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AUTHOR Ortiz, Elizabeth Thompson; Bassoff, Betty Z.
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ABSTRACT

The rapid growth of the proprietary sector in the provision of social services creates a challenge for the social work profession. Little is known about social work services in for-profit organizations or about how they compare to similar non-profit settings. A comparative study was conducted of social work services in proprietary and non-profit hospitals which used the results of the 1985 Membership Survey of The Society for Hospital Social Work Directors and a sample of 50 proprietary hospital social work departments. Differences and similarities in the areas of services and staffing, work settings, characteristics of directors, and changes since the advent of the Diagnostically Related Groupings (DRG's) were examined for non-profit and for-profit groups. The proprietary sample also described changes since DRG's in the areas of discharge planning, direct patient services, administrative responsibilities, new program development, and fiscal support. The results revealed that proprietary hospitals, in contrast to non-profit institutions, were often located in suburban areas, were part of a multi-hospital system, and were small in size. The proprietary hospital social work departments and those non-profits sampled by the Society for Hospital Social Work Directors were found to be different in size and type of staff. Several differences were also revealed in the kinds of services provided by proprietary and non-profit hospitals. The findings suggest several implications for both social work and health care. (Author/NB)

PROPRIETARY HOSPITAL SOCIAL WORK: WHAT DO WE KNOW?

by

Elizabeth Thompson Ortiz, DSW
Assistant Professor
Department of Social Work
California State University Long Beach
Long Beach, California

and

Betty Z. Bassoff, DSW
Professor, Maternal and Child Health Division
School of Public Health
San Diego State University
San Diego, California

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ABSTRACT

The rapid growth of the proprietary sector in the provision of social services creates a challenge for the social work profession. Little is known about social work services in for-profit organizations, or about how they compare to similar non-profit settings. This paper reports a comparative study of social work services in proprietary and non-profit hospitals, utilizing the results of the 1985 Membership Survey of The Society for Hospital Social Work Directors and a sample of 50 proprietary hospital social work departments. Services and staffing, characteristics of directors, and response to DRG's are contrasted. Implications for the profession are presented.

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PROPRIETARY HOSPITAL SOCIAL WORK: WHAT DO WE KNOW?

INTRODUCTION

The rapid growth of the proprietary sector in the provision of social services which have been traditionally administered under non-profit or government auspices creates problems and challenges for the social work profession. The time-honored conceptual, theoretical, and values models of the profession assume that social welfare benefits and services will be provided outside of market criteria, and that the delivery system will be non-profit (either governmental or voluntary). While great concern has been voiced in the profession, little is actually known about social work services delivered in for-profit organizations, or about the ways in which they are similar to or different from comparable non-profit settings[1].

This paper reports on a comparative study of social work services in proprietary and non-profit hospitals, utilizing the results of the 1985 Membership Survey of The Society for Hospital Social Work Directors[2] in comparison with a sample of 50 proprietary hospital social work departments. Ways in which department services and staffing are similar and dissimilar are reported, recent developments in response to DRG's are summarized, and implications of this material for the role of social work in health care are presented. While the health area was selected

because the trend toward proprietary provision is far advanced in this sector, the issues in relation to service delivery are important for all social workers since this is a general trend.

BACKGROUND: GROWTH OF THE PROPRIETARY SECTOR

The large scale growth of proprietary agencies in social service delivery is a relatively recent phenomenon, beginning in the 1960's and mushrooming since the early 1970's. However, it should be noted that historical precedents for proprietary approaches date back to the 18th century[3]. While a small profit-making sector in social welfare has always been with us, the expanded use of contracting with the private sector in the 70's, has provided opportunities for rapid proprietary growth in recent years.

The health care field in particular has seen considerable recent growth, with about 53% of the 23,600 long term care facilities (including nursing homes, homes for the aged, psychiatric institutions, facilities for children, the mentally and physically handicapped, and chronic disease hospitals) in the United States operated for-profit[4]. Within that group nursing homes have a higher rate (75%) of for-profit ownership[5]. American Hospital Association figures for 1983 showed over 11% of general hospital membership to be investor owned (for profit)[6]. Additionally, an increasing number of non-profit hospitals are managed by proprietary corporations. Hospitals and health care have

become big business, but quality information analyzing the impact of these changes is just beginning to appear[7].

In the 1980's for-profit agencies have also become firmly entrenched as providers of home health services, homemaker and chore services, and in many other community services focussed on the aged and disabled. Child welfare and day care are two additional areas where for-profit agencies have become major providers. The 1977 National Study of Social Services to Children and Their Families found that 51% of residential treatment, 48% of institutional care, and 58% of group home care financed by public child welfare agencies were provided by proprietaries. In addition, for-profit entities provided 31% of child day care and 29% of day treatment financed by public agencies[8].

Given these trends professional social workers are increasingly employed under for-profit auspices, although reliable data describing this shift are not yet available. The 1985 survey of the National Association of Social Workers' membership[9], in which 12.31% of all members responding reported primary employment in a for-profit context and 63.29% reported secondary employment for-profit, provides the only information located by these researchers.

THE STUDY

The study presented in this paper compared social work services in 50 randomly selected, acute care, general hospitals in California with a similar study conducted by the Association

of Hospital Social Work Directors of the American Hospital Association in 1985[10]. The Society randomly surveyed 400 of its members by telephone during February and March of 1985, obtaining a total of 308 completed questionnaires. The authors of this paper utilized an adapted form of the Society's questionnaire to survey 50 acute care proprietary hospitals in California, randomly selected from the 170 such institutions listed in the 1985 edition of Hospital Statistics published by the American Hospital Association[11].

The adapted survey used on the California sample consisted of 52 questions constructed as follows: 47 were reproduced exactly from the Society's survey, so that results could be compared. These questions solicited the size and organizational structure of the hospital and the social work department, as well as educational characteristics of the social work department staff, and membership in the Society. Information regarding the social work role in directing various hospital functions, such as discharge planning, utilization review and employee assistance was obtained. An addtional 5 questions were asked in the adapted survey; four were open-ended requests for information about changes in the department since the advent of the DRG (Diagnostically Related Groupings) system[12], and one concerned membership in NASW.

The survey was carried out by telephone between April and May of 1986, using social work department heads or designated personnel as respondents. Nine of the 50 hospitals were dropped

from the sample because they provided primarily psychiatric services, and thus did not represent social work services in an acute care general hospital context. Ten more of the original 50 were found to contract out their social work services and had no on-site department; they were also dropped from the study (but should not be dropped from our awareness). Surveys were completed for the remaining 31 hospitals.

The limitations of the study should be kept in mind as the data which follows are read. First, the 1985 study by The Society included an 11.4% proprietary hospitals, since it randomly selected from membership. Second, the differences in characteristics between the 23% of the the Society's sample on which surveys were not completed and the hospitals which did provide data are not known. Third, data were not obtained from the 20% of the California proprietary sample which used contract services. Finally, social work services in California proprietaries may not be typical of services in proprietaries nationally. The above limitations notwithstanding, the following results provide considerable new information about social work in proprietary hospitals.

COMPARISON OF SOCIAL WORK SERVICES IN PROPRIETARY AND NON-PROFIT HOSPITALS

1. Work Setting

The setting within which medical social services are delivered is significantly different for the proprietary hospitals. Slightly over one half are located in suburban areas compared to 30% of the nonprofits sampled by the Society, and fewer are located

in rural areas. Most of the proprietaries are part of a multi-hospital system (77% compared with 39% of the Society sample) and none were university affiliated. Proprietary hospitals are small in size: none of our sample was larger than 300 beds, while 40% of the SHSWD sample were over this size. Thirty-five percent of our sample represented settings under 200 beds in size.

2. Staffing

Only 42% of the 31 social work directors interviewed in the proprietary sample were members of the Society for Hospital Social Work Directors (the major professional organization for this group). Of these, 19% had been members for four years or more, compared with 75% of the Society's sample. Additionally, only 48% were members of NASW (comparable data were not available from the Society sample).

In terms of race and ethnicity, 84% were white, 10% were black, and 6% were "other". This was very similar to the Society's results, with the exception of the percent of black directors (only 5.5%). The proportion of women to men was greater in the proprietaries than in the Society survey, 87% to 72%. A related sidelight to this issue is the question of salary, which was not addressed in our study. However, a salary survey of 80 members of the Southern California Chapter of the Society for Hospital Social Work Directors conducted in 1982, showed an average annual salary of $34,587 in public hospitals, $33,161 in private nonprofits, and $25,550 in proprietary hospitals[13].

Years of experience as an administrator adds another

dimension to the profile. As shown in Table 1, 42% of the proprietary hospital directors have held such a position for 3 years or less compared to 16% in the Society survey (where almost 65% have been directors for more than 6 years).

TABLE 1

YEARS OF EXPERIENCE AS A SOCIAL WORK ADMINISTRATOR

	SHSWD N=308	PROPRIETARIES N=31
LESS THAN 2 YEARS	14(4.5)	10(32.3)
2 - 3 YEARS	36(11.7)	3(9.7)
4 - 5 YEARS	54(17.5)	4(12.9)
6 - 10 YEARS	103(33.4)	5(16.1)
11 - 15 YEARS	73(23.7)	2(6.5)
16 OR MORE	23(7.5)	4(12.9)
DOES NOT APPLY	5(1.7)	3(9.7)

Level of educational background and graduate social work training further differentiated the two samples, as Tables 2 and 3 reveal. No proprietary directors held social work doctorates, and only 52% had masters degrees in any field (48.4% in social work). In contrast just under 80% of the Society's sample had a masters or higher degree in social work.

TABLE 2

HIGHEST EDUCATIONAL DEGREE ATTAINED

	SHSWD N=308	PROPRIETARIES N=31
DOCTORAL	9(2.9)	0
MASTERS	253(82.1)	16(51.6)
BACHELORS	42(13.6)	11(35.5)
ASSOCIATE	2(.6)	0
NO DEGREE	0	3(9.7)
NO ANSWER	2(.6)	1(3.2)

TABLE 3

MASTERS OR HIGHER SOCIAL WORK DEGREE

	SHSWD N=308	PROPRIETARIES N=31
YES	246(79.9)	15(48.4)
NO	62(20.1)	16(51.6)

The proprietary hospital social work departments and those sampled by the Society were strikingly different in size and type of staff (Table 4). Part of this difference can be attributed to the smaller institutional size in the proprietary sample. All of the proprietary social work departments sampled consisted of 6 or fewer people (compared to 50% of the Society sample), and almost 55% had fewer than 2 full time equivalents. Even more striking is the difference in use of trained social work personel. Only 68% of proprietary hospital social service staff were social workers compared with 90% in the Society sample.

TABLE 4

DEPARTMENT STAFFING: SOCIAL WORK PERSONNEL
AND TOTAL FULL TIME EQUIVALENTS

	SHSWD N=308		PROPRIETARIES N=31	
	SW STAFF	TOTAL STAFF	SW STAFF	TOTAL STAFF
NONE	30(9.7)	29(9.4)	10(32.3)	6(19.4)
LESS THAN 2	61(19.8)	49(15.9)	14(45.2)	11(35.5)
2 - 5	87(28.2)	76(24.7)	7(22.6)	14(45.2)
6 - 10	51(16.6)	58(18.8)	0	0
11 -15	34(11.0)	38(12.3)	0	0
16 - 20	5(1.6)	11(3.6)	0	0
21 OR MORE	40(12.9)	47(15.3)	0	0

3. Services

Respondents in both samples were given a list of fifteen kinds of services commonly provided in hospitals and were asked to indicate which ones were offered in their hospital and whether, if offered, they were administered by the social work department. Table 5 displays the responses of the two groups. An asterisk is used to indicate those services which, if available, proprietary social service directors are (at least 10%) more likely to administer.

TABLE 5

SELECTED SERVICES: PROPORTION OF HOSPITALS OFFERING THEM AND PROPORTION ADMINISTERED BY SOCIAL WORK

	SWHSD N=308		PROPRIETARIES N=31	
SERVICE	SERVICE OFFERED	SW ADMIN	SERVICE OFFERED	SW ADMIN.
* DISCHARGE PLANNING	299(97.0)	261(87.3)	31 (100)	30(96.8)
HOME HEALTH CARE	145(47.1)	41(28.3)	16(51.6)	6(37.5)
* LONG TERM CARE	70(22.2)	34(48.6)	4(12.9)	3(75.0)
HOSPICE	82(26.2)	22(26.8)	6(19.4)	2(33.3)
* EMPLOYEE ASSISTANCE	159(51.6)	69(43.4)	26(83.9)	19(73.1)
* STRESS MANAGEMENT	130(42.2)	45(34.6)	14(45.2)	11(78.6)
* MENTAL HEALTH	159(51.6)	42(26.4)	7(22.6)	5(71.4)
* CHEMICAL DEPENDENCY	130(42.2)	21(16.2)	9(29.0)	9 (100)
* EATING DISORDERS	82(26.6)	13(15.9)	5(16.1)	5 (100)
PATIENT EDUCATION	262(85.1)	52(19.8)	28(90.3)	6(21.4)
* PERS EMERG RESP SYST	124(40.3)	40(32.3)	9(29.0)	4(44.4)
* BIOETHICS COMMITTEE	155(50.3)	13(8.4)	15(48.4)	3(20.0)
* UTILIZATION REVIEW	296(96.1)	28(9.5)	31 (100)	8(25.8)
DRG COORDINATION	249(80.8)	23(9.2)	29(93.5)	4(13.8)
CHILD LIFE	56(18.2)	18(32.1)	6(19.4)	1(16.7)

Several differences are immediately apparent from the data. First, the profile of services offered by the proprietary hospitals is different, since they are less likely to offer mental health, long term care, chemical dependency, and eating disorder programs than the Society sample. They are more likely to offer Employee' Assistance and DRG coordination programs.

With regard to the social work role in directing these programs, we see that in 10 of the 15 services social work personnel in the proprietary sample are over 10% more likely to direct the programs (and almost 10% more likely to direct an eleventh program, home health care). Furthermore they are over 80% more likely to direct chemical dependency and eating

disorders programs when they are present, and 40% more likely to direct stress management and mental health programs. They are also over 30% more likely to direct long term care and employee assistance programs. The only program which the Society sample social workers were more likely to direct is Child Life (by 15.4%).

4. Changes since DRG's

The advent of the DRG (Diagnostically Related Groupings) system was heralded by dire prognistications from the health field; social work was no exception. We were curious to learn about the actual effects on social services in the proprietaries, and were able to make limited contrasts with the Society study data (Table 6), although it should be noted that since the Society's data were from 1985 and ours from 1986 the proprietary sample had one more year to register changes. Additional information was obtained from the proprietary sample alone.

TABLE 6

CHANGE IN SOCIAL WORK DEPARTMENT SIZE SINCE DRG'S

	SHSWD N=308	PROPRIETARIES N=31
INCREASED	76(24.7)	5(16.1)
DECREASED	24(7.8)	9(29.0)
NOT CHANGED	149(48.4)	16(51.6)
NOT APPLICABLE	40(13.0)	1(3.2)
NO RESPONSE	19(6.1)	0

About the same proportion of proprietaries and non-profits, roughly half, have experienced no change in staff since DRG's, a surprising finding considering the

anticipated impact of the new system. Of those who have experienced change, proprietaries proved to be the most vulnerable as 29% lost staff. A surprising number of departmnents (almost 25% of non-profits and 16% of proprietaries) have gained staff.

The proprietary sample was also asked to describe any changes which had occcured in five specific service areas: direct patient services, discharge planning, administrative responsibilities, new program development, and fiscal support. The following is a summary of the responses.

A. Discharge Planning

The greatest proportion of proprietaries described changes in this area (84%) Descriptions of these changes were focussed on earlier contacts with patients, greater work load, issues of maintenance of people in their homes, screening for those needing most attention, and rapidity of the process generally. While some reported decreased resources, others noted the expanding ability to purchase home supports for patients. Respondents commented on the increased complexity of the cases and problems faced in discharge planning because of the more acute medical status of patients at the time of discharge, and an expansion of grief counseling with families.

B. Direct Patient Services

Seventy-one percent of the proprietary sample indicated a change in direct patient services since the DRG's. The most frequent responses were those stating increase in services to

patients, increased needs of patients being served, and decreased resources available inside and out of the hospital. Overall comments indicate that the visibility and importance of social services has increased post DRG's in the proprietaries. Responses on the status of counseling and "clinical" services was ambiguous as some respondents described decreasing possibilities while others spoke of increased opportunities.

C. Administration

Sixty-eight percent of proprietary social work directors indicated an overall increase in administrative roles and tasks. Major areas of added responsibility fell into categories of working with community home health agencies to secure beds, searching for discharge alternatives, increased involvement in utilization review, and increased reports and analyses of services. In some instances billing responsibilities had been assigned to the social work department. Increased time spent in commmittees and in working with other staff also seemed to be a common theme.

D. New Program Development

Sixty-five percent of proprietary respondents reported an increase in new program development activities, mostly in relation to programs listed in Table 5. In addition, directors were involved in developing protocols for diagnosis, psychological outreach, patient ombudsman programs, linkages with community and pre-admission outreach.

E. Fiscal Support

In regard to the critical question of whether the increased program responsibilities described above have been financially supported by the hospital funding of social work services, over 77% of the respondents reported unchanged (41.9%) or increased (35.5%) financial support for their programs.

IMPLICATIONS FOR SOCIAL WORK AND HEALTH CARE

1. Acknowledgement of Differences

The information which emerged from the study shows the proprietary hospital social work departments to differ from their non-profit companions. These differences suggest both strengths and weaknesses in the current state of practice knowledge and provide insights as to needed developments in social work education at various levels and in professional outreach.

The smaller work context of the proprietary hospital social worker is conducive to greater visibility and to administrative responsibility for programs which are seen as marketing to special populations. The advent of DRG's has served, for the most part, to heighten the influence of these social workers in their settings. One can hypothesize that skills in program planning and administration would be great assets to workers who may well have assumed their jobs trained as clinicians. It would be interesting to know the training background of the more than 50% of the sample who did not hold a degree in social work (a good subject for further study).

The profit motive of the proprietary setting appears to influence practice in a number of ways. Certainly the far lower level of trained social work staff is an outgrowth of this dynamic. With more than 388 coccupations listed as health-related the proprietaries have made choices which minimize costs. While old territory and boundary problems in the health field are reactivated, the "bottom line" is represented by the difference in salaries of non-profit and for-profit directors.

Another effect of the profit motive is the marketing of services and programs to special populations and the liklihood that social service directors will hold administrative responsibilities for these programs. Again, the dynamic in the typically small size proprietary flows from cost-saving motives which are likely to place the social worker in the role of the staff member who is most highly trained in the psychosocial area. In comparison, the larger non-profits often abound with competitive departments and specialties such as psychiatry and psychology, ever eager for new territories.

2. Recognition of Similarities

While the study did not attempt to assess quality or quantity of service delivery, it did demonstrate that the same array of social care exists in both proprietary and non-profit settings, although it is provided by personnel at a lower educational level in the proprietaries. These personnel were involved in almost all areas of hospital service, with a clearly increasing focus on discharge planning and community resource

location. Effects of the DRG's on service delivery appeared identical to those reported by the non-profits [15].

Respondents spoke of increased patient loads, pressure for rapid community resource location and placement, more complex and demanding cases. However, they also spoke about the growing diversification of their roles which included chairing utilization review and ethics committees. Given the demands placed on social work in hospital settings, burn-out seems to be a particularly acute risk for both proprietary and non-profit providers.

3. Promotion of Professional Identification

It appears to the authors that a major conclusion which can be drawn from this study lies in the need and opportunities for the social work profession to promote itself with proprietary hospitals and their social services staff. Less than half of the directors were members of either the Society or NASW. An aggressive outreach campaign on the part of both organizations would likely attract proprietary members, particularly if their affiliation would assist in upgrading salaries. Consultation to proprietary hospitals regarding recruitment and hiring of appropriately trained staff should also be developed, and would benefit quality of services overall.

In another vein, there are lessons to be learned by social work educators about the "generalist"(as opposed to "clinical" skills needed by social workers in health care who may increasingly find themselves practicing in proprietary

settings. A first job in the field could find the social worker carrying out the roles of discharge planner, family counselor, grief counselor, community resources catalyst, program developer and administrator. Our curricula in schools of social work at the bachelors and masters levels are not prepared to meet the skill needs of such workers.

Continuing education is another area in which the needs of this group could be addressed. Conferences held by the society and by units of NASW need to specifically address proprietary sector social workers and to support their competency through training in program develop~~metetent~~ment and administration. Proprietary sector social work is not a fleeting phenomenon; it is of growing importance and influence in health care and needs to be brought within the fold.

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