Regulating U.S. Nursing Homes: Are We Learning From Experience?

Nursing home regulation does not work very well, but we need to understand the reasons for its failings in order to improve it.

by Kieran Walshe

ABSTRACT: The quality of care in U.S. nursing homes has been a recurrent matter of public concern and policy attention for more than thirty years. A complex regulatory system of state licensure and federal certification is in place, but problems of poor quality and neglect and abuse of patients still appear to be endemic. This paper describes how the current system of regulation developed, examines its impact, and draws on the wider literature on regulation to outline some characteristics that may have detracted from its effectiveness and contributed to its disappointing results. Future regulatory reform should pay more attention to the lessons of regulation in other settings and make more use of research and formative evaluation.

FOR MORE THAN THIRTY YEARS the quality of care in nursing homes has been a recurring matter of public concern and debate in the United States. In the 1970s and 1980s researchers presented compelling evidence that the frail and vulnerable recipients of nursing home care were too often neglected, mistreated, or abused and that the system of nursing home regulation and licensure was largely ineffectual, failing to protect residents and to prevent quality problems.[1] In 1986 the Institute of Medicine (IOM) published an influential report that set out detailed recommendations for reforming the regulation of nursing homes, intended to bring about a major improvement in quality of care.[2] Those recommendations were largely accepted by Congress, enacted through the Nursing Home Reform Act as part of the Omnibus Budget Reconciliation Act (OBRA) of 1987, and have since been gradually implemented by the Centers for Medicare and Medicaid Services (CMS, formerly HCFA).[3]

It seems that the same quality problems that spurred calls for greater regulation in the 1970s and 1980s are still endemic in many

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nursing homes today.[4] Nursing home regulation remains the constant subject of policy attention, most recently via the Senate Special Committee on Aging, the Clinton administration's nursing home initiative, and the U.S. General Accounting Office (GAO), which has issued a stream of reports.[5] The IOM has just revisited nursing home regulation as part of a wider review of long-term care and has concluded that while regulation has brought some limited improvements in nursing home care, further reform is still needed.[6]

This paper briefly describes how nursing home regulation has developed in the United States from 1986 to the present and summarizes what is known about the impact of regulation on nursing home care. It then draws on the wider literature on regulation and its impact to outline some characteristics of nursing home regulation that may have detracted from its effectiveness and contributed to its rather disappointing results. The paper concludes that fundamental regulatory reform is needed but that greater attention should be paid to the lessons of regulation in other settings, and more use should be made of research and formative evaluation to improve the effectiveness of nursing home regulation.

The Development Of Nursing Home Regulation

More than 1.6 million Americans live in nursing homes, most of them elderly, frail, and vulnerable persons who are likely to live out the remainder of their lives there. Because of their physical or mental infirmity and their dependence on their caregivers, they are often not able to act as assertive, well-informed consumers. In 1999 the United States spent about $90 billion on nursing home care (about $55,900 per resident), and 60 percent of the cost was borne by states and the federal government through the Medicaid and Medicare programs.[7] The great majority of nursing homes (93 percent) are operated in the private sector, 67 percent of them by for-profit organizations, including a growing number of large corporations whose facilities house thousands of residents.[8]

Concern about quality of care in nursing homes can be traced back at least to the 1950s. Before the establishment of Medicare and Medicaid in 1965, there were essentially no federal standards regulating nursing homes, regulation was left up to the states, and standards varied widely. Although federal regulations were enacted once Medicare and Medicaid began to pay for nursing home care, they were inadequate in design, poorly implemented, and often unenforced by the federal and state agencies that shared regulatory responsibility. A succession of studies in the 1970s and early 1980s highlighted continuing serious problems with nursing homes' quality of care and were one reason that Congress asked the IOM in 1984

to investigate and recommend reforms.[9]

The IOM's 1986 report outlined proposals for a comprehensive and radical reform of regulatory arrangements.[10] The standards for nursing homes were to be revised to make them more focused on quality of care, more detailed and comprehensive in their coverage, and more explicit about the rights of residents. The survey or inspection process used to check compliance with the standards also was to be reformed, to make it less oriented toward paper records and structures and more focused on direct observation of care and communication with residents. A much broader range of enforcement mechanisms was to be introduced, including financial penalties, blocks on payment for new admissions or all residents, provisions to take over the management of failing homes, and ultimately termination of participation in Medicare/Medicaid. These reforms passed Congress with broad bipartisan support and were enacted as the Nursing Home Reform Act, part of OBRA 1987.

It took the CMS (then HCFA) three years to put into operation the regulations to implement OBRA 1987 and seven years to implement the regulations needed to put its regulatory enforcement mechanisms in place. Over that time political support for the OBRA 1987 reforms slackened, and although a number of proposals were brought forward in Congress in the mid-1990s aimed at repealing or weakening nursing home regulation, none were successful.[11] Even once the reforms were in place, a succession of GAO reports highlighted continuing quality-of-care problems in nursing homes and major flaws in OBRA's implementation and the management of nursing home regulation by the CMS. In response, the Clinton administration launched a nursing home initiative in 1998 aimed at improving the effectiveness of regulation.

The current regulatory arrangements are administratively complex but conceptually straightforward. The CMS is responsible for producing and maintaining federal regulations with which all homes that wish to participate in Medicare and Medicaid must conform. The state survey, licensing, and certification agencies are responsible for surveying or inspecting nursing homes to check their compliance with the regulations, investigating complaints, and reporting the results to the CMS. When deficiencies are identified, state agencies and the CMS regional offices share responsibility for taking enforcement action to make sure that nursing homes deal with the problems and come back into compliance. The CMS funds most of the costs of Medicare/Medicaid certification and oversees the performance of state survey agencies to make sure that the federal regulations are implemented appropriately. States also have their own licensing requirements, with which all homes (not just

those participating in Medicare and Medicaid) must conform. State regulations may parallel or exceed federal requirements and generally have separate provisions for licensing nursing homes, undertaking surveys or inspections, investigating complaints, identifying deficiencies, and taking enforcement action.

Impact Of Regulation On Performance

Although numerous studies have examined the implementation of nursing home regulation and the management of regulatory arrangements, these reports are of limited help in determining what impact regulation has had on nursing home performance and the quality of nursing home care.[12] The impact of regulation has not been much researched, in part perhaps because it presents several methodological challenges. First, the absence of any control or comparison group (since virtually all nursing homes are regulated) means that one can really only study changes in quality over time and attempt to determine whether those changes can be attributed to regulatory interventions.

Second, much of the data available on the quality of care in nursing homes are the product of the regulatory process itself, which means that changes in the process affect the data and are difficult to distinguish from underlying changes in quality. For example, changes in the deficiency rates found in nursing home surveys over time or variations in these rates across states may result from differences in the stringency, scope, or implementation of the survey process or from real differences in quality of care, and it is not possible to disentangle the two.[13] Third, the reliability, validity, completeness, and timeliness of much of the routinely available data (such as the Minimum Data Set data collected on every nursing home resident and the Online Survey Certification and Reporting, or OSCAR, database of survey findings) have been questioned, and some caution is needed in using such data.[14]

■ **Residents' physical condition.** Nevertheless, there is some evidence that the quality of care in nursing homes has improved greatly in many areas over the past ten to fifteen years and that at least some of that improvement has been brought about by the OBRA 1987 regulatory reforms.[15] For example, the inappropriate use of physical and chemical restraints has declined, as have rates of urinary incontinence and catheterization. Hospitalization rates also have fallen (which may be a good proxy for quality of care if poor care increases the risk of hospitalization). On the other hand, pressure sore rates have not changed; malnutrition, dehydration, and other feeding problems remain relatively common; and rates of bowel incontinence have risen slightly.

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■ **Industry changes.** Nursing home regulation also may have had effects on the nursing home industry. For example, in other settings it has been found that regulation favors larger, multisite corporations over smaller, single-site, owner-operated businesses, because larger organizations can spread the fixed costs of regulation across a greater business volume and are more able to develop in-house skills in regulatory compliance.[16] Over the past decade the nursing home industry has become increasingly dominated by major corporations, the largest of which control hundreds of nursing homes and many thousands of beds. This trend may reflect the economics of nursing home provision but also may have been accelerated by nursing home regulation.

■ **Costs of regulation.** The costs of nursing home regulation are difficult to quantify. The CMS and the states spent $382.2 million in 2000 on running the state licensing and certification agencies that implement both federal and state nursing home regulations. This is only 0.4 percent of all spending on nursing home care and equates to about $22,000 per nursing home or $208 per nursing home bed.[17] However, these costs are probably only a small part of the overall costs of regulation, most of which fall on nursing homes themselves. First, nursing homes incur costs in dealing with the regulatory agencies, preparing for and hosting survey visits, gathering and providing data, responding to complaint investigations, and so on. Second, nursing homes incur costs when they are required to make changes to comply with the regulations. The experience of other sectors suggests that these interaction and compliance costs are probably greater than the regulatory agency costs outlined above, but there are no data available to allow these costs to be quantified.[18]

■ **Stakeholders' debate.** Most stakeholders in nursing home regulation—such as the CMS and state survey agencies, nursing home providers, consumer groups, researchers, and independent governmental evaluators—would concur that the OBRA 1987 reforms have brought some improvements in the quality of nursing home care, but beyond that, opinions fall broadly into two camps.[19] Some think that because many quality problems still exist, regulation should be tightened with tougher standards and more aggressive enforcement, and they argue for more frequent inspections, more use of sanctions and penalties, and more uniform and rigorous application of existing regulations. Others believe that the current

regulatory burden is already too great and that regulation has created a punitive, adversarial climate that is hostile toward quality improvement. They argue that regulation should be simplified and reduced, focused mainly on a smaller number of "problem" nursing homes, and reoriented toward a model based on cooperation and partnership between regulators and regulated organizations. There is little consensus among stakeholders about whether the benefits of nursing home regulation over the past decade outweigh its considerable costs. The debate has become polarized and politicized and, in the absence of robust empirical evidence on the effectiveness of regulation, is likely to remain so.

Learning From Regulation In Other Settings

A substantial literature exists on the use of regulation in a wide range of settings outside health care, including manufacturing industries, financial services, public utilities, and government agencies.[20] Although much research on regulation has been specific to particular countries, industries, or settings, a generic understanding of regulatory issues has begun to develop that offers many transferable concepts, models, and ideas.[21] However, it has been noted that most regulation tends to develop in isolation from similar regulatory initiatives or approaches in other settings, with little sense of a regulatory community able to share findings across sectors.

Over recent years a fast-growing literature has developed on regulation in health care, including the regulation of hospitals, managed care organizations, and the health care professions.[22] It appears that there is scope to make more use of this wider literature on regulation in health care and in other settings, both to review the progress of nursing home regulation to date and to influence its future development. To that end, I draw on this literature to outline six major problems in nursing home regulation and to explore how regulatory reform could improve the effectiveness of regulation in assuring and improving quality.

Problems Of Nursing Home Regulation

■ **Deterrence, compliance, and responsive regulation.** Regulatory theorists often use two terms—*deterrence* and *compliance*—to describe the paradigms within which regulators work.[23] In brief, deterrence regulators see the organizations they regulate as "amoral calculators," out to get what they can and willing to break the rules if they need to and can get away with it. As a result, their approach to regulation is formal, legalistic, punitive, and sanction-oriented. In contrast, compliance regulators see organizations as fundamentally good, well-intentioned, and likely to comply with regulations if they

can. Their approach to regulation is generally more informal, supportive, and developmental, and they use sanctions only as a last resort. Each approach has different advantages and disadvantages.

For example, deterrence regulation is likely to achieve change more quickly and may be more suited to situations in which the regulator is dealing with large numbers of heterogeneous organizations. However, it is usually more costly and can provoke defensive behavior by regulated organizations, which subverts the objectives of regulation. On the other hand, compliance regulation is cheaper, may achieve more change in the longer term, and may work better when dealing with a smaller number of more homogeneous regulated organizations. However, it can be easily undermined or circumvented by regulated organizations if they are determined to do so.

In practice, regulators often make use of a mixture of deterrence and compliance approaches. Robert Kagan and Lee Axelrad argue that regulation is very much a product of the political, social, and economic environment and that approaches to regulation vary considerably among countries.[24] The United States is perhaps the foremost proponent of deterrence regulation and uses this approach in many fields in which other countries use compliance approaches successfully.[25] Kagan and Axelrad characterize the American tradition of deterrence regulation as "adversarial legalism" and assert that it has high costs, a divisive and corrosive effect on relationships between organizations, and few compensating benefits.

Before 1987, American nursing home regulators were much criticized for doing too little to deal with persistent poor performance and widespread, long-standing quality problems. While approaches varied from state to state, many used a compliance model in which education and persuasion were seen as the main tools for improvement.[26] As a result, it was argued, some nursing homes flouted the regulations with impunity, regulators did not have sufficient powers to deal with such offenders, and so the whole process of regulation was brought into disrepute. Since the implementation of the OBRA 1987 reforms, nursing home regulation has developed most of the features of deterrence regulation, with great stress placed on developing and applying formal, written regulations; undertaking inspections or surveys; recording deficiencies and issuing citations; and enforcing regulation through the use of sanctions such as civil money penalties, denials of payment, or decertification. It is therefore not surprising that it suffers the problems of deterrence regulation, such as strained relationships between the various players in regulation, a defensive and uncooperative response to regulation from nursing home providers, and high regulatory costs. Despite its overt deterrence orientation, U.S. nursing home regulation still seems

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to be ineffective at dealing with many problems of persistent poor performance. It is interesting to note that nursing home regulation in other countries is generally less deterrence oriented, as is the regulation of other types of health care organizations in the United States.[27]

A number of regulatory theorists have argued in recent years for a more contingent or adaptive approach to regulation, and their ideas may have some relevance to the regulation of nursing homes. Called "responsive" or "smart" regulation, this approach seeks to find a more effective regulatory paradigm that combines some of the benefits of both deterrence and compliance regulation.[28] The main principle of responsive regulation is that regulatory methods and approaches should be adapted in response to the behavior of individual regulated organizations. A broad, graduated hierarchy of regulatory interventions and enforcement actions is used, and while most regulation takes place at lower levels, the regulator has the capacity and the will to use higher-level interventions and actions if need be. In this way, most of the benefits of compliance regulation—such as cooperation, information sharing, negotiated agreement, and low regulatory costs—are retained, but the powerful incentives and sanctions of deterrence regulation are still available.

At present, nursing home regulation exhibits few, if any, of the features of responsive regulation. Nursing homes are surveyed annually and treated similarly, regardless of whether they are good or poor performers—a "cookie-cutter" approach that neither adequately rewards good-quality care nor deals forcefully enough with poor-quality care. Nursing home regulators have little scope to use their discretion and professional judgment in applying the highly prescriptive regulations and are actually prevented by the regulations from giving nursing homes advice or assistance. It seems that there is considerable scope to make use of the ideas of responsive regulation to create regulatory arrangements for nursing homes that would be less focused on deterrence, more capable of monitoring and discriminating between nursing homes on the basis of their performance, and more able to tailor regulatory interventions to the performance needs of individual nursing homes. This might not reduce regulatory costs overall, and would mean investing more in regulating poor-quality nursing homes, but it would be a much better use of regulatory resources.

■ **Regulatory fragmentation.** Regulation is sometimes fragmented, with different agencies responsible for different functions or performance areas and even some direct overlap of oversight. Regulatory fragmentation may result in duplication, an increased regulatory burden and higher regulatory costs, and some conflict or confusion between the requirements of different regulators. It also may weaken regulatory oversight, because no one agency has either all of the information needed to assess performance or complete responsibility for dealing with performance problems.[29]

The regulation of nursing homes is fragmented in three ways. First, although federal responsibility rests with the CMS, it is split between the central agency and its regional offices, which deal separately with developing and promulgating regulations and setting guidance for state survey agencies, on the one hand, and with financing, contracting with and overseeing state survey agencies, and enforcing regulations, on the other. These responsibilities are only brought together at the level of the CMS administrator, and there is good evidence that this fragmentation causes communication problems and reduces the effectiveness of regulation.

Second, regulatory responsibility is split between the CMS and the state survey agencies, and the relationship does not appear to be an easy one, marked more by bureaucratic direction and dissonance than by real interagency dialogue or collaboration. The CMS sets out in excruciating detail in its *State Operations Manual* what it expects state agencies to do, but those agencies struggle to fulfill their mandate in the real world within the resources that the CMS allocates to them.[30] State survey agencies have a dual accountability—to the CMS and to their state government—so conflicts can and do arise. The CMS is meant to oversee the performance of state agencies but has done little to monitor them and in any case has limited powers to do anything about performance problems.

Third, there is really not one system of regulation, but two—federal certification and state licensure—running side by side. This results in some duplication, occasional conflicts, and considerable confusion. For example, when state survey agencies find a deficiency at a nursing home, they may choose to pursue it through state or federal enforcement mechanisms, or both.

The current level of fragmentation creates unnecessary complexity for regulators and for nursing homes, probably reduces the effectiveness of regulation, and certainly increases its costs. These regulatory structures are an accident of history; they reflect the gradual and piecemeal development of state and federal regulatory arrangements since 1965. A simpler regulatory structure with one regulator would probably be much more efficient and effective. However, im-

provements could be made to the current system of regulation by simplifying and bringing together responsibility within the CMS and taking steps to develop a more proactive and productive relationship between the CMS and the state survey agencies.

■ **Clarity and priority of the regulatory mission.** While some regulators are agencies established for the purposes of regulation, others undertake regulation as one of a number of related activities. There can be some benefits to integrating the regulatory function with other responsibilities, but the main disadvantage is that the clarity and priority of the regulatory mission may be compromised when the agency trades off regulatory objectives against other objectives. Regulatory organizations for which the regulatory mission is not clouded by a host of other competing nonregulatory objectives (such as the Food and Drug Administration or the Occupational Safety and Health Administration) may be more likely to be effective regulators because they can focus on a clear regulatory mission.

Nursing home regulation is only one responsibility among many for the CMS and for the state government departments in which the state survey agencies are located. It competes for attention with a multitude of other policy priorities, and it tends to be seen as a rather unexciting, unglamorous, and low-profile function. In these circumstances, it is likely that nursing home regulation will always struggle to secure resources and gain sustained policy attention unless it is forced up the policy agenda by external influences such as pressure from consumer groups or independent evaluators.[31] This problem of prioritization may be one of the reasons why the implementation of the OBRA 1987 reforms proceeded so slowly (with the CMS taking seven years to introduce some regulations). Reorganizing responsibility for nursing home regulation within the CMS could help to provide greater clarity of mission, but putting nursing home or long-term care regulation in the hands of a separate agency would probably be the most effective way to ensure that the issue gets the attention it deserves. The same problems may exist at the state level, especially when nursing home regulation is one relatively small function of a much larger entity. It might not be feasible to have a separate state agency for nursing home regulation except in the largest states, but it would be possible to reorganize responsibility for nursing home regulation to give it greater visibility and policy attention.

■ **Balancing independence and accountability.** Regulators have to be held accountable for what they do, and public regulatory agencies are generally made accountable by reporting, directly or indirectly, to an elected legislative body. However, regulators sometimes need to take actions that may be politically unpopular or that may arouse the opposition of important stakeholder groups, and in

these instances they need some degree of freedom to act without interference. In any case, a regulator's credibility with stakeholders may depend upon its perceived independence from sectional interests and its ability to act as a nonpartisan "honest broker." Regulatory governance arrangements therefore need to provide a balance of accountability and independence.

Nursing home regulation has become highly politicized, and various stakeholders attempt to influence the regulators and to shape the legislative framework for regulation. For example, nursing home providers have made large political contributions; in some states nursing home providers are prominent in the local political party hierarchies; and some state and federal legislators have substantial financial interests in nursing home care. On the other hand, there are powerful, well-organized national and state consumer and citizen groups that often run influential campaigns. Legislators at both the state and federal levels have taken a close interest in the work of nursing home regulators, held hearings and commissioned reports from evaluators, and sought to influence both, either directly through new legislation or indirectly by controlling the resources made available to run the regulatory agencies. While this kind of attention may be an inevitable result of the political process, it does not necessarily make for effective regulation. Regulators working in the glare of political and public attention tend to be highly cautious, risk-averse, and overinfluenced by the likely political and public response to their actions. Although it is perfectly legitimate and desirable that providers, consumers, legislators, and other stakeholders should be involved in shaping the regulatory process, nursing home regulators need to be freed up to do their jobs without undue interference.

Regulatory accountability is also an important guard against having the regulatory process be "captured" by any one sectional group or interest, most commonly the organizations that are being regulated. However, it can be argued that nursing home regulation has been captured, not by the providers but by the payers for nursing home care. The CMS and state governments act both as regulators of nursing homes and as funders (through Medicare and Medicaid) of 60 percent of the costs of nursing home care. If the CMS, as regulator, makes changes in the regulations that will cost money to implement, then the CMS, as funder, comes under pressure to increase reimbursements. The current debate about whether federal regulations should be amended to set minimum staffing ratios for nursing homes is an illustration of this problem. Some estimates suggest that federal minimum staffing ratios could increase the costs of nursing home care by $3–$15 billion a year, depending on where the mini-

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mum staffing level is set, and the nursing home industry has been quick to assert that Medicare and Medicaid should be ready to increase reimbursement levels accordingly.[32] While affordability is an important issue, and the costs and benefits of any regulatory changes should be carefully analyzed, it is probably unhealthy for the regulatory process to be so completely in the hands of a single interest group. A more balanced model of regulatory accountability might involve the separation of regulatory and funding responsibilities in state and federal government agencies and the provision of a formal role for a wider range of stakeholders such as consumer groups, provider associations, educators, and researchers in holding nursing home regulators accountable for their performance.

■ **Regulatory alignment.** Regulation is most effective when the requirements or objectives of regulatory agencies are aligned with other influences on the behavior of regulated organizations. For example, regulatory compliance with environmental health standards among food producers is generally good, because the producers recognize that any major food-related disease outbreak can result in great harm to their commercial interests, such as loss of market share and damage to their public image and reputation. Alain Enthoven argues for a "procompetitive" approach to health care regulation in market situations, in which, as far as possible, the regulatory regime is designed to reinforce or complement existing market incentive structures or influences on regulated organizations.[33]

However, for nursing homes, the pressures of the marketplace are not well aligned with the objectives of regulation.[34] While nursing home regulation attempts to promote high quality of care, the market does not seem to reward nursing homes that provide such care. First, restrictions on nursing home developments have weakened competition by constraining supply in many areas, even though occupancy statistics now suggest that there is some excess capacity overall.[35] Second, nursing home consumers (potential residents, their families, and caregivers) are poorly equipped with information to compare quality among nursing homes. Thus, their choices are often driven mainly by the proximity of the home to family members. Once they are residents of a home, their dependence on it makes it difficult to speak out about quality problems, and it is difficult for them to move if the quality of care does not meet their expectations. Third, the financial pressures on nursing homes from

low rates of Medicaid reimbursement have driven many to reduce their spending to sustain their profits.

When regulatory objectives and market pressures collide, as they do for nursing homes, organizations will often attempt to reconcile the conflicting pressures, but ultimately the stronger market pressures are likely to prevail. For nursing homes, regulatory alignment might be improved if measures were taken to increase competition on quality grounds and to provide greater financial incentives to provide good-quality care. Regarding competition, initiatives that offer nursing home consumers much more information about the facilities when they are making their initial choice would be helpful, and some examples already exist. It also would be useful to make it easier for residents to change nursing homes. Regarding incentives, some measures of quality need to be incorporated into the complex prospective payment system for Medicare and Medicaid so that a proportion of reimbursement is dependent on the quality of care. This is not an easy task, but it is disappointing that past experiments with quality-based reimbursement have never been implemented widely, despite their promising results.[36]

■ **Regulatory tripartism.** The relationship between a regulator and a regulated organization is not simply bilateral. Many other stakeholders have an interest or involvement in the organization's performance, and it has been argued that regulatory arrangements should be designed to make use of or co-opt these other groups for the purposes of regulation—an approach that is called *tripartism.* For example, workers in a manufacturing firm have a strong self-interest in good workplace safety arrangements, and so occupational safety and health regulations often require manufacturers to have some kind of formal employee involvement and representation in workplace safety structures and processes. In this way, workers and their representatives are brought into the regulatory process, where they can be an important source of information to the regulator and can help to promote regulatory compliance. Regulatory agencies have very limited resources in comparison with the organizations they regulate, and even the most intensive approaches to regulatory oversight are unlikely to involve regulators in inspecting more than a small proportion of the activities they oversee. Tripartism provides a mechanism by which regulators can extend their oversight by using other stakeholders as informants and can secure greater regulatory compliance by using those stakeholders to pressure regulated organizations to change.

Many formal and informal nursing home stakeholders have an interest in the regulatory process. Residents and their families hold perhaps the greatest stake in assuring good quality of care, but

consumer and citizen groups, staff unions and associations, provider groups (including nursing home associations and corporate owners of chains or networks of nursing homes), and other health care organizations and professions (such as hospitals, social workers, and physicians) also interact with nursing homes, and a federally funded network of long-term care ombudsmen oversees nursing home care.[37]

Current nursing home regulatory arrangements are mainly structured bilaterally, around the relationship between the regulator and the nursing home, and they make relatively little use of these other interest groups. While nursing home regulators do interview residents and staff as part of their regular surveys and will respond to and investigate complaints from any source, there is no formal regulatory requirement for any other stakeholder involvement. Regulators could make more use of tripartism by requiring nursing homes to have strong resident and family councils and providing more support for them; by providing more resources for the admirable but chronically underfunded long-term care ombudsman program and doing more to link it up with resident and family groups in nursing homes; by requiring nursing homes to have forums in which workers can raise quality problems and by safeguarding "whistleblower" employees who express legitimate concerns about quality; and by incorporating more extensive consultation with stakeholders into the nursing home survey process.

NURSING HOME REGULATION IS CLEARLY NECESSARY, but not all regulation is good and effective. It seems that although the OBRA 1987 nursing home reforms have achieved some important quality improvements, there is too little evidence to be able to determine whether the benefits justify the costs. The current regulatory arrangements could be improved, and regulatory experience in other settings may offer some valuable insights. Even so, there is clearly a need for more research aimed at developing a better understanding of the costs and effects of different regulatory methods and so informing regulatory policy.

For the future, further regulatory reform for nursing homes is probably inevitable. The IOM has recently recommended a number of changes, including a greater focus on providers that are chronically poor performers (by using more frequent surveys and increasing penalties); more CMS monitoring of the regulatory process to ensure that regulations are applied consistently; and more research into whether regulation has sufficient resources.

However, it can be argued that more fundamental reforms to the current regulatory arrangements are needed that are less focused on

changing the regulations and more concerned with reforming the regulators themselves and changing the culture of the regulatory process. For example, future reforms could include a shift toward a more responsive approach to regulation; changes to the structure of the CMS and the state survey agencies to reduce fragmentation, focus their regulatory mission, and improve regulatory governance; the alignment of regulatory and other incentives for nursing home providers; and the incorporation of a wider range of stakeholders into the regulatory process. Whatever changes are made, it is important that they be properly evaluated.

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NOTES

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