Consumer Discourse in Assisted Living

Paula C. Carder¹ and Mauro Hernandez²

¹Center for Aging Studies, Department of Sociology and Anthropology, University of Maryland, Baltimore County.
²Department of Social and Behavioral Sciences, University of California, San Francisco.

Objectives. The aim of this article is to discuss the cultural construction of the assisted living consumer. Based on theories of consumer studies, it focuses on organizational strategies employed by assisted living practitioners to promote consumer choice and independence while mediating potential risks.

Methods. Data include field notes, participation in manager-training programs, and interviews with residents and family members during a 22-month study of three Oregon facilities.

Results. Consumer discourse is evident in four primary sources, including the state rules, manager-training programs, organizational practices, and an institutional belief in specific consumer demands like independence and choice.

Discussion. Personal care is a complex consumer “good” further complicated by residents with cognitive impairments, family demands, payment sources, and the very novelty of the assisted living philosophy. We conclude with a discussion of benefits and pitfalls based on the use of consumer discourse that represents older persons as active consumers, rather than recipients, of long-term care services.

Assisted living, a type of residential long-term care designed primarily for older persons who require ongoing assistance with daily activities, is often described as “consumer driven” by researchers, practitioners, and policy makers (Assisted Living Quality Coalition, 1998; Kane & Wilson, 2001; Minnix, 2002). Often contrasted with a more traditional model driven by health professionals and regulations, assisted living has been proposed as a more cost-effective alternative because a more empowered consumer provided with more choices is believed to make better use of limited resources (Wilson, 1993). Many statutes refer to a set of social model “values,” including independence, choice, privacy, dignity, individuality, and a home-like setting, that should guide practice, although definitions vary by state (Assisted Living Federation of America [ALFA], 2003; Kane & Wilson, 1993, 2001; Manard & Cameron, 1997; Mollica, 1998, 2002). Assisted living is an increasingly popular alternative for older persons who require assistance with personal care and health monitoring. Every U.S. state has adopted governing rules, indicating that it will continue to attract attention from policy makers, developers, older persons, and researchers.

Although assisted living has been described as consumer driven, the meaning of consumer-driven care has thus far been left largely unexamined in the gerontologic literature. In this study, we explore the implications of consumer discourse used by Oregon’s assisted living practitioners. Based on a 22-month ethnographic study, we describe how practitioners (e.g., those who work in these settings) represent older persons as consumers, rather than recipients, of long-term care services. That is, residents choose to consume assisted living services, including personal care and shelter and the social model values attributed to this setting.

Consumer discourse used by assisted living practitioners, gerontologists, and public agency personnel situates this setting as one choice in a marketplace where older persons act as rational and informed shoppers, seeking the goods and services that best meet their personal preferences. The following analysis relies on theories of consumer studies to explain consumer-based practices in contemporary assisted living settings. By using the phrase “consumer discourse,” we do not suggest that older persons are not “consumers” in the strict definition of the term as “one that acquires goods or services for direct use or ownership” (American Heritage Dictionary, 2000). Instead, we critically analyze the cultural construct of the assisted living consumer.

Consuming Theories

Consumer studies expand the study of consumer practices beyond a strictly economic model wherein rational actors seek to maximize their utility (Featherstone, 1995; Kellner, 1989; Nixon, 1997; Warde, 1990). People shop for fun, make purchases or take trips that convey a desired image, and buy services or products they neither need nor understand. Recent consumer studies projects explore the meaning of place in consumer identity (Urry, 1995), the experience of shopping (Oh & Arditi, 2000), drinking Starbucks coffee (Smith, 1996), and the process of “McDonaldization” (Ritzer, 1998). Most consumer theorists rely on a social constructionist approach, arguing that meanings are culturally and historically mediated phenomena. Consumer activities involve identity creation and maintenance for the involved parties. For example, Du Gay (1997) argues that traditional areas of sociologic study, such as production, industry, and economics, are strengthened by considering cultural production; that is, how meaning is socially constructed through the interplay of production, consumption, regulation, representation (e.g., language and clothing), and identity (e.g., professor, “Material girl,” executive).

Warde (1990) identifies four primary activities and stages in the consumption cycle of a market economy, arguing that we must analyze specific stages between production and the final
enjoyment of a good or service. The four stages are outlined below:

1. The process of production defines the ways that services or products are created, with the scope of focus ranging from mass production to local or unique practices. Warde’s studies of food consumption are based in household processes, whereas Ritzer (1998) considers the meaning of McDonalds and other “fast food” restaurants for contemporary society.

2. Conditions of access to a good or service may include “free market” exchange, familial relation, citizenship right, or some other specified category. The rules of access may be influenced by government, economics, and/or social norms.

3. The manner of delivery varies in style and meaning depending on the prior categories and on the social relations between the involved parties. Many consumer goods are standardized such that one does not need to learn the local rules to purchase a Big Mac regardless of geographic location. Because of inter- and intrastate differences, standardized service delivery cannot be said to exist in assisted living (Utz, 2003), but whether this is a positive or negative reality for consumers is a matter of debate.

4. The social environment of enjoyment during which consumption occurs depends on the participants and the physical place, as well as the prior categories. For example, some states define assisted living as any group shelter, including single-family homes in which five or fewer nonrelated persons live as well as architect-designed hotel-like structures housing 100 or more persons. It stands to reason that the way in which the services are “enjoyed” will vary by setting type and local rules.

In an analysis that informs our study, Baldock and Ungerson (1996) build on Warde’s (1990) consumer stage model to explain the complexities of providing care. Their study of Britain’s implementation of a consumer-driven community care program indicated that the majority of older stroke patients in the study sample, accustomed to the National Health Service model, were confused about how to access and use services organized under a new consumer model. Reflective of our experiences, they report that “the two sides were simply … not talking the same language” (Baldock & Ungerson, 1996, p. 23).

Many consumer theorists focus primarily on the symbolic meaning of commodities and consumer activities. However, Gottdiener (2000) warns against privileging symbols, arguing that goods and services have practical, exchange (usually monetary), and symbolic values to the parties involved. Take as an example an individual’s need for transportation to his/her place of employment. This person might purchase a vehicle that involves both practical (e.g., drive to work or recreation) and exchange (e.g., trade-in, bank loan, or cash) values. The choice of vehicle, such as a Honda Civic or a Mini Cooper, has different exchange rates but similar practical value. However, these two vehicles provide different symbolic values (which would the reader choose?). Gottdiener (2000) rightly argues that a singular focus on symbols leads us to ignore production processes and the individuals involved in producing goods, a primary concern of political economic theories (Estes, Linkins, & Binney, 1995). Most consumer activities include all three value types, likely evident to varying degrees at all stages of the consumer cycle.

ASSISTED LIVING

In the most general of terms, “assisted living” refers to personal care services in a defined environment. The U.S. Senate Special Committee on Aging formed the Assisted Living Workgroup (ALW) to develop a uniform definition and plans to ensure quality care to “consumers” (ALFA, 2003). The workgroup defined assisted living as a residential long-term care option that provides 24-hour personal care and supervision and reported that “residents have the right to make choices and receive services in a way that will promote the resident’s dignity, autonomy, independence, and quality of life” (ALW, 2003, p. 12). Oregon’s philosophy-driven approach includes these values and a consumer orientation (Kane & Wilson, 1993, 2001; Wilson, 1993).

Although consumer discourse has gained interest in the gerontologic literature, especially in discussions of assisted living (Benjamin & Matthias, 2001; Kane, 1995; Polivka & Salmon, 2000; Wunderlich & Kohler, 2001), only a few researchers have critically examined the meaning of consumerism in long-term care programs (Gilleard & Higgs, 2000; Tilly & Wiener, 2001). Because of the explicit commitment some assisted living practitioners make to implementing social model concepts, an increasing number of studies have examined values such as resident independence, choice, and privacy (Ball et al., 2000; Carder, 2002a, 2002b; Fonda, Clipp, & Maddox, 2002; Mitchell & Kemp, 2000; Phillips, Hawes, & Rose, 2000; Zimmerman, Eckert, & Wildfire, 2001). Similarly, the larger study from which this analysis of consumer discourse emerged began with a focus on these values.

METHODS

A number of ethnographic studies of the sociocultural practices of age-segregated housing provided a foundation for the present project (e.g., Diamond, 1992; Gubrium, 1975, 1993; Ross, 1977; Shields, 1988). Upon entering the field, the goal included describing how practitioners and residents defined and experienced the assisted living values. Specifically, we explored cultural constructs such as independence and consumer choice from the perspective of those who work and live in this setting, and qualitative methods are especially attuned to such open-ended goals (Charmaz, 2000; Gubrium, 1991).

Sample and Setting

Following Luborsky and Rubinstein’s (1995) description of “sampling for meaning,” the strategy included collecting data representing instances of the key concept, daily practice of the social model values. Thus, we sampled for settings and situations in which the values were a topic, including manager-training sessions and resident assessments. The study began in a newly opened facility to observe assessments (required for all new residents), new employee training, and marketing events. For comparative purposes, two other facilities (each owned by different for-profit companies) were later recruited, one that had been operating for 5 years, followed by another new facility. The participating facilities, referred to by pseudonym, included (a) Timber Heights (30 units), located in a rural community and owned by a multistate provider that
owned numerous facilities in the state; (b) Spring Hollow (40 units), the first of eight facilities, all in Oregon, owned by a single company; and (c) Valley View (90 units), the second of two facilities owned by a family-run business. The latter two facilities were located in suburban settings. All three were Medicaid-contracted providers under a state home and community-based service waiver and could be described as targeting low- to moderate-income persons. The décor of Timber Heights and Spring Hollow was simple, with commercial prints of country scenes on the walls and furnishings that could have come from a discount chain. Valley View was a little more upscale, with silk flowers on end tables and overstuffed chairs and couches in olive suede-like material. The public social spaces in each were minimal, typically consisting of a television room, beauty shop, and private dining room.

Formal interviews on the topic of independence were conducted with nine residents and six family members. The majority of residents, those observed and interviewed, were White women in their 80s and 90s, comparable with an Oregon-based study of 38 assisted living facilities (Frytak, Kane, Finch, Kane, & Maude-Griffin, 2001) as well as national samples (e.g., Hawes, Rose, & Phillips, 1999; Zimmerman et al., 2001).

Data Collection

The primary data collection method included participant observation, with approximately half of the data for this study deriving from fieldwork in the three facilities, just under half resulting from the manager-training programs, and a small percentage from formal interviews with residents and family members. The first author averaged 7 hours per week at each facility over nearly 22 consecutive months, including 13 months at Timber Heights, 3 months at Spring Hollow, and 6 months at Valley View. Daily research activities included serving meals, facilitating resident activities, and shadowing staff members of all departments on each shift. Twenty-three formal resident assessments (most taking place in the facility, but some occurring in the older person’s home or a long-term care setting) were observed, and the associated service plans were reviewed. These included all assessments conducted at Timber Heights during the first 5 months of operation and a catch-as-catch-can approach at Valley View where invariably other demands delayed these activities. Long-term fieldwork afforded many unstructured interviews with residents, their family members, staff members, and county case managers, all documented as field notes.

The other primary data source included assisted living manager-training programs. The first author completed three unique 40-hour classroom-based sessions and the second author completed one. The training organizations, certified by the Oregon Senior and Disabled Services Division, included two that owned and operated assisted living facilities and a third affiliated with the Oregon Health Care Association.

Data Analysis

The analytic focus is on verbal and text-based discourse, though this is not a formal linguistic analysis. Rather, the present analysis follows Phillips and Hardy’s definition (2002) of discourse analysis by analyzing the processes and meanings of a socially constructed reality, that is, the assisted living consumer. Analysis of field notes and interview transcripts was facilitated by the Ethnograph qualitative data analysis software (Seidel, Friese, & Leonard, 1995). Volumes of training materials collected during those sessions were analyzed by traditional ethnographic methods such as reading, indexing, making notes, and comparing against the interviews and facility-based data. The unit of analysis included specific “practices,” especially resident assessments and negotiated service agreements conducted by assisted living managers (Lofland & Lofland, 1995). The analysis strategy included indexing the data with code terms like “assess,” “services,” “independence,” “activities of daily living,” and “health.” Code terms attached to text allowed for analytic reports based both on individual and on overlapping codes, such as segments of data coded with both “services” and “assess,” as indicated in Table 1. Although this made the data manageable, the main task involved defining the meanings that various participants attached to their words and actions. Themes and patterns observed during analysis were synthesized into the “primary topic” (Luborsky, 1993) of consumer discourse.

Analytic questions included the following: Who are the consumers and what do they demand? What does it mean to define activities of daily living as services rather than functional status constructs? The theoretical framework followed this iterative process of asking questions, fieldwork, analysis, and additional literature review. Thus, the importance of consumer discourse emerged after establishing the significance of the social model value of independence as a marketing concept and as a unifying construct in this social world (Carder, 2002a, 2002b).

RESULTS

Building on concepts from the consumer studies literature, we present an analysis of consumer discourse in assisted living. Because the topic of consumer studies has not been widely addressed in the gerontologic literature, the following section is organized around the stages of a consumer cycle as identified by Warde (1990), including the process of production, conditions of access, manner of service delivery, and environment of enjoyment. The primary data sources for this analysis include manager-training programs and fieldwork in the three facilities.

The Process of Production

This study focuses on local production practices in one state. As to what is being produced, we argue that a model of consumer-driven care is constructed by participants in the “social world” of assisted living. We identify four elements of this process: the state rules governing assisted living, manager-training programs, specific organizational practices, and belief in specific consumer demands.

Oregon Administrative Rules (OARs) require three primary services and products for assisted living facilities: (a) health monitoring and personal care services; (b) a physical structure with individual handicap-accessible apartments and private bathrooms, locking doors, and kitchenettes in addition to communal social spaces; and (c) the social model values. The three 40-hour manager training programs completed during this study presented the rules, with the bulk of the discussion and handout materials dealing with the third category. The rules in effect during this time period (OAR 411-56, amended 1992) came in a slim volume of only 25 pages, and the social model...
values appear on 8 (32%) of these pages. Additional materials from the state unit that governs senior services include “Guideline for Development of Philosophy” with the following statement: “Assisted Living promotes a resident’s self-direction and participation in decisions that emphasize [the six values]” (Senior and Disabled Services Division, 1989).

Manager training programs emphasize that assisted living is a consumer-driven service that older persons choose, as opposed to care in nursing facilities, which older persons reject. The instructors and guest speakers (e.g., facility owners, state employees, and health professionals) consistently defined the social model approach to care, employing terms such as “consumer” and “service agreement” rather than “patient” or “chart” to emphasize that this setting differs from nursing facilities. As many consumer theorists discuss, symbolism in consumer exchanges is important, and we observed that the highly symbolic social model values were a frequent topic at manager-training sessions. For example, a handout at one session indicated: “To live successfully in assisted living, residents must have a strong preference for independence” (Oregon Health Care Association, 1997). Instructors emphasized the importance of “educating” consumers about the values.

Two organizational practices introduced to managers-in-training include the negotiated service and managed risk agreement. Licensing and professional standards in Oregon require that an assessment of the resident’s health care needs (such as health monitoring and medication administration), functional ability based on activities and instrumental activities of daily living, and behavioral needs (such as wandering and inappropriate behaviors) serve as the foundation for the negotiated service agreement. The latter specifies the resident’s needs, the plan for meeting needs in the resident’s preferred manner, and the person responsible for meeting said needs. Consumers have the right to refuse services, including health monitoring, meals, and medication management, or to receive assistance from family members rather than facility employees.

In a discussion of managed risk agreements, one instructor emphasized several times: “These are key aspects of what you’re going to be educating your residents on.” Ideally, the risk agreement process should balance the individual’s choice and the facility’s responsibility to respect a consumer’s demand while reducing potential risks related to that person’s actions or inactions (Brickel, 1997; Kapp & Wilson, 1995; Wilson, Burgess, & Hernandez, 2001). The “diabetic who ate cake” (Carder, 2002b), a standard example used in manager training, describes a case in which the practitioner informs a resident with diabetes of the risks of a nondiabetic diet and the resident agrees to accept said risks in exchange for the (consumer) value of eating cake. This example is transferable to other resident risks (or choices), such as decorating the floor with throw rugs (fall risk), smoking cigarettes (fire risk), and refusing prescribed medications (health risk). Some advocates argue that by using these tools, “the individual [i.e., consumer] actively participates, to the extent possible, in setting priorities, proposing strategies to meet his or her needs, and agreeing to service parameters as part of the plan” (Wilson, 1995, p. 146). This emphasis on negotiation recognizes that consumer choices might lead to negative outcomes (Mollica, 2001).

Interspersed throughout the categories outlined above is an organizational commitment to the idea of assisted living as a consumer-driven business. The most obvious example is the use of the term “consumer” by official documents distributed by the state governing agency, manager-training materials, and practitioners. As mentioned, the rules require facility operators to develop a statement of philosophy addressing the core values. The written move-in materials at Spring Hollow included the following: “It is our belief that each resident residing in our facility is here because they need or want some level of assistance to remain independent. It is also our belief that they wish to take an active part in managing how their care is provided” (emphasis added).

The major components required to produce the assisted living model of care include the state definition of philosophical values, manager-training programs that teach how to implement the values, organizational practices that emphasize negotiation, and a definition of consumer demands that includes independence and choice.

Conditions of Access

Purchasing the “product,” as one assisted living manager in this study called it, requires the consumer to meet specific conditions of access. The first condition, a preadmission
screening, is typically conducted by a facility staff member, usually the manager or a nurse. None of the three facilities in this study accepted consumers requiring ongoing or unpredictable skilled nursing care, and onlone, Timber Heights, accepted consumers who "wander." Ability to pay is another pre-admission criterion. All three facilities accepted persons enrolled in the Medicaid Home and Community-Based Waiver Program, though each placed limits on how many Medicaid clients they permitted. Upon admission, consumers are expected to participate in the negotiated service agreement that either they or their representative must sign. Although the assessment identifies a resident’s need for assistance with bathing, the negotiated service agreement specifies the consumer’s choice, such as the type of assistance desired (e.g., stand-by, full), time of day, and special preferences, such as the use of a sponge rather than a washcloth and the application of powders, sprays, or lotions.

The following example, based on both observation and interview, exemplifies the challenge of the consumer model for people with cognitive impairments. Robert Clark contacted Timber Heights on behalf of his parents, Henry and Mildred Clark (ages 82 and 83, respectively). As he later said, "Dad always said that when the time came they’d move [into a nursing home]. But when it came time, they didn’t know it." The time came after Mr. Clark became increasingly disabled with diabetes, cancer, and osteoporosis, and his wife suffered a brain injury in an automobile accident. Robert negotiated services on his parent’s behalf, and although they were present for the assessment, their verbal input was minimal. A representative sample of 233 facilities in four states suggests that the prevalence of residents with cognitive impairment is around 50% (Zimmerman et al., 2001). Thus, assisted living providers stand a good chance of bargaining with persons who, like the Clarks, have diminished cognitive capacities.

The ideal model of consumer exchange involves a rational actor making purchases on his/her own behalf, with control over the timing, location, and attributes of a particular good or service. In assisted living, the consumer event is mediated by a number of variables including the limited range of choices available to some consumers. Following a hospitalization, Mrs. Martin’s son convinced her that she needed to move into a care facility. At first she felt "mad" because "I had no choice, . . . but what could I do? I knew I couldn’t go home again." Mrs. Martin, age 88, used oxygen 24 hours a day owing to advanced chronic obstructive pulmonary disease. Her son chose Valley View in part because it was conveniently located near his home.

Sometimes residents are admitted under a trial basis, with conditions specified in the service agreement. Florence’s daughter contacted Timber Heights when it opened, hoping that her mother could transfer from the nursing facility where she had lived for 9 years. Based on the initial assessment, the manager explained to Florence’s daughter that with his staffing level, the facility could not meet her physical needs but that the family could choose to hire a private caregiver to assist with bathing and dressing, the option they chose. The segment of field notes in Table 1 indicates that the two private duty caregivers were included in the negotiations involved to admit and retain Florence, who was severely disabled by Parkinson disease.

Conditions of access to assisted living services require more than meeting initial admission criteria. Negotiating access is an ongoing concern, institutionalized through mandated quarterly reviews of each resident’s health, functional, and cognitive status. Training programs introduced new managers to the topic of aging in place, defined as “the process by which a person chooses to remain in his/her living environment (‘home’) despite the physical or mental decline that may occur with the aging process” (OAR 411-56-005[4], amended 1992). The symbolism of home, emphasized during training sessions, made a lasting impression on Bill, the new manager at Timber Heights, who had previously worked in a small adult care home. Mr. Clark’s declining condition resulted in several difficult challenges, and Bill had to reevaluate his prior work habits in keeping with the assisted living philosophy. For example, Mr. Clark had both bowel and bladder accidents throughout his carpeted one-bedroom apartment. Bill said that in the adult care home, he would have “gone in” to the resident’s room and put rubber-backed carpets on the floor. Here, however, he had to respect the physical and symbolic boundary posed by the Clark’s closed apartment door. Although Bill successfully encouraged the Clark’s son to purchase said carpets, Mr. Clark’s continued health decline led to ongoing negotiations about whether he could stay. His physician wanted to transfer him to a nursing facility, but Bill suggested that the family contract with a hospice provider so that Mr. Clark could remain with his wife in their home, and this was the solution they chose.

Supporting an aging-in-place philosophy requires providers to conduct ongoing assessment, plan appropriate services, and encourage resident independence. In a lengthy discussion of “effective service planning,” the instructor at one training session emphasized the tension between “needs,” “wants,” and independence. He said, “They all want to be independent, don’t they? They don’t. There are some that want to be waited on. Maybe they’ve always been that way. Some think they’re in a hotel. What is the goal of assisted living? Independence. You may have to learn that person.” He explained an inherent tension between the way that monthly fees are assessed (based on level of care) and encouraging resident independence: “Now some people have a real need to be dependent. You’ve got to learn your residents. The level system, by its nature, you’re going to breed dependence. That person who was level one, who becomes level two, they’re paying for this whole new level, [so] they want [staff to do more for them].”

**Manner of Service Delivery**

The negotiated service process highlights a manner of delivery that represents the individual as an active consumer of services, transforming the older person’s identity from needs based to consumer based. The amount of assistance provided to consumers by staff members determines the monthly fees. The indexes of activities of daily living (Katz, Ford, Moskowitz, Jackson, & Jaffee, 1963) and instrumental activities of daily living (Lawton & Brody, 1969) serve as the foundation of resident assessment and negotiated service procedures. Facilities have different strategies for packaging their rates, all based on some combination of these items. Because fees are based on negotiated service levels, the most impaired residents do not necessarily pay the highest fees. Residents who pay the most are those who *use*, rather than *need*, the most assistance. For example, the service agreement at Spring Hollow included the
following statement: “Often times, family or friends choose to help assist in meeting certain needs, thus relieving the resident of the cost for that care service.”

In the example of the Clarks, Robert indicated that his mother could do her own laundry because she enjoyed it and, as he said, “it gives her something to do.” However, he claimed responsibility for making health care appointments, transporting his parents to and from medical offices, and for assisting his father with a shower. Robert explained that although his mother had assisted her husband with his insulin injections for years, she no longer recalled how to draw the dose or whether she had done so. Thus, the negotiated service agreement indicated that the facility registered nurse would prepare the dose and that Mrs. Clark would administer it.

When residents engage in risky behavior, as identified by either facility staff or residents’ families, a managed risk agreement may be drafted, specifying how services will address the risk. Although managed risk agreements were a significant topic of discussion during manager-training programs, in practice they were rare. Similarly, a study of 159 residences within a company with managed risk policies and procedures found that though 53.5% of facilities reported having residents with agreements, very few (3.4%) of all residents had one on file (Wilson et al., 2001). Hawes, Phillips, & Rose (2000) report that 29% of 300 facilities allow this process, but the authors did not evaluate the actual rate of use.

At Timber Heights, Mrs. Clark’s handling of laundry led to a potential public health threat in the facility laundry room and the drafting of a risk agreement following several different service negotiations. As she attempted to clean her husband’s clothing, often soiled with urine and feces, she placed unwashed items directly into the clothes dryer, creating an unsafe condition for other residents. The negotiation process began with the manager assigning staff members to monitor Mrs. Clark’s laundry efforts, but her memory impairment made it impossible to schedule a regular laundry time. One staff member wrote detailed instructions and taped them to the washer and dryer, but this effort similarly failed. During an interview, Robert said, “Well I’d rather she did it, it gives her something to do. But I don’t mind if they take it away from her if necessary.” The manager did not present the risk agreement to the Clarks, in part because he knew that Mrs. Clark lacked the cognitive capacity to “agree” to the terms.

Mrs. Martin, the Valley View resident who lacked a choice about whether to move into an assisted living facility, once there, did direct her care services. She clearly expressed her preferences, including assistance with a daily sponge bath around 9 AM and getting to and from the dining room in her wheelchair for a late lunch. Five months after moving into Valley View, she stated, “They’ve got me down pat. Kelly’s a doll. I have two [caregivers] who help, they’re big, they treat me like a baby, pick me up... . I can’t say enough for them.” She appreciated making choices in the manner in which staff members delivered care, including a daily bath, for which she paid an additional fee.

The source of payment for an individual resident’s monthly fees, whether personal, familial, or public, may affect the manner of service delivery. As mentioned, family members play an important role in determining how residents experience assisted living services. During an employee meeting at Spring Hollow, the manager stated that one resident’s son complained because his mother’s hair was not brushed and she did not eat meals in the dining room. Several staff members objected, arguing that this resident preferred to brush her own hair and to eat meals in her apartment. However, the manager countered that “he [the resident’s son] is being charged for it, so it needs to be done.” At a manager-training session, an instructor introduced the difficult issue of public versus private payers. He said, “If you have somebody that wants to be independent, and they have adequate financing, and you have the staffing for it—see, in this country, we have health care rationing—it’s based on finances. If Bill Gates lives here and wants another grape peeled or a bon-bon, [he gets it], If Joe Whistleblower, he’s on Medicaid and he wants another bon-bon, what do you do? Bill Gates is paying, this guy’s not.”

Assisted living marketing materials refer to assistance with activities of daily living as “personal support services” and “personal assistance” that are “custom designed” and “tailored” to each resident (Carder, 2002a). They have appropriated standard assessment constructs into marketable products, repackaging them as consumable items and reinforcement the overall client-driven market orientation of this business. However, the manner of delivery may be reduced from a detailed negotiated service plan of five to six pages in length to minimal daily directions to staff members. For example, at Spring Hollow, the direct care providers receive “assignment sheets” describing their daily care duties. A sample from a typical day is provided in Table 2.

The Environment of Enjoyment

The living environment is an important selling feature of assisted living, with architectural elements designed to enhance marketability (Pearce, 1998). One instructor said, “The goal of a hallway is no more than 170 feet because you create barriers for people who are mobility impaired. You have to find ways to help them be independent. That’s why we have sitting areas.” Another suggested that facilities should make the “Jacuzzi room” look like a “home bathroom” with colored towels, wallpaper, and prints on the wall. Acknowledging families as the target market, she said: “Accommodate some of people’s stuff in the main areas even if it doesn’t match the mauve and gray the interior decorator thought would appeal to the adult children you’re marketing to.” Again, the symbolic values of independence and a home-like setting are evident.

The instructors explained the importance of public social spaces as extensions of the residents’ home. As this very environment poses risks to persons with diminished capacities, “buyer-beware” practices are common. For example, text from a sample move-in package presented during a training session included the following: “Risk of unsupervised snack bar: This area is unsupervised. It is possible for the tenant to divert from a special diet as both diabetic and nondiabetic items are available. Residents have the freedom and risk to use correctly or abuse the snack bar.” As one instructor explained, “Assisted living is not a safe deposit box; if they want 24-hour assurance of skilled care, assisted living is not for her.” Thus, the risks inherent in making choices are part of the environment of enjoyment.

As mentioned above, during the several weeks that the Timber Height’s employees attempted to negotiate and manage
Mrs. Clark’s use of the laundry facilities, Mr. Clark’s cancer progressed. Although his physician suggested moving him to a nursing home, the Clark’s son and the Timber Heights manager agreed to contract hospice services, and Mr. Clark died in the facility about 4 months after he arrived. Robert Clark “appreciated that they let Dad stay” and that his mother was able to continue residing in the apartment.

Assisted living residents consume many of their services in their individual apartments. Asked to describe a typical day, Mrs. Martin said, “I get up, Kelly gets me up from eight to nine sometime, takes me to the bathroom, goes for my breakfast, comes back and gets me sponge bathed, dressed, and back to my chair. I have breakfast here [in her one-bedroom apartment], do whatever until lunch. She takes me to lunch in my wheelchair, then back, I go to the bathroom a time or two, and well here I am at four p.m. reading the paper.” Despite a recent fall that even further limited her mobility, she described herself as “as independent as in my own house.” By quantitative measures, Mrs. Martin would have scored as dependent in most activities of daily living. She described herself as independent because she maintained control over her schedule and environment. This observation compares with other studies about the meaning of independence to assisted living residents as ability to manage activities of daily living (Ball et al., 2000).

For many consumer theorists (Kellner 1989; Urry, 1995), symbols reflect the most important value of consumer goods. Just as some people feel safer (or more stylish) in a sports utility vehicle, older persons might feel more independent in assisted living. Is their independence “real”? Based on a conversation with the adult daughter of Mrs. Moyer, a Timber Heights living. Is their independence “real”? Based on a conversation with the adult daughter of Mrs. Moyer, a Timber Heights resident with severe memory loss, this question is one that people consider: “She thinks she’s being independent, whether that’s real or not, she has a feeling of being independent. ‘Am I gonna go for a walk now? Am I gonna read or am I gonna go in the TV room, or get my friend and do this?’ She thinks it’s gonna go for a walk now? Am I gonna read or am I gonna go in the TV room, or get my friend and do this?” She thinks it’s independent, although we know it’s real structured. . . . She knows she’s living in her own little studio apartment and that she can put the pictures where she wants to and receive a phone call and go to bed. . . . So in that respect, it’s independent living to her. Does that make sense? That’s the way she thinks about it, but we know it’s not really.”

**DISCUSSION**

This study explores the role of consumer discourse in daily assisted living practice. As a consumer entity, assisted living provides product (e.g., private apartment) and service (e.g., assistance with personal care) plus the added symbolic values of independence, choice, risk, and privacy, in exchange for private or public monies. The symbolic “goods” are implemented through practices such as the negotiated service agreement, which lends the assessment- and care-planning process a free-market connotation. Although less common in practice, the concept of managed risk responds to risks that consumers choose.

Consuming assisted living is not as straightforward an exchange as purchasing food, an automobile, or other products. Personal care is a particularly complex consumer “good” (Ballock & Ungerson, 1996). This is especially true when the older person is cognitively impaired or when family members make demands that differ from the resident’s choices. The case of the Clarks indicates the challenges of delivering personal care services under a consumer model. Did the Clarks consume the products of assisted living? The manager and staff members went to lengths to care for Mr. Clark as his medical condition deteriorated, viewing him and his wife as clients with the right to stay in their new home. Mrs. Clark assisted in her husband’s care with staff oversight. Her choice to do laundry was supported to the potential risk of others. Certainly, the Clark family enjoyed many services, even though the elder Clarks were unable to engage fully in either the negotiated service or the managed risk agreement, the two primary organizational means of organizing and documenting consumer direction.

Source of payment may influence the manner of service delivery. In the case of the son who both pays and directs the type of care provided to his mother, the resident’s consumer choice was superceded by her son’s consumer (e.g., payer) demands. Bill Gates can afford to have his grapes peeled, but the Medicaid client cannot. Such examples leave one to question who the “consumer” is while suggesting that negotiated service agreements may be the product of competing consumer priorities. In some cases, facility employees appear to lose sight of the resident, focusing instead on the bill payer. The resident’s loss of control results in a reduction of her consumer choice and the range of options available to her. This practice reduces the resident’s use of assisting living services while attempting to maximize the payer’s utility.

The symbolic values, such as independence, afforded by assisted living have real substance to residents and their families. Although one reviewer of this manuscript encouraged us to define independence, we resisted because it is clear that the term has different meanings to different parties. To Mrs. Moyer, the independence offered by the setting provides practical and symbolic values to her and her family. Manager-training materials defined it in terms of both physical function and choice. That is, people are independent because they make choices. Whether or not Mrs. Moyer’s independence is “real” is almost irrelevant. From a defined situation perspective (Blumer, 1969), if residents consider themselves independent, they are so, even though standard measures of independence (e.g., based on function) would suggest otherwise. Clearly, this

| Table 2. Daily Directions Provided From Manager to Staff Members |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| #2 Assist with LE dressing/put on hand and foot splint/empty commode/ make bed/2-hr checks—wears Depends 24 hr. Have res. walk to the dining room from the couch and to the bathroom from the couch. |
| #3 8:30 a.m.: for cereal in apt. (make sure she is sitting at kitchen table)!/ assist with dressing and hygiene (brushing teeth)!!/ turn on lights, open drapes, turn on TV! walk resident to mailbox and back at 10:00 a.m./ empty trash/make bed (BEFORE 10 a.m.)/ 2-hr incontinence. Check/give res. a glass of juice/wears Attends 24 hr. |
| #5 Wake at 7:00—make sure that she is getting up—at 10:30 have res. walk or ride the bike for exercise—so do not let her refuse, she is going to do this twice weekly. |
| #8 Wake at 6 a.m. standby assist with transfers out of bed, standby assist with dressing. |
| #13 Wake at 7 a.m. |
| #15 Do not disturb in the morning, may or may not come down for breakfast. |
| #28 Walk dog as needed when res. is unable. |

Notes: LE = lower extremity; res. = resident; apt. = apartment; incont. = incontinence. Source: First author’s field notes.
topic, and the related concept of autonomy, deserves more study, given the rapidly changing long-term care arena.

The repeated references to educating, or “learning,” older persons about assisted living goods and services, including values like independence, may not be as odd as it first appears. Common marketing approaches, such as social marketing, strive to educate the public on what to buy or avoid buying (Andreason, 1997). Most of the older persons observed or interviewed during this study lacked a valid reference point for understanding assisted living as a unique type of long-term care. Several described their knowledge of nursing homes, based on the experience of their parents, other relatives, or friends. Martha, a 99-year-old retired nurse, expressed disappointment that Timber Heights did not have registered nurses or provide more care, even though her assessment form described her as “independent” in all activities of daily living. Similar to assisted living residents surveyed in another study based in Oregon (Reinardy & Kane, 2003), the majority of the people observed during this ethnography moved directly from a home in the community. Thus, there is no reason to expect that older persons would know how to be consumers of assisted living. However, our observation that a combination of state rules and assisted living practices has constructed the idea of a consumer-driven model leaves unanswered the question of what this cohort of seniors would demand if they were not being “educated” to choose independence and private apartments. Finally, given the increasing “ethic of consumption” (Rose, 1990) in this consumer society, we wonder how the senior housing industry will respond to the demands from the next generations of consumers.

Conclusion and Implications

Ultimately, we see both benefits and pitfalls in practices based on consumer discourse. The benefits of negotiation include a formal process that creates an open dialogue about older persons as autonomous adults rather than as vulnerable persons, that focuses on abilities rather than disabilities, that reduces the stigma of dependency while still providing assistance with personal care services, and that provides a formal mechanism by which family caregivers can help their frail relatives choose services appropriate to their needs and preferences. Finally, by emphasizing independence, risk acceptance, and choice, assisted living offers symbolic values important to at least some older persons. As Rubinstein’s research (2000) with frail elders indicates, persons who use long-term care services rarely identify with the term “consumer,” and we observed that, although practitioners often use this term, residents did not. Rubinstein (2000) suggests that this discourse does not adequately describe the daily lives of older persons who reside in such settings.

In addition to the benefits already described, we identify several pitfalls associated with consumer discourse. First, residents may not be aware of the consumer role expected of them, including the risks they are assumed to accept by choosing assisted living. The emphasis that practitioners place on “educating” consumers about the social model values appears to be a case of the industry producing, rather than responding to, consumer demands. Second, residents may be too cognitively impaired to negotiate this consumer role. Third, confusion exists over who the client is. Practitioners and residents’ representa-

tives often mediated conditions of access and manner of service delivery, and this rather typical circumstance means that some residents are not primary consumers, but instead consumers once removed. This does not mean that residents cannot enjoy the goods and services, but that providers need to be clear about defining the customer.

Despite the use of consumer discourse, the application of a consumer model is not as well articulated as the social model. Practitioners require standards to guide them in sample cases, such as the resident who cannot fully participate in the consumer role ascribed to him or her. They can draw lessons from durable power of attorney and advance directives. Marketing materials that provide a question and answer format are a positive direction in educating potential consumers (Carder, 2002a). As Baldock and Ungerson (1996) noted in their evaluation of a consumer-based program, the move to this type of care may be “more ambitious” than first realized, and “to succeed it must change not just the practical mechanics” but also “bring about shifts in deeply embedded values and behavioural norms” (p. 12) among not only consumers, but their families, practitioners, and public agencies. Though practitioners are developing new tools for applying a consumer-based model, the norms and values necessary for full adoption are still being shaped. The Assisted Living Federation of America and the Assisted Living Quality Coalition advocate practices such as the resident assessment, negotiated service, and managed risk agreements described here; however, the actual use prevalence is unknown.

Future studies of assisted living would benefit from a consumer studies framework. How do consumer demands shape the values, architecture, interior design, or meal plans provided by various long-term care facilities? Studies of shopping behavior (e.g., Oh & Arditi, 2000) might provide fresh thinking about the predictors that determine how, or if, older persons choose various settings.

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Address correspondence to Paula C. Carder, NCB Development Corporation, 1725 Eye Street, NW, Suite 600, Washington, DC 20006. E-mail: pcarder@ncbdc.org

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