The elderly will be better able to pay for their own long-term care in the future, because of improving pensions and women's work experience, so that tax-deferred long-term care accounts and home equity conversion could enhance private financing; but such programs are simulated to have little impact on the private share of long-term care spending. With public-policy encouragement, private insurance could increase private dollars flowing into long-term care and reduce the number of people facing catastrophic expenditures. It will reduce Medicaid spending insofar as it covers people who would otherwise spend all their income and assets on care, but the simulation predicts only marginal changes, mostly because of predictions about who will find insurance affordable. Life-care communities package housing for the elderly with access to home care, nursing home care, and services like meals, housecleaning, and laundry needed by disabled elderly; the simulation indicates that even if life-care were more widely available, there would be little impact on financing outcomes. The experimental social and health maintenance organization, combining acute health care and some long-term care under a fixed capitation payment, is designed to save resources in acute care by providing home health and nursing home care; again, such organizations even if widespread would have little impact on the division of financing between private sources and the public, means-tested program. Payment to family members is an expensive way to increase our already large supply of family care-giving, and there is little payoff in requiring financial support from adult children. Medicaid spend-down would be less draconian if the individual spending allowance and protected asset level were increased and the spouses of institutionalized persons protected from impoverishment, but the specific policy simulated is shown to cause vast increases in Medicaid spending. Finally, a general public insurance program could spread the cost of long-term care across all taxpayers, entailing a large increase in public spending on long-term care but eliminating impoverishment for elderly nursing home residents.

The simulations imply that private sector initiatives, as defined, will shift few patients from Medicaid, and save few public dollars, at least through the year 2020. On the basis of this finding, the authors support a mixed strategy: they would replace Medicaid with a general public insurance program that covers nursing home stays of longer than two years and buys private long-term care insurance for the poor, with private insurance or individual saving financing the first two years of care.

Despite a list of desiderata for the long-term care of the future, the values that are used to reach this recommendation are not made fully explicit. It appears that to these analysts the problem is Medicaid: the demeaning means test, the burden on state taxpayers, the quality and access problems of a two-tier system, and the spend-down that pauperizes the middle-income recipient. Because the simulation does not identify any private financing solutions that substantially reduce the number of middle-income people ultimately relying on Medicaid, the authors find it necessary to advocate public insurance. However, the deck may be stacked against private solutions: the spiraling rate of inflation in the simulation model makes them unaffordable on the model's terms, and predicted income and pension gains do not work their way to the oldest old, most at risk of nursing home care, by the end year of the simulation. The simulation exercise is saddled by nature with an unrealistic rigidity: it is doubtful that the public, increasingly observing older relatives facing catastrophic expenses at ever-inflating costs, would not express increased demand for fair insurance products, for themselves or for their parents; or that the long-term care delivery system would not respond to private demands with more home care, more efficient nursing home care, and more controlled service packages.

An alternative argument holds that when the needs of some Americans for housing, education, jobs, and health care are so pressing, we cannot justify the use of tax money to fund a public program to preserve the assets of middle-income elderly for the use of heirs. The problem of long-term care is not that needs for care are not being met, but rather that individuals face the risk of catastrophic expense at the end of life and that our public program supplying care for poor elderly has, like public housing programs, offered fewer amenities and lower quality of life than are available to those who can pay. Private long-term care insurance can offer individuals the ability to protect their assets from Medicaid spend-down, and, by insuring that they will be private patients when they need home care or enter nursing homes, to preserve choice about the quality of their lives should they become disabled; choice about quality of life is desirable for everyone, but it may not be consistent to demand it for the elderly disabled before we support it in housing, education, and work life for younger Americans. If fair private insurance is available in the marketplace, it is hard to justify a recommendation that people who would not choose to insure themselves be forced to contribute equivalent tax dollars for public insurance. Instead, reducing market barriers to private long-term care insurance, especially that sold as an employee benefit accumulated over working years, could combine with Medicaid reforms to provide decent, dignified care for all.

By laying out the costs, benefits, and other implications of their preferred option and its alternatives, Rivlin and Wiener set a high standard for others considering long-term care issues. All must clarify the extent to which their judgments about the course to follow involve unknowns that should be studied, like nursing home use patterns; future uncertainties, like long-term care inflation and the incidence of disability, that must be monitored; or policy values.

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AIDS and Communal Values

Private Acts, Social Consequences. AIDS and the Politics of Public Health. RONALD BAYER. Free Press (Macmillan), New York, 1989. vi, 282 pp. $22.95.

Private Acts, Social Consequences is one of the first books on the AIDS crisis to confront the central philosophical issues raised by the epidemic. To date most authors writing on the subject have focused on the vacillation of the Reagan Administration or the impact of the epidemic on one city, San Francisco. Now Bayer gives us much-needed perspective on the epidemic by examining it through the historical, political, and philosophical conflicts of public health in the United States. Bayer, a faculty member of the Columbia School of Public Health, was for a number of years affiliated with the Hastings Center and led projects on public health and civil liberties, including a project on the AIDS epidemic. His detailed knowledge of the many facets of the epidemic, and of the profound changes it is working on many American social and health care institutions, shows in the book.

Beginning with an introductory chapter that lays out the central theme of the book, the conflict between individual rights and community welfare, Bayer examines in successive chapters the controversies over closing the bathhouses in San Francisco and New York City, safeguarding the blood supply, screening for HIV seropositivity, and the associated issues of making tests mandatory and reporting of results, quarantine and isolation, and finally education.

Bayer's analysis of the bathhouse contro-

versies is careful and informative. The account of the opposition of the health commissioners of New York City and San Francisco to closing the gay baths on the grounds that the action would accomplish little to stem the course of the epidemic and would undermine cooperation with the gay community while encouraging even more drastic measures against this at-risk group is the best chapter in the book. Also, the chapters on testing for AIDS and the dilemmas of implementing effective education campaigns aimed at promoting safer forms of conduct that is legally or socially proscribed also reflect his knowledge of drug policy, recent Constitutional history, and public health thinking.

More than other authors, Bayer devotes space to the issues of drug addiction and its role in the spread of the AIDS virus. His previous work in analyzing the shifts in U.S. drug policy adds depth. Yet here, as in other writings on the subject, there is too little: the world of the intravenous drug user remains the great unexplored continent of the epidemic.

In perhaps the most interesting and controversial part of the book, Bayer issues a call for a morality of restraint in private conduct that potentially has grave social consequences. Bayer has in mind filling the void that exists between the majority, which views homosexuality and drug abuse as morally repulsive and disgusting, and a minority that treats these forms of conduct as essentially private and entirely beyond the reach of the majority. As he writes, "The fundamental challenge to public health officials is to foster a culture of restraint and responsibility that would inform sexual behavior, childbearing, and drug use" (pp. 230–31). This is the responsibility not only of health officials but of democratic leadership more broadly. As Bayer knows, one of the more controversial implications of a morality of restraint is that it would necessarily undercut the moral condemnation that now surrounds the conduct in question. A new culture and ethic of restraint not only would create new responsibilities, it would mean far more extensive democratic speech, using the fresh air of democratic discussion and facts about modern sexuality and private behavior to attack the moralism that is enmeshed in views of the viral epidemic.

One quarrel with Bayer's perspective is his equation of public health with communal values. This sets the story of the epidemic as a struggle between health officials seeking to protect the public and civil libertarians defending the epidemic's victims. This dichotomy doesn't survive beyond the first chapter. As Bayer's recounting of the bathhouse controversy reveals, many leaders in public health opposed closing the bathhouses. Even when bathhouses were closed in New York City, public health leadership in the city and the state took pains to delimit regulation of public and commercial facilities from policing of the home and the bedroom.

Though the history of public health in the United States has long been centered on the welfare of the community, it is a paradox that during the '60s public health professionals were among those who fought to establish family planning clinics, to make contraceptives available to everyone, and to secure the right to abortion. Indeed, the rights of privacy won in such landmark Supreme Court cases as *Griswold v. Connecticut* (1965) and *Roe v. Wade* (1973) were pressed and understood as expanding not just private rights but also the compelling society-wide interest in public health.

Behind what Bayer terms the "abstraction of communal welfare" lie many other abstractions and ancient conflicts, civil wars, and latent fears that the welfare of the community is defiled and imperiled by morally repugnant behavior. The AIDS epidemic discloses that society's interest in health and safety must confront both viral plagues and plagues issuing from the collective unconscious. Hence, modern public health must expand private rights and democratic discussion to undercut the moralism that shadows every epidemic. This challenge is captured in Camus's line in *The Plague*, "All I maintain is that on this earth there are pestilences and there are victims, and it is up to us, as far as possible, not to join forces with the pestilences."

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Clinical Advances in Practice

The Diffusion of Medical Innovation. An Applied Network Analysis. MARY L. FENNELL and RICHARD B. WARNECKE. Plenum, New York, 1988. xiv, 285 pp. $34.50. Environment, Development, and Public Policy.

How do promising new methods of diagnosis, treatment, or prevention of illness move from the laboratory to the patient's bedside? How can the process be speeded up (or, if desirable, slowed down)? What levers does the federal government have at its disposal to influence the process?

At a time when the costs of health care are the subject of intense concern, when the federal government has changed the incentives for provision of inpatient care dramatically through its prospective payment system, when new medical technologies are seen by many as responsible for high health care costs, and when debates about "cost" and "quality" in health care are proliferating, a book with the title *The Diffusion of Medical Innovations* is likely to capture attention. And it should. The need for careful examination of the issues it addresses is all too apparent.

The approach taken in the book, however, limits its appeal. The authors are sociologists specializing in organization theory. Their book is likely to appeal primarily to organization theorists, medical sociologists, and researchers interested in the general problem of the diffusion of innovation. Health care economists, health policy analysts, and health care administrators will find less of direct relevance to their concerns.

The Diffusion of Medical Innovations is a carefully researched analysis of initiatives undertaken in the mid 1970s in Arkansas, the eastern Great Lakes, Mississippi, Wisconsin, the Greater Delaware Valley, Illinois, and northern California, with support from the National Cancer Institute, to create community-based networks to encourage wider use of advances in the management of patients with head and neck cancer. At the time the initiatives were launched, NCI believed that there was a gap between the development and the application of techniques for the management of such patients.

The authors' analysis of these initiatives is framed and guided by organization theory; organizations—principally hospitals and medical schools—and the linkages among them are the principal units of analysis. The authors explore how relationships among key organizations evolved in the seven settings in response to the mandate and financial support provided by NCI.

Three broad hypotheses are elaborated by the authors: first, to be accepted, innovations need to be defined as helping to solve performance problems; second, the environment constrains innovation by defining resource capacity and distribution; and, third, performance will be affected by the "fit" between environmental circumstances and network form. The better the fit, the better the performance. These hypotheses are not directly tested. Instead, they are explored indirectly in the context of a series of specific questions, each of which forms the basis for a separate chapter. Chapter 3, "Network environment and response to uncertainty," addresses two questions: what factors stimulated initial interest in innovation among the target audience? and how were perceptions of performance gaps related to agenda setting within the networks? In chapter 4, the authors examine how the environment influenced the formation of channels—inter-