POPULAR GOVERNMENT

PUBLISHED BY THE INSTITUTE OF GOVERNMENT / THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

Social Services

Summer 1978

POPULAR GOVERNMENT

Vol. 44 / No. 1 Summer 1978

Cover Art: The cover art is a lithograph entitled "Holiday" by Joseph Hirsch. It is a favorite of Institute faculty member Dorothy Kiester (see p. 70) because it represents the linking of generations. It is used here through courtesy of Associated American Artists, New York City.

Photos in the day care article are from Frank Porter Graham Child Development Center, Chapel Hill, and Community Life Program, Coordinating Council for Senior Citizens, Durham.

CONTENTS

Published four times a year (summer, fall, winter, spring) by the Institute of Government, the University of North Carolina at Chapel Hill, #438300, Country Club at Raleigh Road, Chapel Hill. Mailing address: Box 990, Chapel Hill, N.C. 27514. Subscription: per year $6.00. Second-class postage paid at Chapel Hill, N.C.

RECAP
North Carolina Social Services

Mason P. Thomas, Jr.

NORTH CAROLINA PROVIDES SOCIAL SERVICES in an extensive array of programs—public assistance, medical care, and other services. The program itself is complex, and it is even more difficult to understand because three levels of government—federal, state, and county—are involved in designing and administering social services.

Social services is a controversial program; it seems to be unpopular with everybody. The political leaders are constantly calling for reform, the taxpayers are alarmed over rising costs, and recipients are dissatisfied with low payments, the stigma of "being on welfare," and the demeaning aspects of determining who is eligible for assistance.

The 1969 General Assembly rewrote the basic statutes governing welfare and called the program "social services" in order to avoid the stigma of welfare. This new name has not created a new image, nor led to greater public acceptance. Professionals sometimes feel that the public prefers to react emotionally or politically to a vulnerable and unpopular welfare program, not really wanting to know the facts about welfare.

Social services in North Carolina is basically a federal program, based on the Social Security Act of 1935 as amended. To qualify for federally supported public assistance programs designed to provide income and medical care, a needy person must fit into one of the specified categories, such as dependent child, aged, blind, or disabled. Two recent federal programs, food stamps and Title XX of the Social Security Act, provide food and services to the working poor.

Social services is structured by state-level legislation designed to implement federal requirements in order for the state to qualify for federal funds, which pay approximately two-thirds of public assistance costs in North Carolina. Although most states prefer state administration of welfare programs, for sixty years North Carolina has administered welfare through the counties. The welfare pyramid thus begins with basic policy dictated by federal law, the state supervises 100 county departments of social services through the four regional offices of the Department of Human Resources (DHR), and the county administers social services but with few options or choices about the federally supported programs that must be delivered uniformly throughout the state. Table 1 shows expenditures of funds by source and for specific programs in fiscal years 1976-77; Table 2 shows social services expenditures over the past decade.

The author, an Institute faculty member, specializes in juvenile law and corrections and social services.

Federal requirements

To understand social services in North Carolina, one must understand the federal legal requirements and how this state conforms to these requirements.

1. Federally supported public assistance programs must be both statewide and uniformly administered throughout the state. These programs include Aid to Families with Dependent Children (AFDC), Medicaid, and food stamps. North Carolina administers the programs through county government (county board of social services and department of social services), and the state must see that each of the 100 counties offers these federally supported public assistance programs to eligible families at the same level of payment, according to applicable federal and state policies.

2. Federal law requires that the state participate financially in the AFDC and Medicaid programs. Since

1937, each successive General Assembly has appropriated state funds for social services programs on the basis of budget requests of the responsible state agency, now the DHR, and state law requires the counties to pay a share of this cost under applicable matching formulas contained in law.

3. Federal law requires that a single state agency administer or supervise administration of the federally supported public assistance programs—in this state the Department of Human Resources.

4. Persons who apply for federally supported public assistance or services have certain legal rights that county government must protect, generally through the county department of social services. For instance, if a public assistance application is not processed within the required time, the applicant has a right to appeal for a fair hearing to the Department of Human Resources; if a recipient's public assistance grant is terminated, he has a right to written notice. According to state law, county social services departments must protect the confidentiality of persons who apply for or receive public assistance or food stamps, and only those who need to refer to the records in the course of official duties may have access to them.

5. Federal law requires that personnel appointed to professional positions in the social services programs at the state and county levels be appointed on a merit basis, not for political reasons. In North Carolina, the merit system is administered by the State Personnel Division in the Department of Administration, which administers the merit examination for state- and county-level positions in the social services program, such as county directors, caseworkers, and secretaries. In some instances, a person who has not taken the merit exam may be appointed temporarily to a position in the program, but he must take and pass the merit exam the next time it is given if he is to be retained permanently.

Table 1

Expenditures by Source of Funds for Specific Welfare and Social Services Programs in North Carolina FY 1976-77

Welfare and Social Service Programs	Federal Contribution	State Contribution	County Contribution	Total
AFDC	$ 91,248,496	$ 23,249,993	$21,914,529	$136,413,018
Medicaid	177,584,923	81,648,292	14,262,222	273,495,437
Title XX (Services)	55,876,932	11,920,412	6,705,232	74,502,576
Special Assistance to Adults	--	8,903,616	9,280,795	18,184,411
Child Support Enforcement	2,044,078	251,832	453,624	2,749,534
Title IV-B (Child Welfare)	1,551,980	1,490,860	2,590,000	5,632,840
WIN	2,317,494	257,500	--	2,574,994
Food Stamp Admin.	5,494,911	1,193,554	4,296,800	10,985,265
TOTAL	$336,118,814	$128,916,059	$59,503,202	$524,538,075[1]

1. In addition to the programs listed, the federal government provided $174,288,000 for the Supplementary Security Income (SSI) and $135,656,751 for the bonus food stamp program (FY 1976-77).

Source: North Carolina Department of Human Resources, Division of Social Services.

Table 2

Expenditures by Source of Funds for All County Welfare and Social Service Programs in North Carolina for Selected Years, FY 1966-77

Fiscal Year	Total	Federal Contribution	State Contribution	County Contribution
1966-67	$108,786,700	$ 75,102,122	$ 15,583,054	$18,101,524
1969-70	163,794,285	113,289,361	24,056,514	26,448,410
1972-73	284,502,221	198,470,685	52,815,007	33,216,529
1975-76	419,866,388	266,392,158	94,457,538	59,016,692
1976-77	524,538,075	336,118,814	128,916,059	59,403,202

Source: North Carolina Department of Human Resources, Division of Social Services.

Role of state government

The General Assembly. The legislature has the option of implementing federally supported public assistance and service programs. If it did not enact legislation that conforms to federal requirements, North Carolina would not be eligible for the large amounts of federal money available to fund public assistance and services programs. In an effort to help the state through the serious economic problems of the Depression, the 1937 General Assembly enacted legislation to conform to the requirements of the 1935 Social Security Act. Since then the General Assembly has continued to adopt legislation that qualifies the state for federal funds.

One recent example of state legislation that meets federal requirements is the child-support legislation, which the General Assembly adopted in 1975.[1] Title IV-D of the Social Security Act offers federal funds to improve child-support services, if a state meets federal requirements, such as enacting legislation to implement the services. In North Carolina, the Department of Human Resources administers the child-support program; in each county the commissioners designate the agency to administer the county program, usually the department of social services; and the federal government reimburses the county for most of the administrative costs of the child-support program.

Child-support legislation is designed to secure financial support from parents, who are responsible for the

1. N.C. GEN. STAT. Ch. 110, Art. 9 §§ 110-28 through -141.

support of their children. The county representative, probably the social services department, must coordinate the program by obtaining support agreements and acknowledgments of paternity, and working in other ways with the court to gain child support from parents. A voluntary support agreement or acknowledgment of paternity, approved by the court, has the same effect as a judgment or court order for support. Payments under such agreements are made through the clerk of superior court. When a child is receiving Aid to Families with Dependent Children, the clerk directs the support payments to DHR, which reimburses the federal, state, and county governments according to the applicable matching formula. The DHR also is responsible for trying to locate absent parents, maintaining a registry on the identity or location of absent parents, and coordinating support activities with other agencies.

Department of Human Resources. The DHR is the state-level "umbrella" department responsible for a number of human services including health, mental health, social services, medical care, services to older people, youth services, and others. The Secretary of Human Resources is appointed by the Governor and holds a cabinet-level position. Recently the legislature consolidated a number of DHR management functions in the Secretary (planning, organizing, staffing, directing, coordinating, reporting, and budgeting), and the general thrust of state reorganization during the past several years has been to consolidate DHR's power in the Secretary, including responsibility for the social services program.

Social Services Commission. The Governor appoints eleven members to the Social Services Commission (SSC), one from each congressional district, to serve four-year terms. State government reorganization legislation defines a commission as "a collective body which adopts rules and regulations in a quasi-legislative manner, and which acts in a quasi-judicial capacity rendering findings or decisions involving differing interests." Usually the SSC's powers, duties, and functions are not subject to the approval, review, or control of either the Governor or the Secretary of Human Resources.

The SSC has authority to adopt rules and regulations for conducting the state's social services programs (including public assistance programs and programs designed to achieve cooperation with other appropriate agencies), to place children, and to pay for foster care for needy and homeless children. The Commission can also establish standards for inspecting and licensing maternity homes, homes for the aged, child-care institutions, and local confinement facilities. The Division of Facilities Services, within DHR, does the actual licensing or inspections under these standards. The SCC has the power to subpoena witnesses, administer oaths, and compel necessary documents to be produced. It may also authorize investigation of social problems, and has authority over certain programs other than social services programs—for instance, the authority to establish standards for inspection of local jails.

Division of Social Services. The Division of Social Services supervises county departments that administer social services programs, thus implementing the responsibility of the Secretary of Human Resources. The Secretary appoints the director, who is administratively responsible to the Secretary.

The State Division of Personnel administers the merit system for state- and county-level personnel appointments in the social services program as federal and state laws require. Figure 1 shows the organization of the Division of Social Services in the North Carolina Department of Human Resources.

County administration

Every North Carolina county has a board of social services consisting of three (or five) members (as the board of county commissioners decides) appointed as follows: one (or two) by the Social Services Commission; one (or two) by the board of county commissioners; and the third or fifth member is appointed by the two (or four) members appointed by the state and the county. Detailed statutes govern the county boards of social services, which act primarily as advisory boards. They do, however, have specified legal responsibilities including: appointment and dismissal of the county director under the merit system; offering administrative advice to the director; approval and review of public assistance cases; community social planning; and planning and presenting the county budgets for social services programs and administration. Although state law authorizes two or more counties jointly to employ a county director, none have ever made such a joint appointment.

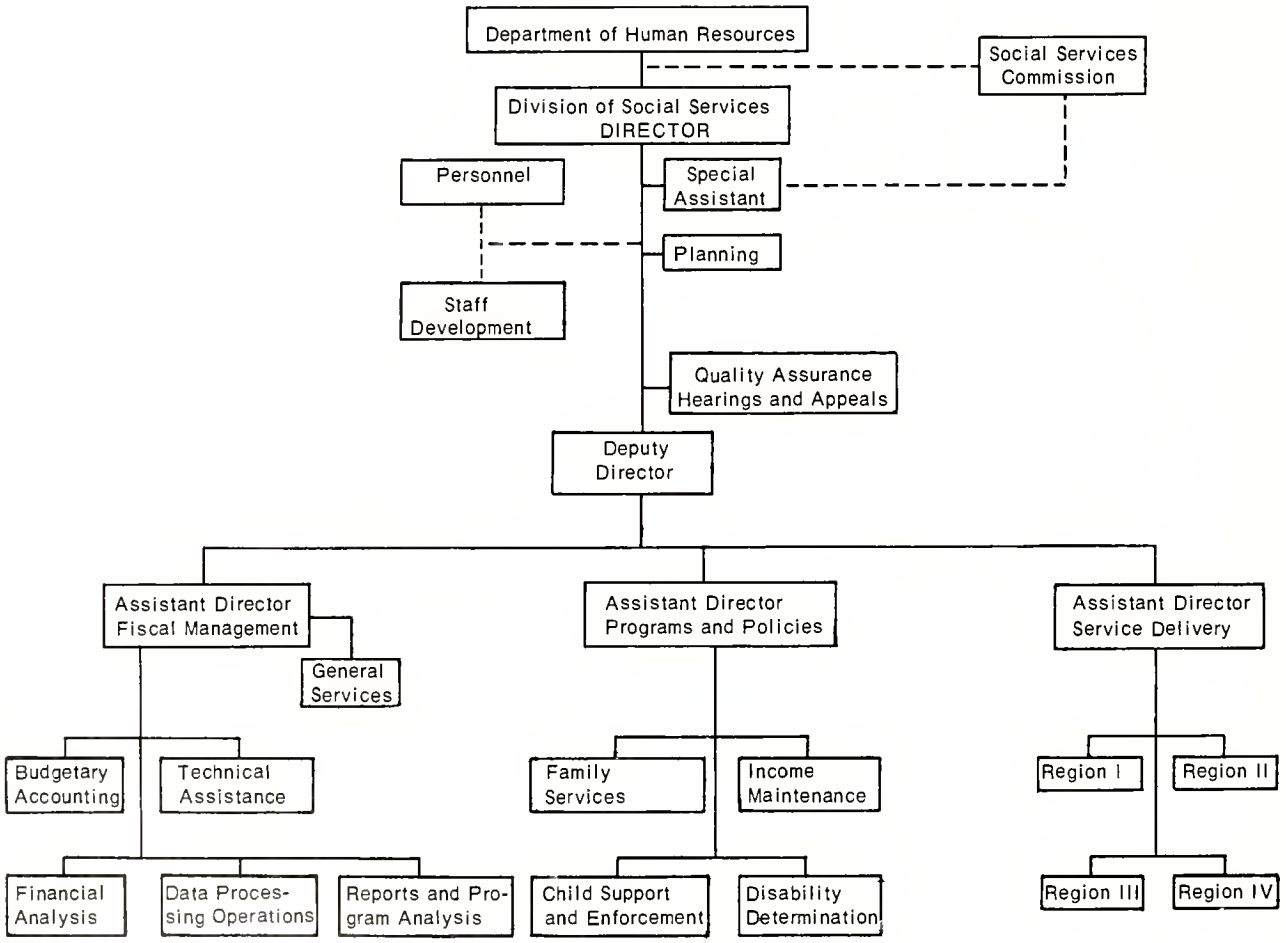
The county social services program is a source of frustration to some boards of county commissioners. For example, the commissioners do not have a free hand in appropriating funds for social services programs, as they do with many other county programs. State law requires each county to carry a percentage of social services costs; therefore the amount of county money required to match the state appropriations for social services is determined by the amount of the state appropriation. Further, according to statute, DHR determines whether funds are adequate and gives final approval to each county's social services budget. Thus, social services budgeting can become a source of tension between a particular county and state government. Also, federal and state laws require that certain mandated social services programs be operated on a state-

wide basis, so the county commissioners have no choice but to administer these programs.

County department of social services and its director. Each of the 100 counties has its own county department of social services and a director. The county director and the department's staff are responsible for administering the social services program under federal and state law, according to the state plan, but under the direction of the county board of social services.

The county social services director has a number of important legal responsibilities: to serve as executive officer and secretary of the county board of social services; to appoint personnel of the county department under the merit system; to administer public assistance programs; to act as agent of the Social Services Commission in relation to work required by the Commission in the county; to investigate cases for adoption and supervise adoptive placements; to issue employment certificates to children under the regulations of the State Department of Labor; to supervise boarding homes, rest homes, and convalescent homes for the aged or infirm under the rules and regulations of the Social Services Commission; to investigate reports of abuse and neglect to children and disabled adults under the applicable reporting laws for abuse or neglect; to accept children for placement in foster homes, and to supervise these placements for as long as each child requires foster care; and to petition district court for sterilization of eligible persons in the county.

Figure 1
Organization of the Division of Social Services



Source: North Carolina Department of Human Resources, Division of Social Services.

Summary of social services programs

Public assistance. County social services departments administer five public assistance programs. Three are mandated by federal and state law—Aid to Families with Dependent Children, food stamps, and Medicaid. Two are permissive—State-County Special Assistance for Adults and County General Assistance.

Aid to Families with Dependent Children. This is a federally supported, categorical program that provides payments to needy children deprived of parental support or care by death, desertion, or incapacity of one of their parents. To be eligible, a needy child must be living with a parent or with certain specified relatives (such as an aunt, uncle, or grandparent) or living in a licensed foster home or a licensed child-care institution, and there are legal limitations relating to age, school attendance, and whether or not the child is needed at home. Payments are determined by comparing the family's needs with its resources, using standard formulas. (State law now authorizes a flat grant approach, the Consolidated Standard of Need.) The parent or relative with whom the child is living is encouraged to work or secure job training under the Work Incentive Program (WIN). If the adult payee of an AFDC payment is employed, a certain portion of earned income is excluded from family resources in determining the amount of the assistance grant, providing a financial incentive for a recipient to work since the grant is not reduced dollar for dollar because of earned income.

The child-support program, described on p. 2, imposes certain limitations on AFDC eligibility. When an AFDC recipient does not cooperate with the county in locating the parent responsible for the child's support—for instance, a mother who refuses to disclose the father's whereabouts—the parent receiving AFDC may be compelled to appear in court and give information about the other parent or be declared ineligible for the public assistance payment. In such cases, the children's needs will be met through protective public assistance payments as authorized by law. This means that the AFDC payment will be made to some other person who will be responsible for the child.

Food stamps. Every North Carolina county must operate the federally supported food stamp program. Families that meet the eligibility guidelines for income and resources are eligible for food stamps. Households that receive public assistance (such as AFDC or Supplemental Security Income) are automatically eligible. To qualify, a family may have no more resources than $1,500; a household with two or more persons and at least one over 60 years of age may have resources of up to $3,000.

At present, through county departments, local banks, post offices, or other approved vendors, an eligible household may buy food stamps that will give it food purchasing power greater than the cost of the stamps. Food stamp recipients may buy only food for human consumption with the stamps—not other grocery items, such as soap. Recent changes in federal law have eliminated the purchase requirement so that when the new program is implemented (perhaps in January 1979) eligible families will receive food stamps without any purchase or payment requirement.

Also, public assistance recipients will not necessarily be eligible for food stamps under the new program.

Medicaid. Medicaid is a federally supported, categorical program providing medical care and services for AFDC recipients, SSI recipients, and the medically indigent who fit into the federal categories for the aged, the disabled, the blind, or dependent children. The Division of Medical Assistance is responsible for the Medicaid program in North Carolina, which includes medical services, eligibility, and fiscal accountability. The county departments of social services administer the Medicaid program at the county level. State law requires that the board of commissioners in each county levy taxes to pay the county's share of the cost. Medicaid provides certain services to recipients by paying the provider of the medical care or services (for instance, doctors or hospitals). For a detailed discussion of North Carolina's Medicaid program, see the article on page 39.

State-County Special Assistance for Adults. The federal government absorbed Aid to the Aged, Aid to the Blind, and Aid to the Disabled into the Social Security System on January 1, 1974, under the Supplemental Security Income (SSI) program. County departments formerly administered public assistance to needy persons in these three categories. Although the county is no longer involved in administering SSI, it sometimes has to supplement SSI payments.

State-County Special Assistance for Adults, a permissive program paid for equally by state and county funds, subsidizes certain SSI recipients and other disabled persons who need residential care facilities.

County General Assistance. Any county may have a county general assistance program, and most counties have chosen to do so. Each county funds the program and operates under its own policies. This program is used primarily to supplement the federally supported public assistance programs such as AFDC or Medicaid.

Protective services for children and disabled adults. Two separate reporting laws require that cases involving neglect or abuse to children or disabled adults be reported to the county department of social services. The Child Abuse Reporting Law requires reporting cases of abuse or neglect of children under 18; the other reporting law protects adults (18 and older) who may be vulnerable to abuse or neglect because of physical or

mental incapacity, including senility. Both reporting laws encourage reporting cases of abuse and neglect. This is the thrust of the law—that persons at risk can be identified and appropriate protective services can be provided. (See the author's book entitled *Protective Services in North Carolina*, published by the Institute of Government.)

Child-placement services. The county social services department is the only child-placement resource that is available in every county in North Carolina. In cases of neglect, abuse, dependency, or delinquency, the district court (exercising juvenile jurisdiction) may order that a child be removed from his home and placed elsewhere if necessary for his protection. The court often places the child in the custody of the county social services department, which then is responsible for arranging an appropriate placement for him. In other cases, the court may order that the county department supervise the child in his own home or in the home of a relative. At times parents may request that the social services department place their child in foster care because of some family crisis, such as illness of a parent, that makes it impossible to keep the child in his own home. In those cases the parents and the agency usually have a written agreement.

When the county department has child-placement responsibility by court order or agreement with the parents, the staff explores where the child might be placed. The possibilities include relatives, licensed foster homes under the supervision of the county department, group homes, child-care institutions, special treatment facilities and boarding schools, placement with relatives outside the state through the interstate placement processes, and adoption. The usual goal is to work with the parents toward the time when the child may be returned to his family. County departments of social services also cooperate with other states through the state Division of Social Services in placing children from other states within North Carolina or children from North Carolina out of state.

Foster care. The Social Services Commission has legal responsibility for adopting standards, rules, and regulations in the licensing of foster homes for children and placing dependent and delinquent children. The program for licensing foster homes is administered through the county departments, and the DHR issues licenses on the basis of home studies conducted by the staff of the county departments.

State law also provides a Foster Home Fund to provide part of the cost of foster care for needy children. This fund is administered under policies of the Social Services Commission that permit the state to participate in half the cost in a licensed foster home, with a maximum of $125 per month.

Some counties pay more than $125 per month per child for foster care, so that county funds pay the entire cost above $62.50. Some children have special needs—for example, mentally retarded or physically handicapped children—that require specialized types of foster care at higher monthly rates. Since current state policies allow state matching funds for specialized foster care to a maximum of $62.50 per month, county funds must pay the balance. County departments must pay other related costs such as clothing, school expenses, and other incidentals that may not be provided by the child's parents.

Adoptions. Every county department of social services provides an adoption program, working cooperatively with the clerk of superior court who is the county's court of adoptions. The law now provides for adoption of both children and adults. The counties administer the adoption program, supervised by the Division of Social Services. This state-level supervision includes providing legal guidance to insure sound adoption; guidelines for services to natural parents, children in need of adoption, and adoptive parents; a central registry for adoption records; and an adoption resource exchange. The 1975 General Assembly established a fund to subsidize adoptions for physically or mentally handicapped children who would otherwise be difficult to place for adoption because of the cost of meeting their special needs.

Services to unmarried parents. County departments provide certain services to unmarried mothers and fathers. These services may include case-work services to an expectant mother concerning plans for herself or placement of her unborn child, and to the father, including his financial responsibility; and planning with both parents for medical care for the mother and the child. The State Maternity Home Fund pays the cost of maternity home care for unmarried, expectant mothers who cannot pay for such services. The Division of Social Services administers this fund on the basis of applications for help submitted through the county departments.

Day care. The Child Day-Care Licensing Commission in the Department of Administration is responsible for licensing facilities that provide for day care for more than five children. Day care services are frequently required by children from families that receive AFDC since federal policies encourage parents to work or to be involved in job-training. Federal funds are available to purchase day care services in certified centers that meet federal standards, which are higher than the minimum standards under state licensing law. Thus, the day care unit in the Division of Social Services is responsible for approving day care programs that meet federal standards so that AFDC families may use the facilities. The state also provides consultation and help to county departments that wish to operate their own day care

facilities. The article on page 32 contains more information on day care.

Family planning. The Social Security Act requires that county social services departments provide family planning services to recipients of public assistance and to other clients of the county department who wish family planning services.

Psychological services. The Division of Social Services has staff psychologists who provide psychological services through county departments of social services on a referral basis without cost to the county or the person tested.

Services to aged or disabled adults. The Division of Social Services develops programs and policies for eligible aged and disabled adults. County social services departments implement these programs and should provide the following services to adults: information about resources, referral to appropriate services, and protective services. Other services to eligible adults would include employment services to obtain self-support, health services, placement services in group care facilities, and services to the aged or disabled person in his own home (homemaker services, attendant care, counseling, and other supportive services).

The Department of Human Resources also has the legal responsibility for licensing certain boarding homes, rest homes, and convalescent homes for aged or disabled persons under standards adopted by the Social Services Commission. Those who are placed in these homes are supervised by the county social services departments.

Supportive services. County social services departments provide other services through the use of paraprofessional personnel, such as homemakers and social services aides. A homemaker is a department staff member who goes into a home temporarily to fill the role of the parent or other responsible adult who cannot function because of illness, absence from home, hospitalization, or other family crisis. Social services aides are departmental staff members who go into community neighborhoods to provide information about available social services resources.

Title XX services. To qualify for funds under Title XX of the Social Security Act the state must develop a comprehensive annual plan for services. This program is administered through the Office of the Secretary of Human Resources. Each county must provide specified mandated services—day care services to children, family planning, casework services to enable individuals to remain in or return to their own homes, health support services, interstate/intercounty placement services for children, foster care services for children and adults, adoption services, and protective services for children and adults. In addition to these services, counties have the option of providing twenty-one other services at the county level—for instance, chore services or homemaker services. The DHR allocates Title XX federal funds on a formula basis each year. An article on page 27 describes Mecklenburg County's experience under Title XX.

Trends toward change

More federal control. States and counties may soon no longer have the responsibility for administering social services, with the current trend toward federalizing welfare programs. The federal government has already absorbed three categorical public assistance programs formerly administered by county social services departments through the Supplemental Security Income program—Aid to the Aged, Aid to the Blind, and Aid to the Disabled. President Carter's proposals for welfare reform include a gradual federal take-over of policysetting, administration, and funding. See the article on the President's welfare reform proposal on page 19.

State influence in county administration. In North Carolina the state gradually has taken a stronger role in administering the social services program, and in the last ten years it has occasionally been proposed that the state change from county to state administration. The Department of Human Resources has established four regional offices (Greenville, Fayetteville, Winston-Salem, and Black Mountain) through which county directors are supposed to work with the Division of Social Services.

Categorical to comprehensive approach. Much of the social services program continues the categorical approach to public assistance begun under the Social Security Act of 1935. For example, AFDC is a categorical program for dependent children deprived of parental support by at least one parent through death, absence, or incapacity. Thus, a family with two unemployed parents would not qualify for AFDC. Medicaid also provides medical services only to AFDC families, recipients of SSI, and medically indigent persons who fit into one of these categories. However, there is a trend toward providing public assistance and services to the working poor. Recent examples are the food stamp program, federally funded services under Title XX, and the child-support program.

County financing. In the last few years several changes have occurred in the law that relate to county financing of social services; they seem to indicate a trend—holding counties responsible for paying their share of the cost of public assistance and administration on an open-ended basis. Before 1974, the county budgeting process for social services was open-ended; counties had to pay their share of public assistance costs when

these expenditures exceeded the county funds appropriated for this purpose. North Carolina had a three-year trial with closed-end budgeting beginning in 1974. The closed-end legislation meant that a county's responsibility for public assistance and administration was limited to state-approved estimates for these costs. If the county had to pay more than the approved estimates called for, this amount was paid from the State Public Assistance Contingency Fund. The 1977 General Assembly rewrote the law to authorize a loan from state funds to any county whose expenditures exceeded approved estimates. Any amount borrowed in one fiscal year must be repaid within the next two fiscal years. Programs and administrative expenses covered under this law include AFDC, medical assistance, State-County Special Assistance for Adults, WIN single-administrative unit, WIN day care, State Boarding Home Fund for Foster Care, and the administrative costs of food stamps.

Reduction of services to cut costs. State legislatures are increasingly concerned about the rising costs of welfare programs, particularly Medicaid. The 1977 General Assembly reduced the services provided by the Medicaid program in order to cut costs. Political pressures to reduce welfare costs may lead to further reductions of other social services.

Curbing welfare fraud. In an effort to impose more severe penalities for welfare fraud, the 1977 General Assembly enacted legislation providing that illegal receipt of money, benefits, or food stamps of $200 or less is a misdemeanor; if the amount is more than $200, the offense is a felony. Providers as well as public assistance recipients under the Medicaid program may be prosecuted for fraud.

Personnel policy. A recent change in the merit system rules by the State Personnel Commission seems to indicate a trend in broadening eligibility for appointment and gives counties more control over personnel policy. Also, recent changes in merit-system rules substitute job experience for specified educational qualifications for hiring. For instance, work experience may be substituted for graduate training in social work as a requirement for appointment as county director of social services.

Growing legal involvement. More attorneys are involved in social services matters. More county departments have access to legal advice through the county attorney, a special county attorney for social services matters, or an attorney hired to represent the county department. Further, 1977 legislation provides for appointment of a guardian ad litem (who must be an attorney) in district court juvenile hearings involving neglected or abused children, and the law gives the guardian ad litem certain authority that may lead to conflict with some county departments (for example, court-approved access to confidential records). Periodic mandatory court review of child custody cases involving the county department also means more attorneys will likely be involved in child-placement cases.

More executive influence. State government reorganization and recent legislation affecting the composition of the Social Services Commission give the Governor more power over social services matters. The Governor appoints the secretary in each of the major state umbrella agencies, including the Department of Human Resources. The Secretary of Human Resources, a member of the Governor's cabinet, is supposed to implement the Governor's policies in DHR. The state budgeting process includes a plan whereby the various departments establish priorities for budget requests. If social services needs are not given a high priority, then they may not be funded.

Before 1977 the Social Services Commission consisted of seven members appointed by the Governor for six-year staggered terms. In 1977 the Commission was reorganized so that the Governor appoints one member from each of the eleven congressional districts, thus increasing its membership from seven to eleven persons. The requirement for staggered terms was eliminated, and the length of terms was reduced from six to four years. Therefore, the Governor in office will be able to appoint the entire commission and will be likely to appoint people who will implement his policies.

Welfare reform. Federal and state legislatures, those concerned with social services, and the general public agree that reform and change are necessary, but not on how the necessary reform will be achieved. President Carter's proposals for welfare reform will be studied and reviewed in Congress during 1978 and may lead to overhauling the out-of-date welfare system. □

A County Official Looks at Welfare Budgeting

John V. Witherspoon

ADMINISTERING social services programs at the county level is like being the tail on a two-headed dog. The county tail is alternately wagged: first by the state head, then by the federal head. Often the tail spins in circles. Occasionally it comes to a complete stop. But most often the two heads alternate in commanding the tail to wag in aimless patterns as if the function of the tail were to create some abstract design in the air.

Similarly, as a nation, we are of two minds regarding welfare. We feel a deep moral or religious obligation to take care of the poor. Often we hear people say that we need to take care of the "deserving poor," slipping in a qualification that reveals another attitude regarding public welfare. We just do not believe there are as many "deserving poor" as show up on the public welfare rolls.

Budgeting for welfare programs

This basic conflict in attitude toward public welfare comes into sharp focus in the administration of county welfare programs in North Carolina. First of all, welfare as administered by county departments of social services is big business. During the last three years, for instance, 25 to 26 per cent of the Guilford County budget of $70+ million went to social services. Perhaps more striking is the fact that though the county budget has gone up 13.8 per cent since the 1974-75 fiscal year, the total social services budget has gone up over 18 per cent.

The projected budget for the Guilford County Department of Social Services for the fiscal year 1977-78 was just under $20,200,000. But, as in most things connected with public welfare, the official figures do not tell the entire story. In simplest terms, a county's budget is primarily composed of items for which the county writes the checks. The county issues checks for special assistance to adults and for Aid to Families with Dependent Children (AFDC) and also takes care of all expenses of local staff who administer the programs. County staff also administer the medical assistance and food stamp programs, though the county does not write the checks for these programs. The two heads of the welfare animal perform this function: the federal government takes care of food stamps, and the state uses federal money, state money, and county money to pay vendors under the medical assistance program. Therefore, a more accurate total fiscal picture of all programs administered by the Guilford County Department of Social Services would include $10 million for food stamps and $12 million for Medicaid. The total *gross* budget for the county's department of social services then rises to a startling $43 million!

State budget control. When a group of county commissioners talk about social services, someone eventually says, "There's not much you can do about it." For the commissioners, there is much truth in that statement. The General Assembly specifies most of the items in the social services budget expended by the counties. In addition, the legislature has granted the Secretary of Human Resources, through the Division of Social Services (the Division), widespread supervisory authority over county departments of social services. Therefore, state officials give detailed directions to county departments of social services, telling them not only what to do but also how to do it.

The state is responding to a similar situation between the state and federal governments. Congress initiates most of the social services programs administered in Guilford County. Congress writes the law, HEW writes the regulations that implement the law, and the North Carolina General Assembly enacts laws parallel to those of Congress in adopting desired programs. The Division of Social Services, with one ear tuned in to the legislature and the other to HEW, writes regulations and directs the activities of county social services departments. A cynic might observe that this illustration leaves the Division, at the state level, unable to hear from the counties, since both ears are occupied. Though the interpretation would be a gross exaggeration, many county officials feel that it is fairly accurate. After all, it is a fact that the tail cannot wag the head.

It is apparent from the examination of county budget-hearing records that county government is powerless in welfare matters. In Guilford County, the money involved in mandated social services programs represents as much as 20 per cent of the county's $70 million budget. A new, inexperienced county commissioner will zero in on this significant

The author is county manager for Guilford County, North Carolina.

portion of the county budget, usually displayed in five or six categories and running six or seven digits. In explaining the mandated social services programs to the new commissioner, the county manager usually tries to summarize how the budget calculations were derived, and may define the different varieties of social services and income. The manager will probably summarize by saying something like this: "This is a mandated program, required by law to be placed in our budget, and the Division of Social Services has the power and authority under the law to determine whether or not our budget figures are sufficient. The Division, through the courts, can force the county to appropriate additional amounts if it determines that the county public assistance budget is insufficient. Our budget amounts represent negotiated figures between our department of social services and the State Division of Social Services in Raleigh." Then, if the county manager is fortunate, he will hear a long-time county commissioner tell the new commissioner that the manager is correct: There really is not much one can do about it.

The state's control over *services* provided by the county departments of social services—in contrast to public *assistance*—is not so precise. Many social services programs are mandated by the state, but the county does have considerable discretion about whether it will offer certain services and at what level. The state does not participate so heavily in financing services as in financing public assistance. This is also true in general administration, for which the county puts up approximately seven dollars for every state dollar. The attitude of the Division with respect to the administration and services portions of county welfare departments is primarily persuasive, with perhaps a hint of the possibility of sanctions. We estimate that the Division controls or influences between 65 and 70 per cent of the county's total social services' budget.

Only in general assistance does the state have no control. In Guilford County, this item has run as high as a million dollars in a year of economic recession. General assistance might best be described as the county's effort to plug the gaps in the state federal welfare system. It comes into play when the county is faced with someone who has obvious needs but cannot meet the criteria for inclusion in a public assistance program. Perhaps the chief recipients of county general assistance in Guilford County are two-parent families, which are ineligible for AFDC under the North Carolina public assistance program. With many people unemployed and unemployment insurance exhausted during a recession, this program can expand quite quickly.

Closed-end budgeting for welfare programs. With welfare such a large part of the budget, county officials cannot afford to be entirely passive. For some years, particularly after state miscalculation of the first six months of Medicaid caused many counties to go into deficit spending, the counties sought to establish a "closed-end" budget. In all other county programs, the commissioners can control the upper limit of expenditures through the budget process, but not so in the mandated welfare programs. The latter programs require that whoever applies and qualifies receives—regardless of whether sufficient funds are appropriated. Schools may be closed for lack of funds, but AFDC and Medicaid must continue.

In 1975 the General Assembly adopted a closed-end budget law in welfare. This act called for county budgets approved by the Division of Social Services to be frozen annually at the total amount of county resources estimated to be required for mandated programs. Overages were to be made up from state funds.

In the second year of closed-end budgeting, counties had trouble in finding the procedures to follow in qualifying for this program. Interest was high, since the lingering effects of the 1974-75 recession were hitting welfare budgets hard. Guilford County was flatly informed, by a high-ranking Division official, that it did not qualify for closed-end budget funds, and Guilford's budget was being overspent by several hundred thousand dollars. After much persistence by the county and a change in personalities in the state office, Guilford received over $350,000.

Other counties also went over their budgets, and the state eventually had to spend a million dollars to cover county budget overruns. The experience killed off any support at the state level for the closed-end budget act, and over the protests of the counties, the 1977 General Assembly repealed the act and established a loan-fund mechanism. Simply put, this new legislation provides that the loan fund will cover county budget overruns until the next fiscal year, when the county must repay the state. The role played by the Division in the administration and demise of closed-end budgeting has only served to reinforce distrust of the state agency by county officials.

Federal funding of county programs. In reflecting upon the county's social services budget, one cannot help but wonder what is left for the county to do at its own discretion. The county is not only forced by state law to participate heavily with its own resources in public assistance but also persuaded to add basic services or administrative programs. Since the county has so little to say over its social services budget, the local board of social services plays a small role in financial matters, except in general assistance. The county commits much of its resources to fulfill the state and federal requirements; therefore, it is easily enticed to use what little is left for programs that contribute even more federal assistance—those, for example, that bring as many as three federal dollars for every dollar of county money.

Such a program is Title XX of the Social Security Act, the main social services program that provides funds that counties can use in a number of ways to assist low-income people. But, as is usual with federal programs—particularly federal programs administered by the state—guidelines are written elsewhere, goals are established elsewhere and regulations are promulgated elsewhere, so that the county's choices in using these funds are greatly narrowed.

Guilford County's experience in establishing a communications center for the deaf under Title XX is an example of the frustrations local officials feel in trying to do something on their own. In current social services programming, concern for the deaf does not rate very high. Apparently no one in Raleigh, or Atlanta, or Washington had ever envisioned a communications center for the deaf—at least not the way that a com-

munity leader in Greensboro did. Attempts to include the communications center in the county's Title XX budget were delayed and frustrated while the county's social services director was repeatedly required to justify its existence. Ultimately, the county commissioners grew weary of the effort through social services channels and, in a remarkable display of independent will, directed that the program be funded with 100 per cent county money directly from the county manager's office. It is not surprising that county commissioners often feel that social services is not the vehicle for reaching county goals and aspirations. Questionable programming and budgeting practices result, since what should be a social services function is handled entirely apart from the department and the county board of social services.

Relationship between state and county administration

Another aspect of state/county relationships in administering social services programs is the way that state and county agencies communicate. In North Carolina, the administration of social services programs is governed by a kind of "bureaucratic overkill" because of a regulation for practically everything an employee might need to do. Many changes in these regulations occur daily and, because of the volume, are communicated directly from the Division to the county departments of social services, completely ignoring all county administrative channels. Most of the changes are insignificant, but major matters, which may cost the county thousands of dollars, are communicated in exactly the same fashion. This places a burden on the local director of social services to follow through within the county administrative apparatus to see that directives from Raleigh are implemented. In matters involving large budget changes, the county social services director appears as the state's representative at the courthouse. Any frustrations that county administration, the board of county commissioners, or the board of social services may feel toward whatever the state is requesting are often taken out on the director. This situation can develop a "we/they" attitude between county administration and county social services.

A major friction point occurs between the state and the county regarding the way each carries forth its role in the welfare system. North Carolina's system is described in the General Statutes as a state-supervised, county-administered program. This means that the state directs most of the action while the counties actually perform the services. While conceptually a clear-cut distinction can be made between supervision and administration, the realities of who finances what, and who decides who finances what, are exceedingly complex and lead to many disputes about mutual responsibilities. Both the state and county departments tend to be defensive of their own tax resources. Thus, when program changes are made or new programs established, county departments—in a purely defensive reflex—look suspiciously at how the state proposes to assign costs. The way this works can be very illuminating.

For example, some years ago social services had a program called "attendant care." This program was designed to enable disabled and elderly people to remain in their own homes and stay out of nursing and boarding homes with help from county-managed part-time homemaker services. The program was optional and was financed on a 50-50 state/county basis. After the program had run a few years, the state mandated that attendant care programs be converted to a similar program called "chore services"—financed with federal funds. The result was that the program was no longer optional and was considerably more expensive than attendant care (financed 75 per cent by federal money and 22.75 per cent by county) with little state participation.

In another instance, the state changed the Medicaid program for mental health institutions. Medicaid costs for mental health institutions were met from state and federal revenues, but in an effort to reduce its Medicaid costs, the state changed the program so that the counties paid a portion of the state's share of these Medicaid costs. Counties even found they were helping to amortize state facilities.

Perhaps one cannot be too critical of state administrators for protecting state interests when their budgets are at stake. For example, in 1976 the state share of administering social services programs was 15 per cent of the nonfederal share. Explaining that it had a budget limitation in 1977, the Division of Social Services reduced the state share to 12 per cent, leaving the counties to raise 88 per cent of the nonfederal share. Such an arbitrary reduction based upon budget limitations dictated by the General Assembly is understandable, for such things happen at the county level. Interestingly enough, the state at the same time devoted some of its resources to catching up on quality-control reviews. As a result, in the fall of 1977 counties were losing revenue on activities dating from 1969. The state's reasoning for taking action in 1977 on work done by counties in 1969-70 is that there was not adequate state staff at that time. The counties replied that in 1969-70 they also had staff shortages, and this led to the errors that the state is now uncovering and charging against the county budgets. The state has been unresponsive to the plight of the counties even though many county officials have wondered out loud how the state can have less money for aid to counties on the one hand and more money for discovering eight-year-old errors in county administration on the other. Are the eight-year-old reviews funded in part by the reduction in aid to counties?

Occasionally, the state does something that seems to be purely punitive from the local perspective. For example, in one social services program a contract that had been approved by the local social services board, the county commissioners, the regional office, and the State Social Services Commission was undermined by a retroactive policy developed by the State Division of Social Services that disallowed certain costs. In effect, the county was left holding the bag with a signed contract and no way to pass on the cost for federal reimbursement. The decision resulted in a total loss of federal revenue, all at county expense. Since no state funds were involved in the matter, one must wonder what inspired the Division to take such a measure.

Conflict between program and fiscal personnel. The problem seems to be that the Division is divided into two groups of employees: those with programming responsibilities who advocate and promote specific social services programs, and fiscal people who

are responsible for reimbursing counties for costs of social services programs. Guilford County Social Services Director Wayne Metz feels that the county administrators' dilemma results from the inability of state program and state fiscal people to talk to each other. This often leads to the counties' suffering the consequences when fiscal people refuse reimbursement for certain items, even though the program people have previously approved them. By their very nature, program people tend to be advocates and are professionally motivated to see that the services under their administration are extended. Apparently they are not well schooled in the details of cost-reimbursement regulations. On the other hand, fiscal employees of state social services are often not brought into the development of programs early enough to avoid cost disallowances. In fairness to the Division, local officials experience the dilemma of being caught between program and fiscal people in almost every federal program, whether it is administered by the state or not. This situation in North Carolina may be accentuated because welfare is so extensive in dollar volume and because the fiscal operations of the Division appear to be understaffed, particularly when compared with the program contingent.

The lack of adequate staff in fiscal operations probably led to an unfortunate situation several years ago. The county attempted to develop an indirect cost-allocation plan in order to recoup federal funds for administrative costs. At first, no one in the Division of Social Services (then Department) knew about the program, and the Division ruled that it was not permissible in North Carolina. Later, in an effort to show his interest in the counties' fiscal welfare, a Secretary of Human Resources "discovered" the indirect-cost grant program and notified all counties of its availability. When Guilford County resubmitted its plan (now a couple of years old), the county had to answer a series of questions from Raleigh. The state then rejected the county's specific indirect-cost plan as being out-of-date, forcing a costly update. Some cost reimbursements were not allowed retroactively, and the county lost thousands of federal dollars through the state's tardy response. It was easy to assume that, despite the Secretary's statements to the contrary, the Division was not really interested in helping counties receive this federal largess.

The counties, by and large, carry the financing costs of the social services program—another source of irritation between county and state over social services administration. Since all public assistance programs and social services programs administered by the county are on a reimbursement basis, the county pays the bills, accumulates necessary records, and files the paperwork for these expenditures with the Division for reimbursement. In recent years, the state has greatly accelerated its reimbursement of county expenses. However, the

Table 1

Guilford County Social Services Budget

Actual Expenditures for Fiscal Year 1976-77

Description of Expense	Cumulative Expenses	Federal	State	County
General Administration	$ 1,228,713	$ 749,515	$ 71,879	$ 407,319
Policy and Program Development	44,951	27,420	2,630	14,901
Staff Development	46,168	30,009	2,424	13,735
Volunteer Coordinator	13,690	10,268	513	2,909
Benefit Payments Administration	1,751,191	875,596	131,339	744,256
Services Administration	2,138,704	1,604,028	80,201	454,475
State Contracts	41,536	0	0	41,536
Title XX Day Care for Children	1,614,848	1,211,136	201,856	201,856
Title XX Day Care for Adults	56,914	42,686	7,114	7,114
Work Incentive Day Care	78,899	59,174	19,725	0
State Foster Home Care	538,293	0	215,400	322,893
Aid to Families with Dependent Children Foster Care	253,488	154,020	39,272	60,196
Client Refunds	115,988	0	0	115,988
County Financial Assistance	661,029	0	0	661,029
Special Assistance to Adults	910,973	0	455,487	455,486
Aid to Families with Dependent Children Money Payments	7,996,384	5,437,541	1,402,248	1,156,595
Medical Assistance	568,856	0	0	568,856
Special Projects — County Contracts	1,293,387	1,045,941	0	247,446
TOTAL	$19,354,012	$11,247,334	$2,630,088	$5,476,590

Request for Fiscal Year 1978-79

	Requested Budget	Federal	State	County Local
General Administration	$ 1,497,536	$ 913,497	$ 52,563	$ 531,476
Policy and Program Development	86,152	52,553	3,024	30,575
Staff Development	53,304	36,327	1,535	15,522
Volunteer Coordinator	16,276	9,928	571	5,777
Benefit Payments — Administration	1,989,204	994,602	89,514	905,088
Services Administration	3,025,869	2,232,139	64,728	729,002
State Contracts	49,529	0	0	49,529
Title XX Day Care for Children	1,451,607	1,088,705	181,451	181,451
Title XX Day Care for Adults	75,000	56,250	9,375	9,375
Work Incentive Day Care	82,740	74,466	8,274	0
State Foster Home Care	660,000	0	300,000	360,000
AFDC Foster Care	256,200	159,489	37,856	58,855
Client Refunds	97,000	0	0	97,000
County Financial Assistance	706,900	0	0	706,900
Special Assistance to Adults	1,091,916	0	545,958	545,958
AFDC Money Payments	8,210,400	5,567,472	1,497,945	1,144,983
Medical Assistance	831,499	0	0	831,499
Special Projects — County Contracts	359,512	265,329	2,237	91,946
TOTAL	$20,540,644	$11,450,677	$2,795,031	$6,294,936

Source: Guilford County Manager's Office.

process inevitably causes counties to borrow funds, in a sense, from other revenues to finance the state and federal shares of these expenditures as they occur. In a budget as large as Guilford's, the reimbursement procedures could cause a loss of revenue because of the lost opportunity to invest these funds. For programs like Medicaid, however, the state pays the vendors. In this case, the state demands that the county's share be delivered to the state *in advance*, declaring that the state cannot finance county operations.

"Fair-share plan" for Title XX funds. On a day-to-day basis, these points of irritation that occur between state and county administrations regarding social services are almost commonplace. Aside from occasionally blowing off steam, administrators at both levels of government learn to live with the situation and hope things will change. Sometimes, however, the problems intensify until local forces rally around the courthouse and march upon Raleigh. This actually happened when the State of North Carolina announced its "fair-share plan" for the use of Title XX funds.

From Guilford County's point of view, this fair-share plan was something of a tragedy. The Title XX program incorporated several previous federal social services programs that were offered on essentially a first-come, first-served basis. Title XX required the state to do some planning for needs and also brought to the Secretary of Human Resource's attention that over half of the North Carolina Title XX money—approximately $60 million—was being returned to the federal government. The Secretary decided that the state should not return any money to the federal government and set about advertising the fact that private social services agencies could obtain three federal dollars for every local dollar by using Title XX mechanisms.

In explaining the specific contractual devices that would be necessary for nonprofit agencies to use Title XX money, the state often referred to contracts that had first been established in Guilford County. At the time, Guilford County was managing a program of over $5 million a year supported by Title XX and its predecessor grant program.

To insure the complete spend-down of Title XX money, the Secretary of Human Resources decided that the funds should be divided among state agencies and counties in accordance with a specific formula, and the Division developed what was labeled a "fair-share" formula for counties. To many counties, their fair share came as something of a shock, for they had in existence Title XX programs involving amounts far exceeding their "fair share." Guilford's "fair share," for example, was slightly over $1,800,000 to support its $5-million program.

Meanwhile, Guilford's Department of Social Services was literally swamped with new applications from private agencies for Title XX funds as a result of the state's encouragement to these agencies to apply for Title XX funding. Our local social services board found itself in something of a squeeze. On one hand, local pressure was high for more Title XX programs and on the other hand the state's fair-share formula indicated that Title XX programs would have to be cut by 64 per cent.

When the march on Raleigh took place, the state-level response was not particularly flattering to the good character and standing of Guilford County and its employees. In fact, the Division of Social Services had been placed in a box, since it had guaranteed Title XX funds to many jurisdictions that had never before used the program. When the state's entire Title XX allotment was divided among state agencies and counties without respect to existing programs, no funds were left to fall back on to insure funding for programs already operating in a handful of counties. In short, the state found that it had robbed Peter to pay Paul, advertised the fact, and thus put Paul on notice that it might try to reverse the process. The state's solution to this predicament was to announce that since the new programs could not be started in a timely fashion, funds not used by other counties would be reallocated—on a periodic basis—to the counties facing the reductions.

By using this reallocation system, which is still going on, the state effectively pushed the disbandment of many county programs to the future. A side effect of this procedure in county government is its apparent conflict with the Fiscal Control Act. Guilford either had to budget revenues of dubious certainty with respect to Title XX or disband programs, which the county is reluctant to do. The unfortunate outcome of this is the cloud of uncertainty that hangs over all of the county's social services programs.

Interestingly enough, a large Title XX-supported program likely to face a severe cutback in Guilford County is chore services, which has a direct relationship to a reduction in Medicaid. In other words, to the extent that Guilford County maintains a chore services program, Medicaid rolls are reduced. Since the state funds none of the chore services operation, but does provide most nonfederal support of the Medicaid program, a decreased chore service program in Guilford County would shift nonfederal welfare cost from the county to the state. At the same time, the legislature is trying to contain the cost of the Medicaid program.

In many respects the Title XX experience reflects the entire welfare system. Title XX was supposed to provide maximum local decision-making in social services programming with a minimum of federal regulations. Title XX replaced categorical programs that restricted both services and who could receive those services. These programs were also greatly circumscribed by federal regulations. Title XX, on the other hand, was supposed to be something like a general revenue-sharing for social services funding.

The earliest signs that something was amiss with Title XX came when HEW took so long in issuing regulations to implement the act after Congress passed the legislation. Many people felt that minimum regulations should take minimum time to develop. It seems that the worst fears of local social services program administrators have been realized in what HEW has produced. From the perspective of a North Carolina county, the result has been to replace local decision-making with state decision-making and to increase the emphasis on reporting. Title XX required state needs to be identified and a state plan to be developed. When the state turned its attention to strategies in using Title XX, it reverted to practices common to its perceived role in the whole social services area, that is, as controlling agent. For example, whereas the state fair-share decision caused Guilford County to face

having to reduce its chore services operation, the county suddenly found a local mental health program being supported with Title XX funds seemingly dropped from the sky. The point here is not that chore services is any more worthy than mental health's drug-abuse prevention, but rather that the *decision* to move moneys from social services to mental health was made in Raleigh. Neither the county board of social services, nor the county commissioners, nor the area mental health board was involved in a decision that diverted funds from one county agency to another.

The shifting of decision-making in the social services field has gone almost unnoted. In fact, counties are so accustomed to direction of their social services program by the state that they find it not a bit strange that any other situation should occur. In any case, the Title XX experience has only reinforced the attitude that there isn't much you can do about it.

Need for state/county stability in fiscal relationships

New state administrations consistently pledge that state/county relationships will improve under the new order. In the last three administrations, relationships did indeed improve at first. Inevitably, it seems that shrinking state and county resources and rapidly expanding welfare costs, combined with pervasive power in the hands of the state, do not result in a happy or equal partnership. Therefore, when a new leader of the Division of Social Services says that he will work with the counties, county officials tend to interpret the remark as if he were a carpenter saying he works with a hammer.

There is no doubt that counties are an agency for executing state policy. Counties do object, however, to being a tool for state officials to use in building a welfare program. Jerry Elliott, writing in the October 12, 1977, issue of *North Carolina County Lines*, called for a coordinated look at the whole state/county fiscal relationships rather than the "putting together of a diffused jigsaw puzzle hurriedly under the last minute strains of pending legislature adjournment."

As Elliott implies, it does seem—from the courthouse perspective—that state budgets are often balanced by last-minute decisions on what the county share of various welfare programs will be. Such a practice places strains on state social services officials, who have to estimate the effect of last-minute budget changes and are forced to defend "runaway" welfare programs. Little wonder that these strains are passed on to the counties. For their part, counties tend to become recalcitrant toward what they consider to be politically motivated raids on county treasuries. Between the political worlds of state and county government are the social services officials—often in conflict with one another out of loyalty to their respective employers, confounded by immense federalized red tape, and working in what is probably the most unpopular government program of these times.

Obviously a stable and clear fiscal relationship between the state and its counties is needed. The local level is particularly sensitive. Here property tax rate-setting is an annual event and taxpayers are afforded an opportunity to express themselves directly to elected officials. North Carolina needs what Elliott refers to as an "orderly, logical, singular and relatively simplified method to determine appropriate amounts of state-shared revenues." He seeks such a system that would apply to *all* state local programs, not just welfare, that would establish a pattern of sharing: the system may vary by program, but it would endure for years. Perhaps, if attention could be diverted from the primary instinct of fiscal survival, state and county agencies could work more smoothly together toward common goals of improving services. Meanwhile, county officials look with hope to President Carter's welfare reform, not so much as an end to the welfare mess but for fiscal relief. Welfare reform, if it does occur, could afford North Carolina the opportunity to eliminate its own welfare mess and move state/county relations on to a more positive track. □

Financing Social Services—The State's Perspective

Barbara D. Matula

IN SOCIAL SERVICES the password is sharing. The federal, state, and local governments are partners in a system that shares authority, responsibility, and funds—and *should* share credit and blame for the system's successes and failures. This article will talk about the state's place in this partnership and about the frustrations that result from the overlapping layers of governmental organization, legislation, and regulation.

The state's responsibility for caring for the poor is spelled out in Article XI, Section 4 of the North Carolina Constitution: "Beneficent provision for the poor, the unfortunate, and the orphan is one of the first duties of a civilized and a Christian State." This responsibility has been overshadowed in the last four decades by sweeping federal social welfare programs intended to offer uniform, equitable treatment and benefits for the needy in the fifty states.

In North Carolina policies are developed at the state level in an effort to assure that the social services program is applied consistently among the 100 counties. Services are delivered primarily at the county level in the belief that decentralized delivery of services is most responsive to the people's needs.

Between any two levels of this pyramid, something is given and something is taken away. If we place the federal government at the top with the state in the middle and the counties at the bottom, we see, coming through the state from the federal government, huge sums of money—"federal" dollars. Along with these dollars, we are deluged with programs, priorities, policies, mandates, options, guidelines, regulations, restrictions, incentives, sanctions, and the like. "Federal" dollars are given; certain freedoms to spend them as we choose are taken away.

The state selects the federal programs it has determined to be in its best interests. In accepting the federal dollars, it also accepts the federal restrictions accompanying these programs and in turn filters, interprets, and explains these to county governments. The state also adds its own programs and dollars to the federal pot. For example, along with the federally assisted Aid to Families with Dependent Children-Foster Care program, the state and counties support, on a 50-50 basis, a State Foster Home Fund to meet the needs of children who are not eligible for the AFDC-FC program.

Counties, in turn, view "federal" and "state" dollars as tied to infinite details and dictates. They complain about burdensome reporting requirements, inadequate funding formulas, and the relative inflexibility of both the state and federal governments. The counties, closest to the people served, deliver the programs and add a few of their own, but not until "local" taxes are raised to meet the county's share of the total cost.

Let us take a closer look at the funding sources. Those "federal" dollars that are so attractive and tempting to the state and the counties are not currency printed in another country, nor are they "free." For every dollar North Carolinians send to Washington, one dollar is returned.[1] Those are *our* dollars, which incidentally have made a long and arduous journey. They return to us wrapped in miles of red tape. Those equally attractive "state" dollars are raised by taxing the county's own residents and businesses. The final source, "local" dollars, come from the same source as the federal and state dollars. If we at each level of government could keep this in mind, we might not be so quick to insist on maximizing, even wasting, "other" tax sources in an

The author, who presents this personal view of the state's role in financing social services, is a budget analyst in the North Carolina Division of State Budget and Management.

1. *National Journal*, no. 27 (July 2, 1977), 1034.

effort to safeguard our own. Instead, we are given to insist that *more* federal dollars or *more* state dollars or *more* county dollars will solve our financial problems, whereas the solution may be a more efficient administration of programs at all levels.

Even HEW Secretary Califano has lamented the mind-boggling mountains of detail, regulations, and required paper work. HEW has undertaken to make the rules and regulations understandable and to eliminate the duplicative, contradictory, or unnecessary regulations. The state and the counties should make a similar effort.

It is unfortunately true that the federal-state-local partnership lends itself to buck-passing and finger-pointing. Instead, we need a positive, constructive, cooperative attitude, for we are all in the same business—working for the same end and supported by the same source of funds. For those who still are not convinced that this partnership is worth saving, consider only briefly the alternatives:

(1) Eliminate the middle man; by-pass the state and let federal dollars and dictates flow directly to the counties. HEW needs ten regional offices to work with fifty state governments. Regional office "interpretations" are not known for simplicity, or even consistency, with policy set in Washington. What monster would be created from a direct federal relationship with over 3,000 county governments?

(2) Centralize administrative and service delivery at either the state or federal level. Experience with federal take-over of assistance programs, such as the Supplemental Security Program, has not yet proved to anyone's satisfaction that centralization is either efficient or responsive to local needs. Rather, the preferred approach is to encourage local initiative along with community-based services.

(3) Refuse federal money for social services. This would eliminate meddlesome federal intervention but also would chop off the massive federal support for state and county social service programs. The programs would have to be cut back or funded entirely with state and local money. Moreover, we would not be able to keep at home the federal tax dollars that formerly supported the programs. The U.S. government would still collect the taxes that supplied these moneys and would send the funds to other states. Of course we could secede, but the Constitution forbids that.

The state budget-making process and its effect on social services

The state budget for social services is a plan for spending that reflects the partnership discussed above. It represents a fairly complete picture of federal, state, and county commitments to funding major efforts in social services. Although the budget is officially certified for two years, it is flexible and can be revised to meet changing needs throughout the year. Funding decisions are not made in a state vacuum; they involve and affect all three partners, since the state social services budget depends heavily on the availability of federal and local funds.

Each quarter the state submits to Washington an estimate of expenditures for income maintenance, medical and food assistance, and all other social services programs. This estimate is in essence a request for federal funds, along with an assurance that sufficient state and local funds are available for matching purposes. If estimates are too low, or if those federal funds are delayed, the state uncomfortably finds itself having to advance state dollars to meet, temporarily, federal obligations.

Until July 1, 1977, the state was also responsible for funding local deficits in approved county social services budgets (closed-end county budgeting). This practice came to an end when it became clear that the state, with all its sophisticated forecasting techniques, could not accurately predict those events and conditions that could cause the counties to spend more than they first projected. Holding the state liable for those projections on a county-by-county basis proved to be costly, and some people even wondered whether the counties might deliberately underestimate their expenditures, making the state hold the bag for more than its share of costs. The 1977 General Assembly abandoned closed-end budgeting and enacted legislation that allows counties with approved social services budgets to borrow from a state revolving fund to meet unanticipated needs.

Counties complain that program changes instituted after their local budgets have been set play havoc with their local budgets. Such complaints are justified when the legislature is in session (biennially and, in recent years, annually). Decisions reached by the General Assembly may make far-reaching changes on local as well as state and federal funding patterns. Futhermore, throughout the year federal actions or judicial decisions may place increased spending obligations on both state and local governments.

Given these uncertainties, the state budget process tries to give a sense of direction and priority to planned governmental expenditures. This process begins long before the legislature convenes. Departments are instructed on budget preparation as early as a year before their requests will be presented to the General Assembly. This allows the agencies time to consult with county officials, but one obvious drawback to such a schedule is that needs can change drastically in the rather long interim. Regardless, each state division solicits requests

for increased funding or program improvements under its jurisdiction and lists them in order of need.

Information-gathering is critical at this stage of the process. Whether a request can be documented may determine its immediate fate. Inaccurate estimates of need or of cost and the difficulty of measuring the actual effects of programs on recipients are common problems of social service programs. Yet these measures of need and of success are significant determinants in the decision-making process. How well an organization can justify its request in concrete terms may well decide whether that request will survive the several stages of budget recommendations. Each request for funding is then weighed on its merits and weighed against all other requests in the Division of Social Services and in the Department of Human Resources as a whole. As final arbiter, the Secretary of the Department must say "no" to many worthwhile projects, as he (now she) determines how resources best can be spent throughout the Department to meet its goals and objectives. The insatiable appetites of some programs are legendary. Simply stated, these programs can (and unless curbed, will) absorb all available dollars without increasing their benefits significantly. Medicaid and Aid to Families with Dependent Children (AFDC) are two examples. In the final recommendations "mandatory" items (those changes required by federal directive or brought about by inflation or unpredictable downturns in the economy) usually receive top priority not because of their desirability but because of absolute necessity. Showing that failure to fund certain items would result in great losses of federal receipts for other items also affects priority-listing.

Needless to say, the "squeaking wheel" is also greased in this process. Vocal and powerful lobbies representing strong community or provider interests demand and often receive special attention in almost all phases of the request and formulation cycles of the budget process.

The products of all departmental efforts are then forwarded to the State Budget Office for further review.

Obviously, not all requests can be funded. Because the budget must be balanced, expenditures cannot exceed available resources. Thus the amount expected to be received in revenue dictates the overall maximum amount that can be authorized for spending. The Budget Office staff compiles estimates of expenditures required for the ongoing, essential governmental functions and obligations for the so-called "continuation" budget, and any "surplus" over minimum basic needs is set aside for the "expansion" budget.

The budget staff completes its review and the Governor determines which proposals he will support.

The final budget package, as recommended by the Governor and the Advisory Budget Commission, goes to the General Assembly, which "dismantles" the package and considers each program in detail. To ensure that no vital purposes have been overlooked, the legislature invites supplemental budget requests from all the departments, including Human Resources. These requests may include proposals that were omitted from the recommended budget or any new proposals that have surfaced since the original package was prepared. The problem of distributing relatively few dollars among many worthwhile programs is compounded in the legislative process by the influx of new spending proposals that come during this supplemental cycle, especially from local and special-interest groups.

How well a social services request may fare before the General Assembly may be determined not by its merits but by the atmosphere in which it is received and the legislature's previous experience with similar efforts. Unfortunately, sensational press coverage of relatively isolated cases of fraud and abuse erodes public confidence and support for public welfare programs. Likewise, the benefits of such programs are often intangible and difficult to measure or prove. Because the program costs are usually great and always growing, legislators are wary of expanding benefits. On the other hand, the legislative committees that make budget recommendations frequently find that it is easier to say "maybe" than to say "no." So it often follows that their recommendations to the leadership contain additional requests with few, if any, deletions or reductions from the original package. Meanwhile, other legislators are busy introducing bills that may also create significant new spending obligations on the state and the counties.

In the closing days of the legislature, after all interested parties have had a chance to be heard, a special subcommittee representing both houses of the General Assembly is left to balance the swollen package of recommended expenditures with a much more precise estimate of revenues than was available earlier in the year. Eventually it presents a balanced budget to the General Assembly and, while no one is ever completely satisfied with the results, the state has a new spending authorization for the next two years.

Funding AFDC: an example

The problems in funding AFDC and in particular meeting mandatory cost increases at the expense of program improvements in AFDC illustrate the pressures and issues that confront decision-makers who wrestle with social services financing in the state budget process.

In North Carolina federal funds provide 67.81 per cent of AFDC payments. This percentage is based on the state's per capita income and is revised every two

years. The remaining cost is split equally between the state and the counties.

Except for certain cases involving disability, only single-parent families are eligible for AFDC in North Carolina. This decision provides little incentive for the low-income family to remain intact. Even if a father is unemployed or his income is too low to support his family, the family is ineligible for assistance. His "disappearance" or desertion removes that obstacle, but the mother must agree to cooperate in locating him through the Child Support Enforcement Program (IV-D) if her children are to participate in AFDC.

If the mother is employed before she applies for assistance, she can expect to have her wages—however marginal or erratic—directly reduce the amount she receives. But if she becomes unemployed before she applies and then is placed in employment through the Work Incentive Program (WIN), she can keep part of those wages and does not have her assistance reduced dollar for dollar.

Governments almost routinely grant cost-of-living increases to service providers, to employees, and even to utility companies (in the form of rate increases), but the AFDC family in North Carolina is still living on a fixed monthly income level that was determined to be "adequate" in February 1970. Opponents of increases argue that revised food stamp allotments, broadened medical coverage, day care, and a multitude of services available at little or no cost through Title XX augment the monthly income sufficiently to offset the rise in the cost of living. In the face of fuel and utility increases amounting to over 30 per cent, probably the only element of a fixed income available to "give" is the food budget; thus any increases in the food-buying dollar intended to improve nutrition and possibly avoid costly medical care go instead to pay fuel or utility bills.

Contradictions and dilemmas like these are well known, and as the state and local governments review plans for spending, invariably requests are made to correct such situations, to increase eligibility or levels of support, or to expand the scope of the programs. Unfortunately, "mandatory" items too often consume all available dollars, leaving little for "optional" program improvements. Recent examples of such mandatory cost increases arise from (1) the decreased level of federal support for ongoing programs and (2) the increased number of persons eligible for AFDC. The federal government revises its formula for sharing in AFDC assistance payments according to the state's ranking in per capita income. Any improvement in the state's ranking results in a decrease in the federal share. The latest revision for 1977-79 lowered the federal contribution from 68.03 per cent to 67.81 per cent. State funds that might have been allocated to program improvements were instead needed to replace federal dollars. Likewise, every increase in the minimum wage benefits those who are employed, but it may keep employers from hiring those who have little training or education. Consequently, the number of persons eligible for AFDC increases even without a broadening of eligibility requirements, and this continued growth requires the state to budget larger amounts that might otherwise be used for program improvements.

Finally, it falsely appears that the average monthly AFDC payments are increasing, which relieves the pressure to make a cost-of-living increase in AFDC payments. This illusion is created by dividing the total amount paid out each month in AFDC benefits by the average number of recipients (each member of an AFDC family is considered one recipient). This calculation yields the AFDC payment in North Carolina. But checks are made out to the family; the budgets are based on families' needs, and they recognize obvious economies of scale. Therefore, while it is family size that determines the amount of the payment, a monthly payment of $200 for a family of four is not reduced proportionately to $150 for a family of three; instead a family of three may receive up to $183 per month. As the AFDC family size continues downward, as it is doing, the average payment per family (and therefore, per recipient) appears to be larger.

With almost 200,000 persons eligible for AFDC maintenance each month in North Carolina, it is obvious that sizable increases in funding would be necessary to effect significant program improvements. But nearly all available funding gets absorbed by mandatory cost items. Besides, increases to improve AFDC require strong public support—an element lacking in most welfare programs. With public confidence in such programs low, it is difficult for state-level elected or appointed officials to allocate money from the state budget for welfare improvements.

Conclusion

Deciding on the budget for social services programs is a cumbersome, complex process that involves many participants and by its nature fully satisfies no one. The process and its result are frustrating to county officials, who are on the end of the line and probably have the least to say about the programs they must implement. State officials, caught in the middle, are forced to respond to ever changing federal requirements and restrictions to bear the brunt of local complaints and criticism—many of which are justified—about the programs. And federal officials, although I should not speak for them, seek broad national goals to reduce poverty or relieve its harsher effects but are frustrated

(continued on p. 51)

Welfare Reform: The Carter Proposal

John M. Syria

PERHAPS NO DOMESTIC ISSUE of the last forty years has presented a greater problem to the American public than the nation's welfare effort. Beginning with the Social Security Act in 1935, federal moneys have been allocated to the states to use in assisting the aged, the blind, the disabled, dependent children, and other categories of people who need help. Over the years the welfare system has been tinkered with and new programs added.

Still, despite these forty years of effort, the existing welfare system clearly is not satisfactory to a great many people. Some contend that the allotments for public assistance are not nearly enough; others say that they are vastly too much, that the burden of supporting welfare falls too heavily on certain geographic areas, and that there are too many "free-loaders" on welfare.

Americans find themselves in a philosophical and historical dilemma. Most of us want to help the needy. On the other hand, our "work ethic" emphasizes the duty to work and to be independent; the poor are considered by some to be merely victims of their own shiftlessness. This moral dilemma is reflected in how we deal with the poor and administer our programs to help them. Also, our heritage of English law and government has taught us that caring for the poor is a local responsibility (a philosophy now reflected in North Carolina by the county-administered assistance and social services programs).

Apparently we will always need some system for extending help to the poor. As population increases and society becomes more industrialized and urbanized, the opportunities for jobs may increase but so also do opportunities for dislocation, with resulting loss of jobs and poverty. Furthermore, the more technical the society, the more skills are needed to fill the jobs of that society. Skilled workers find jobs, while the unskilled find a tighter labor market, which adds to their dependence on government assistance. Also, we have more old people, many of whom will need help after they stop working. And finally, continued inflation cuts into whatever purchasing power the poor may have.

Employees of all agencies that administer income assistance and employment programs have complained for years about the complexity of the rules and regulations governing the programs. The public is appalled at the amount of government "red tape" but simultaneously complains about cheating, fraud, and abuse in the programs. Congress and state legislatures often respond by passing laws designed to eliminate fraud and abuse —which results in further rules and regulations, more red tape, and tighter control measures, and the headache gets worse. On the other hand, when "guaranteed annual income" or "family allowance" programs (in which benefits would be paid on the basis of citizens' rights to governmental support without regard to need, thus eliminating the complex administration of the program) are suggested, most people strongly oppose them because they violate the work ethic and because they would cost so much.

According to public opinion polls, Americans want to help the poor by providing aid to children and food for the poor and by financing health care needs of the poor. At the same time, they feel that the current "welfare system" is not meeting these needs efficiently

The author is Assistant Director for Programs and Policies in the State Division of Social Services, North Carolina Department of Human Resources.

For more detailed information, see the text of President Carter's proposal to overhaul the welfare system as it appeared on page 40 of the *New York Times* on August 7, 1977. See also, Bernice L. Bernstein, *Welfare Reform—Final National Summary Report on Regional Outreach* (Washington, D.C.: Department of Health, Education, and Welfare, April 15, 1977); *Income Security System—Purposes, Criteria, and Choices*, Briefing Paper No. 2, Welfare Reform Analysis (Department of Health, Education, and Welfare, n.p., n.d.); *Better Job and Income Act, H.R. 9030—A Summary and Sectional Explanation* (Washington, D.C.: Department of Health, Education, and Welfare, September 13, 1977).

or effectively. In May 1977 the Department of Health, Education, and Welfare (HEW) conducted a series of hearings on welfare reform throughout the nation. The hearings revealed strong support for:

- —An adequate assistance level, with establishment of a national minimum income.
- —Easily understandable and uniform eligibility rules.
- —Meaningful jobs for aid recipients.
- —A system based on the principle that everyone should earn what he receives.
- —Assistance to families on the basis of need, without regard to whether both parents are present.
- —End to the fragmentation that "shuffles people from program to program and worker to worker."
- —Elimination of practices that are punitive or demeaning.
- —A system that can be administered with integrity, efficiency, and compassion.

A program of aid to the poor should accomplish several purposes. It should assure basic income and protect against catastrophic expenses and interrupted earnings. In doing so, it not only reflects our concern for people and equality of opportunity and results but also works for social stability. Even those strongly opposed to "government hand-outs" admit that aid to the poor is necessary to avoid social unrest.

Any aid system should focus on low-income persons, be adequate and fair, provide incentives to work and save, enhance employability and self-image, promote family stability, encourage private charity, provide for compassionate treatment of recipients and administrative efficiency, permit adequate control, and be clear and simple.

With this background in mind, last fall President Carter, having promised welfare reform in his election campaign, offered his proposal for transforming the way the federal government deals with the income needs of the poor. This proposal, developed by HEW, has two parts —the Jobs Program and the Cash Maintenance (income) Program. It was introduced into the Congress on September 12, 1977, as the Better Jobs and Income Act (HR 9030).

IN ESSENCE, the legislation would:

—Create up to 1.4 million public service jobs for the primary earner in families with children. This part of the proposal should serve up to 2.5 million people on a temporary basis during any year. Its intent is to provide income through jobs and wages.

—Consolidate the three current major income assistance programs—Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), and food stamps—into a single system with simpler, uniform rules.

—Permit families headed by two parents to receive income supplements if the husband earns too little to support the family. Low-income fathers would no longer have to leave their families to make them eligible for help.

—Provide a basic federal benefit floor for all persons. This provision substantially increases income support in some states. In higher-benefit states, the states would be encouraged to supplement the basic federal minimum to maintain income support at present levels.

—Provide for a three-year transition period *after* the new rules go into effect. In this period the federal government will help states maintain benefits to particular recipients of current programs. During the first year, states would be required to keep up a good part of their present effort in supporting programs for low-income people.

— Provide for a three-year preparatory period *before* the new rules go into effect, during which a centralized computer system would be constructed. States, at their option, could receive and process applications for the new consolidated program (90 per cent of this cost paid by federal funds). The federal government would figure benefits and make payments in an attempt to reduce fraud and error.

—Expand the current Earned Income Tax Credit (EITC, a 10 per cent federal tax credit on annual earnings under $4,000) for workers in private-sector and regular public-sector jobs as a supplement to the income of low-wage earners and as an incentive to maintain their work effort. This EITC supplement would not apply to the new specially created public-sector jobs, so that private employment would be more desirable than special public employment.

—In all, state and local governments should save about $2.1 billion, the precise amount depending on state actions that are difficult to predict. No state would save less than 10 per cent of the current cost.

SPECIFICALLY, the *jobs aspect* of the proposed legislation (the Jobs Program) would be administered by CETA (Comprehensive Employment and Training Act) and state employment services officials. The program would be open to both two-parent and single-parent families with children. Private-sector jobs would be emphasized at first, and the earned tax credit would be only for workers in private jobs and regular public-sector jobs—not for specially created public service jobs. This provision would encourage people to seek jobs in the private sector. The Work Incentive (WIN) program for AFDC recipients would be absorbed by the new Jobs Program.

In the proposal's *income aspects* (the Cash Assistance Program), the cash benefits for those not expected to work would be as follows: Cash benefits for aged, blind, and disabled persons without other income are set at

$2,500 for single people and $3,750 for a couple. This is about what many SSI recipients now receive from the federal government, including the bonus value of their food stamps. Single parents in families in which the youngest child is under seven also would not be expected to work, although they would be eligible for the public service jobs. The basic federal cash benefit for such families without other income would be $1,900 for the head of household, $1,100 for the first child, and $600 for each additional child. The total amounts to about 65 per cent of the poverty threshold, or $4,200 for a family of four—a substantial increase in income for present AFDC recipients in twelve states. Moreover, actual payments will be higher in the many states that supplement the basic federal benefits. When persons in families that would not be required to work do take jobs, their cash benefits would be reduced by not more than 50 cents for each dollar earned under the basic federal programs (and not more than 70 cents in states that supplement benefit levels).

The cash benefits for those who would not be expected to work would be as follows: Those "expected to work" would be one parent in two-parent families, the parent in single-parent families with children of school age and above (when the children are seven through 13, only part-time work is expected), childless couples, and single people. The nonworking spouse and and the children in two-parent families would annually receive $1,100 and $600 each, respectively, as the basic federal benefit (benefits would be paid for a maximum of seven family members), while the adult expected to work would receive nothing for eight weeks while he searched for a job and nothing thereafter if he or she refused work. If he could not find a job, a job would be created at the minimum wage, and the family's income would be augmented with cash. The worker in such a family could keep all of the first $3,800 that he earned. Above that level, cash payments would be reduced by 50 cents for each dollar earned under the federal program (and not more than 52 cents in states that supplement). For a family of four under the basic federal program, this would mean that federal payments would end when total income reached $8,400 (higher in states that supplement). If no job could be found or created for a worker, after eight weeks the family would receive an annual $1,900 cash benefit in addition to the cash assistance to the nonworking spouse and the children, bringing the family's annual benefit to $4,200—the same as that paid to a family of four in which no work was required. For single-parent families with all children over 14, the benefits would be the same as those for two-parent families. In single-parent families with the youngest child aged seven through 13 years, the parent would be expected to work at least part-time while the children are in school, and a part-time job would be provided. For childless couples and single people, a basic benefit of $1,100 per adult would be paid and would continue thereafter if he could not find a job. It would be cut off if the person refused a job at the minimum wage. Benefits would be reduced by 50 cents for each dollar of earnings, beginning with the first dollar earned.

States would be permitted to supplement the federal benefit. If a state supplemented this basic amount, the federal government would again participate by contributing 75 per cent of the state supplementary payment between $4,200 and $4,700 and 25 per cent from $4,700 to the poverty threshold.

THE HEW PROPOSAL has many other new features. For example, the unit eligible to apply would be the nuclear family. The period for counting income to determine eligibility would be the six months before application is made; now income is estimated over the one- to three-month period after application. Also, people with jobs would be required to report each month. Expenses of child care up to $150 monthly to a maximum of $300 monthly would be deductible from income taxes. A means test would allow an applicant $500 in liquid assets, to own a car of reasonable value, and to own the house in which he lives. Beyond the $500 liquid assets, 15 per cent of nonbusiness assets up to $5,000 and 10 per cent of business assets would be excluded from countable income.

The bill also provides for emergency needs. This program would provide $600 million to states to cover emergency assistance needs that are essentially left to the states to define. Presumably the moneys would be used to cover those crisis needs of families or individuals that could not be accommodated by the new system. Most North Carolina counties now have general assistance programs for such purposes; these programs are totally funded by the county. Under the HEW proposal, North Carolina would receive $4.7 million for this purpose. No state or local match funds would be required. The states would have the option (subject to federal policies and rules) of processing applications for the cash assistance program.

Federal moneys would support 90 per cent of the total "welfare reform" package. Federal funds now cover 50 per cent of North Carolina's administrative costs for welfare. In the proposed system the federal government would figure the payment and issue checks through a centralized computer system.

Criteria for Medicaid eligibility would be the same as those under present federal and state regulations. Medicaid rolls would not, therefore, automatically expand. This fact allows the Carter Administration to submit a national health insurance proposal to Congress in the

next few months without disrupting the current Medicaid program.

SOME RESULTS of the HEW proposal can be figured numerically. Others are conjectural.

The proposal would establish certain nationwide minimum benefit levels that could increase the income of some poor people. For example, in North Carolina the current annual benefit level for an AFDC family of four is $2,400 plus $1,454 in net bonus food stamps, for a total annual income of $3,854, compared with the proposed $4,200 annual federal benefit level. Single adults, childless couples, and two-parent families (if the wage earner's income cannot support the family) would also be eligible for the first time. As a result of these changes, an estimated 350,000 more recipients would receive benefits in North Carolina, and about $400,000,000 more federal dollars would come into the state.

After 1983-84 the federal funds would provide 90 per cent of all the program costs. Now federal funds cover all food stamp benefits and SSI payments and about 68 per cent of AFDC benefit costs. In essence, then, the federal government would pay a larger share of the costs of maintaining the income of the poor.

The Carter proposal emphasizes finding jobs in the private sector and creating jobs in public service. It also contains incentives for most recipients of cash assistance to work. We may wonder whether there will be enough appropriate jobs in either the private or public sector.

Program costs might be lower in the first years. Just how much lower is hard to figure because the legislation is so complex and because this program might affect the costs of related programs; it might be that the cost to states and counties would increase because of a greater demand for other social services like day care and counseling services and for more vocational rehabilitation and health and mental health services needed to meet the program's job objectives. Federal funds for these types of programs are limited. Also, some of the program's provisions would require more local general assistance to cover gaps in the program resulting from the facts that (a) needs would be determined on the basis of the six months before the application is filed (thereby increasing by three months the time until the applicant could receive federal cash assistance) and (b) the adult expected to work would have to search for a job for eight weeks before he could be given a specially created job or cash assistance. Furthermore, the emergency needs program as it now exists appears to be underfunded.

Employment patterns in certain localities would be affected in an undetermined way by the increased number of public service jobs and the application of the federal minimum wage to these jobs.

The states would continue to be involved in administering an eligibility program whether or not they elected to process applications under the reform proposal. Either way, they would still administer the Medicaid program within the boundaries, at least until a national health insurance program is enacted.

There is some question about the computer capability at the federal level to do the job adequately. The difficulties with implementing SSI in 1974 suggest that the federal computer expertise may be inadequate for the job required in the proposed reform.

The role of state and local governments would be changed under this proposal—greatly strengthened in the Jobs Program and lessened in the Cash Assistance part of the program. But close coordination at all levels of government between Cash Assistance agencies and Jobs Program agencies would still be essential. The complex relationships among agencies required in the current WIN program for AFDC recipients took several years to develop.

The Fair Hearing and Appeal process would have to be carefully studied to assure that it would safeguard the rights of welfare clients.

THE PRESIDENT'S PROPOSAL appears to achieve some desirable goals referred to earlier in this article, but it is still complex and hard to administer. It retains the means test, emphasizes jobs, preserves family units, retains the local and state option to participate in administration, and still involves the state in supporting the program. The proposal reflects our society's values, philosophies, and traditions in meeting the needs of the poor as well as the contradictions that are inherent in them. The question is whether this proposal is a substantial improvement over the current system. Any real reform will cost more, and that should come as no surprise. It is doubtful that the public will accept a system that sways too far from our basic values of "work" and help to only the "deserving" or "truly needy" poor. Consequently, any welfare reform will probably rest on these values and the extent, in Congress's view, to which the taxpayers are willing to fund the expansion.

The proposal will not have an easy time in Congress. Concern has already surfaced there about the program's cost and the increased number of beneficiaries. Special-interest groups will speak out. For example, the AFL-CIO apparently opposes the elimination of the food stamp program. However, the National Association of County Commissioners has supported the President's proposal. Many are concerned that welfare costs to states and counties will still be too high. Others feel the benefit levels and the number of jobs available under the program are both too low.

(continued on p. 51)

Planning and Title XX Requirements

Robert M. Moroney

PLANNING IS STILL A TAINTED WORD to some people. Even today the term is associated with control mechanisms used by socialist governments. But formalized planning has a long and honorable history, beginning with the scientific movement of the nineteenth century. Gradually it has moved from its confines in industrial management and urban planning into most sectors of governmental activity. This article will examine the requirement in Title XX of the Social Security Act that social service activity at both the state and local levels be planned.

Over forty years ago the national government began a process that set in place a commitment to human services planning. Faced with the crisis of the Depression, the government launched a series of impressive social programs that included the Federal Emergency Relief Administration (FERA), the Civilian Conservation Corps (CCC), the Public Works Administration (PWA), and the Civil Works Administration (CWA). To show the scale of the commitment, this last program alone in two months put over 4,000,000 people to work and within six months started 400,000 projects, built or repaired 500,000 miles of roads, built or improved 40,000 schools, and established 500 new airports. While planning for human services started in the 1930s, it has only been in the last fifteen years—after the thaw in the Cold War—that planning as a formally recognized process has become respectable. With the passage of the Title XX legislation in 1975, state and local governments are required to develop planning processes to meet social services needs if they wish to receive federal funds. It needs to be emphasized, however, that the recent impetus for social planning has come, in large part, from elected officials and citizens who seem to be more concerned with efficiency and economy than with rehabilitating clients, finding jobs for people, improving people's health, etc. While no one can or should argue against efficiency, it is limiting to think of planning as useful only in periods of economic retrenchment. Planning can be more than reactive. It can recommend strategies in times of growth and stability.

The author is a professor in the Department of City and Regional Planning at the University of North Carolina, Chapel Hill.

Definition of planning

While people disagree on what planning is or should be, they have generally agreed with certain basic principles. Planning addresses two kinds of questions. What is the purpose of our organization; what are we trying to accomplish? The second follows: What is the best way to achieve these objectives? Planning is not a single discrete activity; rather it is a process that attempts to prepare decisions for action. As a process, planning is a continuous activity and requires resources in order to be sustained. It is ongoing and cannot be viewed as the "once a year" time when a document is written. The document may be a "plan," but it is not planning. Nearly all definitions recognize that planning is directed toward the future. This is perhaps the most important characteristic of planning, since it introduces the notion of prediction. Finally, the planning process cannot operate unless it is directed to more or less defined goals and objectives. This does not mean that planning begins with clearly defined objectives. In most cases the first phase of planning consists of formulating operational objectives on the basis of ambiguous goals that evolve from the political process. Planning tries to reduce uncertainty and brings a rational perspective to decision-making. It introduces analysis and information into the political environment. In our society and probably any other, planning does not replace the political process. Rather, it injects a rational style into the political environment.

Types of planning

There are two distinct but interdependent types of planning—strategic planning and management planning. *Strategic* planning is the process of deciding on the organization's objectives, on changes in these objectives, on the resources for attaining them, and on the policies for acquiring, using, and disposing of these resources. The Planning Regulations (Sections 228.20 through 228.35) in Title XX of the Social Security Act require each state to prepare a Comprehensive Annual Services Program Plan that states program goals and objectives, target populations, services to be provided, organizational structure, and the planning process to be used. In this context, strategic planning is concerned with (1) developing and completing the annual plan; (2) deciding what services the agency will provide by the various means available to it; (3) formulating criteria for deciding what services will be delivered to which specific population groups and to what geographic areas; (4) deciding what information is needed to monitor and evaluate programs, how it will be gathered, and how it will be used.

Management planning is the process by which planners assure that the resources, once obtained, are used efficiently and effectively to reach the organization's objectives. It is concerned with (1) developing operating rules for public agencies—that is, the regulations that deal with eligibility for services, receipt and use of Title XX funds, and so on; (2) developing guidelines for public and private agencies interested in providing services under contract to the Title XX agency; and (3) designing and operating service delivery programs.

Strategic and management planning traditionally have been separated in social services. For almost forty years the federal government has set the objectives and established priorities for social services. Strategic planning, carried out at this level, was controlled through categorical funding, and the states were required to accept federal objectives and priorities and to establish a machinery for carrying them out. There was, and still is, a powerful rationale for this—namely, to achieve national standards for social services. Even if a state objected to the federal objectives and priorities, it had little recourse; it had to provide the services if it wanted federal money. But starting about ten years ago, the states began objecting to this management task. They wanted greater opportunity to set objectives for social services, contending that only the states were sensitive enough to their own needs and capable of establishing priorities. As a result, they asked for federal block grants rather than categorical grants for social services funding. When federal policy did shift, state and local reaction was mixed. The states had to plan strategically, and they had little experience to fall back on. The freedom through the block grants proved to be a two-edged sword, in that the freedom brought new responsibilities. While this has happened in many areas, it is now arising in the context of Title XX. States that had not been responsible for strategic planning in the field of social services now must establish objectives and develop a policy framework.

Comprehensive v. rational planning

Comprehensive planning and rational planning are often used interchangeably, yet they are quite different. Many people speak of Title XX planning as comprehensive planning, and yet technically it is not nor can it be. Comprehensive planning is concerned with deliberately altering institutions to achieve a predetermined end. It begins with the premise that these institutions are interdependent and must be viewed as a whole. In the last two decades, the confidence that the problems of social well-being can be coped with systematically led to many public efforts committed to "comprehensive planning." The Community Mental Health Act was the first and possibly the most successful of these efforts. This and other programs that were based on comprehensive planning were expressions of confidence in society's ability to manage social problems.

But comprehensive planning, because of its encompassing span and its reliance on authority, is now viewed by many as impossible in the American context. Some of the specific reasons include: (1) comprehensive planning requires agreement on goals and values when in fact this integration or aggregation into a single hierarchy is unlikely to be realized; (2) most organizations engaged in planning are dependent on external forces that they cannot control; (3) planners have only fragmentary knowledge about the problems they deal with; (4) comprehensive planning assumes a capacity for central coordination that rarely exists; and (5) comprehensive planning assumes that there is one "best solution" when in fact this is rarely the case. These, then, are some stumbling blocks for comprehensive planning efforts.

Rational planning is different from comprehensive planning. While comprehensive planning has a foundation in a rational process, not all rational planning is comprehensive. Rational planning tries to introduce methods and techniques to problem-solving and decision-making, to reduce uncertainty, and to bring logic and a scientific approach to political decision-making.

Title XX explicitly requires a rational planning process. It speaks of introducing a framework to the planning of social services and providing decision-makers with information and suggestions that they can act on.

The focus of planning: social services or social need

In the context of planning for social services, we must distinguish between two kinds of planning—planning for services and planning to meet social need. "Planning for services" has been the traditional approach. The existing network of social services—e.g., social workers, case aides, homemakers, therapists, day care places, nursing home beds, foster homes, etc.—becomes the starting point for analysis. But these services tend to get set in concrete. The unintended emphasis is on organizational survival. The cart is put before the horse: Rather than first establish what the organization's purpose is (that is, What is the client's need and what services, perhaps new, can the organization set out to provide?), administrators structure their agencies in such a way that the organization's purpose is often defined as the sum total of the services it can now provide. Staff tend to see an old person, for example, as a "nursing home case" or a "homemaker case." A mentally retarded person is a "special education case," a "community home case," and so on. This labeling begins when the agency first sees a prospective client and continues as long as it deals with him or her. Needs are often translated into what a particular agency currently has to offer. For any number of reasons, services that were introduced as one way to help people with a particular need quickly become the *only* way to fill that need. Services that were seen as *potentially* of benefit become solutions whose benefit is rarely questioned. The universal tendency, within this perspective, is to overemphasize the management aspect of planning—the efficiency of the system. Rarely are the *purposes* of these services examined or their value questioned.

Title XX is therefore a major break from the past. It focuses clearly on the needs of individuals, families, and groups, and the difference between the two approaches is fundamental. The Title XX Planning Regulations speak of potential target populations, "populations at risk," populations who are eligible for some form of support. The task has become one of translating their need into services rather than fitting their need into existing services. Accomplishing the goals of Title XX means that the services and the way they have been organized must be re-evaluated. Professionals will have to think about services that can be adapted to fit need (strategic planning).

The required planning process

The planning process has five phases: (1) analyzing the problem and assessing the need; (2) establishing goals and objectives; (3) examining various possible solutions to the problem from which one (or several) can be chosen; (4) selecting and carrying out a particular course of action (program); (5) monitoring and evaluating the program and feedback. These are the elements of rational planning, and these are the activities required by the Title XX Planning Regulations.

But the Regulations are ambiguous, leading to problems in implementing the required system. First, the planning process as defined (Section 228.32) lists the following activities: assessing need, making a resource inventory, setting priorities, setting goals and objectives, and selecting a specific program from possible alternatives. But needs-assessment is only *recommended* as an activity, and states are not to be penalized for bypassing it. While most states have attempted the assessment, it is quite possible that as resources gradually become tighter, this step will be de-emphasized. If this happens, the major planning innovation—the shift to strategic planning and the emphasis on meeting social needs by focusing on at-risk populations—will be gone. Instead, the states will gradually revert to the more traditional management planning approach that is based on how efficiently present services can be administered. The services will become even more impervious to change. Another problem is that the Regulations discuss evaluation not as a part of the planning process but as a distinct organizational activity. This separation has serious implications, and the issue is more than semantic. Planning, as we saw earlier, is a continuous process that requires feedback. Evaluation and monitoring provide this. If evaluation is viewed as separate from planning, either organizationally or functionally, the purposes of planning will be hindered.

This ambiguity has produced a number of problems over the past two years. States have, with varying degrees of success, geared up to carry out the required tasks, but their efforts have been fragmented. Some staff have been given responsibility for assessing needs, others for formulating goals and objectives, others for setting priorities, and still others for monitoring and evaluation. While each group may be technically competent, these efforts have been hampered by not being integrated. Furthermore, in a number of states, these staff are scattered throughout the organization, so that they have trouble communicating. In short, the legislation requires planning and identifies planning activities but has not produced planning systems that can achieve all that planning can potentially accomplish.

The joint endeavor

Although Title XX is a federal-state program in which the state is responsible for meeting the requirements of the legislation, the process outlined in the Regulations

implies that sub-state agencies will also participate in planning. There are a number of reasons for this. Some tasks are more appropriate to the county or region—designing specific programs, monitoring ongoing activities, and deciding on where services will be located. County professionals and officials argue, just as their state counterparts did with the federal government, that they are better equipped than the state to determine need at the local level and establish priorities. The state's response to this is mixed, and local social services people tend to feel that their ability and willingness to plan are questioned.

At the state level, planning for social services is fragmented—dispersed among those designated as planners and program and budget specialists who directly affect planning. Even more, beyond the Department of Human Resources, Title XX is much influenced both by those agencies that have contracts for service delivery and by state planning agencies. Social service planners with official responsibility for carrying out the federal mandate for Title XX planning complain that they are isolated and understaffed and lack power to monitor the process.

It appears, then, that the Title XX planning process lacks accountability. Moreover, despite the need for planning at all levels in a reciprocal relationship, distrust and conflict exist. Artificial and counterproductive divisions of labor have been made. For example, within the framework discussed earlier, states have assumed responsibility for strategic planning and have delegated management planning to the counties, whereas both levels should be involved in both aspects of planning. The state is responsible for formulating the annual plan, but local communities should contribute heavily to that plan. Just as the federal government for decades determined minimum levels of service and standards for the country as a whole, the state now must assess the need of *its* total population, decide which needs are greater, and decide how to allocate resources fairly among the counties. The state should compare the counties' needs on the basis of those criteria that it feels to be important—for example, fairness, numbers in need, presence of high-risk populations with multiple problems, and so on. However, counties should be allowed to identify needs within their jurisdiction and set local priorities. Local planners and administrators point out that having the state establish priorities on the basis of county averages often masks the fact that certain areas of a county can have very great need. Both levels, state and county, have a legitimate role in the strategic planning process, and they both need to understand this. Neither level can do the job by itself.

In establishing goals and objectives, the overall Title XX goals of reducing economic dependency, promoting self-sufficiency, preventing or remedying neglect and abuse, preventing or reducing needless institutionalization, and providing institutional care when necessary, have to be put into operation. To do so, they must be translated into specific services such as day care, meals on wheels, home-maker training, etc., and resources have to be identified for performing these activities. After that, specific programs must be designed and implemented. While the state is in the better position to translate Title XX goals into services (assuming that local participation is encouraged), the county should have the authority and responsibility for designing specific programs to meet the needs. For example, if day care is a priority and resources are earmarked for this service, each county should design its own day care program. Only at that level can services that are sensitive to local conditions be planned.

Finally, both county- and state-level planners and administrators must monitor and evaluate the programs that have been established. From the local point of view, is the program being carried out as planned? Is it meeting its specific objectives? Can the program be made more efficient and effective? From the state point of view, are services being delivered across the state at the levels planned? Are statewide objectives being met? Are some counties' programs more effective and more efficient than other counties'?

Conclusion

This article has talked about what planning is and does and how it can contribute to meeting the social needs of populations. Specifically, it dealt with social service planning as required by the Title XX legislation, especially the problems that will be encountered in establishing state-local planning. If it becomes clear that counties have neither qualified planners nor the resources to hire them, the state might offer them help until they acquire local planning expertise. Also, state and local social services agencies need to be so structured so that they can communicate with each other and avoid confusing their programs with duplicative or contradictory activities. To accomplish this, the necessary elements are planning and a notion of trust and shared responsibility.□

Title XX and Social Services: The Mecklenburg Experience

Joyce B. Massie, Elizabeth K. Thurbee, and Merlene K. Wall

NORTH CAROLINA HAS BEEN A STATE with a tradition of concern for the welfare of its citizens. Early attempts at care were county homes and workhouses. In 1917 the State Board of Charities was created and set standards for the delivery of care to those who needed public assistance. During the Depression years of the 1930s, federal involvement in relieving social ills greatly deepened, and Congress accepted federal responsibility for a certain amount of assistance to the needy when it enacted the Social Security Act in 1935. Although this act basically provided financial assistance, it opened the door to ever-expanding social legislation.

Before 1962 the major emphasis in social services focused on direct financial aid. However, the legislative amendments to the Social Security Act passed in that year recognized delivery of services as a necessary factor in working with dependent children and their families (Aid to Families with Dependent Children, AFDC). After this legislation became effective, the public gradually began to see a number of social programs emerging at the local level: vocational rehabilitation, services to the aged, public housing, nutritional programs, mental health, child welfare services, prevention of juvenile delinquency, and many others.

Often in working with such programs as AFDC, social workers, in their zeal to provide the client with the many services now available, overlooked the recipient's own strengths in dealing with his problems. This was one of the factors that led to the Welfare Rights Organization (WRO). Groups like WRO wanted more money in direct payments, believing that this would enable families to solve their own problems.

The authors are members of the Mecklenburg Social Services Department staff. Joyce Massie is a social work supervisor; Merlene Wall, an assistant director; and Elizabeth Thurbee, a training officer.

During the late 1960s and early 1970s, various legislative remedies were sought in Congress. Some, such as the Family Assistance Plan, were defeated. Some, such as Medicaid, were enacted under Title XIX of the Social Security Act. Some, such as the Older Americans Act, met special needs—for example, the elderly or the disabled. Some are still being tinkered with, such as health care and food distribution.

Legislation of this period, late 1960s through early 1970s, reflects a fundamental change in the basic philosophy underlying services needed to prevent or lessen dependency. The fundamental change is the idea that services will not be imposed—that the client should recognize the need and request those services he wishes. However, the proliferation of services directed toward meeting the needs of certain target groups—the aged, retarded, drug and alcohol abusers—have resulted in administrative fragmentation and duplication of services under a variety of "Titles" of the Social Security Act and other legislation.

Three years ago, January 4, 1975, in an effort to resolve these problems, Congress created a service-delivery system as a separate entity—the Title XX Amendment to the Social Security Act.

Purpose and goals of Title XX

The purpose of Title XX is to "establish a consolidated program of Federal financial assistance to encourage provision of services by the states." Throughout the committee reports that were made before the Title XX amendment was passed, there are statements that indicate a strong feeling on the part of Congress to give the states "ultimate decision-making authority" for social services programs. In other words, Title XX is one of a

number of congressional actions for implementing revenue-sharing. Primarily, the amendment provides for: (1) a single agency within each state to administer the Title XX program of social services, (2) coordination of Title XX with programs authorized under other Social Security Act titles, (3) allocation of funds to be used to fill services gaps, (4) expansion of existing programs, and (5) starting new programs that are not identified in other legislation. The services funded under Title XX are not substantially different from those that existed before. The difference lies in the insistence on *central administration, participatory planning, and fiscal and time accountability.*

The statute, Public Law 93-647, is explicit in specifying expected goals and services from available funds. It also provides for a comprehensive program, fiscal and statistical planning, reporting, and evaluation of the effectiveness of the services delivered to the client population.

The law sets out five goals that must be considered in funding services.

1. To help people become or remain economically self-supporting;
2. To help people maintain or achieve self-sufficiency and reduce or prevent dependency;
3. To protect children and adults who cannot protect themselves from abuse, neglect, or exploitation, and to help families stay together;
4. To prevent and reduce inappropriate institutional care as much as possible by making home and community services available;
5. To arrange for appropriate placement and services in an institution when this is determined to be in a person's best interest.

The Title XX legislation gives the states considerable latitude in deciding on specific services for its citizens, but these decisions have to be the end result of a well-defined planning process.[1] One requirement is that there be broad-based citizen participation in developing the state's service plan: a statement of what services will be offered, who will be served, by which agencies or groups, and at what cost. The North Carolina Comprehensive Annual Service Plan includes the following thirty-one services (the asterisk indicates services required in all county departments of social services):

*Adoption
*Services to Enable Individuals to Remain in or Return to Their Own Home
Chore Services
Day Care for Adults
Day Care for Children
Delinquency Prevention
Educational Support
Employment and Training
*Family Planning
*Foster Care for Adults
*Foster Care for Children
*Health Support
Homemaker Service
Home Management and Maintenance
Housing and Home Improvement
Information and Referral
*Interstate/Intercounty Placement of Children
Legal Services
Personal and Family Counseling
Preparation and Delivery of Meals
Problem Pregnancy
*Protective Services for Adults
*Protective Services for Children
Services to Meet the Special Needs of Alcoholics and Drug Addicts
Services to Meet the Special Needs of the Blind
Services to Meet the Special Needs of Children
Services to Meet the Special Needs of the Aged, Disabled, or Handicapped
Services to Meet the Special Needs of Emotionally Disturbed
Services to Meet the Special Needs of the Mentally Retarded
Social Development and Group Transportation

Each state must provide at least one service directed to each Title XX goal, and at least three services (selected by the state) for Supplemental Security Income (SSI) recipients. In addition, an amount equal to at least 50 per cent of a state's federal Title XX payment must be spent on behalf of people who receive or are eligible to receive AFDC, SSI, and/or Medicaid.

Mecklenburg's response to Title XX

The Mecklenburg County social services staff viewed the required *county participation* in developing the North Carolina state plan as a positive step. Before this, the state presented the completed plan to the counties after review by HEW and approval of the State Social Service Commission; there was no county involvement. Now it seemed that Title XX would require an equitable distribution of funds based on county needs and plans.

We felt, as did social services personnel in many counties, that Title XX's emphasis on *public and consumer participation* would enable clients and citizens to partake in the process that redistributes their tax moneys, and we would develop policies that would respond to self-stated needs and improve the social condition of the total community.

Title XX also held out the hope that *services would be available to more people.* The legislation allowed state agencies to establish fee schedules. As a result, many of those who had been considered ineligible but still could not afford private-sector services would now receive some aid.

Title XX encouraged contracting with the private sector as a means of reducing duplication of services

1. For a detailed discussion of Title XX planning, see the article, on page 23.

within a given community. This meant that there would be more communication between the public and private agencies, and the burden for improving communication would be with the local departments of social services. In the early stages, both public and private groups were enthusiastic and optimistic about this arrangement. Later on, however, sharp competition for Title XX moneys developed between the public and private sectors.

Planning for Title XX

Although we began to plan for Title XX in Mecklenburg County early in 1975, we did not have much information from the State Division of Social Services. Since the final federal regulations were not published until June of that year, the deadline for county and state-proposed service plans, we operated on a "word-of-mouth" basis, with the state trying to second-guess the "feds."

On March 28, 1975, we held a public hearing, a federal requirement. Although considerable effort was made to advertise this meeting, very few people attended, and the response lessened the prospect for true community representation in the funding.

However, our contacts with private and other social service agencies were gratifying, and a productive informal coalition of public and private agencies began. In early spring of 1975, as both the federal and state agencies intended under Title XX, private and other governmental agencies began to suggest that various kinds of service be offered. In Mecklenburg County an enormous number of proposals for services were made, and the county social services board began setting priorities.

At the same time that local proposals were being considered, proposals for statewide services were also being submitted without county knowledge or input. We learned on July 31, 1975, that the state had negotiated contracts with public and private providers and/or institutions to deliver certain services throughout the state.

These contracts and state administrative costs would account for more than $15,000,000 of the total state Title XX allocation of almost $63,000,000 for the first year. Despite the fixed ceiling ($2.5 billion) nationally, Title XX funding then seemed more than adequate, especially since previously North Carolina had never spent more than $40,000,000 annually for services.

Gradually, however, that $63,000,000 began to seem less and less, especially since inflation has reduced the purchasing power of the $2.5 billion ceiling, established in 1972, by as much as one-half. (There is a strong effort in Congress, however, to devise an inflation formula relating to the ceiling on federal spending for services.)

Formulas for county allocations

The formula first used (in fiscal year 1975-76) by the state to allocate funds to the counties was called an "equitable allocation." The funds were allocated in direct proportion to the county's population of income-eligible citizens—that is, people whose income was less than 80 per cent of the median state income. However, some counties were unable to use their full "equitable allocation," and these excess funds were then reallocated to other counties during the year.

"Equitable allocation" remained in effect until FY 1977-78 when the "fair share" formula was adopted. The new formula was based on each county's ranking by number of categorically eligible persons in the county —those individuals or families who received AFDC, SSI, or Medicaid. A quarterly plan for reallocation of county funds was included and a redistribution was made under the new formula for 1977-78.

A third dimension of the "fair share" formula was "phase-up" or "phase-down" in each county's spending level over a three-year period. Mecklenburg was designated as a "phase-down" county. The base for "phase-up" or "phase-down" is what the state "determined" each county spent in FY 1976-77. In FY 1977-78 counties were to receive their base allocation plus or minus 80 per cent of the difference between that base and the projected 1979-80 "fair share." The upcoming fiscal year (1978-79) calls for the base allocation plus or minus 50 per cent of the difference between that base and the true fair share. All counties were supposed to achieve 100 per cent of "fair share" funding in FY 1979-80. However, counties have been "unofficially" notified that the allocations for FY 1978-79 are to be frozen at 1977-78 levels.

It seems to us that distribution of funds should be based on the concept that funding mandatory services should have first priority. The remaining funds would then be allocated on the basis of total county population, the county's categorically eligible population, and the amount of funds counties have been spending in Title XX.

Growing reservations about Title XX

Mecklenburg County developed a plan that included many optional services that have traditionally been offered locally. We have been proud of our ability, with support from the community and the county commis-

sioners, to develop new programs to meet demonstrated needs: for example, our early efforts in family planning, homemaker, and day care services. Because of Title XX's stated objectives of tailoring and funding programs to meet local needs, we hoped to continue and perhaps increase new services with "freed" county dollars. Unfortunately, there have been no "freed" dollars in Mecklenburg County for the social services department to use. The county is still required to provide local money to match Title XX funds. We must also use local funding to meet administrative costs not picked up by federal and state sources. These costs vary from year to year and usually call for the county to assume an increasing share. In addition, many other county departments or functions are totally dependent on local dollars, and the county commissioners are under intense political pressure to keep the local tax rate down and cut spending.

Essentially, we are the single portal of entry into the Title XX system. The department of social services remains responsible for certifying client eligibility no matter which agency delivers the service. At times, however, our staff and the private and public agency contractors find it difficult to establish just who is responsible for what in the overall delivery of services to individuals and families. We are also working under statutes and regulations that specify goals, service criteria and limitations, time limits for action, and increased requirements for documenting and measuring the results of delivered services.

On the one hand we welcome the new eligibility criteria that permit more people to be served; yet we find that some of the new regulations actually limit services that were formerly available. For example, a program in family planning that involved neighborhood visiting was curtailed because of the requirements that each person served apply individually and have his eligibility be determined individually and that a sufficient trail be left so that the delivery of services could be audited.

Perhaps the most disconcerting experience with Title XX has been the mountains of paperwork imposed upon us. Federal regulations require a completely new set of forms; we have therefore had to reorganize all client information and transfer it to a number of different forms that ask for the same information. We not only duplicate our effort in filling out forms, but also find that we then receive little or no statistical feedback. We also receive inadequate notice when forms are discontinued or changed.

Within the framework of the Title XX regulations, it should be possible to provide good services and keep reasonably good records. Instead, we find that the amount of time spent in filling out duplicate forms seriously cuts into our ability to provide the services. State interpretation and planning—specifically, excluding the local departments in developing the original reporting system—is partly to blame for this situation.

Although at first we had many positive feelings about Title XX, we also had reservations.

Counties did participate in developing the state "service plan," but they were not included (except minimally, perhaps) in developing reporting and accounting procedures. Under Title XX, for the first time, the state and local levels were required to look at what we were doing, what the results were, and how much it would cost. This is a sound principle, but we in the counties were excluded from this part of the process, although we felt that we could make a significant contribution. Now the state is seeking the counties' help in designing a better reporting and accounting system.

Problems also arise because the federal fiscal year begins on October 1; North Carolina and the counties adhere to a July-June budget year. Our local pressure to meet deadlines imposed many constraints. For example, the county budgeting process was well under way before we received instructions for preparing the state document. Consequently we were "budgeting" eight months a year. Our budget was due in the county manager's office on March 1, and in mid-February we were deeply involved in the budgeting process even though we had not been notified of our allocation of Title XX moneys for fiscal 1978-79.

A major problem developed as we traveled the "primrose path," confident that there would be adequate funding to continue service delivery at the high level we had developed in Mecklenburg County: In October 1975, the State Social Service Regional Office notified us that no more funds were available for contracts with private service providers. After we heard this word, we began to feel uneasy about future funding for local departmental programs. We were not alone in our uneasiness: Coalitions of public, private, and special-interest groups developed across the state in the interest of self-preservation, to promote special interests, and to find out what was going on in the system. These groups included institutions, private agencies, and counties. We joined a group of urban counties with problems similar to ours; we wanted to mobilize support to achieve the level of funding that was needed to maintain our current level of service.

Despite the confusion and conflict, Mecklenburg County outlined a service plan that we wanted to offer locally. Our plan, along with ninety-nine others, became a part of the state's first Comprehensive Annual Service Plan (CASP) in 1975. The Governor has assigned responsibility to the Department of Human Resources (DHR) to develop this plan and allocate funds. At first, the Secretary of DHR delegated these functions to the Division of Social Services, but they reverted to the Secretary's office in February 1977. Since that date com-

petition for Title XX funds has increased among the divisions within DHR.

Conclusions

Two years of struggling with Title XX's varied interpretations and rigidity in some aspects have forced us to several conclusions. Local planning for local needs is a sound concept—involving all levels in the community in this process and requiring cooperation and coordination between public and private agencies in delivering the services. And who can deny that prevention of dependency and social breakdown is a desirable goal?

But North Carolina's plan for Title XX has been a disappointment in several areas. Although the plan has identified the mandatory and optional services to be offered across the state, what we have failed to define is the level at which these services are to be delivered. For many counties this failure has severely limited the services they can deliver. In some respects it has negated the effectiveness of the required planning process. Because of the state's zeal in promoting a minimum service package in each county, many counties are finding that they can do no more than provide mandatory services within the limit of their funding. It appears that creativity and initiative in planning and delivering services are punished, and we are approaching a statewide program that is mediocre at best.

The Department of Human Resources has assumed responsibility for directing a planning process that will meet federal requirements. Apparently the Division of Social Services has had little, if any, involvement in the process. Counties can only wonder about the implications of this situation. If DHR allocates money and directs the planning of how that money is to be spent, just how much control remains with the Division of Social Services? Who speaks for the county department of social services at the state level?

County departments of social services are concerned about the ways in which the Department of Human Resources has set priorities. Other agencies, such as local health and mental health departments, are not required to meet the same needs assessment and justification criteria for program planning as local social services departments. This inequity can cause resistance and resentment, inhibit working relationships, and finally deprive the client of the full benefit of services.

Our most serious concern right now is the allocation formula that prohibits adequate funding for service programs—especially in urban counties. From the beginning, 1975, we have been concerned about political maneuvering behind the scenes. We have wondered, when we could not get specifics on allocations, whether the whole process had been raped by the political system. We have been afraid that funds were distributed on the basis of who yelled loudest and longest, and this fear does not seem to be entirely groundless. We were told at a Title XX planning workshop in Raleigh last fall that the "dollars were moving East in an attempt to achieve a fairer distribution." ("Fairer distribution" was not defined.)

At present, because so much of Title XX funds is going to other state agencies, local departments of social services and private agencies are faced with curtailing well-established and meaningful programs—a loss also to the positive gains in the working relationship between public and private agencies.

Definitive action could remedy some of the problem areas. First, Congress must revise the current ceiling on spending to reflect current costs more realistically. Mandated services should be adequately funded across the state; then funding of optional services could be based on demonstrated need at both the state and county level. If public and private agencies were thus funded rationally to provide their respective skilled services, the clients would be the ultimate winners.

The State Division of Social Services should assume its rightful place in planning with, and advocacy for, the county departments, and it should draw on local knowledge in developing an appropriate reporting system. A good reporting system would be important in achieving accountability in both fiscal matters and quality of social services.

With adjustment in the present system, the commendable purposes of Title XX—to develop a client-focused, goal-directed service-delivery system and to use tax moneys in a fiscally sound, cost-effective manner—can be achieved. □

Public Policy in Day Care

Dorothy J. Kiester

DAY CARE is a relatively new term in the popular vocabulary. In the past fifteen years it has become both well-known and controversial, partly because an increasing number of families with young children need help in caring for those children and partly because the cost of child day care is increasingly met by public funding. Public money means tax money, which gives every taxpayer a vested interest in how the money is to be spent: who is to benefit and how much? In other words, day care has become a public policy issue. So far, the public's attention has been chiefly engaged with *child* day care, but in the next few years the new community service of day care for the elderly may well become an equally complex and commanding issue.

The family structure and the family's relationship to the community have changed profoundly in the past generation. Since the Industrial Revolution, more and more of what were once family responsibilities have been assumed by the community: police and fire protection, schooling of the young, residential care of the disabled and dependent, and so forth. In this progression, as the size and capability of the family shrinks, society takes over responsibility for providing those services necessary to the well-being of the body politic. How to do it becomes more of an issue than whether it should be done, although at the beginning of any change in old patterns, some people will resist what they perceive as a loss. This loss may be the loss of an ideal, such as "family responsibility"—or the loss of control over the pocketbook, brought on by burgeoning public programs and increasing taxes. For whatever reason, the real issues in day care, both for children and for the elderly and infirm, are confused and emotional, with the loudest arguments often coming from those whose information and viewpoint is the most biased.

The author is an Institute faculty member whose field is social work. She has worked extensively with children and has written several books on day care.

Day care for children

Opinions on child day care are equally divergent: welfare mothers should go to work; "supported" women should not compete in the labor market; mothers are entitled to the same freedom as fathers; good day care is in itself good for children; day care provides a legitimate source of income for owners and employees of centers. It is a fairly safe guess that none of these are unbiased, or unselfishly and totally dedicated to the best interests of individual children and society. All have motives, primary or secondary, ideological or monetary, that bear little relation to what children and families need.

Cost and payment. All recent figures on the cost of day care for children in a licensed program put the average at about $125 a month—$1,250 to $1,500 a year—depending on vacation arrangements. There are, of course, more expensive programs and many perfectly acceptable plans costing much less, but one point of agreement among most knowledgeable people in the field of day care is that *good day care is not inexpensive.* Where and how to cut costs is a constant source of conflict between those who earn a living from day care and those who set the standards for licensing and certification.

The amount of federal money going into child day care has increased enormously. The 1978 national budget for Head Start alone is $625 million—all federal. Approximately $12.5 million of this comes to North Carolina. Other federal sources for day care funding in North Carolina are (1) Child Welfare Services (Title IV-A), (2) Title XX, (3) Work Incentive (WIN) (Title IV-13), (4) Mental Health, and (5) Appalachian Regional Commission. Together these total approximately $75 million for 67,000 children in North Carolina this fiscal year. Considering that the total appropriation to the U.S. Children's Bureau in 1955 was only $10 million, these figures are staggering. Inflation has, of course, influenced the appropriations patterns greatly, but child day care was not big business until heavy federal subsidies began in the 1960s.

Who should pay the cost is another area for debate. If public funds are subsidizing some or all of the cost, who should be eligible to receive the subsidy? Should it go to the provider directly or should parents be given vouchers that could be cashed by any licensed or certified provider? Should day care be provided for *only* the children of working mothers who do (or otherwise would) receive public welfare? Should the amount be tied to the amount of the

mother's earnings? Should the agency that pays the subsidy be the one to set eligibility requirements and to determine which children (which families) may receive "developmental quality" day care?

Should the agency through which the subsidy is paid set the standards? Should this agency determine what constitutes acceptable care and also who meets the standards to qualify as a certified provider, or should that be determined by a neutral agency? Taxpayers tend to rebel when the quality of service for which they provide subsidy is set so high that the cost of the subsidy becomes excessive. If too many families are eligible for subsidy (and if the cost is too high for moderate-income young parents) private entrepreneurs are forced to participate in the federally controlled program of subsidies to survive. Then the providers lose much of their independence as private business operators and lower their margin of profit because of the cost of meeting federal standards. This problem of standards and regulations is discussed beginning on p. 34.

"Pros" and "cons" of child day care. Any program needs a set of assumptions (which may or may not be validated) in order to justify any substantial investment of public money, particularly when there is some question about whether the good of the total community is being served. Both supporters and opponents of subsidized day care sometimes overstate their arguments in regard to these assumptions. This is understandable. Their convictions are strong, and it is easy to become emotional when the well-being of children is involved, especially when the issues are compounded by the equally emotional elements of individual freedom and public expense.

Those *in favor* argue that:

1. If the child's own home is culturally or emotionally weak in fostering his development, a good day care program can provide sound nutrition and health care, an environment in which he can learn, and a balanced program of exercise and play for physical development. This argument, used for Head Start and for subsidized day care, also contends that in good day care the child begins to think well of himself, to trust others, and to develop a basis for later success in public school.

2. If the child comes from a stable, loving, economically secure home, then a good day care or nursery school program complements the home situation by the child's association with nonfamily adults and other children from a variety of backgrounds.

3. Mothers should be able to place their children in reliable, nurturing programs of child care at an affordable cost if they choose to or must work. Availability of *dependable* child care should not have to be a factor in a woman's decision to work.

4. The *quality* of care a child receives outside his own home should not depend on family income. Impressive scientific research has established the importance of *loving* care and individual, lasting, trustworthy human relationships if human infants are to develop normally. Emotional as well as physical growth in the first two years is absolutely critical for normal development, and both are as dependent on psychological nurturing as on food and clean comfort.

5. All parents need occasional time away from their children. Parents who are sometimes abusive may have particular need for help with their child-rearing, and the children may have desperate need to be away from their parents part-time but not permanently. The cost of saving the home with supportive, nonpunitive use of day care may be much less in money, as well as in human values, than the cost of permitting prolonged abuse or radical separation.

6. Adequately trained professionals in child care—child development specialists, social workers, early childhood educators, and others—understand normal needs and growth patterns better than most parents and know how to provide programs that promote the children's development.

Those who argue *against* subsidized day care have a rebuttal for most of the proponents' arguments:

1. There is little proof that day care is the best answer to cultural and/or emotional deprivation. In fact there is growing evidence parents need help more than children in stabilizing a family life conducive to healthy child development.

The all-important developmental experiences of bonding cannot occur for the infant who is deprived of close, continuing contact with either mother or a single mother substitute, and the intimate one child/one mother relationship is almost impossible outside the family.

2. Parents from stable, loving homes, in which economic need is not a factor, will find their own socializing experiences for their children at no extra cost to the taxpayer.

3. Even if a woman's decision about working should not have to depend on whether she can find good, affordable day care, this should not call for millions of federal dollars to set up a network of day care centers. In fact, the National Child Care Consumer Study of 1975 shows that care in a center is not only the most expensive option but also the one least often selected. Care by a relative is likely to be chosen more often by poor, near-poor, black, and Spanish-origin families and especially by single parents. Table 1 shows how the types of care are ranked in order of preference

Table 1

Parental Expenditures for Child Care Compared with Percentage of Child Care Purchased, 1975

	Parents' Expenditures (billions)	Percentage of Total Child-Care Hours
Relatives, in child's or relative's home	$1.1	45%
Nonrelative in child's home	1.7	17
Nonrelative in other home	1.8	20
Nursery schools and centers	1.6	15
Other	.2	3
Total	$6.4	100%

Source: *National Child-Care Consumer Study: 1975, II,* Tables 8-1 and 8-2 (Washington, 1975).

(the results are not weighted for availability) and of parents' cost. The cost in public dollars is difficult to determine, but it should include (1) grants for day care facilities, (2) family subsidies, and (3) tax credits for the costs of child care. However, there is no way to estimate the cost of lost work opportunities because an acceptable child-care plan was not available. As Table 1 shows, *any* care outside the child's own home is expensive, and, as a general rule, the better the care, the more expensive it is.

4. Not many will argue against the importance of healthy, early childhood years for all youngsters, but there is little agreement on what will provide the best substitute for the ideal of socially, economically, and emotionally secure parenting in the child's own home. Nor is there agreement on whether cost should be a determinant. Many people feel that, although a day care experience might be desirable, if the family cannot afford high quality day care the child simply does without this advantage, and "most of them turn out all right anyway."

5. The need for respite care, or for therapeutic placement for abused children, seems a valid part of an enlightened treatment program for certain parents. However, this would probably require a highly trained staff and might be provided better at less cost in a few carefully staffed treatment centers and day care homes. Is there not a risk for both children and staff when too much is expected of a day care facility?

6. Even professionals disagree about what constitutes "optimal developmental opportunities" for children. The general public often feels that any woman "in her right mind" can take care of children. Both lay people and professionals are uncertain enough about what constitutes the most desirable experience for children (especially those over two years old) to question whether any "specialist" knows better than the parents of a particular child what is best for that child. If there is so much doubt, how can a cost of $125 to $175 a month per child be justified? (Therapeutic programs for children with severe mental, physical, or emotional handicaps are, of course, much more expensive and should not be considered in the same category with regular day care.)

7. It makes more sense to pay the mother to stay home and take care of the child, if that is what she wants to do, than to pay someone else—perhaps at greater cost. And this being so, whatever happened to Aid to Families with Dependent Children (AFDC), and why is that program such a hopeless mess? (Or is it only considered so by a few unenlightened persons who object to all "welfare" on principle?)

Standards and regulation. No matter who or what for, no one *likes* being regulated. When the law regulates administrative standards, the person subject to those standards is likely to have a highly personal view of how fair, reasonable, and necessary they are. The private operator may feel that the standards for license mean that the cost of staffing and running a center prohibits a fair profit. On the other hand, child development specialists may feel that the minimum standards are so low that the child's health and safety are jeopardized. In fact, North Carolina state licensing requirements for the "grade A" level are designed only to assure safe custody.

Legally, responsibility for securing a license to operate a day care facility in North Carolina[1] rests with the facility's owner or governing board. The law is administered by the Child Day Care Licensing Commission, Department of Administration, which has a very small staff and limited inspection capability. Under the present law, the facility's operator or board may seek either an A or AA license, but there is currently no staff to administer the AA license. As of November 1977, the Child Day Care Licensing Commission had only five field-staff members, each serving approximately 20 counties. There are now 1,888 facilities licensed to care for 75,000 children and over 4,000 registered day care plans (day care homes). Registration requires no inspection and no minimum standards, except that a woman may care for only a limited number of children without being classified as the operator of a group home that must have a license.

A consulting firm has been engaged to analyze 170 facilities in order to provide a systematic base for reviewing standards in such areas as staff, cost, quality of performance, area served, assignment and admission of children, and administrative operating plan. This study (commissioned by the Office of Children in the Department of Human Resources) will be of great significance for both the Day Care Section in the

1. North Carolina Division of Social Services, *Manual* (Raleigh, N.C.), Subchapter 42A, Sec. .0400.

Student teacher and young child in day care center at Frank Porter Graham Child Development Center, Chapel Hill.

Division of Social Services (Department of Human Resources), and the Child Day Care Licensing Commission (Department of Administration). These two agencies handle two responsibilities: The first certifies that a facility meets federal standards and is eligible to receive Title XX funds; the second licenses according to standards that are mostly prescribed by state statute. A license is a prerequisite to certification. But present license requirements do not guarantee even adequate protection for the child's health and safety. Only since the 1977 amendments to the law, achieved in the aftermath of a tragic fire, has the licensing agency had injunctive powers. To date no facility has been taken to court, but the authority now present has produced much more voluntary compliance.

To be granted a license the operator need only give the Licensing Commission certain information about the facility (number of children enrolled, or planned for; square footage of indoor floor space and outdoor adequately fenced playground; number and classification of staff employed), answer a few administrative questions, and submit inspection certificates properly completed by fire and sanitation inspectors. The law does not even require a visit to the facility, although the place is visited for the first license. Monitoring is impossible except when complaints are filed.

The operator may seek the even higher "certification" level. This level is administered by the Day Care Section of the Division of Social Services, with the standards for "developmental quality" care set on the federal level by HEW's Office of Child Development (OCD). Certification that it meets the Federal Interagency Day Care Regulations (FIADCR) entitles the facility to receive children under the Title XX program of services, with payment coming through the county department of social services. Most "welfare children" are placed while the mother is in a work-training job.

Some professionals feel that, ideally, the regulatory agency should both license and certify the facility and should serve as a consultant in order to help build excellence in programs. The service agency should work to provide the best possible experience for children and their families.

Child-staff ratios. The most controversial requirement for licensing or certification has to do with child-staff ratios. Twice Congress has extended the day care appropriations at existing rates and at the same time continued a moratorium on the enforcement of a higher standard, thus permitting more time for rational decisions about child-staff ratios to be required by law. North Carolina is currently certifying at the higher adult-child ratio proposed by the OCD, but the private operators have petitioned the State Social Services Commission to reduce the ratio (fewer adults to children). Under the terms of the federal moratorium, this could legally be done, but the federally subsidized center operators are much opposed to lowering standards. Neither side of this argument can marshal incontrovertible proof of its contentions.

However, *in terms of the effect on children*, desirable traits will not be fostered if there is inadequate adult supervision. Growing research evidence indicates that children need understanding, individual attention to learn how to handle anger and frustration in nondestructive ways and need to feel individually loved and cared for if they are to develop internal controls. It is this personal attention from capable care-givers that helps to establish the basis for conscience and the capacity for caring. Absence of early, loving security produces indifference to human feelings and lack of motivation to respect the feeling, rights—even life—of others. The consequences for a law-abiding, productive society are clear.

The difficulty of providing clear-cut proof to support one set of ratios over another is the heart of the regulation dilemma. No written standards can possibly cover all contingencies so that subjective judgment can be equitably eliminated. It might be presumed that parents, who logically have the most at stake in this controversy, would be able to influence the decision simply by market control, but parents are also uncertain about what is "best care" and how much it should cost. Parents who benefit from Title XX subsidy have no reason to want the cost lowered. Parents who pay the full cost are often not well informed and are not organized to make a strong case either way. This leaves the private operators arrayed against the professionals in the public agencies, where the contest is more political than scientific.

Types of day care facilities. Another dimension of the debate deals with *where* a child should be cared for and what kinds of options should be available to parents. The Division of Social Services certifies three categories of day

care facilities: the day care *center*, with space and staff to care for more than ten children; the day care *group home* for five to ten children; and the day care *home* for no more than five children. Each category has a distinct set of standards, and each should be able to respond most effectively to the needs of a particular kind of child. In this state the center and the group home are subject to license. Only registration is required for day care homes, referred to in the North Carolina General Statute as a *day care plan*,[2] and there are no legal requirements for "baby sitters" who come to the child's own home. Baby sitters are a common arrangement, particularly for families who can afford to pay the minimum wage for an eight- to ten-hour day, five days a week. Many informal arrangements range from neighborhood cooperatives to "revolving arrangements" with friends and relatives. Sometimes the child is extremely well cared for in such an individual care plan. Sometimes there is really no care or, worse, there is abuse. These plans appropriately are the responsibility of the parents, and the community intervenes only in cases of reported child abuse.

These are questions that cannot be fully answered at the local level. Some of them cannot even be dealt with effectively at the state level. But, in the context of Title XX, only as local-level planners make their desires and priorities known to state planners can influence be exerted at the federal level for the fiscal and administrative tools necessary for broad-gauge planning in child day care. This does not mean that the responsibility for funding or for setting standards should rest entirely at the federal level, but that is where such powers lie at the moment, and there seems to be little disposition to assume major responsibility at either the state or the local level.

2. N.C. GEN STAT Ch. 110, Art. 7.

Choosing a Day Care Center

Regardless of who is paying, a problem for most parents who are looking for child day care is how to evaluate what they see. If parents have a choice of day care centers and the choice need not be determined by money, these clues may help in selecting the best facility for a child:

(1) Does the staff seem reasonably relaxed and happy? If so, staff members are more likely to treat each other with courtesy and to be sensitive to the feelings of children and parents.

(2) Do the children seem relaxed, going about their activities with pleasurable concentration and a minimum of fretful attention-demanding? If so, parents can safely assume that the children are getting a healthy amount of individual recognition.

(3) Does the place seem clean but not sterile—"lived-in," but not cumulatively messy? If so, the atmosphere is probably a healthy one from both a sanitary and an emotional standpoint.

(4) Does the staff treat parents as important to the child's well-being? If so, the staff will probably not try to supplant them or to be critical of the parents when talking with the child.

(5) Are parents welcome as observers, participant-volunteers, or even as suggestion-makers? If so, the openness speaks well of professional security among the staff members. Beware the director who wants parents to have no direct contact with the staff.

(6) Does there seem to be a good balance between intellectual stimulation for cognitive development and individual attention to emotional development? If so, self-confidence, trust, and joyful play are properly regarded as learning, along with "academic" skills.

All these characteristics reflect an attitude of *caring* on the part of the director. Staff will be selected for their sensitivity and cheerful outlook on life as much as for their training in the specifics of early childhood education, and parents need have no fear of what their child will learn or how his or her total growth will be nurtured in such a center.

Adult day care

Day care for the elderly—or adult day care, as it is more properly called because infirmity is not always a function of age—is care in a group setting away from the client's own home for adults who do not need nursing but require daytime supervision in order to continue living at home. Relatives, friends, or part-time paid attendants may not be able to provide 24-hour care, but with several hours of well-supervised day care, the person who can no longer manage alone is spared institutional placement and separation from home. Despite the similarities in child and adult day care—funding, regulatory standards, degree of dependency—the two programs serve different kinds of people. Adults *are* adults, with a lifetime of experience, and their dependency is different from a child's. Until deterioration removes an old person entirely from reality, that person needs to have as much control as possible over the large and small events of his life. When and what to eat, when and where to sleep, are examples of the everyday decisions an adult has the right to make, whereas a child's range of control is much more limited.

Day care is not to be confused with the social center to which senior citizens can go for a few hours of recreation or social, political, civic, or cultural activity when it suits them to do so. Such centers are a splendid service to the community, but they are being superseded by multipurpose centers that offer the full range of services that the old and frail need for a dignified independence in the community. These services encompass such things as information about local resources, medical care (hospital day care in some cases), physical and occupational therapy, and other needs, plus social activities that provide mental stimulation.

Many of the same problems that plague day care for children also beset the persons and agencies who would provide sympathetic, competent care for adults—how much staff, how many of what kind of participants, at what cost, and to whom? If the "participant" is in day care because he needs supervision and personal attention, the nature of his disability is obviously a factor in how many participants can be cared for

adequately by one staff member in the center.

Whether a center fits the "medical model" or the "social model" becomes critical in determining standards and sources of funding. Treatment-oriented facilities receive large amounts of money from the federal health agencies and must necessarily have skilled, treatment-oriented personnel. Therefore the cost of care in a medical-model day care center for adults is not much less than full-time care in an institution. But the saving in human values over institutional care is incalculable. In a social-model day care center for adults, the cost runs to a national average of about $200 a month, somewhat higher than the average for child day care ($125).

Obviously the standards for the medical model and the social model differ. But the wide differences may arise more from the source of the funding than from the needs of the people who participate in the programs. The line between the person who can be almost completely independent and the one who needs a bit of help and supervision may be a fine one. And some days may be better than others. Ideally, a participant could move from one type of care to another, taking advantage of the range of services as needed but not being subjected to activities he did not need or want. But such flexibility requires a very sophisticated operation, and not many facilities yet offer it.[3]

The question of standards becomes subject to controversy according to the involvement of the person holding the opinion. Since cost is inextricably tied to standards, who pays and who benefits can become the adversaries in any argument about the level at which standards for staff, space, program, activities, and extra services should be set.

Arguments for public funding. As in child day care, there are some persuasive arguments for public funding of large-scale day care services for adults —arguments that are based on a set of assumptions. Common sense seems to favor most of them, but these assumptions are not yet validated by controlled research.

1. Day care is infinitely preferable in human terms to full-time institutional care. Therefore it is to society's advantage to maintain a network of day care centers at little or no cost to those who need the service.

2. When old and chronically disabled people prefer to remain in their own homes or with willing relatives, they are entitled to community-supported day care when they need this service.

3. Good day care does much to preserve the dignity of the partially dependent person. Through this service, he will learn to manage his physical and mental resources in order to be as independent as possible and to be as active and positive in attitude as possible.

4. Relatives can often keep an older person at home if this does not disrupt the normal family living pattern too much, does not complicate or prevent their normal working schedule, and does not constitute more of a physical or emotional burden than the family can sustain. Having good day care available to supplement the family's finite abilities is sometimes essential to keeping an older person at home.

5. Although day care does not mean nursing care, medical supervision and/or consultation should be available and some form of occupational, emotional, or physical therapy, if needed, should be planned as a part of the daily program.

6. Social contact and intellectual stimulus help retain mental alertness and a capacity for enjoying life. Good day care helps provide this contact and stimulus.

All of these assumptions are predicated on the further assumption that the day care center and program will be pleasant, ego-supportive to the individual, and adequately staffed and managed. Some centers fall short of the ideal because of the differences in personalities, training, and talents of those who run them and work in them.

The major issues in adult day care are:

1. Should there be tax-supported centers for specified numbers of people who are over 60 or 65 and/or chronically disabled?

2. If so, should they be funded from the local, state, or federal level or some combination? Should the funding source set the standards?

3. Should there be a licensing procedure to assure that standards are met and maintained? Who should administer this regulatory function: Federal, state, or local agencies? Social services, health departments, mental health, or a new agency for the aging?

Durham residents enjoying a daytime craft session with members of the Coordinating Council for Senior Citizens staff.

3. The National Institute of Senior Centers, a private membership organization, has just completed a set of recommended standards for such centers, available from the headquarters office at 1828 L Street, N.W., Washington, D.C. 20036.

4. If the centers are to be tax-supported, should they be free to all old or infirm persons who want to participate, or should there be some requirements for admission? Should the requirements deal only with physical and mental conditions or should they include ability to pay? Who should determine the regulations and who should administer them—the center itself or an agency of the community, and if the latter, which agency?

These are complex questions, and any answers seem to raise other tough questions. For example, who should decide about the mix of senile and alert, rich and poor, cultured and untutored? Or what are the criteria by which such matters are judged?

The Division of Social Services certifies adult day care centers for participation in Title XX funding, just as for child day care, but licensing of adult day care centers is not required by law. In other words, there are no regulations to protect the health and safety of people in adult day care except for local ordinances and zoning requirements that provide protection against common hazards.

Funding, for the most part, comes from a variety of federal sources. The most common plan is support from Title XX through the county department of social services, either in the form of payment for eligible individuals in programs that have been certified by the DSS or a project grant to develop and operate a center. In some fortunate communities the United Way helps, usually in conjunction with one or more church groups. But quality adult day care, like quality day care for children, is expensive.

The staff should have certain qualifications. But how their knowledge is used and the intangible factors of judgment, warmth, a sense of humor, tolerance of irascibility, and simple patience with the slow and forgetful are tremendously important whether the staff member is an orderly, a psychiatrist, a social worker, a recreation worker, or a cook. Staff must have the human relations skills to work well with both the participants and their relatives. Many relatives feel guilty about not caring for the old person or the disabled family member at home. This guilt seems to be much less when the old person is in day care than when he is placed in a nursing home or other institution.

Funding influences programs. The source of funding inevitably influences the kind of program offered and the clientele to be served. If funding comes through mental health agencies, the focus and objectives of the service differ from the focus and objectives when the funding is Title XX (social services) money. With all federal funding, the group to be served must be identified and the grant is for a limited time. Uncertainty in programming is inevitable, because there is no guarantee that a program can be continued; planning becomes almost an act of faith. Some administrators find this uncertainty to be a nearly impossible way to operate; others find their faith justified and manage to keep vital, high-quality programs reasonably secure. The latter usually have strong support in the community because they have developed a reputation for maintaining a needed service, one that people not only benefit from but *like*.

Unfortunately not every community has such a director, nor is the local Council on Aging finding people and resources to build programs to reach the need in every community.

The Council on Aging is an organization available on a city-, county-, or district-wide basis throughout the state that will help to plan a day care program for the elderly and will put administrators in touch with appropriate resources. Each regional council of governments has a consultant with information about funding sources, program planning, and so on. Consultative help is available at the state level in the Office of Aging and in the Adult Services Section of the Division of Social Services.

Adult day care is not as widely available as child day care, and standards are not yet matters of general concern. But as the proportion of elderly increases in the total population, the need for adult day care will undoubtedly attract a group of entrepreneurs who enter the field for profit. When this happens, the debate over standards will inevitably increase. An informed public is the best protection that adults in day care programs can expect. Regulation will probably not become mandatory until the number of adult day care centers is large enough for abuse and exploitation to occur and become evident. Obviously, the more the public knows about what the service should be and what is reasonable payment, the better the service will be, whether by licensing requirements or because private operators fill a consumer demand.

Conclusion

Although child day care and adult day care reflect different needs and their funding sources differ, those who are planning for the development of adult day care programs should benefit from the experience of people in child day care. A program that meets the needs of the individual client benefits both adult and child day care. If the program is good, it is expensive. Adult day care is not a panacea; neither is child day care. But appropriate and well-provided day care can make a strong contribution to community well-being.

We can predict what will happen in child day care less safely than we can predict for adult care. Child day care will continue to be big business, but the rate of growth in federal support is not likely to continue at its present rate. The gap between custodial care at minimum cost and "enrichment" at much higher cost may even widen as planning responsibilities are left more and more to the states through the use of block grants. The trend will probably be toward more Individual Child Care Arrangements (ICCAs) and less center development because of increasing demand from parents for greater flexibility and more options in the child care plans for which financial assistance is available. The wider range of choices for parents seems a socially healthy move; any public policy permitting only custodial care—"warehousing" of children—would be deplorably regressive.

In adult day care, as the proportion of older citizens increases, the amount of federal money will expand, and centralized multipurpose senior centers will increase—perhaps almost as dramatically as child-care centers did in the past decade. The battle between private "for-profit" facilities and subsidized community facilities will almost certainly heat up, focusing largely on standards,

(continued on p. 71)

Medicaid: Is the Program Working In North Carolina?

James D. Johnson

This article was completed in early spring, 1978, and did not include the changes that were made in the Medicaid program during the 1978 legislative session. Significant changes include the following:

(1) Repeal of the statutory provision that prevented the state from contracting for Medicaid claims-processing beyond December 31, 1979;

(2) Removal from the Social Services Commission of the rule-making authority for Medicaid. All rule-making authority for Medicaid is now vested with the Department of Human resources;

(3) Changing the state-county formula for the nonfederal share of Medicaid payments for skilled nursing and intermediate care facilities. The original formula for allocating the nonfederal costs was 85 per cent state and 15 per cent county; the new ratio is 65 per cent state and 35 per cent county for those facilities not owned by the state. As part of this package, the formula used in the Special Assistance for Adults program to distribute the costs of homes for the aged and family-care homes was changed. Before 1978 the state and the counties had split the costs 50/50. The new formula divides the cost 70 per cent state and 30 per cent county. These changes were made to encourage counties to use the lower-cost rest-home bed as an alternative to a nursing-home placement;

(4) Reducing the co-payments for hospital outpatient services and dental services from $2 to $1 and $3 to $2 respectively;

(5) Restoring adult dental services that were eliminated during the 1977 legislative session. A total of $16,000,000 was appropriated for this purpose;

(6) Increasing maximum net family annual income standard for the medically needy. For example, the maximum allowable income for a family of two, which had been set at $2,200, is now $2,500. Additional funds were appropriated to cover the increased cost of new eligibles.

THE RISING COST OF health care has focused both public and legislative attention on North Carolina's Medicaid program. During the 1977 session of the General Assembly, rising costs forced the adoption of a major cost-containment program as well as the curtailment of certain services. Rising Medicaid costs have also prompted the General Assembly to undertake a wide-ranging investigation of the entire area of health costs as they relate to all citizens of the state.

To provide some insight into the Medicaid program, this article will take a comprehensive look at the program in this state—including a summary of eligibility services provided, costs trends of the program, and claims-processing. It will give some attention to the 1977 General Assembly's adoption of cost-containment proposals in an attempt to respond to rising Medicaid costs. Finally, it will attempt to provide some perspective between Medicaid and the overall cost spiral in medical care.

Medicaid came into existence in 1965 as a result of congressional action creating Title X1X of the Social Security Act. It succeeded several earlier welfare-linked medical-care programs, principally the Kerr-Mills program of medical assistance for the aged. Every state except Arizona has elected to participate in Medicaid, although states are not required to take part in the program. In North Carolina overall responsibility for administering the Medicaid program is vested in the Division of Social Services in the Department of Human Resources (DHR). Within the Division, responsibility for the Medicaid program is divided among three administrative units. The Income Maintenance Section *determines eligibility;* the Financial Analysis Section *maintains fiscal control* over the Medicaid program; and the Medical Services Section *monitors and super-*

The author is a member of the North Carolina General Assembly's Fiscal Research Division with responsibilities in the area of Human Resources and Correction. The views expressed here are his and are not the policy positions of the Fiscal Division or the Legislative Services Commission.

Bob Daughtry and Sharon Dantzler assisted with earlier drafts of the article.

vises claims-processors and coordinates activities in the Medicaid program. All changes in the state regulations governing the Medicaid program must be approved by the Social Services Commission (SSC), and the Advisory Budget Commission must give final approval before changes in provider rates or service reductions can be made.

Eligibility requirements

North Carolina's Medicaid program provides coverage for two groups of eligible recipients: the categorically needy and the medically needy. A *categorical eligible* is someone receiving cash payment from some other public assistance program; such a person usually automatically qualifies for Medicaid. Public assistance programs would include Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) for the aged, blind, or disabled. If a state chooses to establish a Medicaid program, then federal law requires that it pay for certain medical services to the categorically needy. Federal law gives each state the option of covering a group of eligibles, the *medically needy*, under the Medicaid program. These are people who fit into one of the public assistance categories (AFDC or SSI) but have a high enough income level or enough other resources (property, bank accounts, cash value of insurance) that they do not qualify for payments under a welfare program. However, these people do not have the means to pay for medical care. Therefore, North Carolina has elected to provide Medicaid coverage to the medically needy, but only after they have spent a portion of their income for medical care. This expenditure (before a person can receive services paid by Medicaid) is commonly referred to as a *spend-down.*

The qualifying income levels for both the categorically and the medically needy are established by the legislature, within the guidelines as established by federal law and regulation and are set out in the special provisions of the 1977 Appropriations Act. Table 1, taken from this act, gives the income levels for these two categories of eligibles. Anyone who meets all of the other criteria for the medically needy category but is above these income levels must expend or incur the difference between his actual income and the maximum allowable income on medical care before Medicaid will begin to pay the bills. For example, an individual with a net monthly income of $200 applies for Medicaid. This person's total income for one year would be $2,400—$700 dollars over the $1,700 maximum allowed. Thus he would have to spend $700 or incur that amount in medical expenses during that year before Medicaid would pay for any expenses. In addition, many aged or disabled people are also under Medicare, the program that covers hospitalization for those over 65. In such cases of dual coverage, state Medicaid programs may "buy in" and pay for Medicare premiums, deductibles, co-payments, and services not provided by Medicare.[1]

Since 1970, when the Medicaid program in North Carolina began, the numbers of persons eligible for Medicaid has both grown and fluctuated—primarily because of increases in the number of persons receiving AFDC. These individuals are in the group of categorical eligibles that automatically receive benefits under the Medicaid program. The other groups of eligibles under the program have remained fairly stable since the Medicaid program began.[2]

Table 1
Maximum Allowable Income Levels for Medicaid Eligibility

Family Size	Categorically Needy	Medically Needy
1	$1,452[1]	$1,700[2]
2	1,908	2,200
3	2,196	2,500
4	2,400	2,800
13	4,020	4,600

1. Income per annum.
2. Assume that an individual with a monthly income of $200 applied for Medicaid. The maintenance allowance for one person for six months would be $850 (one-half of $1700). Therefore, this person must spend $350 of his own money (spend-down) for qualified medical expenses before Medicaid will begin to pay any medical expenses during any six-month period.

Source: North Carolina 1977 Appropriations Act.

Critics of the process, which determines eligibility at the state and federal level, claim that too many ineligibles are qualifying for Medicaid. The North Carolina General Assembly has given special attention to the problem of maintaining control over eligibility. For instance, before 1977 a person could transfer any amount of property to a relative and immediately meet the income levels for Medicaid eligibility. However, last year the legislature passed a law[3] that requires a period of from one to three years—depending on value of the property—to elapse between transfer of one's property and determination of Medicaid eligibility. The penalities for recipient and provider fraud were also strengthened.[4]

Medical services and rates paid to providers

Just as there are categories of people who *must* be extended Medicaid cov-

1. Of the total eligible recipients for Medicaid, the medically needy account for about 44 per cent of the total cost. The principal reason why costs for the medically needy are so much higher than for the categorically needy is related to the services consumed by each group. Although the available data are not totally reliable, it appears that the medically needy use the more expensive services such as inpatient hospitalization, skilled nursing facilities, and intermediate care facilities. Categorical eligibles, although eligible for the high-cost services, tend to consume cheaper services such as physician visits, outpatient hospitalization, and clinic services, and also use these services less frequently. These differences in consumption patterns are due primarily to differences in age and disability, with more of the medically needy falling in the categories of blind, aged, or disabled. Categorical aid recipients—primarily AFDC recipients—tend to be younger and therefore are relatively healthy compared with the medically needy.

Another reason for this discrepancy between costs versus numbers of eligibles is that the medically needy do not generally apply for Medicaid unless they are already faced with medical expenses. Categorical eligibles, on the other hand, are determined eligible when they apply for categorical aid and continue to be eligible for Medicaid during the entire period that they are eligible for categorical aid. As a result, the use rate is much higher among medically needy than among categorical eligibles.

2. Bob Daughtry, Jim Johnson, and John Young, *A Legislator's Guide to the North Carolina Medicaid Program* (Raleigh: North Carolina General Assembly, 1977).
3. N.C. GEN STAT § 108-61.3.
4. N.C. GEN STAT §§108-48, -110.

erage and people who *may* be extended coverage, there are also services that are mandatory and services that are optional for a state to provide in its Medicaid program. Though it is not required to do so by federal regulation, North Carolina has decided not only to extend Medicaid coverage to the medically needy but also to provide the same range of services to both the categorically and medically needy. When a state elects to have a Medicaid program, it must provide certain basic required services to the categorically needy. These include: inpatient hospital care, outpatient hospital care, other laboratory and X-ray services, skilled nursing facility services, home health care, and physician services. Other services such as home health, private duty nursing, clinic services, dental services, physical therapy, intermediate care, and drugs may be provided to the categorically needy and are eligible for federal participation. When a state decides to provide coverage to the medically needy, it may offer the required services or it may substitute some combination of seven services, such as hospitalization, skilled nursing care, and home health.

States can also impose certain limitations on the coverage of both mandatory and optional services. For example, a state may limit the total number of days within a given year that it will pay per recipient for inpatient hospitalization, or it may place a limit on the number of skilled nursing days that will be allowed per occasion of illness. Beyond these limitations on usage, a state may require prior approval before a particular service is used. North Carolina now requires such authorization by the North Carolina Medical Peer Review Foundation before a patient may be placed in either a skilled or an intermediate care facility.

Figure 1 shows a breakdown of the services provided in the North Carolina Medicaid program compared with the programs in the five surrounding states.[5] The designation FMAP (Federal Medical Assistance Percentage) represents the percentage of Medicaid services costs borne by the federal government. Of the six states listed in the figure, North Carolina provides the most services to both the categorically and medically needy under its Medicaid program, with Virginia and Kentucky close behind. Two states, South Carolina and Georgia, provide services to the categorically needy only.

Rates paid to providers (doctors, hospitals, pharmacies, etc.) under the North Carolina Medicaid program were established by the General Assembly in the 1977 Appropriations Act. The services/payment schedule to be used for fiscal year 1977-78 are shown in Table 2. No changes in services or payments for services may be made in the Medicaid program by the Department of Human Resources or the Social Services Commission without final approval of the Governor and the Advisory Budget Commission. Reimbursements for services in the Medicaid program to physicians are calculated on the basis of the actual charge for the service. Hospital reimbursements are based on *allowable* costs, which takes into account such things as depreciation and operating expenses, with settlements made at the end of each year if the *actual* costs have exceeded or gone below the *reported* costs. Reimbursements to skilled nursing homes and intermediate care facilities have, in the past, been based on allowable costs but with a maximum charge per day. The method used to calculate the reimbursement rates to skilled nursing and intermediate care facilities was changed this year when a new federally mandated rate plan went into effect. All costs in both hospitals and long-term care facilities must be documented and are subject to an audit conducted for the Medicaid program by Blue Cross-Blue Shield of North Carolina.

Federal regulations permit a state to establish a co-payment requirement for Medicaid recipients—the amount the individual pays for services. Federal regulations forbid a co-payment for mandatory services that are provided to the categorically eligible. The theory that underlies this policy is that those Medicaid eligibles with the lowest incomes should not be required to pay a co-payment when they receive a certain service. A co-payment may be required for the categorically eligible for optional services, and co-payments are allowed for all services provided to the medically needy. Federal regulations set an upper limit on the amounts charged for co-payments, and these amounts are subject to HEW audit.

The 1977 Appropriations Act established the amount of co-payment to be paid by the recipient for Medicaid services. Table 3 lists amount of co-payment for services. Over the last several years the General Assembly has taken the position that co-payments should be the *maximum* allowed by federal regulation. As part of the Medicaid cost-containment legislation that was adopted during this past session, certain co-payments were increased.

Utilization review

Federal Medicaid regulations require that patient use be reviewed in hospi-

Figure 1
Medicaid Service Comparison in Six States

	Basic Required Medicaid Services	Clinic Services	Prescribed Drugs	Dental Services	Prosthetic Devices	Eye Glasses	Private Duty Nursing	Physical Therapy Related Services	Other Diagnostic Screening etc.	Emergency Hospital Services	SNF Services Under 21	Optometrist Services	Podiatrist Services	Chiropractor Services	Institutionalization for 65—Mental Inst.	Institutionalization for 65—T.B. Sanit.	Psychiatric Hospitalization Under 21
North Carolina FMAP 68%	●	●	●	●		●			●		●	●	●	●	●	●	●
South Carolina FMAP 74%	□	□	□	□	□	□		□		□	□	□		□	□	□	□
Georgia FMAP 66%	□	□	□		□				□		□		□		□	□	
Virginia FMAP 58%	●	●	●			●		●		●	●	●	●		●	●	
Tennessee FMAP 70%	●	●	●		●					●					●	●	●
Kentucky FMAP 71%	●	●	●	●	●			●		●	●				●	●	●

□ Categorical Eligibles Only
● All Eligibles

Source: A Legislator's Guide to the North Carolina Medicaid Program (Raleigh: North Carolina General Assembly, 1977).

5. All graphs and charts on Medicaid expenditures in North Carolina were taken from *A Legislator's Guide to the North Carolina Medicaid Program.*

tals, skilled nursing, and intermediate care facilities. In the acute care hospital this includes an admission, concurrent, and retrospective review of a Medicaid recipient's hospital stay. For all long-term care patients, a review and approval must occur before a Medicaid recipient can be placed in a skilled or intermediate care facility. After a patient is placed in a long-term care facility, a periodic review is made, usually every six months, to determine whether he should remain in a given level of care.

The North Carolina Medical Peer Review Foundation, which was organized in 1973 at the direction of the Executive Council of the State Medical Society, reviews patient use for the state Medicaid program. All licensed physicians in North Carolina may join the foundation and approximately one-third are members.[6] The foundation has been designated a Professional Standards Review Organization (PSRO) Support Center, by contract with the Department of Health, Education, and Welfare (HEW). There are eight PSRO areas in the state.

6. North Carolina Medical Peer Review Foundation, *Annual Report* (Raleigh: North Carolina Peer Review Foundation, 1977), pp. 1-2.

"As part of its continuing obligation to both practitioners and providers of medical care in North Carolina, the Medical Peer Review Foundation is actively developing various kinds of review programs to help ensure that the responsibility for the review of medical services remains with the practicing physicians not with governmental agencies." "The North Carolina Medical Peer Review Foundation, Inc.," *North Carolina Medical Journal* (December, 1974), 750.

When the review work is in full operation, foundation review teams—each composed of a review physician, nurse, and medical social worker—will evaluate the quality of patient care and appropriateness of the level of care. Each eligible patient will be reviewed two or three times a year.

Table 2

North Carolina Medicaid Services and Payment Schedule for FY 1977 and FY 1978

Services	Payment Basis
Hospital (inpatient)	Allowable costs.
Hospital (outpatient)	90 per cent of allowable costs.
State mental and specialty hospitals and mental retardation centers (all Medicaid services including mental, medical, intermediate care, and skilled nursing care)	Allowable costs.
Skilled nursing facilities	Allowable costs not to exceed $28.00 per day.
Drugs	Drug cost as allowed by federal regulation plus $2.50 professional service fee per month excluding refills for same drug or generic equivalent during the same month.
Physicians	90 per cent of allowable usual and customary charges.
Chiropractors	90 per cent of allowable usual and customary charges.
Dental	90 per cent of allowable usual and customary charges for children under 21 years old referred by the Early Periodic Screening and Diagnostic Treatment Program (EPSDT).
Home health	Allowable costs.
Optical services	90 per cent of allowable usual and customary charges.
Medicare buy-in	Social Security Administration premium.
Clinics (public health)	Allowable costs.
Ambulance services	100 per cent of allowable, reasonable, usual and customary charges.
Pre-21 screening	See specific services, i.e., Physician and Clinic.
Hearing aids	80 per cent usual, customary, and reasonable charges (including dispensing fee).
Clinics (mental health)	Allowable costs (federal portion only; non-federal share covered by state/local operating funds).
Intermediate care facilities	Allowable costs not to exceed $23.30 per day.
Family planning	See specific services, e.g., hospital, physician, and clinic.
Independent laboratory and X-ray services	90 per cent of allowable usual and customary charges.
Optical supplies	100 per cent of reasonable wholesale cost of materials.

Source: *A Legislator's Guide to the North Carolina Medicaid Program* (Raleigh: North Carolina General Assembly, 1977).

As they become fully operational over the next two years, the PSROs will review acute-care hospital use for both Medicare and Medicaid.

Changes in cost and utilization in the Medicaid program

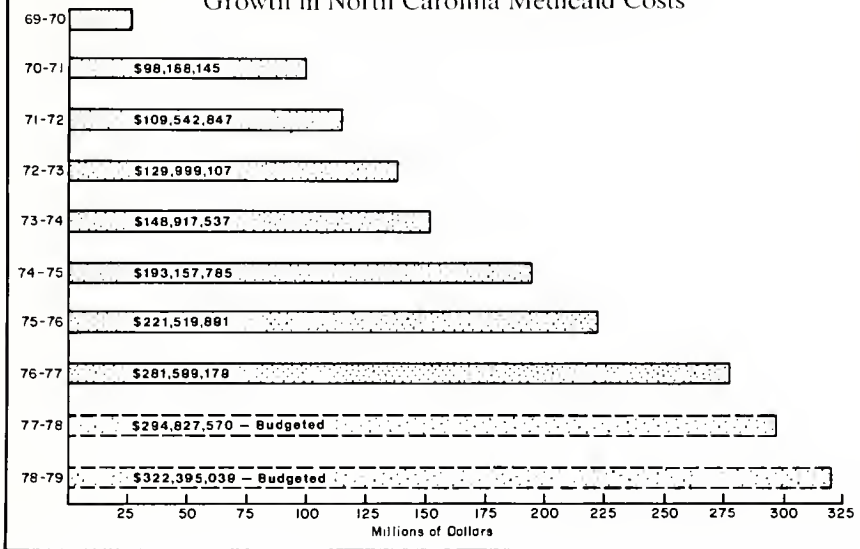
Since the Medicaid program began in fiscal year 1969-70, its costs have risen rapidly, even through the period of wage and price controls in 1973-74. Figure 2 shows the growth in Medicaid costs from 1969 through the fiscal year ending June 1977. In percentage terms the increase in total cost from 1970-71, the first full year of program operation, to the close of fiscal year 1976-77 was 187 per cent. But examination of total costs only masks significant changes that have occurred in service mix within the North Carolina Medicaid program since it began.

Medicaid is financed jointly with federal and state funds: The current federal contribution ranges from 50 per cent to 78 per cent; it is basically administered by each state within certain broad federal requirements and guidelines. In 1969 the General Assembly authorized North Carolina to participate in the Medicaid program and appropriated funds for this purpose. The federal share of Medicaid costs is determined by a statutory formula designed to provide a higher percentage of federal matching funds to states with low per capita incomes.[7] In

7. Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce, United States House of Representatives, *Data on the Medicaid Program: Eligibility, Services, Expenditures, Fiscal Years 1966-77* (Washington, 1977), pp. 35-36.

Figure 2

Growth in North Carolina Medicaid Costs



1969 the federal share in North Carolina was 75.38 per cent; by 1977-78 it had declined to 67.81 per cent. The decline during this period came as a result of a gradual increase in the state's per capita income. This matching rate applies, however, to medical provider payments only. The major exception to this matching rate for medical services is family planning, in which the federal government pays 90 per cent of the costs. Other portions of the Medicaid program relating to administration carry other federal matching rates. Administrative costs are generally matched by a 50 per cent federal contribution, except for the Medicaid Management Information System (MMIS) costs, of which the federal government will pay 90 per cent of the development costs and 75 per cent of the operating costs. The federal government totally covers the costs of skilled nursing facility inspectors and pays 75 per cent of the cost of any professional medical personnel used in program administration.

There are no federal statutory or regulatory requirements on what governmental unit will pay the nonfederal portion of the Medicaid program costs. In North Carolina the General Assembly has determined that the state will pay 85 per cent and the counties 15 per cent of the nonfederal share of the reimbursements to *providers* of medical services. The statutory authorization for this division of the nonfederal share is found in the Appropriations Act and is subject to legislative change. The nonfederal portion of the *administrative costs* of the Medicaid program are not divided between the state and counties by the 85:15 formula. Rather, the legislature appropriates a block of money to aid county administration, and the individual county is left to pay whatever remains of the nonfederal share.

Table 4 looks at Medicaid expenditures by major service areas from 1970-77. In the first full year of operation, 1970-71, expenditures totaled $98.1 million. For that year inpatient hospitalization totaled slightly over 31 per cent of program costs, and drugs, physician fees, and nursing homes made up another 46 per cent of the total. Administrative costs for the first year and those that follow include the costs to both the state and the counties. Included within this area are all county costs for determining eligibility. The segment of the chart labeled "Cost Settlement" that appears first in 1972-73 is for costs incurred in one year, although final payment is not made until the next year after an audit conducted by Blue Cross-Blue Shield of North Carolina.

In fiscal year 1973-74 a significant change occurred in the Medicaid program with the addition of payments to intermediate care facilities (ICFs). The ICFs provide a level of medical care below that of a skilled nursing facility (SNF) and in general receive a lower per-day reimbursement rate. In the first year of operation, ICFs accounted for only 2.3 per cent of total expenditures. By 1975-76, state-owned and privately owned ICFs accounted for over 25 per cent of total expenditures. The state-operated ICFs are located primarily in the state's four mental retardation centers. In 1975-76 the costs of long-term care facilities exceeded the costs of inpatient hospitalization. By 1976-77 Medicaid costs had risen to $281,599,179, with inpatient hospitalization and long-term care accounting for over 57 per

Table 3

North Carolina Medicaid Co-Payment Schedules

Service	Eligibility		Co-payment for Each Occasion of Service
	Categorically Needy	Medically Needy	
Hospital (inpatient)		X	$2.00
Hospital (outpatient)		X	2.00
Physicians		X	1.00
Optometrists		X	1.00
Drugs	X	X	.50
Dental	X	X	3.00
Chiropractors	X	X	.50
Optical supplies and services	X	X	2.00
Mental health services	X	X	1.00
Health departments	X	X	1.00

Source: *A Legislator's Guide to the North Carolina Medicaid Program* (Raleigh: North Carolina General Assembly, 1977).

cent of total costs. For the 1977-79 biennium, Medicaid costs are budgeted at:

	Fiscal Year 1977-78	Fiscal Year 1978-79
Total	$294,627,570	$322,295,039
Federal	196,155,895	214,708,570
County	16,731,860	18,104,767
State	81,739,815	89,581,702

Long-term care. The greatest growth in North Carolina's Medicaid program has come in the areas of skilled nursing and especially intermediate nursing care. Both skilled and intermediate care were developed as alternatives to long stays in costly acute care hospitals. Federal regulations require that skilled nursing care be provided in any Medicaid program in which inpatient hospitalization is provided to the categorically and the medically needy. Intermediate care is an optional service that a state may elect to provide in its Medicaid program. In North Carolina intermediate care is provided to both categorically and medically needy recipients.

Increases in long-term care may be attributed to several factors. First, North Carolina now has a high percentage of persons over 65, with estimates for 1977 at 536,704 in a total population of 5,600,332.[8] In 1970 the over-65 population stood at 412,038 in a total population of 5,084,411 — an increase of approximately 30 per cent in seven years.

Another reason for the increase in long-term care expense may be that in recent years children are unable or unwilling to care for aging parents and relatives in their homes. Other reasons for heavy expenditures for long-term stays, particularly in intermediate care facilities, relate to the structure of other third-party reimbursements, especially Medicare—the program that covers hospitalization expenses for those over 65. Medicare places a limit on the number of paid days in a skilled nursing facility. Medicare provides no reimbursement for a stay in an intermediate care facility. Blue Cross and other private insurance carriers will generally pay for some amount of skilled nursing care, depending on the terms of a particular policy. Intermediate care, however, is

8. Based on population estimates prepared by the North Carolina Department of Administration.

Table 4
Medicaid Expenditures in North Carolina

Service	FY 1970-71		FY 1971-72		FY 1972-73		FY 1973-74		FY 1974-75		FY 1975-76		FY 1976-77	
	Amount	Percentage of Total	Amount	Percentage of Total	Amount	Percentage of Total	Amount	Percentage of Total	Amount	Percentage of Total	Amount	Percentage of Total	Amount	Percentage of Total
Inpatient hospitalization	$30,709,036	31.28%	$ 35,981,036	32.85%	$ 46,219,798	35.55%	$ 41,309,314	27.74%	$ 51,900,120	26.87%	$ 55,126,917	24.89%	$ 68,637,038	24.38%
Nursing homes (SNF)	16,328,631	16.63	17,798,096	16.27	20,148,988	15.50	22,943,562	15.41	26,093,778	13.51	25,070,905	11.32	34,148,368	12.13
Pharmacy	14,545,517	14.82	18,093,246	16.54	20,448,526	15.73	19,776,527	13.28	21,536,621	11.15	25,509,831	11.52	26,668,293	9.47
Physicians	14,526,400	14.80	15,763,161	14.41	17,028,574	13.10	17,003,051	11.42	19,444,944	10.07	22,215,322	10.03	25,528,682	9.07
Dental	6,612,221	6.74	3,039,340	2.78	----	---	----	---	----	---	7,969,502	3.60	10,038,960	3.56
Outpatient, hospital	3,626,076	3.69	4,078,725	3.73	5,160,431	3.97	4,252,192	2.86	6,188,527	3.20	7,488,239	3.38	10,675,315	3.79
Buy-in	----	---	4,161,417	3.81	4,990,947	3.84	6,242,090	4.19	6,235,234	3.23	6,582,547	2.97	7,493,735	2.66
Administration	4,230,498	4.31	3,788,306	3.46	4,658,664	3.58	5,410,358	3.63	8,958,934	4.64	7,789,338	3.52	18,257,378	6.48
Mental hospitals	----	---	----	---	3,655,667	2.81	5,528,667	3.71	6,401,193	3.31	6,161,044	2.78	10,017,294	3.56
Cost settlement	----	---	----	---	4,007,884	3.08	16,248,777	10.91	9,945,191	5.15	17,153,163	7.75	----	---
ICF	----	---	----	---	----	---	3,419,727	2.3	14,764,010	7.64	23,230,161	10.49	39,676,004	14.09
State-owned long-term care facility	----	---	----	---	----	---	----	---	8,971,319	4.64	----	---	----	---
State-owned (ICF/SNF)	---	---	---	---	---	---	---	---	---	---	9,232,164	4.17	18,420,475	6.54
Other costs	7,589,766[1]	7.73	6,839,518[2]	6.15	3,679,628[3]	2.84	6,783,272[4]	4.55	12,717,914[5]	6.59	----	---	----	---
Total:	$98,168,145	100.0%	$109,542,847	100.0%	$129,999,107	100.0%	$148,917,537	100.0%	$193,157,785	100.0%	7,990,758[6]	3.58	12,037,637[7]	4.27
											$221,519,891	100.0%	$281,599,179	100.0%

1. Chiropractors, mental hospitals, optical supplies, home health, buy-in.
2. Home health, mental health, optical supplies, chiropractors, cost settlement.
3. Dental, home health, optical supplies, chiropractors, mental clinics, T.B. sanatoriums.
4. Ambulance, chiropractors, dental, family planning, hearing aids, home health, ICF and SNF (state-owned), lab and X-ray, optical supplies, screening, T.B. hospitals.
5. Ambulance, chiropractors, dental, family planning, hearing aids, home health, labs and X-ray, optical supplies, screening, and T.B. sanatoriums.
6. Ambulance, chiropractors, family planning, hearing aids, home health, lab and X-ray, clinics, optical supplies, optometrists, screening, specialty hospitals.
7. Ambulance, clinics, family planning, hearing aids, home health, lab and X-ray, chiropractors, specialty hospitals, optometrists and supplies, pre-21 screening, cost settlement ($832,398).

Source: *A Legislator's Guide to the North Carolina Medicaid Program* (Raleigh: North Carolina General Assembly, 1977). Figures based on Federal Financial Participation Reports

Note: The first year of the program (1969-70) is excluded because the program operated for only six months in that year.

not covered. Thus if an individual must spend an extended period in a skilled nursing or intermediate care facility, Medicaid most often becomes the payer of last resort. On a national basis, the Medicaid program bears much of the cost of providing long-term care. North Carolina has decided to upgrade the level of care in many of the wards of the four state mental retardation centers to ICF level. Increased funding in these facilities comes at a time when the state is under suit from such groups as the Association for Retarded Citizens over the right to treatment.

It should also be noted that certain types of *residential care* for the elderly are not reimbursable under either Medicare or Medicaid. In North Carolina these facilities are usually referred to as homes for the aged or rest homes. Payments for this type of residential care falls under the Special Assistance for Adults (SAA) program, which is paid for on a 50-50 basis from state and county funds. Even though the total cost of the rest home is generally far less than an ICF or SNF, the cost to the county is usually more because the county is obliged to pay half the cost, while for an ICF or SNF the county portion is less than 5 per cent of total cost. Some observers have felt that the discrepancy between the formula used in SAA and Medicaid might provide an incentive for counties to make more frequent use of the ICF or SNF.

In North Carolina present estimates are that 65-70 per cent of the beds in SNFs and ICFs are filled with Medicaid patients. Overall occupancy rates in SNFs and ICFs are averaging 90 per cent throughout the state, with some counties having occupancy rates above 95 per cent. As of August 1977, there were 18,553 ICF and SNF beds that were either being used or under construction in the state. Another 2,541 had been approved for construction by the state health planning agency. Given the number of beds available and the fact that they are so heavily used by Medicaid patients, the costs in this portion of the program will continue to rise.

History of Medicaid claims-processing

Probably the greatest controversy and public attention in North Carolina's Medicaid program over the last two years has centered on the processing of claims. During this period the state has had contracts with four separate companies for processing claims in various portions of the Medicaid program.

Following legislative authorization of the Medicaid program in 1969, the state contracted with Blue Cross-Blue Shield of North Carolina to process claims as fiscal intermediary for the program. A company that operates as a fiscal intermediary in the Medicaid program receives claims from providers, pays those claims that it considers valid, and receives payment on a cost-per-claim basis. The company, however, assumes no overall responsibility for keeping total expenditures within a fixed budget. Blue Cross also audited all hospitals participating in the Medicaid program to determine whether amounts received were "allowable costs" under federal and state regulations.

In May 1972, after a study by the Department of Administration, the state announced that all portions of the Medicaid program, including claims-processing, would be administered by the state, effective January 1, 1973. From 1973 through April 1975, the state processed all Medicaid claims except those for prescription drugs, which were handled by Paid Prescriptions, Inc., of California.

Health Applications Systems Contract. In April 1975 North Carolina entered into a two-year prepaid insurance agreement in the amount of $376 million with Health Applications Systems (HAS). Under this contract, HAS assumed all administrative responsibilities for the program except for: determining eligibility, inspecting and certifying providers of service, setting overall program policy, paying prescription drug claims, and paying year-end settlements to providers. The contract placed a ceiling on the state's Medicaid cost, with any additional increases above the contract price to be absorbed by HAS. The contract also contained a provision that any savings that occurred would be shared 75 per cent to the state and 25 per cent to HAS.

In 1974 North Carolina had contracted separately with HAS to develop a Medical Management Information System (MMIS). Health Applications Systems had also been involved in the North Carolina drug contract as the data processor for Paid Prescriptions, Inc., and through that contract had a detailed knowledge of North Carolina's Medicaid program—particularly numbers of eligibles, use rates, and cost. As a result of both the MMIS contract and HAS's knowledge of North Carolina's Medicaid program, HAS proposed to contract with North Carolina for the rest of the Medicaid program on a prepaid basis.

In October 1974 a group of consultants, Warren King and Associates, prepared a study for the Department of Human Resources on the state's Medicaid program. Their report, released in early 1975, estimated that substantial savings in Medicaid administration would result from a prepaid contract. When the state sent out its request for proposals to prospective bidders, it received a response from only one company, HAS.

Before DHR could complete the contract with HAS, prepaid contracts in the Medicaid program had to have legislative authorization. The legislature amended G.S. 108-60 in 1975 to authorize the use of prepaid arrangements in Medicaid through 1977. All contracts awarded under this provision were subject to the Advisory Budget Commission's final approval.

After North Carolina decided to enter into a prepaid agreement with HAS, questions were raised in Congress about the federal government's role in monitoring the implementation of the agreement. In May 1975 the United States Senate Subcommittee on Health requested that the General Accounting Office (GAO) investigate the awarding of the contract to HAS and assess HEW's capability to monitor such agreements.

In early May of 1976, HAS notified the state that it was considering canceling the prepaid contract because of "a trend which has led us to conclude that the company may ultimately sustain a loss under the contract in excess of our reinsurance." During May, June, and July, state officials and representatives of HAS met frequently to try to resolve the contract dispute. In the end, however, the risk or prepaid portions of the contract were terminated in August 1976 by mutual agreement of the state and HAS, after the required four-month notice by HAS. Under the terms of this agreement, HAS was to function as a

fiscal intermediary for the rest of fiscal year 1976-77 and would receive additional funds to cover cost increases in the area of skilled and intermediate care and for administrative expenses.

In July 1976 GAO issued its report on North Carolina's contract with Health Application Systems. The report was critical of the procedures that the state had used in evaluating the bid that was originally submitted by HAS and of the estimated savings that were claimed by DHR when the prepaid contract was awarded.[9]

Immediately after the termination agreement was reached with HAS, Governor Holshouser instructed the Department of Administration to begin preparing a request for proposals from companies that might be interested in processing claims for the Medicaid program. On November 16, 1976, the Advisory Budget Commission gave final approval to a new contract for claims-processing with Electronic Data Systems-Federal (EDS-F) of Dallas, Texas. This contract ran from January 1, 1977, through July 1, 1977, with an option to extend for one year at the current price. After the one-year extension, the contract could be extended for three one-year periods by mutual agreement of the state and EDS-F. On July 1, 1977, the state extended the contract for claims-processing for another year, and EDS-F is now processing all Medicaid claims except drug claims.

Processing drug claims. From July 1976 through August 1977 three separate companies—Paid Prescriptions, Inc., Electronic Data Systems-Federal, and The Computer Company—have at various times been responsible for processing drug claims. On August 2, 1976, after a debate of several months, the Advisory Budget Commission awarded a new contract for processing prescription drug claims. The new contract was awarded to EDS-F for a period beginning August 1, 1976, and ending June 30, 1977. On July 29, 1977, the Advisory Budget Commission awarded a new one-year contract for processing drug claims to The Computer Company (TCC) of Richmond, Virginia. Both awards were based largely on the low bids submitted by the two companies.

Problems with processing claims. Beyond the paperwork and cash-flow problems created for medical providers by the failure of the HAS contract and the changes in drug-claims processors, several points can be made about the state's recent experience in processing Medicaid claims. The HAS contract may well have been doomed from the outset because it was based on an essentially faulty premise. This assumption was that a private company, acting as an intermediary under a prepaid risk contract, could contain the costs in the Medicaid program. An intermediary, however, can control only his administrative costs, eliminate duplicate and fraudulent claims, and have some impact on abuse through reviewing use. To the extent that these can be successfully accomplished, a savings may occur. But an intermediary cannot control eligibility determination, use rates, or provider costs. Perhaps most important, the intermediary has absolutely no control over the general inflationary trend in health-care costs. Therefore, one might well conclude that the contract with HAS would have worked only if eligibility, use, and inflation remained relatively constant and within the budget estimates for the Medicaid program. If any of these variables changed dramatically, particularly use rates for a particular service or accelerated inflation in medical costs, then cost overruns would occur and the intermediary would encounter severe financial difficulty. This is precisely what happened to HAS. Use rates, especially in the area of intermediate care, continued to increase at a dramatic rate, and when coupled with the long-term trend in the cost of medical care, the company could not live within a fixed-price contract.

Second, contracts with private firms for claims-processing should be for periods of at least two years to minimize the disruptions for medical providers and to eliminate the high start-up costs that must be incurred by the state with every new contract. Multiyear contracts should allow the state to purchase claims-processing at the lowest cost per claim. A contract of several years' duration would also allow the private company to build a working relationship with the medical community, which is essential if claims are to be processed efficiently.

Finally, it is clear that the state has never adequately evaluated the relative cost benefits of having Medicaid claims processed by a private company and by an in-house, state-operated system. This is true with respect not only to the decision to contract with HAS but also to the decision two years earlier to end the contract with Blue Cross-Blue Shield and make the claims-processing a state-run operation.

A contract for making such an evaluation was recently awarded to the firm of Peat, Marwick, and Mitchell. On March 15 of this year the Secretary of Human Resources, Dr. Sarah Morrow, released the report. Peat, Marwick, and Mitchell recommended:[10]

> The state should not process or perform utilization reviews in-house at the present time for the following reasons: (1) Responsibility for the Medicaid program within the Division of Social Services is fragmented; the addition of claims-processing and utilization review would compound the situation. (2) The projected cost advantages for in-house claims-processing are not significant enough to warrant the risks. (3) The current eligibility system operated by the Division of Social Services must be corrected before either fiscal agent or in-house claim-processing can operate effectively. (4) National health insurance may significantly change the structure of the Medicaid program in the near future. Thus, the state's investment in developing an in-house processing capability may only be useful for a short period of time. (5) The utilization review activities of the North Carolina Medical Peer Review Foundation are expected to gradually decrease as the Professional Standards Review Organizations become more active. Also, there is no significant cost savings to be expected from in-house operation of the utilization review function.
>
> All drug and nondrug claims should be processed by a single fiscal agent

9. Controller General of the United States, *North Carolina's Medicaid Insurance Agreement. Contracting Procedures Need Improvement* (Washington, 1976).

10. Peat, Marwick, Mitchell and Company, *Report on Medicaid Program Administration in North Carolina*, February 1978. Statement of Secretary of Human Resources (Dr. Sarah Morrow), March 15, 1978.

under a four-year contract, with a two-year renewal option.

All utilization reviews, including the drug utilization review now performed by TCC, should be performed under a four-year contract.

At her March 15 press conference, Secretary Morrow announced that a separate Division of Medical Assistance would be created within the Department of Human Resources to assume full responsibility for the Medicaid program. The present contracts with EDS-F, TCC, and the North Carolina Medical Peer Review Foundation would be extended until June 30, 1979. After that point all drug and nondrug claims-processing would be consolidated into a single multiyear contract.

Medicaid cost containment

Activity in the 1977 legislative session. Because the public was so interested in the failure of the prepaid contract with HAS and in the problem of mounting medical costs, the 1977 General Assembly scrutinized the Medicaid program more closely than in any session since the program was established. In January 1977, soon after the legislature convened, the Appropriations Committee and the Hunt Administration expressed concern that the Medicaid cost estimate reflected in the recommendation of the Governor and the Advisory Budget Commission would not be sufficient to cover the mounting costs in the program. In March the Joint Appropriations Committee on Human Resources and Corrections and the Joint Base Budget Committee instructed the staffs of the Division of State Budget, DHR, and the legislature's Fiscal Research Division to re-examine the Medicaid cost projections for the 1977-79 biennium. In April the three staffs gave the legislative committees their report, which said that—given current projected eligibility, use patterns, and medical cost trends—state costs for Medicaid in the coming biennium would probably exceed the recommendations of the Governor and the Advisory Budget Commission by almost $14.5 million in fiscal year 1977-78 and $20.8 million in 1978-79. These projected deficits were based on the assumption that no further cost-containment measures would be put into effect.

The legislature's appropriations committees carefully reviewed the medical cost-containment options and eventually adopted a group of these options based on the recommendation of the Secretary of Human Resources. In this way the state was able to balance the projected $14.5 million deficit for fiscal year 1977-78.

These recommendations included recouping or otherwise controlling the costs of approximately $7 million in nonservice-related options and eliminating the dental program for nearly all categories of eligibles. The projected savings from this cut was approximately $4.5 million.

The savings in nonservice-related costs include: increased third-party collections, increased copayments for certain services, better review of use, fraud and abuse controls, limiting property transfers as they affect Medicaid eligibility, and limiting administrative days in hospitals to a maximum of three.

Two other cost-containment options adopted by the legislature merit special attention. The first was the requirement that generic, rather than trade-name drugs be dispensed for Medicaid recipients. The 1977 Appropriations Act requires the pharmacist to issue the generic drug where one exists, unless the physician instructs him, either orally or in writing, to dispense as written. The second was a freeze on the reimbursement rates to all health care providers on the basis of their rate on April 1, 1977. Excluded from the freeze are hospital inpatient units, intermediate care facilities for the mentally retarded, and drugs. The rates for intermediate care facilities and skilled nursing facilities will no longer be frozen when the new cost-related reimbursement plan, required by federal regulation, is implemented. The freeze on all provider rates will end on June 30, 1978.

The projected savings in nonservice-related costs and from the deletion of the dental program totaled almost $11.5 million. The legislature appropriated another $3 million to make up the remainder of the $14.5 million projected deficit. No final decisions were made with respect to the second year of the biennium pending the General Assembly's review of cost projections in May 1978.

As part of its overall concern with the whole area of rising medical costs, the General Assembly created the Legislative Commission on Medical Cost Containment, which is to study the present health care system in North Carolina and the cost trends associated with the system, including the Medicaid programs.

It is to make recommendations on cost-containment proposals for the state's Medicaid program, and any other medical service or reimbursement programs operated by the state.

The Commission consists of six senators appointed by the Lieutenant Governor and six representatives appointed by the Speaker of the House. The co-chairmen, Senator W. Craig Lawing of Mecklenburg County and Representative Ted Kaplan of Forsyth County, were each appointed by the respective presiding officers. The Commission is to make an interim report by April 1, 1978, and its final report by April 1, 1979. Since October it has met with provider groups, state Medicaid officials, recipient groups, and congressional and HEW officials to discuss various issues relating to rising medical costs. It will also visit medical providers throughout the state in the coming months.

Medicaid and medical care cost containment. The problem of Medicaid costs is part of the whole issue of containing health costs for each individual in this country. Medicaid recipients purchase services from the same providers as you and I, and the variables that produced sharp increases in Medicaid over the past two years have also contributed to the increased costs of Medicare, Blue Cross-Blue Shield, and commercial insurance carriers. Any successful attempt to contain the cost of Medicaid will ultimately have to come to grips with rising costs throughout the entire health care system. Under the present third-party reimbursement system, neither providers, consumers, nor third-party payers (insurance companies, Medicaid and Medicare) are at risk—that is, in danger of financial loss for the cost of medical care. As the overall costs of medical care rise, the consumer risks only the marginal increase in the cost of health insurance. In most instances the increases in the costs of health insurance are shared by employer and employee. Providers of medical services are assured

(continued on p. 72)

Medicaid: Help for the Poor and Elderly, but A Thicket of Problems for Hospitals

John Marston

ON JULY 19, 1977, an 85-year-old woman, whom we shall call "Mrs. Jones," was admitted to Annie Penn Memorial Hospital in Reidsville with a diagnosis of multiple decubitus ulcers, possible urinary tract infection, possible seizure disorder, dehydration, and poor nutritional status. By July 28, Mrs. Jones was well enough to be placed in a skilled nursing facility (SNF). But even though Mrs. Jones was in better health, the hospital knew that its problems were just beginning.

On August 1, Mrs. Jones was officially approved for SNF placement, but the approval form only gave the hospital social worker a hunting license. Her search for a long-term care facility with an available bed that would accept Mrs. Jones would be frustrating. Indeed, it took seventeen days and thirty-nine telephone calls to make the placement.

The search began on August 2. On that day the social worker contacted five nursing homes and the next day another seven, all of which reported no available beds. On August 4, Mrs. Jones's condition became worse and her physician instructed that placement efforts be temporarily halted. Then, eleven days later, on August 15, her condition improved to the point that placement efforts could be resumed.

The social worker began calling nursing homes again. By August 17, thirteen facilities either reported no vacancy or would not accept Mrs. Jones because of her condition. Finally, on August 18, after fourteen more calls (a total of thirty-nine individual attempts—some as far away as a hundred miles), a nursing home and rehabilitation center in the central part of the state agreed to accept Mrs. Jones.

This problem of placement is by no means isolated. Granville Hospital in Oxford, among others, also employs a full-time professional social worker who deals with nursing home placements on a regular basis. But it too has difficulties in placement. According to former director Charles T. Frock, its record is as follows:

Length of time before placement	*Approximate percentage*
Less than three days	3%
Four to eight days	12
Nine to twelve days	45
Over twelve days	40

Lack of nursing home beds creates statewide problems

This documented incident reflects the major Medicaid-related problem facing hospitals in North Carolina —placing patients in a lower level of care after they no longer need acute care.

This long-standing problem for general, acute-care hospitals was aggravated by legislation passed by the 1977 General Assembly. Effective on July 1, 1977, the General Assembly reduced from ten to three the number of days that hospitals have to place a Medicaid patient in a long-term care bed. After three days all Medicaid payments to the hospital cease.

"The hospital cannot simply sit the patient on the curb or call a taxi," Thomas E. Gerlarden, former president, Lexington Memorial Hospital, said. "We employ a full-time social worker who works very hard on these cases, but there are times when we simply cannot get the patient out even in 10 days."

Why do hospitals have such difficulties in placing patients in nursing homes after a medical review board determines that acute care is no longer required?

According to Thomas R. Matherlee, Executive Direc-

The author was formerly Vice-President of the North Carolina Hospital Association and now is Executive Director and Chief Executive Officer, Georgia Hospital Association.

tor of Gaston Memorial Hospital, these six basic constraints are largely responsible:

1. The state process for eligibility determination is slow and we have to wait for the determination.
2. There are no beds available in skilled nursing facilities (SNFs) or intermediate care facilities (ICFs) in our area.
3. The SNF or ICF has no physician to follow the care of the patient there.
4. Members of the patient's family refuse to take him into their homes.
5. No home health-care service is available to meet the patient's needs. The public health program in home health services has more than it can handle.
6. The patient has nowhere to go but cannot live alone.

Who pays?

When payment is completely cut off and the hospital incurs daily costs for the uncompensated care rendered to the patient who still occupies a bed, who pays for such care? You do, if you go to the hospital this year.

"The cost of taking care of that patient beyond three days is simply reworked into the rate structure of the hospital," according to Joseph H. James, Jr., administrator of Wayne County Memorial Hospital, "and the private paying patient through either his insurance carrier or direct payment to the hospital will end up carrying the cost of those additional services not paid for by the Medicaid program. This is a simple fact of life, which we all have to live with. There is no such thing as 'free care' in a hospital."

This approach is reluctantly used by all hospitals to recover for uncompensated care, but it is hardly an ideal solution to the problem.

Robert G. Jeffries, administrator of Albemarle Hospital in Elizabeth City, comments: "It is totally unreasonable to expect the remaining patients of the hospital to bear the costs of these patients. This is a burden every taxpayer should bear through Medicaid payments from tax revenues rather than by the few people who are unfortunate enough to be ill and saddled with their own medical expenses."

Hospitals dependent on nursing homes. In another major cost-cutting action, the 1977 General Assembly froze all Medicaid provider reimbursement rates for fiscal year 1977-78, except for inpatient hospital care, at their levels as of April 1, 1977.

Nursing homes had sought an increase in the maximum 1975-77 per-diem rate—from $28 to $32. By its action the legislature not only did not grant an increase but made it impossible for a nursing home even to rise to the $28 level if its costs were below that figure as of April 1, 1977.

The limit of three administrative days for hospitals and the freeze on nursing home rates may seem unrelated. However, hospitals find that these two actions coalesce and place them in a double bind when they try to place patients.

Last year the author cautioned the General Assembly, in committee testimony presented on May 25, "If you freeze nursing home rates, these facilities are most likely going to be more reluctant to accept Medicaid patients. That, coupled with a reduction in the number of administrative days from ten to three, will probably have the effect of leaving many patients languishing in acute care hospitals receiving care for which the state is unwilling to pay anything at all, not even the skilled nursing facility rate let alone the higher acute care rate."

At this writing, not enough data are yet available to prove the author's prediction definitively, but preliminary reports indicate that this expected trend is indeed occurring.

Costs shifted from taxpayers to patients

Two other actions by the 1977 General Assembly that adversely affected hospitals are the freeze on outpatient rates and the increase in the outpatient co-payment from $1 to $2 for the medically needy.

John F. Moulton, director of Cumberland County Hospital in Fayetteville, pointed out to his legislators early this past summer that for a number of years hospitals in North Carolina "have been receiving only 90 per cent of our allowable costs under the Medicaid program for outpatients, so even now there is a loss on outpatients." To freeze the rates, he said, would just increase the percentage of allowable costs that institutions would not receive.

Another hospital administrator cautioned, "Our hospital has an outpatient emergency room department, and many of our patients, because of the shortage of physicians in this area, are forced to (enter) . . . the health-care system by using the hospital outpatient services. It would create a burden on our hospital to freeze the rates on outpatient care because so many of our people who are on Medicaid are seeking entry into the health-care system by this route."

With regard to the increase in outpatient co-payment from $1 to $2 for the medically needy, Robert R. Martin, administrator of Scotland Memorial Hospital in Laurinburg said, "We feel this would be next to impossible to collect since the Medicaid patient cannot pay for his services in the first place. Again, this would represent an increased service cost that would have to be passed on to private paying patients."

Here again the pattern remains clear. The General Assembly has saved money only in its own budget. In a

larger context, no net savings have been made. Health care costs have merely been shifted from the large group of taxpayers to a much smaller group of hospital patients.

Hospital-based SNF care affected. One of the Hospital Association's predictions has already begun to come true as a result of the General Assembly's freeze on nursing home rates. A number of years ago, some acute care hospitals began allocating space for some beds for long-term care. By the summer of 1977, fourteen hospitals had some facilities containing SNF or ICF beds. Traditionally these units have had higher costs than separate nursing homes because they tend to offer a wider range of services and have sicker patients. Most have operated at a loss because they too have been affected by the $28 per diem cap, even though their costs in fiscal year 1976-77 averaged about $34 per patient per day. Still, the units were perpetuated as a service to the community.

In testimony throughout the 1977 legislative session, the author predicted that if an increase was not granted, these institutions would be plunged into ever greater deficits. The result could be that (1) some of the hospitals with extended care facilities would close those facilities, thus depriving their community of this valuable service, and (2) other institutions considering adding extended care beds as a new service would decide not to do so.

Both prophecies have come at least partly true. After the General Assembly adjourned, the administrator of Transylvania Hospital at Brevard, announced that the hospital would close its long-term care beds. At about the same time, James E. Case, administrator of Catawba Memorial Hospital in Hickory, announced that his institution had indefinitely postponed its plans to open a new 35-bed skilled nursing facility because it would lose between $75,000 and $100,000 in operating costs the first year alone.

Mr. Case also correctly foresaw, no doubt, that "as the hospital began to accumulate Medicaid patients who were denied beds in a for-profit nursing facility because of the limitation on reimbursement, the hospital would find itself totally occupied with Medicaid patients only."

Ironically, the effect of some cases like Mrs. Jones's may be to raise the state's Medicaid expenses rather than to lower them. Many patients in these institutions, who would be too sick to transfer to most free-standing nursing homes, could be placed in the adjunct SNF of an acute care hospital because of the greater intensity of care available within the same institution. Such in-hospital transfers could cut the state's cost to perhaps one-third of that in the acute care part of the hospital; but if such patients are now forced to stay in an acute care bed because there are no hospital-based SNF beds, then the state has in effect tripled its costs for that spell of illness.

It remains to be seen whether other hospital-based extended care facilities also close. No doubt many of these hospitals are waiting to see whether the 1978 General Assembly dissolves the freeze and establishes a payment rate that can keep pace with cost.

Problems antedate 1977 legislature

But not all difficulties with Medicaid have their genesis in the 1977 legislative actions. In fact, the program has had problems for years.

Chief among these has been periodic slow and delayed payments after billing. This matter has often reached crisis proportions, especially during changes of intermediaries. This propensity to move from one intermediary to another has compounded the problem—from Blue Cross to the state itself, to Health Application Systems, and on to Electronic Data Systems-Federal (EDS-F, the current fiscal agent). (See page 45).

The process of determining eligibility for Medicaid is frequently slow, and as a result the transmittal of approval from the counties to the state on to the intermediary frequently is hindered.

Retroactive denials of claims have historically been a problem, although this difficulty has eased considerably with the present concurrent medical peer review of whether care is needed.

A continuing problem lies in obtaining the Medicaid labels from recipients. These labels are a prerequisite for payment and they must appear on billing forms. Recipients frequently forget their labels, lose them, or exhaust their supply. At least one hospital has several people who try to obtain the labels and to expedite Medicaid applications by visiting patient's homes and providing transportation for Medicaid recipients to the county departments of social service.

Hospitals retain positive commitment

Despite having to cope with the technicalities of the Medicaid program, North Carolina hospitals continue their deep commitment to provide the same excellent care to their Medicaid patients as to all of their clientele. These institutions not only accept Medicaid recipients for care but also do not operate on a selection basis; they take any and all Medicaid patients, and accept reimbursement as full payment.

The hospitals of North Carolina are proud of their record of service to the Medicaid recipients of this state. To the best of our knowledge, every licensed hospital in North Carolina participates in a contractual

relationship with the state for treating Medicaid patients, except for one institution that cannot qualify because of building code deficiencies. No other class of Medicaid providers in North Carolina, whether institutional or professional, can claim a better record of service to the state than these hospitals.

The Medical Services Section of the State Division of Social Services, through its director, James Gibson, has continually shown interest and concern in helping to alleviate outstanding provider problems where possible. Similarly, the fiscal intermediary, Electronic Data Systems—Federal, and the North Carolina Medical Peer Review Foundation have always been responsive in immediately following up on hospital inquiries.

How this state might improve its Medicaid program

What can be done to streamline the Medicaid program to improve its administration and remove many of the obstacles to efficient and cost-effective provider participation?

The state might modify the Medicaid program in a number of ways to make it more functional. For example:

1. Immediately implement existing projected plans to reimburse skilled nursing and intermediate care facilities on a reasonable cost-related basis—as acute hospitals are now—and abolish the current reimbursement method. Such an action, featuring reasonable payment for services rendered, should make nursing homes more willing to accept Medicaid patients, eliminate the current shortage of nursing home beds for Medicaid patients in North Carolina, and permit hospitals to discharge more quickly those patients who no longer need acute care.
2. Adopt the so-called "floating" or "swing" bed concept, whereby acute care hospitals that cannot find a nursing home bed for a patient would at least be paid at the SNF rate after the three administrative days had expired, rather than losing all reimbursement.
3. Replace the current system of monthly labels for proving Medicaid eligibility with an identification card system with ready means for providers to check current eligibility.
4. Establish a cooperative effort among the counties, the state, fiscal intermediary, and providers to streamline the eligibility determination process.
5. Adopt a longer-term contract with a well-established fiscal intermediary to promote continuity in the program and reduce the disruptions in provider payments. (The state recently announced general intentions in this regard.)
6. Re-examine eligibility standards to insure that only the truly needy are eligible for Medicaid.
7. Passage of legislation to pay acute care hospitals full costs for outpatient services—as these costs are now paid for inpatient services—and to further encourage Medicaid patients to seek this less expensive method of treatment.

Nothing will eliminate all of the problems that have plagued the Medicaid program, but with people of good will on all sides, perhaps some progress can be made in making a basically good program even better. □

Financing Social Services

(continued from p. 18)

to see their plans and restrictions so often go awry or not achieve the desired effects.

The casual observer is amazed that the welfare system works at all. The concerned administrator is distressed that people spend so much time and energy on fixing blame for the system's inadequacies instead of joining forces to correct the shortcomings and getting on with the business of improving the quality of life for all citizens. The process does work; it can be made to work better. □

Welfare Reform

(continued from p. 22)

Perhaps the most that can be expected at this time are major revisions in AFDC. Congress, in considering H.R. 7200, is already reviewing this program. If our society continues its desire to aid the "deserving," then this would be a logical sequence to SSI and the 1977 reform of the food stamp program. Improving the AFDC program would constitute "reform" if it raises benefit levels on a uniform basis in behalf of children, preserves intact the family, eases welfare costs to the states and local governments, and enhances job and income opportunities for the poor.

Comprehensive welfare reform may not be achieved this year or the next, but the fact that it is being considered will at least bring about discussion throughout the country on programs, attitudes, and government roles in meeting the needs of people. In a democracy this is essential. We may hope that the plight of the poor will be improved in the process. □

Poverty and Malnutrition in North Carolina

James Dykes

IF WE ARE TO CONSIDER the effects of poverty in this state, we need to understand what we mean by that word—*poverty*. The most widely used definition comes from Mollie Orshansky, of the Social Security Administration, who developed the official federal poverty index in the mid-1960s. This statistical tool is based on two measurements: the proportion of the budget that low-income families spend for their food, and the cost of a minimally adequate temporary diet. Any family is considered poor that has a yearly income of less than three times the cost of the United States Department of Agriculture's Economy Food Plan. By definition, therefore, the poor are those who have incomes below that required to purchase a nutritionally adequate diet.

We can infer two unfortunate, but accurate, corollaries to this definition: Poverty often means malnutrition, and high food prices create poverty.

When I speak of malnutrition in North Carolina I will not usually be speaking of the swollen bellies and shriveled limbs of the famine victim, although such cases have been found in the South. I will be speaking about people who have clinical and subclinical disease in the form of anemia; predisposition to infectious and/or chronic disease; high rates of maternal, fetal, and infant death; stunted growth and mental retardation; and lethargy.

These diseases of poverty are commonplace in our state, and I will document their extent and severity. There are those who refuse to see the obvious effects of inequity; I will attempt to remove some of the obstacles to vision. We need not hide our eyes from poverty. If poverty and malnutrition exist in this state, we have a situation that can be corrected. However, we must understand the causes for its existence.

It is no secret that social services remain a symptomatic measure—assuaging ills created elsewhere in society. In one sense, however, the social services effort may be a good beginning because of the concern for the relative well-being of the human population. I feel obligated, however, to echo a warning once given to me: A good physician should worry that any symptomatic therapy might unavoidably conceal the progress of the disease and its cause. Indeed, such symptomatic therapy, if not monitored very closely, might itself be iatrogenic—that is, induced by the therapy—and cause further illness. We might examine the role of social services in this light. The disease of poverty *is* spreading.

What are the facts?

My initial reaction to writing a factual account of poverty and malnutrition in this state was: Who needs another factual account of poverty? There have been many. We all know of such reports. It has been several decades since the U.S. Children's Bureau demonstrated that infant mortality rates increased as family income decreased. In 1977 North Carolina still has one of the highest rates of infant mortality in the nation.

One physician has remarked:

> We have known the general dimensions of the disaster for a long time, just as we have known about the relationships between poverty and health, without fully facing up to either of them. The poor are likelier to be sick. The sick are likelier to get poorer. And that is just what has been happening and is happening today.[1]

North Carolina is often cited as a problem area in nationwide surveys. In 1968 the Citizens Board of Inquiry into Hunger and Malnutrition in the United States

The author is a medical student at Duke University who has been working with the North Carolina Hunger Coalition.

1. Quotation attributed to Dr. H. Jack Geiger, "The Poor and the Professional: Who Takes the Handle of the Broad Street Pump?" (Paper presented at the Ninety-fourth Annual Meeting of the American Public Health Association, San Francisco, Calif., November 1, 1966), p. 1.

published "Hunger USA,"[2] which identified 280 "hunger counties" in the United States. *Twenty-eight of these, or 10 per cent, were in North Carolina.* The county where I have been working with the North Carolina Hunger Coalition was denoted an "emergency hunger county."

In 1973 the Senate Committee on Nutrition and Human Needs identified 263 hunger counties.[3] *Thirty of these, or 11.5 per cent, were in North Carolina.* My assigned county, five years later, was still a hunger county.

A state nutritional survey done in 1971 provided concrete evidence that malnutrition was a significant problem in North Carolina, and its likelihood increased as income decreased.[4] When low income levels and high food costs restrict the food purchasing power of families, malnutrition is incipient.

Progress against poverty? When I arrived in my county in March, 1977, the incidence of poverty was still very high, the infant mortality was 28.4 per 1,000 live births (or more than 1.5 of the national average),[5] and the percentage of participation in the food assistance programs was extremely poor—only 22 per cent of those eligible for food stamps were using them.[6] By all-criteria, this county was still a hunger county.

I have been surprised to learn that we as a nation have not made significant progress against poverty in recent years. Nationally, since 1973 the number of persons falling below the poverty line has been growing, in absolute numbers and as a proportion of the total population.[7] In 1973 there were 23 million Americans below the poverty line, or 11.1 per cent of the population. In 1975 this figure was 25.9 million, or 12.3 per cent of the population—one citizen in eight. (See Table 1.)

One in four American children lives in poverty. There were more children below the official poverty line in 1976

2. *Hunger, U.S.A.* (Washington: Citizens Board of Inquiry into Hunger and Malnutrition in the United States, 1968).

3. *Hunger 1973,* Senate Select Committee on Nutrition and Human Needs, 93 Congress S/N 5270-01803 (Washington: May 1973).

4. *North Carolina Nutritional Survey,* Part 1 (Raleigh: North Carolina State Board of Health, 1971).

5. *North Carolina Vital Statistics, 1976,* vol. 1, sec. 4 (Raleigh: Department of Human Resources, July 1977), p. 5.

6. Conversation with a county director of social services.

7. U.S. Bureau of the Census, "Money Income and Poverty Status of Families and Persons in the U.S.: 1975 and 1974 Revisions," *Current Population Reports,* series P-60, no. 103 (Washington: 1976), p. 34.

High Prices Mean More Poverty, More Malnutrition

Most of the diseases of poverty are beyond the therapeutic reach of medicine. Prescribing sufficient nutritious food is not easy. As a future physician I am interested in preventing illness, not just in treating symptoms. This article is a factual account of the more apparent manifestations of poverty. Too often, however, our analysis ends here, and our efforts to alleviate poverty remain superficial.

Although we may ease some social ills, we will not eliminate poverty by increasing welfare benefits, implementing a new WIC program, remodeling the food stamp program, or reforming the welfare program. Programs to redistribute income and commodities might be seen as an attempt toward justice, but they are in themselves symptomatic; they create dependence, and in the end support the same economy that generates poverty. We can treat the disease of poverty by confronting its source. This article will show the inter-relationship of poverty and malnutrition, often the result of high food prices.

When the availability of food is governed by cost—as it always is in our modern society of landless consumers—and when wealth (that is, food purchasing power) is inequitably distributed, then the control of food costs becomes one of the few ways we have of keeping food resources generally accessible. Food prices have increased 45 per cent since 1972. It should, therefore, be no surprise that we have not reduced the incidence of poverty since that time.

What happens to food between the time the farmer produces a commodity and the time it reaches the table is the crux of the rising cost of food and its effect on consumers, particularly those at the poverty level. In the summer of 1974 the Department of Agriculture's chief economist reported in an office communication that over the past two decades the 94 per cent increase in food prices resulted from added costs by corporate middlemen; only 6 per cent of the rise went to the farmers. In addition, rising costs of petroleum affect the farmer's cost of inorganic fertilizers, pesticides, gasoline, lubricants, and transportation. Add to these factors the costs of processing and marketing, and the hope of holding food prices at a reasonable level for low-income families appears hopeless.

One way to prevent the medical problem of malnutrition may be local production and marketing of food for local consumption—a farmers' market. High food prices are already disabling thousands of North Carolinians. Until we control the spiraling cost of food, poverty-related disease will continue to spread.—J.D.

than in 1970.[8] The rural poverty rate has not decreased since 1969, and in 1976 it increased.[9] In the South, poverty is still primarily a rural phenomenon. Over 50 per cent of the poor live in rural areas. An amazing 45 per cent of our nation's poor live within the 13-state southern region.[10]

There are 10.5 million poor people in the South. Six million are white and 4.5 million are black. However, 45 per cent of all blacks in the nonmetropolitan South are below the poverty line compared with only 15 per cent of whites.[11] This should be kept in mind during later considerations of the differences in morbidity and mortality between these populations.

According to the most recent census, the North Carolina poverty rate is 20.3 per cent of the state population, or one person in five.[12] This is significantly above the national average. In the county where I worked the incidence of poverty is 34.5 per cent, or one person in three. Fourteen North Carolina counties have even higher incidences.

Does malnutrition exist in North Carolina?

Poor health. As I suggested in the introduction, the most important statistic to remember when determining the extent of disease in a community is the poverty rate. This figure is crucial to understanding the relationship between poverty and malnutrition. To be poor is to be improperly nourished.

The poor buy cheap. They *must* buy cheap. All USDA studies to date have shown that the poor budget their money for food more wisely than others,[13] but are forced to buy the least expensive foods. Too often this means Kool-Aid instead of milk. When inflation causes food prices to soar, they are hurt the most. If they cannot "spend down," then they simply buy less: less milk, less eggs, less cheese, less vegetables, less meat, less fruit. It takes a toll on their health. Federal food programs attempt to buffer the damage.

In the rural South where poverty is commonplace, death rates are 22 per cent higher than in the general

Table 1

Poverty in the United States since 1973

	Number Below Poverty Level (in thousands)			Percentage of Poverty Rate		
	1975	1974	1973	1975	1974	1973
All persons	25,877	23,370	22,973	12.3	11.2	11.1
White	17,770	15,736	15,142	9.7	8.6	8.4
Black	8,107	7,634	7,831	29.3	28.3	29.6

Source: U.S. Bureau of the Census, "Persons Below the Poverty Level by Family Status, Sex of Head, Race and Spanish Origin, 1966, 1969, 1971 and 1973 to 1975," *Current Population Reports*, series P-60, no. 103 (Washington: 1976), p. 34.

population.[14] Infant mortality in the 13-state southern region is higher than elsewhere for both blacks and whites. For rural blacks, it is 64 per cent higher.[15]

In North Carolina for all age categories, the nonwhite 1976 death rate was higher than the white death rate. The nonwhite maternal mortality rate is four times that of the white.[16] A nonwhite child aged 0-4 years was almost twice as likely to die as a white child the same age.[17] Forty-four states have a lower infant mortality rate, and forty-two have a lower neonatal mortality rate.[18] The problem exists regardless of the fact that 98 per cent of all North Carolina mothers received some prenatal care and over 99 per cent of the infants were delivered in hospitals by physicians.[19] The cumulative incidence of premature, or low birth-weight, babies in 1976 was 8.3 per cent.[20] However, nonwhite mothers gave birth to low birth-weight babies twice as often as white mothers.[21] A distressing 15 per cent of all low birth-weight infants die shortly after birth.[22]

In the county where I worked, one in three are poor, and the incidence of perinatal mortality is 47.5 per 1,000 live births.[23] The nutritionist for the supplemental food program (WIC) in this county recently said that over 50 per cent of the 500 WIC participants were anemic. She also reported that over 60 per cent of the

8. *America's Children, 1976* (Washington: National Council of Organizations for Children and Youth, 1977), p. 15.

9. National Rural Center, Southern Regional Council, and the Office of Continuing Education in Health Services, *Report and Recommendations of the Southern Rural Health Conference* (Chapel Hill: University of North Carolina, 1976), p. 18.

10. *Ibid.*, p. 11.

11. *Ibid.*, p. 18.

12. *North Carolina Government Statistical Abstract*, 3rd Ed. (Raleigh: Division of State Budget and Management, 1976), p. 172.

13. *National Nutrition Policy Study, 1974*, Hearings before the Select Committee on Nutrition and Human Needs of the U.S. Senate, 93rd Congress, Part 3, "Nutrition and Special Groups," National Nutrition Policy Study, 1974 (Washington: 1974), p. 826.

14. *Report and Recommendations of the Southern Rural Health Conference, op. cit.*, p. 11.

15. *Ibid.*

16. C. Arden Miller, "Health Care for Children and Youth in America," *American Journal of Public Health*, 65, no. 4 (April 1975), 355.

17. *North Carolina Vital Statistics, 1976, op. cit.*, p. 1.

18. *North Carolina Vital Statistics: January, February, March Quarterly Provisional Report, 1976* (Raleigh: Department of Human Resources), 1976.

19. *North Carolina Vital Statistics, 1976, op. cit.*, pp. 1-3.

20. *Ibid.*

21. *Ibid.*

22. Raymond Wheeler, M.D., Testimony before the North Carolina Committee on Aging, February 1976.

23. *North Carolina Vital Statistics, 1976, op. cit.*, p. 5.

babies born to mothers in the county WIC program were low birth-weight/high-risk infants.[24]

Does malnutrition exist in North Carolina?

Poor nutrition. In early 1970 the North Carolina Board of Health began a statewide nutritional survey intended to establish the percentage of North Carolinians with inadequate diets and to relate diet to, among other things, economic status. It was clear from the study that the percentage of households with inadequte diets decreased as reported income increased.[25] Among households with annual incomes under $1,500 over 77 per cent had less than optimum diets; 43 per cent had inadequate diets. It has been estimated on the basis of this survey that fully 200,000 children, or half the youth population below the poverty line, show physical evidence of malnutrition.[26] A Charlotte doctor recently testified to this before the State Committee on Aging; he stated that "they have iron deficiencies, stunting of growth, and 50 per cent more illness than children of higher income levels."[27]

A year after the North Carolina survey, the United States Government Department of Health, Education, and Welfare published the "Ten State Nutritional Survey," which is a landmark in America's understanding of its own hunger problem.[28] For the first time research scientists adept at recognizing nutritional deficiencies in poor populations abroad turned their expertise toward the American poor. These scientists produced data that estimated both the severity and the prevalence of specific nutritional deficiencies within the poverty-level population. North Carolina was not included in the ten-state survey, but we could conclude that many of the results might apply here. (South Carolina was included.) Biochemical and dietary data collected in low-income communities confirmed that a significant portion of the population surveyed was malnourished or at a high risk of developing nutritional problems. The director of the survey concluded:

> In general, the most widespread nutritional problem is one of multiple nutrient deficiency of a combination of one or more nutrients such as protein, vitamins, minerals and calories. It is important to bear in mind and perhaps shocking to realize that the problems in the poverty groups in the United States seem to be very similar to those we have encountered in the developing countires.[29]

It is clear that a higher per capita income was associated with greater stature, body weight, thickness of subcutaneous fat, and skeletal development, as well as earlier maturation and attainment of maximum stature. These trends were evident in the first year of life and consistent thereafter.

The poverty/malnutrition cycle. Poor nutrition is injurious to maternal, fetal, and infant health, and its effects are seen in children and adults. Developing bodies and brains require quality nutrition; a healthy plant springs from rich soil. This is common sense.

Bodies and brains are created in a process that begins with conception. The growth and differentiation of tissues require a sustained supply of a wide variety of nutrients. Maternal nutrition is critical to the strength and well-being of the fetus. Although the chromosome structure will dictate the kinds of cells and tissues formed, the number of these cells (in the brain, liver, adrenals, kidney, etc.) seems to be a function of the nutrients available. In the research laboratory, animals that have been undernourished will have significantly fewer cells in these vital tissues than properly fed animals. They will also have a greater incidence of sterility, spontaneous abortion, still births, and premature births.[30]

In a recent study of over 10,000 human infants, maternal high weight gain during pregnancy was related to higher birth weight and to better growth and performance of the infant.[31] The nutrition of pregnant females and the birth weight of the baby are strongly associated with economic status.[32] A recent editorial in the respected *New England Journal of Medicine* stated that the sequelae, or consequences, of poor maternal nutrition are low birth weight, neonatal death, mental deficiency and minimal brain dysfunction; and it concluded that adequate nutrition, especially the use of protein foods during pregnancy, can in large part prevent the "continuum of reproductive casualty."[33]

Among human populations, it is clear that severe early malnutrition curtails cell division in the brain.[34] The brains of infants who die of malnutrition are reduced in weight and have less nucleic acid and protein

(continued on p. 71)

---

24. WIC nutritionist for Regional Council of Governments (WIC is the Special Supplemental Food Program for Women, Infants, and Children.)

25. *North Carolina Nutritional Survey, op. cit.*, p. 43.

26. *Ibid.*, p. 47.

27. Raymond Wheeler, M.D., *op. cit.*

28. *Ten State Nutritional Survey, 1968-70,* DHEW (HSM) 72-8132 (Washington: July 1972).

29. Dr. Arnold Schaefer. (Prepared statement given in testimony before the Select Committee on Nutrition and Human Needs of the U.S. Senate, 90th Congress, First Session on Nutrition and Human Needs, Part 3—The National Nutrition Survey. Washington, January 22, 1969).

30. Roger J. Williams, *Nutrition Against Disease: Environmental Protection* (New York: Pitman Publishing Company, 1971), p. 51.

31. "Maternal Nutrition—What Price?", *New England Journal of Medicine,* 292, no. 4 (January 23, 1975), 208.

32. *Ibid,* p. 268.

33. *Ibid,* p. 208.

34. Myron Winick and Pedro Rosso, "The Effect of Severe Early Malnutrition on Cellular Growth in the Human Brain," *Pediatric Research* Vol. 3 (1968), 181-84.

Civil Liability of Social Services Staff and Board Members

Bonnie E. Davis

THIS ARTICLE CONCERNS the potential civil[1] liability of social workers, directors, and social services board members. Liability under state law will be considered first and then developing liability under federal law.

Traditional civil liability

The traditional law governing the resolution of private noncontractual disputes or grievances is known as the law of torts. A *tort* occurs when one person breaches a legally recognized duty he owes to another, thereby causing the second person an injury. The injury suffered must have been a reasonably foreseeable consequence of the breach of duty. In the tort context "duty" must be broadly defined: it usually means an obligation to refrain from intentionally harmful conduct or to use reasonable care in one's normal activities. For example, if you drive an automobile you have a duty, in the tort sense of the word, to drive the car so as to neither intentionally nor carelessly harm another. In tort law, duty rarely means an obligation to take a particular affirmative action unless a person occupies a position of special trust, as in the relationship between parent and child.

There are two kinds of torts that are important in social services. An intentional tort occurs when a person voluntarily takes an action that he knows will result in injury to another. If A strikes B knowing that his blow will harm B, without a justifiable excuse, such as self-defense, A has committed the intentional tort of battery. A tort of negligence occurs when a person fails to use reasonable care in his conduct, which causes an injury that was the foreseeable consequence of his carelessness. For example, if A fails to use due care in driving his automobile and causes an accident, he is liable for the reasonably foreseeable consequences of his negligent conduct. Note that there need not be an intent to cause harm. Reasonable or due care is defined generally as the care that a prudent person would have taken in similar circumstances; whether reasonable care has been exercised is decided on a case-by-case basis. Gross negligence lies somewhere between a knowing intent to cause injury and a simple lack of due care; it is reckless disregard of a high probability of injury. A worker's failure to investigate an apparently reliable child-abuse report is an example of this more aggravated kind of negligence.

Typically the person injured (the plaintiff) brings a lawsuit against the person he believes caused the injury (this person is called the defendant but the term has nothing to do with criminal law). A successful plaintiff will recover a judgment[2] against the defendant that will cover the damages[3] he incurred as a result of his injury.

The law of torts has been developed over centuries, first in England and then in this country, on a case-by-case basis by the courts, rather than by enactments of the legislature. The court must decide, as a matter of

---

The author is an Institute faculty member whose fields include social services law.

1. To be liable means that one can be sued; civil liability means noncriminal liability. While actions that give rise to civil liability may in some cases also be crimes, the two areas of liability are by no means coextensive.

2. In this context, a court order to pay a sum of money.

3. Damages may cover such things as the plaintiff's out-of-pocket expenses, an award for pain and suffering, loss of future earnings, etc. In rare instances, in intentional tort suits or those involving gross negligence, the plaintiff may also recover punitive damages — a sum of money amounting to a private penalty or fine imposed for the purposes of punishment and deterrence.

law, whether the defendant had any duty to the plaintiff before the jury is allowed to decide whether the evidence proves that the defendant breached his duty, thereby causing the plaintiff's injury. Legal advice concerning probable future liability is based on a study of past decisions and an assessment of how the court is likely to rule in a similar case.

Tort liability of public officials

Public officials (including social workers, social services directors, and social services board members) are liable for intentional torts they commit in the course of their work exactly as they are liable for intentional torts committed in their personal lives. The fact that they are public officials makes no difference. For example, if a social worker struck a client, he would be liable to the client just as he would be liable to a social acquaintance if he hit him.

However, depending on the nature of the responsibility involved, special rules have been established governing the liability of a public official for torts of negligence committed within the scope of his office. This protection from suit is referred to as *discretionary immunity*. Although all of the elements of a tort may be present—that is, a duty, breach of it, and consequent injury—if an official has discretionary immunity, the court will not allow a suit against him.[4] For example, two of the county social services board's legal responsibilities are to hire the director and to give him administrative advice; in effect, the board has a general supervisory duty toward the director. This is the kind of duty that calls for the exercise of judgment and discretion. Suppose the director carelessly mismanages trust funds he is responsible for. Although the board may have been negligent in allowing the situation to develop, under state tort law its members would probably not be held individually liable for any loss.

A recent case furnishes another good example. In *Vaughn v. County of Durham*[5] the plaintiff had been a foster parent for the Durham County social services department. She alleged that a foster child, who had been found to be a carrier of a rare disease that causes birth defects, was placed in her care and that the social workers in charge of the case should have known that the child was a carrier. The plaintiff became pregnant; when she discovered the risk of birth defects because of the foster child's presence, she underwent an abortion. The plaintiff alleged that her emotional harm as a result of this episode was caused by the workers' negligence. The court considered only the county's liability for the workers' actions and not the question of the workers' personal liability. But assume for discussion purposes that the workers' personal liability was in issue. The court would then have to decide whether the workers' duty of placing children in foster care involved the exercise of judgment and discretion. If the court found that it did, the workers would be protected by discretionary immunity even if they were negligent in making the placement.

The rule of discretionary immunity was developed to protect officials who exercise their judgment and discretion in good faith—that is, in the sincere belief that they are doing the right thing. It is a *qualified* immunity in that it does not apply if an official acts with a corrupt or malicious intent. Immunity would not extend to board members who denied assistance to an applicant out of spite or a desire to punish. Board members should be particularly careful about awarding contracts[6] in potential conflict-of-interest situations, because the court has indicated that it considers such an action persuasive evidence of a corrupt intent. Nor does discretionary immunity protect an official who acts beyond the scope of his office.[7] It would not protect a social worker who assumed custody of a child without authorization from the juvenile court.

Not all responsibilities of social work involve the exercise of judgment and discretion. In trying to decide what actions of an official are covered by discretionary immunity, the courts have distinguished between duties that are ministerial and those that are discretionary. If the law imposes a duty that is mandatory and gives the official no options in fulfilling it, that duty is considered ministerial. The responsibilities of social work often combine ministerial and discretionary duties. For example, the 1977 General Assembly passed a law[8] providing that if a child is removed from his parents' home because of abuse or neglect, the court must determine that the child will receive proper care from his parents before he can be returned to them. This imposes a duty on the worker responsible for the child to arrange a judicial hearing before the child is returned to his parents. The worker must exercise his judgment and discretion as to *when* the parents and child are ready to be reunited, but he has no discretion as to *whether*

4. In some cases the unit of government that employs a public official may be an alternative source of compensation for injuries received as a result of the official's negligence.

5. 34 N.C. App. 416 (1978).

6. As in awarding Title XX contracts to third-party organizations. For example, suppose a Title XX third-party contract was awarded to a day care organization that was operated by a person related to a board member. While this action may not violate the conflicts-of-interest law (N.C. GEN. STAT. § 14-234), it may be evidence of a corrupt intent sufficient to defeat the discretionary immunity of board members. *See* Betts v. Jones, 203 N.C. 590 (1932).

7. *See, e.g.*, Gurganious v. Simpson, 213 N.C. 613 (1938).

8. N.C. GEN. STAT. § 7A-286 (2).

judicial review is necessary, so that part of his duty would probably be classified as ministerial.

In the past, the North Carolina courts have held that there is no liability for negligent performance of a ministerial duty unless the law creating the duty specifically makes the official who has the duty personally liable for its breach.[9] To continue the previous example, since the law does not state that an official who fails to secure judicial review before returning the child to his parents will be liable to the child for any later injuries by them, one would expect no tort liability to be imposed if he were so injured. At present, none of the laws imposing mandatory duties in the area of social work impose personal liability on an official for their breach.

However, there are two important qualifications to this position. First, some court decisions have distinguished between public *officials* and public *employees*. These decisions have held that unlike a public official, a public employee is liable for any negligent acts committed within the scope of his employment, without consideration of the ministerial/discretionary distinction.[10] But all of these cases involved negligence growing out of relatively mechanical tasks, such as driving a car, by low-level employees. The author's opinion is that in this context social workers and directors would be considered public officials rather than public employees because of the nature of their duties, unless they were engaged in a routine task like driving a car.

Less certain is the impact of another recent case. In *Robinson v. City of Winston-Salem,*[11] the North Carolina Court of Appeals had to decide whether a police officer should be held personally liable for negligently arresting the wrong person under an otherwise valid order for arrest. It decided that the police officer would be liable if he failed to use reasonable care in ascertaining the identity of the person he arrested. The court did not indicate whether it considered the arresting officer's duty to be ministerial or discretionary, but since it was willing to impose liability for negligent execution of the arrest order, it can be argued that the court assumed the duty was ministerial in this case.[12] More important, the court did not consider the fact that the laws pertaining to arrest do not impose personal liability on an officer who is negligent in making an arrest. Thus the decision casts doubt on the continuing validity of the restriction of personal liability for negligent performance of a ministerial duty to those situations in which the law expressly imposes liability.

The difficulties that may arise if the court declines to follow its rules requiring express imposition of liability is illustrated by a Virginia case, *Semler v. Psychiatric Institute of Washington, D.C.*[13] Under Virginia law a public official may be held liable for negligent performance of ministerial duty regardless of whether the law also imposes personal liability. In the *Semler* case a man with a history of molesting young women was convicted of abducting a young woman. He was given a twenty-year sentence, suspended on the condition that he remain in a psychiatric institution under the care of a particular psychiatrist. The court order specified that the man could not be released without the court's approval. Approximately eighteen months later the psychiatrist transferred the man to outpatient status with the knowledge and approval of the probation officer but not the court. While he was an outpatient, the man murdered a young woman. The victim's family successfully sued the psychiatrist and the probation officer for their negligent failure to obtain the court's approval before transferring the man to outpatient status. The family recovered $25,000—half from each defendant. The court held that while the psychiatrist and the probation officer had to exercise judgment and discretion over many aspects of the man's treatment, obtaining court review of his release was a ministerial duty, and their negligence in failing to do so rendered them liable.

In sum, as the state rules of tort liability now stand, social workers, directors, and board members are fairly well protected. While everyone is liable for intentional torts and conduct animated by malice, the likelihood of being successfully sued for negligent performance of legal responsibilities is not great at this time. But recent developments in the law suggest a willingness on the court's part to reconsider the rule in regard to negligent performance of ministerial duties. These developments underscore the importance of scrupulous adherence to the mandatory legal duties imposed on social services professionals.

Liability under federal law

The Civil Rights Act of 1871, now codified as 42 U.S.C. Section 1983,[14] is a *federal* law that establishes personal civil liability for public officials who violate

9. *See, e.g.,* Langley v. Taylor, 245 N.C. 59 (1956); Old Fort v. Harmon, 219 N.C. 241 (1941); Etheridge v. Graham, 14 N.C. App. 551 (1972); *but see* Moffit v. Davis, 205 N.C. 565 (1934).

10. *See, e.g.,* Miller v. Jones, 224 N.C. 786 (1944); Hansley v. Tilton, 234 N.C. 3 (1951); West v. Ingle, 269 N.C. 447 (1967).

11. 34 N.C. App. 401 (1978).

12. If the court assumed that the officers' duty was discretionary, it would have dismissed the suit, because the officers would have been protected by immunity even if they had been negligent. Note that the officers were acting pursuant to a magistrate's order for arrest, the equivalent of a warrant. It could be argued that the decision to arrest without a warrant involves the exercise of judgment and discretion and that an officer who made such an arrest would be protected by immunity for any negligent conduct.

13. 538 F. 2d 121 (4th Cir. 1976), *cert. den.* 429 U.S. 827 (1976).

14. 42 U.S.C. § 1983 (1970).

the constitutional rights of others. It frequently provides an alternative basis of liability for public officials who have immunity under state tort law.[15] Violation of Section 1983 is sometimes referred to as the constitutional tort. To establish a claim, a plaintiff must prove that a public official's actions taken under the authority of his office resulted in a reasonably foreseeable violation of a constitutionally protected right or interest of the plaintiff. Since it is federal law that grants the right to sue, a Section 1983 lawsuit may be brought in either state or federal court, but other than that, it proceeds in much the same way as a state tort lawsuit.

In the last several years the United States Supreme Court has interpreted the Fourteenth Amendment to the United States Constitution so as to bring a wide variety of interests under its protection, thereby expanding the grounds on which a Section 1983 suit may be based. The volume of Section 1983 cases has increased dramatically during the same period. While an exhaustive listing of an individual's constitutional rights and interests that may possibly form the basis for a Section 1983 suit is beyond the scope of this article, the following paragraphs discuss three general rights and interests of most likely concern to those who work in social services.

Due process of law. In a long series of cases the United States Supreme Court has held that the state must use a procedure that is fundamentally fair when it seeks to take an action that is adverse to an individual right or interest protected by the Constitution. Using such a procedure is said to accord the individual *due process of law*. While the exact contours of due process vary depending on the gravity of the constitutional right or interest involved, generally it includes the right to know and contest the validity of all of the information used by the state in reaching its decision, the opportunity to present additional information, and the right to have the decision made by an impartial decision-maker. Note that using a procedure that accords the person due process does not determine the result in a particular case; it merely specifies the way the result must be reached.

In a landmark case, *Goldberg v. Kelly*,[16] the U.S. Supreme Court held that an AFDC recipient had a constitutionally protected interest in continuing to receive public assistance. The Court held that since AFDC benefits provided the basic necessities of life, the recipient's interest was significant enough to require a hearing concerning eligibility *before* benefits could be terminated. The Court required the state to establish a procedure whereby a recipient is given notice of the agency's intention to terminate his benefits, a statement of the exact reasons why the agency believes the recipient is no longer eligible, and a hearing by an impartial decision-maker at which the recipient may appear, be represented by counsel, cross-examine the witnesses relied on by the agency, and have an opportunity to present additional evidence. The decision must rest only on the evidence presented at the hearing, and the decision-maker must indicate the evidence relied on in his decision. In following these procedural safeguards, regardless of whether the individual is found to be eligible, his constitutional right to procedural due process has been observed. The principle to be drawn from this case is that any departure from these procedures, as in summary or arbitrary termination of benefits, involves a risk of being sued under Section 1983.

The Supreme Court has often recognized that a parent's interest in bearing and raising children is protected by the Constitution from unwarranted state intrusion. But the parent's right is not absolute, and the state may intervene in the parent-child relationship to protect the child's safety and welfare. A balance is struck between the parent's interest and the state's attempt to protect the child by requiring the state to accord the parent procedural due process before intervening in the parent-child relationship. These procedural safeguards are established in state laws dealing with dependent or neglected children.[17] In general the law requires a full judicial hearing before[18] a parent's right to unfettered custody may be curtailed in any way; in effect, the agency cannot take any action without judicial authorization. Since the law protects the parent's *constitutional* right to procedural due process, failure to observe it may give rise to Section 1983 liability. For example, a protective service worker who assumes custody of a child without any judicial authorization may incur Section 1983 liability, even if a court would have authorized the action, because the summary assumption of custody denied the parent the procedural protection to which he is entitled.

The Supreme Court has also ruled that a public employee who has been employed long enough to

---

15. Some conduct may be both a tort under state law and a violation of a constitutional right, so that an official would be liable under either legal theory. A police officer who uses excessive force in making an arrest may be liable for the tort of battery under state law and for violating the arrestee's constitutional rights under the Fourth Amendment. However, the two areas of potential liability are not identical.

16. 397 U.S. 254 (1970).

17. N.C. Gen Stat § 7A-277 *et seq.* (Supp. 1977).

18. When a child's health or welfare is in imminent danger, the court may authorize the agency to assume immediate custody of him without a prior judicial hearing. However, to protect the parents' procedural rights as much as possible, the law requires a hearing to be held within five days after the agency assumes custody. N.C. Gen Stat §§ 7A-284 (Supp. 1977). This balancing of rights in an emergency was held constitutional in Newton v. Burgin, 363 F. Supp. 782 (W.D.N.C. 1973), *aff'd.* 414 U.S. 1139 (1974).

develop a reasonable expectation of continued employment has a right to procedural due process before being disciplined or discharged. In this context both the staff of a social services department and the director are public employees, and their right to procedural due process probably comes into effect when they become a "permanent" employee.[19] The exact procedures that must be followed in order to discipline or discharge an employee are set forth in *Personnel Policies for Local Government Employment Subject to the State Personnel Act.* In general, the procedure required is a series of warnings that dismissal may result if an unsatisfactory practice is not corrected, followed by written notice of dismissal containing the reasons therefor, and a hearing before the state agency if the employee requests it. The director and board members should follow these procedures carefully to avoid Section 1983 liability. It is important to realize that even if adequate reasons exist to discharge or discipline an employee, failure to use the correct procedure may itself violate the employee's right to procedural due process. An example, drawn from an actual case, involved a local board who became dissatisfied with the director's pre-emptory manner of conducting board meetings and voted to fire him. It gave the director none of the required warnings nor a statement of reasons for the discharge. The director began a suit against the board members and was reinstated. Once reinstated, he elected not to pursue the issue of individual board member liability.

In sum, as long as the procedures set forth in the state laws and regulations concerning clients and personnel are followed, there is little chance of incurring liability. But it should be realized that these procedures were established to protect constitutional rights, so violating them may result in Section 1983 liability.

Unconstitutional basis for action. A public official exposes himself to liability whenever he takes an action that would otherwise be acceptable for a constitutionally impermissible reason. The federal Constitution forbids discrimination on the basis of race, sex, creed, or national origin; therefore an action involving either clients or personnel that is motivated by discrimination may result in Section 1983 liability. For example, the director must make decisions regarding the promotion and compensation of staff members. While he is free to exercise his judgment and discretion in these matters, his decisions may not be based on constitutionally impermissible factors. A director may not deny a promotion to a deserving employee on the basis of race. Nor may a board who is looking for a new director refuse to consider applications from qualified individuals who happen to be black or female. The same principles apply to actions concerning clients; benefits and services cannot be given or withheld on the basis of these factors.

An otherwise permissible action may not be taken to penalize an individual for exercising his constitutional rights, such as the freedoms of expression protected by the First Amendment. For example, an employee may not be dismissed for publicly criticizing the department;[20] nor may the department treat clients who join a welfare rights organization differently from those who are not members. Recently the Supreme Court held that patronage dismissals of employees in nonpolicy positions violated their constitutional right.[21] The principle of this case adds another layer of insulation to merit-system employees in nonpolicy-making positions when a new political party gains control of the policy-making seats.

Thus the Constitution protects clients and staff from actions detrimental to their interest that are taken on the basis of constitutionally impermissible factors like race or ethnic origin and protects them from any punitive measures imposed for exercising their constitutional rights. To minimize the risk of Section 1983 liability, the director or the board should make clear to the client or the employee why an action is taken; a statement of reasons should refer to the facts that support the action to preclude the charge that constitutionally impermissible factors were considered.

Privacy. The extent of Section 1983 liability in this area of the law is still unclear. The privacy interests of both clients and staff are protected by state law. The law states that information concerning a public assistance applicant or recipient shall not be disclosed except for a purpose that is directly connected with the administration of the public assistance program; the only exceptions are the recipient's name, address, and amount of grant, which are matters of public record.[22] Violating the law is a misdemeanor, but the statute imposes no civil liability on an official who violates it. Another law protects the privacy of an employee's personnel file. It makes a few basic facts about the employee matters of public record[23] and prohibits dis-

19. Under federal regulations the state must maintain a merit system for social services employees, and no permanent merit-system employee may be disciplined or discharged except for good cause. Thus a social services employee may be distinguished from a regular civil servant who was not constitutionally protected by attaining permanent status [Bishop v. Wood, 426 U.S. 314 (1976)].

20. *See* Pickering v. Bd. of Education, 391 U.S. 563 (1968); Johnson v. Branch, 364 F. 2d 177 (4th Cir. 1966), *cert. den.* 385 U.S. 1003 (1965).

21. Elrod v. Burns, 427 U.S. 347 (1976).

22. N.C. GEN STAT § 108-45 (Supp. 1977).

23. Only the following facts about any employee are matters of public record: name, age, date of original employment, current position title and salary, date and amount of most recent change in position, such as suspension or promotion, and office to which the employee is currently assigned. N.C. GEN STAT § 153A-98 (Suppl. 1977).

closure of any other information in the file. Again, violation of the law is a misdemeanor, but no civil liability is imposed by statute.

Whether the privacy interest of a client or an employee is also protected by the Constitution is not clear. The answer to that question depends to a certain extent on the kind of information that is disclosed. If the information is legally confidential, but not of an intimate nature, and does not damage the person's reputation, in all likelihood no Section 1983 liability would arise. The situation may very well be different if the information disclosed concerns decisions about contraception, pregnancy, abortion, or other matters of family life because the Supreme Court has ruled that an individual does have a constitutional right of privacy that protects these kinds of decisions from governmental intrusion.[24] It could be argued that this constitutional right also extends to unauthorized disclosure of such information by a public official, and hence renders him liable under Section 1983 for such an action.

If the information disclosed is damaging to the client's or employee's reputation, then yet another Supreme Court decision must be considered. In *Paul v. Davis*[25] the Court ruled that before a public official may be held liable under Section 1983 for unjustifiably damaging a person's good reputation, that person must show that the injury to his reputation caused him some tangible harm, such as the loss of his job. The Court held that without some tangible harm, the person's interest in his reputation was not significant enough to warrant constitutional protection. Two examples may show the distinction the Court made. Suppose a staff member informed a reporter than an AFDC mother was being investigated for fraud because the department believed that her children were living with someone else and she did not spend the AFDC check for their needs. While such a disclosure would certainly violate the state law described above, in order to impose Section 1983 liability on the official, the mother would have to show some tangible harm she suffered as a result of the disclosure other than a general lowering of her esteem in the community's eyes. On the other hand, suppose a food stamp recipient, without any fraudulent intent, under-reports his income. Suppose further that the local board accepts a repayment plan in lieu of prosecution. Somehow getting wind of this, the recipient's employer calls a board member and inquires about the case. Assuming that the employer wants to help the recipient, the board member discusses the case with him. The employer then fires the recipient, saying that he does not want anybody in "that kind of mess" working for him. Here there is a real danger of Section 1983 liability because the recipient can show a tangible loss caused by the unauthorized disclosure.

Too few cases have been decided on this point of law to warrant a firm conclusion. However, the wise course would be to err on the side of confidentiality, because the likelihood of incurring any personal liability for refusing to divulge information is very remote while the possibility of incurring criminal liability under state law for an unauthorized disclosure certainly exists. Furthermore, in certain circumstances additional civil liability under Section 1983 may also be present.

Supervisor liability

It is clear that a person in a supervisory position will be liable under Section 1983 for his subordinates' actions if the supervisor orders or directs the action or knowingly acquiesces in it. For example, a director who ordered a unit supervisor to discipline an employee for publicly criticizing the department would be jointly liable with the unit supervisor. The extent of his liability if the director-supervisor had no direct knowledge is not clear.

Liability would probably depend on whether the wrongdoing would have come to the director's attention in the normal course of events if he had been meeting his supervisory responsibilities as a reasonably prudent supervisor would. Liability may arise if one employee consistently engages in unconstitutional conduct or if several employees engage in wrongdoing to the point that a departmental pattern develops. Once again, too few cases have been decided to allow a more precise definition of what constitutes a consistent pattern of wrongdoing. A recent Supreme Court decision involved the Philadelphia police department.[26] A citizens' group sued several supervisory police officials alleging that their failure to properly investigate claims of brutality and other unconstitutional conduct of line officers and to discipline and retrain the officers involved rendered them liable under Section 1983. Twenty separate instances of abuse over a one-year period were proved. The Supreme Court held that given the size of the police force (7,500), twenty instances were not sufficient to prove a pervasive pattern of wrongdoing for which the supervisors could be held liable, and therefore dismissed the case against them. It left open the possibility of supervisory liability where the facts show a consistent pattern of unconstitutional conduct by subordinates but gave no further guidance on when that point is reached.

24. *See, e.g.,* Roe v. Wade, 410 U.S. 113 (1973); Griswold v. Connecticut, 281 U.S. 479 (1965).

25. 424 U.S. 693 (1976).

26. Rizzo v. Goode 423 U.S. 362 (1975).

Some lower courts have allowed Section 1983 actions when the supervisory official knew or should have known of unconstitutional conduct of a subordinate and failed to investigate, retrain, or reassign the person or to take other appropriate steps to prevent a recurrence of the offending conduct.[27] For example, suppose the supervisor of the AFDC eligibility determination section consistently denied opportunities for advancement to qualified female eligibility specialists because of their sex; suppose also that the director had been made aware of the supervisor's conduct. The director's failure to take any remedial action may make him jointly liable with the supervisor.

One theme that has clearly emerged from the judicial decisions is that a supervisory official may not avoid liability by claiming ignorance of his subordinate's actions, assuming that a consistent pattern of wrongdoing exists. This point should be of particular interest to board members. In view of the board's legal duties to select the director, give administrative advice, and approve public assistance cases, board members need to be generally informed on a regular basis of what is going on in the department so that if some pattern of wrongdoing does arise, it will come to their attention in the normal flow of information they receive. While directors are more likely to incur supervisory liability because they are directly responsible for the staff, board members may be held responsible for a notorious and consistent pattern of wrongdoing.

Defenses. Many cases have arisen concerning the defenses available to a public official sued under Section 1983. The following statements are intended to give a very general idea of the defenses the courts have allowed. If the official's conduct that allegedly caused a constitutional injury involved the exercise of judgment and discretion, the official has a defense of good faith and reasonableness. This means that an official will not be held liable if he can show that he acted in good faith and that his actions were reasonable in light of the circumstances known to him at the time, unless they violated a clearly established constitutional right.[28] For example, the right to a hearing before AFDC benefits may be terminated was established in a Supreme Court decision some years ago; thus a worker who terminated a recipient's benefits without giving him a hearing would be liable even if the worker could show that he had thoroughly investigated the recipient's eligibility and sincerely believed that his action was correct. On the other hand, whether a child or a foster parent has a constitutional right to procedural due process before the child is removed from the foster parent's home is an unsettled question of law at this time,[29] so a court is not likely to impose personal liability on a worker who removes a child from a foster home in accordance with the prevailing practice. The Supreme Court has yet to indicate when a constitutional right becomes "clearly established."

If a public official is sued under Section 1983 for violating a constitutional right in the course of fulfilling a ministerial duty, then he may avoid liability by showing that he acted in good faith according to an apparently constitutional law.[30] For example, eligibility requirements for public assistance are established in accordance with federal and state laws. A worker who determines that an applicant is not eligible under these regulations is not going to be held personally liable if an applicant subsequently successfully challenges their constitutionality.

Impact litigation

In addition to recovery for constitutional injuries from public officials personally, Section 1983 lawsuits are also used as a mechanism to bring about change or reform of the social services system in general. Since the county and the state cannot be sued directly, a reform-minded plaintiff must sue the public officials who administer the system in their personal and representative capacities. The goal in a lawsuit of this kind is not to impose personal liability on a public official but to force him to exercise the authority of his office to make some change in the system. Typically the plaintiff in this type of suit is most interested in securing *injunctive relief*—that is, a court order directing the official to change the system in some way. Two examples of this kind of litigation have arisen in North Carolina. In *Alexander v. Hill*[31] the plaintiffs were AFDC and Medicaid applicants who contended that their applications were not processed within the time frames established by federal regulations. While the suit nominally proceeded against social services officials personally, the objective was not to impose personal liability on these

(continued on p. 73)

27. *See, e.g.*, Pitrone v. Mercadante, 420 F. supp. 1384 (E.D. Penn. 1976); Fialkowski v. Shapp, 405 F. Supp. 946 (E.D. Penn. 1975); Moon v. Winfield, 368 F. Supp. 843 (E.D. Ill. 1973).

28. Wood v. Strickland, 420 U.S. 308 (1975); Scheuer v. Rhodes, 416 U.S. 232 (1974).

29. In Smith v. Offer, 53 L.Ed.2d 14 (1977), the Supreme Court held that any constitutional interest a foster parent has in having a foster child continue to live with him was adequately protected by the relatively extensive procedural safeguards provided for in New York law. The question that remains after this decision is whether a foster parent has a constitutional right that is violated when the state law provides *no* procedural safeguards, as is the case with North Carolina.

30. *See, e.g.*, Pierson v. Ray, 386 U.S. 547 (1967); Eslinger v. Thomas, 476 F. 2d 225 (4th Cir. 1973); Alsager v. District Court, 406 F. Supp. 10 (Iowa 1975).

31. No. C-C-74-183 (W.D.N.C., *order*, Nov. 16, 1977).

The Welfare Wilderness: One Way Out

Dorothy N. Gamble

WELFARE RECIPIENTS often feel that they are trapped. They are involved in a system grounded on the work ethic—people should work for whatever they receive. There is strong evidence that the only kinds of jobs that are available to welfare recipients are "secondary-sector jobs"—those with little security, no fringe benefits, low pay, and capricious supervisory practices—and that the welfare system gives these people little opportunity to prepare themselves for anything else.

It is difficult, then, for a welfare recipient to move out of dependence on a system that seems designed to keep her dependent and to find dignified economic self-sufficiency. I want to describe to you how one group of women did challenge the welfare system head on, made it work for them in spite of itself, and finally kicked the system off their backs.

The setting

My work with a county Welfare Rights Organization (WRO) from 1969-74 was a valuable education in how welfare works. The WRO had already been organized by my predecessor the year before I accepted a position with a small private social service agency in 1969. There were about 300 welfare families in this North Carolina county during the years the organization was active, but only fifty recipients were ever dues-paying members and only twenty of those could be considered active members (i.e., involved in welfare rights activities at least three times a month).[1] The group had already established communication with the National Welfare Rights Organization and included former sharecroppers from rural tobacco lands as well as urban recipients from a medium-sized city.

The organization's twenty active members were all black women. These women often emphasized their blackness in their response to welfare slurs. This perhaps inadvertently discouraged whites from becoming active members, although white recipients attended meetings from time to time and active black members helped them with specific problems.

To complete the picture, it is important to describe the county welfare department and welfare programs available to recipients in the late 1960s and early 1970s. Welfare employees have varying degrees of training and wide differences in their value orientations. Nevertheless, under the pressures they face, many of them are compelled to behave in ways that their clients regard as cool or callous. In spite of the system, some workers do not succumb to these behaviors.

The county welfare board was led by people who had a traditional view of welfare recipients. Most believed that their Depression years' view of poverty was adequate for understanding the issues of poverty in the early 1970s. Having suffered from poverty themselves during the Depression and having now reached levels of economic security, they believed welfare recipients could do the same. They did not or could not see how the mechanization of southern agriculture and their ethnic advantage had enhanced their own post-Depression economic success while at the same time devasta-

---

The author has taught at the School of Social Work and the Department of City and Regional Planning and is currently doing research in the School of Nursing, University of North Carolina at Chapel Hill.

1. In February of 1969 there were 929 AFDC recipients in the county, all of whom were women and children. The number increased to 1,342 in 1971 and then began decreasing again to 953 in 1976. About 400 individuals in the county received Aid to the Aged and Aid to the Disabled in the early 1970s. The average monthly payment to AFDC recipients in 1970 was $31.51. *North Carolina State Government Statistical Abstract* (Raleigh: Division of State Budget and Management, 1976), p. 47. *Profile: North Carolina Counties* (Raleigh: Division of State Budget and Management, March 1975), p. 139.

ting the lives of many black sharecroppers who were forced off the land.

The WRO members knew, without reading the experts, that the only way to get off welfare was to get jobs that were not in the "secondary sector." They also knew that besides money, "success" meant that (1) the income had to be steady, (2) the job had to offer some self-respect and opportunities for advancement, and (3) they had to become involved in decisions that affected their lives. The majority of the active members found their way to many of these goals. This is how they did it.

Deciding on a common goal

Although a welfare recipient often has to share life secrets with the caseworker, health nurse, housing authority social worker, and loan company, she does not easily do so with friends and neighbors. In fact, sometimes it has been necessary for her to keep personal activities (fortunes and misfortunes) secret lest a neighbor, eager to look upright in the eyes of the welfare department, inform the department. Sharing their lives, their misfortunes, and their methods of survival with one another came gradually to the members of the organization.

The urban members acknowledged the lack of public respect for welfare recipients more easily than rural members because they had been exposed to more media coverage, which they felt presented welfare recipients in a negative way. The actual distance (fifteen miles separated the two county meeting places—rural and urban) and the perceived distance tended to separate the group until the main leadership and the majority of the members were urban recipients. The group's nucleus felt that it was right to be angry when you were treated disrespectfully, but it was also right to be able to laugh at yourself and the incredible situations in which you found yourself. Women who could not yet allow themselves to get angry felt uncomfortable in the group. Women who were so angry that they stayed hostile to the world were also hostile to the group.

But their concern for each other and their sharing grew steadily as the group evolved. When one member was dying of cancer, although it was a fifteen-mile trip to visit her and her family, they did so with sincere compassion. If one received some produce from a country relative's garden, she often shared with others. Most important, they shared with each other their various experiences with the welfare department and began to see that there were individual differences in the payments received, differences in treatment, and differences in services provided. They shared equally disagreeable experiences concerning the local hospital's treatment of their children. They compared the ways in which their children were thwarted by the public schools simply because they carried the tell-tale signs of poverty: free lunches, no dime for a school project, and coats that were too thin for the winter wind.

This was the type of information that they gathered in a supportive social organization as they pursued their goal, which clearly became economic survival with personal dignity.

Learning new skills

Trying to keep up with the complexities and constant changes of welfare regulations is a formidable task, even for welfare bureaucrats. It was even harder for us in the WRO because information was sometimes not available to us. Not until 1968 did the State Department of Welfare allow the regulations to be made public. Once the regulations were public and members of the organization became familiar with them, they became expert in interpretation and calculation. These skills were particularly important in 1970, when the state decided to pay only a certain percentage of a recipient's payment in an effort to trim welfare costs. Welfare Rights members became so proficient in interpreting and calculating that they became consultants to new welfare applicants, helping them to prepare an appropriate budget before they saw their eligibility specialists. Learning to do the calculations and explaining the regulations were important steps for many recipients. These skills put them on an equal level with the eligibility specialists. In fact, they knew that they often had a better understanding of the regulations than the eligibility specialist, the very person who held control over the meager allotment on which they and their families tried to survive. It was an important threshold.

Applying knowledge and gaining confidence

Gradually the new knowledge and ability, which gave these people confidence, began to affect nearly all aspects of their lives. First, they began to encourage other recipients to appeal various decisions about their welfare budgets. Members of the WRO joined recipients in appeal hearings, whether or not the recipient was a member of the organization. Some cases were won and some lost, but the welfare department knew it was dealing with well-informed, confident recipients—something it surely had not seen before.

Schools. The group began to question public school officials. Teacher conferences took on new meaning for the individual members. They began a campaign to make the school system aware of the way certain

teachers and principals singled out children who received free lunches. Members of the organization began to be active on the Title I (Elementary and Secondary Education Act) advisory board in an effort to get school funds earmarked for poor children to be spent on those children rather than used indiscriminately within the school systems.

Housing and health care. Problems with the local housing authority were challenged as well as problems relating to private rental housing. The hospital policy not to treat anyone who had an unpaid bill was challenged and changed. Local doctors began to feel the ripples of the welfare members' new knowledge and confidence; the recipients began to demand adequate care through Medicare and Medicaid programs. Hardly a public or private agency in the area was not at some time challenged by members of the organization to provide adequate services.

Work Incentive programs. An important area in which the members showed their initiative and their support of each other was in their Work Incentive training programs and classes. As the "work" emphasis of the WIN program evolved, some members found it necessary to be in training for three years or more. They often had to drop out of their classes when family matters consumed all of their time and energy, but they usually came back with a new determination to complete high school, typing courses, or licensed practical nursing school. The members now were convinced of the need for the training in order to get a decent-paying, steady job; otherwise, they would just be back on welfare again. It was a vicious cycle: on-again and off-again with low-paying, short-term jobs and welfare. These people found that the cycle always left gaps of several months of no income while they tried to get another job or to get back on welfare. They found that getting an unsteady job was simply not worth the physical and psychological trauma of agonizing months when children had nothing to eat and they were forced to beg from a friend. An unfortunate work experience, then, often becomes an incentive to accept welfare status.

When the Employment Security job counselor came to encourage the WIN participants to accept various job offers (such as stock clerk, nurse's aide, or cleaning crew), she was confronted by a new breed of knowledgeable welfare recipients. WRO members refused jobs, even with the threat of losing welfare. They held out for more training and education or a job that was not dead end.

At last, four, five, and even six years after they had entered initial training, these people did manage to get off welfare. Most found jobs that paid a decent wage and had some degree of security. Three are bus drivers, one is a social worker, one is a clinical assistant in a health center, five are licensed practical nurses—in the same hospital that once refused to treat them—and four are secretaries.

Some of these women still receive benefits in the form of decreased child-care payments or supplemental rent, but they no longer have that "welfare monkey" on their backs. In freeing themselves from welfare, they have not turned their backs on other welfare recipients, or potential recipients, and still spend a lot of volunteer time helping them to understand and negotiate the intricacies of the welfare system.

In summary

When I first became involved in this county welfare situation, I found that there were several steps I could take to help this group of women build their organization. First, it was important *to listen.* I needed to know how various programs and problems had affected their lives. Often it was like a puzzle: A piece of one person's problem helped to clarify a piece of the problem described by another, and when the pieces fit together they became useful information for the whole group.

Second, it was important to respond to their stories by *reinforcing the latent anger* they felt about something. If someone told me she had been threatened with being cut off welfare unless she accepted a particular job offer, I would say, "Now that would make me mad!" or "How can those idiots do that to you when they know you only have another year to go to finish your course!" People who have been hurt so many times sometimes forget that it is quite natural to react to something that hurts.

It was also important to *identify the main goals* of the group. In this case I perceived their goals to be "success" and "dignity"—getting a job in the "primary sector," maintaining self-respect, and having some control over decisions that affected their lives. I often made suggestions about group strategies and activities, but the group never responded to them unless they fit their own strong purposes.

Fourth, it was important to *collect and share as much information as possible* about the issues so that the group could analyze the implications of certain policies. The linkages the group had with the national organization alerted us to proposed federal legislation and provided information about various programs that could be started or improved on a local level. Because I had more time, I did most of this information-gathering, but we all shared in collecting state and local laws and regulations.

As a fifth point, it was important to encourage activities that would *acquaint members with their own latent strengths and abilities.* Whether it was organizing a fund-raising party or discussing welfare in front of a

college-level sociology class, members of the organization learned new things about themselves, how well they could express themselves, how much money they could raise, or how well they could sort out the essence of complicated regulations.

Finally, it was important to *manage internal conflict.* Personal problems, ideological problems, and organizational problems crop up in any organization and sometimes drain energy away from group goals. I tried to minimize those problems in order to allow the group to move forward. When I could not manage a conflict, the group dealt with it, usually by cutting itself off from it or moving away from it. For example, I had tried to keep the urban and rural recipients together in order to have a larger, stronger organization. The rural members felt the urban members were too aggressive in some of their strategies, such as challenging a public official in public. Urban members felt the rural members should be more aggressive. Resolving these divergent approaches at each meeting was beginning to consume too much time. The two subgroups began planning fewer activities together, and eventually the urban group made a cordial, but definite, move away from the rural members.

Various approaches to community organization, including the one I used, have been described elsewhere, and it does not seem useful to advocate one over another. What does seem important is the need to initiate and stimulate these kinds of supportive social organizations, especially among the poor.

I would submit that these women were able to reach the level of economic success and personal dignity they achieved because of the support and encouragement they provided to each other. Without the group, they would not have reached these levels as effectively, and probably not at all. When you are all by yourself it is very difficult to ignore the threat of being cut off welfare. The knowledge and skills they gained as a result of keeping the group viable served them in many different ways. Principally they became more assertive with the health, welfare, social, and economic systems that touched their lives.

While it has had an enormous impact on their personal lives, what these women have done has not much changed the way the local welfare department operates, nor can it be considered the solution to national welfare problems. The changes needed to prevent some of the basic social and economic injustices in this country would require a commitment to a major redistribution of goods and resources, thus far not likely to be accepted by the public. In the meantime, a human response to the problems of the poor is the very least we can ask of our profession.□

REFERENCES

Alinsky, Saul D. *Rules for Radicals: A Practical Primer for Realistic Radicals.* New York: Random House, 1971.

Baker, Sally H., and Levenson, Bernard. "Earnings Prospects of Black and White Working-Class Women," *Sociology of Work and Occupations* 3, May 1976. Pp. 123-50.

Brager, George, and Specht, Harry. *Community Organizing.* New York: Columbia University Press, 1973. Pp. 67-87.

Cox, Fred M.; Erlich, John L.; Rothman, Jack; and Tropman, John E., eds. *Community Action, Planning, Development: A Casebook.* Itasca, Ill.: Peacock Publishers, Inc., 1974. Pp. 46-62.

Doeringer, Peter B., and Piore, Michael. "Unemployment and the 'Dual Labor Market,'" *The Public Interest,* 38, Winter 1975. Pp. 67-79.

Goodwin, Leonard. *Do the Poor Want to Work: A Social-Psychological Study of Work Orientations.* Washington: Brookings Institution, 1972. Pp. 51, 112.

Grinnell, Richard M., Jr., and Kyte, Nancy S. "Delivering Concrete Environmental Services in a Public Welfare Agency," *Journal of Social Welfare* 2, 1975. Pp. 69-82.

Hasenfeld, Yeheskel. "The Role of Employment Placement Services in Maintaining Poverty," *Social Service Review* 49, December 1975. Pp. 569-87.

Kahn, Si. *How People Get Power: Organizing Oppressed Communities for Action.* New York: McGraw-Hill, 1970.

Levitan, Sar; Rein, Martin; and Marwick David. *Work and Welfare Go Together.* Baltimore: Johns Hopkins University Press, 1972. P. 100.

Liebow, Elliot. *Tally's Corner: A Study of Negro Streetcorner Men.* Boston: Little, Brown & Co., 1967. Pp. 29-71.

Mayo, Judith. *Work and Welfare: Employment and Employability of Women in the AFDC Program.* Chicago: University of Chicago Community and Family Study Center, 1975.

Miller, S.M., and Roby, Pamela A. *The Future of Inequality.* New York/London: Basic Books, 1970. P. 12.

Osgood, Mary H. "Rural and Urban Attitudes Toward Welfare," *Social Work* 22, January 1977. Pp. 41-47.

Ostow, Miriam, and Dutke, Anna B. *Work and Welfare in New York City.* Baltimore: Johns Hopkins University Press, 1975.

Piven, Frances Fox, and Cloward, Richard A. *Regulating the Poor: The Functions of Public Welfare.* New York: Pantheon Books, 1971.

Schler, Daniel J. "The Community Development Process," *Community Development as a Process.* Edited by Lee J. Cary. Columbia, Mo.: University of Missouri Press, 1970. Pp. 113-40.

A Conversation with a Social Worker

(Editor's Note: Recently Bonnie Davis, an Institute faculty member who works in the field of social services, talked with Miller Godwin, a social worker with the Craven County Department of Social Services, about his work and some of the problems he encounters.)

Davis: Since this issue of *Popular Government* is devoted to social services, we are especially interested in social workers. Tell us about your present job.

Godwin: I've been with the county department of social services (DSS) about nine years. Right now I work with families through protective services, foster care services, and adoptions, with emphasis on placing older or difficult children. That's the most satisfying part of my job—finding an adoptive home for one of these children.

Davis: What are the hallmarks of a good social worker?

Godwin: You must be very conscious of your own values and feelings and try to prevent them from interfering with your efforts to help people. You have to try to avoid making judgments about people, and you have to be a very good listener.

I think most social workers try to be nonjudgmental, and they succeed maybe 50 per cent of the time. The rest of the time even if they don't express it, they still make a value judgment, and also they get caught up in what *they* want the family to do. It's a tendency that you have to be constantly aware of.

Davis: What about a bad social worker?

Godwin: Well, he doesn't have much patience, and he is very authoritarian. This type of person sits clients down and tells them what to do. He's easily frustrated with his clients and ends up yelling at them.

Davis: Do you find that racism is a problem?

Godwin: Yes, it is a tremendous problem for many of our clients outside DSS, and I think it is part of the reason DSS has such a poor image. Inside the agency we deal with people from different races and different heritages and never even think about it. Sometimes I amaze myself in that respect. But when I'm away from the office I'm quicker to recognize and to express prejudices.

Davis: What's the most frustrating part of your job? What keeps you from doing what you think you ought to do in your job?

Godwin: The paperwork. It's enormous. To me, the paperwork has to come after delivering services to people. You know, when you place a child in foster care, the important thing is to help the child understand what is going on, help the foster family to be receptive to him, and help his parents understand that we are trying to help them even though we are taking their child away. That is the important part. But to do that—there's so much paperwork you have to do! If there were one single form that you could use, so much time would be saved. Instead there's a lot of duplication, and Title XX made the problem worse.

Davis: What percentage of your time do you spend on paperwork?

Godwin: Perhaps 50 per cent. If a social worker wanted to, he could simply retreat behind all the paperwork. It sometimes happens, and it also happens that people don't get the paperwork done. You do all that *must* be done first and the record-keeping comes last. You can put that off more easily.

Davis: Do you think generally that the people who are in supervisory positions are sensitive to your problems along this line?

Godwin: Yes, I think so, and they try to be understanding. In our agency we complain to the supervisor, the director, and the state office up in Raleigh—we even sent a petition to Jimmy Carter. But

I think everybody is aware that we are bogged down with paperwork.

Davis: Do you have other problems like that?

Godwin: Another big problem is inadequate office space. When you're discussing intimate or embarrassing matters with a client, you need some privacy. Sometimes three or four eligibility specialists have to interview people in the same office at the same time—asking what their income is, whether they have any money in the bank, whether they're telling the truth, and so on. The same thing happens with social workers. Two of them share an office, and while one is doing paperwork the other is trying to help a client work through an emotionally distressing problem. It's not fair to the client, who is crying and pouring her heart out, to have a stranger sitting there doing paperwork. It's very unprofessional.

Davis: Is adequate protection given to a client's privacy?

Godwin: People have to constantly be reminded of this—people in the total system. Otherwise there is a good bit of gossip. A worker might tell an outside person something about a client and even if he doesn't give the client's name, the person may eventually guess who it is. Probably most people in the system don't keep the fact that their work is confidential firmly in mind.

Davis: You've been in social services for almost nine years. That's a long time for someone to stay on the front line working in services. Do you have a problem with burn-out?

Godwin: Yes, I suppose that's why I've done just about everything I could do within this agency. I've talked with some other social workers who have been here a good while longer than I have about it—there's a general consensus that every two-and-a-half or three years you just really get fed up. You do burn out. You get tired. You have worked with some of these families the whole time and after a while, you reach a point where you feel you can't do any more. That's when I go to my superior and say, Look, I'm tired of the same thing—I feel I'm not getting anywhere and I need to do something different. So I change jobs within the agency.

Davis: Do you think that's the best possible solution to the problem, or can the system be changed to minimize burn-out?

Godwin: The team approach could be used, so that other people are working with you with a family. You can support each other and hear each other's gripes and frustrations.

Davis: How about philosophical differences within a social services agency about the agency's goals and how they ought to be achieved?

Godwin: Well, they do exist, particularly because of the way the typical agency is organized. Food stamp people are by themselves. Eligibility specialists are by themselves. Service workers are by themselves. The intake unit is by itself. And so forth.

Davis: Do eligibility specialists and social workers have different attitudes?

Godwin: I think social workers show more concern toward people. The eligibility specialists don't have as much training in dealing with people—they're more like accountants. Their main concern is to make sure the client is telling the truth and not committing fraud. With all the emphasis outside the system on preventing fraud, they can't help having this attitude. But I do think that by separating eligibility and services we have given up opportunities to help people. When I used to do both, a social worker could help someone receiving assistance get job training or get into school or something like that. Now clients may be so embarrassed or humiliated going through eligibility determination that they're not interested in seeing or working with the social worker.

Davis: How do you handle cases for which you see no reasonably satisfactory solution?

Godwin: It takes me a long time to get to that point. I've had some cases that two or three other workers have given up on. The previous workers would say, "Boy, are you dumb trying to do something with *that* family." Dealing with family problems can be very difficult. Sometimes getting them to perceive the importance of something is almost impossible. You keep working with them in areas they are interested in and hope that they will eventually pick up on what you think is important. You just have to keep trying.

Davis: Do you find that your enthusiasm for the situation dwindles as you try more and more things and they don't work?

Godwin: Yes. I can think of families that I worked with for a year or more and tried every resource I could think of. Every time I initiated something with them, something—some relationship—would go haywire and blow up the whole plan. And so you finally sit down and say, "Well, nothing works." You do reach that point. Then you have to try at least to salvage the children from the family if you can't help the family.

Davis: Do you feel there is a difference in the values that you as a middle-class person have for yourself

personally and the values of some of the people that you try to help?

Godwin: Yes. Definitely. Let me give you an example. I work with families whose problems involve alcoholism and sexual promiscuity, on the part of either the parents or the children—or sometimes both. I know that the parents care about their children, but this doesn't always show up in the way they treat them. When I'm away from work, at home, I think about this and it upsets me. At work I try not to make those kinds of value judgments.

Davis: How much do you feel that you should be led by your clients and how much should you lead them?

Godwin: I don't feel you can out and out lead a client. You have to begin where they are, try not to make judgments about them, and start with the goals they have for themselves. You have your own goals for them, but they can't be imposed.

Davis: What if there's a big difference between their goals and yours?

Godwin: This causes a social worker a great deal of frustration. If there is a vast difference I think the social worker has to handle what the family wants—what they value—and if it's reasonable, at least try to work with them on it and try to put aside what the social worker sees as a goal.

Davis: Do you think that a case is more likely to end up in court if there is a big disagreement between the worker and the family about what the goals ought to be?

Godwin: I think so, especially in a child-abuse situation in which the child has been removed and the parents are very hostile. They do not want to really get down and talk about things with you. They just want their child back. They may accuse you of kidnapping even though you have a court order. This leads to anger on everybody's part.

Davis: In presenting his welfare reform proposals President Carter said the present system was very anti-family. Do you agree with him?

Godwin: I'm not now familiar with all the public assistance eligibility regulations, but in lots of ways I think the system has been very anti-family. But the new emphasis in protective services has been pro-family. Some time ago—and not necessarily here but overall—the majority of social workers were too rash in removing children from their homes. Now the responsibility is on the social worker and the agency to help this family stay together by providing counseling or other supportive services such as day care.

Davis: Would you recommend social work as a career?

Godwin: I would for a person who really has concern for other people, who wants to give time to others and try to help them. But you have to be realistic about it and know that you are not going to work miracles. At least half the time, if not more, depending on what kind of work you are doing, the work you do in social work will be very difficult to do, like following a court order when a mother is emotionally ill and cannot understand that you have to take her child away. I've had to take a baby from the arms of a mother like that who had to be restrained. She was unable to care for the child but she couldn't see that. You can sympathize with someone like her who can't understand.

Davis: Do you take your clients' problems home with you?

Godwin: I try not to, but sometimes I go home in such a poor mood it takes a while to forget and relax. This is a greater problem for new social workers. When you first go into social work you take it home, and maybe even dream about it. Some of the things you see and do are a cultural shock—they were for me when I first went into social work. I think you have to *learn* to leave the problems at work. Most social workers do.

Davis: Do you ever wish that just once you could work a miracle?

Godwin: In some ways I've seen miracles. I really have. In some cases I was so surprised that I was overwhelmed, and of course terribly pleased. There are those days. They are rare and far between, and when they happen it really feels like a miracle after a long, hard road you've been on with a person. □

Dorothy Kiester Retires from the Institute

ON JUNE 30 Dorothy J. Kiester—a professional social worker, gifted teacher and writer, and sensitive and dedicated member of its faculty—retired from the Institute of Government.

Dee Kiester has strengthened the Institute's work in public law by contributing the social worker's skills touched with a warmth and humanity that might have otherwise been lost behind the bare words of court decisions and statutes.

For fifteen years she brought her talents to the Institute in the sensitive area of human relations—working with the North Carolina Human Relations Council, Community Action agencies, Model Cities Programs, local Human Relations Councils, and other governmental bodies. In particular, Dee has pioneered in child welfare, day-care licensing, and juvenile corrections. Eleven books, a number of articles, and countless sets of teaching materials carry her name as author.

As a consultant on social welfare, she worked with the State Department's International Cooperation Administration in several Latin American countries, as Assistant to the Chief of the former Children's Bureau, HEW, and with the League of Woman Voters' Overseas Education Fund. As if this were not enough, Dee has also served in many ways within both the University and Chapel Hill communities.

Dee yields to nobody in her personal conviction of equality among people. Few persons—certainly none in my experience—have lived by that conviction both professionally and personally more fully than she. Always alert to inequality, she has moved persistently, tactfully, and thoughtfully to help those who are trying to overcome it—either victims or those who can help victims.

Dee will be traveling abroad for a few months and then will return to Chapel Hill to work as a consultant and to continue her writing.

On her retirement, the Institute's faculty and staff gave Dee a party and presented her with a scroll, signed by the entire Institute. It is inscribed with a few brief phrases that summarize who Dorothy J. Kiester is: dedicated teacher, perceptive counselor, productive scholar, humanistic colleague, and warm and resourceful friend.—HRT

Day Care

(continued from p. 38)

which in turn have a great bearing on costs.

Legislators and other decision-makers should learn from the experience of child day care and pass regulatory legislation designed to protect the dependent persons entrusted to their care.

The availability of federal money for child day care has influenced the number of people who have sought professional training in the field of child development and child day care management. Increasing availability of money through the Older Americans Act will almost inevitably lead more people into the business of services for the elderly. The number and quality of training resources for these people should keep pace with the demand.

We must focus clearly on what constitutes a service that offers dignified help for older citizens who want and need it. At the same time, we must prevent the subversion of these services by unscrupulous business interests. That is the new problem for adult day care and the continuing problem for child day care. Society must cope with the age-old problem: how to be truly benevolent without robbing the beneficiaries of independence and dignity. □

REFERENCES

Fraiberg, Selma. *Every Child's Birthright: In Defense of Mothering.* New York: Basic Books, Inc., 1977.

"Feasibility Report and Design of an Impact Study of Day Care," in *Selected Readings in the Issues of Day Care.* Edited by James A. Harrell. Washington: Day Care and Child Development Council of America, 1972.

Office of Child Development, HEW. *National Child Care Consumer Study: 1975, II.* Washington: 1975. Woolsey, Suzanne H. "Pied Piper and the Child-Care Debate," *Daedalus* 127, Spring 1977.

Poverty and Malnutrition

(continued from p. 55)

content than the brains of well-nourished babies.[35] Recent findings further suggest that caloric intake affects cognitive development as well as physical growth and health status.[36] Low-income children are fifteen times more likely to be diagnosed as mentally retarded than other children.[37] Over three-fourths of our mentally retarded children are found in impoverished rural and urban areas.[38] Organic brain damage resulting from inadequate diet before and after birth leads to incapacitating mental retardation at the worst and, at the least, to children stigmatized for life by failure in school.

The poor and malnourished are predisposed to infectious disease, because adequate nutrition is critical to the function of the body's immune defense system. A leading cause of infant mortality in North Carolina is influenza/pneumonia. Diarrhea is often implicated. These are infectious diseases that can usually be overcome by a healthy child. They are deadly to the undernourished child. Between the ages of one and four, a nonwhite child is three times more likely to die of influenza and pneumonia than a white child.[39] This is not a racial predisposition; the cause is economic.

Finally, and not surprisingly, the incidence of chronic disease is significantly related to socioeconomic status. Besides being more susceptible to disease than middle-class people, poor people are also more likely to have more than one disease.[40] This tendency has been termed the "clustering principle"—for instance, nine in ten Kentucky poor have more than one pathological condition.[41] I doubt that poor people in rural North Carolina would be significantly different. The U.S. Vital Statistics for 1976 provides additional evidence that chronic disease is related to socioeconomic level. In the age group from 45 to 64, 12.6 per cent of the poor were unable to work, compared with 2.2 per cent of those with a higher family income.[42]

In a sense, we have come to the end of the cycle. From birth on, those who survive poverty are compelled to remain poor. There are few who escape. Those who fail our educational system become the low-wage earners later on. As chronic disease interferes with their ability to work, even the marginal economic security of these families is in jeopardy. Because of high food costs and the fixed nature of other household expenses, food is the first item to be cut back in the budget. The cycle continues. The demand for welfare grows. It is not surprising, then, that in a recent study of rural health in the South, mental depression was considered an extremely significant health problem.[43] It is a natural response to a hopeless situation. □

35. *Ibid.*, p. 184.

36. Freeman, Howard E., et al., "Relations Between Nutrition and Cognition in Rural Guatemala," *American Journal of Public Health*, 67, no. 3 (March 1977), 239.

37. Miller, *op. cit.*, p. 355.

38. *Ibid.*

39. *Ibid.*

40. Roger Hurley, "The Health Crisis of the Poor," *The Social Organization of Health, Recent Sociology* no. 3, ed. Haus P. Dreitzel (New York: MacMillan, 1971), p. 95.

41. *Ibid.*, p. 85.

42. U.S. National Center for Health Statistics, *Health U.S. 1975*, DHEW (HRA) 76-1232 (Washington: 1975).

43. Southern Rural Health Conference, *op. cit.*, p. 18.

Medicaid

(continued from p. 47)

payment, since they bill either a private insurer, Medicaid, or Medicare, and are reimbursed on the basis of reasonable and allowable costs or charges. Third-party insurers, such as Blue Cross, are not risking financial loss since they can simply pass the cost through to the policyholder, generally as part of a group policy in which the employer pays all or the major portion of the cost. In practice, insurance companies are in the business of spreading risk, not taking risks. The employer is not at risk because the cost of health care for employees becomes a tax-deductible part of the internal cost of his business operation and can be passed on to the consumers of his product in the form of price increases. Medicaid recipients are not at risk since all of their cost increases are passed on as an increased cost to the state and federal government.[11]

The demand for medical services appears to be virtually limitless, especially since nobody is at risk for controlling the cost of services. The result is that the proliferation of high-cost, high-technology services not only goes unchecked by any economic mechanisms but also is actually encouraged by the health care system in its attempt to provide high-quality medical care.

Over the short and the long run there are at least three options for containing medical care costs: the first relies on market mechanisms in the form of greater risk- or cost-sharing by consumers or greater risk-sharing by the providers of medical services. The second option is a regulatory system similar to that governing public utilities or a ceiling imposed by state and federal planning authorities on expenditures for medical care in a given region. A third possibility would be some combination of options one and two.[12]

The proponents of greater cost-sharing by consumers argue that wide availability of comprehensive health insurance—providing first-dollar coverage of health costs—has removed any need for the individual to be a prudent consumer.[13] Their solution is a system of health care insurance with deductibles high enough that consumers would not treat health care as free.

Other proponents of a market-oriented solution have argued that while a system of deductibles that varied with family income would help to contain medical costs, it probably would not be adopted. They propose a system that places the providers at greater risk for containing costs and allows provider groups to compete for customers.[14] Their primary vehicle for accomplishing this goal is some variation of the Health Maintenance Organization (HMO), which, with its prepayment mechanism, seems to encourage providers to reduce costs while permitting the consumer to evaluate its performance against the traditional fee-for-service system.

The other option is to move away from market-oriented solutions and regulate the health care industry as a public utility.[15] States such as Maryland, Massachusetts, and Connecticut have established rate-regulation commissions as a method for controlling hospital costs. In some states costs for long-term care are regulated in this manner also. It is still too early, however, to evaluate the impact of these rate-setting agencies on health care costs. A stronger version of the public-utility approach would be to impose a ceiling on health expenditures in a given state or region and force the health care system to live within a fixed budget. Such an approach would be similar to the health-planning mechanisms now used in Great Britain, which provide for a degree of control that may not be acceptable in this country.

What we are likely to see in the United States over the next several years is some combination of the market and the regulatory approach. It remains to be seen whether these two can be made to complement each other's strengths and weaknesses.

North Carolina is now having to develop short-range strategies to cover rising Medicaid costs, while searching for methods to contain the overall rise in medical cost. The political spotlight will undoubtedly focus on medical costs for some time in the years ahead.□

11. Medicare recipients share some portion of the cost of medical services provided under that program through a system of deductibles.

12. Walter McClure, "The Medical Care System Under National Health Insurance: Four Models," *Journal of Health Politics, Policy and Law* (Spring 1976), 22-68.

13. Martin S. Feldstein, "A New Approach to National Health Insurance," *The Public Interest* (Spring 1971), 93-105.

14. Paul Ellwood, "The Health Maintenance Strategy," *Medical Care* (May 1971).

15. Karen Davis, "Rising Hospital Costs: Possible Causes and Cures," Health Care Conference of the New York Academy of Medicine, April 1972.

(continued from p. 62)

officials but to force them, via court order, to make sure that all applications were finally acted on within the required time frames. In *Guilliard v. Craig*[32] the plaintiffs were AFDC recipients who contended that the state had erroneously interpreted a federal eligibility regulation, thereby reducing the amount of the monthly grant they received. Again, although the suit was brought against public officials personally, the objective was to compel a different interpretation of the regulation. The point to be made here is that not every Section 1983 lawsuit involves the personal liability of the public officials sued.

Conclusion

At this point, the reader should appreciate the difficulty of giving a definite answer to an apparently simple question concerning personal liability. An attempt to answer the question involves consideration of two different bodies of law, state tort law and federal law under Section 1983. Furthermore, federal law has developed rapidly, and hints of the same are appearing with regard to state tort law. And yet, despite the tangled growth of decisions and rules and exceptions to them, some fairly simplistic advice will go a long way toward minimizing risks. Speaking very generally, personal liability is likely to be imposed under either state or federal law only if the defendant had some commonsense inkling that he ought not to be proceeding as he has—that is, that a reasonable person would see the situation as being somehow wrong or unfair. If you find yourself in such a situation, do not discount your concerns but instead act on them and *get legal advice.* At worst your lawyer will make you feel that you raised a foolish question. Also, if you are going to take an action that is adverse to an important interest of either a client or an employee, become familiar with the required procedures and follow them *carefully* and *consistently.* Finally, insurance can be obtained for most if not all of the risks discussed in this article. This may be done only by the board of county commissioners. Since availability and cost vary so much from county to county, further discussion must proceed on a local basis.

Some may lament the passage from simpler times when questions of personal liability never arose in the social services context. For better or worse, that situation no longer exists and, to borrow a phrase, it is "in the best interests" of social workers, directors, and board members to be aware of such considerations and yet not be intimidated by them, for they warrant attention but not fear.□

32. 331 F. Supp. 587 (W.D.N.C. 1971).

RECENT PUBLICATIONS OF THE INSTITUTE OF GOVERNMENT

PROTECTIVE SERVICES IN NORTH CAROLINA. By Mason P. Thomas, Jr. $1.00.

NORTH CAROLINA LAW AND THE HEALTH DEPARTMENT. By M. Patrice Solberg. $8.00.

KIDS AND COPS: Law Enforcement Services for Children in North Carolina. By Mason P. Thomas, Jr., and L Lynn Hogue. Interim Rev. Ed. $2.50

GUIDEBOOK TO SOCIAL SERVICES IN NORTH CAROLINA. By Mason P. Thomas, Jr. $1.00.

DRIVER'S LICENSE LAW. By Ben F. Loeb, Jr. $3.00.

NORTH CAROLINA CRIMES: A Guidebook for Law Enforcement Officers. By Stevens H. Clarke, Michael Crowell, James C. Drennan, and Douglas R. Gill. Rev. Ed. $4.00.

THE ZONING BOARD OF ADJUSTMENT IN NORTH CAROLINA. By Michael B. Brough and Philip P. Green, Jr. $6.50.

- - - - - - - -

To be published soon—

THE LAW AND THE ELDERLY IN NORTH CAROLINA. By Lucy Strickland and Mason P. Thomas, Jr.

To order, write to the Publications Clerk, Institute of Government, P.O. Box 990, Chapel Hill, N.C. 27514. Please enclose a check or purchase order for the amount of the order, plus 3 per cent sales tax (4 per cent in Orange County).