRAM ADEQUACY			
	YES (1)	NO (2)	TOTAL	RATIO
.95	4	0	4	4.0:0
1.00	7	1	8	7.0:1
1.05	13	1	14	13.0:1
1.10	9	2	11	4.5:1
1.14	8	1	9	8.0:1
1.19	6	3	9	2.0:1
1.24	5	2	7	2.5:1
1.29	5	7	12	0.7:1
1.33	3	6	9	0.5:1
1.38	1	8	9	0.1:1
1.43	0	6	6	0.0:1
1.48	4	2	6	2.0:1
1.52	2	3	5	0.7:1
1.57	0	2	2	0.0:1
1.90	0	1	1	0.0:1
TOTAL	67	45	112	1.5:1

Table 6: Service Availability and Program Adequacy

SERVICES	PROGRAM ADEQUACY			
	YES	NO	TOTAL	RATIO
1.24	52	10	62	5.2:1
1.29	15	35	50	0.4:1
TOTAL	67	45	112	1.5:1

chi-square (observed) = 33.83 chi-square (corrected) = 31.61***

*** p <_ .001

Table 7: SRS Management Areas -- Population per County

NONRURAL	COUNTIES	MEAN POPULATION	% OVER 65
Wichita (5)	1	366,531.0	9.6
Kansas City (12)	1	172,335.0	11.6
Olathe (13)	2	162,539.0	7.9
Topeka (11)	2	111,278.0	10.6
Hutchinson (6)	4	33,567.3	15.1
Parsons (16)	2	23,993.0	17.1
Pittsburgh (17)	3	23,179.7	19.3
RURAL AREAS			
Winfield (7)	5	19,860.8	16.1
Junction City (9)	8	19,688.6	11.4
Chanute (15)	4	19,494.0	18.3
Emporia (8)	5	15,706.6	16.9
Osawatomie (14)	6	14,225.3	17.4
Hiawatha (10)	5	13,294.2	16.4
Salina (3)	8	12,385.3	17.5
Pratt (4)	12	9,914.8	17.6
Garden City (2)	19	6,574.3	11.5
Hays (1)	18	6,523.8	16.8

Table 8: Population and Program Adequacy

POPULATION	PROGRAM ADEQUACY			
	YES	NO	TOTAL	RATIO
Nonrural	25	5	30	5.0:1
Rural	32	30	62	1.1:1
TOTAL	57	35	92	1.6:1

chi-square (observed) = 8.632 chi-square (corrected) = 7.337*

* p <_ .01

Table 9: Population and Service Availability

POPULATION	SERVICES			
	1.24	>1.29	TOTAL	RATIO
Nonrural	26	4	30	6.5:1
Rural	31	32	63	1.0:1
TOTAL	57	36	93	1.6:1

chi-square (observed) = 12.021 chi-square (corrected) = 10.494*

* p <_ .01

THE STRUCTURE OF DEMOCRATIC COMMUNICATIONS

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Mid-American Review of Sociology, 1985,
Vol. X, No. 2:55-76

Democratic Communications offer the practical, everyday solution to the problem of alienation. Alienation is located in those social relations which systematically distort communication rather than in purely religious or intellectual life. Five such distorting relationships are mentioned. The solution to alienation set forth here posits a system of communication which is a) information rich, b) interaction rich, and c) oriented to the constitution of a public sphere. Several theoretical domains are used to ground this presentation among which are the Marxian theory of alienation, information theory, cybernetics theory, systems theory and communications theory. The more disorganized a system is, the more important it is that the communications media be organized democratically in order to maximize the search for quality variety.

> One of the most interesting parts in Wiener's Cybernetics is the discussion on "Time series, information, and communication," in which he specifies that a certain amount of information is the negative of the quantity usually defined as entropy in similar situation...Take an issue of the New York Times, the book on Cybernetics, and an equal weight of scrap paper. Do they have the same entropy? According to the usual physical definition, the answer is "yes." But for an intelligent reader, the amount of information contained