The future of residential aged care in Australia; a mixed methods analysis of the relationship between policy, structure and the provision of care

PhD Thesis – Volume 1, Chapters 1 to 7

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Certificate of original authorship

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

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Publications and presentations

The following publications and presentations have been made based on the research for this thesis.

Peer Reviewed Publications

- Baldwin, R., Chenoweth, L., dela Rama, M. & Liu, Z. 2014, 'Quality failures in residential aged care in Australia: The relationship between structural factors and regulation imposed sanctions', *Australasian Journal on Ageing*, pp. n/a-n/a.

Conference Presentations

- Richard Baldwin, Lynn Chenoweth, Marie dela Rama and Zhixin Liu, Quality failures in residential aged care in Australia: an analysis of the relationship between structural factors and regulation imposed sanctions, Paper presented at the Australian Social Policy Conference, UNSW Kensington NSW, August 2013.
- Baldwin, R., Lynnette Chenoweth, Marie dela Rama, Managing at the edge of an ageing Australia: Trends in the organization of residential aged care in Australia: are we learning from evidence, Paper presented to the Australian and New Zealand Academy of Management Conference, Hobart 6 December 2013.
- Baldwin, R., Aged care policy in Australia: Who sets the agenda?, Australian Political Studies Association Conference 2011, 28 September 2011, Canberra.

Professional Association Publications

- Baldwin, R., Kelly, J., Sharp, D., 2014, The Aged Care Workforce in Australia - a Discussion Paper, Aged and Community Services Association, Canberra.
- Baldwin, R., Stephens, M., Kelly, J., 2013, The financial viability and sustainability of the aged care sector, Aged and Community Services Association, Canberra.

- Baldwin, R., Stephens, M., Kelly, J., 2013, Issues facing aged care services in rural and remote Australia, Aged and Community Services Association, Canberra.

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Table of definitions and acronyms

Terms/acronym	Definition
Australian Bureau of Statistics (ABS)	'The Australian Bureau of Statistics (ABS) is Australia's national statistical agency. The ABS provides key statistics on a wide range of economic, environmental and social issues' (Australian Bureau of Statistics 2012b, p. 2).
Aged and Community Services Australia (ACSA)	The ACSA is one of two peak provider organisations across Australia representing primarily the not-for-profit aged care sector.
Aged Care Approval Round (ACAR)	'ACAR is an annual process enabling prospective and existing approved providers of aged care to apply for new Australian Government funded aged care places, and/ or financial assistance in the form of a capital grant. The ACAR operates in accordance with: Part 2.2 of the Act and associated Aged Care Principles - for residential aged care places and home care places; and Part 5 of the Act and the related Aged Care Principles - for capital grants. The broad objectives of the ACAR process are to provide an open and clear planning mechanism, and to allocate places in a way that best meets the identified aged care needs of the community. This is achieved through a three-step planning process: • creation of the number of places in each jurisdiction by the Assistant Minister for Social Services; • distribution of those places within states and territories by the Secretary of the Department of Social Services (the Secretary); and • receipt and assessment of applications to determine the final allocation of places to specific providers' (Australian Governmernt of Social Services 2014, p. 2)
Aged Care Funding Instrument (ACFI)	The ACFI is a 12-question resource allocation instrument completed by residential aged care providers for each resident. The score is used by the Australian government to assess the level of subsidy a residential aged care provider is entitled to for each resident. It is based on an assessment of the resident using three domains: Activities of Daily Living, Behaviour Supplement and Complex Health Care Supplement.
Aged care industry	This describes the combination of residential, community- and home-based services for the aged. These services are provided because the care recipients are frail or disabled due to age and are unable to manage or achieve unaided all the activities of daily living. The industry includes both government-funded services (the majority) and those that do not receive government funding.
Australian Aged Care Quality Agency	This agency commenced operation on 1 January 2014 under the Australian Aged Care Quality Agency Act 2013. It replaced the Aged Care Standards and Accreditation Agency Ltd as the accreditation body for residential aged care. Its functions, as set out in the legislation, are (inter alia): to accredit residential care services, to advise the Secretary of the Department about aged care services that do not meet the Standards, to promote high-quality care, innovation in quality management and continuous improvement and to provide information, education and training.
Approved place	This is a bed in a residential aged care service or a place in a community age care service or a flexible place where the funding can be used for either. Approved places are allocated to the 'approved provider' based on an assessment of their application following an invitation to apply during the annual ACAR round released by the Department (Australian Government Department of Health and Ageing 2012a).

Approved provider	This is an organisation that has been approved by the Department, under Section 8-2 (1) if the Aged Care Act 1997, to be a eligible to be allocated an 'approved place' and to receive subsidies from the government to pay for the care of an assessed resident or client in an approved place. Providers are approved based on their ability to provide care, to meet relevant standards for aged care, their record of financial management and their commitment to the rights of aged care recipients (Australian Government Department of Health and Ageing 2012a).
Assisted Living Facilities (ALFs)	In this thesis Assisted Living Facilities is the term used in the research literature originating in the USA to refer to facilities that provide the equivalent of low care in Australia.
Charitable	The type of organisation that intends to add social value or utility to the general community or an appreciable section of the public, and that is not established primarily to provide profit, gain or benefit to its individual owners or members[1].
Client	Generally a client is a person who receives paid care from a community- or home-based service (often called the 'care recipient') but may also be the carer of a care recipient where the carer is in receipt of services from a funded service provider.
Community-based	The type of organisation formed for a particular common purpose by members of an identifiable community based on locality, ethnicity or some other identifiable affiliation, whose activities may be carried out for the benefit of its members but which does not provide financial profit or gain to its individual owners or members.[1]
Consumer	This is the 'care recipient' and may be a person receiving formal care, the carer of a person receiving formal or informal care or a person making an enquiry about the receipt of care.
Consumer-directed care (CDC)	'CDC is a way of delivering services that allows consumers to have greater control over their own lives by allowing them to make choices about the types of care they access and the delivery of those services, including who will deliver the services and when. Under a CDC approach, consumers are encouraged to identify goals, which could include independence, wellness and re-ablement. These will form the basis of the Home Care Agreement and care plan' (Australian Government Department of Health and Ageing 2013c, p. 8).
Daily Accommodation Payment (DAP)	A DAP is an amount paid by a care recipient towards their accommodation costs in a residential aged care facility calculated on a daily basis (Aged Care Financing Authority 2013). The alternative to paying a DAC is to pay a RAD.
Data Envelopment Analysis (DEA)	DEA is a non-parametric linear programming technique used to determine technical efficiency of decision-making units using quantities of inputs and outputs (Björkgren, Häkkinen & Linna 2001). It is an established methodology and similar to that used by CEDA on behalf of the Australian Aged Care Pricing Review, conducted by Hogan (2004).
Department	This term is used to refer to the Australian government department with responsibility for the Aged Care Act 1997 and its predecessor Acts. These Departments have been named (Australian Government Department of Health 2014) the • Department of Health and Family Services (1996 to 1998) • Department of Health and Aged Care (1998 to 2001) • Department of Health and Ageing (2001-2013) • Department of Social Services (from 2013).
EBITDA	EBITDA is an accounting term which measures earnings before income tax depreciation and amortisation.

[1] The definitions of local and state governments, not for profit, for-profit, religious, community-based and charitable were sourced from the Department of Health and Ageing (Australian Government Department of Health and Ageing 2009).

Formal (or paid) care	This is care provided by a person who is paid to provide that care generally by an organisation in receipt of government funding, but the person may also be paid directly by the person receiving care or their carer.
For-profit	This is the organisation type that operates primarily for the financial profit or gain of its owners, members or shareholders. For-profit organisations include private incorporated bodies that are registered by the Australian Securities and Insurance Commission or companies listed on the Australian Stock Exchange
Government	The Australian federal government.
Gross domestic product (GDP)	GDP (of Australia) 'is the total market value of all goods and services produced within Australia in a given period of time' (Parliament of Australia 2014).
High care	The term 'High care' replaced the term 'nursing home' with the passage of the Aged Care Act 1997. It is used for two purposes: to classify a residential 'approved place' allocated to an 'approved provider' by the Department and to classify a resident who scores 'high' on one of the three categories of the ACFI or medium (or high) in at least two of the three categories. Following the implementation of amendments to the Aged Care Act 1997 that will come into effect on 1 July 2014, the distinction between high and low care will become largely redundant.
Informal care	This is care provided to a care recipient by a person who is not paid to provide that care and generally includes family, friends and neighbours of the person receiving care.
Leading Age Service Australia (LASA)	The LASA is one of two peak bodies representing aged care providers. Its members are state organisations whose membership is made up of for-profit and not-for-profit providers. It is the successor organisation to Aged Care Association Australia which represented for-profit providers.
Living Longer Living Better	Living Longer. Living Better[2] is the name given to the Australian Government's Aged Care Reform Package announced in April 2012.
Local government	A body established for the purposes of local government by or under a law of a state or territory.
Long-term care (LTC)	LTC is the term used by some international authorities such as the Organisation for Economic Cooperation and Development (OECD) to refer to both institutional and home care for people with long-term care needs. Institutional long-term care includes both high care (nursing homes) and low care (hostels for the aged, assisted living).
Low care	This term replaced the term 'hostel' with the passage of the Aged Care Act 1997. It is used for two purposes: to classify an 'approved place' allocated to an *'approved provider'* by the Department and to classify residents who have scored less than 'high' for all three domains on the ACFI instrument (since 2008). Following the implementation of amendments to the Aged Care Act 1997 that will come into effect on 1 July 2014, the distinction between high and low care will become largely redundant.
Neo-liberalism	This term relates to 'a movement that regards the freeing up of trade restrictions and economic relations as a basis for greater economic development and social freedoms' (Butler 2014)

[2] For ease of reading and drafting using Microsoft Word the full stop inserted in the middle of the name Living Longer. Living Better has been omitted when the name is included in the text.

Not-for-profit	This is the organisation type that is a non-government entity which does not distribute operating surpluses for the profit or gain of its individual owners or members (residual claimants); whether these gains would have been direct or indirect, while operating and when it winds up. The Australian Taxation Office accepts an organisation as not-for-profit where its constituent or governing documents prevent it from distributing profits or assets for the benefit of particular people. Where, in reviewing the literature, the study has included government organisations in this category, this has been specifically noted in the text.
OSCAR	OSCAR is the Online Survey, Certification and Reporting data repository held by the Centres for Medicare and Medicaid Services (CMS); the CMS is an agency of the US Department of Health and Human Services.
Paid (or formal) care	This is care provided by a person who is paid to provide that care generally by an organisation in receipt of government funding, but the person may also be paid directly by the person receiving care or their carer.
Policy	In this thesis the term 'policy' implies 'authoritative choice' (Althaus, Bridgman & Davis 2007, p. 6); that is, decisions and actions made by the Australian government and, on behalf of it, the Department. These policies are identified because they have been specifically defined in government documents or defined by a series of actions which are sufficiently consistent to imply a formed policy is being implemented, even if it has not been formally and publicly documented.
Quality of care	Quality of Care refers to indicators that purport to measure the quality of the care provided by the direct care staff of a residential aged care facility. Selected variables and validated instruments are used by researchers.
Quality of life	Quality of Life refers to indicators that purport to measure the quality of a resident's life based on self-report or observation. Selected variables and validated instruments are used by researchers.
Productivity Commission (PC)	The Productivity Commission was established in 1998 as the Australian government's independent research and advisory body on a range of economic, social and environmental issues. Its focus is on ways to achieve a more productive economy. Its influence depends on the power of its arguments and the efficacy of its public processes (Productivity Commission 2014).
Refundable Accommodation Deposit (RAD)	A RAD is an amount paid as a lump sum by a care recipient for their accommodation costs in a residential aged care facility (Aged Care Financing Authority 2013). The alternative to paying a RAD is to pay a DAP.
Religious	The type of organisation whose objectives and activities reflect its character as a body instituted for the promotion of religious objectives and where the beliefs and practices of its members constitute a religion[1].
Resident	This is a person who permanently or temporarily resides in a residential aged care facility. This person may be classified as 'high care' or 'low care'.
Residential aged care sector	This term is used to describe that part of the 'aged care industry' that is concerned with the provision of resident services and not community or home care services. In Australia all residential aged care services receive government subsidies.
Service	The term 'service' is used to reflect the Department's terminology in their census data. A service is a residential aged care facility or a community care outlet or a combination of both residential and community care as in an MPS. In most instances in this thesis the term refers to a residential aged care facility.
Service provider	This is the organisation that is providing an aged care service and which receives a payment either from the government, another funder or the care recipient or carer to provide care. Service providers in receipt of government funding must be an approved provider or meet certification or standards before being funded.
State/territory government	Includes state or territory government authorities, instrumentalities and local health authorities established under state or territory legislation[1].

SPO	Structure Process Outcome (SPO) is the conceptual framework first articulated by Donabedian (1966). A full explanation of this framework is provided in Chapter 3.
Sustainability	This term refers to the combined financial viability of aged care services within the residential aged care sector, or parts of the sector, to the level that the numbers of providers continuing to operate are sufficient to enable the sector to continue functioning to a level that will achieve social and financial objectives that are acceptable to the community or have been agreed.
Viability	This term refers to the financial capacity of an organisation to provide sufficient financial return to satisfy the requirements of the operators to the extent that the owners or operators of the organisation are prepared to continue to operate the service both in the short and long term. The determination of the viability of an organisation may be based on its current operational performance measured by its EBITDA or its project return on investment.

Abstract

Governments, providers and consumers will make substantial investments to expand the residential aged care sector in Australia over the next decade. Australians have the right to expect that the structure (size, ownership and location of services) of the sector that emerges from this expansion will be consistent with evidence based best practice.

This mixed methods study analysed secondary census data on all residential aged care services in Australia over 10 years, secondary data on sanctioned services and primary data from semi-structured interviews with elite stakeholders. The study finds that the structure of the residential aged care sector impacts quality and government policy impacts structure. It also finds that current structural trends are inconsistent with evidence based best practice and that these trends are likely to continue, particularly if market based reforms are introduced. The study also finds that market based reform will likely to fail outside major cities and a two tier system of residential aged care will be required. The study recommends a new conceptual framework for the relationship between structure, process and outcomes and that market based reforms should not be pursued until there is a national set of freely available and reliable data to inform decision makers.

CHAPTER 1 INTRODUCTION AND OBJECTIVES

'Aged care must be regarded as a work in progress.' (Fine 2007, p. 292)

1.1 Introduction

The increase in the number of people in Australia who will need paid care because of their age will require the Australian community to agree to a number of policy choices that will determine who will have access to care, how it will be delivered, how it will be paid for and who will provide it. Perhaps more importantly, the community will need to decide, from time to time, the level of quality they are prepared to pay for in response to the level of quality demanded by recipients of care and their families, and how that will be achieved. As Colebatch (2009) reminds us, the business of policymaking is unlikely to be linear, may ignore facts and evidence, can be messy and appear contradictory and is not restricted to governments. Nevertheless it is important that we strive to create the knowledge that will assist with these decisions.

The government funded aged care industry in Australia consists of two sectors: the residential aged care sector and the community and home care sector. Both sectors are regulated through the Aged Care Act 1997 and are complementary, with many residential aged care providers also providing community and home aged care. This thesis focuses on the residential aged care sector because of the substantial capital investment in its infrastructure both in the past and required in the future. These investment decisions require decision makers to determine where they are going to build, what they are going to build and who is going to operate the services once they are built. These structural characteristics of the industry are important as they are determinants to the performance of the sector and have

a direct impact on the lives of those in these facilities (Harrington 2007; Harrington, Carrillo, et al. 2011). Furthermore, the history of decision-making by governments in relation to the funding and regulation of residential aged care, which is summarised in Chapter 2, demonstrates that many past decisions have been based on inadequate understanding of the impact of structural elements on the performance of the industry and the outcomes for residents.

Current regulations provide the Australian government with tight control over the structural element of this industry and its development, and through this control the government has a direct influence on the performance of the industry and the outcomes for residents. However, recommendations from recent commissioned reports argue that the government should relax these controls and allow market forces to determine, partially or wholly, the supply of residential aged care services. Such a reform, if introduced, will most likely change the structure of the sector. In order to make evidence-based decisions, detailed knowledge is needed of the relationship between these structural determinants, the performance of the sector and the outcomes for residents. While there is substantial research data on the relationship between structure, performance and resident outcomes conducted in other countries, there is very little research data on these in Australia.

Of interest to this research are the trends in the structure of the residential aged care sector and the implications of these trends for future policy.

1.2 Background

Although there are differing views on the impact that the ageing of the Australian society will have on the demand for residential aged care (Fine 2007; Productivity Commission 2008; Richardson 2009), there seems little doubt that this sector will continue to grow significantly over the planning horizon. The Aged Care Financing Authority (2013, p. 10) estimates that 74,000 new places will be needed by 2013, requiring an investment of $25 billion from the Australian community. Ignoring replacements of existing

ageing facilities, this growth pace is the equivalent of a new 140-bed residential aged care facility opening somewhere in Australia every week for the next 10 years and approximately twice the growth of the past decade. The aged care industry is already of a substantial size; costing approximately 1.0% of the gross domestic product (GDP) of Australia and is poised to rise dramatically over the coming decades to nearly 2.0% of GDP (Australian Treasury 2010). The operational cost of a larger residential aged care sector will also require increasing government funding and individual contributions.

If current trends continue, the nearly 300,000 people living in residential aged care in 2030 will each have chosen the facility from fewer than 2,000 available across Australia (compared with a choice from 2,760 in 2011 (Australian Government Department of Health and Ageing 2011b)). The facility they select is more likely, than at present, to be operated by a large organisation (operating more than 10 facilities), more likely to be owned by a for-profit organisation, and each resident will live with, on average, about 150 other residents. Such a scenario will constitute a reduction in the choice available to prospective residents compared to today. These changes in facility size will also create challenges for operators in achieving a high quality of care as larger facilities tend to be associated with lower quality of care (Harrington, Carrillo, et al. 2011) and will provide a challenge to operators to maintain quality of life standards related to privacy and individuality (Kane et al. 2004).[3] Some, but not all, research studies have shown that larger facilities provide poorer care, chains of facilities find it difficult to maintain a consistently high standard of care and quality of care can differ depending on the 'profit' status of the operator (Comondore et al. 2009; Harrington et al. 2001; McGregor et al. 2005). There has been very little research to date on the relationships between ownership, size and quality of services in the Australian residential aged care setting. Developing a better understanding of the relationship between structural features of the sector and service quality will be extremely important for

[3] The definition of quality of life and quality of care are provided in the table of definitions on page xv.

Australian policymakers when planning future provision of residential aged care services.

1.3 What this study contributes to knowledge

A number of overseas reviews have commented on the relationship between ownership type and quality of care (Clarfield et al. 2009; Comondore et al. 2009; Gage et al. 2009; Harrington 2007; Harrington, Hauser, et al. 2011; Harrington et al. 2001; Konetzka 2009; O'Neill et al. 2003). Studies in Australia into the difference between for-profit and not-for-profit services are few and refer to operations at a single point in time (dela Rama 2006; Ellis & Howe 2010; Pearson et al. 1992; Tannous & Luo 2006). What this study will add to our current knowledge is a detailed analysis of trends in the residential aged care sector, particularly in relation to ownership, size and location and the relationship between these factors. These trends will be examined in regards to the structural features of the aged care industry based on a well-established conceptual framework of a relationship between structure, process and outcome in health and aged care services. In addition it will interrogate available data to examine the relationship between these variables and service quality. The study will also investigate aged care industry trends from the perspectives of well-informed elite stakeholders who have potential influence on policy decisions in the sector, both the future shape of the sector and how it will operate.

The triangulation of these data, the international literature, evidence from Australia and the beliefs of elite informants will develop a unique understanding of these relationships. In this way the research adds to the evidence needed to inform future decision-making on policy in relation to the aged care sector in Australia and internationally.

1.4 Objectives, research questions and methods

The overall aim of this thesis is to gain an increased understanding of the trends in the structure of the residential aged care industry in Australia,

in order to identify what service provision can be expected in the future and what this might mean for aged care residents.

The objectives of this research are to identify:

- the trends in the structure of the residential aged care industry in Australia
- the relationships between structural elements and the quality[4] of residential aged care in Australia
- the perspectives of key decision-makers on the structure and future development of the residential aged care industry in Australia.

Four research questions were posed in seeking to achieve to the study objectives:

- What are the trends in the structure (ownership, size and location) of the residential aged care sector across Australia?
- What is the relationship between the structural characteristics of the Australian residential aged care sector and the quality of services?
- What are the perceptions of elite stakeholders on the future trends of the residential aged care sector?
- What are the implications for future policymaking in response to the identified and perceived trends?

The study is composed of three sub-studies:

- Analysis on the structural elements related to residential aged care facilities in Australia (ownership, size of facilities, size of provider organisations and location of services)
- Analysis on the characteristics of residential aged care services on which sanctions[5] were imposed because the services were assessed as failing to achieve minimum standards

[4] The quality indicators used in this analysis are sanctions data. These data are used in the absence of more comprehensive data on quality in Australian residential aged care services.
[5] Part 4.4 of the Aged Care Act 1997 provides the Department with the power to impose sanctions on residential aged care providers who fail to meet their responsibilities under the Act. The role of sanctions in the quality assurance framework is described in section 2.4.2.

- The perspectives of elite stakeholders on current and future trends in the aged care sector.

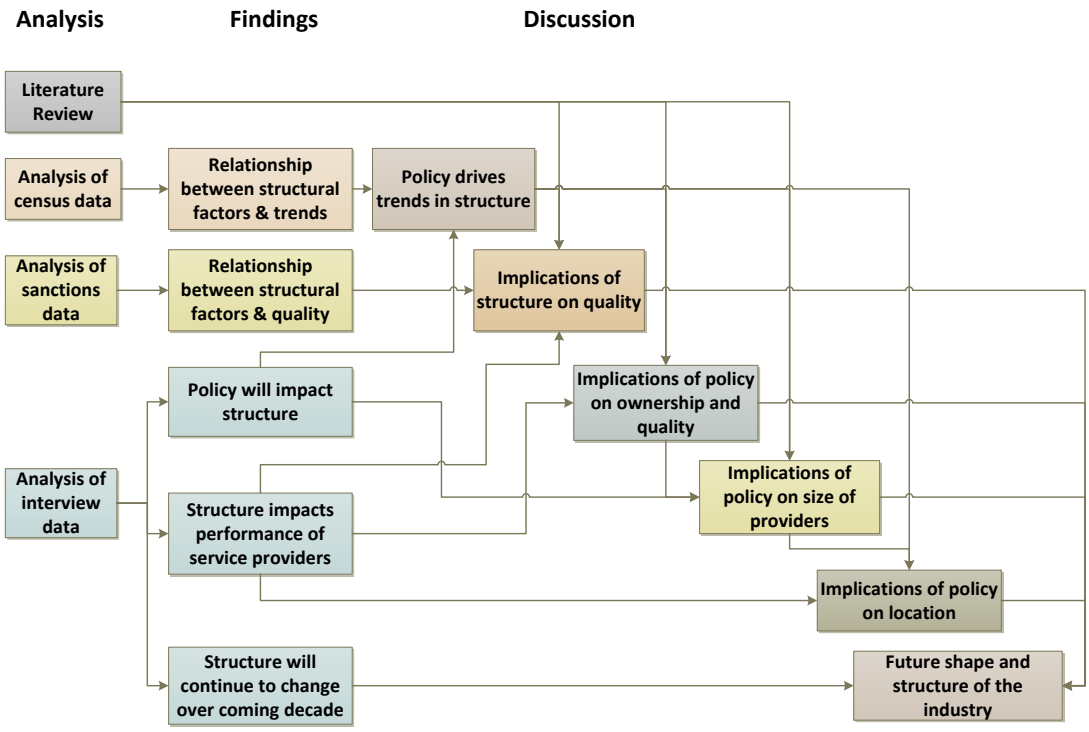
1.5 How this research will be progressed

Chapter 2 examines the historical development of the residential aged care sector in Australia. It reports the analysis of past government decisions that have framed the structure of the industry and have created the current mix of ownership types and geographical distribution. Evidence will be provided that past policies have focused on a narrow range of structural factors related to access to care. This chapter also analyses the current system of regulation and funding provided by the Australian government. By imposing tight regulatory control on the industry it may be that the government has, in effect, determined the current and future structure of the industry.

Also examined in Chapter 2 are the dominant themes apparent from recent recommendations for policy reform of the sector, the role of stakeholder organisations and the recent response by government. A comparison will be made between the structural elements of the Australian residential aged care sector with similar services in comparable countries to determine the applicability of international research to Australia. The chapter concludes that the similarities with the structure of the industry in Australia and with other countries, particularly the United States of America (USA), are sufficiently similar to be applicable to the Australian setting. It also examines some theoretical frameworks on the differences between for-profit and not-for-profit providers to provide a framework for the review of literature in Chapter 3.

Figure 1 illustrates the logical and conceptual flow of the thesis beyond Chapter 2. This illustration links the analysis, findings and discussion. It shows how the literature reviewed in Chapter 3 contributes to the findings that emerge in Chapter 5. It also demonstrates how the literature and the findings contribute to the elements of the discussion and how these elements are linked in Chapter 6.

Figure 1 Overview of the conceptual and logical framework of this thesis



Chapter 3 provides a detailed literature review of international research on the relationship between the structural factors of ownership, size of services and chain affiliation and quality. Also reviewed is the relationship between structure and residential aged care service performance in terms of profitability, efficiency and regulatory compliance. This literature review was guided by three questions:

- What is the association between structural variables, service performance and quality?
- If such an association is established internationally, does this justify undertaking an analysis of the structural trends in the Australian residential aged care industry?
- Do established associations between structural variables and service outcomes provide a platform on which predictions can be made about the future performance of the residential aged care industry in Australia?

Chapter 4 outlines the approach to the collection and analysis of the quantitative data to search for trends in the residential aged care sector and to plan the approach to the collection of qualitative data, following a

modified sequential exploratory design adapted from Creswell and Plano-Clark (2011). The quantitative data accessed from the Australian Government Department of Health and Ageing (the Department) describes the characteristics of all residential aged care facilities in Australia for each financial year from 2002-03 to 2011-12 and all facilities that received a sanction for failing to meet minimum standards during an inspection by the Aged Care Standards and Assessment Agency. Analyses of these data focused on the trends in structural variables and the relationships between structural variables using SPSS software (IBM 2013). The analysis of the characteristics of aged care facilities which failed to meet standards are outlined in determining the relationship between structural factors and quality of care using SAS (SAS Institute Inc. 2010). Also described are the thematic procedures undertaken to conduct semi-structured interviews with elite stakeholders from peak bodies, major provider organisations, government and advisory organisations. These interviews gathered data on their perspectives on current trends in the structure and future shape and regulatory regime in Australia and were analysed using NVIVO software.

Chapter 5 reports on the composite data findings on the structure of the residential aged care industry over the 10 years to 2013, the characteristics of services which failed to meet minimum care standards and the elite stakeholder perspectives on key industry trends and preferences based on current policy parameters.

Chapter 6 discusses the composite data findings and identifies apparent paradoxes in residential aged care policy direction, the significance of elite stakeholder recommendations for the introduction of greater aspects of neo-liberal[6] ideology in policymaking and the application of evidence to decision-making.

Chapter 7 makes recommendations on the possible structure of the Australian residential aged care industry into the future based on the key trends

[6] A definition of neo-liberalism is provided in the list of definitions commencing on page xii.

identified in the research data. It discusses the consequent implications for access, cost and quality of care in the sector.

1.6 Conclusion

This chapter has presented the notion that trends in the nature and shape of the Australian residential aged care sector are little understood and that there is scant evidence of the relationships between structural characteristics, service performance and quality of care for residents. The limited knowledge on these associations warrants further investigation in relation to future decision-making, particularly in the light of substantial expansion facing the industry. This chapter argues that policymakers need to gain a clearer understanding of the potential impact that current trends in the residential aged care industry will have on future policy decisions. To contextualise this argument, the next chapter will examine the residential aged care sector in Australia, its origins, recent trends and current structure, and review similar details reported on aged care industries in comparable overseas countries.

CHAPTER 2 Residential aged care in Australia

No public official or important political element in the United States has ever argued that the care of the old, sick and indigent should be turned over to the … for-profit sector. However … a series of government financial programs … have done just that. (Kaffenberger 2000, p. 45)

2.1 Introduction

This chapter provides details on the residential aged care sector in Australia. It begins with a concise description of residential aged care service providers and residents in 2012 and provides a short summary of estimates of the future demand for residential aged care in Australia. These estimates predict the need for substantial capital investment in the aged care industry and illustrate the importance of this thesis to inform future development. This is followed by section 2.3 which provides a short analysis of the historical development and political influences that have shaped the sector, providing a context for understanding the structural elements of residential aged care services. This analysis identifies a pattern occurring in past policy initiatives regarding the structure of the Australian aged care industry that has had a substantial impact on access to care. Neo-liberalism ideology and stakeholder organisation influences on policy recommendations are briefly explored in this chapter ahead of a more in-depth review of this body of literature in Chapter 3.

The second part of this chapter, section 3.4, describes the regulatory and quality framework of the residential aged care industry and the stakeholder organisations that seek to influence policy. This review establishes the importance of structural element to policy development and supports the development of a conceptual framework on which the relationship between structure and performance and outcomes is examined in the following chapter.

The next section, section 2.6, compares the structural elements of the residential aged care industry in Australia with comparable Organisation for Economic Cooperation and Development (OECD) countries and makes the argument that there is sufficient similarity between Australia and some other countries, particularly the USA, for the research findings from these jurisdictions to have applicability in Australia. Finally, in section 2.6.2, the theoretical differences between for-profit and not-for-profit providers of aged care services are briefly explored. This analysis of the comparability of aged care service in different countries and the theoretical differences between for-profit and not-for-profit services provide a framework for the discussion of the literature in Chapter 3.

2.2 Background

2.2.1 The aged population in Australia and aged care residents in 2013

The most recent census of the Australian population taken on 30 June 2011 counted just over 3 million people in Australia over the age of 65, about 14.0% of the population (Australian Bureau of Statistics 2012a). Of these 2,092,000 were over the age of 70 (9.7% of the population and the age group for which the Australian government plans residential aged care services) and 402,681 Australians were over the age of 85 (1.9% of the population) (Australian Bureau of Statistics 2012a). In 2012 more than 50% of Australians aged over 75 years needed some form of assistance with personal and everyday activities of living (over 1 million people) and this increased to 80% for those aged 85 years and over (Australian Bureau of Statistics 2014).

At 30 June 2013, 186,278 people were residents in permanent care in operational residential aged care places funded by the Australian government[7]

[7] There are no known residential aged care services in Australia that do not receive the Australian government subsidy. Some residential aged care services may, from time to time, provide care to a small number of residents who do not attract a government subsidy, particularly where a sanction has been imposed on the service denying them the subsidy for a period of time; however these numbers are believed to be very small. There are a number of long-term aged patients in public hospitals, operated by state and territory governments who effectively receive high level of care while

(Australian Government Department of Social Services 2013). Seventy per cent of the residents were female and more than half were aged 85 years and over. The number of permanent residents at 30 June 2013 was about 8.0% of the Australian population over the age of 70 years.

Residents on admission to aged care services are classified as either 'high care' (nursing home level of dependence) or as 'low care' (hostel or assisted living level of dependence); and are reclassified at regular intervals (Australian Government Department of Social Services 2014). On 30 June 2013 74% of all residents were classified as 'high care'. Many residents who enter an aged care facility needing low care are reclassified at some future time to high care due to their increased need for care. The Aged Care Act 1997 also introduced the principle of 'ageing in place', which prohibits providers from transferring residents to another service against their choice when they are reclassified as needing high care, with the result that, on 30 June 2013, 58% of residents in low care beds were classified as needing high care (Australian Government Department of Social Services 2013, p. 57).

However, recent changes to the funding mechanisms will result in the distinction between high and low care becoming increasingly less important. The first of these changes introduced the Aged Care Funding Instrument (ACFI)[8] in 2007, and the second removed the prohibition on charging a refundable accommodation deposit in high care from 2014 as part of the Living Longer Living Better package of reforms. These reforms are analysed below on pages 24 and 29.

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waiting for a residential aged care bed to become available, but are not counted in the data collected by the Department.

[8] From 20 March 2008 payments for the daily subsidy have been based on the ACFI. Assessment of a resident using the ACFI involves three 'domains': Activities of Daily Living, Behaviour and Complex Health Care needs. Following assessment each resident is allocated a numerical score against each of these domains and ranked high, medium or low for each domain for funding purposes (Australian Government Department of Health and Ageing 2008).

2.2.2 The future demand for residential aged care

This study is important because future demand for residential aged care in Australia will result in substantial capital investment as well as increases in expenditure, by both governments and individuals. The estimation of future demand is based on population predictions and assumptions about the level of disability of future populations over the age of 70 years. Based on mid-range assumptions, the Australian Bureau of Statistics (ABS) estimates that the ageing of Australia's population, evident in the current population's age structure, will continue[9] and is illustrated in Table 1. This table details the current population and the number of persons over the age of 65 and 85 years in Australia at 30 June 2011, and the estimate of these populations in 2056 using Series A, B and C.

Table 1 Current and est. population, over 65 years and over 85 years: Australia 2011 and 2056

ABS series	Population	Population over 65 years		Population over 86 years	
	(millions)	%	(millions)	%	(millions)
			2011		
	22.6	13.7	3.1	1.8	0.4
			2056		
A	42.5	23.0	9.9	4.7	2.0
B	35.5	24.0	8.5	6.0	2.1
C	30.9	25.0	7.7	7.3	2.3

Sources: (Australian Bureau of Statistics 2008, 2011)

There have been a number of estimates of the expected increasing demand for aged care services arising from this population increase; these include Access Economics (2009a, 2010); Allen Consulting (2002); Hogan (2004); Madge (2000); Productivity Commission (1999, 2008, 2010a); Treasury (2003, 2007, 2010). Despite methodological differences the results are broadly similar, but with some notable exceptions as discussed below. The Australian Treasury

[9] The Australian Bureau of Statistics uses three projections to estimate future population size, growth, age structure and distribution of the Australian population; Series A, B and C (Australian Bureau of Statistics 2008). Series B largely reflects current trends in fertility, life expectancy at birth, net overseas migration and net interstate migration, whereas Series A and Series C are based on high and low assumptions for each of these variables respectively (Australian Bureau of Statistics 2008, p. 3).

supports the use of Series B for its estimates of the future demand for aged care (Australian Treasury 2010, p. ii). Table 2 shows the details of Treasury's unpublished modelling (which were provided to the Productivity Commission) and which estimate the number of people requiring aged care in the future for both care in the community and in residential settings. These estimates suggest a fourfold increase in the number of persons in high care and receiving aged care packages in the community. The increase in low care is expected to be only a threefold increase, as is the demand for home and community services.

Table 2 Est. persons 65 year or older receiving care, nature of the care: Australia 2006-07 to 2046-47

Year	2006-07	2016-17	2026-27	2036-37	2046-47
Number of places/persons	'000	'000	'000	'000	'000
High care residential	108	148	205	303	405
Low care residential	58	60	82	122	162
Total residential	167	208	287	426	567
Community aged care places	31	50	71	100	125
Home & community care services	518	697	976	1251	1448

Source: (Productivity Commission 2008, p. 38)

There is significant variation in the estimates of the future cost of residential aged care services. According to the *Intergenerational Report* published by the Australian Treasury, government spending on aged care is expected to grow from 0.8% of GDP in 2010-11 (around $7 billion) to around 1.8% of GDP by 2049/50 (approximately $15.75 billion in current dollars) (Australian Treasury 2010, p. 56). This is a lower estimate than predicted in the earlier *Intergenerational Report* (Australian Treasury 2007). Based on current policy parameters and population predictions, the same basis as the Treasury modelling, Access Economics estimates expenditure on residential aged care will reach $38 billion by 2050 due to the higher expectations of the incidence of dementia (Access Economics 2010). The Treasury's 2007 estimates of the cost of aged care services as a proportion of the growth in GDP are shown in Table 3, as they represent a reasonable midpoint between these different estimates. These data estimate that government expenditure will increase by 28% between 2016-17 and 2026-27 and a further 125% by 2046-

47. These estimates are driven by both demand and increases in the cost of care.

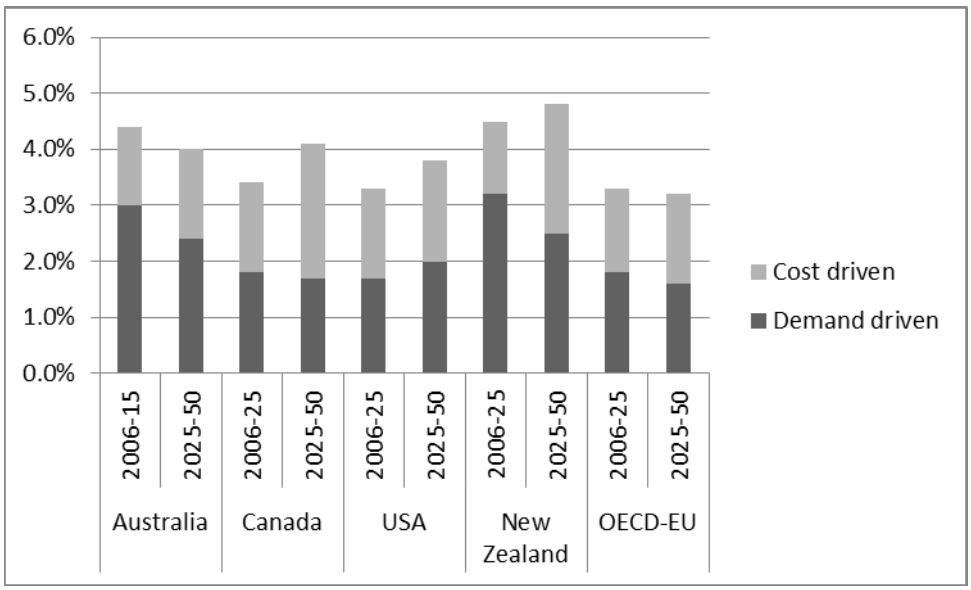
Table 3 Est. of the level of government expenditure as % of GDP: Australia 2006-07 to 2046-47

Year	2006-07	2016-17	2026-27	2036-37	2046-47
			% of GDP		
Residential	0.54	0.68	0.87	1.21	1.53
Community aged care places	0.04	0.06	0.08	0.10	0.12
Home & community care services	0.09	0.12	0.15	0.18	0.20
Other	0.04	0.05	0.06	0.07	0.08
Total	0.71	0.90	1.16	1.57	1.93

Source: (Productivity Commission 2008, p. 38)

The OECD also estimates that growth in the cost of long-term care in Australia and other selected OECD countries will be generated by both cost and growth driven demand and will exceed the rate of annual growth in national GPD. The OECD predicts, as illustrated in Table 4, that Australia will have continuing growth in demand for expenditure on long-term care that is greater than the USA and Canada and approximately the same as New Zealand until 2025 and greater than the OECD in Europe as a whole over the period to 2050.

Table 4 Av. est. growth of long-term care expenditure: Selected countries 2006-25 and 2025-50



Source: (OECD 2011d)

In addition to the level of expenditure by governments, the contribution individuals make to the cost of their care through payments to providers brings the current level of expenditure on aged care to 1.1% of GDP in 2010-11 (about $9.6 billion) (Australian Treasury 2010). The *Intergenerational Report* 2010 (Australian Treasury 2010, p. xi) also predicts that the 'fiscal gap' (government expenditure relative to government income) facing Australia will become negative in about 20 years due to the predicted demographic changes in Australian society. With an ageing population, aged care policy will remain an area of significant community attention. Future governments will likely be looking to secure a larger proportion of expenditure on residential aged care from other sources such as residents and their families, long-term care insurance, superannuation and possibly release of equity in residents' family homes (Aged Care Financing Authority 2013; KPMG 2013b).

The Productivity Commission (2011) has predicted that by 2027 there will be a need for 287,000 residential aged care beds across the country (an additional 105,000 beds over 15 years). At approximately $250,000 to construct a new residential aged care bed in 2013 (Stewart Brown 2013) this will require an investment of about $26 billion across Australia over this period (Gates & Grayson (2012)). Supporting these predictions, the Aged Care Financing Authority (2013, p. 10) estimates that 74,000 new places will be needed by 2013, at a cost of $25 billion. Ignoring replacements of existing beds, this is the equivalent of a new 140-bed residential aged care facility opening somewhere in Australia every week for the next 10 years and approximately twice the rate of growth of the past decade. This will most likely result in changes to the structure of the industry such as location, size and ownership of services.

While this predicted demand for residential aged care will require changes in government policy, history suggests that these changes will be incremental and based around the established mechanisms at the disposal of the government. In short, the future residential aged care sector in Australia will build on past decisions. For this reason it is important to understand

the historical development of the residential aged care sector in Australia and how it operates today.

2.3 Historical development of the residential aged care sector

This section describes the changes to policy over the recent decades and the impact these changes have had on the development of the residential aged care sector. This discussion demonstrates the impact that policy has had over the structure of the industry and the establishment of the current system of funding and regulation. The current regulatory system is described in section 2.4. Following this explanation of history and current operations, the proposals for reform of the system are discussed in terms of the pressures for change and the ideological frameworks that seek to change the sector in particular directions.

The pathway of policy decisions made by successive colonial, state and Australian governments in establishing aged care programs is well documented (Allen Consulting Group 2003; Cullen 2003; Cummins 1971; Fine 1999; Le Guen 1993; Sax 1984) but what is not so clear is the evidence successive governments have used to make those policy decisions and the policymaking processes. The substantial literature in this area tends to document the outputs and outcomes of policy (Berry 2007; Borowski & Olsberg 2007; Encel & Ozanne 2007; Fine 2007; Fine & Stevens 1998; Kendig & Bridge 2007; Swerissen & Duckett 2007); there is little to explain the way that governments used the information available to them in their decision-making. Fine (2007, p. 292), writing on the development of aged care policy in Australia, claims that:

> *the history of the current, rather complex and diverse system of provisions [of aged care] indicate that the tensions besetting the existing system will have a profound effect on the way that services develop over the coming decades.*

If this claim is correct then an understanding of the way that the current structure of the residential aged care sector was developed, the tensions

that have influenced its structural development and recent trends, will provide a valuable insight in understanding the present landscape.

2.3.1 Residential aged care in Australia up to the 1960s

Structure has been an important element in the development of residential aged care policy in Australia over the past 200 years. The first aged care policy was effectively developed in 1821 when Governor Macquarie approved funding for the building of the Benevolent Society Asylum to provide services for the citizens of the colony who were aged and indigent,[10] (Benevolent Society 2009; Braithwaite, Makkai & Braithwaite 2007; Browning 2000) on a site approved by the government of the day (NSW State Records 2003). This policy decision established the relationship between aged care providers and (the then) Australian governments that, in some aspects, continues to the current era; that is, Governor Macquarie's provided funding to a not-for-profit organisation to build and operate a facility for the 'poor and indigent', of a size and at a location acceptable to the government (Cummins 1971). This policy decision foreshadowed the current policy of Australian governments as funders of care rather than direct providers, and as regulators of the location, size and operators of services.

In the late 1850s the New South Wales (NSW) Colonial government took over the administration of the facilities operated by the Benevolent Society (the government had never relinquished ownership of the sites) and established the state hospital system (NSW Department of Health 2003). Continuously, from that time until after the Second World War, the NSW government was the largest provider of residential aged care in the state through the state hospitals which focused on the indigent aged (NSW Department of Health 2003). The histories of the development of aged care in other states in Australia during this period are similar; all had a preference for government ownership and control over the size and location of facilities. A feature of this period, and particularly in the last decades of the nineteenth century, was

[10] These services were for free citizens, as convicts and military personnel received care and accommodation from the colonial government.

the number of government enquiries in NSW, Victoria and South Australia (Barling 1897; Cullen 2003; South Australia Royal Commission 1898). These reviews repeatedly found fault with structural elements, such as the inadequate size of the facilities, deficiencies with operators and the quality of staffing (Cullen 2003).

For those with no family or wealth to draw on, the state hospital system remained the predominant regulated and systematic mechanism for formal residential care during this period (Fine 1999) and these facilities continued to operate up to the 1980s (NSW Department of Health 2003). Aged care for those with family with the means to look after them was either provided at home in the community, or in the first half of the twentieth century in one of the relatively few and unregulated residential services operated by for-profit or not-for-profit operators. A third source of care was public and charitable hospitals where the care was continued for those admitted as patients but with no options for discharge (Fine 2007).[11]

As part of a wide range of post war social policy programs, in 1954 the Australian government introduced a scheme to provide capital grants to assist existing and new service providers to build new homes for older people with low level care needs, along with some regulatory control (Cullen 2003). These early attempts at reform of residential aged care continued the well-established practice of basing policy around structural factors. Grants were restricted to not-for-profit organisations and the policy specifically excluded state government and for-profit providers. The legislation broke new ground as it was the first policy of the Australian government to provide

[11] This practice continues in many public hospitals, particularly in non-metropolitan locations. The Australian Institute of Health and Welfare reported that 265 public acute hospitals had nursing home care units in 2011-12, mostly in regional and remote locations and most in receipt of Australian government residential aged care subsidy (Australian Institute of Health and Welfare 2013, p. 72 Table 4.13). However not all costs of public hospital residential aged care services are met by the subsidy (Baldwin & Dickson 2007). Long-term care is also possible in private hospitals under the Private Hospitals Act 2007, although heavily discouraged by the health funds (Australian Institute of Health and Welfare 2013; Australian Minister for Health and Ageing 2007).

support to the aged, other than through the provision of pensions, which were introduced in Australia in 1909 (Borowski & Olsberg 2007). However, the government was soon to discover the limitations of basing a policy on only one structural element (in this case ownership), as by 1959, five years after its introduction, housing for only 5,000 people had been built across the country by not-for-profit organisations, with a disproportion of all new facilities built in Victoria (Cullen 2003, p. 31).

2.3.2 Residential aged care from 1963 to 1997

Subsidies for people in long-term care in 'approved' nursing homes (high care) commenced in 1963 and were paid by the Australian government. On this occasion there was no discrimination against for-profit providers, but state government aged care providers were still excluded (Gray 2001). Subsidies were introduced for older hostel (low care) residents in 1979 (Cullen 2003).[12] The introduction of the daily care subsidy began a period of rapid growth in the sector, particularly of facilities operated by for-profit providers, that was unforseen by the policymakers. Kaffenberger's (2000) description of the emergence of for-profit providers of residential aged care in the USA during this period may just as well describe the approach adopted in Australia. He wrote:

> *No public official or important political element in the United States has ever argued that the care of the old, sick and indigent should be turned over to the … for-profit sector. However, … a series of government financial programs ranging from old age assistance in the states, to FHA [Federal Housing Administration] loan guarantees, to Medicaid, have done just that (Kaffenberger 2000, p. 45).*

By 1968 in Australia, 220 new aged care homes had been built, a growth of 20% over just five years (Parker 1987) and by 1983 the number of aged care places eligible for this subsidy had increased by 282% (an annual growth rate of 7%) (Cullen 2003, p. 44). Cullen (2003, p. 33), asserts that the reversal of the

[12] These programs, nursing care and hostel care, continued to be funded as separate services until the introduction of the Aged Care Act 1997 .

policy that had operated during the 1970s (which had favoured not-for-profit hostel funding over nursing home funding, including for-profit providers) resulted in the Director General of Social Services (the responsible Australian government department[13] at the time) to come to the conclusion that too many people were being admitted to nursing homes rather than aged care hostels. The policymakers had failed to anticipate the growth in the number of for-profit facilities - 62% compared with 26% growth in the not-for-profit sector, and the growth in the average size of for-profit nursing homes in the fifteen years to 1980 (Cullen 2003). This failure to anticipate these trends resulted in a distortion in the sector. By 1983 90% of funding for residential aged care was directed at nursing homes (Le Guen 1993, p. 12) and Australia had one of the highest rates of older people living in residential care in the world (after the USA and Denmark) (Le Guen 1993).

Other policy reversals were required during the 1970s and 1980s. To remedy the slow growth of the aged care hostel sector, in 1972 the government introduced legislation for grants, over a limited period of three years, to provide up to 100% subsidy of the cost of building a hostel. However, the policy initially failed to stimulate building construction and the life of the program had to be extended and merged with other grant programs (Cullen 2003, p. 34). This time the number of grant applications exceeded the available budget and within a year, 1976, the government returned the subsidy to the previous level. By 1988-89 (16 years after the Aged and Disabled Persons Hostels Act 1972 was introduced) only 12,564 aged care hostel places had been built (Cullen 2003, p. 34).

The 1980s and early 1990s was a period of review and policy 'reform'. The Australian House of Representatives Standing Committee on Expenditure, chaired by Mr L McLeay, in May 1980 reported that the cap imposed by the

[13] The responsible department has changed and the name of the relevant department has changed over time. A list of responsible department names is provided in the List of definitions and acronyms. Where the word 'Department' is used it means the Department responsible for regulating aged care at the time of the reference.

government on extra funds for domiciliary care[14] had backfired by directing people to residential care. The increased cost to the government through these additional residential care subsidies was more than the savings it had made on the domiciliary care program (McLeay 1982) (McLeay, 1982). The subsequent McLeay Report was based on strong social policy principles and had a major influence on the aged care policies of the Australian government and the reforms introduced with the 1986-87 Australian government budget (Le Guen 1993). These reforms (inter alia) introduced:

- the population based funding formula to distribute services evenly
- an emphasis on quality with a new set of standards and routine inspections
- a new funding model with separate elements for care and not-care costs
- coordinated assessment services for admission to residential aged care
- funding for specific groups such as migrants and Aboriginal and Torres Strait Islanders.

These reforms were well received and reasonably robust, with some aspects of the funding model not replaced until 2008 (Productivity Commission 2011) and the principles were still being used in 2014 to annually allocate new aged care places.

Despite the perceived success of the new policies the government, in 1991, announced a 'mid-term review of aged care reform strategy'[15] in response to the industry's concerns that the funding system did not allow some nursing homes to achieve financial viability (Le Guen 1993). This review, by Professor Bob Gregory, was principally concerned with:

> *the sustainability of funding arrangements, the lack of choice for residents in the current arrangements, inequities and gaps between the nursing home*

[14] This cap had been introduced as part of the former government's fiscal restraint policies after it won government in 1975.
[15] It was at the mid-term of the government's expected three years in office until the next federal election was required.

> *and hostel schemes, problems with the quality of care and buildings and complex and unwieldy regulation (Cullen 2003, p. 73).*

The Australian government's responses to the Gregory report 'were overtaken by the commencement of the Aged Care Act 1997, which increased the emphasis on consumer capital contributions' (Hogan 2004, p. 38).

2.3.3 Residential aged care between 1998 and 2012

The Aged Care Act 1997 introduced significant changes to residential aged care policy and provided the framework of the current residential aged care sector. The Act enshrined the focus on location as the central principle on which new 'approved places'[16] were allocated, a principle that had been adopted 10 years earlier. These government powers, described in more detail on page 25, continue to enable the Department to determine the number of beds operated by individual providers and, through this mechanism, to regulate the structural elements of the industry. The Act also regulates transfers of ownership; thus providing the government with the option to control the development of aged care provider chains under the control of one owner, or approved provider, should it choose to do so. The new Act also changed funding arrangements, established a set of principles for the operation of residential aged care facilities funded under the Aged Care Program and strengthened the regulatory mechanism around the assessment of quality standards at each facility (Aged Care Act 1997).

The passage of the new Act did not stem the regular pattern of reviews and reports into the Aged Care Program. Between 1997 and 2011 there have been two major independent reviews commissioned by the government (Gray 2001; Hogan 2004), five reports from the Productivity Commission (Productivity Commission 1999, 2008, 2009, 2010a, 2011), two of which were also commissioned by the government, and a Senate enquiry (Senate Standing Committee on Finance and Public Administration 2009). These reviews and reports have tended to focus

[16] 'Approved places' are effectively licences issued by the Department to a provider to provide a service and receive government funding. A full explanation of this system is provided on page 14.

on: the financial viability and sustainability of the industry under the current legislation and subsidies (Cullen 2003, p. 76; Hogan 2004; Productivity Commission 2011); the future demand for care (Productivity Commission 2008, 2010a, 2011); the supply of services (Hogan 2004; Productivity Commission 2011); the level of competition and choice by consumers (Hogan 2004; Productivity Commission 2011); and the level of regulation by the government (Hogan 2004; Productivity Commission 2011). In addition to these major reviews there have been a number of other reviews commissioned by the government into specific aspects of the operation of the Aged Care Program (Australian Government Department of Health and Ageing 2005a, 2005b), commissioned by industry or consumer organisations (Access Economics 2009a, 2009b, 2010; Allen Consulting Group 2002; Deloitte Access Economics 2011; Grant Thornton 2009, 2011), or generated from within the organisation producing the review (Productivity Commission 1999, 2005, 2008).

Although many of the recommendations of these reviews and commissioned reports have not been adopted by governments the pattern and focus of reforms over the past 40 years has changed, arguably by the collective influence of the reports and their changing nature. Early government approaches to support the industry reflected social policy principles of assistance to the poor and disabled, with an emphasis on funding for capital works and regular subsidies provided with a light hand of regulation. However, since the early 1990s the focus of review and reform has changed to an environment of tighter regulatory control, an emphasis on efficiency and value for money and a focus on competition and choice. While the principal mechanism for allocating new aged care beds and community places is based on location, other structural features such as ownership have been abandoned as a central plank of resource allocation and regulatory control.

2.4 Government control over structure and quality

This section describes the current funding and regulatory system which has emerged from the historical development. This description provides a platform for the discussion of the proposals for further development in section 2.5.

2.4.1 Policy and practice on the allocation of beds and approval of services

Under the Aged Care Act 1997 and its regulations, the Australian government provides daily aged care subsidies to *'approved providers'*, who hold *'operational aged care places'*. Section 11.1 of the Act specifies that an *'approved provider can only receive subsidy ... for providing aged care in respect of which a place has been allocated'* (Aged Care Act 1997). Consequently, one of the defining aspects of the residential aged care program in Australia is the regulatory mechanism the government uses to control the supply and distribution, and subsequently the growth of services and through this mechanism, to shape the industry. The government achieves this level of control through the Aged Care Approvals Round (ACAR) (Australian Government Department of Social Services 2013). Each year, the government determines a target number of aged care places (both residential and community) that it will allocate across Australia and the number to be allocated in each planning region. It then conducts an 'approvals round' (Australian Government Department of Health and Ageing 2010), inviting approved aged care providers to bid for the new places. The determination of the number of available places is based on a planning formula. The current (2014) planning formula specifies a target of 86 residential aged care places and 27 community care places (in total 113 places) per 1,000 people aged 70 years and over in each planning region. This target will rise to 125 places per 1,000 people aged 70 years and over by 2022 (Australian Government Department of Social Services 2013).[17]

Illustrated in Table 5 is the number of operational aged care places by jurisdiction across Australia at the end of June 2013. These data signify the

[17] To apply this planning formula Australia is divided into planning regions based on the eight states and territories (Australian Government Department of Health and Ageing 2010).

level of government control on the size and structure of the aged care industry.[18]

Table 5 Operational residential and home care places per 1,000 people aged 70 years or over, at 30 June 2013, by state and territory

State/ Territory	Residential care			Home care			Total Places
	High	Low	Total	High	Low	Total	
NSW	44.6	41.8	86.4	4.3	20.7	24.9	111.3
VIC	41.3	43.9	85.2	4.5	20.7	25.2	110.4
QLD	39.1	42.3	81.4	6.8	20.9	27.8	109.2
WA	36.6	40.3	77.0	13.9	22.9	36.8	113.8
SA	50.1	42.8	92.9	3.5	21.3	24.9	117.8
TAS	43.7	37.2	80.9	5.0	20.9	25.8	106.7
ACT	30.6	42.8	73.4	17.4	24.7	42.2	115.6
NT	48.1	39.1	87.2	21.6	104.7	126.4	213.6
Aust.	42.3	42.2	84.5	5.9	21.4	27.2	111.7

Source: (Australian Government Department of Social Services 2013, p. 11 Table 1)

Through the planning process, the growth in the size[19] of facilities, the distribution of for-profit and not-for-profit owners, the development of large provider chains and the location of facilities are determined by the officers of the Department. According to the Department, the ACAR *'is a highly competitive process and all applications are assessed against a nationally consistent assessment framework that follows the provisions of the Act and the Aged Care Principles'* (Australian Government Department of Health and Ageing 2010, p. 3). What is not made explicit is how the government uses evidence-based research to determine the selection of ownership[20] types, the desirability of granting additional places to established facilities, or the expansion of existing provider numbers by approving the establishment of new facilities, or the transfer of ownership of existing facilities. The Department does make clear, however, that

[18] It is worth noting that, except for allowances made for the relatively high proportion of Aboriginal and Torres Strait Islander populations in Western Australia and the Northern Territory, the planning formula takes no account of socio-economic status of a particular region, a planning region's ethnic mix, changes to length of stay or bed occupancy.

[19] Size of facilities is the number of 'approved' beds as listed by the Department.

[20] Ownership is defined as the 'approved provider' of the service and the definitions of different ownership types are provided in the list of definitions commencing on page xii.

evidence of quality failures is taken into consideration when allocating aged care places and funding.

2.4.2 Quality assurance and prudential requirements in Australia

All residential aged care services are subject to a web of regulatory and accountability requirements established by the Aged Care Act 1997 and the Aged Care Quality Agency Act 2013. Within these requirements all operators must meet and maintain 'approved provider' status, all approved providers must achieve and maintain accreditation[21] for each service for which they are allocated funded beds and all approved providers must meet a set of prudential requirements designed to protect residents' assets held by the approved providers. The quality framework, within which the residential aged care industry in Australia operates, forms the basis for the quantitative analysis of the trends in the industry reported in Chapter 5 of this thesis.

The accreditation process is undertaken by the Australian Aged Care Quality Agency[22] and is based on a three-year accreditation cycle reinforced with unannounced visits from the agency staff between full accreditation audits (Aged Care Quality Agency 2014). The complaints process is managed by the Aged Care Complaints Investigation Scheme within the Department of Social Services and complements the accreditation process. In addition to accreditation, the prudential regulations require approved providers to supply a statement annually to the Department which declares their capacity to repay anticipated resident accommodation deposits (Australian Government

[21] The terms used in Australia to define the quality framework differ from other counties. For example, in the USA 'certification' applies to the requirement to meet national statutory minimum standards and 'accreditation' is a voluntary process undertaken with a non-government organisation (Rosewarne 2002). In Australia 'certification' means that a particular aged care building meets structural and design regulations and 'accreditation' is the national compulsory scheme that requires all residential aged care services to meet minimum quality standards.

[22] The Aged Care Quality Agency replaced the Aged Care Accreditation and Standards Agency on 1 January 2014 following the passage of the Australian Aged Care Quality Agency Act 2013 (Australian Government Department of Health and Ageing 2013b). This new agency is a statutory body under federal government law responsible to the Minister with responsibility for the Aged Care Act 1997 (Australian Government Department of Health and Ageing 2013b).

Department of Health and Ageing 2011b). Finally the Department has the power under the Act to impose a sanction on an approved provider where, in the opinion of officers of the Department, the approved provider has failed to meet and maintain minimum standards (Australian Government Department of Health and Ageing 2011b). These regulatory and quality assurance mechanisms generate publicly available data that can be used to analyse the performance of the residential aged care sector. The findings from the analysis of these data are reported in Chapter 5.

Although the existing system of allocation of places and regulation of quality has been in place for some time, what is clear from announcements by both the previous and the current government, is that the reforms will continue by reducing Departmental control over supply and encouraging market-based competition to determine the size, ownership and location of services (Australian Government Department of Health and Ageing 2012b; Australian Liberal and National Parties 2013).

2.5 Proposals for reform of aged care policy in Australia

This section provides an analysis of the current proposals for reform and the ideological frameworks which influence these proposals. This analysis seeks to explain the current emphasis on reform based on neo-liberal principles that have emerged over the recent past and are set to shape the development of the industry in the future.

2.5.1 The influence of neo-liberal principles on aged care policy reform

In the years immediately following the Second World War, aged care policy reform by the Australian government followed social policy principles (Encel & Ozanne 2007; Fine 1999). However, Encel and Ozanne (2007, p. 296) argues that since the 1980s, neo-liberalism has dominated the Australian government's approach to social welfare to the extent that Australia can be

now labelled *'a neo-liberal welfare state with corporatist leanings'*.[23] The commencement of these trends is reflected in the differences between the approaches to reform suggested by Macleay and by Gregory described above. Fine's assessment of the aged care reforms of the 1980s, based on the McLeay review, were that they demonstrated a *'strong concern for equity and social justice'* as evidenced by the introduction of user rights strategy, outcomes monitoring in residential care and assessment of quality in community care (Fine 2007, p. 276). Professor Gregory, an economist from the Australian National University, was appointed to review nursing home funding. The terms of reference for his review reflect a focus on neo-liberalism values such as choice, financial efficiency and competition.

These neo-liberal values are also reflected in the recommendations of aged care policy reviews conducted by the Productivity Commission[24] between 1999 and 2008, which emphasise market-based mechanisms of efficiency, co-payment, competition and choice. The Commission has recommended that:

- Resident's ability to pay should be taken into consideration, they should have greater *'sovereignty'* over available funds and, along with access, transparency of quality measures, *increased choice, efficiency and productivity* are important goals (Productivity Commission 1999).
- The community has to decide trade-offs between equity, efficiency and sustainability, and objectives relating to quality and choice (Productivity Commission 2008).
- The public debate in Australia needs to address five key issues:
    - user preferences and decision-making capacity

[23] A critical review of the characteristics of neo-liberal approaches to social welfare is provided in Chapter 3.

[24] The Productivity Commission is an influential body on government policy and government decision-making in Australia. It describes itself as *'the Australian Government's independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians … the Commission's focus is on ways of achieving a more productive economy'* (Productivity Commission 2014*).*

- the scope of services included in any arrangements
- implications for regulatory settings covering, for example, information and quality assurance
- the nature of the market for aged care services (Productivity Commission 2008).

2.5.2 Caring for Older Australians 2011

In 2010 the Australian government requested that the Productivity Commission conduct a comprehensive review of aged care in Australia building on its previous reports with the terms of reference to (inter alia):

> *systematically examine the social, clinical and institutional aspects of aged care in Australia … develop regulatory and funding options for residential and community aged care … [and] recommend a path for transitioning from the current regulatory arrangements to a new system* (Productivity Commission, 2011, p. vii).

In its report, *Caring for Older Australians*, the Commission found that '*the aged care system was difficult to navigate, services and choice were limited, quality and coverage of needs were variable, pricing, subsidies and user co-contributions were inconsistent or inequitable*' (Productivity Commission, 2011, p. xxii).[25] The Commission made a number of recommendations, which continued the focus they had followed for the past decade, and which included (inter alia):

- phasing out the government's control on supply which limits the number of beds a provider can receive government funding for
- removing regulatory restrictions on accommodation charges for residents

[25] In addition to the Commission's findings, a number of recent industry-based investigations have suggested that the aged care system is not sustainable in the long term under the current structural and financial parameters (Deloitte Access Economics 2011; Grant Thornton 2011).

- increasing access to the equity in residents' homes to pay for their accommodation costs in residential aged care
- allow providers to charge for extra services without government approval
- increase co-contributions by consumers of both residential and community care
- increase transparency in the pricing of accommodation costs
- introduce choice through consumer-directed care.

They also commented that the '*opening up of supply, and creation of a responsive and competitive market, will require providers to change their business models and will test the management skills of some*' (Productivity Commission 2011, p. xxxiv).

In this extensive report the Commission made no reference to the substantial volume of empirical research evidence on the relationship between structural factors and outcomes for residents, and performance of providers. The Commission made no recommendations on the future shape of the residential aged care sector (such as ownership, size of facilities, size of providers and location of services) that should emerge from this liberalisation of the controls on supply. A reasonable conclusion may be that the Commission considered market-based solutions would achieve efficiency, quality and access without a need to take into consideration the structural features of the sector, despite the strong international literature suggesting that these features do have a relationship with quality and performance within competitive markets such as the USA and the United Kingdom (UK).[26] The evidence of the relationship between structural factors, outcomes and performance of aged care is reviewed in detail in Chapter 3.

[26] A different explanation could be that the Commission did not believe that an examination of the international literature was within its terms of reference.

2.5.3 Living Longer Living Better

In response to the Commission's report and recommendations, the Australian government announced a series of reforms called Living Longer Living Better, which were to be introduced over three phases; 2012-14, 2014-16 and between 2016 and 2022. These reforms adopted a number of the Productivity Commission's recommendations for short-term introduction, rejected some recommendations outright and suggested that others be introduced progressively. Living Longer Living Better included a range of initiatives aimed at providing more choice for consumers, increasing consumer co-payments and preparing the industry for the removal of regulatory controls on supply after 2016 (Australian Government Department of Health and Ageing 2012b, p. 21). The reform package included (inter alia) the following elements (Australian Government Department of Health and Ageing 2012b):

- an expansion in the number of community aged care packages with the view to absorb unmet demand for aged care in preparation for the removal of controls on supply
- greater access to information for consumers to enhance choice of services
- increased accommodation charges and mandating that consumers have a choice on how they pay for their accommodation charges through either the payment of refundable accommodation deposit (RAD) or a daily accommodation charge (DAP)
- the requirement that providers advertise the level of RADs and DAP thereby stimulating competition between providers
- increased subsidy payments to enable higher wages to be paid[27]
- the introduction of consumer-directed care initially in community care and progressively to all aged care where consumers have more choice and flexibility in the nature, timing and mix of services they receive

[27] This initiative was subject to conditions related to providers meeting certain requirements in relation to employment arrangements and was removed by the incoming government in late 2013.

- increased user charges for community aged care.

Living Longer Living Better also stated an aim was to remove the controls on supply and to introduce market-based competitive elements. The Department's policy stated that:

> *Years 5-10 (2016-17 to 2021-22) will see … further reform to remove supply controls and provide a common funding system determining consumer entitlements for both community and residential care* (Australian Government Department of Health and Ageing 2012b).

In developing this approach to supply, the government worked closely with stakeholder groups, most notably the National Aged Care Alliance (NACA), which provided a platform for a range of organisations to develop a shared view and negotiate with government. The key organisations in this movement are described in the next section.

2.5.4 The role and structure of stakeholder organisations

This research is concerned with the implications for policy of identified trends in the residential aged care sector in Australia. Bearing in mind Colebatch's observation that for some stakeholders *'policy may be a vehicle for contesting the existing order and asserting a right to participate'* (2009, p. 2) in the policymaking process, this overview of the Australian aged care industry's development would not be complete without an analysis of the influence of key industry and consumer groups on aged care policy. The perspective of elite stakeholders' influence over recent policy reforms and the influence of the aged care providers who they represent are reported in Chapter 5 and discussed in Chapter 6.

The two major industry associations representing residential aged care providers are the Aged and Community Services Association (ACSA) and Leading Age Services Australia (LASA). ACSA emerged from a national association of church and charitable providers in the 1950s and was 'rebadged' under its current name in 1991 (Encel & Ozanne 2007). It has since partnered with

universities and research centres to broaden its activities in the areas of workforce planning and housing, as well as the traditional areas of residential and community care (Encel & Ozanne 2007). LASA was formed in 2012 from the membership bodies of the former Aged Care Association Australia and two state bodies that were formerly members of ACSA. It represents both for-profit and not-for-profit providers and claims to be the only truly national peak body representing the views of providers.

Two consumer groups are notably active in the field of residential aged care policy. These are the Council on the Ageing (COTA), claiming to represent the interests of people over the age of 50 in Australia and Alzheimer's Australia (AA). In recent years these organisations and other provider, consumer, industrial and professional organisations have joined together as the NACA to develop shared policy and perspectives, with its secretariat housed with COTA.

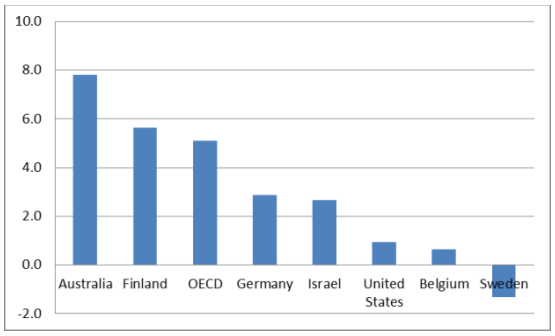
In 2000, 17 organisations initially formed the NACA (National Aged Care Alliance 2013) for the stated purpose of *'reforming aged care'*. NACA claims that the inclusion of consumer, professional organisations, industrial unions and providers was unprecedented due to their deep differences on many issues across the industry (National Aged Care Alliance 2013). By 2013 the membership had grown to 41 member organisations. In the development of the Living Longer Living Better reform package, the NACA prepared a unified position on a range of issues to present to the Australian government at the time (National Aged Care Alliance 2012, 2013) and according to the government, achieved a consensus on the Living Longer Living Better reform package. The beliefs of elite stakeholders on the influence of the NACA are further explored in Chapters 5 and 6. The next section addresses the applicability of the international and theoretical evidence on the significance of structural factors on aged care services.

2.6 International and theoretical implications for policy reform

2.6.1 International comparison of residential aged care sectors

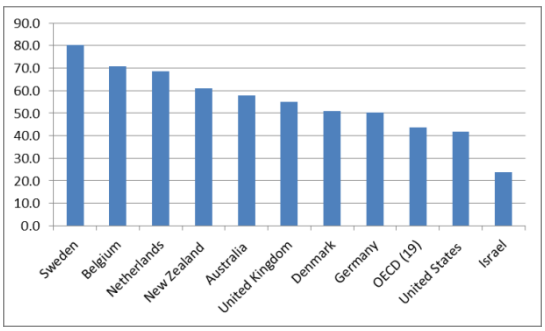
Because of the limited research on these issues in Australia an examination of the evidence on the relationship between structural factors, outcomes for aged care residents and the performance of providers from other countries has been conducted. Chapter 3 provides a detailed review of this international literature. Research on residential aged care services in other countries may be applicable to Australia if there are sufficient similarities across a range of features of the residential aged care systems. Australia's growth rate in residential aged care beds for the over 65-year age group is within the mid-range of comparable countries, as illustrated in Figure 2 and Figure 3. Table 6 below provides data on a number of variables across selected countries that were identified in the international literature, reported in Chapter 3.

Figure 2 Percentage trends in growth of LTC beds: selected countries, 2000-09



Source: (OECD 2011c)

Figure 3 LTC beds per 1,000 people in the population over 65 years, 2009



Source: (OECD 2011c)

The bulk of the literature on the relationship between structural elements and outcomes for residents originates in the USA and Australia's residential aged care sector is similar in many ways. As Table 6 shows, both Australia and the USA have a similar percentage of aged citizens in residential aged care (5.3% and 5.7%), relative to other countries. In both Australia and the

USA residential aged care is regulated with a single national accreditation system.[28] Both countries spend a similar amount of their GDP on long-term care and have a mixture of for-profit, not-for-profit and government-owned facilities (although the proportions vary). Governments in Australia and the USA provide a not dissimilar level of funding towards the care of residents; 89% in Australia and 78% in the USA. A difference is that in Australia all residents attract some government funding and the level of co-payment is means tested, while in the USA access to government contribution is means tested. There are differences in the average size of facilities between Australia and the USA (Australia's are smaller) and in the source of government funding (only the national government provides funding in Australia but in the USA state governments contribute through Medicaid). This comparison provides a level of confidence that, where structural elements are concerned, the research findings from the USA should be taken into consideration when analysing Australia's structural features.

Similar levels of Australia's government contribution to residential aged care are made by the governments of Canada (82%) and New Zealand (92%) (OECD 2011e). The proportion of government funding in Australia is closer to the USA and Canada than it is to the UK, Belgium, Germany or the Netherlands. In addition, Belgium, Germany and the Netherlands rely heavily on long-term care insurance to meet the cost of residential aged care; no similar schemes operate in Australia.

These comparisons on structure naturally do not take into consideration other potentially significant differences between countries that could influence outcomes for residents and performance for services such as community values, cultural approaches to care for the aged, socio-economic differences and the management and professional approaches to care. In addition, the characteristics of Australian residents could differ from other countries and

[28] In the USA the accreditation system is administered by state-based agencies (American Health Care Association 2012) and in Australia by the state offices of a single agency (Ellis & Howe 2010).

this difference could have a bearing on resident outcomes and research findings for Australia. This would be an important factor to consider if the purpose of this research was to compare absolute performance of the sectors across countries based on the research literature. However, the focus of this study is not on comparative quality or comparable performance, but on the relationship between structural factors and quality, and performance. For this reason it seems appropriate to take the international and theoretical evidence into consideration.

For the research on the impact of ownership to be applicable across jurisdictions, two assumptions need to be made about the markets where the research was conducted and the one where the findings would be applied. The first of these assumptions is that different ownership types have a similar level of access to the market. While a full examination of the issue of access to market is beyond the scope of this study, the existence of a mix of for-profit and not-for-profit owners in the marketplace and a comparison of the aggregate level of supply of services can act as a crude indicator of similarity. This comparison can be inferred from Table 6 by the percentage share of for-profit and not-for-profit providers and the availability of the number of beds per 1,000 persons over the age of 65 years shown in Figure 3. Based on these arguments and using the data in Table 6 on the distribution of ownership types, research in Belgium, Canada, England, Germany, Israel and the USA may reasonably be applied to Australia, ceteris paribus. The number of beds per 1,000 population over the age of 65 years in Australia appears to be somewhat in the middle of the range of the countries whose data are recorded in Table 6; having a higher level of supply than Denmark, England, Germany, Israel and the USA and a lower level than Belgium, New Zealand, Sweden and the Netherlands.

The second assumption is that it is useful to compare the quality of service of both for-profit and not-for-profit providers. Some researchers, particularly in the USA, have argued that the not-for-profit sector may be providing care to a different group of consumers than the for-profit sector,

and the two groups may have different preferences in relation to outcomes (Amirkhanyan, Kim & Lambright 2008). If this is the case, then comparisons on performance and quality at the individual or service level may not be helpful. However, this argument does not apply when evaluating the relationship between structural factors and performance at the aggregate or national level, in jurisdictions where regulations and quality standards apply equally across all providers regardless of ownership, and the same objective measures of quality and performance are used. Since Australia has a national and consistent system of regulation and quality standards, then it is worth comparing Australia's quality and performance data with research findings from countries with similar aged care systems.

Table 6 Comparison of structural characteristics across 11 countries

Country	% GDP on LTC [15]	% Ownership			Av. Size (beds)	% funding for care (excl. accommodation)			Level of regulation	Classification of funding [h]	% > 65 in LTC	Beds/1000 pop. >65
		FP	NFP	Govt		Govt	Other[a]	self				
Australia	0.84	35 [11]	59 [11]	6 [11]	65 [10]	89 [21]	2 [21]	9 [21]	National	UC [21]	5.3 [b] [11]	57.7[c] [15]
Belgium	1.90	20 [1]	40 [1]	40 [1]	30 [1]	31 [21]	69 [21]	0	National	UC [21]	6.7 [15]	71.9 [15]
Canada	1.30	41	34	25	55 [8]	82 [21]	1	17 [21]	National & Province	MS [21]	3.6 [3]	n/a
Denmark	2.50	0 [1]	28 [1]	72 [1]	39[1]	90 [21]		10 [21]	National	UC [21]	4.5 [15]	51.2 [15]
England	n/a	29 [18]	27 [18]	44 [18]		52 [17]	8 [17]	40 [17]	National & Local	SN [21]	4.0 [16] [e]	55.1 [15]
Germany	1.00	26 [1]	49 [1]	25 [1]	46[1]	13 [21]	55 [21]	31 [21]	National	UC [21]	3.8 [15]	50.3 [15]
Israel	n/a	42 [19]	28 [19]	27 [19]	80 [19]	n/a	n/a	n/a	National	n/a	2.3 [15]	31.1 [15]
New Zealand	1.30	68 [22]	32 [22]	0	57 [22] [j]	92 [21]	4 [21]	4 [21]	Region	UC & MS [21]	5.3 [15]	60.9 [15]
Sweden	3.70					99 [21]		1 [21]	Local	UC [21]	5.9 [15]	81.7 [15]
Netherlands	3.80	0 [1]	95 [1]	5 [1]	171 [1]	10 [21]	90 [21]	0	National	UC [21]	6.6 [1]	68.5 [15]
USA	0.60	68 [14]	26 [14]	6 [14]	108 [14]	78 [d] [14]		22 [14	National & State	SN [21]	3.9% [15]	42.6 [15]

Notes and Sources for Table 6

(a) includes social security and compulsory insurance, health insurance and other insurance e.g., motor vehicle compensation
(b) includes high care and low care beds, based on number of residents
(c) estimated from Table 1 and from Australian Institute of Health and Welfare (2010)
(d) refers to principal payer source; government funding is 63.4% Medicaid and 14.4% Medicare; data applies to certified homes in year of report
(e) includes both nursing homes and residential homes
(f) representative sample of English Nursing Homes
(g) kibbutz owned (Clarfield et al. 2009)
(h) universal coverage within a single program [UC], mixed systems [MS], means-tested safety-net schemes [SN] (OECD 2011e)
(i) some younger disabled but primarily care for people over the age of 65
(j) estimated from table 12 in Grant Thornton (2010, p. 38)

(1) (OECD 2012) includes both high and low care
(2) (Clarfield, Bergman & Kane 2001)
(3) (OECD 2011a)
(4) (OECD 2011b)
(5) (OECD 2011f)
(6) (OECD 2011h)
(7) (OECD 2011g)
(8) (Berta et al. 2006) long-term care facilities
(9) (Amies et al. 2003) nursing homes
(10) Findings reported in Chapter 4
(11) (Australian Government Department of Health and Ageing 2011b)
(13) (American Health Care Association 2011)
(14) (Harrington, Carrillo, et al. 2011)
(15) (OECD 2011c) GDP include Health and Social LTC; Beds/pop. include hospitals
(16) (Conroy et al. 2009)
(17) (Forder & Allan 2011)
(18) (Gage et al. 2009)
(19) (Clarfield et al. 2009)
(20) (Colombo & Mercier 2011)
(21) (OECD 2011e)
(22) (Grant Thornton 2010)

2.6.2 Theoretical difference between for-profit and not-for-profit providers

In comparing system outcomes, one first needs to consider the system's goals or mission statements against which outcomes are measured. The relationship between the different classes of ownership (for-profit, not-for-profit and government) and quality for aged care residents and service performance has been of interest to scholars across a number of countries over recent decades. Grabowski and Hirth (2003) and Santerre and Vernon (2007) attribute Kenneth Arrow (1963) with the foundation work in this area of study. His seminal paper on health economics has been widely cited by authors comparing for-profit and not-for-profit health and aged care services over the decades since it was originally published (Cohen & Henderson 1988; Duckett 2007; Feldstein 2011; Henderson 2009; Newhouse 1970; Powell et al. 2009; Santerre & Neun 2010; Stiglitz 2000; Weisbrod 1975). Arrow (1963) argued that in a market-based economy, where both classes of providers are free to operate and compete, one of the reasons that consumers show a preference towards the not-for-profit enterprise is their unequal access to information. He argues, where consumers are unable to determine for themselves the quality of the care they receive, they are attracted to the not-for-profit provider on the assumption that quality, and not profit, is maximised in not-for-profit organisations (Arrow 1963).

Building on Arrow's work, other scholars argue that differences in the behaviour of for-profit and not-for-profit providers arise because of payment of dividends to owners and taxation to the government (Henderson 2009; Lyons 1993, 2003; Simon, Dale & Chilsolm 2006). These differences place for-profit providers at a financial disadvantage compared to not-for-profit providers, ceteris paribus, as they are required to use some of their income for these purposes. Not-for-profit aged care providers have more freedom to use their financial surplus for the care of residents and potentially to provide higher quality care (Konetzka 2009; Spector, Selden & Cohen 1998).

A counter-argument proposes that the requirement to make a profit forces for-profit providers to be more entrepreneurial, innovative, better at managing costs and to provide equal or better care than not-for-profit providers (Santerre & Vernon 2007). Santerre and Vernon suggest that the *'lure of greater profits provides a powerful incentive for [for-profit] health care providers to satisfy the demands of consumers (patients) by offering the best care at the lowest possible price'* (Santerre & Vernon 2007, p. 382); although they propose this as something of a null hypothesis which they claim to disprove in their paper. This argument of more focus on business operations by for-profit providers is supported by Feldstein (2011) who speculates that for-profit owners and managers have clearer goals and that not-for-profit owners and managers often have numerous and sometimes conflicting goals, such as a predominant focus on mission and simultaneously offering a range of other charitable services. Having clearer goals and more focused professional management, it is argued, enables for-profit providers to achieve quality care at a lower cost. Aligned to this argument is the notion that because they are relieved of the need to satisfy 'residual claimants' with a distribution of dividends, not-for-profit providers are seen as less efficient than is necessary to deliver the same level of care as for-profit providers.

A number of researchers have investigated these assumptions (Santerre & Vernon 2007; Spector, Selden & Cohen 1998; Tannous & Luo 2006) and the impact that not-for-profit ownership has on quality of care. A review of these studies is provided in Chapter 3. A different view is that the size of the organisational provider may be important in determining the business approach adopted, on the basis that large organisations tend to have similar methods of operation regardless of profit status (Davidson 2012). This builds on earlier work on the motivations of small for-profit organisations that seek to provide social services which to some extent blurs the distinction between for-profit and not-for-profit providers (Kendall 2001; Kendall et al. 2003; Marceau 1990; Rush 2006). However this focus appears to have been applied more to the community care sector than to the residential aged care sector.

2.7 Conclusion

The anticipated expansion of the residential aged care sector in the foreseeable future will require substantial investment by individuals, organisations and the government. Since the 1960s the numerous aged care policy changes have been incremental, including the reversal of unpopular and ineffective policies. With the benefit of hindsight a number of these policies appear to have been made without due regard to the available evidence on trends in the sector and the impact the structural features of the industry (type of service, type of owner, number of services) would have on access, quality and performance.

Government policy since the 1980s has been focused almost exclusively on the location of services, and in recent decades successive governments have appeared to ignore the ownership or size of services, or the size of providers, in formulating policy and implementing the program. Despite the lack of articulated policy on these structural factors, regulation by government has controlled the supply of services and subsequently, the shape of the industry. Arguably, regulatory control over ownership, size of services and size of provider organisations is evident in practice if not in policy. As these structural factors are either controlled or heavily influenced by government policy and practice, then the relationship between structure and outcomes for residents and the performance of providers is an important area of study, particularly in light of the numerous past policy changes.

Overarching the funding and regulatory mechanisms is a web of accountability and quality assurance processes that monitor the provision of care. The funding and regulatory mechanisms produce a modest range of descriptive data with which to monitor performance and quality and to guide decision-making. Analysis of these data will likely reveal trends in structure of the industry as a result of government policy and practice.

There is evidence that the concepts of neo-liberalism have some influence on those charged with the responsibility of forming future residential aged care

policy. Neo-liberal influence is found in the continuing and persistent themes in the recommendations made on reform to the sector: deregulation of the industry; introduction of wider choice by consumers and more competition between providers; and increases in the proportions of consumer co-payments. While some small changes have been implemented in response to this particular reform agenda, the main policy parameters and operational regulations covering the industry appear to have largely resisted the call for deregulation. What is also apparent is that the current mechanisms for control of the residential aged care sector in Australia are inconsistent with the principles of a deregulated market as has been recommended. The implications of deregulation can be assessed from the trends in the industry, the research evidence and the beliefs of elite stakeholders.

The features of the Australian residential aged care sector have been identified as having sufficient similarities to other countries, most notably the USA, to warrant the application of international research findings to the Australian aged care setting. Consequently, in making policy decisions there seems to be good reason for policymakers to take into consideration the experiences of comparable countries. This chapter has also examined important foundational concepts in the research literature investigating the differences between for-profit and not-for-profit providers, which are a topic of sustained research interest in other countries. The following chapter reviews the literature which reports the links between the structural variables of residential aged care services and service outcomes.

CHAPTER 3 Literature Review

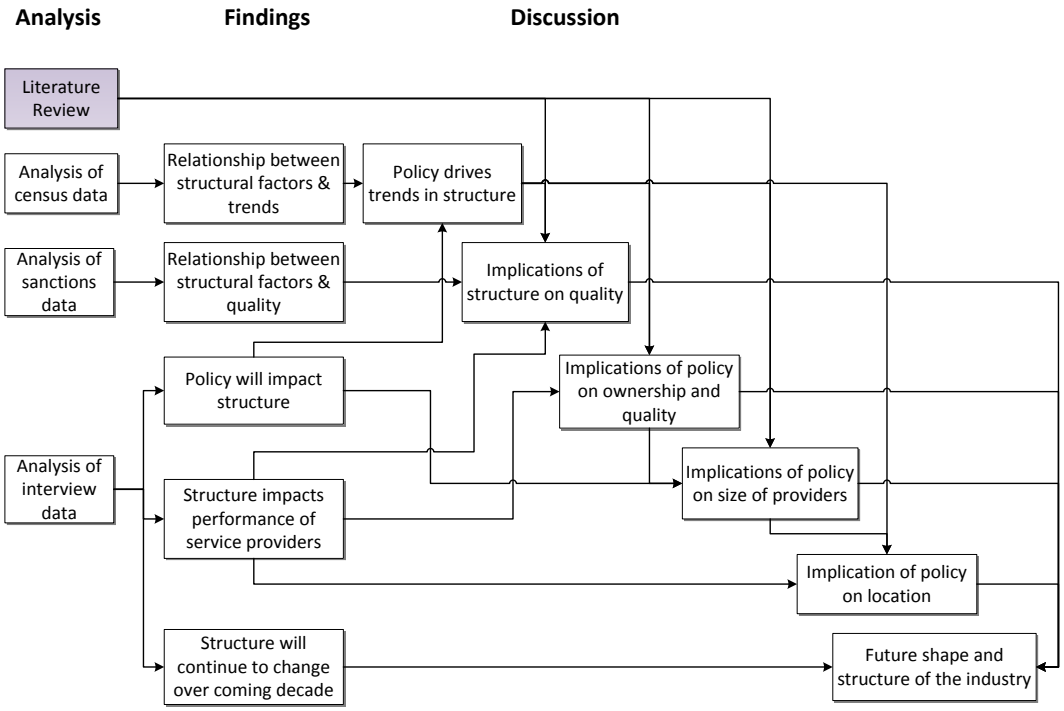
> *These three areas of care are interlinked, in that sound structures facilitate good processes, which in turn facilitate positive outcomes - the endpoint of care. (O'Reilly, Courtney & Edwards 2007)*

3.1 Introduction

This chapter offers a conceptual framework for the relationships between structure, process and outcome relevant to the aged care industry in Section 3.2. The literature on the relationship between structural factors and the performance of residential aged care services and the outcomes for residents[29] is subsequently reviewed in supporting this framework in section 3.3. Finally, in section 3.4, the review examines the literature on the aged care policy process, focusing on how governments and stakeholders formulate and make decisions on policies. The contribution of this chapter to the overall logical and conceptual flow of the thesis is illustrated in Figure 1

[29] This literature draws heaving on that originating from the USA due to the predominance of that country's contribution to research in this area.

Figure 4 This chapter's contribution to the logical and conceptual framework of this thesis



3.2 A conceptual framework for this study

This section introduces the conceptual framework which proposes a link between structure, process and outcomes (SPO) and was first developed by Donabedian (1966, p. 132; 1988, 2005). This conceptual framework is still widely used today in the broader health and aged care literature (Asmus-Szepesi et al. 2011; Bamm, Rosenbaum & Stratford 2010; Brooke et al. 2010; Chandrasekaran, Senot & Boyer 2012; Fancott et al. 2010; Massoud et al. 2001; Monroe-DeVita, Teague & Moser 2011; Peacock et al. 2001; World Health Organisation 2007).[30]

[30] At 26 June 2012, Donabedian's 1966 article had been cited 3,050 times and on 20 January 2014 it had been cited a further 734 times (n=3784) (Google Scholar search http://scholar.google.com.au.ezproxy.lib.uts.edu.au/scholar?hl=en&q=avedis+donabedian&btnG=&as_sdt=1%2C5&as_sdtp=). Castle (2010) estimates that between 2005 and 2010 57% (n=3,950) of nursing home studies either directly or indirectly applied this approach.
The use of Google Scholar as the citation source is supported by the work of Harzing (2013) who concluded that it was stable over time, comprehensive and may redress the traditionally disadvantaged position of the social science in citation analysis when using other more traditional citation sources.

In proposing a measurement of quality, Donabedian believed that an evaluator needed '*detailed information about the causal linkages among the structural attributes of the settings in which care occurs, the processes of care, and the outcomes of care*' (Donabedian 1988, p. 1743). Over the decades since the original paper was published, the SPO model has been widely accepted by researchers, and in particular those completing systematic reviews of the research evidence on outcomes and performance in aged care.

Charlene Harrington (2005), a widely published researcher into resident outcomes in residential aged care, used the SPO approach in outlining a research agenda for residential aged care. She argues that the focus of much of the previous investigative work focused on the outcomes of care, but that recent research raised concerns about the reliability and complexity of measuring outcomes without also taking into consideration the associated structural and process measures. She summarises the relationship between structural issues such as staffing and resident outcomes and highlights that the drivers of staffing issues are structural factors such as ownership, chain affiliation and facility size, and that, therefore, these all have a bearing on quality and outcomes for residents. O'Reilly, Courtney and Edwards (2007), writing about the measurement of quality of care in Australia, appear to strongly support the SPO model. They argue (2007, p. 78) that '*sound structures facilitate good processes, which in turn facilitate positive outcomes*', and that feedback from quality indicators should inform decisions on structure and process. However, Donabedian's SPO framework has not been universally accepted by researchers in aged care.

Castle and Ferguson (2010) note that the SPO model was not designed for residential aged care, although they use it to frame a summary of the measurement of quality nursing care in this setting. Similarly, Glass (1991) questions the suitability of using Donabedian's framework because it was developed for acute care, but she offers no other critical analysis of the

model.[31] While Zinn et al (2009) use structural inertia theory as the conceptual framework to link government subsidy payment (a structural variable) with performance failures measured by citations[3233] (an outcome variable), in this study the core independent variables (mission, ownership, technology, market strategy and other organisational attributes) and their relationship with performance fit the SPO structure.

Stevenson et al. (2000) describe a conceptual framework for quality improvement initiatives in nursing homes that is based on a systems approach and uses four interacting dimensions: organising arrangements, social factors, technology and physical setting, however the model does not include a range of variables extensively researched by others, such as ownership, regulatory environment, nursing processes and specific outcome measures. It does not use the SPO relationships, however this framework has not been widely adopted.[34] Rantz and colleagues (2004) provide a multidimensional model to guide nursing home quality using the dimensions of central focus, interaction, milieu, environment, individualised care, staff, and safety. Most, if not all, of the elements in this model can also be found in the SPO model.

In a systematic review of studies on nursing homes performance, Unruh and Wan (2004) examine available models to test the adequacies of the SPO model. They conclude that an SPO model provides the most comprehensive model but propose

[31] Glass (1991) proposes a framework for evaluating residential aged care that has four dimensions staff intervention, physical environment, nutrition/food service and community relations. However, this paper is conceptual only and is not empirically validated, does not categorise the dimensions with clear mutually exclusive criteria and leaves out important factors such as regulation, ownership and environment. Although cited 33 times since publication (Google Scholar, visited 23 March 2014), the model has not been subsequently developed.

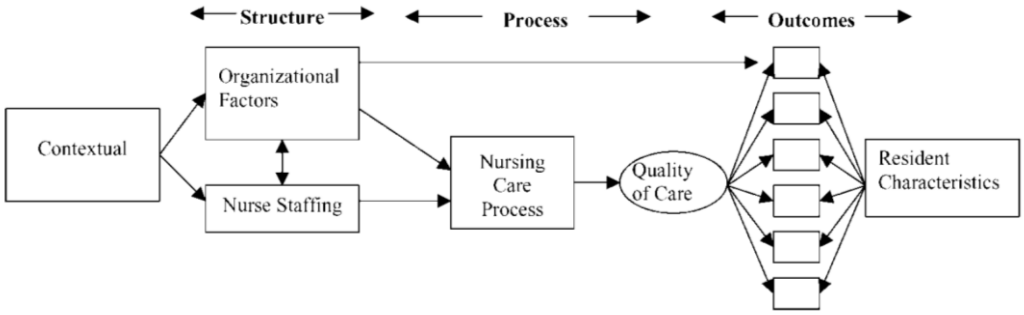
[32] Citations are either money penalties or required action and are equivalent of sanctions applied in Australia when facilities are found on inspection to be substantially in breach of minimum standards.

[33] In this study Zinn and Mor examined the relationship between change of ownership, diversification of services offered, changes to government subsidies, performance of support services (e.g. finance) and size, and performance failure as measured by termination from Medicare and Medicaid programs.

[34] Five citations according to Google Scholar and four according to Medline (visited 22 March 2014).

refinements to overcome perceived inadequacies.[35] These refinements are illustrated in Figure 5. Unruh and Wan's model has been cited by 48 authors (Google Scholar 23 March 2014)[36] as a variation of the SPO conceptual framework.

Figure 5 SPO model of system quality; Unruh and Wan 2004 p. 209



Roh (2012) also advocates refinements to the SPO model in a study that examined the impact of organisational ownership on nursing home quality.[37] He argues that a limitation in the original SPO model has the potential for confusion between indicators that can be used to describe both process and outcomes. He reinforces Unruh and Wan's (2004) argument for the inclusion of environment[38] as an important predictor that was not specifically included in the original SPO model. Roh's (2006) model, Figure 6, links structural factors, process factors and specific environmental factors to service quality, but not to each other.

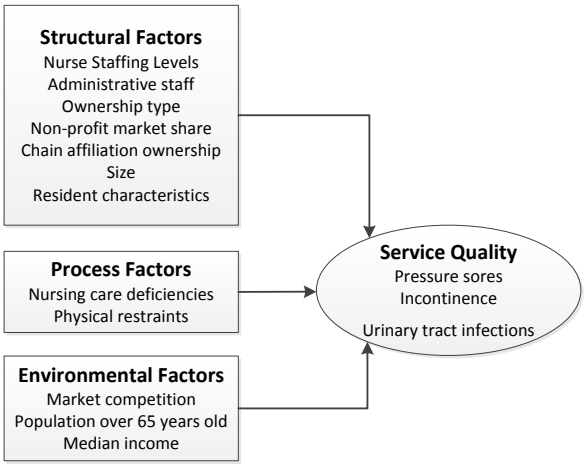
Figure 6 SPO model of nursing home quality: Roh (2006)

[35] These refinements are: the inclusion of contextual factors as a precursor to structural factors, 'nursing staffing' as an additional component to organisational factors under 'structure', a split of process into 'nursing care process' and 'quality of care', and the addition of 'residential characteristics' as an independent variable impacting on outcomes.

[36] For example, Forbes-Thompson (2006) uses this model to evaluate the impact of organisational culture and other factors on resident outcomes, Thompson (2012) to examine quality of care and quality of dying and Goodson (2008) to develop her model of aged care quality using a Bayesian network approach.

[37] Quality was measured by using data on the rate of pressure sores, bladder or bowel incontinence and urinary tract infections.

[38] His environment variables included location, market competition, median income and population over the age of 65 in each county.



Atchley (1991) believes that the SPO model has often been used inappropriately in cross-sectional studies and argues that there is a time element to the relationship between these variables; that is, the structure today may not impact outcomes for some time. She argues that the feedback relations between the variables are important and uses new terms such as 'inputs' for structure, and 'actions/procedures' for process. Inputs include all the factors associated with the organisation (financial, social, physical, environmental and regulatory).

The acceptance of a relationship between structure, process and outcome is supported by some robust research, notwithstanding the well-established arguments by some who propose refinements. The SPO conceptual framework forms the basis for this research, that is, that structural factors have a relationship with process and outcomes. For this reason structural factors should be taken into consideration by policymakers and key stakeholders in making decisions on the future of residential aged care in Australia.

The following section of this chapter reviews the research evidence on the relationship between structural factors and outcomes and performance to investigate the strength and direction of these relationships. A final assessment of this conceptual model, based on the findings of the literature and this research, will be discussed in Chapter 6.

3.3 A review of the literature

The first two research questions for this study relate to the past trends in the residential aged care sector in Australia and the beliefs of elite stakeholders in the importance of structure in future policymaking. The following sections review the literature on structural variables found to have a relationship with the quality and the performance of residential aged care services. The findings from this literature review will guide the selection of data to be analysed for trends in the sector.

3.3.1 Levels of evidence

An investigation into the relationships within the SPO model is limited by the choice of research methods used by the various researchers. The most common research method used in studies of the relationships between structure, process and outcomes is retrospective cross-sectional analysis. No reported experiments using randomised control trials (RCT), or a similar method, were found, although one recent paper claims its treatment of resident data is equivalent to randomisation (Grabowski et al. 2013).

All studies reviewed were assessed for quality using the Oxford Centre for Evidence-based Medicine Levels of Evidence Grades of Recommendation (LOE) (Phillips et al. 2001).[39]

3.3.2 The significance of ownership as a structural variable

3.3.2.1Ownership and resident outcomes

Chapter 2 provided the theoretical background to the study of ownership of residential aged care services and its impact on outcomes and performance. This section reviews the evidence to this theoretical argument.

Systematic reviews of literature published to 2006

[39] Using this framework a high score 1a would be achieved for a systematic review of RCT and a low score of 5 would be applied to 'expert opinion'. Cross-sectional studies were allocated a score of 2b. The table of grades is included in Appendix B.

Three well-regarded systematic reviews on the literature examining the relationship between ownership and performance and outcomes arrive at similar conclusions. Early work by Davis (1991) systematically reviewed USA-based research on residential aged care services from the 1970s and 1980s. He concludes that while some papers show evidence in favour of not-for-profit services on quality, a number were lacking rigour and the evidence was not demonstrated beyond doubt. While a number of studies were in favour of not-for-profit services, he states that *'it would be premature to conclude that non-profit nursing homes provide higher quality care, ceteris paribus'* (Davis 1991, p. 147).

Hillmer and colleagues (2005) completed a systematic review of papers published between 1990 and 2002 which address the question *'is there an association between profit status and the quality of care?'*. This review is particularly valuable as it specifically identifies studies that controlled for extraneous variables; a feature identified by Davis as lacking in earlier studies. Three hundred and sixty-five studies were identified and 38 were selected for inclusion in the study. The bulk of the studies used cross-sectional analysis and the logic for the review was based on the SPO framework (Donabedian 1966). The 38 studies revealed 81 relationships between ownership and quality (Hillmer et al. 2005, p. 144). Only six of these 81 relationships showed better performance by for-profit providers. The reviewers report evidence of systematic differences between for-profit and not-for-profit residential aged care providers and conclude that for-profit facilities appear to provide lower quality of care in many important areas of process and outcomes (Hillmer et al. 2005, p. 158). The apparent strong findings of the review are reduced by the authors' identification of methodological weaknesses in a number of the studies reviewed. Despite these limitations the authors were unequivocal that the general direction of the research is clear; that is, that not-for-profit services provide better care than for-profit facilities.

A third systematic review and meta-analysis was completed by Comondore and colleagues (2009). It analysed a final set of 82 articles published between

1965 and 2006 from over 8,000 identified in the original searches. They set out to *'to examine the quality of care in for-profit and not-for-profit (privately and publicly owned) nursing homes to enhance the evidence base for public policy'* (Comondore et al. 2009, p. 1). The studies analysed included 74 from the USA, 5 from Canada and 1 each from Australia and Taiwan. Four meta-analyses were performed, based on staffing, physical restraint, government regulation and accreditation citations. Of the 74 articles analysed, they conclude that 42 found in favour of not-for-profit facilities, 37 were unclear and 2 reported positive outcomes for for-profit facilities (Comondore et al. 2009). Statistically significant results were identified in the meta-analysis in favour of not-for-profit facilities concerning staffing hours, staffing mix, less use of physical restraint and incidence of pressure ulcers identified in accreditation citations. Like Hillmer and colleagues, the authors comment that the lack of agreed standard definitions on quality of care and methodological weakness in some studies make final conclusions difficult (Comondore et al. 2009). Despite the weaknesses in the studies reviewed, Comondore and colleagues point out that their findings in relation to for-profit facilities are consistent with *'higher risk adjusted death rates in for-profit hospitals and dialysis units as shown in previous reviews'* (2009, p. 14). They conclude that *'this systematic review and meta-analysis of the evidence suggests that, on average, not-for-profit nursing homes deliver higher quality care than do for-profit nursing homes'* (Comondore et al. 2009, p. 1).

Konetzha (2009), in an article reviewing Comondore and his team's study, argues that a failure of many of the studies to control for both socio-economic variables and the level of dependency of the residents in these studies limits the confidence in their findings. These limitations are recurring themes in this literature and reinforce the need for researchers to examine if residential aged care providers are in fact providing the same service to similar residents, for the same price and therefore, can reasonably be compared. More recent research, published after 2006, have controlled for some or all of these issues.

Studies on ownership and outcomes published since 2005

An electronic search of three databases, CINAL, Medline and Pubmed was completed for articles published between 2005 and the end of 2013 using multiple combinations of search terms.[40] Twelve articles with a rating of 2b or above on the Oxford Centre for Evidence-based Medicine Levels of Evidence Grades of Recommendation were discovered that examined the relationship of ownership on quality and outcomes. Table 7 illustrates that eight of these studies took the level of disability of residents into account, seven controlled for socio-economic status of residents and associated income,[41] seven controlled for morbidity, and five took consideration the competitive environment and/or occupancy level of facilities. A summary of these studies is provided in Appendix B.

[40] Search terms included 'ownership', 'for-profit', 'not-for-profit', 'commercial', 'proprietary' in association with 'quality', 'outcomes', for 'nursing homes', 'aged care facilities', 'long term care', 'residential aged care' and 'assisted living'.

[41] This is based on the assumption that residents in the same socio-economic strata desire the same level of quality, or alternatively, lower wealth individuals may demand lower quality care.

Table 7 Studies on ownership showing variables controlled for and published since 2006

Author	Country	Study controlled for Income	Disability	Morbidity	Competition/ occupancy	Comment
Amirkhayan et al. 2008	USA	√			√	
Cai et al. 2011	USA	√	√	√		
Castle & Engberg 2007	USA		√	√		
Clarfield et al. 2009	Israel					
Decker 2008	USA	√			√	
Doupe et al. 2006	CAN		√	√		Poorly controlled
Dwyer et al. 2010	USA	√	√	√		
Ellis & Howe 2010	AUS					Limited but Australian
Gage et al. 2009	UK (ENG)		√			
Grabowski er al. 2013	USA	√	√	√	√	Well controlled
Harrington et al. 2011	USA		√	√	√	
McGregor et al. 2006	CAN (BC)				√	

Controlling for socio-economic variables

Amirkhayan, Kim and Lambright (2008), in a study involving the analysis of accreditation survey data on 14,423 residential aged care facilities across the USA between March 2000 and December 2003, found that the percentage of Medicaid[42] residents was a suitable proxy for facility income; that is, a higher percentage of Medicaid residents results in lower per resident income. It used the online data repository held by Medicare and Medicaid Services, OSCAR, which contains a range of data supplied both by accreditation inspectors and directly by facilities[43]. The researcher's hypothesis was

[42] Medicaid is a means-tested health program in the US for low-income adults, their children, and people with certain disabilities. It is a state-based program and the largest source of funding for medical and health-related services for people with limited income in the USA. In 2010 it funded health care for 67 million US citizens (Centres for Medicare and Medicaid 2012).

[43] OSCAR is the Online Survey, Certification and Reporting data repository held by the Centres for Medicare and Medicaid Services (CMS); an agency of the US department of Health and Human Services. 'OSCAR is a compilation of all the data elements collected by surveyors during the inspection survey conducted at nursing facilities

'*compared to public and for-profit ownership, not-for-profit ownership is positively associated with nursing home quality of care*' (2008, p. 331). They found that '*For-profit nursing homes have significantly lower care quality compared to public and not-for-profit nursing homes. … not-for-profit and public facilities were not statistically different … The effects of ownership persisted even after controlling for essential organisation and environmental characteristics such as size, staffing and revenue levels*' (Amirkhanyan, Kim & Lambright 2008, p. 345). Similar results were found in a large and robust study by Cai and colleagues (2011) on the differences in hospitalisation rates for 67,256 Medicaid-funded nursing home residents in 545 facilities in New York State while controlling for income.

Gage et al. (2009) studied inspection reports of 258 facilities in one county in England and took into consideration the level of publicly funded residents in these facilities, because these residents generate lower income for the facility than privately funded residents. The findings by Gage et al were that small, for-profit facilities with lower income in one county in England had a higher probability of failing a standard on inspection than comparable not-for-profit facilities. Dwyer and colleagues (Dwyer et al. 2010) examined the incidence of poly-pharmacy (concurrent use of nine or more medications[44]) in 13,500 nursing homes in the USA and controlled for disability levels,

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for the purpose of certification for participation in the Medicare and Medicaid programs. OSCAR is the most comprehensive source of facility level information on the operations, patient census and regulatory compliance of nursing facilities' (American Health Care Association 2012).At least every 15 months state-based survey agencies conduct onsite evaluations of all nursing home and the findings are entered into the OSCAR database. These data include operational characteristics and aggregate patient characteristics for each nursing home. Surveys are made against 179 specific standards in 17 major categories: (1) resident rights; (2) admission, transfer, and discharge rights; (3) resident behaviour and facility practices; (4) resident quality of life; (5) resident assessment; (6) quality of care; (7) nursing services; (8) dietary services; (9) physician services; (10) rehabilitation services; (11) dental services; (12) pharmacy services; (13) infection control; (14) physical environment; (15) administration; (16) laboratory; and (17) other. The data are considered to be accurate as the findings of the surveys can be subject to review and deficiency certifications to appeal (Amirkhanyan, Kim & Lambright 2008; Harrington et al. 2000).

[44] Polypharmacy is used as a quality indicator as the risk of adverse events due to the interactions between drugs that may not be anticipated or predictable increase with the number of medications administered.

morbidity and income. They found that the odds of receiving poly-pharmacy were higher in a small for-profit facility.

Ellis and Howe's (2010) paper is of interest because it is Australian and is one of the few studies published in this country which addresses the relationship between ownership and quality. It analyses the characteristics of residential aged care facilities across Australia that have been the subject of a sanction issued by the Department between 2000 and 2008 for failing to meet minimum standards. They found that residential aged care facilities are more likely to be sanctioned if they are operated by for-profit providers.

Doupe and colleagues (2006) in Manitoba, Canada, used data on six resident outcome indicators and four indicators related to medication errors after adjusting for resident characteristics. They found poorer service quality was more likely to occur in for-profit facilities. McGregor and colleagues (2006) examined 15,519 hospital admissions between 1996 and 1999 in British Columbia, Canada, to link aged facility ownership type with hospital admissions and mortality rates. Overall in this study, for-profit facilities produced higher adjusted hospitalisation rates for selected diseases and incidences compared with not-for-profit facilities.

Two of the most published researchers on structural issues in aged care in the USA are Charlene Harrington (Harrington 2005, 2007; Harrington et al. 2005; Harrington, Mullan & Carrillo 2004; Harrington, Olney, et al. 2011; Harrington & Swan 2003; Harrington et al. 2008; Harrington et al. 2001; Harrington et al. 2000) and Nicholas Castle (Castle 2000, 2002; Castle 2012; Castle, Barry & Vincent 1997; Castle & Engberg 2005; Castle & Engberg 2006; Castle & Engberg 2007; Castle & Shea 1998). Both have compared ownership with a range of other variables and with a particular focus on staff and staffing levels. A number of their papers published prior to 2006 were included in the Comondore systematic review (Castle 2000, 2002; Castle & Engberg 2005; Comondore et al. 2009; Harrington & Swan 2003; Harrington et al. 2001). Since then they have both published material on ownership and quality. Castle and Engberg (2007) analysed data from a survey of administrators and from OSCAR

for a random sample of 40% of facilities (n=1540) in six states of the USA. They reported that for-profit facilities were associated with lower quality services, compared with not-for-profit facilities, after allowing for differences in mortality and disability.

Harrington et al.'s (2011) most recent and very large study compared records on staff (n=86,618) and deficiencies awarded by nursing home inspectors (n=87,057) on all nursing homes in the USA (n=17,316) by ownership group for the period 2003 to 2008. They then identified the largest 10 for-profit owners, who provide care to about 14% of all residents in the country. The top 10 aged facility chains received 36% higher deficiency citations by state government inspectors and 40% higher serious deficiencies than government facilities. Other for-profit facilities also had higher total deficiencies and serious deficiencies and these findings are consistent with previous studies (Banaszak-Holl et al. 2002; Harrington, Mullan & Carrillo 2004; Harrington et al. 2001; Kim, Harrington & Greene 2009; O'Neill et al. 2003). Despite relatively minor methodological limitations, this remains a powerful and important study because it measures the changes in quality performance of facilities after they have been purchased by a large for-profit provider.

Another powerful study examining trends in the performance of nursing homes whose ownership changed is that of Grabowski and Stevenson (2008). It used multiple regression analysis based on records of 16,100 nursing homes housing 1.5 million residents between 1998 and 2004. During that time 1,151 facilities converted from for-profit to not-for-profit, 1,019 from not-for-profit to for-profit and smaller numbers converted to and from government ownership. Facilities converting from not-for-profit to for-profit generally had deteriorating performance after conversion, while those converting from for-profit to not-for-profit generally exhibited improvement in performance. Performance was measured by quality improvement data collected by inspectors and available from the OSCAR database. The researchers conclude that:

> *Policy makers have expressed concern regarding the implications of ownership conversions for nursing home performance. Our results imply that regulators and policy makers should not only monitor the outcomes of nursing home*

> *conversions, but also the targets of these conversions (Grabowski & Stevenson 2008, p. 1184).*

If these findings were to be applied to the Australian sector then they have important implications for government decision-making in the transfer of approved places between ownership types.

More recently, in a large and well-controlled study, Grabowski and colleagues (2013) used a novel approach to mimic randomisation of 874,143 residents newly admitted to 13,980 nursing homes within an 18-month period in 2004 and 2005. The study estimated the impact of ownership on the quality of post-acute care. Quality was measured by change in activity of daily living (ADL) functioning, mobility, pain status and re-hospitalisation within 30 days. It controlled for demography, morbidity, medications and cognition. At the facility level it controlled for occupancy rate, size, urban/rural status, chain membership, income, poverty rate and state effects. The study reports that people admitted to non-profit facilities from hospital are less likely to be re-admitted to the hospital within 30 days, and more likely to experience improved mobility, pain status and ADL functioning. Grabowski et al. report that *'admission to a non-profit is associated with between 9.5% and 19.9% better quality relative to admission to a for-profit'* (Grabowski et al. 2013, p. 18).

This literature review indicated that in most studies the not-for-profit residential aged care services provide higher quality care services than the for-profit services.

3.3.2.2Ownership and efficiency and financial performance

Ownership has been identified as an independent variable in a number of studies into the financial performance and efficiency of residential aged care providers. In Australia efficiency becomes largely a measure of the capacity of the operators to minimise costs, because of the limits placed on how much they can charge the resident for care. If one or other category of provider can be identified as consistently and inherently more efficient, without deterioration in resident outcomes, then this finding could be an

important contribution for future Australian government policy. However the pursuit of efficiency is often associated with an impact on other competing goals such as access and quality. The findings of the relationship between ownership and relative efficiency in Australia is discussed below and the relationship between efficiency and access is discussed in section 2.5.

The 2004 Review of Pricing Arrangements into Residential Aged Care (Pricing Review) in Australia commissioned an analysis of the efficiency of the residential aged care industry (Hogan 2004). The analysis was undertaken by the Centre for Efficiency and Productivity Analysis (CEPA) at the University of Queensland.[45] This analysis reports that for-profit services 'performed best' on efficiency measures, that services in 'rural and remote locations' had lower efficiency, and that there is *'limited scope for production gains from economies of scale'* (Rao, Coelli & O'Donnell 2003). In a second report commissioned by the same Pricing Review, the Allen Consulting Group, (2003) argue that because not-for-profit service providers have the advantages of favourable taxation concessions and the absence of a requirement to pay dividends to shareholders, they should be, ceteris paribus, more efficient than for-profit service providers. To compensate for this favourable tax treatment they argue that there should be a social benefit, such as different or better services, provided by the not-for-profit sector.

This report acknowledges the contribution of the not-for-profit sector in providing services in rural and remote locations, targeting special groups and in achieving a higher standard of care as measured by accreditation assessments (Allen Consulting Group 2003, p. 6). It makes the case that not-for-profit providers may be serving a different market than the for-profit providers, at least in some locations. However, it acknowledges that the 'social benefit' is difficult to estimate (Allen Consulting Group 2003, p.

[45] This analysis was based on the financial returns collected by a sample of 675 residential aged care facilities; 20% of all facilities in Australia (Allen Consulting Group 2003), however the sample was not randomly selected and some types of homes are not well represented.

7) and concludes that the financial analysis undertaken by the Pricing Review reveals that not-for-profit facilities 'cost more to run on average' than for-profit facilities and that this additional cost could be more than $250 million per year.

In the final report of the Pricing Review, Hogan writes that there is a:

> *high level of technical inefficiency in [Australian] residential care but with variations between jurisdictions, locality, ownership categories and chain affiliation. Efficiency scores based on ownership showed the highest score for for-profit services (0.89), a medium range for not-for-profit services (0.84 and the lowest for government owned facilities (0.75) (2004, p. 74).*

Hogan particularly notes that 'for-profit services are over-represented amongst the group of best practice services [sic], which define the production frontier of efficient practice' (2004, p. 74).

He asserts that this is supported by the international literature but provides no review of the research evidence to support this statement. However, in a footnote on the same page he makes the claim that:

> *it is important to note that the greater efficiency of for-profit facilities is not explained by a diminishment in the quality of care (2004, p. 75).*

This claim is contradictory to the findings, discussed above, of the Allen Consulting Group (2003) - a report Hogan commissioned - which identifies superior outcome performance by the not-for-profit sector. Furthermore, the local and international literature reported in the previous section of this chapter, and much of it available to Hogan prior to 2004, does not support his claim on this point.

In a cross-sectional study of a 10% random sample of 14,307 nursing homes in the USA, DeLillis and Ozcan (2012) examined the OSCAR database, data from the US Bureau of Labour Statistics and data from the US Bureau of Economic Analysis, to estimate the relative efficiency of residential aged care homes based on facility characteristics. They used the Data Envelopment Analysis

(DEA)[46] and report higher average efficiency scores for homes in urban areas, locations with a higher level of competition and higher incomes, and in not-for-profit and government-owned facilities. They also compare quality scores derived from the OSCAR data and determine that homes scoring higher on quality correlated with higher efficiency.

Two small European studies also used DEA to assess relative efficiency. In the Lombardy region of Italy researchers assessed the performance of 40 nursing homes (Garavaglia et al. 2011) and in a study in Finland 64 residential aged care facilities were similarly examined (Björkgren, Häkkinen & Linna 2001). The Lombardy region is unique in Italy as it is the only area where health care is organised as a 'quasi-market', where the local authority purchases services from providers (Garavaglia et al. 2011). The researchers claim that private homes (for-profit and not-for-profit non-government facilities) are more efficient than government homes. The finding that government-owned services have a potential to significantly improve their efficiency as reported by Garavaglia in Italy and Hogan in Australia, is also supported by the Finnish study (Björkgren, Häkkinen & Linna 2001).

A longitudinal study (Weech-Maldonado et al. 2012) of financial data on 11,236 nursing homes between 1999 and 2004 reports that for-profit nursing homes in the USA delivered better financial performance than not-for-profit services. Similar results are reported for Australia. The Aged Care Financing Authority (2013) reports that for-profit providers have the highest financial returns of all provider types and have proportionally more providers in the top quartile in relation to financial performance, and KPMG (2013a) reports that for-profit providers in Australia in 2012 had financial returns of 10.5% while not-for-profit providers reported 4.5%.

This review of the literature on the relationship between ownership and efficiency, and ownership and financial performance, revealed a strong

[46] DEA is a non-parametric linear programming technique used to determine technical efficiency of decision-making units using quantities of inputs and outputs (Björkgren, Häkkinen & Linna 2001). It is an established methodology and similar to that used by CEDA on behalf of the Pricing Review, cited above.

association between these variables; that is, for-profit services are more technically efficient and more profitable than not-for-profit services.

3.3.2.3Ownership and size

Internationally, for-profit residential aged care facilities tend to be larger than not-for-profit facilities. Tannous and Luo (2006) report that for-profit residential aged care services in Australia were more likely to be larger than not-for-profit facilities and this finding is consistent with Hogan's findings, that for-profit operators are more likely to own facilities with more than 80 beds (Hogan 2003). Ellis and Howe (2010) found that small for-profit facilities in Australia are the most likely of all size and ownership categories to be issued with sanctions for failing to meet minimum standards. Amirkhayan (2007) reports that publicly owned facilities in the USA are smaller on average than those operated by the private sector. This finding is consistent with that of Harrington (2001) who found, in a study of 13,693 nursing homes, that for-profit facilities are larger than not-for-profit facilities, and these in turn are larger than government-owned facilities.

Conversely, in Canada, Berta (2006) found that government-owned facilities are significantly larger than for-profit and not-for-profit facilities, and facilities owned by religious organisations are significantly larger than for-profit and other not-for-profit facilities. No significant difference was found in the size of facilities based on ownership among a sample of 127 nursing home in Israel (Clarfield et al. 2009).

While there are some differences in Canada and Israel, international studies suggest that for-profit services are larger than not-for-profit services and this is reflected in the Australian aged care sector.

3.3.2.4Ownership and staffing

The research findings from a number of countries indicate that ownership, as a structural component of the aged care industry, is an important independent variable in relation to staffing, and through staffing, to resident outcomes.

In a number of these studies the level of staffing of nurses is measured in hours of potential care, the mix of and education of nursing staff in residential aged care facilities, and has been identified as varying with ownership type. Staffing levels and mix have also been shown to influence performance and outcomes, and staffing culture and climate, as the following review indicates.

In the first of two studies, of 13,693 facilities in all 50 states in the USA (Harrington & Swan 2003; Harrington et al. 2001), the researchers found that nursing staff hours (for both registered nurses and assistants in nursing) were lower in for-profit facilities after controlling for case mix, including disability levels. Harrington found that for-profit facilities in California had lower staffing rates than not-for-profit and government-owned facilities (Harrington & Swan 2003). They also identified that the quality of care in for-profit facilities across the USA was correlated with a lower level of staffing and was poorer than in comparable not-for-profit facilities. These findings build on earlier research that linked lower levels of nursing care with an increase in the number of deficiencies in quality identified during inspections (Castle 2000; Castle & Shea 1998; Cohen & Spector 1996; Harrington et al. 2000; Hendrix & Foreman 2001).

A study of long-term care facilities across Canada found that '*total direct care staffing levels are significantly higher in government-owned and not-for-profit facilities across all regions*' (Berta et al. 2006, p. 191) than in for-profit homes. Two other Canadian studies produced the same result (Doupe et al. 2006; McGregor et al. 2005). In Israel, Clarfield (2009) found that not-for-profit facilities had higher staffing levels in all professions and in Finland Heponiemi et al. (2011) found that not-for-profit facilities had higher staffing levels than publicly funded nursing homes. In Australia a similar result was found by Martin (2005) who report that for-profit services had one direct care staff member to every 4.2 beds and not-for-profit services one direct care staff member for every 2.6 beds. Although completed over 12 years earlier, two other Australian studies (Pearson et al. 1992,

1993) also found higher staffing levels in not-for-profit residential aged care services.

The relationship between staffing levels and quality care has been investigated on numerous occasions and found to be positive (Castle 2000, 2002; Castle & Engberg 2005; Castle & Engberg 2006; Castle & Engberg 2007; Castle & Shea 1998; Cohen & Spector 1996; Davis 1991; Grabowski 2001; Harrington & Swan 2003; Harrington et al. 2000; Kim, Harrington & Greene 2009). However, these findings have been qualified, to some extent, by a systematic review conducted by Spilsbury and colleagues (2011) who found that staffing mix, turnover, use of agency staff, training and experience of staff are important factors in relation to performance and resident outcomes, but these relationships are not strong. Commenting on this finding, Castle (2012) makes the point that this conclusion is reasonable, since there are major challenges related to research in this area. These challenges arise from the difficulty of matching facility and resident characteristics, interpreting how staffing levels relate to the actual amount of care given and the lack of consensus within the research community on how to measure quality.

The international studies suggest that staffing levels are related to quality and that not-for-profit services tend to have higher levels of direct care staffing, which may partially explain better resident outcomes and quality of care reported above. However, the complex array of variables associated with staffing levels, mix, skills and performance are difficult to control in evaluating the quality of resident care.

3.3.2.5Conclusions on the impact of ownership on performance and outcomes

If a definitive answer to the question as to whether residents in aged care facilities owned by not-for-profit providers have a better chance of receiving quality care and better outcomes than residents in facilities owned by for-profit providers was to be based solely on the number of authors who have claimed that finding in their research, then an affirmative answer is beyond doubt. The systematic review by Comondore and colleagues (2009) and

the robust literature reviewed since then (Amirkhanyan, Kim & Lambright 2008; Cai et al. 2011; Decker 2008; Dwyer et al. 2010; Grabowski et al. 2013; Harrington, Hauser, et al. 2011), appear to indicate that there is a strong but not definitive relationship between ownership and quality, particularly in the USA where the bulk of this research was completed. The comparison between the residential aged care sector in the USA and Australia, provided in Chapter 2, suggests that the USA findings should not be ignored by Australian aged care policymakers. It seems reasonable to conclude that the research has shown a sufficient association between ownership and performance and outcomes to support the validity of the SPO conceptual framework reported above.

3.3.3 Size of residential aged care services, outcomes and performance

The following section reviews the literature on the relationship of size (measured by the number of beds in a facility under study[47]) and dependent variables that measure resident outcomes, quality of care, quality of life, regulatory compliance, financial performance and efficiency. Although a larger number of studies report that they collected data on size, only 44 articles were found that report a relationship between size, service performance and quality. Of these, four found no significant relationship between size and quality, 31 found a relationship and provided sufficient detail on bed size and results to enable comparison and the remaining 9 reported a relationship but not in a way that the results can be compared with other studies. The 31 studies with comparable results are charted in Figure 7 on page 74. Details of the individual studies are listed in Appendix B.

3.3.3.1The relationship between size and quality

Following his systematic review of the early literature Davis (1991, p. 138) was of the view that facility size may act as a moderator variable and that

[47] Castle (2010) suggests that the number of beds in a facility is a 'crude indicator' because of the variety of different units within many facilities. However it remains a commonly collected and reported statistic.

researchers should '*consider the potential influence of facility size when assessing quality differences*'. Several more recent studies with designs that controlled for other variables have reported relationships between size and outcomes.

Outcomes and quality in small and very small facilities

In Surrey, England, a correlation between 'small' nursing homes (mean number of beds 31.4 SD 18) and quality violations was found for homes surveyed for the first time under new standards in 2003 and 2004 (Gage et al. 2009). A similar study in Australia (Ellis & Howe 2010) found that facilities with fewer than 60 beds had a statistically significant higher chance of being sanctioned for failure to meet minimum standards, than facilities in size range of 60 to 100 beds.[48] Phillips et al. (2005) found Medicare expenditure was higher for residents of facilities with more than 73 than on those in smaller facilities and speculate that smaller facilities are better at detecting health deterioration and instituting early intervention than larger facilities. In a later study, Phillips and Guo (2011) found more complaints in facilities of more than 55 beds.

The outcomes for residents of small group living units have been compared with larger (traditional) sized facilities in a small number of studies and the results are inconclusive. Kane et al. (2007) report a strong positive association between quality of care and quality of life in a longitudinal study when comparing small-scale 'green houses' with traditional aged care facilities. Using a quasi-experimental design in their study, de Rooij and colleagues (2012) found small positive changes in quality of life scores for residents in facilities with between 6 and 20 beds compared with larger facilities. Using a similar design, te Boekhorst et al. (2009) report positive differences in ADL for aged care residents, but none for cognitive

[48] However, in Australia at that time facilities with 60 to 100 beds represented only 26% of all facilities whereas facilities with fewer than 60 beds represented 60% of all beds, and this distorted distribution may reduce the significance of the findings.

or behavioural indicators. Verbeek (2011; Verbeek et al. 2009; 2010) found no difference in resident outcomes in smaller facilities compared with larger facilities.

Quality in moderate sized facilities with fewer than 100 beds

Pearson and his team (1992), in an Australian study that controlled for level of dependency of residents, report that there are positive relationships between the variety of outcome measures, and services with 40 to 80 beds. In Canada, Bravo (1999) investigated 88 facilities in Quebec, with an average size of 29 beds (maximum 241, SD 41.9), and found lower quality of care in 'larger' facilities.

In an early study, Riportella-Muller and Slesinger (1982) report that smaller homes (<100 beds) have fewer deficiencies, a finding supported in later studies. Harrington and colleagues (2000) found that facilities with fewer than 119 beds are less likely to have quality of life and quality of care deficiencies, which was confirmed in a later study (Harrington, Olney, et al. 2011). Amirkhanyan, Kim and Lambright (2008) also identified a small association between larger organisations (>90 beds) and more quality deficiencies.

Harrington and colleagues (2001; 2000) found that smaller facilities (with fewer than 119 beds) were less likely to have deficiencies discovered on inspections than larger facilities; and in the 2001 study that for-profit facilities with more deficiencies were 'larger'. Based on resident outcomes, Rantz et al. (2004) found consistently 'good' nursing homes had a mean size of 60 beds. The authors speculate that in smaller facilities the residents are more likely to be known to the staff and to be associated with group and team processes. A recent study reported that the odds of receiving poly-pharmacy was statistically greater in facilities with fewer than 100 beds (Dwyer et al. 2010).

Quality in facilities with more than 100 beds

O'Neill and colleagues (2003) found that facilities of more than 100 beds had significantly more deficiencies than smaller facilities, and this finding

was replicated by Banaszak-Holl et al. (2002) when examining quality in nursing homes following acquisition by large chains. Flynn et al. (2010, p. 2404) report that larger *'facility* size [> 150 beds] *was the only facility characteristic associated with higher deficiency citations'*. Kamimura and colleagues (2007) report that total deficiencies and pressure ulcer prevalence were higher in facilities of more than 100 beds. Castle and Engberg (2005; 2007) report that facilities with more than 60 beds have fewer deficiencies, and subsequently found a significant association between larger facilities (over 100 beds) and low quality of care using a composite of outcome and care indicators. In contrast with the above findings, Castle (2000, p. 1159) found that larger facilities with an average bed size of 107 (SD of 72), are more likely to decrease their restraint use. Similarly, a study of 164 Texan residential aged care facilities (Anderson, Issel & McDaniel Jr 2003, p. 20) report a relationship between a size greater than 113 beds with less frequent use of physical restraint and lower prevalence of aggressive behaviour in residents. Zinn and colleagues (2009) found that nursing homes with more than 100 beds were 63% less likely to fail assessment of minimum standards than smaller facilities. This result is supported by a large study of 17,000 facilities in the USA which found that larger facilities (> 110 beds) were associated with a lower chance of having a citation for abuse of residents.

Castle and Shea (1998), in a study of mental health care for aged care residents, found no relationship between facility size and quality. Kane's (2004) early exploratory study of a non-representative sample found quality of life improvements were not related to facility size. In a study comparing quality of life and care between assisted living facilities and nursing homes, the researchers (Zimmerman et al. 2005) found a difference between the two but no relationship with size. Finally Richardson (2006) found that both large and small residential aged care providers in Australia were highly effective in compliance with the regulated outcome standards.

Given the variable findings in relation to bed numbers and quality resident indicators, the evidence linking facility size with quality is inconclusive,

although tends to lean in favour of moderate sized facilities with fewer than 100 beds.

3.3.3.2The relationship between size and performance

The study by Garavaglia et al. (2011) of efficiency in Italian nursing homes suggests that facilities with 60 to 100 beds are the most efficient, although their sample size was small and the uniqueness of the regulatory arrangements in Lombardy makes generalisation to the rest of the country challenging. A study in Finland claimed that efficiency increased with the number of beds up to 50 beds (Björkgren, Häkkinen & Linna 2001). In Australia, Rao, Coelli and O'Donnell (2003) estimate that facilities with the size range 61-90 beds are the most efficient. These patterns persist, with a survey of 700 residential aged care across Australia reporting that facilities in the 76-100 bed range have the highest profitability (Grant Thornton 2009).

Similar to research findings in relation to facility size and service quality, there are conflicting findings in relation to facility size and performance. Weech-Maldonado and colleagues (2012) found that services in the USA with more than 120 beds had the highest profitability. In contrast, Delillis and Ozcan (2012) found that facilities in the USA with more than 110 beds were more inefficient. The larger the facility the more risk there is of consumer complaints about service quality. Johnson et al. (2004) found that the larger the facility (>100 beds) the more likely they are to be sued in courts over care issues, and Allen, Kellett and Gruman (2004) found larger facilities (>120 beds) have more complaints lodged with the ombudsman's office.

In summary, these studies found no significant relationship between size and performance.[49]

[49] McGregor et al. (2011; 2005; 2010; 2006) include size of facility as a variable in studies on nursing homes in Canada when investigating differences in ownership, hospital transfers and staffing levels, and report no difference in performance based on size.

3.3.3.3Conclusions as to the importance of size as a variable

Of the 44 studies reviewed, four studies indicated no relationship between facility size, performance and service quality, nine included size but did not report a relationship between size and quality or performance, and 31 reported a relationship between size and quality or performance. Comparing these findings is challenging because inconsistent language was used by the various researchers to describe bed size categories (e.g., smaller, larger), and there was wide variation in the average size of facilities in the samples across the studies.

To provide a visual comparison of the reported relationship of aged care facility size, performance, service quality and resident outcomes, the 31 studies with sufficient data and details to warrant inclusion have been charted graphically in Figure 7. The studies are grouped by the area of research interest in the study: resident outcomes, quality of care and quality of resident life, composite scales (of outcomes and quality), regulatory compliance and performance (financial performance, efficiency and legal history). Where a study reports findings for 'larger' or 'smaller' facilities, without specifying the bed range, the 'most favourable' range was estimated from the mean of the bed sizes in the sample[50] and the standard deviation. The 'boxes' used in this figure indicate the range of the beds reported as most favourable in the study.

Analysis of studies suggests that the smaller half of the sample showed the most favourable results; but not for all studies. The findings by Wagner et al. (2006) of more favourable results in facilities with more than 150 residents in the Netherlands is inconsistent with the other studies on outcomes. This study must be considered an outlier due to the much larger average size of residential aged care services in that country, compared with

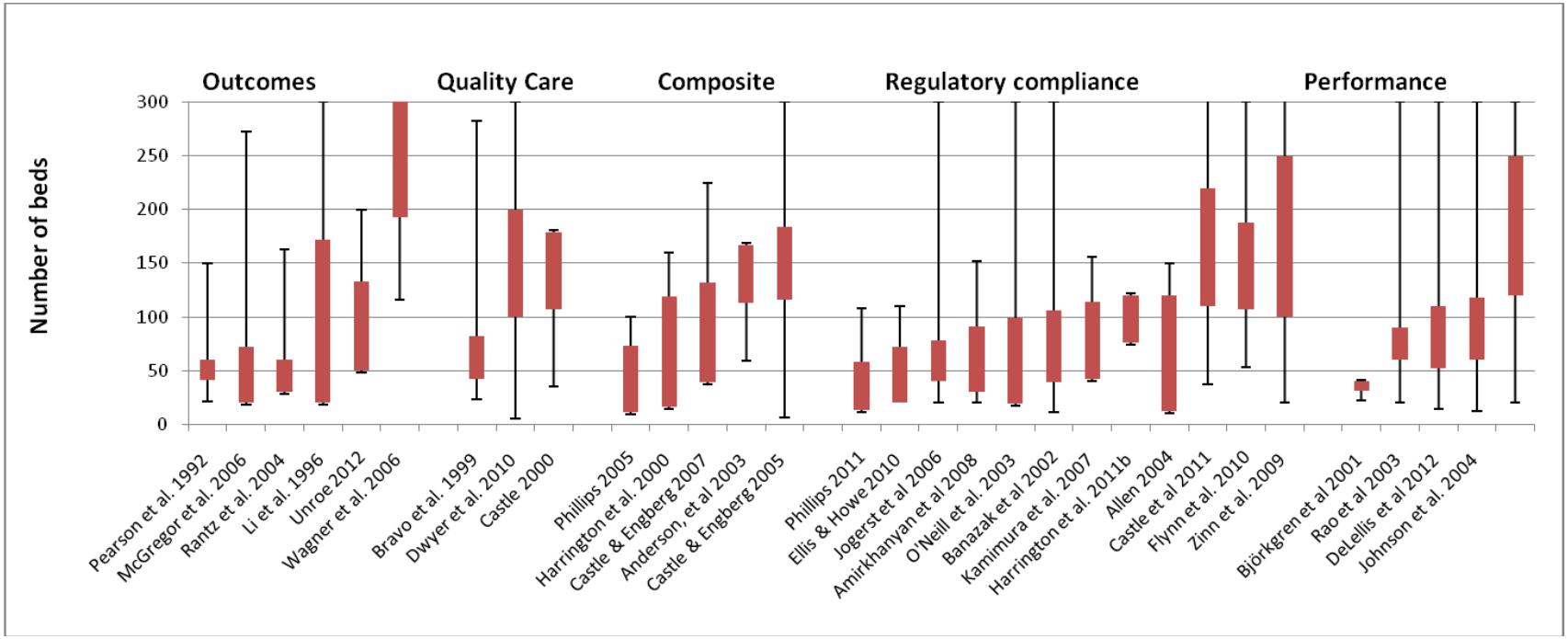
[50] For example O'Neill et al. (2003) report a statistically significant relationship between size and a higher chance of a regulatory violation where the mean size was 90 beds in a sample of 14,400 beds and report that larger facilities had more violations. Thus the 'more favourable' result is with facilities with fewer than 90 beds and this is depicted in Figure 7.

the average size of the services in the other studies that reported more favourable findings from small services in Australia, USA and Canada.[51] The studies that reported findings based on measures of quality of care and resident quality of life, and composite measure of both outcomes and quality, also do not present a consistent result on bed size; four studies report more favourable results with facilities of more than 100 beds and four studies report favourable results with the majority of facilities of less than 100 beds.

However, the studies on regulatory compliance (measured as failures to meet minimum standards which results in government action) demonstrate a more consistent picture. Nine of these studies show more favourable results in facilities with fewer than 100 beds and only three studies showing similar results in facilities of more than 100 beds. A similar picture emerges from the studies on performance where one convincing study suggests that services with more than 100 beds yield better financial results, while studies with weaker findings suggest that smaller sizes yield more favourable results in terms of efficiency.

[51] The reported average size of residential aged care services in selected countries is provided in Table 6 on page 47.

Figure 7 Range of beds with most favourable results: quality or performance (n=31)[52]



[52] For graphical purposes the top of the range has been trimmed at 300 beds although six papers report larger facility sizes in their samples (DeLellis & Ozcan 2012; Flynn et al. 2010; Jogerst et al. 2006; Johnson et al. 2004; Li et al. 1996; O'Neill et al. 2003). Where a minimum number of beds (e.g., 'less than 30 beds') was not provided, a minimum of 20 was adopted for purposes of charting. Not shown in this chart are papers that did not provide sufficient data on means, medians, standard deviations and ranges to enable data to be graphically displayed. Details of studies included in Figure 7 and those not included and why they were not included are provided in Appendix B.

3.3.4 Chain affiliation, outcomes and performance

While the interest in the formations of chains of nursing homes has been at its most intense in the USA, there is also interest in other countries such as Australia (dela Rama 2006; Hogan 2004), the UK (Gage et al. 2009) and Canada (McGregor et al. 2006).

Harrington and her colleagues found that: chain affiliation in the USA predicted more than 10% of the additional deficiencies found in for-profit facilities (Harrington et al. 2001); that states with a higher percentage of chain-operated nursing homes are predictive of higher levels of enforcement of penalties for deficiencies in quality on inspection (Harrington, Mullan & Carrillo 2004); and that facilities in the 10 largest for-profit chains have lower registered nurse and total nurse staffing hours than comparable facilities, and that these chains receive 35% more deficiencies and 41% more serious deficiencies than other facilities (Harrington, Olney, et al. 2011). Castle reports that use of physical restraint is higher in facilities owned by a chain (Castle 2000; Castle & Engberg 2005). Kamimura (2007) reports that health deficiencies (but not pressure ulcers) are lower in chains with greater overall corporate standardisation in the USA, and suggests this finding indicates that the negative effects of chain affiliation can be overcome.

Johnson et al. (2004) found that facilities owned by chains also have a statistically significant higher chance of law suits than non-chain facilities. Hogan (2004) found no difference in the efficiency scores between facilities in a chain or not in a chain in Australia,.

A sub-category of for-profit facilities is those owned by private equity firms. The concern with the use of private equity investments in residential aged care facilities is the short-term nature of the investing activity and the focus on the capital value of the investment, rather than the value of the business as a continuing entity. An exploratory study by dela Rama and colleagues (2010) reports an increasing, although not always transparent, presence of private equity firms in the Australian residential aged care sector. Harrington and her team (Harrington, Hauser, et al. 2011; Harrington, Olney, et al. 2011) studied the top

10 private equity owned facilities in the USA and conclude that they have lower registered nurse staffing hours, 36% higher deficiencies and 41% higher serious deficiencies against standards than government-owned facilities (after controlling for other factors such as resident characteristics), and the number of serious deficiencies increased in facilities after they were purchased by private equity chains. A similar result was observed by Stevenson and Grabowski (2008) but their findings had lower significance scores than Harrington's study. They note that ownership of residential aged care facilities by private equity firms raises questions of investor experience in residential aged care, transparency and accountability and the short-term timeframes of the financial arrangements.

These findings suggest a continuing concern with the development and management of large chains of facilities in residential aged care. There is a consistent pattern of lower staffing levels in chains which may be a proxy indicator of a poorer level of care. The strength of this evidence suggests that this is a valid area for further scrutiny of the Australian residential aged care sector as some providers have an interest in producing larger chain-affiliated services.

3.3.5 Australian research on facility structure, quality and performance

The early work of Braithwaite and colleagues in researching the use of quality inspections and the regulatory framework surrounding nursing homes in Australia (Braithwaite 1998, 2001; Braithwaite & Braithwite 1995; Braithwaite et al. 1993) has arguably had an impact on the subsequent development of the system of standards and regulation in Australia. Of particular note to this research is the study on the reliability of nursing home inspections against standards in Australia in 1987 (Braithwaite & Braithwite 1995). In this study the authors found that the regime of nursing home inspection in Australia had a high level of inter-rater reliability despite criticisms that the standards were too broad, and a much higher reliability rate than comparable systems in the USA. The authors concluded that the regulatory system should opt for standards that are simple and few in number, be resident-centred and outcome-oriented and that the 'regulatory pyramid' should commence with dialogue and discussion reinforcing strengths and use punishment as a last resort. There are no known studies published more

recently of inter-rater reliability within the Australian accreditation system. They have also researched the aged care industry's response to regulation (Ayres & Braithwaite 1992), compared regulatory mechanisms for accreditation and quality measurement in three countries (Braithwaite 1998) and the challenges to of regulating aged care in Australia (Braithwaite 2001).

The substantial body of work was bought together in a monograph (Braithwaite, Makkai & Braithwaite 2007) in which the authors record a detailed development of the regulatory system applying to the residential aged care industry in Australia and compare it with the USA and the UK. They conclude that the development of broad, outcomes based accreditation standards where inspectors are professionally trained has been a strength of the Australian system and superior in many respects to that of the other countries (Braithwaite, Makkai & Braithwaite 2007 Chapter 6).

This cumulative work of Braithwaite and colleagues makes a number of observations concerning competitive markets for residential aged care, which they apply to the residential aged care sector in Australia. They argue

(Braithwaite, Makkai & Braithwaite 2007 Chapter 8) that market mechanisms fail in the market for nursing homes for four main reasons. First, because so many of the services and goods residents would normally choose for themselves (food and drink, recreation, furniture etc.,) are bundled in a residential aged care service and choice is taken away from the individual consumer who can only choose between one bundled service and another. This severely limits the capacity of markets based on the quality of care to operate and may result in a consumer 'putting up' with care service quality limitations because other elements of the service (location, food, home-like environment etc.,) are acceptable to them. Second, without a validated assessment measure, good quality care is hard to judge, document and compare with a 'gold standard', with the result that the consumer's and carer's purchasing choice, based on care, can be challenging. That is, the market for residential aged care does not operate in the way other markets for consumer goods operate.

The authors also argue that the evidence suggests the cost of moving from one home to another, which would normally be a mechanism consumers choose when faced with unacceptable quality, is too high for consumers, both in terms of stress and

complexity involved. This means that consumers may stay in a poor quality service rather than risk the negative impacts of moving. Consequently, in this aged care sector there are limits to the usual signals of good or poor quality services that would be available in other markets. Braithwaite, Makkai & Braithwaite (2007)) also highlight the limitations on 'league tables' to assist consumers to make purchasing decisions, although on balance they suggest the evidence is in support of comparative measure to assist choices by consumers and carers.

Finally they argue that the absence of contestability within the market for aged care limits the degree to which true completion can be established. They conclude with their theory of regulatory ritualism and argue for a new paradigm of a strengths based pyramid for the regulation of aged care services (Braithwaite, Makkai & Braithwaite 2007 Chapter 10). A strengths based accreditation system would require accreditation inspectors to record strengths of a residential aged care service, and their capacities to remedy identified problems, and not just rely on the identification of weaknesses. This model builds on the contemporary underpinning philosophy of the Australian accreditation system, which is an assessment of continuous quality improvement within residential aged care services.

A study by Richardson (2006), using a quantitative methodology, examined reports from the first and second round of accreditation surveys (up to 2004) on residential aged care facilities in Queensland. The aim of this research was to determine the relationship of structural efficiency of residential aged care and access to care. Richardson identifies an important trade-off between the competing objectives of efficiency and access. The pursuit of efficiency is an important component of the neo-liberal focus that can be identified in the recommendations of the Productivity Commission and the Hogan Pricing Review described in the previous chapter. Richardson's findings reveal that when structural design was directed by technical efficiency decisions, barriers to access were created for residents who were regionally or culturally disadvantaged. This was because operations in rural and remote areas, and those targeting cultural-specific groups, incur greater costs (Richardson 2006, p. v). She also found large-scale operations with limited scope are more likely to be efficient, while small-scale

operations with a broad scope are more likely to be equitable (Richardson 2006). These findings are also consistent with the international literature on the differences between for-profit and not-for-profit providers, where for-profit services have been found to be more focused and offer a narrower range of services (efficiency) and the not-for-profit providers tend to provide a wider range of services and also are more likely to operate small services (access). This distinction in the size and location of services by ownership type is examined in more detail in Chapter 5.

Richardson's (2006) study supports the directions of the present study, in that it links structural features to quality and performance in its general findings, but is limited to a broad application across the industry in a number of areas. The study is limited to residential aged care facilities in Queensland, it focuses primarily on the outcomes of all accreditation findings, rather than on the administrative actions of the Department in imposing sanctions (such as is the case with the present study) and it is limited to data collected over only five years - 1999 to 2004. The findings from Richardson's study suggest the need for future analysis of the whole of residential aged care in Australia, the identification of structural trends apparent since 2004 and the inclusion of recent data on quality and performance since 2004.

A second and more recent paper relevant to the present study was published by Ellis and Howe (2010). It examines the use of sanctions by the Department in regulating the residential aged care industry in Australia and is based on national data collected up to 2008. These researchers found that there is a relationship between the risk of sanctions and structural characteristics of residential aged care services (Ellis & Howe 2010, p. 452). However, there have been a number of potentially significant changes in policy and structural characteristics of the industry since 2008. The issues identified by both Richardson (2006) and Ellis and Howe (2010) are considered in the design of this study as reported in Chapter 4 and in considering the findings in Chapter 5.

3.4 The policy process, policy networks and neo-liberalism

The fourth research question of the present study relates to the implications for policy from the findings on the trends in the residential aged care sector and the perspectives of elite stakeholders. The findings from the literature review detailed above, when combined with the study findings reported in Chapter 5, may have implications for aged care policy. The determination of any implications for policy will require some understanding of the policy process around which aged care policy in Australia is formed. It is also important in analysing the perspectives of elite stakeholders and their potential influence on residential aged care policy to consider both the interests of those with the potential to influence policy and the dominant policy ideology that may influence the thinking of elite decision-makers. Brief reviews of the policymaking process, including the potential for sectional interests to dominate policy making, and the nature of neo-liberalism as a political ideology are provided in section 3.4.3. These reviews provide a theoretical platform for the discussion on the study findings in Chapter 6. There are three 'legs' to this theoretical platform: theories of the policy process that help to makes sense of the decision-making process, a theoretical framework on how stakeholders with different interests may influence policy and an understanding of the dominant ideology currently prominent in policymaking in Australia.

3.4.1 The policymaking process

3.4.1.1Theories of the policy process

Overview of policy theory

The first 'leg' to the theoretical platform is an understanding of the major theories of the policy process. Schlager (2007) identifies two major groups of theories of the policy process: common pool resource theory and 'others'. Common pool resource theories seek to explain the conditions that support self-government of shared resources and how self-governing institutions are formed, governed and relate to larger scale governance structures (Hess & Ostrom 2003; Schlager 2004). These theories, which include institutional rational choice and related constructs

(Hess & Ostrom 2003; Ostrom 1999, 2007), mostly focus on policymaking around the adoption of local or regional settings and seek to explain citizen self-governance. For reasons of focus, they are not particularly applicable to the examination of residential aged care policy in Australia.

The 'others' group that Schlager identifies (2007, p. 297) focus on pre-decision and decision-making processes and include those which reflect the different interests of stakeholders and their influence on agenda setting and policy adoption. These include punctuated equilibrium theory (Baumgartner et al. 2009; True, Jones & Baumgartner 2007), multiple streams theory (Kingdon 1995), social construction theory (Schneider & Ingram 2008) and advocacy coalition theory (Sabatier & Weible 2007). Each has its particular focus. Punctuated equilibrium theory promotes system-level patterns of decision-making on policy adoption. Multiple streams theory focuses on agenda setting, the interests of stakeholders and the influence of policy entrepreneurs who seek to open 'windows' of opportunity through the merging of previously separate problem, political and policy streams (Kingdon 1995). Social construction theory concentrates on how policy designs are shaped by the power and social constructions of target groups who seek to influence the democratic process (Weible 2008). Advocacy coalition theory sees policy as the result of the use of information by different groups who seek to influence policy in times of conflict (Sabatier & Weible 2007).

As the present study seeks to examine long-term trends in policymaking, the theory of punctuated equilibrium and its essential components may provide a suitable platform for understanding the implications for policymaking from the findings of this research. Punctuated equilibrium theory posits that the policymaking process may be characterised by relatively long periods of stability where policy changes are minimal and incremental. These periods of stability are punctuated by new actors, or new ideas, which challenge long-held beliefs or dominance by key actors or institutions (Walt et al. 2008). These challenges may result in major and often disruptive change. Schlager (2007) theorises that the periods of instability are

characterised by incremental decision-making by boundedly rational people.[53] Following a period of change the system may return to a new period of equilibrium.

A different approach to the analysis of trends in aged care policy than the one adopted in this study, is to use multiple streams, or advocacy coalition theory, as mentioned above. The application of these alternative theories would focus attention on the separate and sometimes competing interests of the different stakeholder groups. While analysis of the interests of stakeholder groups using these theories would be a valuable contribution to the literature, that is not the core focus of this thesis. To some extent the evidence that stakeholders focus on different aspects of policy or see the world differently is reflected in the responses of service providers from different organisational classes and from different sectors that is reported of the findings in Chapter 5. As the prime objective of this thesis is to identify the trends in residential aged care that are likely to be experienced in the future, the adoption of the theoretical framework of punctuated equilibrium, which seeks to explain the style of the policy process, is more appropriate than that those theories which address the actions of interest groups and the impact that interest groups have on policy development. Further analysis of the qualitative data collected through this study (including interview material collected but not analysed in this thesis) could, in the future, apply the advocacy coalition or multiple streams theories to address the difference in these interest groups and their impact on policy making.

Incrementalism

The concept of incrementalism is largely attributed to the descriptive theory first articulated by Lindblom in his well-known paper[54] 'The science of muddling through' (1959). He subsequently clarified some of his earlier claims and sought to address the arguments of the critics of his initial theoretical premises, by distinguishing between 'incremental analysis' and 'incremental decisions' (Lindblom 1979; Lindblom 1982). His principal argument is that rational

[53] Punctuated equilibrium theory is not the only theory to incorporate incrementalism and bounded rationality.

[54] A Google Scholar search on 8 July 2014 identified 8,638 citations to Lindblom's original article with 627 of these occurring since the beginning of 2013.

comprehensive planning - in the sense of firstly gathering all information before a decision is made - is not the preferred behaviour of governments in liberal democracies. His core argument, which is still frequently cited, is that the notion of rational comprehensive planning, which seeks to undertake a comprehensive analysis of all the possible aspects of a policy issue and all the possible preferences of the community, is not possible. This argument asserts that governments tend to make small, easily reversed, incremental changes to policy. Incremental changes are less likely to result in unsustainable losses (or gains) by different groups, making this process preferable to policymakers than 'big bang' changes to policy. A key component of this theory is that the network of stakeholders in any policy areas provides the information decision-makers need to assess the 'workability' of their incremental decisions. Related to and consistent with the theory of incrementalism is the concept of bounded rationality.

Bounded rationality and evidence-based decision-making

Embedded in the punctuated equilibrium theory, together with incrementalism, is the notion of bounded rationality (True, Jones & Baumgartner 2007). Like incrementalism, bounded rationality is based on the perceived limitations of the 'ideal model', or the rational-comprehensive concept of decision-making. That is, before any decision, all available knowledge is investigated and bought together so that a truly informed decision can be made. Bounded rationality argues that the capacity of individuals (and institutions) is 'bounded' by the cognitive limitations of their mind and the information available to them at the time (Simon 1991). Building on these notions is the concept of 'serial shifts' in decision-making, which occurs as attention is drawn towards one, or at most, a few things at a time, making it difficult for individual decision-makers to comprehend all alternatives to a complex policy issue (True, Jones & Baumgartner 2007). This concept is, at some level, at odds with the notion of evidence-based policymaking which advocates that decision-makers should take all the available evidence into consideration before making a decision.

Evidence-based policymaking has been labelled both a '*political slogan and an academic movement*' (Botterill & Hindmoor 2012, p. 367). It is the idea that sound

policies should be based on the best evidence available on 'what works' (Williams & Glasby 2010). In the area of health policy this idea promotes the rigorous analysis of services and policy options so that policy decisions are based on all the proven or accepted science rather than limited information, usual practice, opinions, accepted wisdom or the preferences of key stakeholders (Head 2013). The basis of the evidence-based approach can arguably be found in the rational comprehensive ideal which Lindblom (1982), Simon (1991) and True, Jones & Baumgartner (2007) believe to be inadequate to explain decision-making. Another idea is that it may not be so much that the basis of decision-making is not evidence based, but the reality of the policy and political process requires decisions to be made in the absence of all the information that would ideally be available, or the requirement that a decision be made irrespective of whether the information is available or not (Botterill & Hindmoor 2012). A further challenge to decision-making based on evidence occurs where decisions are made in a policy area that is subject to considerable influence by multiple and potentially competing stakeholders. The influence of elite stakeholders on policymaking in residential aged care in Australia is discussed in Chapter 6.

3.4.2 Policy networks as a specific form of governance

The second platform for making sense of the implications for policy is the way stakeholders influence policy. Due to the strong involvement of stakeholders in seeking to influence aged care policy, an examination of their involvement may also assist in explaining the policy implications of the trends in aged care. Kenis and Schneider (1991) argue that the emergence of the modern state essentially results in a decentralisation and fragmentation of the state. This fragmentation is fuelled by interests of the departments of government and their relationship with their constituencies. This has led to the blurring of boundaries between public and private interests. These interests come together in some form for the purpose of influencing or making policy.

Consistent with this argument, Adam and Kriesi (2007, p. 132) propose that '*the model of a unitary, state-centred hierarchical political decision making structure has always been a fiction*', while others argue that this has been particularly

the case since the middle of the twentieth century (Kenis & Schneider 1991). This view is supported by several scholars writing about policy decision-making in Australia (Colebatch 2009; Considine & Lewis 2003; Lancaster, Ritter & Colebatch 2014; Lewis & Considine 1999). One way stakeholders seek to influence policy is through the formation of policy networks.

Policy networks have been defined as a new form of governance characterised by the predominance of formal and informal, decentralised and horizontal relations between politicians, government decision-makers and influential stakeholders (Kenis & Schneider 1991, p. 30). Kenis and Schneider (1991) attribute the increased scope of government policymaking, decentralisation of government organisations, the increasing importance and availability of information and the trans-nationalisation of policymaking within global markets to the emergence of this horizontal form of governance. Others note a blurring of interests between the public and private sectors (Adam & Kriesi 2007, p. 132) and some researchers have identified network relationships, known as 'iron triangles', which allow non-government actors to have a very strong influence over policy (Adams 1981), although this may be more of a North American and European phenomenon than Australian.

Hazlehurst (2001, p. 2) argues that, although network approaches to policymaking have emerged from Europe, various forms of engagement of a broad coalition of stakeholders have been a characteristic of Australian approaches for some time. His view is that these engagements have tended to be more on the government's terms and established to achieve some specific government objective, unlike the European model where policy networks tend to be more influential with government. Nevertheless this argument supports the existence and influence of policy networks on decision-making in Australia.

3.4.3 Neo-liberalism, contestability and choice

In Chapter 2 the recommendations of a number of reviews and enquiries into the residential aged care sector in Australia were described as adhering to neo-liberalism ideas. The features of neo-liberalism as a policy framework, and related concepts such as contestability and choice, provide a basis for the

analysis of elite stakeholder perspectives about the current and future aged care industry in Australia that are discussed in Chapter 6.

Larner (2000) argues that 'neo-liberalism' can be defined as either a policy framework, an ideology or as a form of 'governmentality'.[55] She explains that the introduction of neoliberalism as a policy framework marked *'a shift from Keynesian welfarism towards a political agenda favouring the relatively unfettered operation of markets'* (Larner 2000, p. 6). Scalmer (2009) and Ahamed and Davis (2009) claim that, in Australia, neo-liberalism had already rapidly colonised the Australian bureaucracy and leading political parties by the early 1990s. Others claim that the broad adoption of neo-liberal ideology across governments and government departments was as much the result of broader structural change in the global economic system as it was the sudden adoption of new ideas by the dominant bureaucracy (Pusey 1991).

When following this policy framework, governments chose policies that focused on enhancing economic efficiency and international competitiveness over previous policies that sought to ensure an inclusive welfare system. These concepts are reflected in the conflicting objectives identified by Richardson (2009) in relation to the structural characteristics of residential aged care in Australia and reported in section 3.3.5 above. This preference for efficiency results in *'the "rolling back" of the welfare state activities and a new emphasis on market provision of formerly "public" goods and services'* (Larner 2000, p. 7). The stimulus for this shift in thinking is the adoption by key institutions and political actors of five core values: the individual, freedom of choice, market security, and a preference for laissez faire and minimal government (Belsey 1996).

In adopting these neo-liberal values, governments engaged in the reform of programs and services focus on mechanisms of deregulation, privatisation where possible, an emphasis on choice by the consumer, marketisation of social services,

[55] That is the ways of government or the art of government. In an Australian-based study, Nicoll (2011, p. 233) describes governmentality as a useful concept to enable '*comparisons to be drawn between configurations of cultural, economic and political forces which shape social institutions, subjective experiences and understandings of citizens in different times and places*'.

contestability of markets for social services, competition and a preference of reliance on market forces than on government regulation (Davidson 2009, 2012; Keating 2004). The introduction of the process of contestability between providers of services would, it has been argued, enable the entry of 'good', new providers and lead to the exit of 'poor' existing providers.

However, the use of contestability mechanisms to introduce market forces into services for vulnerable people presents a number of challenges because human services are different to other government services, such as for example, public transport, postal services or meteorology. The factors that are different in human services and which present challenges are the asymmetry of information between consumer and provider, the risks of allowing a poor quality provider to enter an open market and the uniqueness of each episode of human service.[56] These factors place limits on productivity improvement through standardisation, highlight the difficulty of measuring quality (and the achievement of minimum standards) and expose the inability of the purchaser (the government) to observe the provision of the services purchased on behalf of consumers (Blank 2000; Carson & Kerr 2012; Davidson 2009; Denhardt & Denhardt 2000; Shergold 2009). Notwithstanding these concerns, proponents of neo-liberalism claim that the introduction of the requirement of contestability into the selection of providers for government-funded services would also result in an increase in quality, improved access, greater efficiency and responsiveness, increase diversity of services and increase accountability of providers (Davidson 2012; Le Grand 2007).

An additional challenge to the notion of contestability in the area of residential aged care is the high capital cost of entry to and exit from the market by providers. Traditionally, the theory of contestability assumed no cost of entry or exit by providers to the market. Clearly this is not the case with residential aged care and, in practice, that requirement is not strictly adhered to when applying the principles of contestability to the selection of providers of government-funded services (Davidson 2012). Despite this limitation to the

[56] That is, each occasion of the provision of personal care will vary in some way from all others due to the differing needs of the consumer and the way the provider delivers the care.

'pure' test for contestability in the residential aged care sector, it remains a cornerstone of a move to a more market-based approach. Also of interest is the relationship between contestability and the notion of choice. Choice of services and provider are one of the key objectives for the introduction of marketisation of services through contestability mechanisms. Davidson (2012) argues that the concepts of choice and contestability are closely linked, but that it is important to note that there can be contestability without choice, but not choice without contestability.[57] This implies that for a market such as residential aged care to achieve the goal of choice, it must first achieve a level of contestability, that is, to achieve a level of competition based on easily accessible and easy to understand consumer information on prices and indicators of outcomes.

Policy critics argue that the evidence of the outcomes for care recipients and the performance of providers, following the application of market approaches to human services, is contextual and variable. Some research results suggest that the price effects of competition are small and the effects of competition on quality are mixed or negative (Forder & Allan 2014; Grabowski 2004), while others report the opposite (Castle, Engberg & Liu 2007). Brennan and colleagues (2012, p. 388) argue that there is *'no firm evidence that either increased quality or lower costs have resulted from increased competition, marketisation and increased penetration of for-profit service in childcare and eldercare'* across three countries reviewed (Sweden, England and Australia). They observe that Australia, compared to England, has been relatively late in introducing these mechanisms, particularly in relation to residential aged care, in part due to the low level of public delivery of these services.

3.5 Conclusions

This chapter has explored a well-accepted conceptual framework to describe the relationship between structure, process and outcome in residential aged care and

[57] This argument appears to mean that providers can be selected to be the recipients of government funding though a competitive process but this does not necessarily extend choice to care recipients. On the other hand, if the goal is to achieve choice by care recipients (or their carers), care providers must be selected through a contested process that demonstrates in a transparent way the differences between providers.

has adopted this framework as the basis for the present study. The chapter presented a review of the literature on the relationships between structure, process and outcomes and on the policy process relevant to decision-making around policies that shape the residential aged care sector in Australia.

Three structural variables have been identified by researchers as being important in relation to the performance of residential aged care facilities and quality. These variables include ownership, size of services and size of providers (chain affiliation). While the bulk of the evidence on ownership is in favour of not-for-profit providers over for-profit providers, the evidence is not conclusive, owing to weaknesses in the research methodology of some studies and a lack of industry-wide agreement on the measurement of quality. Nevertheless, the weight of evidence in favour of the provision of residential aged care by not-for-profit providers suggests that it should not be ignored in decision-making on sector reform. Similarly, while the evidence reviewed on the size of facilities is not conclusive, on balance, it appears to favour facilities with fewer than 100 beds when considering positive facility performance and favourable resident outcomes.

Additionally, the review of the literature on the policy process, which provides a platform for interpreting the research findings in Chapter 6, revealed key concepts to help explain the development of policies and the perspectives of the elite stakeholders. These concepts include the theory of an incremental approach to policymaking, the limitations of the decision-makers to absorb all the information that can be obtained from the available evidence, and the pervasive influence of neo-liberalism as the dominant political ideology which provides the basis for Australian residential aged care policy decisions.

This chapter exposed a key tension between the available evidence and the values of a neo-liberal policy approach. The evidence, while not conclusive, suggests that structural variables have a relationship with performance and outcomes for residents and, arguably, should not be ignored by policymakers and decision-makers allocating resources. The limitations of the research reviewed highlight the challenges of measuring the relationship between structural variables and quality, and also between structural variables and performance. The evidence suggests that

the structural variables of ownership, size of facilities and size of providers should not be ignored in the policymaking process.

This review of the evidence guides the methods for the collection of data for this study, which is described in the next chapter.

CHAPTER 4 Methodology and methods

> *One of the major debates in research circles is whether the proprietary nature of the nursing home industry affects process and outcomes in terms of quality of care. (Harrington, Carrillo, et al. 2011, p. 6)*

4.1 Introduction

This chapter is in two parts and explains and justifies the choices made in the selection of the methodology and methods adopted and why these are the most appropriate to conduct this research.

Part A, Section 4.3, explains the collection, cleaning, coding and analysis of the quantitative data and justifies the statistical methods used for the analysis of the quantitative data.

Part B, Section 4.4, explains the collection, transcribing, coding and analysis of the qualitative data, and justifies the methods used for the analysis of the qualitative data.

The selection of methodology and methods was guided by the research questions. These questions seek to identify structural trends in the residential aged care industry; ascertain the relationship between structural characteristics, quality and performance; and determine the understanding of elite stakeholders about these trends and their views on future trends. This study will also seek to determine if these trends are consistent with those that may be expected to produce quality care services and quality performance of the industry.

This is a pivotal time in the development and expansion of Australian residential aged care services and in the light of the numerous changes in residential aged care policy that have occurred and likely to occur in the near future, this research is timely. The literature reviewed in Chapter 3 produced evidence of the relationships between structural characteristics and quality and performance of residential aged care services. To determine the extent the Australian industry is

trending in a manner consistent with international aged care providers that produce the best outcomes, it is necessary to establish these trends, determine if there is a relationship between structural features and quality and performance (to the extent that the limitations on data allow) and analyse information obtained from key informants and decision-makers about current and future trends in the Australian aged care industry.

4.2 Methodology

4.2.1 Choice of mixed methods

Although mixed methods is not a new research methodology, as some authors trace its origins back to the nineteenth century (Tashakkori & Teddlie 1998), it has been used more frequently and become more accepted since the 1950s (Creswell 2009). Bryman (2009) claims that there has been a threefold increase in research articles based on mixed methods published in the period 1994 to 2003. He also claims mixed methods research has acquired credibility in the field of organisational studies based on his finding that around 12% to 17% of the research conducted in this field is based on mixed methods design (Bryman & Bell 2011, p. 630). However, some of the justifications for the use of mixed methods research design, according to Bergman (2011), are problematic.

Mixed methods offers a supplementary perspective to a research question is, Bergman (2011) says, an insufficient reason for adopting this approach. Secondly, the argument that a quantitative component cancels out the 'method' effect of a particularly qualitative approach is also not a sufficient justification, in his view, for the use of mixed methods. Thirdly, he argues that the use of mixed methods should be justified only on the basis that it improves the limits of using a qualitative or a quantitative approach, rather than focusing on the limitations of either methodology. He also warns that researchers may be tempted to argue that mixed methods research is good in principle, or to claim that a method is mixed when they simply report official statistics or a numerical summary of their qualitative findings. Table 8 identifies the components of the relationship between the research questions, the data collected, its analysis and the contribution that analysis makes in addressing the aims of the present study.

Table 8 Relationship between the research questions and the data collected

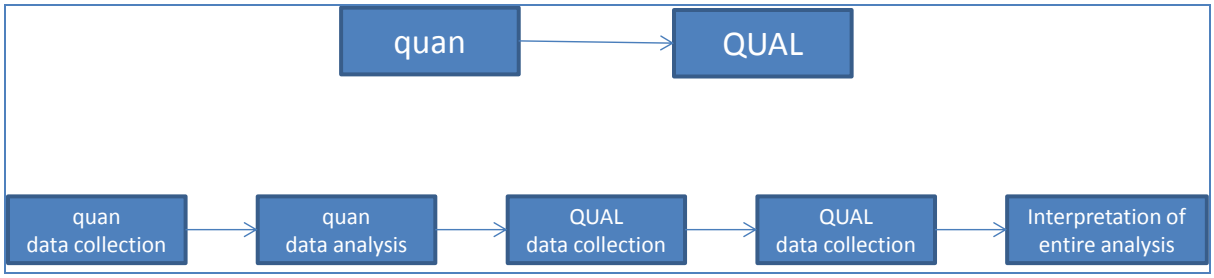
Research Question	Quantitative data Census data	Data on sanctions	Qualitative data Interviews transcripts
What are the trends in the structure (ownership, size and location) of the residential aged care sector across Australia?	Analysis of trends in descriptive quantitative data		Analysis of qualitative data obtained from interviews
What is the relationship between the structural characteristics of the Australian residential aged care sector and the quality of services?		Statistical analysis of the data on trends and the data on sanctions	Analysis of qualitative data obtained from interviews
What are the perceptions of elite stakeholders on the future trends of the residential aged care sector?			Analysis of qualitative data obtained from interviews
What are the implications for future policymaking in response to the identified trends?	Findings from the analysis of the census data	Findings from the analysis of the data on sanctions	Analysis of qualitative data obtained from interviews

The following points explain how this research avoids Bergman's concerns in the application of mixed methods. First, the collection of the qualitative data is not supplementary to the analysis of the quantitative data; rather it is additional as it answers related but different research questions. The quantitative data, by its nature, focuses on the past. The qualitative data focuses on the present and future. Together these aspects provide a complementary and explanatory perspective of the research questions, rather than a supplementary perspective. Second, there is no attempt to use the quantitative data to 'cancel out' any of the limitations of the qualitative data. Rather the qualitative data has been used, not only to assist in the explanation of the trends in the quantitative data, but also to provide context to, and gain insight into, the likely future trends in this industry. There is no certainty that the trends in the past will continue, however, the analysis of the data collected at interview will provide some insight into the future without limiting the rigour of the analysis of the quantitative data which provided insight into the past.

4.2.2 Study design

Bryman and Bell (2011, p. 632) advocate two features for classifying study design using mixed methods: *priority* of the quantitative or qualitative method as the principal data gathering tool and the *sequence* of data collection based on the choice of design.[58] Using the notation method first described by Morse (1991) and adapted by Creswell (2009) and Bryman and Bell (2011),[59] the following figure illustrates the study design adopted for this research. It illustrates that the qualitative data is the predominant data collected. The quantitative data collection and analysis is completed prior to, and shapes, the collection and analysis of the qualitative data. The study follows a modified sequential explanatory mixed methods design. Consequently, a mixed methods design has been adopted, as neither the examination of the quantitative data on trends in the structure of residential aged care services nor the qualitative interview data will on their own answer the research questions.

Figure 8 'Modified' sequential explanatory design based on Creswell (2009)



[58] They argue that this method provides nine possible research design types from which one can be selected. Alternatively, Creswell et al. (2003) advance six types of design; three sequential and three concurrent. Building on this model, Creswell (2009) advocates that the choice of mixed methods design should take into consideration four principles: timing, weighting, mixing and theorising and while advocating the six main design types, admits that there are others. The main difference in the models illustrated by Bryman and Bell (2011), and Creswell and colleagues (2003), is that Bryman and Bell show designs where the priority may be quantitative data but its collection is second in timing to the collection of the qualitative data; whereas, Creswell's designs are limited to the data collection type being collected first, where it is the priority; that is Creswell's 'sequential explanatory design' shows quantitative data the priority and being collected or generated first. In this study the qualitative data has the priority and the quantitative data is collected and analysed first.

[59] This notation method uses capitalisation to emphasise the dominant method.

4.2.3 Ethics Committee approval and data handling methods

4.2.3.1Ethics Committee approval

Although none of the quantitative data sets obtained from the Department contains information on individuals, they identified individual aged care services and service provider organisations. For this reason Ethics Committee approval was also sought for the use of these data. The proposed collection of the qualitative data required the interview of individuals and required Ethics Committee approval. Approval was provided by the UTS Human Research Ethics Committee on 6 December 2012 for both the quantitative and qualitative data collection and analysis. The approval number is UTS HREC REF NO. 2012000366.

4.2.3.2Consent, collection, coding and data management

Consent

The consent form and explanation sheet approved by the Ethics Committee are provided in Appendix C. The consent form, together with the introductory letter and explanation sheet, were emailed to each potential participant following the initial verbal request for interview. At the commencement of each interview it was made clear to the participant that the contents of the interview would be confidential and the report of the findings would maintain anonymity. The participant was asked if they agreed to the interview and agreed for the interview to be recorded, if they understood the purpose of the interview and that they could withdraw their consent at any time. Following the signing of the consent form each participant was provided with a 'revocation of consent form' to keep should they wish to withdraw their consent at a later date. Participants were also informed that the transcript of the interview would be sent to them to check.

Data collection and transcription

Electronic recording of interviews is an acceptable and commonplace method of data capture in research interviews (Bowling 2009; Kvale 2007; Liamputtong & Serry

2010). Two devices were used simultaneously to record each interview.[60] One was an Apple iPhone using HT Professional Recorder version 6.81, which, when operated, requires no microphones or other intrusive equipment. The other was a Pulse Smartpen with Livescribe desktop version 2.8.3, which enables the operator to record the conversation electronically, while simultaneously taking hard copy notes.[61] The use of two devices, and particularly the features of the Smartpen, was explained to the participants. This provided a natural and convenient ice-breaking opportunity at the commencement of the interview. All the participants (n=26) agreed to the use of both devices simultaneously.

I had initially intended to do my own transcription. However, after transcribing the first two recordings, I realised my typing speed and accuracy were insufficient to transcribe all anticipated interviews to an acceptable standard and I engaged a professional and experienced transcriber. The transcriber was provided with no identifying information concerning the participant. Each transcription was checked for accuracy by simultaneously listening to the recordings and reading the transcription. Only minor errors were detected and were corrected.[62] Each checked and amended transcript was returned to the participant by email as a Microsoft Word file attachment, as was agreed in the introductory consent process. Edited transcripts were received from four participants who

[60] Using two recorders proved invaluable on a number of occasions. Indistinct comments on one recorder could sometimes be heard more clearly on the second recording and interferences from surrounding noises (traffic, cups, pages turning etc.) would tend to be less intrusive on one recording than the other.

[61] In addition to audio recording, the Smartpen also video records any handwritten notes that are made with the pen, which can be later transferred to a computer, to provide additional material for analysis. After the first few interviews I reached the conclusion that note-taking was interfering with my engagement with the participant and my notes did not really add new insights to those provided by the recording. Consequently I became more trusting of the recordings than my notes. This focus on listening rather than writing meant I was better prepared to seek clarification, explore some areas in depth and return to points my participants skipped over earlier in the interview.

[62] Edits were necessary only to minor mistakes and omissions such as spelling of surnames, use of acronyms, technical names and where the sound on the recording was indistinct. Indistinct words were referenced in square brackets by the transcriber with the time of occurrence of the word in the recording, making it easy for me to check.

suggested a small number of minor changes.[63] Follow-up emails from the other participants elicited no requests for changes to the transcripts.

Coding and data management

To ensure confidentiality and anonymity, each consenting and interviewed participant was allocated a unique alphanumeric identifier. Data tables linking individual participants with the unique identifier are stored in a password-protected file, separate from the interview data. Recordings were transferred to the transcriber through an encrypted and secure internet site and were destroyed on completion of the transcription. The findings of the research results have been reported in keeping with the protocols of the Australian Institute of Health and Welfare (2011). These protocols require that when it may have been possible to identify an individual service or provider due to small numbers in table cells, these data should be amalgamated with other cells to ensure that services or participants are not identified.

Data management and storage followed the established procedures and protocols of the UTS Human Research Ethics Committee. All electronic quantitative and qualitative data have been, and remain, password protected. Interviews were digitally recorded on a password-protected portable device and downloaded and stored on a password- and firewall-protected personal computer that only I was able to access. Raw and transcribed data on all portable devices were deleted after download to more secure storage. After the research was completed, consent forms, other hard copy data, such as notes from interviews, and electronic data were transferred to the UTS systems for storage for seven years in accordance with University and Faculty policy.

[63] These edits corrected grammar in sentences spoken by the participant, spelling of names quoted in the interview, clarification of poorly articulated sentences and removing slang or disrespectful comments.

4.3 Part A: Methods – quantitative study

4.3.1 Study population

The aims of this component of the research were to identify and describe the trends in the residential aged care system across Australia and to analyse the characteristics of the residential aged care facilities associated with identified quality failure. To achieve these aims the study population includes all residential aged care services in Australia. The decision to include all residential aged care facilities in this analysis rather than a sample is based on two pragmatic reasons. First, the data on the whole population are available. Second, the incidences of the imposition of government sanctions are a relatively rare event and selecting a sample of facilities – either randomly or as a purposive sample determined by, say, location such as the practice adopted by Richardson (2006) – may yield too small a number of incidents to achieve sufficient statistical power in the analysis. This would severely limit the ability to generalise these findings to the Australian aged care service sector.

4.3.2 Validity and reliability of the quantitative data

The method of data analysis makes some assumptions concerning the face validity and reliability of the data. There appears to be no reasons to question the face validity of the residential aged care census data, as these data collection rely on everyday meanings of service characteristics (that is, number of beds, ownership status, location) and definitions provided in the regulations under the Aged Care Act 1997. In relation to the residential aged care sanctions data, the extent to which the decisions of the Department were valid (that is, that a service failed minimum standards) cannot be checked. However, in the opinion of the key stakeholder participants, the decisions made by the Department to impose a sanction on particular facilities were considered to be appropriate, providing some confidence that the sanctions data were valid. The participants were less convinced concerning the validity of the Department's decisions not to apply

sanctions in some cases where they may have been warranted (see section 5.11.8.3 below).[64]

The self-reported census data are highly likely to be reliable, since these data are derived from the documentation provided to the government by approved providers in seeking government financial subsidies. The self-interest of the provider in receiving the right level of government funding is a sufficient motivator to ensure that the data are reliable. Consequently, there is little reason to reject the census data as unreliable; however these required extensive cleaning to address anomalies in the way that these data were recorded. Likewise, the sanctions data report the actions taken by the Department in its determination to impose a sanction on a facility, or a provider, and for this reason it can be accepted that the sanction record refers to an actual event (similarly the self-interest of the reported sanctioned services will ensure that reported data is reliable). However, like the census data, the sanctions data required significant checking and cleaning as described below.

The nature of the accessible quantitative data drove the methods used to analyse these data, as they required both descriptive and inferential statistical approaches to answer the research questions. The analysis of census data required primarily a descriptive approach to data analysis, as with the population data. The analysis of the relationship between structural variables and quality data used inferential statistics techniques, since these data required an analysis of the relative risk of incurring a sanction. This section provides details on the census and sanctions data, the study population, the selection of dependent and independent variables for analyses, and provides details on how the data were collected, cleaned, coded, stored, amalgamated and analysed.[65]

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[64] Two concerns are raised here, the reliability of the decision on sanctions and the rate of false positives and false negatives. The only know study on inter-rater reliability of accreditation assessments found a high degree of correlation between inspectors and independent raters (Braithwaite & Braithwite 1995).The clear view of the participants, as detailed in Chapter 5, is that the officers of the Department are aware of the significance of the imposition of a sanction and are therefore are much more likely to not sanction a service that should be sanctions (a false negative) than to sanction a service which should not be sanctioned (a false positive).

[65] These data were generated by the Department through its administrative processes. The system of allocating residential aged care places, approving providers, the nature of the

4.3.3 Census data

4.3.3.1Data items and source of data

Since 2003, the Department has prepared an annual census of all aged care services it provides funding to under the Aged Care Act 1997. This census includes a range of characteristics of the aged care service at 30 June each year. Application was made to the Department by email census data for the years 2002-03 to 2007-08 and this was provided on 16 December 2012 as five separate Microsoft Excel data files. Data for the years 2008-09 to 2011-12 were downloaded directly from the Department's website[66] on 19 December 2012 and 10 January 2013 (for 2011-12 data) as Microsoft Excel data files. Table 9 provides a description of the items in the census data and the type for each data item.

4.3.3.2Data cleaning and database creation

The 10 separate files accessed from the Department included data on both residential aged care and community aged care services and in total included over 45,000 records, see Table 10 below, each with the 15 separate data items described in Table 9 above. This study is concerned only with the records related to residential aged care services.

Table 9 Variables included in the data on the Census of Aged Care Services 2003 to 2012

Data items	Description	Type of data
Service Name	Name of aged care service	Alpha, nominal
Suburb	Name of suburb	Alpha, nominal
State	State in which service is located	Alpha, nominal
Postcode	Postcode	Alpha, nominal
Planning Region	Planning region where the facility is located	Alpha, nominal
Local Area Name	Statistical local area name	Alpha, nominal
Care Type	Residential or community care	Dichotomous Yes/no,
Community Care Places	Number of operational community care places	Numerical continuous
High Care Places	Number of operational high care places allocated	Numerical continuous
Low Care Places	Number of operational low care places allocated	Numerical continuous

quality and accreditation system and the practice of the Department in imposing sanctions on approved residential aged care providers were described in Chapter 2.

[66] The data was obtained from http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-servlist-download.htm.

Data items	Description	Type of data
Approved Provider (AP)	Name of approved provider - company or organisation	Alpha, nominal data
Organisation Type[67]	Type of organisation (see definitions in Chapter 1)	Alpha, nominal data
Remoteness Area	Score for remoteness	Alpha, ordinal data

Table 10 Number of records sourced from the Department

Year to which the data refers	Total number of records in each year' s data
2003	3881
2004	4125
2005	4095
2006	4273
2007	4429
2008	4609
2009	4586
2010	4787
2011	5206
2012	5392
Total	45383

The data sourced from the Department identified aged care services and providers by name only - no unique identifier was supplied with the data. For the purpose of analysis it was necessary to allocate each service and approved provider with a unique code. However, in allocating unique codes a number of anomalies were discovered due to lack of consistency in the data. The challenges were addressed in one of the following ways:

- Where there was more than one service listed with the same name in the same year, and it was clear that the records referred to the same service (e.g., same provider and postcode), the records were combined to create only one service and were allocated a single code.
- With different services with the same name where it was clear that the records did not refer to the same service (e.g., different provider and postcode), the records were provided with different codes.
- Where services had different names in subsequent years, but it was clear that they were the same service (same provider and location), they were given the same code.

[67] The definitions of organisational class and organisational type are provided in Chapter 1.

- Where approved providers changed their name from one year to the next but it was clear that they were the same provider they were allocated the same code.
- Where a single service provider was listed as different approved providers, but it was clear from checking their websites and other data that they were the same provider, they were allocated the same code.

A list of the facilities and providers where duplicates or errors were identified and were subsequently provided with the same or different codes is provided in Appendix E.

Further cleaning of the data is summarised in the following points:

- Codes were created for 'provider name', 'approved provider', 'suburb name', 'state', 'planning region', 'care type', 'organisation type' and the 'ASGC remoteness code'.
- A master list of facility names and a separate master list of approved provider names were created from the combined list of all facilities and approved providers from all of the census data. Each service and approved provider was then provided with a unique code.
- 'Organisational type' was missing for the years from 2003 to 2008 and was populated from data on the same services provided after 2009. Where the provider no longer appears in the records after 2009, each was reviewed and organisation type was allocated based on Internet or archival data.

With the initial combination of 10 years of data there were 8,445 separate names for residential aged care and community aged care services. After removing duplicates, the number was reduced to 8,147 separate names over the 10 years of the data. The initial list of 2,578 individual residential aged care and community aged care approved providers was reduced to 2,346 over the 10 years of the data.

After cleaning, each of the 11 files were then converted to SPSS version 21 (IBM 2013) and finally merged into a single SPSS database. Assistance was provided by an independent contractor, Ms Christine Eastman, to help with the merger of the files and the creation of a single 'long' database. Assistance was also provided by Ms Eastman with the creation of a series of tables on the number of residential

aged care services operated by individual providers. I undertook all other analyses of these data.

4.3.3.3Analysis of the census data

Initial analyses of these data revealed changes in the pattern of ownership, size and location that were further investigated. Time series analysis was not considered to be appropriate or as helpful as initially contemplated, as only 10 observations at different times were available. A series of descriptive tables are provided below and as these are based on population data and clearly indicate trends in the areas of interest, no further statistical analysis of these data was considered warranted.

4.3.4 Data on sanctions

4.3.4.1Data items and sources of data

This section describes the steps taken to develop the database on sanctions[68] from data obtained from four sources; 1) the census data, 2) the Reports[69] of the Operations of the Aged Care Act 1997 for the year 2000 to 2012, 3) details from the Department's website and 4) a spreadsheet provided by the Department following a request for the data on sanctions. The annual Report on the Operations of the Aged Care Act[70] provides, inter alia, details on each of the sanctions imposed during the reporting year and these data were extracted from each year's report over the period 1999 to 2012. As a first step, the data were copied as a text file and then converted to an Excel file for ease of management and data cleaning. This continuous record was the primary source of the sanctions data, however these data included gaps and errors in facility name and other details. To clean these data a request was made on 10 September 2012 for the Department to provide a copy of the data which is used to inform the data on sanctions included

[68] The definition of a sanction and the process by which a sanction is imposed are provided in Chapter 2.
[69] The Act requires the Minister responsible for the Act to provide a report to Parliament each year .
[70] These reports are available from the website of the Department of Health and Ageing (http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-reports-acarep.htm).

in the Department's website.[71] Although the request was initially denied, following an appeal the Department supplied the data on 8 November 2012. A final source of data for checking details was the Department's website. Text data of the sanctions were then coded for analysis. A description of the sources and the sanctions data is provided in Table 11

Table 11 Sources of sanctions data and data selected

Description	Source of data	Data selected
Census data on all services at 30 June 2003-12	Website of the Department	Size, ownership type, nature of beds, location
List of sanctions imposed for each year	Annual Report of the Operations of the Aged Care Act 1997 for each year 2000-12	Names of services and approved providers, description of sanctions
Details of sanctions	Website of and a data file supplied by the Department	Name of services, approved providers, sanction types

4.3.4.2Data cleaning and database creation

Checks for incomplete records and missing data, duplicates, consistency and the range of data items were undertaken to ensure that prior to analysis the database was complete, accurate and comprehensive (Bowling 2009; Liamputtong 2010).[72] The database was searched for missing details and duplicate records were eliminated by cross-checking the three sources of data, and the most recent website data update was used as the most accurate record. Further explanations of the methods used for cleaning and coding the data are provided in Appendix F.

4.3.4.3Sanctions data analysis

The data revealed that the Department may impose one or more sanctions on an individual service at the same time and this was labelled as a 'sanction event'. Some services experienced more than one sanction event at different times, mostly

[71] The Department's website contains details on all sanctions imposed since 1997. However, these data are only accessible by first entering the name of the facility of interest one at a time and it is useful only as a validation of details on individual, sanctioned services and not as a primary source of data.

[72] The data supplied by the Department recorded 11 facilities that had been subject to sanctions but which had not reported in the various Reports of the Operations of the Aged Care Act 1997. Details of three facilities listed as having had sanctions imposed earlier than 2003 could not be matched with any archival data and they were deleted from the record.

in different years. The establishment of the database allowed the following variables to be recorded: the number of services which experienced a sanction event, the number of sanction events and the number of individual sanctions. Poisson regression models were used to explore the time trend of sanction event rate (number of sanction events divided by total service years of exposure) and the association between structural characteristics and the sanction event rate were examined. Univariate analysis was conducted, followed by multiple Poisson regression with backward model selection to obtain the final model. Chi-square test was used to investigate the association between sanction type/reason and structure characteristics. Statistical analysis was conducted using SAS 9.2 (SAS Institute Inc. 2010). The assistance of Dr Xhixin Liu is acknowledged in completing the statistical analysis.

4.4 Part B: Methods – qualitative study

This section describes the methods used for the collection of qualitative data, the selection of the study population, the challenges of interviewing elite stakeholders, the interview process and how the data was captured, stored, coded and analysed. The methodological approach is guided by these research questions:

- What are the perceptions of elite stakeholders on the future trends of the residential aged care sector?
- What are the implications for future policymaking in response to the identified and perceived trends?

To address these questions, data were obtained from elite stakeholders working in the aged care industry or in government using semi-structured interviews. Three subsidiary questions presented themselves for examination simultaneously and each informed the other:

1. Why interview elite stakeholders?
2. Who are the elite stakeholders and how will they be identified, sampled and selected?
3. What is the best method of collecting data from them?

The justification for interviewing these participants is detailed in the next section, followed by an explanation of the method for participant identification and data collection.

4.4.1 Elite participant sampling and selection

4.4.1.1Choosing elites as study participants

The decision to interview a range of elite stakeholders was made because they are the group most likely to understand and interpret industry trends and policy directions from a national and global perspective. Interviewing elites is an established method in health policy studies both in Australia and internationally (Baker 2013; Lewis & Marsh 2012; Lewis 2006; Lewis 2005a).[73] While elites are

[73] Elites informants have also been used in diverse studies of politics (Berry 2002; Considine 1998; Goldstein 2002), with business and government department leaders (Aberbach

defined as 'those with close proximity to power' (Lilleker 2003; Morris 2009), they may not necessarily be in prominent or public positions. Elites are knowledgeable and influential people who are defined as those who make, or have the potential to make, a significant difference at one or more stages of policy decision-making (Considine 1998). What distinguishes individuals as 'elites' is that they can be expected to interpret events, and how and why certain decisions are made (Aberbach & Rockman 2002; Baker 2013; Goldstein 2002). The desirable qualities of participants in this study are that they are seen by their peers as:

- knowledgeable about the residential aged care industry by having a 'helicopter' and strategic view of the industry
- influential (top tier or near top tier) within their organisation and are currently or recently viewed by their peers as influential with policymakers.

Participants for this component of the research are in service provider organisations, peak bodies, consultant/advisory groups and within government. The next challenges in this research were to determine: a) the data collection method, b) how to identify potential participants and c, how to access a representative sample.

4.4.1.2Choice of data collection method

Three possible mechanisms were considered for collecting data from the elite participants: a cohort survey, focus groups and interviews.

A cohort survey is used to collect data from a population with similar characteristics (Bowling 2009, p. 221). Such a method could involve data collection by self-completed questionnaire ('hard copy' or electronic), or through telephone or personal interview. For this study a cohort survey was rejected because:

- there was no way to identify prospective elites for the purpose of distributing a survey; for example, the use of membership lists or

& Rockman 2002; Harvey 2009), leaders in economics and Nobel laureates (Stephens 2007), board members (dela Rama 2012; Ostrander 1993), leaders of secret and security services (Davies 2001) and communities in education policymakers (Batteson & Ball 1995).

organisation affiliation[74] may exclude a number of independent elites, such as consultants and advisors

- no validated questionnaires could be identified that would address the research questions
- a telephone or face-to-face survey would not allow the investigation of particular issues in any depth.

Focus groups have the potential to collect in-depth data from a number of key informants simultaneously. Compared to surveys and face-to-face interviews they reduce the number of data collection activities and may generate interesting data as the individuals interact with each other and stimulate ideas (Bowling 2009; Liamputtong 2010). However, focus groups have major limitations when targeting elites, particularly the practical difficulty of assembling senior people at the same time and place. Also, by their nature, there is a loss of confidentiality around participant responses concerning business strategy, political views and personal beliefs when discussing matters in a group (Bowling 2009).

Given the limitations of conducting focus groups with elite stakeholders, semi-structured interviews were chosen. This method had the potential to provide the most likely way of covering common material, while at the same time allowing both the interviewer and the elite participant the flexibility to explore particular issues in depth and in confidence if requested (Bryman 2004, p. 113). [75] Face-to-face interviews were chosen as it was considered important to establish a trusting

[74] Consideration was given to using a national organisation such as NACA to find elite participants for a survey, however, there is no guarantee that its members (or similar body) are 'elites', as defined, as many organisations send representatives to national bodies rather than their most influential individuals.

[75] Bryman (2004) defines the major types of interview methods and distinguishes between structured, semi-structured and unstructured interviews. In structured interviews the interviewer asks all questions to all participants but with more flexibility in recording responses than in a survey. Unstructured interviews tend to be focused around a list of topics or issues where the phrasing and sequencing of questions may vary widely between participants (Bowling 2009). This type of interview has been described as a 'guided conversation' (DiCicco-Bloom & Crabtree 2006) and while it is useful for eliciting meanings about behaviours and beliefs, it is not well suited to this study where responses to specific topics are sought. Semi-structured interviews allow the interviewer to investigate in some depth aspects that may be of particular interest or knowledge of the participant rather than being required to ask the full set of questions in a particular order, as would occur in a structured interview (Bowling 2009).

relationship quickly with the participant. The issue of trust when interviewing elites is discussed more fully below.

4.4.1.3Finding elite participants using snowball sampling

In some studies of elites the targeted individuals are publicly known and easily identified.[76] However, where influential people have formed policy communities or networks they are not as easy to find. As the use of policy networks is well established in Australia (Hazlehurst 2001) (as discussed in Chapter 2), those who influence policy in the residential aged care sector are likely to be known to each other. To overcome the challenge of finding elites a snowball method was used to enrol participants.

Snowball sampling, or respondent-driven sampling, is a research approach used for locating key informants where their identity cannot be ascertained with certainty in advance.[77] Both Considine (1998) and Baker (2013) put forward arguments for using a snowball method to interview health policy elites in Australia. The snowball method of selecting participants for interview was selected for the following reasons:

- the number of people in senior positions in government and aged care organisations is very large and it would not be possible to interview all of them in the hope of capturing the most knowledgeable and influential
- a random sample of individuals in senior positions may not identify those who are most knowledgeable and influential
- not all individuals in senior positions in aged care organisations are considered knowledgeable and influential by their peers
- there was no identifiable list of people who are knowledgeable and influential in the aged care industry in Australia to select a representative sample from

[76] For example, where the targets are elected members of the House of Representatives or Senate (Aberbach & Rockman 2002) or Nobel Prize laureates (Stephens 2007), their identity is in the public domain and finding them physically is straightforward.
[77] This has been an accepted sampling method in social sciences research for several decades (Goodman 1961; Heckathorn 1997, 2002; Jeon, Glasgow, Merlyn, & Sansoni, 2010; Lewis 2009; Patton 1990; Salganik & Heckathorn 2004).

- not all individuals in key stakeholder organisations are influential, and conversely, not all influential individuals come from influential organisations
- knowledgeable and influential individuals are in the best positions to be able to identify other knowledgeable and influential individuals.

The snowball sampling method asks consenting research participants to identify others they know who meet the criteria of the research. To commence the snowball method I approached three individuals who knew of me from my former positions in the field of aged care. They were the chief executive officer of a major provider organisation (CEOMP1), the chief executive officer of a peak body representing service providers (CEOPB1) and a senior executive of a government organisation (DirGov1). Each agreed to be interviewed. These three interviews served as a valuable test for the relevance of the semi-structured interview questions. At the end of each of these initial interviews I asked the participants to recommend others in the Australian aged care industry they considered knowledgeable and influential. No definitions were provided to these criteria and it was left to these participants, and subsequent participants, to determine the meaning of these terms. This method has been used previously to access key informants both internationally (George & Bennett 2005; Yin 2009) and in Australia (Lewis 2005b; Pforr 2006).

Requests by participants to disclose whom I had already interviewed (or was planning to interview) were declined for two reasons. First, disclosure would have breached confidentiality and secondly, I needed to assess the level of consensus among the participants on others considered knowledgeable and influential.

Following the initial three interviews a grid was created to assess the number of recommendations each potential participant received. Subsequent potential participants were selected from potential participants recommended by more than one of the previous participants. This process was continued until all the participants with two or more recommendations were interviewed, with a small number of exceptions. The details of the final sample are provided in Chapter 5.

4.4.1.4Strengths and weaknesses of the sample method, participant selection and final sample

Baker (2013) poses two questions regarding elite population sampling in health policy research - 'how to access the most influential participants?' and 'is the final sample reasonably representative?'

To address the issue of sample validity, consideration was given to only selecting recommended participants who were confirmed by their peers because of their publically acknowledged level of activity and influence in the industry and/or because of their organisational position and influence. Two 'lists' were considered for the purpose of confirming their relevance to the study. The first was the list of organisations that provided a submission to the recent Productivity Commission inquiry into aged care in Australia. However, there were 490 submissions to the inquiry and many of them were from small organisations with potentially limited influence (Productivity Commission 2011, p. 9). The second list was the membership of the NACA as this is the key body used by the federal government in recent years to provide advice on proposed regulatory changes. However, this advisory group also includes organisations with only a peripheral role in aged care, for example, Exercise and Sports Science Australia, the Royal Blind Society of Australia and the National LGBTI Alliance. The NACA list was used as a 'reasonability check' and based on this check, I am confident that the key organisations that work on this body have been included in the sample.

Another test for sample validity was to exclude those participants recommended by only one participant, since having only one recommendation would not indicate a reputation in the industry as knowledgeable and influential.[78]. The wisdom of this selection criterion became apparent after only a few interviews. Some participants appeared to recommended participants with similar or opposing views, but not necessarily because they were considered knowledgeable or influential. Others

[78] This decision also has a practical dimension, as there was a need to contain the number of interviews I could complete.

suggested that I should talk to 'x' or 'y' because they had an interesting or controversial point of view, but was not necessarily one that was widely held.[79]

It is not possible to assess with accuracy the extent that the elite stakeholder sample is representative of the population that is knowledgeable and influential in the residential aged care industry. However it may be reasonable to expect that the sample should represent the industry along some structural dimensions that could represent a spread of views. This distribution required including a sample of participants from the for-profit and not-for profit aged care sectors, consultants and senior advisors to the industry, consumer and advocacy groups, and government. The distribution of the final sample by role and organisational type is provided in Chapter 5.

Two factors - new ideas and newly recommended potential participants - were taken into consideration in determining that the sample size and representation was sufficient. The extent to which new ideas and new material were surfacing at subsequent interviews was tested by the assessment of new codes being established in NVivo (see the section below for a full description of the coding methodology used with NVivo). Interviewing was stopped when the coding of the transcripts indicated data saturation. This occurred when five consecutive interviews did not result in the addition of any new codes (only additional material to existing codes) or any new recommended potential participants for interview. Similarly, potential participants recommended by the last five interviewees were individuals that the previous participants had already recommended and had already been interviewed.

4.4.2 Data collection

4.4.2.1 Interview method and questions

The intent of the interviews was to gain an understanding of the perspectives of the elite stakeholder study population on the current trends and anticipated future for the residential aged care sector. The examination of aged care policy

[79] Naturally, where 'x' or 'y' was also recommended by another participant they were included in the sample for interview.

over the recent past, and the analysis of the current regulatory framework explored in Chapter 2, identified recent directions in policy and the preferred approach of successive Australian governments. These revelations helped to shape the review of the literature on residential aged care by identifying the structural variables that have featured in past policy decisions and the current approach to policy development. The literature review reported in Chapter 3, in turn, helped to shape the analysis of the residential aged care census and sanctions data and the interview questions, by identifying the key variables of interest in the international literature that have been found to have a relationship with quality and performance. The initial analysis of the census and the sanctions data also revealed areas of interest that the interviews were designed to explore. As this analysis suggested, there are well-established trends in the residential aged care sector that have some consistency with overseas trends. Consequently, the interview questions were developed to elicit the participants' perspectives on these trends, the factors that are likely to influence them, whether they believe these trends will continue and in what way the trends will be different in the future than in the past. The semi-structured interviews were based around the questions listed in Table 12.

Table 12 Questions asked during the semi-structured interviews

1. What will be the impact of the government's current policy package, Living Longer Living Better, on the residential aged care sector in the future?
2. How is this reform process different to past ones and how will it impact on the implementation of the reforms in the future?
3. Which groups are currently the most influential in the current policy reform process and what makes them so influential?
4. Can you tell me about (name of your organisation's) approach to the future?
5. How do we measure quality now and how should we measure it in the future?
6. What do you think the sector will look like in the future, say by 2020 or 2025 (in terms of structural elements of the nature of service provision, size of owners, nature of operators, size of facilities etc.)?
7. Do you and your organisation have a view as to the preference for what the sector should look like in the future?

The first three interviews, with elite stakeholder participants who were known to me, allowed me to become familiar with the impact of the questions and the way I should ask the questions to other participants who were recommended, some of whom were initially unknown to me. The first question asked the participant to express their views on the recent aged care policy reforms. This open-ended question was designed to place the participant at ease by providing them with an opportunity to express their view on a relevant, well-known and much discussed topic. All the elite stakeholders would likely be very familiar with the regulatory changes recently announced by the government. Their response to this question often touched on the responses I was seeking to elicit from other questions and I realised that the most effective method to interview these participants was to allow the conversation to flow, and to use the set questions more as an 'aide memoire' to ensure all questions were covered. Reviewing the recordings of these three initial interviews before continuing with the next round provided me with valuable insight into my questioning style. I noticed that I sometimes spoke over participants in my eagerness to draw them out on a particular point and that I provided frequent verbal reinforcers ('yes', 'right', 'un huh' etc.,). I was conscious that these verbal reinforcers may have been perceived by the participant as reinforcement for giving me the responses I was looking for, when they were intended merely to encourage them to continue talking.[80] In subsequent interviews I minimised the time I spent talking to maximise the time available to the participants. This conversational style of questioning meant that the interview questions were not necessarily asked in the order they are listed above, and while the same question content was consistent for all interviews, the questions were not always worded in exactly the same way. I also asked further questions when it was necessary for me to clarify the meaning of the response, while at the same time taking care not to lead the participant to a particular response. The following table provides examples of clarification questions asked.

Table 13 Examples of clarifying questions and responses

[80] I suspect this method of interviewing is a hangover from my early clinical career in mental health where it is important to provide positive reinforcement to a client's comments.

1.	*RB: And so, is what you are saying, the not for profits could, if they don't grow, decline as a proportion of the industry?* *CEOMP1: That's exactly true.*
2.	*CEOMP1: It's just as variability [sic] between the sites in my organisation, you know some of them do better than others for a whole variety of reasons and certainly in terms of quality but for financial performance as well; local management is probably the biggest factor.* *RB: The X factor, the black box?* *CEOMP1: Yea, if you get a really good manager, who manages people well, manages the families effectively and manages his or her staff well, you get a very good quality usually on every metric, you know, in terms of complaints, in terms of accreditation and in terms of financial performance; if you get the right person with the right skills*
3.	*RB: If I've heard you correctly, what you're saying is that there's a gap in our current basket of services that sits somewhere in between this triangle of home, nursing home, and hospital, there is something in the middle there, what in the old days was called a convalescent home?* *CEOMP8: That's not a bad summary of it.*

4.4.2.2Overcoming the challenges in interviewing elites

There is a reasonable agreement in the published literature on the challenges and limitations of interviewing elites (Aberbach & Rockman 2002; Baker 2013; Davies 2001; Goldstein 2002; Lilleker 2003; Morris 2009; Ostrander 1993; Stephens 2007). These challenges and limitations are summarised below, together with the strategies I adopted in recruiting participants and in conducting the interviews.

Gaining access

The first challenges for researchers in interviewing elites is to navigate the variety of protective gateways often erected around senior executives and to quickly establish themselves as an informed interviewer.[81] I anticipated that I could quickly establish my credentials as an informed interviewer with an initial telephone call and achieve a success rate that would not be possible through email or posted letters. Unlike many PhD students, I have three decades of experience at a senior level in government and private organisations engaging with senior executives, consultants and policymakers and have the skills to converse with ease

[81] Elites are generally busy people who may not regard providing time to a PhD student as a priority in their crowded schedule. As Goldstein (2002) emphasises, the most well-developed study of elites is of no value if you don't get the interview.

with my targeted participants. The telephone conversation was followed by an email providing an introductory letter, explanatory sheet and consent form. (Copies of these documents are provided in Appendix C.)

Establishing rapport and trust through face-to-face interviews

Several authors note that having achieved access to the elite participant it is important to establish rapport and trust to gain the most from the interview (Baker 2013; Goldstein 2002; Harvey 2009). A key question with elites is whether a face-to-face interview is necessary, or whether the required level of rapport and trust could be established through an electronic interview (telephone, Skype, videoconference).[82] I decided to aim for all face-to-face interviews for a number of reasons. First, I was conscious of the challenges inherent in convincing the potential participants to give time to me as a PhD student and was of the view that my own personal attributes would greatly assist me in establishing rapport and trust with the participants. I am an ageing male with grey hair, I wear business attire with confidence and I understand and work comfortably within the culture that surrounds senior people in large organisations. These attributes would be of lesser value in a telephone or Skype interview. Second, I intended to explore some issues in depth with these participants and I wanted the advantage of being with them in their own environment to judge the extent to which I could persist in exploring a particular issue. Third, it was anticipated that the majority of the identified elite stakeholders would be based in four cities - Sydney, Melbourne, Canberra and Adelaide - all of which are accessible to me; thus reducing the need for an electronic interview. Finally, my own availability was not an issue and I would be able to easily accommodate the time availability of these time-poor participants. Telephone, Skype or videoconference would have been

[82] Scholars have found that each study with elites should adopt the most appropriate strategy to balance cost, effort and quality. Some researchers report success with telephone interviews with elite participants (Stephens 2007), while others prefer face-to-face interviews but have accepted telephone interviews when face-to-face interviews were not possible (Harvey 2009). Sturges and Harahan (2004) suggest that telephone interviewing may result in the same quality of transcripts but with qualifications, however, their research was not conducted with elites. Stephens (2007), for example, distinguishes between 'elites' and 'ultra-elites' and decided to interview the 'ultra-elites' face-to-face due to their smaller number and the particular focus of the research, while content to interview 'elites' by telephone.

used if necessary, however, it was possible to conduct all interviews face-to-face.

Participants as skilled interviewees

A number of authors (Batteson & Ball 1995; Kvale 2007; Lilleker 2003; Morris 2009) comment on the particular challenges of interviewing elites who are familiar with being interviewed, are skilled in avoiding disclosure of particular material, are adept in not answering the question and are practised in deflecting the conversation to another topic. In addition, many of the potential participants I intended to interview were senior executives, comprising a particular group of elites who have been found to prefer dominating the discussion and controlling the interview (Batteson & Ball 1995; Lilleker 2003; Morris 2009). Other challenges can occur for the interviewer when the participants seek to present themselves and their organisations in the best possible light, to rewrite history, or to exaggerate the roles and contribution of either, or both, themselves and their organisations. As Berry (2002, p. 680) notes '*interviewers must always keep in mind that it is not the obligation of a subject to be objective and to tell us the truth*'. Morris (2009) argues that for these reasons and because researchers lack power in relation to elite interviewees, they need clever strategies.

The strategies I employed to overcome these challengers include those noted by others, including flexibility in asking questions, triangulating responses, self-disclosure about my background and experience and employing mechanisms to signal control of the interview, such as switching on the recorder and consulting my watch when approaching the end of the interview (Baker 2013; Berry 2002; Goldstein 2002; Lilleker 2003; Morris 2009). As my participants were executives with varying backgrounds, roles and responsibilities, it was reasonable to expect that the different participants would have more knowledge and more developed views on particular topics than on others. The flexibility allowed with semi-structured questions enabled me to vary the depth of discussion to enable intensive discussion of some topics, with less attention paid to others where there was little prospect of gaining an informed response. In some interviews I purposively sought multiple responses to the same issue or event in order to pursue

contrasting or complementary views, particularly where some participants expressed a strongly held view.[83]

I was conscious that, when interviewing elites, the researcher needs to disclose their own knowledge and expertise in order to gain the level of rapport with the participant that will elicit open and comfortable responses, but without influencing the participant's responses. Morris (2009, p. 212) refers to this as 'positionality' or being seen as an 'outsider' or 'insider'. Being seen by the participant as uninformed on key aspects of the industry (an outsider) may lead the participant to waste time providing explanations on the mistaken belief that the researcher does not understand basic issues. More importantly, where a participant is of the view that the researcher's knowledge of the industry is limited, they may provide a simple explanation of the issue, in the mistaken belief that a more complex response would not be understood. In such situations, failure to disclose knowledge and experience may lead to participant embarrassment when it emerges that the researcher is very knowledgeable with the subject at hand. On the other hand, presenting oneself to the participant as an 'insider' in order to streamline the discussion to a productive level may have the effect of discouraging participants in different ways. Participants may omit key details in the expectation that these details are 'common knowledge' to 'insiders'. Alternatively they may choose not to comment on a particular issue to avoid the embarrassment that the researcher may know more about that issue than they do.[84]

I sought to position myself on the boundary of 'insiders' and 'outsiders' by demonstrating that I was sufficiently familiar with the industry to discuss issues

[83] For example a leading banker who specialises in residential aged care could be expected to comment in depth on the potential impact of the recent reforms to aged care on the capacity of different categories of providers to access capital in the future, but may have less knowledge or interest in how quality will be measured by his or her clients. However a banker's views may be coloured by their particular perspective, therefore in subsequent interviews I was conscious to explore issues of future capital with senior executives in provider organisations to test the level of consistency on this issue across a range of participants.

[84] It was not possible to avoid some occasions where the participant sought to convey a strongly held view that was not particularly relevant to the interview. I was conscious of the need to both provide the participant with sufficient time to answer the questions I asked in detail and also to bring the discussion to a conclusion to move on to the next question.

in detail, but that I currently held no senior position in the industry and was therefore, not familiar with 'day-to-day' issues. I did this by revealing that I previously chaired the board of a medium-sized not-for-profit residential aged care facility and had completed multiple projects for private aged care provider clients, peak bodies and the Department while working as a consultant with a large international consulting firm. I stressed that these experiences were in the past and I was seeking the views of current 'senior people' on the future of residential aged care.[85] My decision to be transparent and honest is consistent with that advocated by others (Morris 2009; Ostrander 1993).

My previous experience as a senior executive and consultant enabled me to adopt the strategies proposed by Ostrander (1993) of not behaving in the manner of a guest, a friend or a colleague. I was careful to adopt an approach that was respectful, business-like but not overly deferential. On meeting my participants I thanked them for their time but not in a manner that suggested ingratiating gratitude, inferior status on my part or a lack of confidence in the situation, which would allow the participant the opportunity to control the interview. Using the mechanism both Ostrander (1993) and Morris (2009) advocate, I consciously assumed, and attempted to convey, the expectation that the participant would be as committed to the interview as I was. Another strategy I adopted was to use the setting up of the recording device as the signal that as I was in control of the interview - that is, he who controls the recorder controls the interview.

4.4.2.3Balancing the researcher's potential biases

Scholars agree that expertise in the field being researched is a necessary attribute for those seeking to interview elites (Baker 2013; Goldstein 2002; Lilleker 2003). I have been involved in the aged care industry through both governance, advisory, research and evaluation roles (Baldwin 2013; Baldwin, Stephens & Kelly 2013a, 2013b; Baldwin, Tess & Johnson 2007). However I am conscious of the possibility of bias in both the interviewing and the analysis of

[85] I did have some concern that revealing my involvement with a not-for-profit organisation may have prejudiced me in the view of for-profit providers, however I felt that to not reveal my background may impact my credibility in the field should participants believe I had misled them.

the interview transcripts. Furthermore, the design of the approach to this research (mixed methods) was adopted to assess the trends apparent from the quantitative (census and sanctions) data, in order to inform the qualitative component of the research. I was conscious that the trends that I had identified to elicit from the quantitative data (Chapter 5) may have biased the focus of my interview questions. To overcome this I was careful to ensure that the lead questions were open ended and did not indicate a bias toward the direction of one trend over another. Subsidiary questions were often necessary to clarify meaning or intention of the participants' response, or to encourage a more detailed response. However, in asking additional questions, I took care that they were not directional and allowed for a free response by the participant.

4.4.3 Analysis of qualitative data

4.4.3.1Thematic analysis and NVivo 10

Interpretive thematic analysis, a well-established method (Braun & Clarke 2006; Liamputtong & Serry 2010; Ryan & Bernard 2003), was used to analyse the interviews. Braun and Clark (2006, p. 78) define thematic analysis as '*a method for identifying , analysing and reporting patterns (themes) within the data*' by finding repeated patterns of meaning. The first step in thematic analysis is 'meaning coding' (Kvale 2007).

Coding was undertaken using NVivo 10 following established methods (Hutchison, Johnston & Breckon 2010). NVivo 10 is software product produced by CRS International, which aids researchers in thematic coding to analyse text, audio and visual data by enabling them to group selected data with a similar meaning by the use of 'nodes'. The nodes are labelled with key words describing the content of the data coded to that node (NVivo 10). Nodes enable the researcher to collect selected excerpts together from different transcripts that relate to the same idea, subject, topic, attitude or viewpoint etc. The same text can be coded to more than one node. Nodes can be collected as hierarchical families of related or subordinate concepts.

Coding was both inductive and deductive. Inductive coding allocated meaning to textual material based on the factual content of the text, for example, size of

facilities, provider mix, and financial performance. It was also deductive when text was coded on the perceived meanings of views and beliefs expressed, for example, the impact of 'market forces', the concepts of 'choice', and the 'influence of different stakeholders'. The analysis was undertaken in stages, which are described in the table below.

Table 14 Stages in the coding process using NVivo

1.	Initial coding	uploading transcripts into NVivo and coding the first five transcripts by the creation of nodes within NVivo
2.	Review of nodes	review of the nodes created with the first five transcripts and refinement of the node names and definition, merging nodes with similar names creating new nodes where warranted
3.	Initial analysis and emerging themes:	first analysis of each node with further refinement of material in nodes to clarify meaning and initial development of emerging themes
4.	Refine codes and produce a code book	examination of the content of potentially duplicated nodes and further refinement of subordinate nodes within 'families', progressive creation of node descriptions and the creation of a code books (Appendix D);
5.	Detailed analysis and final theme identification	progressive analysis of the data stored in each node to analyse established themes and iteratively refine the final themes emerging from the analysis

4.4.3.2Coding

Creating and reviewing coding

The initial approach was to adopt 'broad brush' or open coding (Bazeley 2013; Bazeley & Richards 2000). This practice provides a quick and easy way for the researcher to collect the responses to each question from each participant in one place. Consequently, my first groups of nodes were headed with simple names related to each of the semi-structured questions such as 'Before the reforms', 'Future', 'Living Longer Living Better', 'Locality', 'Market forces', 'Size', 'Provider type' etc. However, almost immediately after the commencement of the coding of the first transcript I realised that the data was much richer and deeper than these simplistic headings allowed and the open coding approach would result in nodes containing a very large volume of data. These initial nodes were retained as 'parent' nodes and subordinate 'family' nodes

were arranged hierarchically under them. For example, the original node 'Future' became a parent node with subordinate nodes such as 'future access to care', 'future demand', 'future of your organisation', 'long-term care insurance', 'shape of the industry in the future' etc., created beneath it. Additional parent nodes were also added to capture the richer aspects of the data that were immediately apparent from the first group of transcripts.

Initial thematic analysis and review of codes

As new themes emerged, new nodes were needed to reflect the participants' perspectives that had not initially been identified. The new nodes reflected themes on choice, competition, management skills, market forces, 'disappointments' with the policy approaches of government, policy and regulations and business strategies. Coding was continued progressively as each interview transcript was received from the transcriber. After every five or so transcripts had been coded, the nodes that had been created were reviewed for duplications and redundancies. During these regular reviews duplicate nodes were merged and some nodes moved to more appropriate 'parent' nodes.[86] New 'parent' nodes were created to capture emerging themes that were not initially anticipated and included 'approaches to business', 'financial performance', 'neo-liberalisms', 'policy process', 'quality - achievement and measurement', 'community relations' and 'staffing'.

Refine codes, create code book

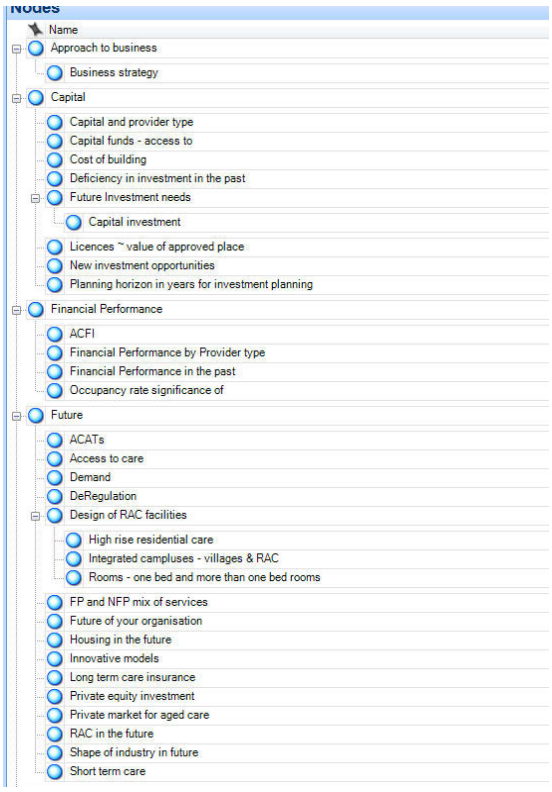
When all interview transcripts had been coded, a further detailed examination of the node structure was undertaken. This examination resulted in some name changes for both parent and subordinate nodes to better reflect their content, some further mergers and some transfers of subordinate nodes to more appropriate 'parent nodes'. At the end of this process a code book was created - Appendix E. This code book details the node structure at this point in the analysis and reports 16 parent nodes with 121 subordinate nodes.

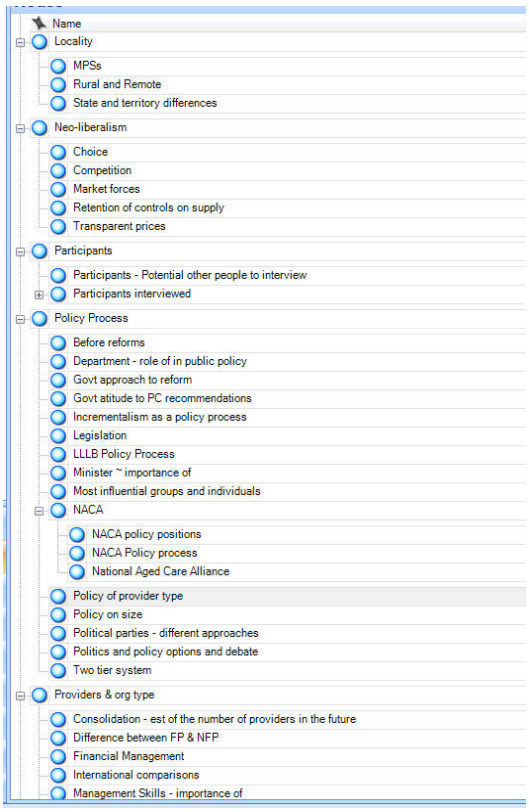
[86] For example, I found I had created two similar nodes related to access to care, one under the parent node 'Future' and one under the parent node 'Neo-liberalism'. The content of these nodes was then reviewed and access to care was consolidated under 'Future' as this theme was a more appropriate than 'Neo-liberalism'.

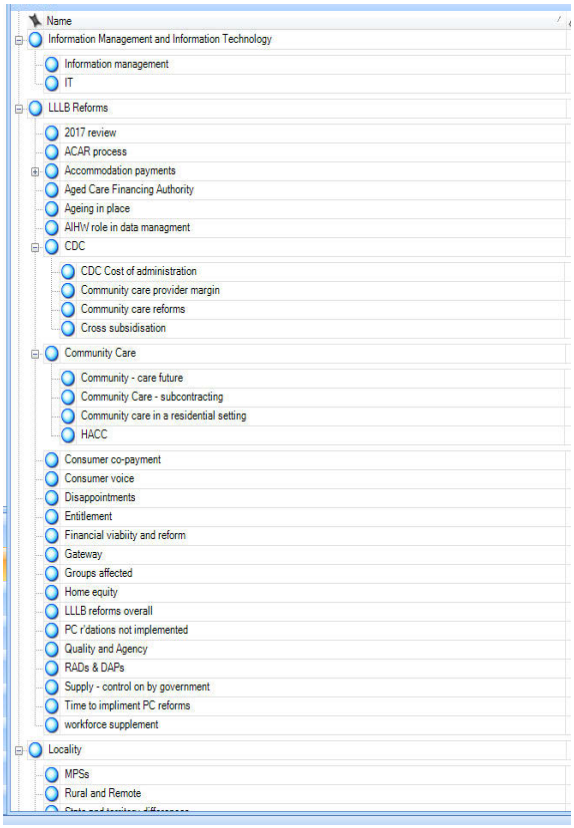
Detailed analysis and final theme identification

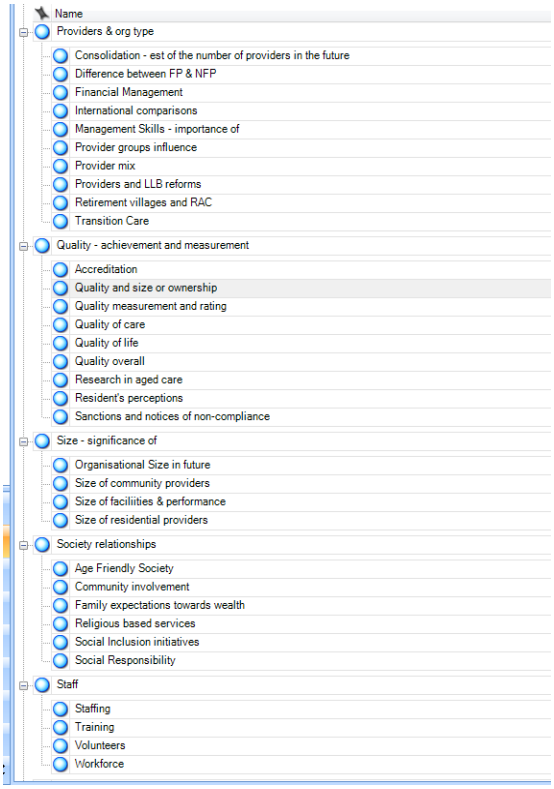
After all interview transcripts had been coded, detailed analysis was undertaken by reviewing all the final parent and subordinate nodes. This resulted in further merging and de-merging of some nodes and in a final identification of the themes as represented in Figure 9, which is a 'screen shot' of the code structure at the commencement of the analysis phase. Analysis of each of these themes was progressively undertaken by examining the content of the transcripts in each theme and the subordinate material. The final themes are reported in Chapter 5 within three broad categories of themes.

Figure 9 Screen Shots of the node structure - Stage 5









4.5 Conclusion

This chapter has described in detail the methods used to collect and clean the quantitative data on historical trends in the residential aged care sector, to establish a database for the analysis of the data on structural characteristics and sanctions and how these data were analysed. The analysis of these data followed an exploratory descriptive method and the findings are reported in the following chapter.

The interview questions were guided by the emerging areas of interest identified in Chapter 2 and the literature review in Chapter 3. They were developed subsequent to the initial analysis of the quantitative data, and the trends that emerged from these data informed the development of the interview questions. These questions were designed to elicit the perspectives of elite stakeholder participants on the current forces shaping the residential aged care sector and what will emerge in the future.

This chapter has explained and justified the choice of face-to-face interviews with elite stakeholders selected using a snowball method and how the sampling and interviewing processes resulted in valid and reliable data from elites associated with the Australian aged care industry. The interviews were undertaken using established research procedures for collection, storage and analysis of data. Also described in this chapter were the methods used to safeguard ethical, security and privacy issues regarding participant interviews. Finally, this chapter has described how the qualitative data were analysed using NVivo software which identified the perspectives and preferences of the participants. This method enabled the establishment of a number of key themes which are reported in the following chapter.

CHAPTER 5 Findings

> *Quality of care has been a longstanding concern in the nursing home sector with policy makers, researchers, media and the public all identifying low quality. Policymakers and researchers alike have been interested in linking these two ideas by suggesting a causal relationship between ownership status and quality of care. (Grabowski et al. 2013, p. 12)*

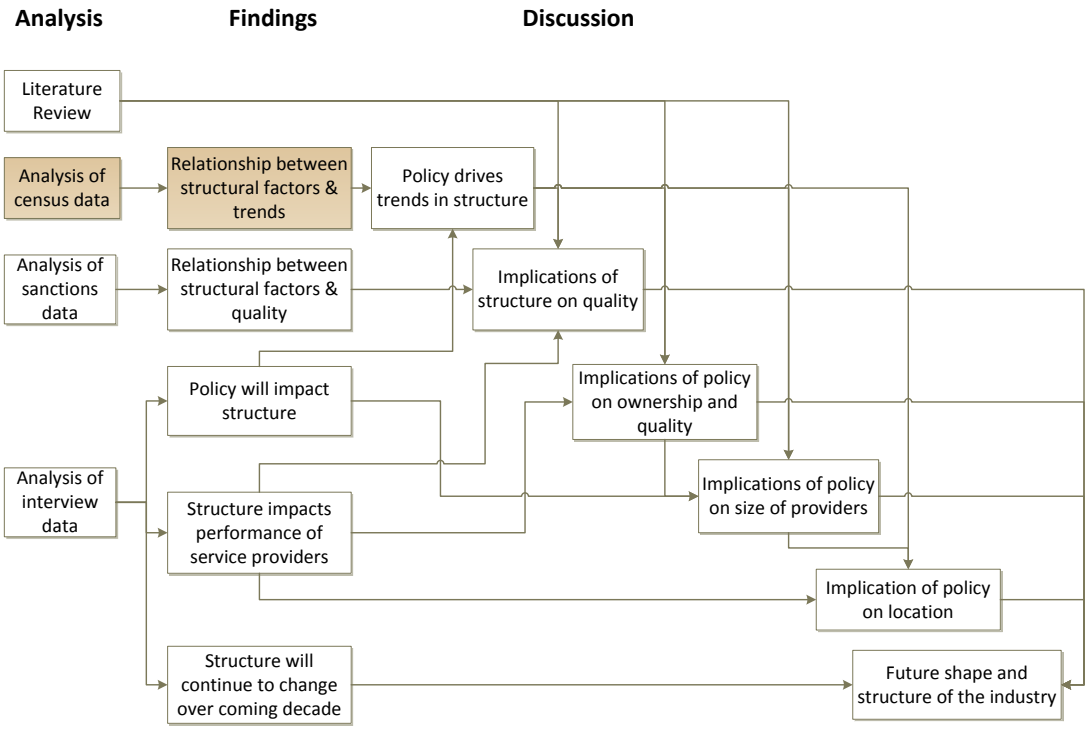
5.1 Introduction

This chapter reports the study findings in two parts: Part A, Section 4.3, reports the findings from the analysis of quantitative data on the trends in structural factors and sanction events in Australian residential aged care facilities; Part B, Section 4.4, reports the findings of the qualitative data obtained through semi-structured interviews with elite informants. Assistance with the statistical analysis of the data on sanctions reported in Part A of this chapter was provided by Dr Zhixin Liu. Dr Liu completed the Poisson regression analysis reported in section 5.8.4 below and detailed in Table 34. All other work in this chapter was completed by me.

5.2 Part A – Relationship between structural factors and trends

The figure below places this part, the analysis of the census data, within the logical flow of the thesis.

Figure 10 Contribution of this section of Part A to the logical framework of this thesis



As described in the previous chapter, the secondary data were sourced from the Department of Health and Ageing and required considerable cleaning prior to analysis to remove duplicates and errors, and correct data omissions and inconsistencies in the names and locations of services and service providers. Inconsistencies in ownership types, locations and the names of services were also corrected. This process resulted in a unique dataset that differs from the aggregated totals that are published in the public domain (for example, by the Australian Institute of Health and Welfare (AIHW) (2012a) and the Department of Health and Ageing (2012d)).

The data were analysed to answer the following research questions:

- What are the trends in the structure (ownership, size and location) of the residential aged care industry across Australia?
- What is the relationship between structural characteristics and quality outcomes within the residential aged care industry in Australia?

Based on the historical development of residential aged care services examined in Chapter 2 and findings from the literature review in Chapter 3,

these quantitative data were examined to investigate the following propositions:

- Proposition 1: Trends in the structural characteristics of the residential aged care industry will exhibit the impact of government regulation of the residential aged care sector.
- Proposition 2: There will be fewer but larger residential aged care services and fewer but larger residential aged care providers over time.
- Proposition 3: Trends in residential aged care services will differ by organisational type.
- Proposition 4: There will be a relationship between structural characteristics and quality failures.

The trends in structural variables over the period 2003 to 2012 are reported first, propositions 1, 2 and 3. This is followed by the relationship between residential aged care structural features and sanctions, proposition 4.

5.3 Trends in the number of aged care services

The first step in this analysis was to identify the overall trends in residential aged care services in Australia. Table 15 (page 130) provides details on the number of Australian government-funded operational aged care places[87] and services.[88] On 30 June 2012 there were 184,942 operational beds in residential aged care services across Australia, an increase from 148,187 beds (26.4%) since 30 June 2003. These beds were almost evenly divided

[87] The Australian Government Department of Health and Ageing (2011b) uses 'place' to refer to an approved residential or non-residential aged care place. The Department makes a distinction between allocated places (the number allocated to an approved provider) and operational places (the number of allocated places in use). To avoid confusion, in the tables in this chapter, where the data refer only to residential places they are referred to as 'beds'. Non-residential places are referred to as 'places'.

[88] 'Service' refers to the facility which provides the approved aged care 'place'. An approved provider can operate more than one 'service'.

between allocated high care and allocated low care beds.[89] On that date there were in 2,725 separate residential aged care services across Australia, which is 5% fewer than in 2003. Over this period the occupancy rate for residential aged care services steadily declined from 96.1% in 2003 to 92.9% in 2012. However these trends were not evenly spread across the sector.

The number of multipurpose services (MPSs)[90] in outer regional and remote locations increased from 95 to 137 across Australia between 2004 and 2012 and the total number of beds in MPSs increased from 1,757 to 2,891 places (an increase of 65%). However, this may not indicate an overall growth in residential aged care places in rural and remote locations, as a number of these places will have been transferred from a previous stand-alone residential aged care or community care service into the newly built MPSs.

Table 15 indicates the number of community aged care services and places[91] funded under the Aged Care Act 1997 mainly through Community Aged Care Places (CACP) and Extended Aged Care at Home (EACH) packages. CACP were introduced as an alternative to residential care for persons with low-care needs and who have sufficient support to stay at home. EACH and Extended Aged Care at Home for Dementia (EACHD) services fund home care at a level intended to be equivalent to high-level residential care. Over the 10 years to 30 June 2012 the number of community care places has increased from 27,361 to 61,180, an increase of 135% and the number of services providing community care has increased from 940 in 2003 to 2,573, an increase of 174%.

[89] In 1997 the new Aged Care Act recognised a distinction between high care (previously nursing home) beds and low care (hostel or assisted living) beds within a single funding program.

[90] MPSs are based in small rural communities (< 5,000 population (NSW Health 2014)) and are state government operated. They are funded by both the state and Australian governments. Funding from both governments is pooled across residential/inpatient and community settings to provide a mixture of acute health, aged care and disability services within the one organisation. Not all MPSs have at all times included residential aged care beds.

[91] These data do not include services provided under the Home and Community Care (HACC) program.

Table 15 Operational beds, services (including MPS) and places: Australia 2003-12

Descriptive Data	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	% Change 2003-12
High care beds	73,899	76,059	77,770	79,772	81,166	84,019	85,846	88,581	89,735	91,658	24%
Low care beds	74,220	78,7758	81,000	83,894	86,153	87,498	89,757	91,583	92,126	93,284	26%
Total beds	**148,119**	**153,817**	**158,770**	**163,666**	**167,319**	**171,517**	**175,603**	**180,164**	**181,861**	**184,942**	**25%**
No. services (excluding MPS)	2,883	2,898	2,892	2,913	2,862	2,806	2,777	2,769	2,759	2,725	-0.5%
Occupancy[92] (%)	96.1	95.8	95.3	95.0	94.5	93.9	92.9	94.4	93.1	92.8	
MPS beds[93]	0	1757	1856	1951	2085	2394	2671	2707	2794	2891	65%[94]
MPS with beds	0	95	91	94	100	116	126	129	134	137	44%[95]
No. of beds in the largest residential service	300	300	306	310	325	336	336	336	336	336	3.27%
No. of community care places[96]	27,361	29,329	32,130	38,029	43,500	47,886	48,961	53,480	59,259	64,180	135%
No. of community care services	940	1,079	1,137	1,287	1,501	1,714	1,729	1,919	2,364	2,573	174%
Places in the largest community service	179	312	312	352	372	204	260	282	251	285	60%

[92] These data on occupancy were extracted from the Reports of the Operation of Aged Care Act 1997 published annually by the Department (Australian Government Department of Health and Ageing 2012d).

[93] Beds in MPSs were not reported separately before 2004.

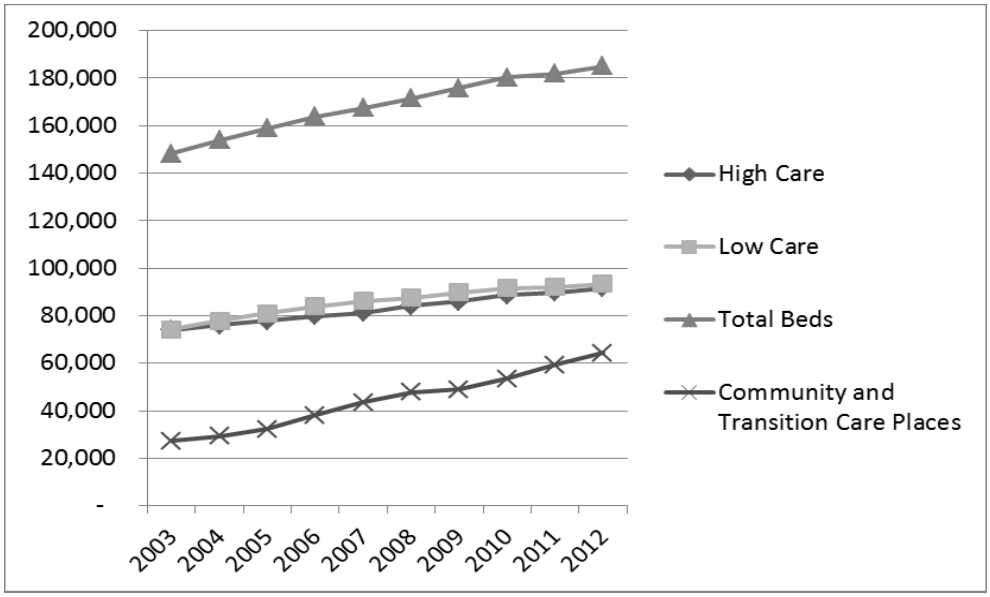
[94] Percentage change from 2004 to 2012.

[95] Percentage change from 2004 to 2012.

[96] Includes CACP, EACH, EACHD, Innovative Pool places, National Aboriginal and Torres Strait Islander program places and Transition care places.

Figure 11 illustrates the growth in the number of beds. The growth of low care (24%) and high care (26%) beds is similar over the 10-year period. It should be noted that this growth does not reflect the distribution of the number of high and low care residents.[97]

Figure 11 Growth in aged care beds and places: Australia 2003-12



5.4 Trends by provider class and type

Three organisational classes are used to define the operators of services in these data - not-for-profit (NFP), Government (Govt.) and for-profit (FP). These classes are consistent with the organisational classes identified in the international literature described in Chapter 3. There are three not-for-profit organisational types: charitable, religious and community; two government types: local government and state government; and three for-profit organisational types: private incorporated, private non-incorporated and publicly listed. These organisational types are allocated by the Australian

[97] As discussed in Chapter 2, due to ageing in place policies, an increasing number of high care residents are being cared for in low care places. The growth in the number of high care residents occupying low care places is not reflected in these data. The distribution of low and high care residents by service provider is not released by the Department.

Government Department of Health and Ageing[98] in the original data. The data are presented by ownership, class and type for two reasons. It allows the reader to compare the findings of this analysis with other published data and it identifies the different growth patterns by type within ownership classes. For example, the following tables enable comparison of trends in size between ownership types, such as the different growth patterns between religious and charitable organisations; which when combined, largely cancel each other within the overall classification of not-for-profit.

All state governments operate residential aged care services, however the two territories and the Australian government do not operate any aged care services.

5.4.1 Trends in the number of services provided by organisational types

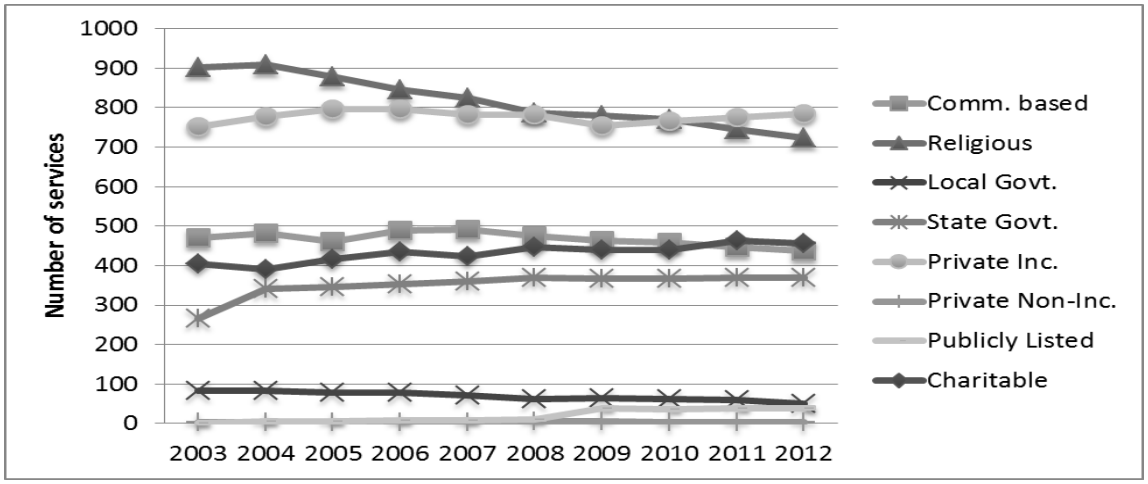
The number of individual residential aged care services declined by 5% over the period under review, but this decline was not consistent across organisational classes and types. Figure 12 illustrates the trends in organisational types and Table 16 details the trends in the number of services operated by these organisational classes and types across Australia between 2003 and 2012. In 2003 not-for-profit organisations provided 1,777 services (61.6% of all services), state and local governments 350 (12.1% of all services) and for-profit providers operated 756 (26.2% of all services). By 2012 the number of services provided by not-for-profit operators had reduced to 1,618, (59.2% of all services) and the number of services operated by for-profit organisations shows the largest change, an increase to 826 (30.3% of all services). The number of services operated by local and state governments has reduced from 350 (12%) to 286 services (10.5%).

[98] The definition of 'for-profit', 'not-for-profit', 'charitable', 'community based', 'religious', 'local' and 'state government' are provided in the definition table in Chapter 1.

Table 16 Services by organisational type and class (including MPS): Australia 2003-12

Organisational type	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Change 2003-12
Charitable	404	389	416	435	423	442	434	436	459	454	12%
Community based	470	479	460	490	492	474	463	457	446	436	-7%
Religious	903	908	876	842	822	779	776	768	743	722	-20%
Not-for-profit	**1,777**	**1,776**	**1,752**	**1,767**	**1,737**	**1,695**	**1,673**	**1,661**	**1,648**	**1,612**	**-9%**
Local government	83	82	78	77	70	60	64	60	58	50	-40%
State government	267	262	256	262	261	254	242	242	236	236	-12%
Governments	**350**	**344**	**334**	**339**	**331**	**314**	**306**	**302**	**294**	**286**	**-18%**
Private incorporated body	751	769	796	796	782	781	754	765	776	786	5%
Private non-incorporated entity	3	3	4	4	4	5	5	4	3	3	0%
Publicly listed company	2	6	6	7	8	11	39	37	38	38	1800%
For-profit	**756**	**778**	**806**	**807**	**794**	**797**	**798**	**806**	**817**	**827**	**9%**
TOTAL	**2,883**	**2,898**	**2,892**	**2,913**	**2,862**	**2,806**	**2,777**	**2,769**	**2,759**	**2,725**	**-5%**

Figure 12 Residential aged care services by organisational type: Australia 2003-12



The analysis of trends in organisational type, Table 16, suggests that residential aged care service operated by private incorporated bodies constitute the largest organisational type across Australia (785 services), followed by services operated by religious organisations (724 services). Over the period under review there has been a 20% decline in the number of services operated by religious organisations, a 7% decline in the number of services operated by community-based organisations and a 40% decline in the number of services operated by local government. These changes are balanced by a 12% increase in the number of services operated by charitable organisations, a 5% increase in the number of services operated by private incorporated bodies and a substantial 1,800% increase in the number of services operated by publicly listed companies, albeit from a very small provider base.

5.4.2 Trends in the number of beds provided by organisational types

The trend in the number of services differs substantially from the trend in the number of places provided by different organisational classes and types. Despite the decline in the number of services operated by religious and community-based organisations there has been an increase of 3% and 28% respectively in the number of beds they provide, with the number of charitable beds increasing by 48%. Similarly, although there has been only a modest increase in the number of services operated by private incorporated bodies, the number of beds they provide has increased by 40% over this period. The substantial increase in the number of services operated by publicly listed companies is reflected in the increase in the number of beds they provide (1,788% increase). Beds provided by local government providers declined by 33% and the number of beds provided by state governments increased by 22%. The details of these trends are provided in Table 17 and are illustrated in Figures 3 and 4.

Table 17 Beds by organisational type (including MPS): Australia 2003-12

Organisational type and sub types	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	% Change 2003-12
Charitable	21839	22302	24955	26678	26717	29476	29638	30516	32084	32424	48%
Community based	19679	20731	20397	22026	23456	23963	24377	25012	25015	25104	28%
Religious	48812	49732	49097	48310	49438	49280	49919	50296	49397	50342	3%
Total not-for-profit	**90330**	**92765**	**94449**	**97014**	**99611**	**102719**	**103934**	**105824**	**106496**	**107870**	**19%**
Local government	2816	2913	2882	2870	2710	2445	2544	2378	2294	1887	-33%
State government	9646	11034	11219	11569	11673	11923	11812	11845	11752	11762	22%
Total state government	**12462**	**13947**	**14101**	**14439**	**14383**	**14368**	**14356**	**14223**	**14046**	**13649**	**10%**
Private incorporated body	45122	48373	51555	53635	54657	56760	57196	60135	61322	63383	40%
Private non-incorporated entity	128	128	180	180	180	221	229	185	135	135	5%
Publicly listed company	145	361	362	400	625	696	2648	2568	2731	2737	1788%
Total for-profit	**45395**	**48862**	**52097**	**54215**	**55462**	**57677**	**60073**	**62888**	**64188**	**66255**	**46%**
TOTAL	**148187**	**155574**	**160647**	**165668**	**169456**	**174764**	**178363**	**182935**	**184730**	**187774**	**27%**

Figure 13 Beds by organisational type: Australia 2003-12

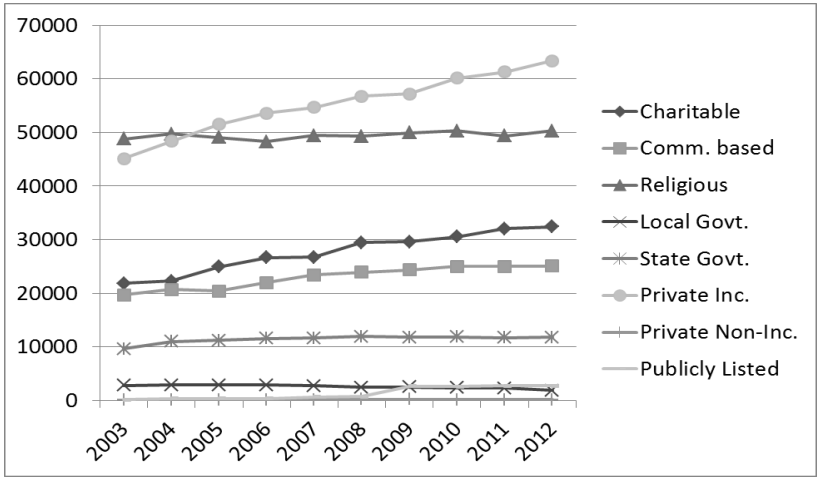
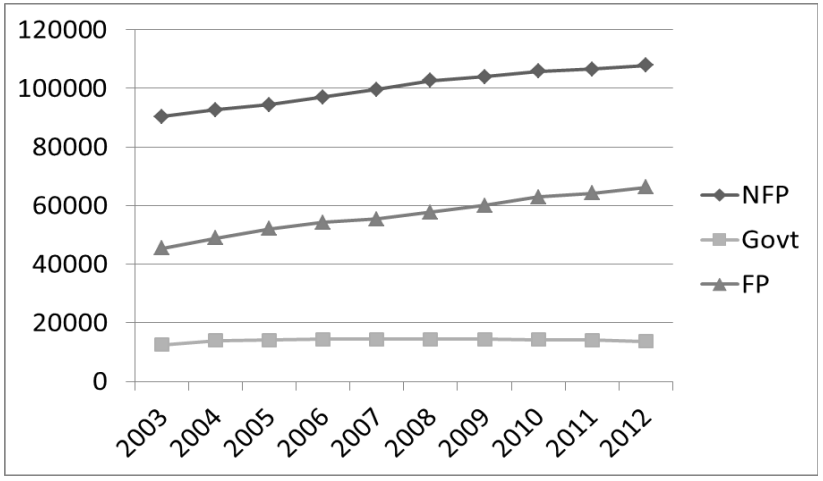


Figure 14 Beds by organisational class: Australia 2003-12



5.5 Trends in the size of residential aged care providers

The period under review also witnessed a decline in the number of providers and a corresponding change in the size of providers, measured by the number of services they operate, and this is reflected in Table 18 below. This table shows five size categories of provider by the number of services they provide; that is, providers with 1, 2, 3 to 9, 10 to 49 and those with more than 50 services. The total number of individual providers has declined by 22.8% over the 10 years under review from 1,236 in 2003 to 954 in 2012. The number of providers with only one service has declined by 25%; by 28.3% for providers with two or three services and by 10.6% for providers with between three and nine services. Conversely, the number of providers with between 10 and 49 services has increased by 15.8% and the number of providers with more than 50 services has increased by 50%; albeit from two to three providers.

Table 18 Residential aged care providers by provider size: Australia 2003-12

	Number of residential aged care providers										change
Provider size	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	'03 -12
Providers with 1 service[99]	866	857	826	783	746	707	703	689	675	652	-24.7%
Providers with 2 services	226	216	207	209	198	181	177	176	168	162	-28.3%
Providers with 3 - 9 services	104	103	101	99	101	98	89	84	88	93	-10.6%
Providers with 10 - 49 services	38	42	43	44	42	45	44	45	45	44	15.8%
Providers with 50+ services	2	2	2	2	2	3	3	3	3	3	50.0%
	1236	1220	1179	1137	1089	1034	1016	997	979	954	-22.8%

Table 19 and Table 20 list the six largest providers in 2003 and in 2012 respectively. In 2012 these providers operated nearly 16% of all services in Australia compared with the six largest providers in 2003 with 12.4%. The three largest providers have not changed in the 10 years under review and the Victorian Government remains the largest provider in Australia in 2012, as

[99] 'Service', in this table, refers to a residential aged care facility listed, by the Department, as a separate service. An approved provider may operate more than one service on the same site.

was the case in 2003 (although individual services are operated through local health services owned by the Victorian Government and operate within state-wide policies). The three largest for-profit providers in 2012 provided 6.4% of all services, while the two largest for-profit providers in 2003 provided only 2.9% of all services.

Table 19 The six largest chains of providers in Australia, 30 June 2003

Provider	No. of beds	% all beds in Australia
Victorian Government	5,834	3.1%
Uniting Care NSW (NFP)	5,203	2.8%
Uniting Care Qld (NFP)	4,971	2.6%
Moran Health Care (FP)	3,281	1.7%
Amity Group (FP)	2,071	1.1%
Baptist Community Care (NFP)	1,918	1.0%
Totals	23,278	12.4%

Table 20 The six largest chains of providers in Australia, 30 June 2012

Provider	No. of beds	% all beds in Australia
Victorian Government	6,203	3.3%
Uniting Care NSW (NFP)	5,852	3.1%
Uniting Care Queensland (NFP)	5,220	2.8%
Domain Principal Group (FP)	4,953	2.6%
BUPA Asia Pacific (FP)	4,409	2.3%
Japara Holdings (FP)	2,896	1.5%
Totals	29,533	15.7%

5.6 Trends in the size of residential aged care services

5.6.1 Service size and ownership

Trends in the average size (number of beds) of residential aged care services by organisational type for the period under study are shown in Table 21, Figure 15 and Figure 16. The average size of services operated by private incorporated bodies was the largest in 2012, and they have been the operators of the largest facilities, on average, over most of the years under review. Publicly listed providers also tend to operate large services although the number of residential aged care services run by them is small in comparison to other providers. Figure 15 shows that local and state governments have, consistently over the 10-year period, operated the smallest services, and they are markedly smaller, on average, than those operated by for-profit or not-for-profit providers.

The mean number of beds in residential aged care services in Australia has increased from 51.36 to 65.54 (27.6% increase) over the 10 years to 2012.

Table 21 displays the percentage change in the average size of facilities operated by organisational provider types. The average size of services provided by charitable, community-based, religious and private incorporated bodies have all increased by more than the mean for the whole of the residential aged care industry. Services operated by state governments and publicly listed companies decreased in size, although the latter declined only marginally. Residential aged care services operated by local governments and private non-incorporated bodies showed little change.

Table 21 Average size of services by organisational type (including MPS): Australia 2003-12 (beds)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	% Change 2003-12
Charitable	53.92	57.18	59.84	61.19	63.01	66.09	67.51	69.35	69.30	70.95	32%
Community based	41.78	43.01	44.34	44.95	47.67	50.45	52.54	54.61	55.96	57.45	37%
Religious	54.06	54.71	55.92	57.17	59.92	62.54	64.08	65.23	66.30	69.53	29%
Local government	33.93	34.68	36.48	36.79	38.17	40.08	39.14	38.98	38.88	37.00	9%
State government	36.13	32.36	32.52	32.68	32.52	32.31	32.27	32.19	31.85	31.79	-12%
Private incorporated body	60.08	62.18	64.77	67.38	69.89	72.49	75.86	78.61	79.02	80.74	34%
Private non-incorporated entity	42.67	42.67	45.00	45.00	45.00	44.20	45.80	46.25	45.00	45.00	5%
Publicly listed company	72.50	60.17	60.33	57.14	78.13	63.27	67.90	69.41	71.87	72.03	-1%
Overall	51.36	51.98	53.82	55.04	57.15	59.48	61.27	62.99	63.70	65.54	28%

Figure 15 Av. size of services by org. type: Australia 2003-12 (beds)

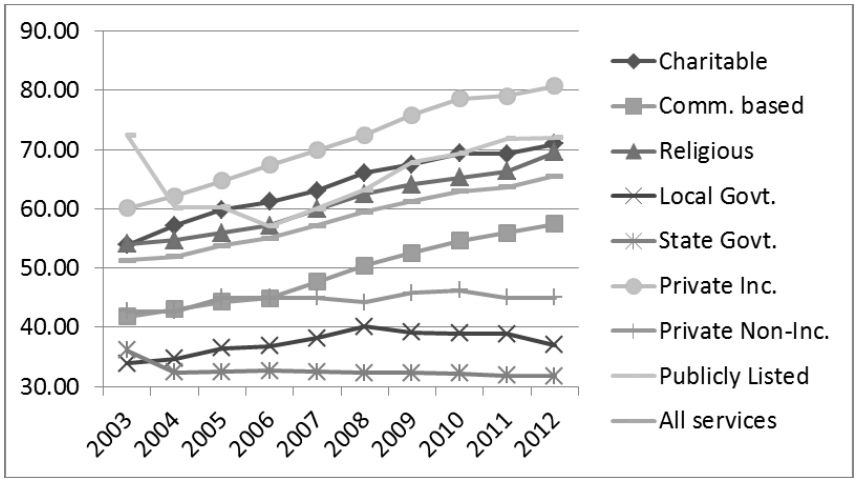
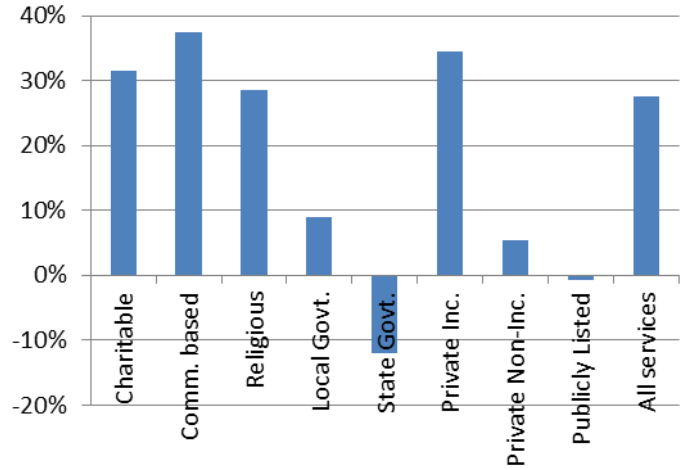


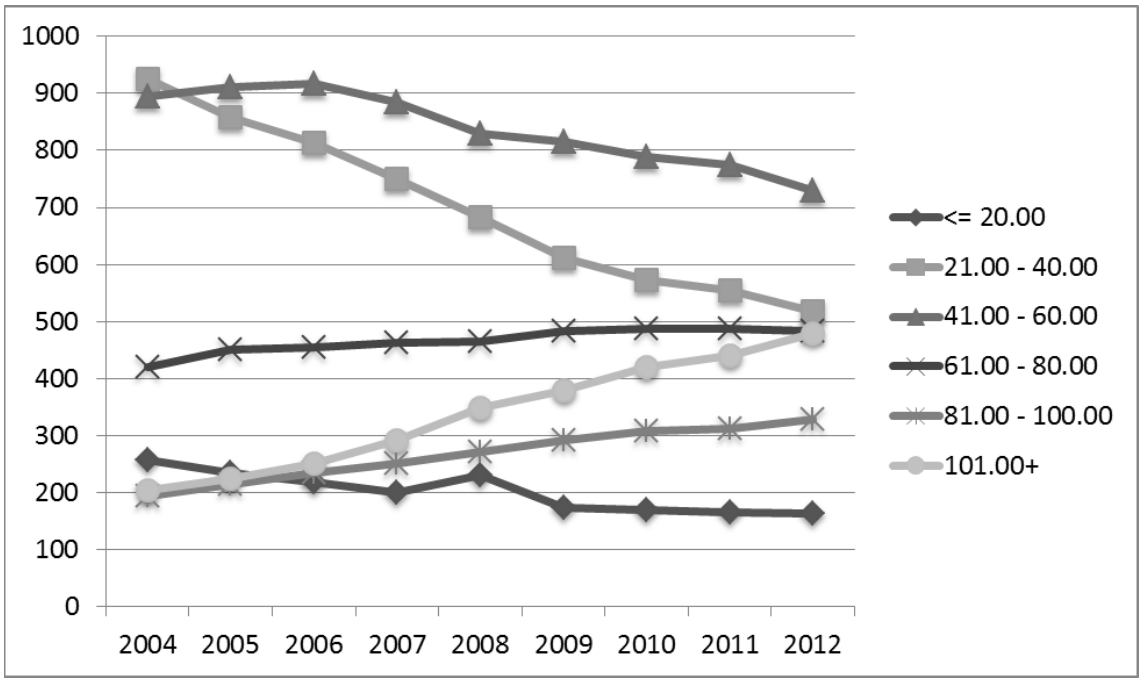
Figure 16 Changes to av. service size by org. type: Australia 2003-12 (%)



5.6.2 Service size by size category

In addition to the overall average size of residential aged care services there have been different trends in the size categories. Figure 17 show the trend in the number of services by service size categories over the 10 years to 2012. It illustrates that the number of services in each of the three size categories with fewer than 60 beds (less than 20, 21 to 40 and 41 to 60 beds) has declined since 2003, and the number of services in each of the size categories with more than 60 beds (61 to 80, 81 to 100 and 100+ beds) has increased. The size category of 21 to 40 beds shows the steepest decline and the size category with more than 100 beds shows the steepest increase. Also of interest are the trends in the number of services with more than 100 beds and the number services with 41-60 beds. In 2012, there were almost as many services with more than 100 beds as services with 41-60 beds. However, in 2003, the former was the smallest size category and the latter the largest size category.

Figure 17 Services within size categories by year 2004-12: Australia (number of services)



5.7 Trends in the location of residential aged care services and places

5.7.1 Trends in services and places by location

While overall there has been a decline in the number of services nationally, this decline is not spread evenly over all locations. Table 22 (page 142) shows the trends in the number of services by location category across Australia. Services in very remote locations increased by 11 services (55%) over this period and by comparison the number of services in major cities declined by 76 (-4%). Although the number of services in remote and very remote locations increased, these location categories contain the second smallest and the smallest number of services respectively.

Table 23 (page 142) and Table 24 (page 142) detail the trends in the number of beds across the location categories in Australia between 2003 and 2012. Table 23 shows that all locations increased their number of beds, but with remote and very remote locations receiving the lowest percentage increase in the number of beds (2%). The relative distribution of beds across locations changed little over the 10 years, as shown in Table 24 (Page 142), which may reflect the distributional formula used by the Department to allocate a set number of beds per 1,000 persons over the age of 70 in each planning region.

Table 22 Services (including MPS) by location: Australia 2003-12

Location	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Change No.	Change %
Major City	1736	1756	1749	1747	1709	1706	1700	1696	1686	1660	-76	-4%
Inner Regional	714	730	734	741	735	704	687	683	687	680	-34	-5%
Outer Regional	363	353	352	353	347	325	320	320	318	317	-46	-13%
Remote	50	41	38	41	40	39	37	38	37	37	-13	-26%
Very remote	20	18	19	31	31	32	33	32	31	31	11	55%
Total	2883	2898	2892	2913	2862	2806	2777	2769	2759	2725	-158	-5%

Table 23 Beds (including MPS) by location: Australia 2003-12

Location	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Change No.	Change %
Major City	98,796	103,058	106,220	109,130	111,273	117,345	120,681	123,990	125,008	126,760	27,964	28%
Inner Regional	33,686	35,744	37,313	38,843	40,153	38,682	39,187	40,111	40,631	41,582	7,896	23%
Outer Regional	13,937	13,707	13,950	14,204	14,346	13,842	14,084	14,423	14,610	14,971	1,034	7%
Remote	1,215	973	952	1,001	1,056	1,357	1,116	1,139	1,121	1,133	-82	-7%
Very remote	485	335	335	488	491	491	535	501	491	496	11	2%
Total	148,119	153,817	158,770	163,666	167,319	171,517	175,603	180,164	181,861	184,942	36,823	25%

Table 24 Beds (including MPS) by location category: Australia 2003-12 (%)

Location	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012		
Major City	67%	67%	67%	67%	67%	68%	69%	69%	69%	69%	2%	
Inner Regional	23%	23%	24%	24%	24%	23%	22%	22%	22%	23%	0%	
Outer Regional	9%	9%	9%	9%	9%	8%	8%	8%	8%	8%	-1%	
Remote	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	0%	
Very remote	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		

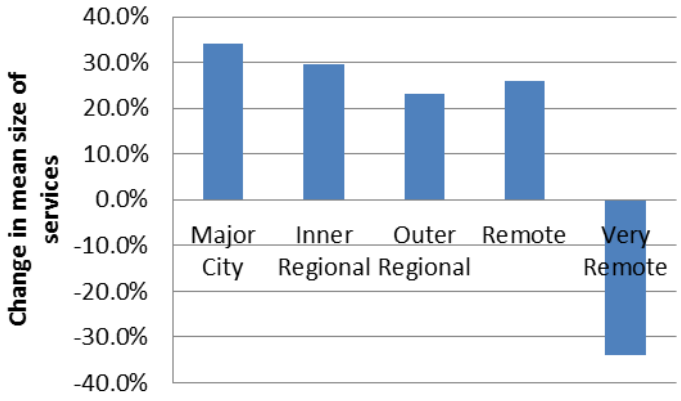
5.7.2 Trends in size by location

There has been an increase in the average size of residential aged care services in all locations during the period under review, with the exception of services in very remote locations. Residential aged care services in major cities increased in average size by 34% as illustrated in Table 25. There was a 34% decline in the mean size of services in very remote locations between 2003 and 2012. The comparative changes in mean size of service is illustrated in Figure 18.

Table 25 Average size of services by location (including MPS): Australia 2003-12 (beds)

Location	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	
Major City	57	59	61	62	65	68	71	73	74	76	34.2%
Inner Regional	47	49	51	52	55	56	57	59	59	61	29.6%
Outer Regional	38	39	40	40	41	43	44	45	46	47	23.0%
Remote	24	24	25	24	26	25	30	30	30	31	26.0%
Very Remote	24	19	18	16	16	17	16	16	16	16	-34.0%
	57	59	61	62	65	68	71	73	74	76	34.2%

Figure 18 Change in mean size of services by location: Australia 2003-12 (%)



The consequence of establishing services at a higher rate of growth than beds in very remote locations means that the average size of facilities in these locations has declined considerably. The reduction in the average size of services in very remote locations has important consequences for the future of services in these locations and these issues are discussed on Chapter 6.

5.7.3 Services by organisational type and organisational class

Services are not distributed evenly by organisational type across location categories as illustrated in Figure 19. There are only a relatively small

number of for-profit services outside major cities and there has not been any growth in the number of for-profit services in any location categories, other than major cities, in the 10 years to 2012. The number of not-for-profit services has declined in both major cities and inner regional locations and the number of services operated by government providers in outer regional, remote and very remote locations has increased.

Figure 19 No. of services by org. class and location: Australia 2003 and 2012

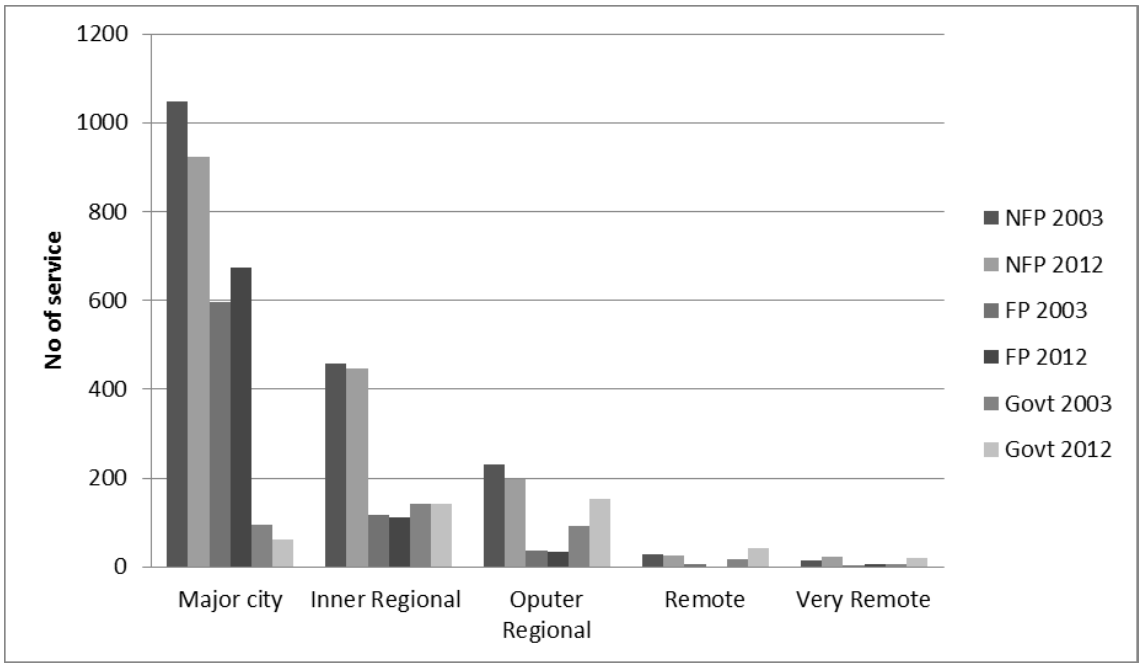
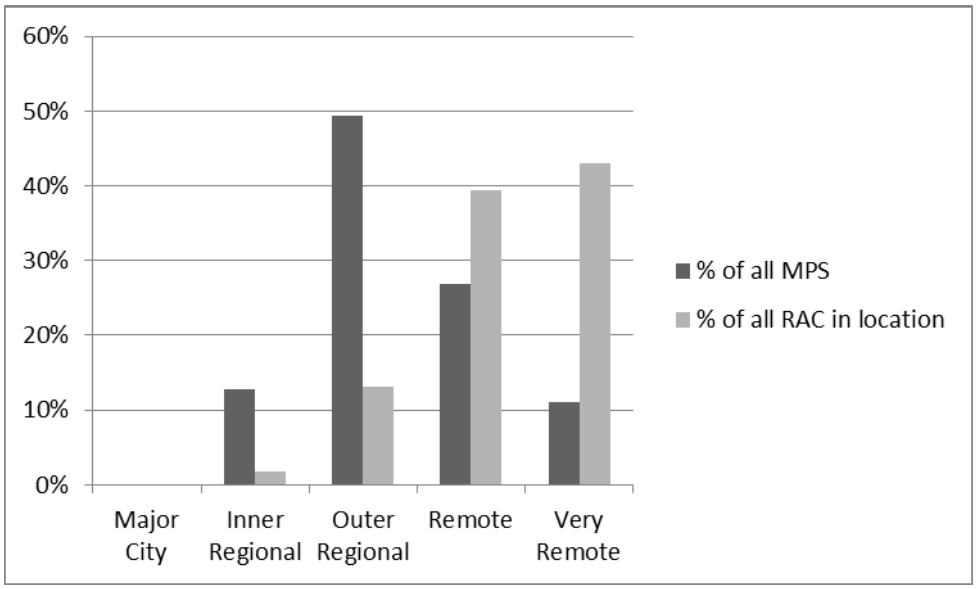


Figure 20 illustrates the increasing proportion of MPSs as service provider organisations in remote and very remote locations. Although only 11% of MPSs are in very remote locations, these government-operated services now represent nearly half of all services in these locations. This illustrates the increasing responsibility placed on state governments for providing services to small and remote communities and this has significant policy implications. These implications are discussed in Chapter 6.

Figure 20 MPS as a % of all MPS and of all services, by location: Australia 2003-12



5.7.4 Distribution of services by organisation class across jurisdictions

Figure 21 and Figure 22 illustrate the distribution of services by organisational class and jurisdiction. Table 26 and Table 27 (page 147) detail the distribution of residential aged care services by organisational type across Australian states and territories for 2003 and 2012. In all states and the Northern Territory the number of services operated by local and state governments has declined. Victoria with 23% of all services and South Australia with 9% of all services have the only governments with a noticeable role in the provision of residential aged care services in their state. This analysis also reveals that services operated by publicly listed companies are concentrated in New South Wales (NSW) and Victoria, the two most populous states with the two largest cities.

The analysis of the distribution of organisational types across jurisdictions shows a marked difference between Victoria and the other large states. This analysis reveals that Victoria had the highest proportion of services provided by state and local governments, the highest proportion of services

provided by for-profit providers and the lowest proportion of services operated by not-for-profit organisations in 2003; and this pattern continues to 2012. The significance of the different distribution of services in Victoria is highlighted in the next section on the imposition of sanctions and is discussed in Chapter 6.

Figure 21 Percentages of services by ownership class by jurisdiction 2003

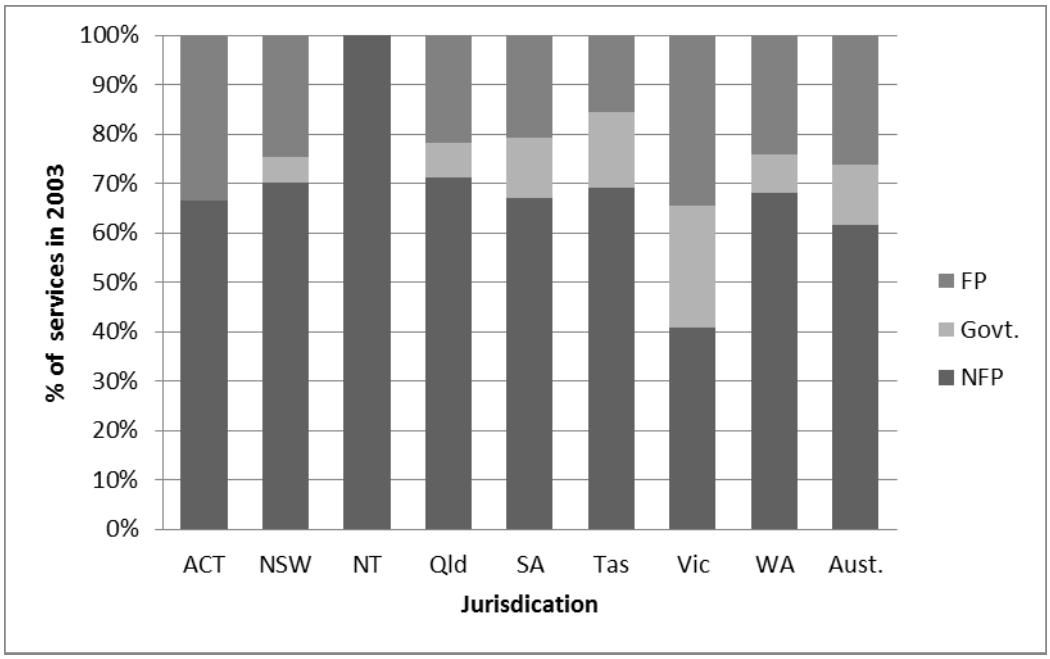


Figure 22 Percentages of services by ownership class by jurisdiction 2012

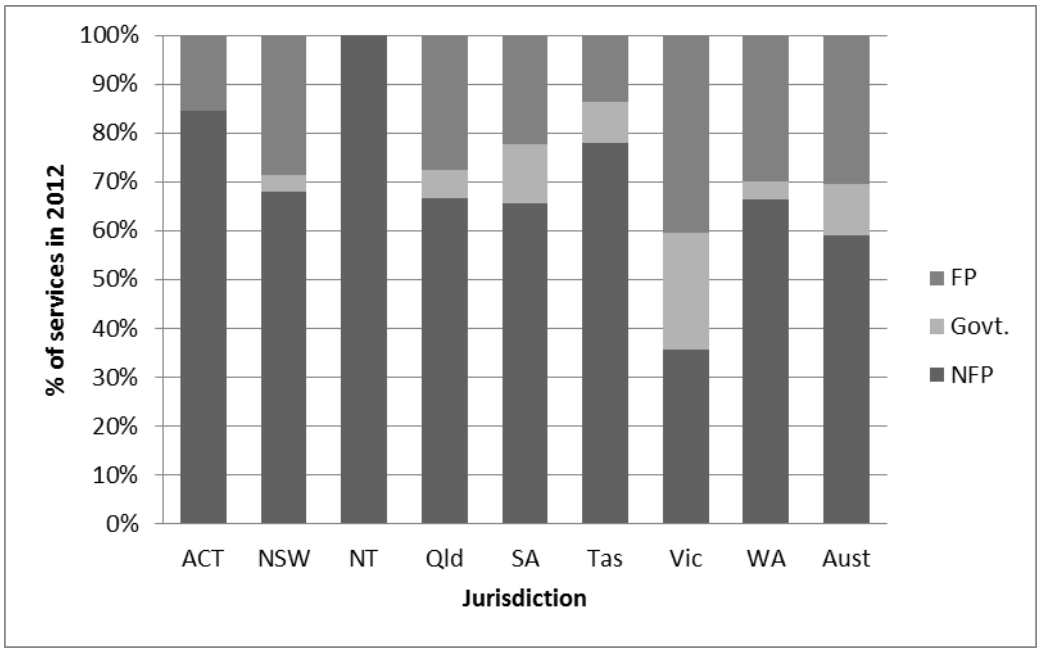


Table 26 Services by organisation type and jurisdiction: Australia 2003

	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Totals
Charitable	4	161	2	63	53	14	63	44	404
Community Based	1	160	3	67	59	23	125	32	470
Religious	9	328	8	220	74	21	143	100	903
Not-for-profit	**14**	**649**	**13**	**350**	**186**	**58**	**331**	**176**	**1777**
Local Government	0	24	0	11	8	3	19	18	83
State Government	0	24	0	23	26	10	182	2	267
Government	**0**	**48**	**0**	**34**	**34**	**13**	**201**	**20**	**350**
Private Inc. Body	7	227	0	106	58	13	278	62	751
Private non-inc. Body	0	2	0	0	0	0	1	0	3
Publicly Listed Company	0	0	0	1	0	0	1	0	2
For-profit	**7**	**229**	**0**	**107**	**58**	**13**	**280**	**62**	**756**
Totals	**21**	**926**	**13**	**491**	**278**	**84**	**812**	**258**	**2883**

Table 27 Services by organisation type and jurisdiction: Australia 2012

	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Totals
Charitable	8	217	2	61	61	14	53	38	454
Community Based	3	157	5	60	50	17	111	33	436
Religious	11	227	13	184	64	26	107	90	722
Not-for-profit	**22**	**601**	**20**	**305**	**175**	**57**	**271**	**161**	**1612**
Local Government	0	17	2	7	6	1	10	7	50
State Government	0	13	0	20	25	5	171	2	236
Government	**0**	**30**	**2**	**27**	**31**	**6**	**181**	**9**	**286**
Private Inc. Body	4	233	0	123	57	10	287	72	786
Private non-inc. ody	0	2	0	0	0	0	1	0	3
Publicly Listed Company	0	18	0	3	1	0	16	0	38
For-profit	**4**	**253**	**0**	**126**	**58**	**10**	**304**	**72**	**827**
Totals	**26**	**884**	**22**	**458**	**264**	**73**	**756**	**242**	**2725**

5.7.5 Ratio of places sought to places available in the 2011 ACAR

The *Essential Guide to the 2012-13 Aged Care Allocations Round* provided, for the first time, details on the previous 2011 ACAR. Using these data on the number of allocations made and the number of allocations sought by planning region across Australia (Australian Government Department of Health and Ageing 2013a Section 8), a crude competition score can be obtained. To create these comparable scores, each planning region was allocated a location category based on the five location categories used in other data releases (but with one category for remote and very remote).

The ratio was created by dividing the number of places sought (by providers) by the number of places available for each of the 72 planning regions across Australia. This ratio was then averaged within each location category. These data suggest that there were nearly two places sought for each place available in major cities, but only half the number of places sought for each of the places available in inner and outer regional and remote locations. This suggests that while there is substantial demand from aged care providers in major cities for the available places, there is little competition in non-urban areas for the available places.

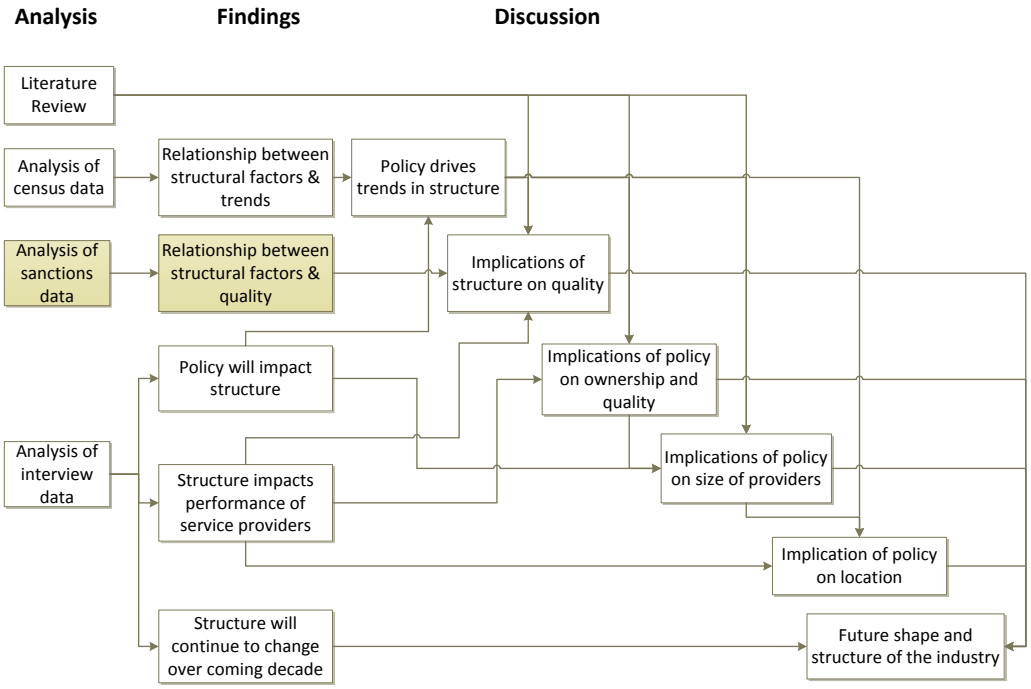
Table 28 Ratio of places sought to places available by location: Australia 2011

Location of planning regions	Ratio of places sought to places available
Major city	1.96
Inner Regional	0.66
Outer Regional	0.52
Remote	0.52

5.8 Relationship between structural factors and quality

This section reports the analysis of the data on the imposition of sanctions.[100] Figure 23 illustrates the contribution it makes to the logical framework of this thesis. The findings were published in 2014 (Baldwin et al. 2014) and a copy of the published paper is provided as Appendix G.

Figure 23 Contribution of this section of Part A to the logical framework of this thesis



5.8.1 Number of sanctions imposed

This section reports on the findings from an analysis of the data on sanctions imposed between 1999 and 2012. Chapter 3 described how the Aged Care Act 1997 empowers the Australian government to impose sanctions on

[100] There is a difference in the time span in the sanctions and census data reporting. The sanctions data are available as a complete set from the year commencing 1 July 1999 to the year ending 31 December 2013, with the exception of a small number of records which were incomplete and could not be included in the final data set. The census data are available as a snapshot of services on 30 June for each of the years 2003 to 2012. To enable comparison with previously published data on the imposition of sanctions under the Aged Care Act 1997, the analysis of trends in the imposition of sanctions includes all the reported sanctions data between 1999 and 2012. To compare the sanctions data with all other residential aged care services data, only the sanctions imposed from the year 2003 to 2012 were analysed.

residential aged care providers which, based on the assessment by officials of the Department of Social Services,[101] failed to meet and maintain regulated minimum standards. Chapter 4 described the data on sanctions and defined 'sanctions events' (the act of imposing a sanction) and 'sanctions' (the denial of government subsidies or a requirement placed on a service provider to take a particular action). It also explained that the Department may impose more than one sanction at each sanction event. After the removal of incomplete records from the government database, the data indicated that 176 services had sanctions imposed between 1 July 1999 and 31 December 2013, with some having up to four sanctions imposed at one sanction event; resulting in a total of 205 sanction events. There were 412 individual sanctions imposed within the 205 sanction events. These results are reported in Table 29.

There was considerable variation across the years under review with only 12 sanctions imposed in 2009-10 and 63 in 2008-09, as indicated in Table 29. However, a Cochran-Armitage Trend Test yielded no significant linear time trend in the rate of sanctions imposed over this period (P=0.08). The absence of a linear trend may be explained by the three-year cycle of accreditation which may identify more services failing sanctions in the accreditation years than in the non-accreditation years.[102]

Table 29 Services sanctioned, sanction events and sanctions: Australia 1999-2012

	Sanction events imposed						
Year	No. of services with 1 sanction imposed	No. of services with 2 sanction imposed	No. of services with 3 sanction imposed	No. of services with 4 sanction imposed	Total No. of Sanctions imposed	No. of services sanctioned	Total No. of sanctions imposed
1999	5	3	0	2	10	8	19
2000	7	15	3	0	25	24	46
2001	5	8	1	0	14	13	24
2002	5	6	3	0	14	12	26
2003	5	13	1	0	19	19	34

[101] Responsibility for programs funded under the Aged Care Act 1997 moved from the Department of Health to the Department of Social Services in late 2013 as a consequence of a change in government in September 2013.

[102] In accreditation years the Aged Care Standards and Accreditation Agency would have conducted more detailed inspections than in non-accreditation years.

2004	4	7	0	0	11	10	18
2005	3	7	1	0	11	11	20
2006	7	12	2	0	21	18	37
2007	3	8	3	0	14	11	28
2008	4	19	7	0	30	24	63
2009	2	5	0	0	7	6	12
2010	3	2	5	1	11	6	26
2011	1	0	6	7	14	10	47
2012	1	0	1	2	4	4	12
Total	55	105	33	12	205	176	412

Table 30 shows that 17 services experienced a second sanction event and three services experienced a third sanction event. Approximately half the services sanctioned had two sanctions imposed on them at the same time, and only one service experienced eight sanctions over all events.

Table 30 Sanction events, services sanctioned and No. of sanctions: Australia 1999-2012

Number of sanction events experienced by any one service		
Sanction events	Number of services	Total number of sanction events
One sanction event	153	153
Two sanction events	17	34
Three sanction events	6	18
	176	205
Number of Sanctions imposed at one sanction event		
Sanctions Imposed	Number of sanction events	Total number of sanctions imposed
One sanction imposed	55	55
Two sanctions imposed	105	210
Three sanctions imposed	33	99
Four sanctions imposed	12	48
	205	412
Total number of sanctions imposed on services over all sanction events		
Number of sanctions imposed on one service	Number of services	Number of sanctions imposed
1 sanction	37	37
2 sanctions	86	172
3 sanctions	27	81
4 sanctions	17	68
5 sanctions	4	20
6 sanctions	2	12
7 sanctions	2	14
8 sanctions	1	8
	176	412

5.8.2 Types of sanctions imposed

Analysis of the original Departmental descriptions of 19 different sanctions identified six main sanction types (see also Appendix G). These are summarised in Table 31.

Table 31 Sanction types – short description and definition

Sanction type short description	Definition of the sanction type
Appoint Admin.	The requirement to appoint an administrator for, usually, six months
Appoint Nurse Adv.	The requirement to appoint a nurse advisor for, usually, six months
Provide Training	The requirement to provide training to staff of the service
Restrict Funding	Restricts the payment of government subsidy for new residents; usually six months
Restrict New Places	Restricts the allocation of new approved places by the Department; 6 or 12 months.
Revoke Approval	The permanent or temporary revocation of approval as an approved provider.

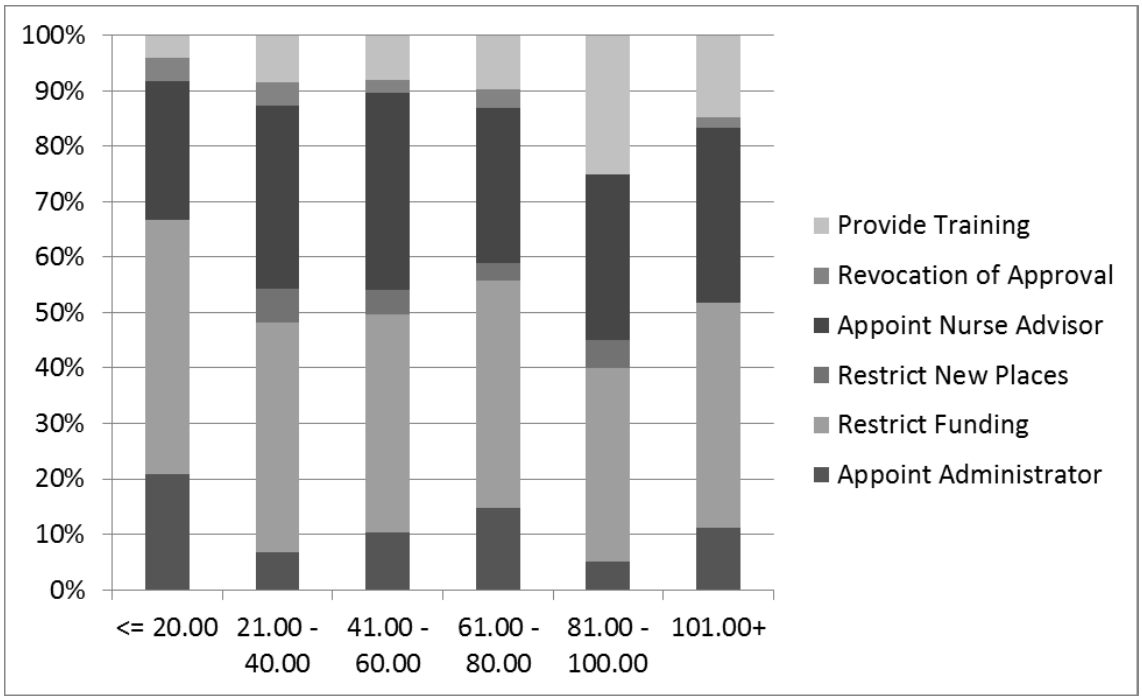
The frequency of these sanction types across the years under review is provided in Table 32. The restriction on funding of new residents ('restrict funding') made up 41% of all sanctions over this period and was imposed most frequently in all except two years. The requirement to appoint a nurse advisor ('appoint nurse adv.') was the second most frequently occurring sanction; 32% of all sanctions. The sanction to restrict the allocation of new places to the approved provider ('restrict new places') and to revoke the approval of the provider as an approved provider ('revoke approval') occurred infrequently.

Table 32 Types of sanctions imposed and the year of imposition (n=420): Australia 1999-2012

	1999/00	2000/01	2001-02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	Total	%
Appoint Admin.	1	7	5	1	1	0	2	6	4	4	0	2	9	2	44	10
Appoint Nurse Adv.	2	13	5	7	11	9	8	12	10	26	7	7	13	4	134	32
Provide Training	0	0	0	3	6	0	0	2	1	7	0	6	14	3	42	10
Restrict Funding	13	20	12	11	13	9	10	16	10	25	5	10	14	3	171	41
Restrict New Places	4	6	1	2	1	0	0	0	0	2	0	1	0	0	17	4
Revoke Approval	2	0	1	2	2	0	0	1	3	1	0	0	0	0	12	3
Total	22	46	24	26	34	18	20	37	28	65	12	26	50	12	420	100

In Figure 24 the proportion of sanctions types is compared within bed size categories. Of interest is the almost equal proportion of 'restrict funding' sanctions (range 36% (81-100 beds) to 47% (1-20 beds)) and 'appoint nurse advisor' (range 28% (81-100 beds) to 35% (1-2- beds)) across all size categories. The consequence of government-imposed sanctions that require the service provider to commit to additional financial expenditure, or have to their income restricted, is significant for small remote services. This finding is discussed in Chapter 6.

Figure 24 Proportion of sanction types by the size of services: Australia 2000-12 (n=420)



To analyse the relative risk of sanctions based on service characteristics, the sanctions data was merged with the census data for the years 2003 to 2012. There were 142 sanction events during this period imposed on 119 services.[103] For statistical analysis, as the number of services in each jurisdiction is different and varies from one year to the next, 'service/years' has been estimated for each jurisdiction. This statistic is

[103] For this analysis the sanctions imposed from 1999 to 2003 were removed from the data set as accurate data were not available on the characteristics of the facilities on which sanctions were imposed during those years.

the sum of services at the end of each year for each jurisdiction, location size and ownership class over the period of the study. Using this statistic it is possible to compare the relative risk of a sanction event across jurisdictions, locations, service size and ownership classes.

5.8.3 Sanctions and jurisdictions, location, size and ownership

The distribution of sanction events and the number of services sanctioned within states and territories and the number of service/years for each state and territory are shown in Table 33. Victoria, with 36.6% of all sanctions imposed across Australia, had the highest number of sanction events (52), and the highest number of services sanctioned (45), yet only 28.1% of all service/years occur within that state. By contrast, NSW had only 12.7% of all sanctions, yet 32.2% of all service/years were provided within that state.

Table 33 also provides details of each state’s and territory’s years of service, frequency of sanction events and sanctions by location and size. The majority of service years occurred in major cities, 61%, with only 2% of services years in remote locations. Services in remote locations had 13% of sanction events and constituted 8% of all services sanctioned. Fifty one per cent of sanctions events were imposed on for-profit organisations, although they constituted only 28% of service years, as shown in Table 33. Not-for-profit services accounted for 43% of all sanction events (60% of service years). Government-operated services accounted for 9% of all sanction events (11% of service years).

Table 33 Service years, sanction events, services sanctioned by jurisdiction, location, size and organisational class: Australia 2003-12

	Service years		Sanction events		Services sanctioned	
Jurisdiction[104]						
ACT	240	0.9%	3	2.1%	2	1.7%
NT	129	0.5%	5	3.5%	2	1.7%
QLD	4755	16.9%	37	26.1%	29	24.4%
SA	2750	9.8%	18	12.7%	16	13.4%
TAS	790	2.8%	1	0.7%	1	0.8%
VIC	7930	28.1%	52	36.6%	45	37.8%
WA	2504	8.9%	8	5.6%	7	5.9%
NSW	9078	32.2%	18	12.7%	17	14.3%
	28176	100.0%	142	100.0%	119	100.0%
Location						
Major City	17172	60.9%	90	63.4%	77	64.7%
Regional	10433	37.0%	34	23.9%	32	26.9%
Remote	571	2.0%	18	12.7%	10	8.4%
	28176	100.0%	142	100.0%	119	100.0%
Size in beds						
<= 20.00	2065	7.3%	12	8.5%	6	5.0%
21.00 - 40.00	7270	25.8%	37	26.1%	31	26.1%
41.00 - 60.00	8424	29.9%	45	31.7%	38	31.9%
61.00 - 80.00	4597	16.3%	24	16.9%	20	16.8%
81.00 - 100.00	2596	9.2%	8	5.6%	8	6.7%
101.00+	3224	11.4%	16	11.3%	16	13.4%
	28176	100.0%	142	100.0%	119	100.0%
Ownership class						
For-profit	7978	28.3%	72	50.7%	61	51.3%
Govt.	3185	11.3%	9	6.3%	5	4.2%
Not-for-profit	17013	60.4%	61	43.0%	53	44.5%
	28176	100.0%	142	100.0%	119	100.0%

5.8.4 Poisson regression analysis

Multiple Poisson regression was undertaken to determine the likelihood of a sanction event occurring based on all the structural factors listed in Table 33. This analysis shows that jurisdiction (X2[7]=38.07, P<.0001), ownership

[104] ACT is the Australian Capital Territory; NT is Northern Territory; Qld is Queensland; SA is South Australia; TAS is Tasmania; VIC is Victoria; NSW is New South Wales.

type (X2[2]=36.06, P<.0001) and location (X2[2]=36.91, P<.0001) are significant predictors for receiving a sanction. The association between size of service and sanction was insignificant (X2[5] =2.76, P=0.74). As shown in Table 34, five jurisdictions were more likely to experience a sanction event than was NSW; services in ACT were 6.99 (95% CI 2.04, 23.92) times more likely; NT was 4.63 (95%CI 1.49, 14.44) times more likely; QLD was 3.43 (95% CI 1.93, 6.08) times more likely; SA was 2.43 times (95% CI 1.78, 6.60) more likely, and VIC was 3.11 (95% CI 1.80, 5.36) more likely. Services in remote areas were 9.35 (95% CI 4.96, 17.63) times more likely to experience a sanction event than those in a major city. For-profit services were 2.79 (95% CI 1.91, 4.07) times more likely to have a sanction event than not-for-profit services.

Table 34 Relative risk of a sanctions event by jurisdiction, location and ownership type

Structural factor		Relative risk of a sanction event	95% confidence interval (CI)	P-value
Jurisdiction	ACT	6.99	2.04, 23.92	0.002
	NT	4.63	1.49, 14.44	0.008
	QLD	3.43	1.93, 6.08	<.0001
	SA	2.43	1.78, 6.60	0.0002
	TAS	0.62	0.08, 4.70	0.64
	VIC	3.11	1.80, 5.36	<.0001
	WA	1.37	0.59, 3.16	0.46
	NSW	1	--	
Location	Regional	0.96	0.63, 1.47	0.85
	remote	9.35	4.96, 17.63	<.0001
	City	1	--	
Type	FP	2.79	1.91, 4.07	<.0001
	Govt.	0.58	0.28, 1.22	0.15
	NFP	1	--	

5.9 Conclusion to Part A

This part reports the findings of analysed trends in the structural elements of residential aged care services across Australia from 2003 to 2012 and the number of sanctions imposed on services which failed to meet minimum standards. These results show clear, stable and strong growth of the sector over this period. There is evidence of small changes in the proportions of services provided by organisational class and type, but there is a marked change in the proportion of the number of beds operated by organisational

type and class. There are substantial changes over time in the size of services and in the size of organisations. The analysed data reveal differences in the growth of services based on location and the distribution of services by organisational type across locations; for-profit services are expanding in major cities but not outside them, and the bulk of services in regional and remote areas are provided by not-for-profit providers, with an increasing reliance on government services in remote locations. The sanctions data findings indicate a statistically significant difference in the relative risk of a service having a sanction imposed in relation to ownership, jurisdiction and location. Services in NSW, Western Australia and Tasmania, those operated by not-for-profit providers and services in major cities were least likely to receive a sanction, while services in some jurisdictions, operated by for-profit providers and in remote locations were most likely to receive a sanction.

Part B provides the findings from the qualitative data collection. These data reveal the understanding of the elite stakeholders on the current and future trends in the residential aged care industry, the factors influencing these trends and trends into the future.

5.10Part B - Findings of the qualitative data

5.10.1 Introduction

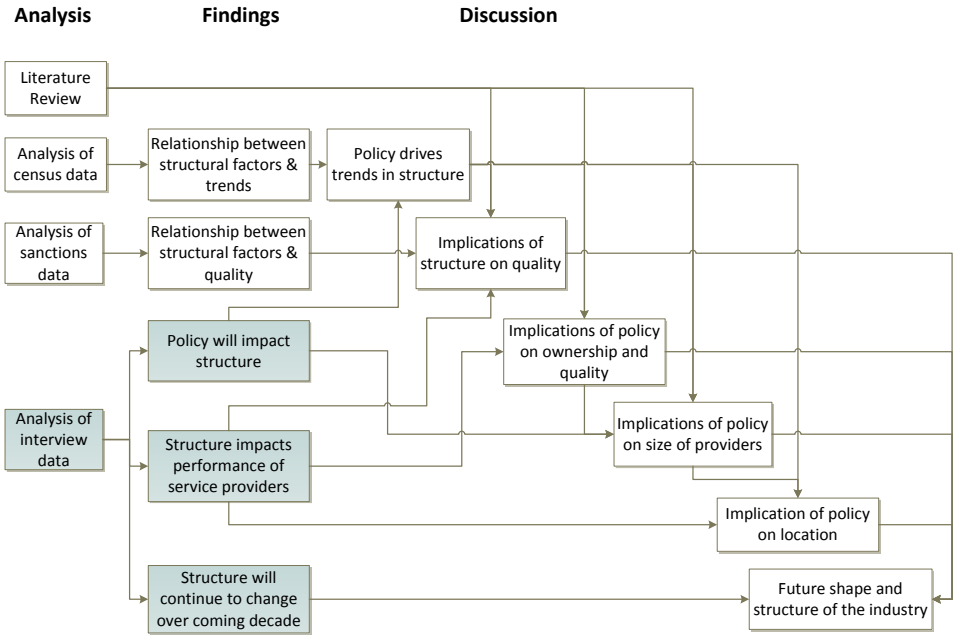
This section reports the details of the elite stakeholder participant sample and the results of the participant interviews. These findings are organised around three key themes and 24 sub-themes. The three key themes are:

1. that the Australian government policy reform (Living Longer, Living Better) will have an impact on the structure of the aged care industry
2. that structural factors will impact business approaches and the performance of aged care service providers
3. that the structure of the aged care industry will change over the coming decade.

Figure 25 illustrates the contribution this section makes to the logical flow of the thesis.

The analysis of the data in Part B is presented within themes, consequently some repetition of 'topics' or 'subjects' is unavoidable. For example, the topic of rural and remote services is discussed within the themes of 'choice' in section 5.11.4, 'impact of markets' in 5.11.6, 'impact of location of services' in section 5.12.4 and 'consolidation of the industry' in section 5.13.4. However, while this topic is repeated within the chapter, on each occasion the data related to rural and remote services is different and supports the emergence of these different sub-themes.

Figure 25 Contribution of Part B to the logical framework of the thesis



5.10.2 Description of the sample

As described in Chapter 4, a snowball sampling method was used to select participants by inviting recommendations from those already interviewed. A determination of a person as a suitable participant, that is, 'knowledgeable and influential', was made if they were recommended by more than one participant. The numbers of recommended participants and of those subsequently interviewed are listed in Table 35. Sixty-seven people were recommended by other participants, but only 32 of these were recommended by more than one other participant, and 26 of those recommended were subsequently interviewed.[105] In addition, one key elite stakeholder was interviewed but not recommended,[106] one of the original three participants subsequently received only one recommendation, and six participants - who

[105] On two occasions, for the convenience of the participants, two people were interviewed at the same time and on both occasions they were executives from the same organisation.

[106] One senior government official was interviewed early in the data collection because of that person's limited time availability and on the expectation that other participants would recommend this person. However, this participant subsequently received no recommendations from others. The interview was included in the analysis because of this person's specialist knowledge and their close association with decision makers.

were recommended by more than one other participant - were not interviewed to avoid oversampling from the same organisation or their lack of availability.[107]

Table 35 Number of individuals recommended for interview, interviewed and not interviewed

Recommendations received	Interviewed	Not interviewed	Totals
No recommendations	1	0	1
1 recommendation	1	35	36
2 recommendations	6	6	12
3 recommendations	7	0	7
4 recommendations	4	0	4
5 recommendations	3	0	3
6 recommendations	4	0	4
Sub totals	26	41	
Total	67		67

To maintain anonymity only two role codes (CEO - Chief Executive Officer and Dir - Director)[108] and four organisational type codes (MP - major provider; PB - peak body; Con - consultant/advisor; Gov - government organisation) are used. These descriptors are combined with a numeral to create a single code for each individual. The explanation for the codes used to identify the participants in this and subsequent chapters is provided in Table 36 and the characteristics of the final sample are provided in Table 37 (page 162), including their time in their current role and the span of responsibility of their position - state based or national.

As the population of influential and knowledgeable actors in the residential aged care industry in Australia is unknown, it is not suggested that this is a proportional sample, but it is representative of the structure of the industry. This is justified by the reasonably even distribution of participants between the different roles and organisational types as shown in Table 37. The distribution of participants from the for-profit and not-for

[107] Of these six, multiple but unsuccessful attempts were made with three people to arrange an interview (voicemail messages, emails and discussions with executive assistants); one was on extended overseas travel at the time of the interviews and two others were in organisations where more senior officials had already been interviewed and it was determined that in the interest of balance for the final sample they should not be interviewed.

[108] Although there were two top officials in the government body organisational category, which may have been more accurately coded as CEO, they have been allocated a Director code to ensure every cell in Table 37 on page 65 has sufficient participants to maintain anonymity.

profit sectors is reasonably representative of the distribution of these types across all providers. For nine participants the geographic spread of their role was limited to a state-based enterprise but they were seen by their peers as influential nationally and knowledgeable of industry-wide trends. The other 17 participants had a national scope to their formal role. The sample also falls equally between those labelled 'Director' and 'CEOs' of provider organisations and peak bodies, although for some, these are labels of convenience to ensure anonymity (see footnotes to Table 36). Across the sample, 16 had more than 10 years' experience in their current role, with variations in role length from one year to over 30 years.

Table 10 in Appendix H indicates the recommendations made and received by the participants and show that all the interviewed participants were recommended by two or more other participants, except for the one individual (as explained above).

The following section reports the interview findings according to the major themes: policy reform will impact the structure of the aged care service industry; structural factors impact the performance of service providers; and the structure of the aged care industry will change over the coming decade.

Table 36 Explanation of the participant codes

Code	Explanation
CEOMP	Chief executive officer (CEO) of a major provider; an organisation with eight or more[109] residential aged care facilities
CEOPB	CEO of a peak body[110]
DirCon	Director[111] of an accounting or consulting firm, or independent consultant
DirGov	Director[112] in a government body
DirMP	Director or Managing Director or Division Director of a major provider

[109] CEOs or Managing Directors from three of the six largest providers, as indicated in Table 20 were interviewed.
[110] Four participants were from provider peak bodies and two participants were from consumer peak bodies; two were CEOs and two (recent) former CEOs.
[111] The DirCon category included a senior banker, three senior participants from accounting firms and an independent advisor to the not-for-profit sector. This group included one CEO and one Managing Director and all have been labelled Director to ensure anonymity.
[112] The DirGov category included a former Australian government Minister, two serving CEOs of government bodies and two senior Department officials and all have been labelled as Director to ensure anonymity.

Table 37 Role of participants and organisational type, scope of focus and length of time in current position

Role	Organisational type & participant code (period in current role and Jurisdiction)				Totals
	Government body (Gov.)	Major Provider (MP)	Peak body (PB)	Consultant/ Advisors (Con)	
CEO		CEOMP4 (>20 years, Vic) CEOMP5 (11 years, NSW) CEOMP1 (5 years, NSW) CEOMP3 (15 years, Vic.) CEOMP2 (12 years, NSW) CEOMP6 (12 years, NSW) CEOMP8 (>20 Years, SA)	CEOPB1 (2 years, national) CEOPB2 (10 years, national) CEOPB3 (13 years, national) CEOPB4 (1 year, national) CEOPB5 (>10 Years, national) CEOPB6 (10 years, national)		13
Director or Consultant / advisor	DIrGov1 (10 years, national) DirGov2 (8 years, national) DirGov3 (12 years, national) DirGov4 (2 Years, national) DirGov5 (10 Years, national)	DirMP1 (3 years, national) DirMP2 (< 1 year, national) DIRMP4 (12 years, NSW)		DirCon1 (31 years, national) DirCon2 (>10 years, NSW) DirCon3 (5 years, national) DirCon4 (>5 years, NSW) DirCon5 (>10 years, National)	13
Totals	**5**	**10 (4 FP and 6 NFP)**	**6**	**5**	**26**

5.11Policy reform will impact structure

This section reports on the data extracted from the interviews within the theme 'policy reform will impact structure'. These data are assembled in eight sub-themes, which indicate the level of concurrence or difference in the views of the participants. While the sub-themes focus on different topics and subjects they each support the major emergent theme 'policy reform will impact structure'.

5.11.1 The aged care policy process in Australia has been, and will continue to be, incremental

There was consensus among the participants that the Living Longer Living Better package of reforms will result in a limited set of regulatory changes to be progressively implemented during 2013 and 2014, and after 2017. One senior government officer, who was involved in putting the Living Longer Living Better reforms together, argued that the limited and incremental approach by governments to policy reform should not be a surprise. Contrary to the view of others who expressed disappointment that the government had not immediately adopted all the recommendations of the Productivity Commission, this participant was of the view that simply adopting the recommendations of others is not how governments in Australia have traditionally gone about developing aged care policy. This participant saw the Productivity Commission's report as only one part of wider and longer term incremental reforms, and during this reform process the government selects those elements of the recommendations from a number of advisors and commentators that fit with its reform agenda:

> *I wouldn't conceptualise it as the government chose some recommendations and didn't choose others. I think the PC's [Productivity Commission] a process that one goes through in order to undertake reform. I think we [the Department] went to government with a reform plan which has been fully*

> *adopted. Some of those elements may or may not line up with what the PC recommended. You don't go to government with a 'why don't you give a tick to these three things and not to those three things'; [you go with] an entire plan. And I think you have to see it as a microeconomic reform of the industry, which has been working its way through the system for about 10 years. Another way to put that is it's not like the PC recommendations are anything that people haven't spoken about before (DirGov3).*

This participant also reflected the view that the reform process is incremental and is broader than, and independent of, any one government. This participant's perspective was that the recent reforms are designed to address systemic issues over a long period, at least 10 years:

> *… in 10 years' time we will have an aged care industry which has no supply constraints, which has no price constraints, and which is a growing part of the economy ... It will be a fundamentally different industry, and [with] all the things [that] are in place now that will happen and no government will be able to stop it from happening. From the government's perspective, you have to see that over, say, a 40-year period, these reforms will see [the aged care] industry as a whole grow probably by 40% more than what it would have done under old policy settings [and] at a lower cost to government than the old policy settings (DirGov3).*

This participant's view is that the reforms will take 10 years to fully work through the system:

> *It fundamentally fixes the sustainability problem that the IGR[113] have identified for aged care … yet the industry will increase to a stage where demand is totally saturated, and people will have a lot more power - individuals … But, that's a 10-year period for that to work its way through. (DirGov3).*

Other participants agreed with DirGov3's assessment of the length of time and the incremental approach to for reform:

[113] IGR is the intergovernmental report produced by Treasury which estimates the cost to Australian society of an ageing population and the shift in the proportions of tax payers and non-tax payers as the population ages (Australian Treasury 2010).

> *I should also say that we were probably the only organisation during the Productivity Commission process to actually say that it will be a 10-year process … If you looked at the history since the middle-'80s and the changes in aged care, one had to acknowledge that change in Australia is only slowly achieved. And the changes embodied in Living Longer Living Better are quite significant … in cultural change, organisational change, attitudinal change, particularly around the expansion of community care (CEOPB3).*
>
> *This is an incremental change. I see it as being an incremental change, because the Living Longer Living Better reforms, they really [don't] change anything to do with the operating revenue stream (DirCon5).*
>
> *But I think when they [the new Australian government] get in they'll realise they'll have to do that [further reform] more slowly. They will commit to it, but I think they'll say to the market, you need time to adjust in terms of the way you treat capital and the way you treat assets, and the way your accounting standards deal with it. We'll give you a couple of years to work through that but from '16 [2016] onwards we're going to do what we want. (CEOPB1).*

The same government official (DirGov3) also considered that the logic of the market will set the price for services and this should be allowed to happen in preference to the pricing being set by government, provided there are sufficient funded services to meet demand:

> *What we created is a situation where the logic of the market will demand that [the removal of current constraints on supply]. The outcomes of that review [in 2016-17] are not difficult to predict. What we're [the government is] trying to do there, and the reason why it's taking a while is that … it's better to spend a few years kind of managing it towards somewhere close to the equilibrium. So that's why there's a big expansion in community care rather than residential care, because we know that people are going to demand that. So you better build a base for it. Pricing is being released but because there are still … ratios in place, you've got to have a regulated price release where you have the authority to determine whether it's reasonable or not. But you get into a stage where there is individual pricing … which is a reasonable price, not a set price by government (DirGov3).*

5.11.2 Reforms will influence the future structure of the industry

Consultants/advisors, provider directors from both for-profit and not-for profit organisations and peak body participants representing consumer groups all supported these reforms but to varying degrees. None of the participants were opposed to the reforms:

> *As you would know, Richard, the Living Longer Living Better reforms are the most significant reforms I think that we've had for decades … I think what's been put in play with the Living Longer Living Better reforms is going to benefit the consumer [the client] in a significant way (CEOMP3).*
>
> *I think the reforms were well thought through. I thought they were logical, and I thought they had the potential to address some issues that had been intractable for the whole time that I was involved in aged care. I didn't see anything really to criticise. (CEOPB6).*
>
> *The simple answer is that reforms were probably needed, and I think the industry in general, the aged care sector in general, probably welcomed the fact that there were reforms that were required and needed. So I think the reforms satisfied a need for change (DirCon1).*

Despite this general consensus, some participants commented that they were disappointed that the previous Australian government did not decide to introduce large-scale and sudden changes to the industry by adopting all the recommendations of the Productivity Commission's (2011) report. Because the government did not adopt the 'free market reform' advocated by the Productivity Commission, one participant saw the government's reforms as an 'opportunity somewhat lost' (CEOPB4). However, this participant acknowledged that 'reform is what the industry actually wanted' and went on to say that:

> *The market itself believes that reform is required in order for them [sic] to be sustainable and viable in the future. So you have all the components there for a change program: change and adoption, if you want, of change, or a new paradigm (CEOPB4).*

This same participant foresaw a period of unclear directions for both for-profit and not-for-profit sectors over the coming few years, because of the introduction of the choice for aged care consumers to make Daily Accommodation Payments (DAPs) rather than Refundable Accommodation Deposits (RADs), but without the removal of control on supply by the government. These concerns were supported by a major for-profit provider who regarded these partial reforms as introducing a level of liquidity risk into the industry that could have been avoided:

> *The risk is that there may be a flight of capital from aged care because of the change or the bias toward daily payments. You can't lend against daily payments; the banks won't do it, and if they do you don't get the return that you're looking for (CEOPB4).*
>
> *There is concern in the industry of why go through the pain of removing liquidity from the industry that when the industry gets into a really bad position and the government has to step in and do some emergency thing, why not just plan so that that doesn't happen? (DirMP1).*

Another participant thought that the government had 'cherry picked' the Productivity Commission's recommendations:

> *… in the way that it's [the government has] cherry picked the report, is that it really hasn't made a lot of difference to, and certainly hasn't given the industry a really good clear pathway going forwards in terms of how we continue to fund it, make it viable and have it sustainable (DirCon2).*

Another issue of disappointment in the reform process that was voiced by some participants was the lack of flexibility in the use of government funds for residential care in the same way that occurred with funding for disability and community care services. A CEO from a peak body commented that for the members of that organisation, consumer choice, which it believed would emerge from more flexible use of funding, is a bigger issue than structural change:

> *… if you look at the rigidity of the product offerings as a result of the allocation formula between residential structure of care packages and then home support at the bottom, you haven't got a system that's designed yet to respond to consumer needs. So I think those issues in the short term are much*

bigger and more important than the structural issues for the industry (CEOPB3).

5.11.3 Government policy has been indifferent to some structural factors

Participants recognised the government's focus on the allocation formula as the principle mechanism for controlling supply, as was described in Chapter 2. According to one participant, who was a government employee at the time, the origins of the policy on location in the 1980s was to provide guidance to Departmental officials on the release of government funding for new residential aged care places:

We did it because nursing home places were out of control and … unless we could bring those places under control the Treasury wouldn't give us this quid pro quo the extra resources we needed for community care. So everybody won at the end of the day, including the Treasury (CEOPB3).

In the participants' views the allocation formula is inconsistent with the intention to introduce market forces and consumer-directed care as it funds places in particular locations, while consumer-directed care policies would fund consumers who could receive their services in the location of their choice.[114] The following statement highlights the ambiguities pointed out by participants on the choices between policy approaches:

And, also, I like the [allocation] formula. I still like the formula in the sense that it's transparent. It may be inefficient but you know where government is ... So I think we know what we don't like. We don't actually know what we want (CEOPB3).

Participants were of the view that government policy, while focused on location, has been indifferent to provider type, service size or provider size. When asked about the government's policy on the mix of for-profit and not-for-profit providers in the lead up to the announcement of the recent

[114] The policy of government control on supply through the allocation of places by location will be subject to review after 2016-17, with the possibility that the regulatory control will be reduced or removed, thus freeing providers to establish services in any location they choose and any number of places they choose.

reforms, and after it, one senior government officer said that he can 'see a very strong reason to have a mixed economy' (DirGov3).

Another participant believed that the government 'did not have a view' in relation to provider mix (CEOPB6). This participant commented that:

> *They see it [the mix of providers and mix of service sizes] as something that there is no compelling argument either way, there's strengths and weaknesses and they're happy to let the market do what it does (CEOPB6).*

This view is reflected in the comments of a CEO from a peak body:

> *But I think that successive governments' view has been [they] don't care who the owner is, we're insisting on other standards and prudential arrangements and so on, and if you can meet those (CEOPB5).*

Two senior government officers, who were familiar with policy in this area, were strongly of the view that governments are indifferent to provider type, except where they may determine that a particular provider type is more likely to deliver services to a particular group identified as having special needs:

> *It's deliberate not to discriminate on provider by size or the nature of their organisational makeup, absolutely. When we allocate aged care places, and when we approve providers, we're looking at whether or not that organisation has the capacity to deliver the service. We're agnostic as to whether they are for-profit or not-for-profit. The only time we ever actively discriminate is a positive discrimination around whether or not services will be provided for particular groups and, so, under the Act, we have special needs groups, so we are more inclined to provide places to a service that is going to meet the needs of a special needs group that is having difficulties accessing those services in the region (DirGov2).*
>
> *[Governments] don't care whether they're for-profit or not-for-profit, they clearly care about whether they're fit and proper people, etcetera. But there is no philosophy … But from a government perspective … if you've got beds to get out and you want people to build nursing homes then you'll give them to whoever is prepared to build them. I don't think it matters. I've not ever heard anything in the last 10½ years from a Minister that it actually mattered who had them. I've certainly had Ministers say they have a*

> *preference for not-for-profit because they think it's a more altruistic thing and, in fact, arguably the philosophy about who is better, who would they prefer to deal with is driven somewhat by politics (DirGov1).*

Another participant who was a long-standing advisor to governments believed that there would have to be overwhelming evidence to convince a government to favour one sector over another in the allocation of funding. This participant considered that recent policy directives had been to actively reverse the policies of previous decades, which favoured the not-for-profit sector, and not to discriminate based on ownership type:

> *In fact it's gone the other way, where they made the capital funding exactly the same whether you're for-profit or not-for-profit. I think governments are seeing it as putting in place a level playing field … I can't see any Australian government favouring one sector over the other. There would have to be overwhelming evidence (DirCon3).*

This view was supported by service provider participants:

> *I think that there's not a preference for the not-for-profit or a preference for the for-profit sector. I think it's about having a diversity of service delivery (CEOMP3).*

5.11.4 Choice will lead to structural change in the industry

Participants suggested that the Living Longer Living Better policy will result in more choice for the consumer and higher consumer payments. A government employee succinctly summarised the government's policy position, which underpinned the reforms, on the issue of choice for consumers:

> *What we've done is we've said that there are certain choices that consumers make which increase costs, and what this reform says is that if they make those choices they bear the cost. Whereas in the past we let people make choices and then the government said 'we'll come up with the extra money' (DirGov3).*

Consumer choice was seen by some participants as not only occurring between one service provider and another, but also between home care and residential care. Participants were confident that the impact of choice will be to

increase the level of competition between service providers. They see this increased competition as requiring changes by service providers:

> *The fact that home care is going to become such a large proportion of the rationing over the next 10 years will give people a lot more choice as to where they receive their care, and I think that will have a significant impact on competition between residential and the community sector … And I think as the quality of home care improves there will be fewer and fewer people going into residential. It's already the case (DirCon3).*
>
> *If there is any overarching thing about the Living Longer Living Better program it'll make the market more competitive, and the people [service providers] who are prepared to adapt and deliver services more akin to what people want, are probably more likely to survive. Because part of choice and resident choice and preparedness to pay for it is in fact a feature of the Living Longer Living Better stuff (DirGov1).*

However, some participants (including one not-for profit provider) questioned the reality of consumer choice in rural and remote locations, the reality of choice between home and residential care for people needing high care and the impact that choice may have on the balance of for-profit and not-for-profit providers:

> *If you live in Dubbo, or Manilla, or Moree, or Bathurst, their [sic] choices of nursing home are limited anyway ... So for people who live in big cities there will be a bit more competition, but if you live in a one nursing home town not much is going to change (DirGov1).*
>
> *Choice is fine when we had a low care system but the system is now almost entirely high care frail aged or dementia so choice becomes irrelevant (CEOPB1).*
>
> *If we're going to truly embrace a consumer-directed model with giving people choice, I think to have a healthy system, a healthy sector we need to maintain the balance between the not-for-profit and the for-profits. There is always going to be a sector of the population that will not have the financial resources to go in[to] a for-profit' (DirMP4).*

5.11.5 Currently competition is weak or non-existent

The views of participants varied on the current level of competition in the residential aged care industry. None of the participants offered any empirical evidence of the existence, or absence, of the current level of competition. The differences in views were between those who believed that there is competition in the current market, some of which is not clearly visible, and those who believed that due to government regulation, there is little or no effective competition. There were also those who viewed the current competition framework as being based on physical amenity and those who argued that competition is currently based on quality.

In the view of one of the government employee participants, there is currently competitive pressure between the for-profit and not-for-profit sectors. This participant believed it is in the interest of the government for this 'mixed economy' to continue into the future as it produces competitive pressures on both price and quality; that is, where the not-for-profit sector competes on quality and the for-profit sector competes on price. This participant suggested that this form of competition establishes a cycle where the for-profit sector increases quality to match the not-for-profit sector, and the not-for-profit sector increases efficiency to match the for-profit sector on price:

> *In a market you can either compete on quality or you can compete on price. When you've got an area which is free from competing on price to an extent, like the not-for-profit, they choose to compete on the quality side and therefore the other one has to match. So that's the theoretical advantage you're having not-for-profits in the mix. Fundamental to that working from the governments' perspective is that you have both (DirGov3).*

This view had some support from two other government employees. One commented, *'I'm not sure that there's lack of competition, there's the lack of visibility of competition. I think that's a non-subtle distinction, frankly'* (DirGov4). A third participant from government considered that competition in the residential aged care industry is currently driven by the quality of the building stock, with owners of older buildings having

difficulty competing with providers who have built services in the past 10 years.

Dissenting from these views, a fourth government employee (DirGov3) suggested that true competitive forces are yet to be seen in the market for residential aged care because of the government control on supply and on price, a lack of meaningful quality indicators and high level of government contribution. This participant suggested that increased transparency through public reporting of aged care will drive improvements *'where the home is in a competitive environment. If it is not in a competitive environment then public reporting has limited impact'* (DirGov3). A fifth government employee did not believe that there was any effective competition in the marketplace:

> *Because we have an artificial scarcity in supply I don't know that providers have had to innovate or market themselves around quality. As long as they've been able to meet the government regulatory standards they've been able to say we're quality (DirGov2).*

This perspective was not shared by service provider participants who believed that there is competition based on quality, that there is an understanding of quality in the marketplace and that the difference in quality is between service providers. A CEO of a for-profit provider was of the view that services with high occupancy rates are those reputed to be high on quality, and that the occupancy level is not a result of regulatory control on the supply of beds, but on higher demand because of the perception of better quality of care and quality of life for residents:

> *I don't really think that theoretical argument of high occupancy reducing competition and quality is justified in practice, or certainly not sufficiently to say that that's the rule. I know it has a great deal of appeal in economic market terms. I think the difference is that some of the best performers are the ones who manage their organisations to achieve 99/100% occupancy, and they do that because they're seen to be delivering high-quality care and a residential environment that people want to be in (CEOMP8).*

A consultant to the industry agreed that competition is based on word of mouth about the quality of services provided; 'so you're not talking physical amenity, you're talking the quality of care' (DirCon5). This view was shared, but qualified, by a CEO of a large not-for-profit provider who commented *'communities tend to know if a place is good or bad in their communities. Where people don't have established links within the community then it's more difficult for them to work that out'* (CEOMP2). DirGov2 was of the view that the residential aged care industry will have to adjust to a system where quality is determined by the consumer, measured with agreed universal indicators beyond minimal compliance and ones that are acceptable to the government as the major payer:

> *I think the market itself will actually have to adjust to its perceptions of quality from consumers and also probably more evidence-based measures of quality that government will be concerned about, because government will … want value for money and will want to ensure the older vulnerable people who are in care receiving appropriate quality (DirGov2).*

The concept of future indicators being directed by consumers was shared by other participants. One for-profit provider, commenting on the new requirement on providers to set and advertise the price they change for Refundable Accommodation Deposits from 1 July 2014, suggested that 'competition will drag that price [for a RAD] to a reasonable level' (DirMP2).

5.11.6 Mixed views on the impact of an increase in market forces

Participants had mixed feelings about the impact of an increase in market forces on the aged care industry. One long-standing CEO from a not-for-profit provider expected to see a progressive removal of all controls over the number and location of residential aged care beds:

> *I expect it [de-regulation of control on supply] will be progressive over a period of, I don't know; let's say 5-10 years from now, but, ultimately, I don't see any reason why we need to have supply controls in Australia. And I don't think the government's going to be able to justify that to consumers, because if you look at their supply controls, the price controls and everything else that we have, I think consumers will want more choice and*

> *therefore they will demand the capacity for providers to actually offer that in different places (CEOMP2).*

Participants held apparently conflicting views, supporting the removal of controls while at the same time voicing concerns about an unfettered marketplace for aged care beds. The response of one not-for-profit provider illustrates these conflicting perspectives. In this statement the participant clearly welcomes the increased choice that is believed will emerge from a more competitive environment, but does not believe that the supply of aged care services are really driven by 'supply and demand':

> *The delight of making the stuff more competitive and more available and all that kind of stuff is that it really does force a sector that's become unbelievably un-consumer focused without choice and all that. It forces it out into that kind of world, and I love that, that's the first thing. The second thing is, however, nobody should ever think that these are really economic models driven by supply and demand. It's just not true (CEOMP8).*

A second CEO from a for-profit provider also had mixed feelings about the reduction of regulatory controls on the impact of competition on small providers and small communities, but believed that these are evolutionary and not revolutionary changes:

> *I think opening the supply more generally has its advantages, but it could be potentially dangerous for the more marginal providers, and they're particularly in the rural areas. And when you get small rural towns, let's call it a triangle of small towns, that each have their own probably less than critical mass provision, a new provider can come in without any of the baggage of any of the three, build a brand new one right in the middle of the triangle and put all three of them out of business. That could have political negatives. It could have care positives: it could be providing much better care for the residents of those townships. So I don't know; there's a lot going to play out in the evolution. But I think it's evolutionary. I don't think it's revolutionary (CEOMP4).*

A not-for-profit provider (CEOMP2) considered the policies of his organisation would differ from that of for-profit providers by continuing to provide services in locations that are not financially attractive. While not

opposed to the reduction of regulatory controls, this participant expected that there will be a need for a new government intervention to ensure poorer communities continue to be provided with services:

> *That's a huge problem … Deregulation will mean the people [providers] will go where it's the most attractive financially, that doesn't include us … but generally there will be more people focused on those well-to-do areas, and there will be fewer people focused on areas which are not as well-to-do, including regional and remote areas. And if government doesn't come to grips with the fact that certain areas need additional funding, or support, then there's just going to be a breakdown in services in those areas (CEOMP2).*
>
> *If you do away with rationing, then would market forces actually take services to the places you need them? Look at Medicare and location of doctors, and who gets access, and you can see that with the best of intentions programs don't work unless you've got some financial incentives built into them (CEOPB3).*

One not-for-profit participant saw those providers in the middle range of the suburban market as being vulnerable in a more competitive market:

> *There are some who have what you describe as suburban aged care, is actually very focused extra-service services … And there are others who do actually just provide the run-of-the-mill aged care service. I don't think they're going to do too well. At the moment the supply controls guarantee them occupancy. In future that won't be the case (CEOMP2).*

One aged care industry consultant/advisor did not believe that a future government will tolerate a loss of control over the number of residential beds that the government will be required to fund. This participant believed that the risk to uncontrolled expenditure by government will be too great a risk for Treasury to take:

> *I think the government's response is, we don't know what will happen if we take the hand off the supply sheet, and so they will maintain their control over supply. They'll talk about all this stuff but at the end of the day I can't see Treasury letting them let go of what they believe is their only mechanism of control (DirCon4).*

5.11.7 Consumer-preferred policies may have long-term impact

New regulations, arising from the Living Longer Living Better reforms (described in Chapter 2), seek to introduce more choice in the way that aged care residents pay for accommodation. Some participants were expecting residents (or their families), whose main asset is the family home, to choose a DAP over a RAD, on the basis that most new residents will be admitted to high care and their length of stay in residential care may not be long enough to get their house sold in time to make an accommodation deposit from the proceeds:

> *They're dealing with a whole family in crisis. A decision has to be made quickly. To get the house ready to sell you're looking at 3-6 month period anyway, during which time they're going to have to pay the daily charge anyway … So I think by the time they get the house on the market and get it sold the real situation is that person may not be alive any longer (DirMP4).*

Other participants also viewed this change with some concern because of the unknown impact that a preference for daily payments over refundable deposits will have on service provider liquidity and the balance sheets of providers:

> *I think the industry aren't altogether convinced that they've got what they need because consumers will have the choice of an accommodation charge or a bond, and for the industry the bond [RAD], the capital charge, is much more attractive because it gives them the money they need for investment (CEOPB3).*
>
> *Let's say you're an organisation and you've lost five bond-paying residents and replaced them with five [daily] accommodation payment residents, and the average bond is $300,000, you've lost $1.5 million worth of cash. And even though you're getting accommodation payment coming in, that could put enormous strain on your overall equity, direct on your [liquidity] ratio (DirCon1).*
>
> *You could have made it simpler. There's a very complex balance sheet management for providers because too much bonds, they don't have any cash flow, too much cash and they can't afford to repay the loans. So they've got to get it into this zone and yet they don't have the control over it getting there, because the choice with the consumer, it's just complex (DirCon4).*

Participants from both the for-profit and not-for-profit sectors saw this reform as substantially benefiting the for-profit sector, as it has a higher proportion of high care beds than low care beds compared with the not-for-profit sector:

> *I think there'll be a huge improvement, certainly in relation to the high care sort of nursing home area … overall I would expect that certainly more capital, whether it's enough I don't know, but certainly more capital will flow in (CEOMP2).*
>
> *But of course if you've got a portfolio of residential aged care that is predominantly in the low care space and you've already maxed out on your accommodation bond payment, well, then obviously you're feeling some exposure (CEOMP4).*

5.11.8 Measurement of quality is important

5.11.8.1 A poor system for quality measurement in Australia

Most participants believed that the quality of care in Australian residential aged care facilities is good, as illustrated by the following comment from a not-for-profit provider:

> *I'm on the board of the [a national body], I get into quite a lot of aged care services and poke around them, and talk to lots of providers across Australia. It's just remarkable what goes on in residential care. So that's the first thing, it's pretty good (CEOMP8).*

There was agreement that there is a poor system operating to measure and compare the performance of aged care services in Australia, in terms of service quality, and that there is an inappropriate reliance on the accreditation system as an indicator of quality. This is explained in the following exchange:

> *RB How do we measure quality in the system at the moment?*
>
> *CEOPB3: We don't. We don't. We have the Australian Standards and Accreditation Agency that monitors systems … But there is nothing which the agency does that reports on outcomes.*

Another commented:

> *The other thing is, we're not very good at measuring quality, and I think the government is moving towards quality indicators. They haven't got there yet, and it's not going to be easy to come up with indicators that are effective (DirCon3).*

The accreditation system was considered to only distinguish between services that meet or fail the minimum standards and was unable to distinguish between services on the basis of the level of quality they provide and produce. This issue was seen by some as a priority for the industry to address in the future:

> *There is no evidence in Australia that one [service compared with another] delivers better quality of care based on their accreditation standards. For me, if somebody said to me what are the three big issues for you in the next three years, I would say quality, quality, quality (DirGov1).*
>
> *But we don't have a system that measures quality, what we have is a quality assurance process through the accreditation scheme. We don't have an objective measure of quality (DirGov2).*
>
> *The reality too is that we have providers who meet all 44 outcomes, who several months later are going through major compliance actions due to quality failure. So there appears to be mismatch between some of the things that we're finding in the accreditation scheme and the quality on the ground that's been received by individuals (DirGov2).*

5.11.8.2 Competition not regulation will drive quality in the future

Some participants expressed the view that service quality is lower than it could be because of the high level of regulation in the aged care industry. The lack of competition in the industry was seen as taking the pressure off providers to demonstrate quality and to distinguish themselves from their competitors in a market based on quality outcomes. These participants considered that a move to a more market-based industry will result in more focus on quality and quality measurement. Quality indicators in the future were predicted to be more consumer-focused than at present:

Because we have an artificial scarcity in supply I don't know that providers have had to innovate or market themselves around quality. As long as they've been able to meet the government regulatory standards they've been able to say we're quality … when you talk to consumers about what do they want out of an aged care service, particularly in an aged care home, they want good relationships with the people who are providing care, they want those people to be skilled and capable, and they want them to be available. So quality is very much about what consumers care about (DirGov2).

So I think the market itself will actually have to adjust to its perceptions of quality from consumers (DirCon2).

And certainly if we moved to a market-based approach I think there's a stronger imperative for residential providers to start to say we measure ourselves against these quality standards and we do well. It will be interesting to see whether it's a market-driven approach or a regulatory approach (DCEOMP2).

5.11.8.3 Regulatory approaches to quality are reliable in indicating poor performance

Participants expressed confidence that when sanctions were imposed for incidents of poor quality this action was justified. They were not as confident that all services that warranted this action were identified:

I think the chance that someone gets sanctioned who shouldn't have been sanctioned is miniscule. Lots of people don't get sanctioned who should be sanctioned. The Department will always try and work out a way to achieve their own outcome without a sanction, rather than to give a sanction (DirGov3).

I think you got to be pretty bloody awful to get a sanction (CEOPB3).

All I'd say is that there's probably nothing that the Department does in aged care that gets greater scrutiny, and the decision to impose sanctions, they are a very, very serious thing to do … So if there's any sort of bias it's a bias towards not imposing a sanction. Firstly, because it is a major step that has severe impacts on the person's business but, even more importantly, it has a dramatic impact on the residents in the aged care service. And the ultimate sanctions where we decide to revoke an approved

provider status ultimately mean that we need to find places for some very vulnerable people (DirGov2).

5.12Structural factors impact the performance of service providers

5.12.1 For-profit and not-for-profit providers should have different roles

The general view held by the participants was that there was little difference in the position in the marketplace of the majority of the for-profit and not-for-profit providers, since most residential aged care services provided care to the mid range of the market. There were some differences in perspectives concerning what the position in the 'marketplace' should be between the for-profit and not-for-profit sectors. Participants acknowledged that some not-for-profit providers focused on services to low-wealth individuals, and some for-profit providers focused on those with high levels of wealth. However they pointed out that some not-for-profit providers also targeted high-wealth individuals and a small number of for-profit providers supplied services in low-income areas. Some not-for-profit providers expressed the view that there should be a difference in the role of for-profit providers and not-for-profit providers.

DirGov3 said that from the Government's perspective there is no difference between the services expected of a for-profit provider to those of a not-for-profit provider, because the government pays all providers the same level of subsidy and expects the same level of service and quality. This participant believed that where a not-for-profit provider chooses to use surplus funds for higher staffing levels or a better quality of facility than for-profit providers, or to subsidise some low-wealth residents, these provider choices are not the province of the government when allocating funds. One participant questioned public perceptions that charities are doing 'wonderful things in aged care' and argued that from the government's position, as the major

funder of residential aged care, it is purchasing a service and is indifferent to the nature and philosophy of the service provider:

> *There is a mystique about what charities do in this country, and it goes back to when governments didn't give money to charities and they were genuinely doing something which other people weren't. Now they're just another service provider (DirGov3).*

Another participant put forward the view that not-for-profit providers should operate as efficiently as for-profit providers because they both receive the same level of subsidy:

> *It's inexcusable that we have such a large proportion of our industry not breaking even when this government has invested more in ACFI*[115] *and subsidy; it's inexcusable that waste is allowed to happen. Yet it gets couched as being all about mission. Well, that's the biggest load of BS I've ever heard because it's pure waste. Government should expect good governance for the dollars that it invests into aged care (CEOPB5).*

When asked if the for-profit and not-for-profit sectors are providing a different service, one participant responded 'not to my knowledge, no' (DirGov4). Another participant, also employed in government, commented that there was no evidence that one sector delivers better quality of care than another, on the basis of their accreditation standards achievements. This response was supported by two not-for-profit executive participants as evident in the following exchange:

> *RB: Does one sector provide better care than the other?*
>
> *CEOMP6:No.*
>
> *RB: How do we know that?*
>
> *CEOMP6:Well exactly.*
>
> *DirMP4:Well we don't. We can only go on the fact there's just as many not-for-profits as for-profits that run into issues with quality and sanctions, so you sort of weigh up and say the common belief would probably be that the*

[115] ACFI is the Aged Care Funding Instrument used by the Australian government to determine the level of subsidy paid to a residential aged care provider based on each resident's level of dependency, cognitive impairment and morbidity.

> *for-profits cut corners and therefore their quality is not as good, that's not borne out by the accreditation system (DirGov1).*

Other participants shared the view that there is little or no difference between the sectors. One indicated that the '*difference [between the sectors] were more imagined than real and some of the differences are philosophical*' (CEOPB2). A for-profit provider expressed the view that he resented the fact that the not-for-profit sector did not pay tax; '*it really bothers me that tax is not paid when absolutely equivalent services are being provided by a taxpaying entity*' (CEOMP4). This participant commented that, despite this advantage, only a few not-for-profit providers focus on particular disadvantaged groups, others, particularly some of the large not-for-profit providers, have entered the high-fee end of the market.

However, a contrary view was put forward by a provider CEO, that the not-for-profit sector does have a different role and should provide a different service than the for-profit sector. This participant made the case that the not-for-profit providers have an obligation to provide services that are different to the for-profit sector, and that they do:

> *There is an argument isn't there that the not-for-profit sector does receive a social benefit through different benefits that we get. For instance, we don't pay tax, etcetera, etcetera. I just raise this question, is there a greater obligation on the part of the not-for-profit to actually provide a broader social benefit than an organisation that's looking at it from a purely commercial return? So I guess what I'm saying, is there a greater responsibility? And I would argue yes there is, and in fact that's where the not-for-profit sector delivers, to actually give a greater social benefit. And we do that in regional areas. We do that in specialist spaces such as the homeless, such as disability (CEOMP8).*

In support of this view was the belief that the not-for-profit sector does the 'heavy lifting' when it comes to providing services in locations that are not profitable. This participant commented that for-profit providers '*just build where it makes money and won't where it doesn't … and then we*

have to go along and pick up all the crap and we don't make any money in the process' (CEOMP8).

Another not-for-profit CEO stated that '*we will cross-subsidise a regional service space because that sits very comfortably with the vision and mission*' (CEOMP4).

The lack of consensus among the participants on the role of the not-for-profit sector in the aged care industry is perhaps best summarised in this quote from a senior executive of a not-for-profit provider:

> *If it's not a different service, and I take your point, it's not different between not-for-profit and for-profit [services], but if we can't create a different service then we [not-for-profit providers] shouldn't really be doing the work (CEOMP2).*

This participant went on to explain his service's business model:

> *We will tend not to focus on the wealthier people; we will focus on affordable services for people with lesser means. We'll also be focused on the CALD*[116] *communities and people who are disadvantaged and marginalised. We will have a presence in regional and remote areas. And I think also the way we provide care will be different. Also we will go to places where the for-profits won't go (CEOMP2).*

The provision of services to rural and remote locations across Australia is one area where there was clear agreement between participants on the role of the for-profit and not-for-profit sectors:

> *You might ask yourself how many for-profit providers have beds in rural and remote communities, or country communities? The answer: very few. Most of the for-profits are in cities. If you look at the deployment of beds it's the churches and charities and the local communities that are in rural [locations] (DirGov1).*

One long-serving government employee (DirGov2) commented that the distinction between for-profit and not-for-profit service providers has diminished over time and that the real distinction in the marketplace is between small and

[116] CALD means 'culturally and linguistically diverse'.

large providers. That participant also commented that there has always been a place for faith-based services to meet the particular needs of religious groups, but whether the not-for-profit sector needed to dominate the market to provide services for this population group was not clear. The same participant observed that the high degree of regulation in the industry in the past may have been another reason for the dominance of the sector by the not-for-profit providers, suggesting that a reduction in regulation would encourage the for-profit sector to also provide services to these population groups:

> *For-profits are quite happy for regulation where it protects their return on investment. But I don't see that most boards look at the regulation in aged care as protecting their investment. The Commonwealth cap supply, which a for-profit provider would be quite excited about. I've got an economic scarcity in my hand, I've got a licence, but because government has regulated supply, it's also regulated its price (DirGov2).*

5.12.2 Structural factors influence business approaches

Participants believed there was a difference between the for-profit and the not-for-profit providers in two important areas. The first concerned the clarity of the business model, particularly the vision and mission of the organisation; the second concerned the strength of governance and management they exhibited.

There was a consensus view that for-profit providers are clearer about their objectives and exhibit stronger governance and management capabilities than the not-for-profit providers, and that these differences will impact the growth and role of the two provider groups in the future:

> *… there's always been a general view that the for-profit sector is going to get a greater return because they're going to run it much more professionally, much more efficiently (DirCon1).*

> *… obviously the not-for-profit have got many charters. So they have charters for not just aged care but for other pastoral investments. But they also, by virtue of their charter and the nature of their organisations, are risk averse and won't take on debt. And if you have a look at the for-profits,*

> *they leverage their bonds much more financially aggressively than the not-for-profits (DirGov4).*

Although for-profit providers were seen as having a narrower focus (making a profit) than not-for-profit providers (multiple missions), the participants were of the view that the not-for-profit providers are also motivated by quality of care and quality of life as a means to make a profit:

> *If you're a for-profit company you're going to spend a lot of time thinking about return on investment, how much you made, the money things. If you are a not-for-profit you're more likely to spend time worrying about 'are we achieving mission'? Mission, not meaning as in mission and vision, like if you and I had a company, but rather mission as in church … they [the board of a not-for-profit organisation] were very focused on the question of do we have enough homes and where were the homeless, where were the down-and-outers, are we giving enough room, that sort of stuff (DirGov1).*
>
> *… where I think in relative terms the not-for-profits will lose out. [Even] though, on balance, a lot of them have got quite old stock, and fabulously located quite old stock, [they have] to go through the process of getting planning approvals, getting their board across the line in terms of how they can redevelop that stock, decant it; deal with resident issues ... All those sort of issues I reckon they are going to struggle to respond to the opportunity … whereas those in the for-profit sector they do that better just because it is what it is. I'm not being critical of the [not-for-profit] sector, it's just from an observation point of view (DirCon5).*

Some participants considered that the for-profit providers allocated a lower level of staffing for care delivery than the not-for-profit sector. The reasons offered in support of this view were the requirements for the for-profit sector to pay taxation and to meet the expectations of shareholders to a suitable return on investment, thus reducing their capacity to afford the same level of staffing as not-for-profit providers. These requirements may result in a lower level of care compared with not-for-profit providers. The following statements reflect these views:

> *… when we look at comparing ourselves with many of our cousins in the for-profit sector we have a higher level of staff than they have … and the*

> *result is that our cost structure is slightly higher but, from a health point of view, we are providing care at a level we are comfortable that is actually providing good care' (CEOMP1).*
>
> *[For-profit providers have] two objectives that they've got to meet before they can consider extra care. They have to meet their taxation objective and they've got to give their shareholders a suitable return … So they've got less money after those two areas to put into care … they [for-profits] certainly don't put anywhere near the amount of resources into training and education, into those areas but, generally, they run it at a much leaner way. Now, does a leaner way therefore translate into better care? Probably not (DirCon1).*

Not-for-profit providers were seen as having a range of missions which included, but were not restricted to, residential aged care, citing less focus on financial performance and emphasising quality and service as goals to achieve the organisational mission. However some participants speculated that large, well-established not-for-profit providers may have forgotten the original mission they had for moving into the aged care sector. The range of missions of not-for-profit providers and the loss of clarity around their principal mission were both considered to weaken these providers' governance and management focus. It was suggested that this weakness led the not-for-profit providers to be indecisive and to lack innovation, and at times to reduce their financial viability and even to lower the quality of their care services:

> *My opinion is when the rubber really hits the road, when it gets really tough, some of the not-for-profits will really struggle because their focus on mission will override the necessity to be looking at the numbers. So a desire to do the right thing will override good financial management (DirGov1).*
>
> *A lot of the not-for-profits are managed by part-time boards. They're there with their heart on the shirt sleeves and doing good things (CEOPB6).*
>
> *… some of the smaller community-based ones with a strong sense of 'we have to be here', their business acumen, such as it is, will be overtaken by*

their sense of community delivery, such [sic] to the extent that financially they will get into trouble (DirGov1).

… the big risk is that the not-for-profits end up doing all the kind of non-viable business, like the country business, people with no money business, and the for-profits move in and cream off all the stuff that makes money (CEOMP8).

5.12.3 The size of services will be important in the future

Small services were seen to be struggling to generate sufficient capacity to meet minimum accreditation standards and thereby, to achieve financial viability, provide clinical oversight and attract quality management. Management of small services was seen to be less sophisticated in relation to managing change and innovation:

Now we know from a compliance point of view via their accreditation standards that there are more small services that are coming into strife when it comes to support contacts or just generally with accreditation (CEOMP5).

We (the Department) thought about it from a theoretical perspective and that's where I was saying, there comes a stage when you can't get the right level of clinical oversight. I think you have to worry about size from that perspective (DirGov3).

The other thing that might possibly push people in a direction of greater size is that it's my view that the aged care provider sector is a bit undermanaged … And one by-product of making bigger places is you can actually afford to have a larger management component and to have people who cannot just run the show but think about how they're going to run it next year type of thing (CEOPB6).

5.12.4 Location of services is important

There was ambivalence in the minds of some participants about the impact of deregulation on services in rural and remote Australia. The concern for rural and remote services was broadly shared. Services in these locations were seen as unlikely to benefit from proportionally lower government subsidies and higher consumer payments. Participants were agreed that there has been no

policy articulated to deal with the impact of policy changes on services in these locations. One participant, from a major not-for-profit provider, recognised 'a huge problem' in removing the geographical controls on approved places as this may lead to a preference by providers to build in wealthier suburbs:

> *And so government's going to need to develop some policies around regional and rural. At the moment there is lip service but not much more. You've got viability supplements and that sort of thing, but the reality is there isn't really a policy around aged care and regional, rural and remote areas. In remote areas the cost of providing services is just in a different league to the cities, and the government needs to come to grips with that (CEOMP2).*
>
> *The market model might meet the market's needs. The two areas I would always be a bit cautious of Australia's unique remote, rural, regional issues … The other issue I think in a market model, even though I'm a market model biased person, with social deliverable program areas, I think there has to be a level of regulation and control (CEOPB1).*

While there was general agreement among participants that the Living Longer Living Better reforms will improve the financial viability of the majority of services in major cities and inner regional locations, this was not considered to be viable for services in rural and remote locations. Participants believed that many services in rural and remote locations would struggle to remain financially viable due to the higher cost of operating in these locations, their small size and the limited capacity of older people and/or families to pay the level of accommodation payment the services would need to survive:

> *And so the rural model has been moving into your low care at a younger age and less frail than in the city because it's a local place that's nicely appointed … But the nature of ageing in place and where aged care is going, is that that model will be obsolete … So how do you fund it? They're going to have problems with their occupancy levels (DirCon1).*
>
> *[Rural and remote services attract] almost half or less than what the average bond in the city is. So the ability of facilities to garner those bonds has always been difficult anyway. So the change to daily payment which will*

> *impact cash flow, or their ability to manage cash flow would be even worse. So … we think that some of the changes will actually mean that the viability and the sustainability of those services will actually diminish quite rapidly (CEOPB4).*

The participants acknowledged that rural and remote services are provided primarily by the not-for-profit sector and state governments. Not-for-profit providers are seen as doing the 'heavy lifting' in these unprofitable areas which are unlikely to attract the for-profit providers. Some participants considered the consolidation of not-for-profit providers in these locations:

> *You might ask yourself how many for-profit providers have beds in rural and remote communities, or country communities. The answer: very few. Most of the for-profits are in cities (DirGov1).*
>
> *I imagine that consolidation in this country will require the non-profits to pick up most of the remote rural regional because if I worked for investor relations for Japara or Lend Lease or something, I'm not quite sure I'd be putting my money up to set up places at Boolarra and Geraldton (CEOPB1).*

A number of the participants commented that the recent policy changes aiming to encourage competition to drive quality and efficiency will face difficulty where there is effectively no marketplace for competitive pressures to take effect:

> *There's no reason why a provider who is offering a service that's in a genuine competitive place shouldn't be forced towards consolidation, you would expect that to occur. There are so many benefits to it. But in the 25% of Australia where an aged care home isn't really in competition with anyone, then we haven't done anything in the industry to fix that (DirGov3).*
>
> *If a nursing home closes down in Parramatta, it's not a major, major issue, vis-à-vis, if the sole nursing home in Young or Cootamundra closes down … The challenge for the government is to come up with a model that works outside of the metropolitan areas (DirGov1).*

While there was agreement that some additional assistance would be needed for rural and remote aged care providers, there was no consensus on what that additional assistance should be:

> *The one size fits all methodology for accommodation and pricing and care pricing, etcetera, means that these guys [rural and remote providers] are disadvantaged. There's no doubt about that (CEOPB4).*
>
> *So I think there is a question about whether you need to top up funding, essentially the government funding, to that sector to recognise there are some cost issues, but they're critical mass liability issues … But more broadly in regional communities I think there is a real concern (DirGov5).*
>
> *One of the things that ACFA [Aged Care Financing Authority] is required to look at, is whether the new arrangements need some supplementation in terms of those [rural and remote providers], without taking the easy solution of just saying, 'Oh, don't you worry about being efficient or effective, we'll just give you more money' (CEOPB5).*
>
> *I think certainly rural and remote are acknowledged by both governments as being a subset of the community that need to be addressed carefully (DirGov4).*

A number of participants mentioned the need for 'block funding' payments to rural and remote providers, as recognition of the challenges they face in achieving financial viability. These participants recognised that block funding would likely create a two-tier system and move away from a consistent policy across Australia:

> *Block funding or whatever. I think we need to make some pragmatics for rural Australia (CEOPB1).*
>
> *So whether we need to look at block funding or other methods to ensure quality of service, and the viability and presence of services in those areas is something I think the government needs to consider (CEOPB4).*
>
> *I don't think the role of government is to ensure that there can't be a two-tier system. The role of the government is to ensure that the bottom tier is good (DirGov3).*
>
> *Hogan certainly spoke about government providing a top up. I think he called it a voucher, where essentially government bids how much extra it would have to pay for a large organisation or a provider to operate a service in a particular region, when it would otherwise not be financially viable. So it'll be interesting to see what sort of model government chooses because it*

will continue to care greatly that people in regional areas have access to aged care services in their communities (DirGov2).

5.13 The structure of the industry will change over the coming decade

Participants believed that the structure of the industry will change over the next 10 years in terms of the relative mix of organisational types, provider sizes, low and high care, and between generalist aged care providers and those that specialise in providing particular forms of care and/or care to particular groups. Across the participants there was an acceptance of the estimates of the KPMG report commissioned by ACFA (KPMG 2013a) on the level of investment required over the next decade.[117] However, there was a general lack of confidence in the industry's capacity to attract the level of funds needed to build the recommended number of beds:

ACFA's estimated that over the next 10 years I think there will need to be an investment of at least $25 billion into residential care. Now, where is that money going to come from? Who's going to have the capacity to raise that money? Who's going to be able to attract equity? Who is going to be able to have the balance sheet to attract more loans? (DirCon3).

See, [the predicted growth to meet demand is] the equivalent of building two 100-bed facilities every week for the next seven years. So that puts the reality into 'well that's impossible, we're not going to do it.' … even if [the level of demand] ends up being 30[,000]. Thirty is probably still something that will be a challenge. We'll probably get there for 30 but the others will be looked after in a more innovative way, and that's why I'm saying market innovation is critical (CEOMP2).

[117] As outlined in Chapter 2, KPMG estimates the industry will need to build 74,000 new beds at a cost of $25 billion by 2023.

5.13.1 There will be a change in the mix of for-profit and not-for-profit providers

Participants from both not-for-profit and for-profit services agreed that there is a difference between the provider groups in access to capital and this will result in different growth patterns in the future. Access to capital is seen as the key factor in the predicted change in the proportion of for-profit and not-for-profit providers over the coming decade. The for-profit sector was considered to have better access to capital for funding the building of new services than the not-for-profit sector. Participants believed that access to equity funding by for-profit operators give them an advantage over not-for-profit providers, who are generally extremely reluctant, or unable, due to their ownership to offer equity to others. Increased capacity to access equity funds would enable the for-profit providers to respond more easily and quickly to increasing demands for residential aged care than the not-for-profit group. This view is illustrated by the statement from a senior advisor to the industry:

> *… the not-for-profits … can't go out there and find equity partners. It doesn't gel with the mission-based approach … [And] the trouble is they've got all these low care facilities that were built with capital grants … they're left with these 20-, 30-year-old legacy buildings for low care, where are they going to get the capital to renew the high care? (DirCon3).*

Participants were asked what the mix of providers will 'look like' in 10 years' time. The majority of participants believed that most of the growth in the sector will come from the for-profit providers and that this group will be the major provider of aged care services in 10 year. However the views of the participants varied as to the extent of that market dominance, as confirmed by the response of a senior government employee:

> *You can't imagine that those 75,000 [additional beds to be built over the next 10 years] aren't going to be built predominantly by the for-profits … I'd be very confident that in 10 years' time you still have at least a third not-for-profit (DirGov3).*

Another participant predicted the relative proportion of for-profit and not-for-profit providers may be 'more like 50/50' (DirMP1). Some participants had a more qualified perception of the change in provider mix, expressing the view that the not-for-profit providers will still dominate the industry in 10 years on the basis that the for-profit sector has not yet shown an interest in providing care in small communities:

> *The view of some participants was that the growth of the for-profit sector will be dependent on a change to a more mixed service model of care. [If] they get a different model, then I think that the for-profits will definitely move in that direction, much quicker than the not-for-profits. Not-for-profits are much more traditional (DirCon1).*

DirMP1 compared the future growth of the residential aged care industry with that of the private hospital industry over the past 20 years. This participant pointed out that in the private hospital industry, over that period, the not-for-profit private hospital providers did not reduce their number of beds, while the number of for-profit private hospital providers substantially increased their number of beds. As a result the for-profit sector now dominates the private hospital industry in Australia.

A dominant view held by the majority of participants was that a decrease in regulation and an increase in market forces will favour the for-profit sector:

> *So, again, I think if the five-year review occurs and the government chooses to either increase the supply beyond the point of demand, or to deregulate, that is, uncouple supply, then I think you will probably see a market response and more for-profit providers move into those areas where they think they can make a better return (DirGov2).*

Participants anticipated opportunities for growth and innovation in the industry after 1 July 2014 when providers can collect and use RADs from new high care residents.[118] This new source of revenue for high care providers was

[118] Since 1997 operators of high care beds have been prevented by regulation from collecting deposits (bonds) from persons entering residential aged care classified as high care.

identified as not only introducing a new source of capital funds, but also increasing the opportunity to borrow funds from a bank and attract equity investment. The for-profit sector was seen as being better placed to take advantage of this opportunity because they hold a higher percentage of high care beds than the not-for-profit sector. Participants, both not-for-profit providers and advisors to the aged care industry, were of the view that the failure of growth in the not-for-profit sector will not be because of a lack of desire to grow, but because of the lack of access to capital to fund growth. As one CEO of a not-for-profit provider explained:

> *[If] we decide we can't carry more bank debt, which is distinctly likely, in which case our contributions to the sector slow down, and the people who can get more capital speed up, and that's the question you're asking is that likely to happen? I think it's a huge risk (CEOMP8).*

Access to capital may also depend on the choices made by consumers on the way they decide to pay for their accommodation. Some participants expressed the concern that should a significant number of residents choose to pay for their accommodation in daily payments, rather than as a deposit bond, then this will impact the capacity of that service provider to borrow for further building:

> *I think it depends on consumer behaviour, how much of a charity do they become if consumers pay only the daily rate and liquidity is removed from the industry. It certainly won't attract private investors seeking a return on their money, who want to distribute the profits. Yes, I think that would go out the door very quickly, and if it did go out the door very quickly the government would be in trouble because you just wouldn't have investment into the industry. I wonder whether church and charitables would continue to invest in an industry that provided no return for mission at all (DirMP2).*

5.13.2 There will be a change in the mix of small and larger providers

Participants were of the view that the future will witness a reduction in the number of small providers and an increase in the number of large providers. For example '*if you want me to make a prediction, there will certainly be a*

lot fewer for-profit single [facility] providers' (DirGov3). This perception was proffered on the notion that small services do not have the capacity to maintain minimum standards and to attract staff and are, therefore, vulnerable to the loss of key staff members. In talking about small services one participant, from for-profit provider, made the following point:

> *… you just have a change in personnel, particularly a registered nurse or even your manager, and a very good business can actually go sour in as short as four weeks (CEOMP5).*

Small services were also considered likely to struggle with the changes in regulation and technology in the future. Changes that were seen as challenges for small providers include a more competitive environment, consumer-directed care and the potential removal of government control of supply. In the view of the participants this will mean more transparency involving the supply of more information to different levels of government and consumers, which will require investment in systems. One not-for-profit participant commented:

> *Increased regulation means the small player just can't go with the expectations of the main payer, that's the government. Like national datasets, investing in computer systems to collect data and deliver care … I personally feel there's a huge value in consolidation in health care. Health care is expensive. It is specialised, and it needs training, development, thinking time, systemisation, investment in computer systems to try to drive technological benefit. So we've got to get to that because you're not going to achieve that from single homes (DirMP2).*

The view was also expressed that capital-raising capacity will depend on the size of the organisation, with larger organisations better positioned to grow:

> *It will be the larger organisations that will be able to scale it up quickly, because if you look at the past growth relative to what has to happen in the future, stand-alone organisations that aren't of significant scale really won't have the capacity to undertake the growth that's needed (CEOMP4).*

5.13.3 A change in the service provided in residential aged care

The belief is widely held among participants that there has been an increase in the recognition of the role of residential aged care services in providing specialist clinical care services, particularly palliative care. Some participants also anticipated that there will be an increase in short-term transition care and rehabilitation provided by residential aged care. CEOPB5 commented that *'we'll see greater diversity in aged care, because I think we will see residential aged care be used for palliative care'*. The view was expressed by CEOMP6 that, *'we already are half way to hospices, we'll just become more and more short-term sub-acute centres.'* According to another participant:

> *There's a gap in our current basket of services that sits somewhere in between this triangle of nursing home, home and hospital … which in the old days was called convalescent home; where you went in for a short time respite … a bit of rehab … on the way home from hospital, and that model has disappeared out of our system, and we need to reinvent it, but we don't have a funding scheme or a regulatory scheme, or a program to do that (CEOMP8).*

In the participants' views this increase in the level and complexity of service will come about partially because of the increased capacity of the community sector to enable consumers to stay at home longer, and partially because they will more easily be able to return home following time spent in hospital, rehabilitation or residential aged care. It was suggested that the increase in the capacity of the community sector to care for older people will result in people entering permanent residential aged care with a higher level of dependency than previously.

> *There is a strong sense that people ought to be able to go in and come out of residential care … I think we'll also see, well I know we will see, a greater degree of planned respite, so the family can cope, and actually they need time off, so let's plan it. Let's not wait until everybody runs down (CEOPB5).*

> *Residential care is really going to be for the 80-plus, highly dependent, very much like a hospital-type care in later life: palliative, intense and probably not all that long - a couple of years (CEOPB1).*

However, it was considered that the increased complexity of service provision will place additional pressure on small providers and the not-for-profit sector, which has a higher proportion of low care beds than the for-profit sector, and particularly on aged care services that were built and operated for many years for low care residents. Some high care providers had already positioned their organisation to take advantage of the trends in the industry:

> *So we [a for-profit provider] see ourselves positioned for that high care market, potentially, depending on government policy, looking at transitional care-type services and things like that. So, yes, we see ourselves at that more acute end of the market as well. Our clinical systems and our clinical models and our staffing models are all designed around that higher acuity service provision (DirMP1).*
>
> *[We, a high care provider, are] probably at a decision point where we may look at providing a variety of care as opposed to the more vanilla-flavoured high care and low care ... Most care is now high care … That's still our core business … But in the main we just plan to continue to provide the highest quality of care we can and meet the market (CEOMP4).*
>
> *One thing that we [a not-for-profit provider] have taken as a kind of strategic decision is that our preference is to develop multipurpose services, but I don't mean literally like the rural MPS model, but certainly we would have a continuum from independent living through low-level community care through high-level community support care through into the residential care where would ideally provide a mix including low-level care, although we can see the low-level residential care ebbing away. So you are providing dementia support and high level that is pretty intensive, sometimes palliative care and sometimes shorter length of stay as people are coming in quite ill (CEOMP1).*
>
> *I think you will continue to see the resident profile get more frail and the prevalence of dementia increase … Put people in there for shorter periods of*

> *time, which poses a challenge for providers managing their business (DirGov5).*

5.13.4 There will be fewer providers in the future

All participants believed that the Living Longer Living Better reforms will result in increased competition, generating consolidation of the industry and fewer residential aged care providers; and particularly fewer small for-profit providers over the next 10 years. It was considered that the timeframe for the introduction of this competitive pressure will be felt over the next five years to 2020. This view is perhaps best summarised by the following statement:

> *[As a result of competitive pressure] you would expect there'd be consolidation as there is in other sectors, like supermarkets and so on, you'll end up with much more dominance of the commercial part of the industry by a smaller number of providers (CEOPB6).*

While not explicitly stated in any policies released by the government, a number of providers were of the view that consolidation may be a direct result of government policy. DirGov3, speaking from one government perspective, believes that '*as a matter of pure theory what we've done economically should result in consolidation*'. The belief that the Australian government's unarticulated intention is to encourage consolidation was a shared view:

> *It's highly fragmented and cottage in nature, and I don't think that's good for consumers. And I think at the end of the day it's probably what government wouldn't want anyway (DirMP1).*

This view was also reflected by a participant from a peak body, CEOPB3, who believed that the NACA suspected a bias by governments towards large providers, and believed that the approach toward the de-regulation of supply will favour this bias. One senior government officer expressed the view that '*great efficiency gains can be made from being a large organisation*' (DirGov3). This participant saw benefits from a quality perspective in a reduction in the number of single stand-alone providers, because the

reputation risk that large providers face, should there be evidence of poor quality released to the public about their services, will drive them to provide a quality service (DirGov3).

However, there was some concern that the competitive pressures toward consolidation will not work in those areas where there is little competition. Participants considered that in rural and remote locations services no longer financially, or operationally, viable may have few opportunities to combine with another provider to rescue their future. This was acknowledged as a gap in the current reform policy by a participant adviser to the government:

> *But in the 25% of Australia where an aged care home isn't really in competition with anyone then we haven't done anything in the industry to fix that (DirGov3).*[119]

Another participant, from government, saw this as a gap in the government's approach to providing care for small populations and asked rhetorically:

> *So how does it [the government] address [service to small populations] where [the] private sector or other providers are not interested in running a small and therefore, not a profitable service? (DirGov2).*

Participants distinguished different factors that will tend to motivate for-profit and not-for-profit providers to consolidate in the future. It was suggested that consolidation in the for-profit sector will be based on purchasing a business for what is perceived to be the 'right price'. The capacity to generate more efficiency and improved marketing opportunities were additional factors suggested which will motivate for-profit providers to grow their business by acquisition. A senior executive in a large for-profit provider expressed the view that:

> *A lot of efficiency comes out of that [consolidation], a lot of collaborative marketing: you can get your brand out there; you can move residents around in different homes (DirMP1).*

[119] This quote was also used above in relation to the lack of competition in rural and remote locations.

Participants also expressed the view that a major deciding factor in relation to consolidation in the not-for-profit sector is based around the 'fit' in mission between the acquiring and the acquired service providers. They also suggested that within the not-for-profit sector there are expected to be different models for consolidation and some of these will be based around partnerships and shared services, but without the need to cede ownership to another organisation. There was also an expectation that a number of providers will narrow their mission and choose to focus on other services, such as children's services and disability, and leave aged care to other providers. It was considered that these providers will be prepared to pass their aged care services to other not-for-profit services that are already well established in the sector and which may not necessarily seek a financial return:

> *So, case in point, Catholic Health Care [is] consolidating up, smaller stand-alone facilities, no public transactions, they're simply just passing over their balance sheets and their businesses and they're coming under a consolidated management (CEOMP5).*

Despite these examples, there was also a view that there will be less consolidation in the not-for-profit sector than in the for-profit sector and that there will be little cross-sector consolidation; that is, few of the not-for-profit services will be bought by for-profit providers. Some participants believed the rate of consolidation will vary across the states and territories.

Consolidation was seen as a mechanism to improve financial viability for individual services, more industry sustainability and improved quality, consumer responsiveness and innovation. Quality and consumer responsiveness were believed to improve through consolidation, because larger organisations are more protective of their brand in a competitive marketplace and therefore are more responsive to consumer complaints. Financial viability, industry sustainability and innovation were believed to be possible because larger organisations will no longer be wholly focused on survival:

> *I feel I [as a consumer] have options if that [major] brand does not perform to my expectation … whereas a 'no brand', just mum and dad owning a home and something goes wrong, who am I going to complain to and what would happen? (DirMP2).*
>
> *[As a large organisation] the viability issue is not your total focus any more. And what you're selling … is innovation and opportunity (CEOPB1).*

Perspectives varied as to the level of consolidation that will occur by 2020, in that it will be driven by whatever decisions the government makes in 2016-17.[120] The participants quoted some industry observers, suggesting there will be as much as a 50% decline in the number of residential aged care providers across Australia over that period, while one participant, CEOPB1, considered that this will be achieved in five years. Other participants saw consolidation as being slow and steady and the extent of the impact on the number of providers as being much lower: *'My view would be you'd be lucky to have 10% [consolidation]'* (DirCon1). However, this was a moot point:

> *So we might have this conversation in five years and I'll say, 'yeah, we're down to 600 [providers] but the Baptists have gone out completely. And the Churches of Christ have, but the Catholics are still in and Uniting are still in it' (CEOPB1).*

5.14Conclusion

This chapter has reported the analysis of the Department's aged care census and sanctions data and the elite stakeholders' interview data. The census data reveal steady and continuing changes to the structure of the residential aged care industry in Australia. These trends include changes in the proportion of services provided by for-profit and not-for-profit providers, changes in the average size of residential aged care services, changes in the size of services depending on their location and changes in the size of organisations. The analysis of the sanctions data indicates that there are

[120] Under the changes to the Aged Care Act 1997 made in 2013, the government of the day is required to commission an independent review of the industry and the impact of the Living Longer Living Better reforms during the financial year 2016-17.

differences in the rate of sanctions imposed by the Australian government, with for-profit providers and providers in some states and territories and in remote locations more likely to be found to have poor compliance with minimum standards.

The analysis of the stakeholder interview data indicates that these participants generally support the regulatory reforms of the previous and current Australian governments, welcome the potential for a more competitive and less regulatory environment in the future and are comfortable with offering more consumer choice. They had mixed views on the level of competition currently in the sector, but considered that there were no differences between for-profit and not-for-profit services in the roles they played in residential aged care services and in the quality of care services that they provided. Participants believed that the structure of the industry will change over the next 10 years. They suggested that there will be an increase in the proportion of services provided by for-profit providers, a decrease in the number of individual provider organisations and small aged care services, and a decrease in the number of low care residents in the residential sector. There was a shared concern with the need to develop better policies to regulate services in rural and remote locations. The participants considered that that there will be more government and industry focus on the measurement of quality, so that providers would be able to distinguish their services in a more competitive market. They all agreed that the current regulatory mechanisms, of imposing sanctions on the most poorly performing providers, correctly identify poor performers.

These data indicate that the predicted future trends in the structure of the sector are consistent with past trends. However these findings also indicate that there are some inconsistencies between the perspectives of the elite stakeholders and the evidence on the performance of the system according to the census and sanctions data. The data also reveal some policy paradoxes in the apparent support for reform and the need to ensure that all Australian communities are provided with residential aged care services in the future.

The significance of these findings and the implications for the residential aged care sector in Australia will be discussed in the next chapter.

CHAPTER 6 Discussion

> *There is an oft-quoted line that the things you should never watch being made are sausages and public policy. To this duo might be added research. And, indeed, other than a handful of specialists paid to do it, few people actually observe either the policy process or the research process. (Lomas 2000, p. 140)*

6.1 Introduction

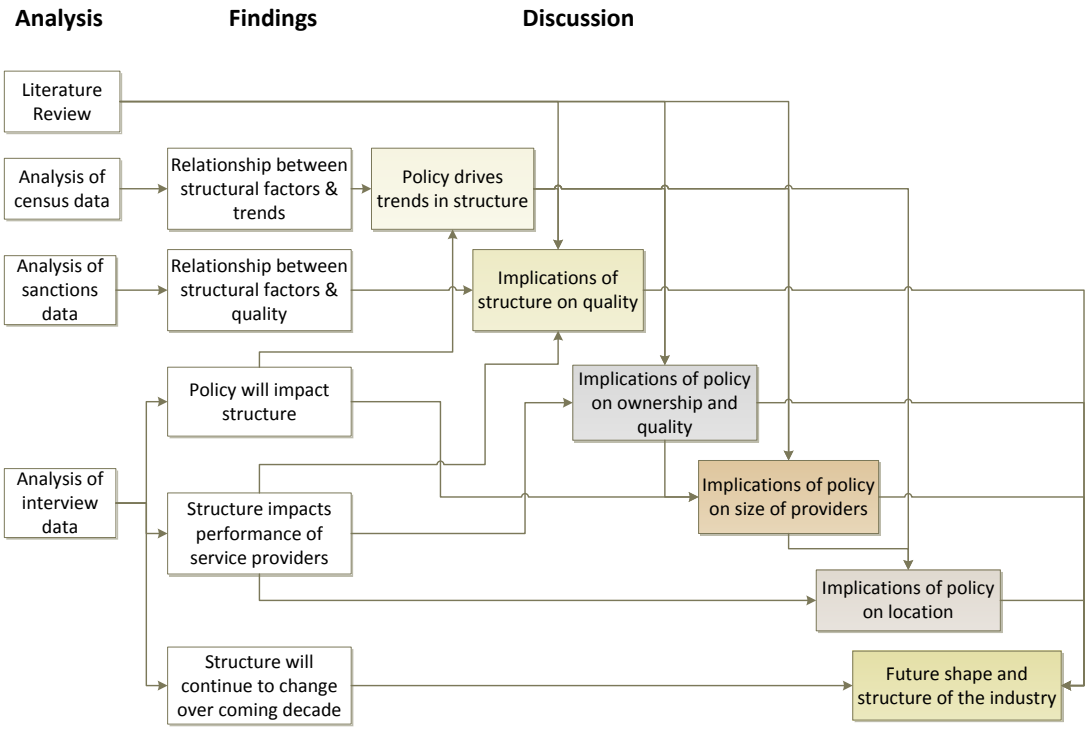
6.1.1 What this chapter does

The discussion in this chapter analyses the study findings and addresses two concepts: that policy is influential on the structure of the aged care sector and that structure is important to quality and performance of residential aged care services. This discussion initially establishes that policy is influential on structure. It then examines the policy implications of the trends in the structure of the residential aged care sector in Australia, the relationship between structural features and quality and the perceptions of elite stakeholders on these and future trends. A number of policy paradoxes and apparent contradictions between policy and practice emerge from this analysis, and also within the views of the elite stakeholders. This discussion seeks to explain these paradoxes and contradictions within the limitations of the study. Finally, emerging from the study findings is a new conceptual framework to represent the relationships between structure, process and outcomes (SPO) in the residential aged care sector in Australia. One conclusion of this discussion is that the introduction of a more competitive market and a relaxation of the government's control on supply, based on neo-liberalism ideology, risks ignoring the importance of structure as a mechanism for providing the most accessible and best quality care.

6.1.2 Content of this chapter

Figure 26 illustrates the logical flow of the rest of this chapter. The key themes and issues explored are how policy drives trends in structure, the implications of structural factors on outcomes (quality failures), the implications of policy on ownership, size and the location and the future shape of the sector.

Figure 26 Contribution of Chapter 6 to the logical framework of this thesis



6.1.3 The aim of the research

The aim of the study was to gain a better understanding of the trends in the residential aged care sector in Australia and the implications of these trends for future Australian aged care policy. This understanding was achieved by undertaking a detailed analysis of past and current trends in residential aged care provision, examining the relationship between structure and quality failures in residential aged care, and exploring the preferences of elite stakeholders on the future shape of the industry in Australia. The research contributes to the evidence needed to inform future decision-making on policy in relation to the aged care industry in Australia and internationally.

Specifically the study answers the following questions:

1. What are the trends in the structure (ownership, size and location) of the residential aged care sector across Australia?
2. What is the relationship between the structural characteristics of the Australian residential aged care sector and the quality of services?
3. What are the perceptions of elite stakeholders on the future trends of the residential aged care sector?
4. What are the implications for future policymaking in response to the identified and perceived trends?

Following a review of the literature on residential aged care policy and practice development in Australia, these research questions were answered by analysing and synthesising the findings from the following sources:

- census data on residential aged care services in Australia over the 10 years to 2012;
- data on quality failures in residential aged care services; and
- semi-structured interviews with a cohort of elite aged care industry stakeholders.

6.1.4 The contribution this research makes to knowledge

This study contributes to new knowledge in six ways.

1. **It establishes that policy drives the structure of the residential aged care sector**

It finds that policy drives the trends and the structure of the residential aged care sector; that is, regulation or Departmental practice related to the funding or standards of the residential aged care sector will impact its structure, including the location of services, the pattern of ownership, the size of services and the size of providers. This is indicated by the data provided in Table 5 in section 2.4.1, which shows that the distribution pattern of aged care places across Australia directly reflects government policy. This finding is also supported by the results of the analysis of the

qualitative data presented in section 5.11 where participants shared the view that policy drives the structure of the industry.

2. **It establishes that structure has a relationship with quality and performance**

This study establishes that the structural features of residential aged care services, such as location and ownership, are related to quality and performance and should be taken into consideration in developing policy. The study findings confirm that the current and past trends in the ownership of residential aged care services in Australia are similar to those seen in other countries and are likely to continue as outlined in Chapter 2. The literature suggests that these trends are not supported by the evidence of best practice as identified in Chapter 3. The consequences of these findings are that the residential aged care sector could be trending towards a structure that is not likely to deliver the best possible service quality.

3. **It identifies the nature of the relationships between structural variables and quality**

The study of the imposition of sanctions provided in Chapter 5 Section 5.8 increases our understanding of the relationship between structural variables and quality. This analysis provides new knowledge that is consistent with previous evidence both nationally and internationally. These results add to the body of work on this relationship, most importantly in Australia, where the research evidence is small and thereby, fills a gap in the research literature. The contribution that this study has made to knowledge about aged care service operations is, that structure influences outcomes, and supports the conclusion on the relationship between policy and structure identified in 1 above.

4. **It identifies tensions and paradoxes between evidence-based and competition-based policies**

This study identifies, in Chapter 5, the acceptance of neo-liberal ideology regarding aged care service policy by elite industry stakeholders. It also identifies a number of paradoxes and apparent contradictions between evidence

on the structural factors that are more likely to deliver the most favourable results and market-based policies. This analysis enhances our understanding of the policymaking process related to aged care in Australia and to the limited use of evidence to inform policy in this sector. It therefore questions the prudence of adopting a policy approach that assumes policy does not drive structure and that structure is not important in delivering quality.

5. **It increases our understanding of the relationships between policy and outcomes and the implications of policy-driven trends**

The study increases the depth of understanding of trends in the structure of residential aged care in Australia, in relation to the policy decisions made by governments and in the views of elite aged care industry stakeholders. It does this by a more comprehensive analysis of the trends in the residential aged care sector that is provided in Chapter 5. Building on the findings that structure is influenced by policy, these findings strengthen our understanding that trends in the sector are not simply the outcome of economic forces, markets or the preferences of providers. Rather, the aged care industry structure is directly influenced by the Australian Government and government policy. Combined with the finding that structure has a bearing on the quality of services, this reinforces the significant role that the government can play in influencing aged care service quality which might be less likely in a deregulated market.

6. **It confirms and strengthens the SPO conceptual framework**

The findings of this study reinforce the conceptual framework explaining the relationship between Donabedian's (1966) SPO model of residential aged care services in Australia. This contribution supports the initial conceptual framework developed by Donabedian (1966) and enhancements proposed by others (Roh 2012; Unruh & Wan 2004), and offers a new framework to support future policy and research into the residential aged care sector in Australia. In particular the findings from this study reinforce the impact that environmental factors have on the structure of the Australian aged care

sector and subsequently, service outcomes. The findings also reinforce the relationship between structure and outcomes in the Australian context. The strengthening of the SPO framework within an Australian context provides an enhanced lens with which to view the proposals for a deregulated industry.

6.2 Policy drives trends in structure

To explore the implications of the trends in the residential aged care sector in current and future policy, it was first necessary to determine the relationship between policy and structure and the relationship between structure and outcomes. If the study findings showed no relationship between policy and structure or between structure and outcomes then the policies of the government were not related to outcomes and other factors would likely be responsible for outcomes.[121] However, if an association between policies and structure and between structure and outcomes was found, then this would have had a significant bearing on the development of future policies. The study findings, however, determined that past aged care policies have had an impact on the structure of the residential aged care industry and that future policies are expected to have an impact on structure. It was also found that structure has had an impact on the quality and performance of residential aged care services.

Through its aged care policies the Australian government has, in summary, striven to achieve three main goals in relation to the residential aged care sector: to foster equity of access, to provide financial assistance and to

[121] Other factors such as staffing levels, staffing qualifications, resident characteristics and income have also been associated with poor quality in the international literature (Castle 2011; Clarfield et al. 2009; Comondore et al. 2009; Harrington, Carrillo, et al. 2011; Phillips & Guo 2011) and may also be applicable in the Australian context. These factors have been found to be correlated with the structural variables identified in this study; for example, staffing levels with ownership type (Castle & Engberg 2007; Spilsbury et al. 2011), ownership type and income (Zinn et al. 2009), location and staffing levels (Harrington & Swan 2003) location and income (Hogan 2004).

ensure quality by regulating for minimum standards (*Aged Care Act 1997*).[122] To achieve these goals the Government's policies, and the regulations and practices established to implement these policies, have focused on controlling the number and location of residential aged care beds, has set subsidies and resident fees and has regulated for minimum standards (inter alia). In considering the relationship between these policies and the structure of the residential aged care sector, two negative propositions are proposed.

The first negative proposition is that the structure of the residential aged care sector in Australia is not the result of these policies and the structure of the residential aged care in Australia develops independently to the control of the supply of beds, the setting of fees and subsidies, and the regulation of standards; that is policy *does not* drive structure. If such a proposition were true then residential aged care policy on these issues could be adopted which did not need to take into consideration the impact on the structure of the sector. For example, a policy to deregulate the control of the supply of beds could be adopted by the government without concern that it would influence the distribution of beds, as the distribution of beds is already independent from policy.

The study found that this proposition is not supported, as the current policies directly affect the shape of the sector by specifying the location of allocated beds and that this policy has achieved its aims of an equal distribution of beds across jurisdictions in Australia. There was also evidence that the level of subsidies encourages larger services and larger provider organisations, since smaller services and stand-alone services have found it increasingly difficult to remain financially viable (Stewart Brown 2013). Some of the elite stakeholders suggested that small services also

[122] The aims specified in the Act are; to protect the health and well-being of recipients of care, to target those most in need, to facilitate access to care, to meet the needs of recipients of care, to facilitate independence and choice, and to have due regard to limited resources (*Aged Care Act 1997*, p. 3).

struggle to meet quality standards and regulation compliance, because of a lack of resources, and will continue to struggle to remain financially viable in the face of increasing compliance demands introduced as part of the Living Longer Living Better reforms. The current level of financial subsidies has also failed to attract for-profit providers to locations outside major cities and inner-regional locations, leaving the not-for-profit and government sectors to fill the gap by providing care in these locations. If the payments and fees policies were not influential in relation to financial performance, for-profit providers would be more equally distributed in these locations.

Participants were also in agreement that past policies on accommodation payments favoured the not-for-profit sector. This distortion emerged because of the not-for-profit sector held most of the low care beds (the only category of beds for which an accommodation bond could be charged). They believed that the new policies on accommodation payments (which commenced in July 2014) will favour the for-profit sector. It seems reasonable to conclude that Australian government policies do influence the structure of the residential aged care sector, whether it is an intentional outcome or not. These findings are explored in more detail below in the section on policy paradoxes.

Although it appears that policies in relation to residential aged care have shaped the structure of the sector, successive Australian governments have not articulated formal policy preferences in relation to structural variables, other than location. This suggests that no Australian government has adopted a formal policy on these structural features of the residential aged care industry, or possibly have undertaken to have no formalised policy on the industry's structural features. The preference of government to make incremental decisions, in an effort to avoid setting policy for difficult or risky decisions, has been recognised (Althaus 2008; Sundakov & Yeabsley 1999). While the elite stakeholders agreed with the view that the government appears not to have a preference for structural factors other than location, they believed that the Department does have a preference for larger rather

than smaller residential aged care services and providers. Nevertheless, the absence of formal policy does not mean that government practices will have no influence on the structure of the industry.

The second negative proposition is that the structure of the residential aged care sector *is not* related to its quality or financial performance. If this proposition were true, policy that influenced structure could be adopted, but this influence would not matter in relation to quality or performance, since structure did not influence them. For example, the introduction of a competition-based policy that resulted in a change in the proportion of the mix of providers would be of no concern if quality were wholly independent of ownership. Since this study has found that structural factors are related to quality and performance in Australian residential aged care, as identified by the sanctions data, that proposition is rejected. The structural factors found to be important in achieving quality and performance according to the international literature, in descending order of importance, are ownership, size of providers, size of services, and to a much lesser extent, the location of services. Of interest is that the Australian government places the most emphasis on the structural variable of 'location' that appears from the literature to have the least influence on quality.

6.3 The relationship between structure and quality

This study found statistically significant differences in the likelihood of sanctions being imposed on residential aged care services across Australia based on structural features; whereby aspects of facility structure have a relationship with quality of services. This result is similar to that identified by Australian researchers Ellis and Howe (2010) and researchers in other countries (Castle & Engberg 2006; Gage et al. 2009; Harrington, Hauser, et al. 2011). These findings raise questions concerning the adoption of policies by governments that appear to be indifferent to residential aged care facility ownership and changes to the patterns of ownership. Another finding is that services in remote locations, irrespective of jurisdiction,

have a significantly higher likelihood of quality failures than services in regional locations and major cities. This raises questions of the comparative viability of services in these locations and reinforces the impact that policy has on the structure of the sector. These findings question the predominant Australian aged care policy that promotes the equal distribution of services by location, when the findings clearly indicate that such a policy leads to a trend towards increasingly non-viable services in some locations. These findings should also be taken into consideration by policymakers in any consideration of a move to a market-based model distribution of services, as under the current policy framework these services would be unlikely to continue without significant additional government subsidies.

Following multivariable analysis, there was a statistically significant higher likelihood of sanctions occurring in Victorian residential aged care services compared with NSW services. Since Victoria and NSW have similar-sized populations and economies, this is an issue that warrants further investigation.[123] It is beyond the scope of this study to fully investigate the cause of the consistently higher rate of sanctions by services in Victoria, however it does raise for question the continuing policy by governments of ignoring structural factors (other than location) when the quality of services in two comparable states is significantly different and they have different patterns of ownership.

The elite stakeholders were of the view that the investigating quality officers were unlikely to apply a sanction for quality failures in a residential facility unless there were good reasons to do so. When sanctions

[123] In Victoria (in 2011) 40% of all residential aged care services were for-profit providers, 25% government provided with only 36% not-for-profit providers. This pattern of ownership differs from NSW (in 2011) where 28% of all services were operated by for-profit providers, 4% by governments and 68% by not-for-profit providers (Australian Institute of Health and Welfare 2012b). The higher percentage of for-profit and government providers in Victoria than not-for-profit providers may explain this difference. These results are also similar to the findings of the earlier Australian study by Ellis and Howe (2010).

were imposed for incidents of poor quality this action was justified. The elite stakeholders' views give confidence to these findings of continuing patterns of relationship between some structural features and incidences of quality failures in residential aged care facilities in Australia.[124]

These findings, although limited in scope, support the contention that the residential aged care facility structure will impact on service quality, as identified by the international literature. The challenge for policymakers is how to take these findings into consideration when determining aged care policy. For example, how can the Government affect aged care policy in light of the finding that for-profit providers in Australia are more likely to seriously fail to meet minimum standards? In consideration of Australian aged care policy principles, this finding should have a bearing on policy decisions which seek to influence the most effective pattern of ownership in Australia's residential aged care sector. The implications of the trends in the pattern of ownership for policy are discussed in the next section.

6.4 Implications for policy of trends in ownership

The study identified clear trends in the changing pattern of ownership and the perceptions of the elite stakeholder on future trends in ownership patterns. When these trends are considered alongside the international literature regarding the relationship between ownership and quality, it raises serious implications for policy.

[124] Structural factors and their relationship with quality failures were selected for analysis as both of these data are publicly available in Australia. Other factors such as staffing levels, staffing qualifications, resident characteristics and income have also been associated with regulatory failure in overseas studies (Castle 2011; Clarfield et al. 2009; Comondore et al. 2009; Harrington, Carrillo, et al. 2011; Phillips & Guo 2011) and may also be applicable in the Australian context but these data are not collected for all services, are not available for study in Australia or cannot be linked with data on quality failures. Structural factors have been found to be correlated with other variables; for example, staffing levels with ownership type (Castle & Engberg 2007; Spilsbury et al. 2011), ownership type and income (Zinn et al. 2009), location and staffing levels (Harrington & Swan 2003) and location and income (Hogan 2004). These correlations support the validity of using the available data on structural variables and quality failures in the absence of other data.

If there are no differences between not-for-profit and for-profit providers in the quality of services, the efficiency of service delivery or in the populations they serve, then it would be appropriate for the major funder, the Australian government, and through it the Australian community, to be indifferent to changes in the proportional mix of ownership types. Such indifference would lend weight to a decision to remove the controls on residential aged care bed supply and to move to a market mechanism for the distribution of services.

Conversely, if there are differences in quality and efficiency between the sectors (that is, one sector is using government funds more efficiently) then this is an important issue for public debate as it raises the question of the community's preference for quality or efficiency. The challenge then for policymakers is to determine if there are differences occurring with different provider types, and, if there are, what they are and how significant they are for the consumer. A determination of a difference may be achieved from an examination of theoretical concepts of difference and actual performance. The perceptions of the participants on perceived differences between provider types are also valuable as they provide an insight into future policy decisions.

Past and anticipated changes in the mix of ownership type in Australia

The study revealed clear trends in the pattern of ownership of residential aged care services in Australia. There is an overall increase in the proportion of beds operated by for-profit providers and an increase in the size of services owned by for-profit providers. Also, for-profit services are larger than services owned by not-for-profit providers. There is an increase in the proportion of for-profit providers and a decrease in the proportion of not-for-profit and government providers in the major cities. This trend is the opposite in rural and remote locations which are experiencing an increasing number and proportion of government-provided services.

This pattern of change is consistent with the international experience in other English-speaking countries. In the USA, in the twentieth century, there was a shift from predominately not-for-profit to predominately for-profit provision of care (Kaffenberger 2000). In New Zealand the percentage of services operated by for-profit providers increased from 65% to 76% between 2005 and 2009 (Grant Thornton 2010). In Ireland the beds operated by for-profit providers increased from 22% in 1998 to 69% in 2013 (Hickey 2014) and in the UK between 1980 and 2005 the proportion of beds in the for-profit sector rose from 18% to 90% (Johnson, Rolph & Smith 2010). Faced with the likelihood of changes in the proportion of for-profit and not-for-profit providers, the challenges for policymakers and stakeholders are to determine the significance of these changes in the light of the evidence on the differences in quality or efficiency between the ownership classes.

Theoretical and actual differences

The conclusions that emerge from the literature are that there should be a difference in performance between for-profit and not-for-profit residential aged care service providers. When both types of services are operating in the same marketplace, not-for-profit services have a financial advantage over for-profit services, as they are not required to pay dividends to shareholders and are exempt from (some) taxation. This enables not-for-profit providers to pay for additional care and services to those provided by for-profit providers who attract the same levels of Government subsidy (ceteris paribus). The Australian not-for-profit residential aged care sector behaves consistently with these theoretical notions and has been found to have higher direct-care staff levels than for-profit providers (King & Martin 2009).

The surplus funds available to not-for-profit providers, which for-profit providers need in order to pay taxes and shareholders, can also be spent on capital investment. This preferential taxation arrangement provides the community with another advantage, as it relieves the government of the

responsibility of providing these investment funds directly[125] and also relieves it of the responsibility of becoming the default provider of residential aged care services (Allen Consulting Group 2003; Henry et al. 2009; Productivity Commission 2010b) in those locations unattractive to the for-profit sector. This taxation framework suggests that successive Australian governments do not regard the not-for-profit aged care providers in the same way as the for-profit providers. Arguably this difference should be reflected in residential aged care policy and Departmental practice.

Conversely, scholars (Feldstein 2011; Santerre & Neun 2010) argue that for-profit services have an advantage over not-for-profit services in the areas of business focus and management practice. They claim that the managers and governors of not-for-profit providers are distracted by the need to achieve a range of charitable or religious missions. For-profit managers, on the other hand, have clearer goals and a tighter focus on the business of residential aged care. The diffusion of focus of not-for-profit providers, they argue, hampers their competitive performance in an open market.

The empirical findings of the international literature support these theoretical arguments and find difference between for-profit and not-for-profit providers when researching quality and efficiency. As reported in Chapter 3 and above, the majority of international studies have found that outcomes are more favourable for residents in not-for-profit services than in for-profit services and that for-profit providers are likely to be more efficient. These research findings have been consistent over recent decades and across different countries and are reflected in this and other Australian studies (Ellis & Howe 2010; Rao, Coelli & O'Donnell 2003). Furthermore, a commissioned Australian study (Allen Consulting Group 2003) found that not-for-profit services in Australia have a different role to for-profit

[125] The Henry Taxation Review (Henry et al. 2009, p. 44) supports this notion that the intention of taxation advantage given to not-for-profit providers is to free the government from providing capital grants to not-for-profit providers as has been the practice of the Australian government in past decades as described in Chapter 2.

services. This study found that compared with the for-profit sector, the not-for-profit sector was much more likely to provide services in rural and remote locations (and to provide services to indigenous communities), less likely to provide extra service places (to higher wealth residents), and more likely to be assessed as providing higher quality care (based on accreditation reports) (Allen Consulting Group 2003, pp. 2-3). This study finds that there are still these same differences; for-profit providers are absent from outer regional and remote locations and are more likely to have a sanction imposed based on an assessment of failing to meet minimum standards.

Perceptions of current differences

While participants acknowledged that not-for-profit services are more likely to be found in impoverished non-urban communities, their general view is that, for the majority of services, there is no difference in the role of for-profit and not-for-profit providers, or the services they provide. This is because outer regional and remote residential aged care services are only a small percentage of the overall number of these services in Australia. Participants in this study, who were senior government officials, reinforced the general view that the different sectors have the same roles and do not provide different services. They believed that this lack of difference is reflected by the Department's practice, which is to show indifference to ownership status when approving providers or allocating beds. One senior government official also strongly believed that there is no difference in the quality of care provided by the for-profit and the not-for-profit sectors despite previous research in Australia which found a difference (Allen Consulting Group 2003; Ellis & Howe 2010; Richardson 2006). These positions held by the participants suggest that they are either unaware of the evidence, are aware but choose to ignore it, or do not find it of sufficient strength to change their view.

Notwithstanding the general view of the participants that there is no difference between the sectors in most services, some not-for-profit providers believed there should be, and there is, a difference. This is

evident, they said, because the not-for-profit sector is doing the 'heavy lifting' by providing services in locations that are not profitable and some not-for-profit providers are actively targeting their services to low-wealth individuals. This perception, held by the elite stakeholders, that there is or is not a difference between the sectors, may have important implications for the future policies they influence.

The future mix of providers

The stakeholders accepted the anticipated growth in the residential aged care sector of 74,000 beds over the coming 10 years (Aged Care Financing Authority 2013; KPMG 2013b). They expected the current trend to continue and for the for-profit sector to build and operate more of these new aged care beds than the not-for-profit sector, to the point where for-profit providers will become the majority provider within the sector. Recent commissioned reports (Deloitte Access Economics, 2011; KPMG, 2013) also argue that the for-profit sector is better placed than the not-for-profit sector to take advantage of the expansion of the industry[126]. Participants offered six reasons to explain the future growth and dominance of the sector by the not-for-profit providers:

- For-profit providers have more access to equity partners and to the capital with which to fund expansion.
- For-profit providers are seen as more focused on their business philosophy, more decisive and more willing to explore new and innovative operational and business models than not-for-profit providers, even though they must consider the needs of equity holders and their taxation obligations before the extra needs of residents, yet still meet the same quality standards as not-for-profit providers.

[126] This argument is based on the perception that for-profit providers exhibit a higher level of comfort with debt and have tax advantages from borrowings, compared with the not-for-profit sector, and these factors give them easier access to capital.

- Executives and governing bodies of not-for-profit providers were often distracted by the broad range of services and business they offer, which reduces their focus on their residential aged care business and consequently their growth potential, while others commented on the lack of corporate governance skills of not-for-profit boards and their comparative slowness to innovate, which reduces their competitive advantage.
- The introduction of refundable accommodation deposits from high care residents, from 1 July 2014, will favour the for-profit sector because this sector has a higher percentage of high care beds from which accommodation deposits have not already been collected.'
- Larger organisations are more likely to grow than smaller ones and this is seen as favouring the for-profit sector as they can 'scale up quickly' in preparation for expansion.

It is important to take note of these perceptions because of the likely influence that these stakeholders will have on future policymaking. This scenario raises some paradoxes in relation to the approaches of government and the practices of the Department.

Paradoxes in policy on organisational type

The conclusion from the examination of the evidence is that there is a difference in the role and performance of for-profit and not-for-profit providers both in Australia and other countries. However, the policies and the practices of the Department do not appear to reflect these differences when contracting for services. Participants agreed that this is how the current system works; that is, the Department contracts services from approved providers and is indifferent to the category of provider. The only concern of the Department is that services meet minimum standards and this view is supported by the government's publications (Australian Government Department of Health and Ageing 2012a) and recent literature on contracting out of Government services in Australia (Housego & O'Brien 2012).

The Department's practice to treat all competing providers equally in contracting for services is consistent with a marketisation approach to the awarding of contracts for services, favoured by neo-liberal ideology. A marketisation approach assumes there is a market, yet there is a lack of consensus among participants on the extent to which there is an effective competitive market currently operating in the residential aged care sector and there is evidence of market failure in outer regional and remote locations.[127] The belief that the market is a sound mechanism for the distribution of social services has been questioned by researchers (Meagher & Cortis 2009), yet remains the basis of recent recommendations for reform. Current practice also fails to acknowledge the apparent opposite trends in service types in major cities and rural and remote locations, which suggests market failure outside major cities.

The view of the elite stakeholders that there should be a difference in the role of the two residential aged care provider types is supported by a recent review of not-for-profit organisations by the Productivity Commission (2010b) and also by the Allen Consulting Group (2003). However the differences found between the provider types are not reflected in the Hogan (2004) review, or the Productivity Commission (2011) report into aged care, as neither has shown much interest in exploring differences in the roles of for-profit and not-for-profit providers.[128] Hogan's (2004) final report ignored the findings

[127] While supplements are provided to compensate providers for service in remote locations, the evidence on the ownership patterns demonstrates that this does not fully compensate providers, as this policy has manifestly failed to attract for-profit providers to these locations. The lack of accuracy to reflect the true cost of providing care for the range of supplements provided by the Aged Care Program is further illustrated by the withdrawal of the Dementia Supplement by the Assistant Minister for Social Services on 27 June 2014. This supplement, part of the Living Longer Living Better package of reforms, had exceeded its budget by more than four times within the first year of operation. The inaccuracy of the mechanism to cost this supplement supports the participants' view that while the supplements are welcome they do not accurately represent the true cost of care.

[128] The reports did comment in relation to differences in economic efficiency (Hogan 2004) and the issue of lack of competitive neutrality arising from the different taxation treatments between the sectors (Productivity Commission 2011).

of the Allen Consulting Group (2003) (a subsidiary enquiry he commissioned), that there was a difference in quality between the two sectors.

The question arises as to why both Hogan (2004) and the Productivity Commission (2011) reports failed to acknowledge the evidence of differences between the two main residential aged care providers. Possible explanations are that they were not aware of the evidence (although that would be surprising given the resources available to both enquiries), or they may not have found the evidence convincing (even to the extent that it was not worth mentioning in their reports and discussions). A third possibility is that the evidence that structure is important to quality may be inconsistent with the neo-liberal ideology dominant in the nature of their recommendations. In short, a difference between for-profit and not-for-profit providers may be an inconvenient truth when advocating for a market-based approach to the distribution of services and contracts. As the findings of these two reports are widely discussed and understood within the residential aged care sector, their ideological base is likely to have become very familiar to the elite stakeholders participating in this study.

It seems reasonable to conclude that there is currently not a competitive market in residential aged care in Australia, at least not one that is recognised by the elite stakeholders interviewed for this study who are regarded by their peers as knowledgeable and influential. This conclusion is supported by the continuing control on supply by the Department, preventing a free growth of services, and by the evidence of market failure outside major cities and inner metropolitan areas, despite the provision of the 'viability supplement' to reimburse providers for the cost of providing care in rural and remote locations. The taxation relief for not-for-profit providers suggests that the Department should ensure that those services would target low-wealth communities; that is, all service providers should not be treated equally for the purpose of the allocation of beds. The paradox emerges, on the one hand, between the practice of the Department, the perception of the elite stakeholders and the commissioned reports that for-profit and not-for-

profit residential aged care services are the same, and on the other hand, the international and local evidence that this is not the case. This paradox will be further explored below, following the discussion on the implications for policy on trends in size and location of services.

6.5 Implications for policy on trends in the size of providers and services

There has been moderate industry consolidation over the past decade as evidenced by the reduction in the number of residential aged care service providers overall, the decrease in the number of providers who operate fewer than 10 services and the increase in the number of providers who operate 10 or more services. The elite participants believed these trends will continue because small services will struggle to survive due to the increasing complexity of compliance, requirement for more technology, the lack of attraction of small services as a preferred employer, the increased need for higher management expertise than small services can attract and the anticipated increase in competitive pressure from the introduction of the Living Longer Living Longer reforms. Generally, the elite stakeholders viewed consolidation as positive for the sector because larger services are more financially viable and more responsive to consumer needs. Participants also believed that for-profit providers will be more successful in consolidating due to their more concentrated business focus.[129] The level of comfort with these trends appears to be consistent with the participants' concern that the residential aged care sector is still dominated by small providers and their wish that a more professional industry will emerge from further consolidation. Given this view, future policy is unlikely to be interventionist in relation to the size of services or the size of provider organisations.

[129] There is also the view that the motivation of for-profit and not-for-profit providers towards acquisition differs, with not-for-profit providers focused on the match with their mission and for-profit providers guided by the opportunity for profit.

However policymakers may need to be alert to the prospects of very large providers emerging from an unregulated market. Provider organisations with more than 10,000 beds in the USA have been the subject of concerns of over quality (Harrington, Olney, et al. 2011). While Australia is yet to see provider organisations of this size, with potential future growth a few providers may be providing care to more than 10,000 consumers in the next few years. While there have been no major corporate failures of aged care providers in Australia, the experience with ABC Learning, which was the largest child care provider in Australia and possibly the world at the time of its collapse in 2008 (Press & Woodrow 2009), should alert policymakers to develop policy safeguards against a similar occurrence in the residential aged care sector.

6.6 Implications on policy of trends in location

The policy objective to achieve an equitable distribution of beds across Australia has largely been achieved on a jurisdictional basis by 2013, but it has not relied on market mechanisms. The target for the allocation of aged care places in 2013[130] was 88 beds (plus 25 community care places for a total of 113) per 1,000 persons over the age of 70 in each planning region (Australian Government Department of Social Services 2013, p. 25). On 30 June 2013 the mean number of operational residential aged care beds by population across Australia was 84.5 beds and 111.7 total places per persons over the age of 70 years. There is strong evidence that a reliance on market mechanisms to achieve an equitable distribution would not succeed due to market failure in locations outside major cities and inner-regional locations. This market failure[131] is demonstrated by the lack of sufficient bids in outer-regional, remote and very remote locations for all the newly

[130] The government has announced that the planning targets will change to 125 places by 2021-22 with the increase of the number of home care packages from 27 to 45 places (Australian Government Department of Social Services 2013, p. 25).
[131] Market failure occurs where the market, if left to itself, does not allocate resources efficiently and results in the involvement of government, or the supply of services by not-for-profit organisations (Arrow 1963; Duckett 2007; Stiglitz 2000).

available aged care places through the 2012 ACAR process, the failure to attract for-profit services to these locations and the increase in the number of state-government services in small remote communities,[132] presumably as the default provider. In addition, the average size of services in these locations remains below that recommended as a financially viable size.[133] Elite stakeholder participants recognised the lack of competition in rural and remote locations, the trends in market failure and a lack of financially viable services in these locations. There was also a strong view that there has been a failure in past and current policy to address the challenges faced by services in these locations.

The recognition of these trends seems inconsistent with the level of comfort these elite stakeholders expressed towards the government's intentions to move towards a more competitive market for residential aged care[134] across Australia. The paradox that emerges is that the policy direction preferred by all these participants is for more competition in the residential aged care industry and yet the creation of a competitive market may not be feasible for large parts of Australia. This is not to suggest that the best alternative is the current system that is operating, since equal distribution does not necessarily mean equal access to services by all groups.

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[132] Except for Victoria, state governments have been decreasing their involvement as providers in residential aged care in other geographical locations over the past two decades.

[133] Recent industry-funded benchmark research reports (Ansell, Dovey & Vu 2012; Stewart Brown 2013) advocate for a facility size of over 60 beds to maximise profits and viability. It is also worth noting that neither of these two current benchmarking reports, that recommend an average size of 60 beds, (Ansell, Dovey & Vu 2012; Stewart Brown 2013) make any mention of the impact on quality of care or quality of life by increasing the average service size to 60 beds or more. These benchmark reports are consistent with recent commissioned Australian reports, which have also questioned the financial viability of small aged care services, particularly those in remote locations (Hogan 2004; Productivity Commission 2011). This suggests that either these authors don't consider a relationship between size and quality or they are not aware of any evidence, or that they regard their role to be concerned with financial viability only and not with quality.

[134] At the time of writing, the 'new' Australian government has not revoked Living Longer Living Better and has altered only a few matters of detail and timing in the implementation of the reforms, such as the method of payment of the workforce supplement.

In its review of government services, the Productivity Commission (2014, p. 13.28) noted that although places were reasonably distributed across jurisdictions, the rate of use by residents per target population varied between jurisdictions. This variation was observed for all residents, indigenous residents and residents born in a non-English speaking country and they also noted that '*there is greater variation in usage rates by remoteness area than amongst jurisdictions*'. This suggests that geographical distribution does not necessarily result in equitable access to services and that even under the current system of allocation by location, equal access is still difficult to achieve. Where distribution is left to the marketplace, there is very little evidence to suggest access would improve.

These findings, of variation in access, support the earlier work of Richardson (2006) who found that barriers to access were created in regional areas when decisions on the structure of the industry were based on notions of technical efficiency; that is, the necessity to be financially viable. This occurs because small services (because that is all the population density requires) are relatively inefficient. A logical conclusion from Richardson's (2006) findings is that a policy that allows the development of larger but fewer services (which is the most likely scenario in a fully competitive model, as these will be more efficient services) is not likely to also achieve the same ease of access as smaller, less efficient, more evenly distributed services. The alternative to a policy that encourages efficiency through size is to maintain access to care locally, while recognising that such a service is unlikely to be efficient or financially viable when funded in the same way as services in other locations. The tensions building around the financial viability of small residential aged care services and their continuing capacity to provide services that meet minimum standards in relatively small and isolated communities, suggests there is a need for a different policy solution for these services. This solution is unlikely to be a market-based one.

Some elite stakeholder participants recognised that a different funding system will be needed for services in outer-regional, remote and very remote locations. They acknowledged that this could result in the emergence of a 'two-tiered' system of funding; where one 'tier' operates in major cities and inner-regional locations and the other in outer-regional and remote locations. The current availability of a viability supplement for both community and residential providers based on location and size - the more remote and smaller the service the larger the supplement (Australian Government Department of Health and Ageing 2011a) - established some elements of a two-tiered system. In addition, the higher proportion of state government-provided services in remote and very remote locations also distinguishes them from other locations. However, these differences are not reflected in overall policy, as all residential aged care services in Australia are funded and regulated the same way. Participants were of the view that the viability supplements were inadequate and a new model of 'block funding' for small services in rural and remote locations was needed. The 'block funding' model suggested would cover core infrastructure costs and not rely on payments for individual residents.

In summary, while the elite stakeholders strongly supported a move to a more competitive market for residential aged care, they recognised this may only work in the most populated parts of the country. This presents a major challenge for future governments should they wish to move to a market-based system for the allocation of resources, as there may be significant political challenges in any policy that could be construed as providing second-best services in rural and remote Australia.

6.7 Implications of the discourse on competition, quality and choice on future policy

Although the elite stakeholders were generally supportive of the reforms announced as part of the Living Longer Living Better package, and the

subsequent reforms arising,[135] they believed these were only the beginning of change in the industry and that more structural reform towards a relaxation of control on supply will follow the 2016-17 review.[136] They were of the view that competition is good for consumers; however, there was no shared view as to what constitutes competition, how to know if it exists and how to measure it. There was also a lack of consensus on what was meant by service quality, with some believing that quality was the achievement of minimum quality standards, while others saw service quality as mechanisms to distinguish care and outcomes that were higher than minimum standards between services. Despite these differences, there was general agreement that more transparency on indicators of service quality than is currently available will drive competition and the consumer will benefit.

Notwithstanding the experience of the elite stakeholders, their common belief that competition will improve service quality may prove to be naive, as the evidence on the relationship between competition and quality in the residential aged care sector is currently mixed or negative. Of particular note are the findings of a recent UK study (Forder & Allan 2014) which contradicts the perception that competition in the residential aged care sector drives up service quality. It concludes that competition in a publicly funded residential aged care market, which has moved from predominately not-for-profit to predominately for-profit, drives down quality to minimum standards. This occurs where government purchasers are driven by notions of efficiency (Forder & Allan 2014). Governments seek to achieve efficiency by paying lower subsidies and subsequently choose those competing providers who

[135] The areas where there was dissatisfaction with the policy reforms were in the level of uncertainty concerning the directions of the accommodation payments (which could create financial difficulty for some providers), the limits on user co-payments (particularly the failure to introduce mechanism to free up equity in the family home), the failure to remove controls on supply in the current round of reforms (as recommended by the Productivity Commission) and the lack of flexibility in the use of subsidies (allowing consumers to use funding for either residential or community care).

[136] This review was built into the 2013 amendments to the Aged Care Act 1997 (Australian Government Department of Health and Ageing 2012c).

offer the lowest price. This forces providers to reduce their price and therefore income. The lower income forced them to reduce quality to the minimum. As Forder and Allan comment:

> *The policy implications of this analysis on nursing home markets in England depend largely on judgements as to whether minimum quality standards are acceptable. If competition is pushing prices down such that providers are producing services at minimum quality, but this quality is acceptable to policy makers, then greater competition can be seen as beneficial. Such an interpretation can only be sustained, however, if we are confident that the (non-market) actions of the regulator are sufficient to maintain minimum quality levels. Without robust regulation, and without a change in public commissioning behaviour, quality could deteriorate below acceptable levels (2014, p. 82).*

It appears as if the elite stakeholders' perceptions of the benefits of market competition in the aged care industry are driven by the ideological framework of neo-liberalism, rather than by the available evidence. This belief in a better outcome for aged care residents through a more competitive industry echoes the persistence of Hogan's (2004) review recommendations and those of the various Productivity Commission's reports (Madge 2000; Productivity Commission 1999, 2005, 2008, 2010a, 2011).

All elite stakeholder participants believed a more competitive environment would also provide more choice for consumers. Their understanding of 'choice' was that it enabled consumers to choose between alternative providers, although some questioned its applicability in real terms, as this is only possible in locations where there is more than one provider, or where participants have the means to choose between providers with different charges. Interestingly, this view is inconsistent with the Australian Government's aged care policy. In the Living Longer Living Better policy document (Australian Government Department of Health and Ageing 2012b), 'choice' is defined as between payment methods and between community and residential care, not between residential aged care providers. However, as

discussed above, the elite participants believed that competition will be based on the differences in quality between providers, that is, consumers will be able to choose between good quality providers and poor quality providers and this will drive competition and improve quality.

Competition in this discourse is seen as good for choice and good for quality, yet the notions that they expressed about 'competition', 'quality' and 'choice' exhibited aspects of policy confusion for the elite stakeholders. The implications of this confusion are that both current and future policies are possibly not clearly understood by the elite stakeholders, or their understanding is not consistent. It would also appear that both Australian aged care policies and the perceptions of elite stakeholders are not based on the evidence of trends in the industry. A possible explanation may be that the policy elite, represented by the participants in this study, are not aware of the evidence, do not find the evidence compelling or find it conflicts with their own preferences. Moreover the confusion between policy and practice, differences in views between participants and inconsistency in both practice and perception suggest a lack of shared understanding.

This discussion has posited that aged care policy drives the structure of the residential aged care industry and that while structure is important, this is not acknowledged by Government policies or Departmental practices. A more significant conclusion is that key government objectives regarding residential aged care, which are enshrined in the Aged Care Act 1997, are unlikely to be achieved in relation to access and quality in a market-based environment. This is because of the challenges of achieving an effective market in large areas of Australia and the unequal performance of the for-profit and not-for-profit providers in achieving service quality. It seems clear that a policy objective that favours efficiency will be comfortable with a market-based solution, as this is likely to favour the for-profit sector. Alternatively, a policy objective that favours quality is unlikely to be achieved with a market-based solution to the distribution of beds. The

current situation in policy development presents an opportunity for reflection on the future residential aged care sector that the community will prefer. The method of arriving at society's preferred position may depend on the nature of the policy process experienced in this policy arena.

6.8 Implications for the policy process

From the analysis of the trends in the residential aged care sector and the perceptions of elite stakeholder participants, some observations can be made about the policy process. The first is that the approach to policy by successive Australian governments over recent decades has been incremental. The past pattern of decision-making and implementation are consistent with the policy process described by Lindblom (1982). The second observation is that there are paradoxes and inconsistencies in the logical framework of the elite stakeholders in articulating their preferences for policy direction and sector reform, and in the practices of the Department, for which an explanation is not immediately clear. One possible explanation for these paradoxes and inconsistencies may be provided by the theory of bounded rationality, which proposes that there are limits on the cognitive capacity of even senior policy makers to deal with all the competing ideas and factors in a complex policy arena.

Although incrementalism has been criticised by some for its empirical weakness in establishing a causal connection to link the actions of government within the incremental model (True, Jones & Baumgartner 2007), the underlying concepts have proven to be enduring and have applicability to this discussion. Lindblom's (1982) view was that liberal democracies take small, potentially reversible steps when changing policy instead of attempting to identify the preferences of all stakeholders in one stage of reform. This process is preferred to rational comprehensive decision-making where all the policy options, delivery mechanisms and implementation strategies are examined and comprehensive changes are made to the policy arena. Incrementalism advocates that governments avoid 'big bang' policy changes

(rational comprehensive decision-making) on the basis that it is just not possible for policy analysis to identify all the preferences of the community and to understand all the implications of complex policy changes. The theory of incrementalism explains the Australian Government's aged care policy process over many past and recent decades. Chapter 2 described the almost continual process of review and reform of this sector since the 1980s, which reflects this approach to policy making. A pattern has emerged of intermittent commissioned reviews with each of these followed, perhaps, by some action of the government to introduce some of the recommendations contained in the report, but inevitably rejecting or ignoring others.[137]

In this study some elite stakeholders expressed frustration with the failure of the government to implement all the 2011 Productivity Commission's recommendations immediately. Providing some insight into the policy process, one of the elite stakeholders who was a senior government official, pointed out that the public perception that governments commission reviews to tell them what to do is an erroneous view of the Australian government's policy process. This participant's view was that the government didn't *'choose some recommendations and* [not] *others'* but rather it engaged with the Productivity Commission to lend weight to the idea of microeconomic reform that had been *'working its way through the system for 10 years'* and *'that it's not like the PC recommendations are anything that people haven't heard about before'* (DirGov2 Chapter 5 page 196). This participant's view lends weight to the argument that governments favour an incremental approach to aged care policy.

The introduction of a clause to the Aged Care Act 1997, as part of the Living Longer Living Better policy, which requires the government to commission a

[137] The lack of action by government, or the outright rejection of seemingly well-developed recommendations, has not been well received by some of those appointed to conduct the enquiries. This is particularly true of Hogan (2007a, 2007b)who voiced his disappointment and frustration publicly a number of times and may partially explain the preference in recent years for the government to use the Productive Commission as its reviewing authority because, as a government body, it is less likely to be vocal concerning the subsequent decisions of government.

review of the reforms in 2016-17, lends additional weight to the idea that the conceptual framework of incrementalism helps to explain the aged care policy process. By including a fixed review process into the Act, the government achieved two goals: it removed the pressure to act immediately and risk making potentially contested decisions, and it left open the possibility of action in the future. Such a step provided those in favour of radical change with hope for the future and those who prefer the status quo to remain with a level of comfort for a few more years. In this way the government also enshrined one of the elements of incrementalism, the option of reversing changes that don't work after the 2016-17 review.[138]

Complementary to the model of incrementalism is the notion of bounded rationality, which may explain the apparently erroneous and dissonant perceptions and preferences of elite stakeholders and the practices of the Department. Participants stated they believed in the goal of consumer choice as an essential foundation for a competitive market and at the same time, they recognised the absence of detailed information on the quality of services needed to exercise that choice. There was no shared understanding of the notion of service quality among elite stakeholders, although they appeared to believe that quality has a crucial role in the establishment of a competitive market. They also believed that competition in the industry will improve service quality, although this view is not supported by evidence from studies of the aged care industry. The elite stakeholders recognised market failure in parts of the sector but still advocated market-based reform. They had the perception that both for-profit and not-for-profit services provide the same level of service, yet they acknowledged that for-profit providers are absent from some parts of the sector and did not refer to the evidence of

[138] This review will examine the Living Longer Living Better reforms such as the introduction of consumer-directed care into community care, removal of the restriction on providers from extracting RADs from high care residents, introducing more transparency into the cost of entering aged care, taking steps to facilitate easier access to aged care and the increase in consumer co-payments for both community and residential aged care.

differences between the consumers served and the quality of services occurring in for-profit and not-for-profit residential aged care providers.

Nielsen (2009, p. 46) defines fully rational behaviour as behaviour '*that is optimal in the sense that it is in complete correspondence with environmental incentive and constraints, as well as the preferences of the decision maker*' and boundedly rational behaviour as behaviour that is not fully adapted to the information present in the decision environment. This phenomena occurs because '*information rich environments and complex tasks are notoriously difficult to tackle for the human cognitive apparatus*' (Nielsen 2009, p. 47). Consequently the boundedly rational actor pays attention to some external stimuli and not others. It is beyond the capacity to this research to fully explore the extent to which this phenomenon is occurring here, but it does appear to offer a possible explanation for the preference and policy paradoxes that have been identified. It also appears to offer some explanation of the apparent failure of the participants, as knowledgeable and influential stakeholders, to take into consideration all the evidence before forming their perceptions and preferences about future industry trends.

These two elements, incrementalism and bounded rationality, are foundations for the theory of punctuated equilibrium. This theory hypothesises that policy systems are basically stable unless subject to interference from outside the policy subsystem (True, Jones & Baumgartner 2007, p. 176). While somewhat axiomatic, continuous incremental changes evident in the aged care policy arena provide an element of stability, or equilibrium, by guiding gradual reform and adaption. In reviewing the introduction of policy changes in this sector over recent decades in Chapter 2, no 'comprehensive rational' (big bang changes) reforms have been introduced. Each reform has built on the last and made small changes to existing policy and practice. Even the introduction of the Aged Care Act 1997 was primarily incremental in its approach as it 'tidied' up existing practices in legislation and gave a

legislative framework to establish policy directions.[139] The same can be said of the Living Longer Living Better policy, which made important but still marginal changes to existing practice.

This approach to decision-making makes sense when both the findings of this research, that policy impacts on structure, and the structure of the industry is important, are taken into consideration. The residential aged care sector is made up of a large number of non-Government providers, all of who have made considerable financial investment in their facilities. The Australian government has no alternative mechanisms to provide care should the sector fail. An incremental approach to policy reform, thereby, enables the sector to adjust before making further changes. It also allows for ineffective Government decisions to be reversed without undue damage; there are numerous examples of small and moderate reversals in policy.[140] The recognition that policy impacts on structure may be a key factor in the continuation of an incremental approach to decision-making.

The model of punctuated equilibrium includes incrementalism with the phenomena of bounded rationality. It recognises that decision-makers are bounded by their ability and resources to make rational, comprehensive decisions. An incremental approach to aged care policy making makes sense, as it provides the opportunity to repair mistakes arising from the bounded rational decision-makers. The policy paradoxes that have emerged, and the apparent contradictions in the perceptions of elite stakeholders, provide

[139] For example, the use of the ACAR for allocating beds was in place for 10 years before it was enshrined in this legislation. In addition, the Act provided legislative safeguards to the collection of accommodation bonds that had been the practice for some years in low care services. Although the introduction of 'ageing in place' enshrined in the legislation was a new concept, its introduction was incremental as it applied to residents only when their conditions changed.

[140] Examples of policy reversals are the removal of the dementia policy in July 2014 (Australian Ageing Agenda 2014), the adjustments to the ACFI in 2011-12 to remove the discrimination in payments against people who were homeless (Australian Government Department of Health and Ageing 2012d), introducing measures to restrict the unexpected growth in the ACFI payments (Australian Government Department of Social Services 2013) and the reversal of the ban on accommodation deposits by high care residents (Australian Government Department of Health and Ageing 2012b).

evidence of bounded rationality particularly in the apparent resistance or failure to take into consideration the evidence that would refute some tightly held positions. The failure of policymakers to take evidence into consideration in health-related policy is well established (Botterill & Hindmoor 2012; Head 2013), as reflected in the Australian residential aged care policy arena. It would appear that the incremental approach to policymaking provides a safeguard to the bounded rationality of aged care policy influencers interviewed for this study.

6.9 Refinement of the SPO conceptual framework

The study has provided new insights into Donabedian's SPO framework, while also confirming that structure is influenced by government policy and practice. Consequently, it is recommended that the relationship between policy, structure and outcome and performance should be included in the SPO model. The inclusion of these external factors in the SPO framework has been advocated by others. Atchley (1991) takes the view that broader contextual factors, such as the social, political and regulatory environment, should be included in the SPO model and with these inclusions the label 'structure' should be changed to 'inputs'. Unruh and Wan (2004) include 'contextual' factors as a precursor to structural factors in their redevelopment of the SPO framework to apply it to the residential aged care sector. Roh (2012) also concludes that 'environmental factors' should be included, in addition to structure, process and outcome factors. The findings of this study support these arguments. It has been shown that government policy (an environmental factor) regulates the location of services (a structural factor). Government action through the imposition of sanctions (an environmental factor) will often require changes to management arrangements and income (structural factors). These findings provide sound arguments to place environmental (contextual) factors as a separate set of inputs influencing organisational structure as recommended by Atchley (1991). To reflect these findings, a new SPO framework, taking both Unruh and Wan's and Roh's models in mind, is

proposed in Figure 27, even though the study findings did not support these models.

In Figure 27 the factors found in this study to have relationships with each other are shown in black, while relationships based on the work of others are shown in grey. Unruh and Wan (2004) argue that resident characteristics act separately and independently on 'outcomes' and do not influence structure or process factors, such as staffing, which conflicts with Roh's (2012) model, which places the characteristics of the population residents are drawn from as an environmental factor. However, Unruh and Wan's proposal of the representation of resident characteristics acting separately on outcomes and not on other elements of the framework is not supported by the literature or by the study findings. While researchers agree that resident characteristics are important in influencing resident outcomes, they also influence other factors, as was demonstrated in this study.

In Australia, as in other countries, resident characteristics influence income through the payment system (ACFI). Using resident characteristics, government and other payers estimate the amount of subsidy to be paid to the provider and this locates resident characteristics as a structural factor, as they have an influence on income and income has been demonstrated to have an impact on processes and outcomes (Cohen & Spector 1996; Dwyer et al. 2010). The resident's level of care needs, and/or the resident mix, will also impact the processes used by care staff (Konetzka, Spector & Shaffer 2004; Mor et al. 2004). Consequently, Unruh and Wan's thesis, that resident attributes act only on outcome and not on other factors in the conceptual model is not supported by the study findings and should more appropriately be displayed alongside other organisational inputs.

Finally, Unruh and Wan's (2004) proposals that 'nursing staffing' should be shown as a separate structural factor, and that 'process' should be separated into 'nursing care process' and 'quality of care', seem to add complexity to the model without particular benefit and do not fit with the mix of direct care staff in Australian services. Direct-care staff, in

residential aged care services in Australia, include a mix of nursing and non-nursing care staff (personal care assistants and allied health staff). As there are more non-nursing care staff than nurses (registered and enrolled) (King et al. 2013), there seems no sound reason for separating out one category of direct care staff (nurses) from others and for this reason Unruh and Wan's proposal that 'quality of care' is also not supported. They also recommend the inclusion of 'quality of care' as a separate 'lateral component'. However, separating out quality of care from other process and outcome indicators is problematic due to what Roh (2012) identifies as the confusion in the literature in relation to quality of care indicators, which he claims can be used to measure both processes and outcomes. Papers reviewed for this study support Roh's argument that quality of care indicators are used for measures of both process and outcome, for example, the measurement of the incidence of pressure ulcers may be an indicator of quality of care (Castle & Engberg 2005; Comondore et al. 2009; Johnson et al. 2004), but also the absence of pressure ulcers can be used as a resident outcome measure by others (Banaszak-Holl et al. 2002; Kamimura et al. 2007; Spector, Selden & Cohen 1998).

The conceptual framework proposed in Figure 27 is based on the original SPO model, the findings of this study and the proposals of Unruh and Wan (2004), Roh (2012) and Atchley (1991) and has been designed to reflect the residential aged care sector in Australia. It has four elements, each containing a number of factors. The number of elements distinguishes it from previous models and emerges from the recognition that inputs fall into two elements: 'environment inputs' and 'organisation inputs'. Environmental factors are those that influence the organisation but are external, and include government regulation and standards, economic and competition conditions, professional practice and industry practice, community expectations and demand and technology.

Regulation and standards are included as environmental factors and are shown in red as they have emerged from this study. This factor, in the Australian

context, includes policies related to access, fees and subsidies, and accreditation standards as this research has demonstrated that these policy areas influence structure. Other elements included as environmental factors are community expectations and demand, economic and competition factors, professional and industry practice, and technology. These elements are supported by the literature.[141] Studies that examined the relationship between community expectations and demand with structural and outcome factors include Grabowski (2001), Hillmer (2005), and Mukamel et al. (2010). Studies that link local economic factors and competition with structure and outcomes include Amirkhanyan (2007), Amirkhanyan et al (2008), Blank (2001), Blank and Eggink (2001) and Castle et al. (2008). Two other factors are suggested to complete the environmental inputs - professional and industry practice and technology.

This study has identified four organisational input factors - organisational size, ownership type, service size and service location - that have a relationship with environmental inputs. These factors have also been shown in this study to have a relationship with financial performance, regulatory compliance and efficiency, either directly or through the literature reviewed in Chapter 3.

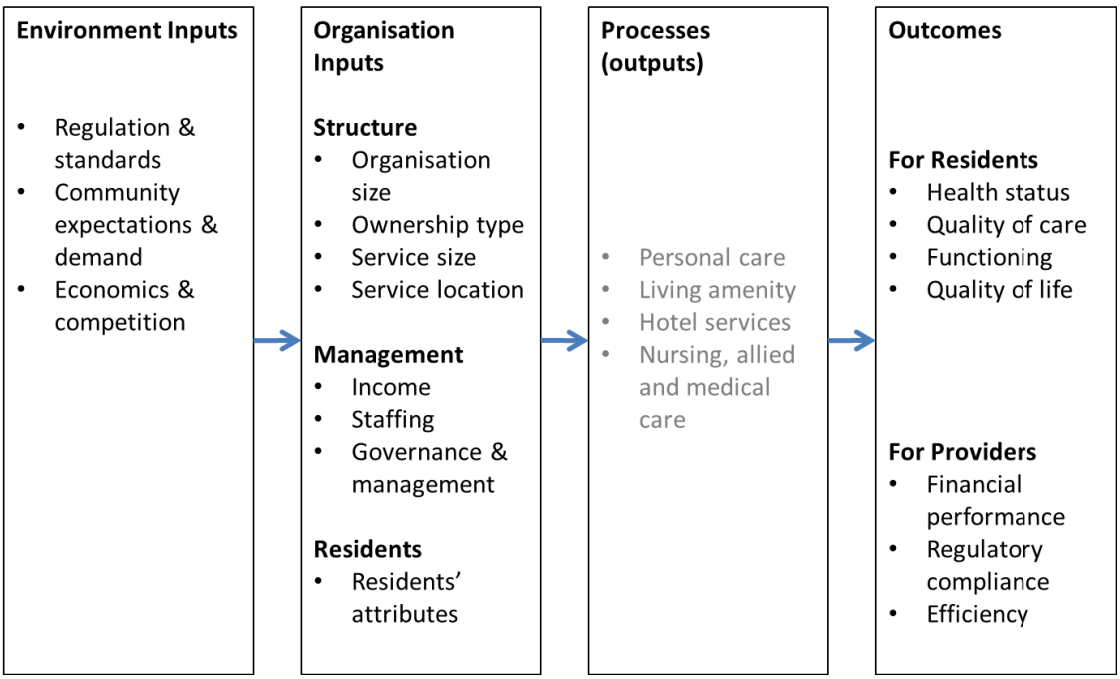
Other factors included as part of organisational input elements are income which has been shown to influence outcomes (Clement, Bradley & Lin 2009; Weech-Maldonado et al. 2012; Weech-Maldonado, Neff & Mor 2003), and efficiency (DeLellis & Ozcan 2012; Kamimura et al. 2007; Weech-Maldonado et al. 2012). There is a substantial literature on the staffing of residential aged care services with a particular focus on staff mix and staffing hours and the relationship with outcomes. An excellent review of this literature has been recently provided by (Spilsbury et al. 2011) and reviewed by Castle (2012). Although the influence of governance and management on residential aged care performance has also been investigated by fewer researchers than

[141] A summary of these papers is included in Appendix B.

other input variables, a number of authors have reported a relationship between these factors and both regulation and standards (Dewaelheyns et al. 2009; Dewaelheyns, Eeckloo & Van Hulle 2011); while others report on the relationship between management practices and outcomes (Anderson, Issel & McDaniel Jr 2003; Stevenson, Bramson & Grabowski 2013). The factors included as part of the process elements have been included from the previous studies (Courtney et al. 2010; Harrington 2005, 2007) but have not been specifically examined in this study.

This revised framework illustrates the relationships between the elements and factors of the residential aged care sector that have been recognised both internationally and in Australia. It reflects contemporary knowledge and contributes to our understanding of how the relationship between inputs, structure, processes and outcomes works. This contribution to the literature enhances our understanding of the importance of these significant relationships and their role in resident outcomes.

Figure 27 Enhanced conceptual framework on the relationship between environmental and structural inputs, process and outcomes arising from this research



6.10Limitations

There were a number of unavoidable limitations with this study. First, the government census and sanctions data were collected by many different people and thus, were subject to bias and error. As identified in the Methods Chapter, the census data have face validity due to their use for transferring funding, and for this reason providers are motivated to ensure accurate data are held by the Department, but the level of accuracy is not possible to determine. Second, the sanctions data may be limited by the subjective judgements of accreditation surveyors who collect and record these data. Third, the statistical analysis of the sanctions data and its generalisability to the total population of residential aged care service are limited by the small sample size. Sanctions on facilities remain a relatively rare event in Australian residential aged care, but the absence of an accessible, systematic, national database on indicators of quality mean that these data are the only available source of evidence for an approximation of the quality of residential aged care in Australia. This is an issue of national importance given the continuing market tends in the sector. The sample of participants was limited to those recommended by others and did not include any health care professionals (other than those in senior management positons) or academics, as none were recommended. Similarly, consumer input was limited to elite stakeholders and there were no participants from employee organisations, as none were recommended as elite stakeholders.

6.11Conclusion

This study has shown clear trends in a number of structural factors of the residential aged care sector in Australia, some of which would not be encouraged if policy was based on the international evidence of the relationship between structure and outcome. This is particularly apparent in relation to the trends in residential aged care service ownership. What

emerges is the prospect of a sector that in future years will be dominated by for-profit providers, a view shared by all participant stakeholders. Stakeholders also agreed on the future deregulation of the sector and that competition is a 'good' thing. Participants from both the for-profit and not-for-profit sectors indicated a level of confidence in the potential movement towards marketization of the residential aged care sector. Where for-profit and not-for-profit participants differed in their views was on whether there should be a different role for the two sectors with some not-for-profit providers firmly of the view that there should be a different role for their services compared with for-profit providers.

This study has also revealed a direct relationship between the key policies of the Australian government that regulate the distribution, funding and quality of residential aged care services and the structural features of the sector. It has also found that there are clear relationships between service structure and service outcomes, which reflect the international literature. The implications of these findings have significance for the future development of aged care policy in the light of the expectation and support of the elite stakeholders of the adoption of neo-liberal reform in the sector towards a more competitive market. The consideration of a reduction in the level of control over the geographic distribution of residential aged care services and the strengthening of competition forces in service provision must also include the absence of quality indicators to guide consumer and purchaser decisions and the evidence of market failure in large parts of the country. The conclusions that can be drawn from this study and the recommendations for future action are discussed in the next chapter.

CHAPTER 7 Conclusions and Recommendations

7.1 Introduction

The residential aged care sector in Australia, like that in comparable countries, will require considerable capital investment by providers and an increase in recurrent costs for government and for consumers to meet future demand. Together the community, the Australian government, providers and investors will need to decide where future services are to be located, how big they should be and who should operate them to ensure the best balance of the competing objectives of access, efficiency and quality. The Australian community has the right to expect these investments and operational decisions will be evidence based and that the residential aged care sector will be regulated by evidence-based policies. However, there is an absence of evidence on the optimal structural features of residential aged care in Australia on which to base these decisions. The study sought to address that issue by conducting a mixed methods study to answer four research questions:

1. What are the trends in the structure (ownership, size and location) of the residential aged care sector across Australia?

2. What is the relationship between the structural characteristics of the Australian residential aged care sector and the quality of services?

3. What are the perceptions of elite stakeholders on the future trends of the residential aged care sector?

4. What are the implications for future policymaking in response to the identified and perceived trends?

A number of policy paradoxes have emerged from the analysis of elite stakeholder perceptions about current and future trends in the residential aged care industry, the review of the international and Australian literature

on aged care policy and market trends, and the analysis of census data and data on quality failures in the Australian residential aged care sector. These paradoxes include a failure of the elite stakeholders to reflect on Australian and international evidence to frame their perceptions, their apparent preference for a market-based system while concurrently recognising market failure in parts of Australia, and their failure to acknowledge the distinct role of the not-for-profit services in Departmental practice. These findings raise a number of implications for future policy. This chapter summarises these findings, identifies the implications for the future, identifies the contribution these findings have made to the issues framing the research questions and how this study has identified gaps in our current knowledge. A number of recommendations are made both in relation to future research and to future policy development.

7.2 Research findings

The policy review identified that the Australian government has pursued an objective of equal distribution of residential aged care beds across all planning regions in Australia for the past 25 years. In achieving this goal, the government has retained a tight control on the distribution of beds by determining which provider is allocated beds, and how many and where they must be built. While formal policy is silent on the government's preference for other structural variables, the elite stakeholder participants believed there is a preference for larger providers and larger services. The conclusion is that aged care policy influences the structure of the industry and this has implications for the future structure if changes in policy move towards a more competitive market for residential aged care.

There are clear, steady and strong trends in the size of services, ownership patterns and the size of providers. The overall average size of residential aged care services has increased, and the group of services with more than 100 beds is now the fasting growing category in Australia. This trend is inconsistent with the international evidence that services over 100 beds, for

some indicators of quality, tend to provide poorer care than smaller services. Although the residential aged care sector is still dominated by a large percentage of small providers, the six largest providers are larger than those of 10 years ago.

The question of ownership has emerged as the most important of all structural considerations. The for-profit sector has grown faster than the not-for-profit sector over the past decade and looks set to increase that expansion to the point where it could dominate the sector in 10 years' time. The substantial international literature indicates that for-profit providers are more efficient than not-for-profit providers but provide poorer care. The local evidence and this study's findings support the literature. This finding raises important considerations for the Australian government and community decision-making, particularly in light of the development of the government-funded residential aged care sector in the USA, which has many similarities to the Australian sector.

Kaffenberger (2000) observes that the USA for-profit sector grew to dominate the aged care industry in the absence of a specific government policy advocating this direction. He says that while no public officials or important political elements argued in favour of for-profit provision of residential aged care, over time a series of policy changes and government financial programs resulted in this dominance. Research on this trend in the USA concludes that market dominance of for-profit providers has not achieved the best possible outcomes for residents as not-for-profit service consistently have been found to provide better care.

The analysis of sanctions, which the Australian government applies to residential aged care services that fail to achieve and maintain minimum quality service standards, also indicates that for-profit residential aged care services in Australia have a significantly higher likelihood of receiving a sanction for poor service quality. Services in relatively remote locations that are generally operated by Government and not-for-profit providers and in some other jurisdictions also have higher likelihood of

sanctions and poorer quality of services. These findings confirm Australian and international research; for-profit residential aged care services have a higher likelihood of being found to have poorer service quality.

The study also identified paradoxes regarding current policy. The data indicate that there is market failure in residential aged care service provision in outer-regional, remote and very remote locations. It appears that government policy is poised to move towards a competition-based system for resource allocation. The paradox is that the elite stakeholders recognise this market failure but at the same time still preferred market-based reforms to the current system of Government allocation of services. They recognise that market competition is unlikely to result in supply of residential aged care services in large parts of Australia and that there is no current policy approaches to remedy this market failure. The discourse on the nature of competition, choice and quality reveals a lack of consensus among the elite stakeholders who are influential in policymaking. Gaining a shared understanding of these concepts would appear to be a requirement for moving towards the removal of the government's control on supply.

There is also a paradox regarding the view of the elite stakeholders that there is no difference in services offered by for-profit and not-for-profit providers, including stakeholders within the Department. However, the evidence suggests that there is a difference; both in terms of quality and populations served, and taxation policy would suggest that there should be a difference. Despite the absence of specific policies, the current pattern of residential aged care service provision that has been influenced by Government control on supply, has carved out a specific role for some not-for-profit providers who serve disadvantaged communities. These findings suggest that the SPO model requires the addition of further constructs to explain the relationship between structure, process and outcomes for the residential aged care industry.

7.3 Theoretical implications

The study findings support Donabedian's (2005) SPO framework, in the sense that quality and performance outcomes are related to structure, but some modifications are required. The relationship between service quality and performance outcomes has been convincingly reported in the international research and has been further supported by the study findings, in relation to Australian residential aged care structural variables and the quality of services. In light of these findings, a new conceptual framework has emerged. It builds on the available literature as well as these findings. This framework provides a new understanding of the nature of the relationship between different factors in the Australian residential aged care sector.

The findings also suggest that the elite aged care stakeholder participants, who have an influence on Australian aged care policy, have accepted the neo-liberalism ideology regarding the future structure and operations of the sector in Australia. This was most apparent in their consensus view that the current level of Government control on supply should be reduced and that an increase in competition and choice is preferred and that this will improve the quality of care. Notwithstanding their preference for a competitive market in the belief that it will deliver higher quality care, this view is not supported by empirical research findings from other countries such as the UK.

Two theoretical constructs - 'incrementalism' and 'bounded rationality' - contained within the model of punctuated equilibrium (True, Jones & Baumgartner 2007) were considered in helping to explain policymaking in the Australian residential care sector and to understand the strongly-held perceptions of the elite stakeholders regarding their preferred model of aged care. Incrementalism in aged care policy making in Australia is evident when analysing the consistent pattern of small changes made by the Australian Government, each reversible should they prove ineffective. These small changes appear to contribute stability or 'equilibrium' within the system

by enabling stakeholders to adjust to policy changes. This policy process may be a result of the nature of the sector where substantial investments have been made by a large number of non-government providers who would find rational comprehensive reform (“big bang” reform) unacceptable and unachievable.

In addition, because the aged care sector provides services for vulnerable people, incremental rather than rational comprehensive change may also be more palatable for the community who largely pay for these services through taxation. It is possible that the practice of incremental policy making may be a protection within what appears to be paradoxes and inconsistencies in policy and practice. An incremental approach to policy making allows for changes to be easily reversed if they are found, or considered by the public and/or aged care providers, to be inappropriate; a mechanism that has been used frequently in the past in this policy arena.

These policy paradoxes and inconsistencies can be explained by the theory of bounded rationality. This theory suggests a limitation in the capacity of actors to take into consideration all the available information when making decisions or forming a view. This phenomenon appears to be evident in the failure of the knowledgeable and influential elite stakeholder participants to take all the available evidence into consideration when forming their views and preferences about future trends in residential aged care. The non-use of evidence in establishing social policy has been linked to bounded rational theory by others (Botterill & Hindmoor 2012) and thus, might explain what is occurring in regard to forming residential aged care policy in Australia.

7.4 Policy implications

Two key findings from this study are that policy influences the structure of the residential aged care industry in Australia and that structural variables are important in achieving quality outcomes. This implies that aspects of the industry’s structure should not be ignored by policymakers if their aim is

to lay the foundations for equitable, quality residential aged care services across the nation. Australia is on track to replicate overseas trends in the mix of service providers; that is, a decline in the proportion of not-for-profit providers. This will arise because recently introduced reforms are expected to encourage the for-profit sector to grow faster than the not-for-profit sector. The evidence also suggests that a move to a more open market would favour for-profit over not-for-profit providers. This will also result in larger services and larger providers, since larger services are more efficient for the for-profit providers which are expected to be more successful in acquisitions than not-for-profit providers. These trends are likely in Australia, even though the evidence indicates that not-for-profit providers and moderately sized services will tend to deliver better quality care and outcomes for residents. These findings constitute an important issue for public debate given the trends leading in the opposite direction to international evidence.

This is most apparent in outer-regional, remote and very remote locations in Australia, where an equitable distribution of services is unlikely to result from a competitive market. The introduction of neo-liberal based reforms (higher user co-payments and lower government subsidies) is likely to result in a decrease in the financial viability of small, not-for-profit providers, which currently supply the bulk of services in these locations. State governments will increasingly feel the pressure to become the provider of last resort in these locations. A two-tier system will be necessary in the future if the Aged Care Act (1997) equity principle is to hold; with one policy framework based on marketisation principles for major cities and inner-regional locations and another policy and payment mechanism to govern residential aged care in the rest of the country. Again this is an issue of significant public interest.

The absence, in Departmental practice, of a recognised distinction between the role of for-profit and not-for-profit providers in residential aged care also raises significant policy questions. If it is the decision of the

Australian Parliament to recognise the special work of not-for-profit residential aged care providers through taxation law, it seems that this ought to be a reflected in government policy by identifying the differences in the roles of the for-profit and not-for-profit aged care service providers in relation to the individuals, groups and communities they serve. The adoption of marketisation principles, which do not distinguish between provider types in the Australian residential aged care sector, is at odds with the government's intention to recognise a difference between the two classes of providers through the taxation regime. In the absence of regulatory control and adequate incentives there may be no mechanism for government to ensure that low-wealth individuals and communities benefit from the taxation relief provided to not-for-profit providers.

There is, therefore, some concern about the future return on the investment that the Australian community can expect from the exemptions given to not-for-profit providers in a deregulated market. The Australian public has the right to expect that not-for-profit providers will continue to provide different services as a result of this investment. However, if all controls on the supply of beds are removed and all services are to be equally competitive, what incentives will there be to ensure that not-for-profit providers continue to undertake the special role in aged care service supply that the community expects.

Confusion in the discourse around key concepts related to future aged care reforms raises further policy implications. The first is that the current program of policy reform is grounded on the rhetoric that it is designed to increase choice (Australian Government Department of Health and Ageing 2012b), however the 'choice' targeted by the government in its reform documents has a different meaning to the 'choice' referred to by the key stakeholder participants. Another policy implication is the notion that competition in the residential aged care industry will improve quality, a notion which is not supported by the international literature. A further implication of future reforms is the recognition of current market failure in

outer-regional, remote and very remote locations, with no clear indication by the elite stakeholders on how this failure is to be reconciled with a preference for a market based sector. In analysing marketisation of welfare services in Australia, Davidson (2012)argues that it is possible to have competition without choice but it is not possible to have choice without competition. Since the elite stakeholders strongly favoured both choice and competition in future residential aged care policy, but did not come to a consensus on a shared understanding of these concepts, it appears that further work is needed to develop the foundations for a workable market model should this emerge.

7.5 Recommendations and future research

The major gap in the research and the administrative databases in Australia is the lack of a comprehensive, accurate, accessible and timely national dataset on the quality of residential aged care services. Having this dataset would enable the Government and the public to evaluate the achievement of standards of residential aged care providers and compare organisational, resident and staff outcomes. The production of an accessible national database of comprehensive service inputs and outcomes will provide the foundation for a competitive market-based residential aged care system. Ideally it would be based on the measurement of actual, proxy and composite indicators for quality of care services and resident outcomes such as clinical, functional and quality of life indicators.

The public availability of data on quality has three main users; service providers, governments and regulators and consumers. There is evidence that public access in the USA to this kind of information has had a favourable impact on the quality of residential aged care services in the USA (Castle, Engberg & Liu 2007; Castle, Liu & Engberg 2008; Ladd et al. 2008; Mukamel et al. 2007). Although the favourable changes were in some cases small, they are most evident in aged care services with low occupancy and in those experiencing competitive markets. These studies indicate that the data

available on the USA Nursing Home Compare Website has influenced the performance of service providers. While there is less evidence on the use of indicators to inform aged care consumers, Castle (2009) found that consumers use the internet based data available on nursing home quality and have a high level of understanding of the information that they access. What is less clear is the extent to which aged care consumers rely on these data or how the information on quality influenced their decisions to access services. Finally the public availability of data may serve to encourage the use of evidence in decision making where that evidence is available for general consumption. This recommendation does not suggest that the availability of data on quality solves all problems for consumers, or creates a transparent competitive environment, since the complexity of the sector is unlikely to allow a single reform to dominate decision-making on service use.

A national minimum dataset incorporating these data, such as that collected by quality assessors in the USA, together with numerical data of the results of accreditation reviews, and on the characteristics of services, their financial performance and operational details (staffing, training, qualifications etc.), is an urgent priority if future marketisation is to be contemplated. It is premature for policy reform to remove controls on supply and move to a more competitive market without the availability of these data.

There is clearly a lack of research evidence on the residential aged care sector in Australia to provide a suitable platform for radical reform. An urgent need exists for further research across the whole of the sector in Australia on the relationship between a broad range of structural and other input factors and service quality. The literature finds an association between quality, ownership, size, staffing, resident characteristics and relative incomes in other countries but this type of rigorous evidence is lacking in Australia. A number of excellent studies have examined input factors and quality in residential aged care in Australia, but these are based on relatively small representative samples in different states and territories(Chenoweth et al. 2009; Courtney et al. 2010; dela Rama et al.

2010; Jeon et al. 2012; Jeon, Merlyn & Chenoweth 2010; O'Reilly, Courtney & Edwards 2007), The lack of nation-wide studies hampers evidence-based policy development. What is needed is the development of a research agenda that will be able to make use of the currently available secondary data and the mix of data that will emerge from a national minimum data set.

Prior to the development of this minimum data set there is need for improvement in the existing data. This study has identified systematic inconsistencies in the method of reporting of quality failures that limits the capacity of the sector to adapt and learn from these experiences. Consideration could be given to more consistently reporting the imposition of sanctions; for example, consistent recording of the reasons for the imposition of sanctions (and notices of non-compliance), the nature and length of the sanction, and the relationship between the sanction and the reason for the sanction. Data collection in other countries appears to enable the identification for the reasons for the imposition of similar penalties; for example, restraint use (Castle 2000, 2002), and professional standards, care plans, poor clinical records and failure to prevent pressure sores (Harrington, Carrillo et al. 2011). There is also a pressing need for the investigation of the different rates of sanctions between jurisdictions and across locations.

As a basis for policy development and industry practice, the findings from this study suggest there is little evidence to support the development of larger facilities and it is not recommended that facilities of over 100 beds are supported or encouraged by government policy or practice. Within smaller services there is also no clear support for one particular size group over another. This is of particular importance with the emergence of very small residential aged care services in a range of countries which care for residents in small groups (de Rooij et al. 2012; Kane et al. 2007; Verbeek 2011) and which could provide a model for small Australian communities. In the light of the findings of this study that the size of buildings is planned almost entirely on financial performance, rather than on community need or

expectation of quality, further research into the relationship between the size of services and quality of care in Australian residential aged care services is needed.

Finally, the study findings suggest that the structural characteristics of facility ownership may be significant in predicting the future quality of care for residents. The prospect of changes to the proportion of for-profit and not-for-profit residential aged care providers should be the subject of broader debate. There is also the possibility of differences in quality in relation to the size of service providers. Davidson (2012) suggests that provider size may be as important, or more important, than ownership class or type in its impact on quality. More research in Australia is needed to determine the structural characteristics most likely to impact on meaningful outcomes for residents and the structural features that are likely to dominate with the removal of government control on supply.

7.6 Conclusions

This study has found that the structure of residential aged care services influences the service quality and the outcomes experienced by residents. It has also found that in Australia residential aged care service structure has been directly influenced by government policy. This suggests that government policy that aims to limit the government's influence over the structure of the residential aged care sector in favour of a market-based system, may not bode well for residential aged care consumers, unless such policy also emphasises the maintenance of a robust system for monitoring and influencing the quality of service delivery and consumer outcomes. The structure of the residential aged care sector in Australia is already showing strong trends which are not likely to deliver the best possible quality of care and outcomes for residents and these trends are likely to continue. Also of major concern is the finding that influential residential aged care stakeholders support a move towards a market-based approach to the allocation of resources and the distribution of services in the absence of evidence to support such a

change. It is strongly recommended that any further policy decisions in favour of a more competitive market for residential aged should be based on evidence that such a move is likely to result in better care and outcomes for residents.

Appendices

The Appendices to this thesis are contained in Volume 2.

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The future of residential aged care in Australia; a mixed methods analysis of the relationship between policy, structure and the provision of care

PhD Thesis – Volume 2 Appendices

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31 July 2014

This thesis is in two volumes. This volume contains Appendices A to H. The other volume contains Chapters 1 to 7.

Contents

List of Tables

Appendix A – Key aged care policy decisions 1997 to 2014

The following table lists significant changes in policy and reforms to the residential aged care sector in the period 1997 to 2014. It reveals the frequent changes in policy and the implementation of numerous small changes. There are also several policy withdrawals providing support for the argument that the residential aged care policy process in Australia follows an incremental pattern.

Table 1 Summary of major policy change and program initiatives within the aged care program 1996 to 2009

Year	Policy or implementation decision	References
1997	Passage of the Aged Care Act 1997 through Parliament by the new Australian Coalition Government	(*Aged Care Act 1997*)
	Decision by the Prime Minister to change policy and not allow bond to be collected in high care Decision by government to move from a central funds pool of bond moneys to allowing individual operators to keep the bond balances	(Ozanne 2004)
	Points based viability funding program replaces earlier viability supplement program for small facilities	(Australian Government Department of Health and Ageing 2001a)
	Aged Care Standards Agency established to develop standards and to accredit residential aged care facilities	(Kendig & Duckett 2001)
1999	Decision by government to establish a '2 year review'	(Kendig & Duckett 2001)
	New building certification standards come into place	(Kendig & Bridge 2007)
2000	2000-2001 Budget initiative increases the viability supplement and changes the emphasis from small facilities to 'rural and remote facilities'	(Australian Government Department of Health and Ageing 2001a)
2001	Response by government to the recommendations of the two year review	(Australian Government Department of Health and Ageing 2001b)
	First round of accreditation completed using new accreditation and survey procedures	(Australian Government Department of Health and Ageing 2001a)
2002	National Audit Office releases report on the performance of the Aged Care Standards and Accreditation Agency prompting changes to the mechanisms for scoring accreditations	(The Auditor-General 2002)

Year	Policy or implementation decision	References
2003	Government announces a 'Review of Pricing Arrangements in Residential Aged Care'	(Australian Government Department of Health and Ageing 2003)
	Government decision to introduce the Extended Aged Care in the Home packages following evaluation	(Australian Government Department of Health and Ageing 2006a)
	Department commissions a number of studies on residential aged care in selected policy areas	(Aged Care Evaluation and Management Advisors 2003)
2004	2004-2005 budget initiative to increase the viability funding for rural and remote locations and loss of emphasis on 'small' facilities.	(Australian Government Department of Health and Ageing 2004)
	Release of the policy statement 'The way forward' that indicated a research and actions by the commonwealth government and state governments	(Australian Government Department of Health and Ageing 2004)
	Introduction of the 'Conditional Adjustment Payments'	(Australian Government Department of Health and Ageing 2008b)
2005	Introduction of the new viability supplement in rural and remote residential aged care facilities	(Australian Government Department of Health and Ageing 2006c)
	Introduction of new legislation to strengthen the security of accommodation bonds and to enable government to repay bonds to residents in the event of liquidation by operators	(Australian Government Department of Health and Ageing 2005)
	Allocation formula increased from 100 to 108 places per 1000 persons over the age of 70	(Australian Government Department of Health and Ageing 2012d, p. 7)
2006	Decision to develop an alternative to the Residential Classification Scale for the payment of subsidies to residential aged care providers	(Australian Government Department of Health and Ageing 2008a)
	Final response to the Pricing review	(Australian Government Department of Health and Ageing 2006b)
	Commencement of the Extended Aged Care in the Home for people with Dementia	(Australian Government Department of Health and Ageing 2006a)
2007	Allocation formula increased from 108 to 113 places per 1000 persons over the age of 70 and the proportions of low and high care places changed to 44 places for each (from 48 and 40 respectively)	(Australian Government Department of Health and Ageing 2007b, p. 3)

Year	Policy or implementation decision	References
	Government announces the new Aged Care Funding Instrument (ACFI) to be introduced progressively from March 2008	(Australian Government Department of Health and Ageing 2008a)
	Release of the funding package 'Securing the future' which makes changes to the accommodation payments but continues the ban on accommodation bonds in high care	[Find reference](Australian Government Department of Health and Ageing 2007a)
	The Aged Care Complaints Investigation Scheme (the Scheme) commenced operation on 1 May 2007, and was established through changes to the Aged Care Act 1997 (the Act) and the introduction of regulations under the Act: the Investigation Principles 2007.	(Australian Government Department of Health and Ageing 2011, p. 88)
2008	ACFI introduced New certification standards come into place	(Australian Government Department of Health and Ageing 2008a)
	New legalisation requiring police checks on employees, reporting of missing persons, amending the list of 'special needs' groups and strengthening the protection of accommodation bonds	(Australian Government Department of Health and Ageing 2012c)
2009	Additions to the categories of special needs groups Introduction of Zero Real Interest Loans to enable some residential aged care providers to building areas of high need.	(Australian Government Department of Health and Ageing 2010)
2010	Amending the classification of high care to change some high care classifications to low care and return the ACFI score to something like it was prior to 2008	(Australian Government Department of Health and Ageing 2009)
	Temporary changes ot the allocation formula for residential aged care beds	(Australian Government Department of Health and Ageing 2012d)
2011	Introduction of a new set of Principles, the Accreditation Grant Principles 2011, on 20 May 2011.	(Australian Government Department of Health and Ageing 2011)
2011	Amendments to the Act to strengthen the prudential regulation of accommodation bonds.	(Australian Government Department of Health and Ageing 2011, p. 85)
2011	Australian Government assumes full responsibility for funding and policy for all aged care services	(Australian Government Department of Health and Ageing 2012d)

Year	Policy or implementation decision	References
2011	Accommodation supplement increased to $30.55	(Australian Government Department of Health and Ageing 2011, p. 45)
2011	Expansion of the viability supplement for services in remote and very remote locations	(Australian Government Department of Health and Ageing 2011)
2011	Amendments to the prudential standard and disclosure standard	(Australian Government Department of Health and Ageing 2012d, p. 104)
	Amendments to the scores for questions in the ACFI in relation to ADLs and Complex health care	(Australian Government Department of Health and Ageing 2012d, p. 104)
2012	Inclusion of people who identify as lesbian, gay, bisexual, transgender and intersex in the list of special needs groups	(Australian Government Department of Health and Ageing 2012d)
2012	Australian Government assumes full operational responsibility for all aged care services	(Australian Government Department of Health and Ageing 2012d)
2012	Reduction to the payments made for some categories of claims under the ACFI to bring the growth in the level of payments back to the level expected from historic trends	(Australian Government Department of Social Services 2013, p. 62)
2013	Additional supplements commenced for dementia and severe behaviours and for the care of veterans	(Australian Government Department of Social Services 2013)
	Introduction of changes to the viability supplement for remote and very remote services	(Australian Government Department of Social Services 2013, p. 129)
	Further changes to the ACFI	(Australian Government Department of Social Services 2013, p. 130)
2013	Five acts amending the Aged Care Act 1997 became law. These had the effect of introducing the Living Longer. Living Better reforms:	(Australian Government Department of Social Services 2013, p. 128)
2014	Increases in consumer co-payments for care and accommodation	(Australian Government Department of Health and Ageing 2012b)
	January: Revocation of the three levels of maximum accommodation payments and introduction of a single maximum figure for a RAD above which approval is necessary	(Australian government Department of Social Services 2014)

Year	Policy or implementation decision	References
	July: commencement of RADS and DAPs which give consumers (not providers) choice between which payment they prefer and introduces a higher accommodation supplement for concessional residents	(Australian Government Departmernt of Social Services 2014a)
	June: Minister revokes the Dementia Supplement after only 12 months of payment due to the four-times higher level of payment that allowed for in the budget	(Australian Ageing Agenda 2014)
	May: all providers are required to have their list of accommodation charges advertised on www.myagedcare.health.gov.au in preparation for 1 July.	(Australian Government Departmernt of Social Services 2014b)

Appendix B – Summary of studies reviewed on ownership and size

The following table summarises the analysis of the 50 studies listed in Table 7 on papers on ownership published since 2006 and which include size (number of beds) as an independent variable.

Thirty one studies, which reported a relationship between the number of beds and the dependent variable of interest, and provided sufficient detail on the number of beds in the facilities studies to enable their results to be compared with other studies, were included in Figure 7. Studies included in Figure 7 are indicated with the symbol, § inserted behind the country name in the top row.

Table 2 Summary of papers included in Table 7 and Figure 7

Author	**(Allen, Kellett & Gruman 2004) USA §**	**(Amirkhanyan, Kim & Lambright 2008) USA §**
Study design	Retrospective case record review	Cross-sectional study
Independent variables	Facility and staffing characteristics	Ownership status and other organisational structural features
Dependant variables	Complaints filed with the Long Term Care Ombudsman's office	A total deficiency score derived from the number of deficiency against standards
Sample selection	No. of complaints for abuse (269) or care (791) per 100 beds between July 1998 and July 2000	All facilities in the national OSCAR database in continuing operation & ownership over three years
Sample size (facilities)	261	14,423
Size range (beds)	<10->150	n/a
Mean no. of beds	120 (est.)	90.88
Significance	p=<.001	P=.001
SD of the mean	n/a	60.6
Nature of analysis	Multiple regression analysis to examine the combined effect of the independent variables on the two continuous, complaint subcategories	Two regression equations to estimate the effect of ownership on quality and access including control variables
Reported findings	Size is positively correlated with documented abuse and care concerns	higher number of regulatory violations but there was no difference between non-profit and public homes. Organizational size is positively and significantly associated with the number of regulatory violations in for profit facilities. There were variations across
Statistical controls	Relationships were controlled for all independent variables	Ordinary least squares estimations, clustering errors, to produce robust standard errors and tests for homoscedasticity were used. Poisson and negative binomial regression was used to adjust for skewness.
Conclusions	Larger nursing homes are associated with higher rates of abuse complaints	Larger facilities are positively associated with the number of deficiencies against standards
Notes and LOE	3b	2b

(Björkgren, Häkkinen & Linna 2001) Finland §	(Banaszak-Holl et al. 2002) USA §	(Anderson, Issel & McDaniel Jr 2003) USA §	Author
Cross-sectional correlational field study	Cross-sectional study	Cross-sectional correlational field study	Study design
Categories of nursing staff, number of beds	Acquisition of nursing homes by chain operators	Management practices; communication openness, decision-making, relationship-oriented leadership, and formalisation	Independent variables
Technical efficiency	Citations of health deficiencies on state inspections and percentage of residents with pressure ulcers	Behaviour, restraint, complications of immobility and fractures	Dependant variables
Convenience sample	OSCAR data on all certified USA facilities over six years	Proportional, stratified, random sample resulted in a 51% survey response rate which was matched with secondary data	Sample selection
64	I9,558	164	Sample size (facilities)
n/a	10-500	n/a	Size range (beds)
30	106	113	Mean no. of beds
P=0.01	P=0.05	P=.001	Significance
8.9	67	54	SD of the mean
Data Envelopment Analysis (DEA) was used to measure the nursing care efficiency	Logistic regression to estimate the likelihood of acquisition and ordinary least squared techniques to analyse pooled cross-sectional data to estimate effects on changes in health performance	Multiple linear regression models were tested for each of the four resident outcomes following analysis of the variables for skewness and kurtosis	Nature of analysis
Results indicated considerable variation in efficiency between units, suggesting that efficiency could be improved through better management and allocation of resources	Nursing home chains tend to acquire lower quality and poor performing home at a 'bargain' price	More beds and greater levels of RN participation in decision-making explained lower prevalence of behaviour problems. More beds, a more experienced DON with longer tenure, and greater levels of communication openness explained lower use of resident restraints	Reported findings
1. Calculation of efficiency scores based on DEA, 2. T-statistic and Wilcoxon were used to test for and compare the efficiency scores of the two clusters by facility type	Control variables included nursing home characteristics, speciality services provided, staffing intensity	Size, ownership and nurse manager years of experience used as control variables	Statistical controls
Larger facilities are more technically efficient than smaller facilities	Larger facilities have greater increases in ulcer rates and deficiency citations	Larger facility size predicts lower prevalence of aggressive behaviour and restraint use	Conclusions
Consider an outlier - small sample size and small size of facilities 2b	2b	2b	Notes and LOE

Author	(Castle & Engberg 2005) USA §	(Cai et al. 2011) USA	(Bravo et al. 1999) Canada §
Study design	Cross-sectional study	Stratified cross sectional study	Cross-sectional study
Independent variables	Staff turnover rates	Individual's payer status (Medicaid vs. private pay)	Facility characteristics and environmental factors, resident characteristics, functional status
Dependant variables	pressure ulcers, psychoactive drug use, certification survey quality of care	Any hospitalizations	QUALCARE scale composite of quality of care and quality of life indicators
Sample selection	Nursing homes in 4 states; 2 with high and 2 with low turnover rates	67,256 NH residents who were aged 65 years or older and were enrolled in Medicare Part A	301 residents randomly selected
Sample size (facilities)	354	545	88
Size range (beds)	7-611	n/a	<10-241
Mean no. of beds	116	n/a	29
Significance	P=.01		P=.001
SD of the mean	68	.01	42
Nature of analysis	Multivariate analysis using negative binomial regression	Conditional fixed-effects logit and a random-effects probit model	Hierarchical linear modelling using 25 variables over two levels of analysis
Reported findings	There was a negative relationship between RN turnover and quality, turnover of other nurses was negative but only at higher levels	Medicaid residents were more likely to be hospitalized than private-pay residents within a facility	Cognitive functioning has most impact on quality scores. Most of the variation in quality scores was significant in relation to nursing training, facility size and the existence of external collaborators impacting this relationship
Statistical controls	Control variables included staff per resident ratios. Size, organisational type, chain affiliation, occupancy, competition, income and resident characteristics	Controlled for case mix acuity, ADLs, changes in health, end stage disease and symptoms and signs scores, unstable disease conditions, falls, BMI, infections, and chronic disease conditions, advanced care plans, socio-economic status	Large size facilities negatively impacted on the relationship between cognitive functioning and quality outcomes
Conclusions	No significant association with quality indicators but a significant relationship between larger size have fewer quality deficiencies against standards	Medicaid residents have a higher risk of hospitalisation than private pay in FP facilities	Larger facilities (>40 beds) have more difficulty in caring for residents with cognitive deficits
Notes and LOE	Check on how this is presented in the figure 2b	2b	2b

Author	(Castle & Engberg 2007) USA §	(Castle 2000) USA §	(Castle 2011) USA §
Study design	Cross-sectional study	Cross-sectional study	Cross-sectional exploratory study
Independent variables	Staffing levels, staff turnover, stability and agency use rates as well as size, organisational type, chain membership, occupancy rates and income type	Ownership, special care units, occupancy rates, chain membership, size	Facility, resident and staffing characteristics
Dependant variables	Composite quality indicator composed of 14 quality measures	Physical restraint	Citation for resident abuse
Sample selection	A random sample of 40% of facilities in 6 USA states matched with secondary data	Data on all facilities contained in the national OSCAR database in the USA	All facilities in the USA OSCAR national database from 2000 to 2007
Sample size (facilities)	1,071	15,455	17000 (approx.)
Size range (beds)	n/a	n/a	n/a
Mean no. of beds	131	107	110
Significance	P=.01	P=.001	73
SD of the mean	93	72	
Nature of analysis	Stepwise multiple regression	Multinomial logistic regression analyses of organisational factors associated with an increase or decrease in physical restraint use	Logit link regression to estimate the probability of mutually exclusive events with dichotomous dependent variables
Reported findings	Mixed results on the relationship between staffing factors and quality results. For profit facilities and high bed size are associated with lower quality	The adjusted odds ratio of a decrease in constraint use was 1.05 for size increase but was a smaller odds score than other variables such as ownership	Staffing levels were not significant; poor quality was with a deficiency citation; greater number of beds for-profit ownership, chain membership, high occupancy were associated with a lower likelihood of receiving a deficiency citation.
Statistical controls	Regression used 12 linear staffing characteristic and 8 organisational and market characteristics	Independent variables were analysed for their relationship with three outcomes - increasing, decreasing and stable restraint use. Adjusted odds ratios were estimated	Generalised estimating equations were used because biases can occur in data consisting of repeat observations
Conclusions	Larger facilities are associated with lower quality	Larger facilities are more likely to decrease their restraint use	Larger nursing home were associated with lower chance of having a citation for abuse
Notes and LOE	2b	2b	Significant because of the size of the study but has a different finding to other research on staffing, size and ownership

Author	(Doupe et al. 2006) Canada	(Decker 2008) USA	(Clarfield et al. 2009) Israel
Study design	Cross sectional study	Cross sectional study	Cross sectional study
Independent variables	Facility and resident characteristics	Ownership and income	Ownership
Dependant variables	Ten quality indicators	Restrain use, RN staffing levels	an assessment of seven quality items each with a possible score of 0 to 3 giving an overall score with a maximum of 21
Sample selection	Administrative data	OACAR database for inspection reports between 1999 and 2003	Inspection reports from three quarters of Israel's 193 residential aged care facilities
Sample size (facilities)	122	16,625	128
Size range (beds)	<30->140	n/a	n/a
Mean no. of beds	78.6	n/a	76 (FP) 89 (NFP)
Significance	n/a	n/a	.001
SD of the mean	n/a	n/a	n/a
Nature of analysis	Multivariate analyses	Generalised estimating equations	SAS statistical package using t tests and linear multiple regression analyses
Reported findings	Diagnostic indicators and antipsychotic medication were more likely to have occurred in FP than NFP facilities in Manitoba	Restraint use increased and RN staffing levels decreased among NFP and NFP facilities when the Medicaid census increased and Medicaid payment decreased.	NFP services scored higher on a range of quality indicators consistently for all range of scores
Statistical controls	Facility size and staffing	Case mix	Staffing, daily income, number of beds
Conclusions	FP services provided poorer care than NP services	FP facilities showed more restraint use and lower staffing than NP services which may be related to income	FP NHs provide poorer care than NFPs
Notes and LOE	2b	2b	2b

(Dwyer et al. 2010) USA §	(DeLellis & Ozcan 2012) USA §	(de Rooij et al. 2012) Netherlands	Author
Retrospective, cross-sectional study	Cross-sectional study	Longitudinal study	Study design
Facility & resident characteristics including ADLs and comorbidities, and length of stay. included ownership and size	Characteristics of facilities	Traditional and small-scale care settings and demographic factors	Independent variables
Polypharmacy	Technical efficiency	Depression, social engagement, visiting frequency of relatives, functional status and QOL	Dependant variables
Data from 2004 National Nursing Home Study using a national probability sample of nursing homes	A 10% random sample of from the OSCAR database and other secondary data	Convenience sample of 179 residents with dementia	Sample selection
1,174	1,430	16	Sample size (facilities)
3->200	20-360	6->20	Size range (beds)
> 100 (est.)	110	n/a	Mean no. of beds
P=.01	P =.05	Various	Significance
n/a	52.29	n/a	SD of the mean
Bivariate and multivariate analysis using the SUDAAN multiple function for logistic regression, to generate odds ratios	Data envelopment analysis (DEA)	Hierarchical linear modelling techniques comparing means of the samples and scores of the dependent variables over time	Nature of analysis
Odds ratios were higher for polypharmacy in residents <85 years old, paid by Medicaid residents, in not-for-profit facilities and in small to medium facilities	Not-for-profit and government homes, urban areas, counties with a higher level of competition, average income, or number of home health agencies had statistically significant higher average efficiency	Residents in small-scale settings in the Netherlands had higher scores on a number of QOL indicators than residents in traditional settings	Reported findings
The analysis used multivariate analysis to estimate odds ratios for each independent variable	The study used the variable return to scale model to take into account the difference in nursing home size as a factor in economy of scale	Significant differences between the groups were estimated using F-tests followed by multilevel modelling	Statistical controls
Polypharmacy use decreases with increasing bed size	Quality measures were mostly favourable for efficient nursing homes. Larger facilities are less technically efficient	Small-scale living settings have some beneficial effects on residents compared with traditional size facilities	Conclusions
These findings were inconsistent with previous studies on polypharmacy	2b	Single variables and validated instruments are used by researchers	Notes and LOE
2b		2b	

(Gage et al. 2009) UK	(Flynn et al. 2010) USA §	(Ellis & Howe 2010) Australia §	Author
Cross sectional study	Cross-sectional study	Cross-sectional study	Study design
Size, specialist registration, staffing qualification, mix, ownership, resident dependency	Facility size, occupancy rate, ownership status, resident characteristics	Organisational characteristics	Independent variables
Inspection outcomes	Deficiencies, practice environment scale index of nursing work and pressure ulcers	Government sanctions imposed	Dependant variables
Nursing homes in Surrey England	Random sample with a 51% response rate resulted in 1,143 responses matched to secondary data	All Australian facilities reported in publicly available data as having sanctions imposed	Sample selection
258	63	3,000	Sample size (facilities)
2-122	54-552	<20- >100	Size range (beds)
30	186	n/a	Mean no. of beds
	P=.02	P=.007	Significance
	107	n/a	SD of the mean
A Poisson count maximum likelihood method	Following analysis of power from the aggregated variables a linear regression model was used, followed by logistic regression to validate the findings	Chi-square test of differences between sanctioned and non-sanctioned homes, and z scores to identify variables underlying differences	Nature of analysis
A higher probability of failing a standard was significantly associated with being a home that: was a FP small business	For profit status was the only characteristic associated with pressure ulcer rates. Facility size was the only characteristic associated with deficiency citations. A supportive nursing practice environment is associated with better outcomes	There were variations in the rate of sanctions based on jurisdiction, size, ownership status and level of care	Reported findings
Trial and error best fit modelling on independent variables	Simultaneous multiple regression controlled for the effect of the nursing practice environment. Together the nursing practice environment and facility size accounted for 25% of the variance in the number of deficiencies	Standardised residual scores (z scores) are also given for significant associations between these characteristics and the risk of sanctions being imposed	Statistical controls
Corporate for-profit ownership was significantly associated with higher quality care (fewer failed standards) in comparison with small for-profit and not for-profit homes in both the models. Small for profit were more likely to provide poorer care than small not-for-profit	Increased facility size is positively associated with more quality deficiencies	Smaller homes (< 60 beds) are more likely to have government penalties for quality standards	Conclusions
2b	2b	2b	Notes and LOE

(Harrington et al. 2000) USA §	(Grabowski et al. 2013) USA	(Garavaglia et al. 2011) Italy	Author
Cross-sectional study	Cross sectional study	Cross-sectional study	Study design
Nursing staffing hours, resident characteristics, facility characteristics, jurisdictional factors	Ownership, staffin levels	Costs for health and nursing services and costs for residential services	Independent variables
ADL, depression, mobility, behaviour, incontinence, ulcers	Hospitalisation rate, mobility, pain functioning	Technical efficiency	Dependant variables
Data from OSCAR surveys of all certified nursing homes in the USA over one year	OSCAR data	Geographical	Sample selection
81,534 (reports)	13,980	40	Sample size (facilities)
16->160		35-300	Size range (beds)
n/a	120	n/a	Mean no. of beds
P=.01		n/a	Significance
n/a	80	n/a	SD of the mean
Ordinary least squared regression modelling and logistic regression	Study mimicked randomization of residents into more or less “exposure” to non-profit homes when estimating the effects of ownership on quality of care.	DEA assessment of efficiency with Tobit regressions and the Kruskall–Wallis tests of hypothesis to the efficiency scores	Nature of analysis
Fewer nursing hours, smaller facilities, more depressed and demented residents had fewer deficiencies. Facility characteristics and jurisdictional location were stronger predictors of deficiencies than staffing hours and resident characteristics	After instrumenting for ownership status, we found that post-acute patients in non-profit facilities had fewer 30-day hospitalizations and greater improvement in mobility, pain, and functioning	Even though public nursing homes are moving towards their private counterparts, and thus competition is benefiting efficiency	Reported findings
Nursing hours estimates were controlled for other variables	Demographic, income, morbidity and geographical characteristics of residents	Not reported	Statistical controls
Smaller facilities (< 119 beds) are less likely to have quality of care/life deficiencies and have fewer quality deficiencies than larger facilities	Not-for-profit services have higher staffing levels and more hospitalisations, less mobility, more pain and poorer functioning	No significant relationship between facility size and technical efficiency	Conclusions
2b	2b	2b	Notes and LOE

Author	(Johnson et al. 2004) USA	(Jogerst et al. 2006) USA §	(Harrington, Olney, et al. 2011) USA §
Study design	Cross-sectional study	Cross-sectional study	Cross-sectional study
Independent variables	Staffing, number of beds, multistate system membership, for-profit ownership, quality survey deficiencies, pressure soredevelopment, and market area.	Facility, resident and staffing characteristics, rate of reports of abuse	Organisational characteristics, staffing, resident characteristics, market competition
Dependant variables	Legal performance indicated by law suits	Citations for abuse	Deficiencies against standards
Sample selection	Stratified random sample	355 nursing homes in Iowa	The 10 largest for-profit chains of nursing homes in the USA
Sample size (facilities)	2,378	14,000 approx.	1,977
Size range (beds)	10-657	16-544	n/a
Mean no. of beds	118	78	120
Significance	P=.001	p=<.05	P=.001
SD of the mean	60.29	40	44
Nature of analysis	Poisson regression analysis	Multiple linear regression models were used to test for the associations between number of beds, number of residents, locations, Medicare participation and ownership type	Descriptive statistics and generalised estimation equation panel regression models using XTGEE generalised effects estimator
Reported findings	Staffing levels and multistate chain membership were negatively related with higher numbers of law suits	Larger facilities, and for-profit facilities, had significantly higher incidents, report and substantiation rates for abuse	Total nursing hours were lower in the top 10 for-profit chains than other providers, total deficiencies and serious deficiencies were higher. Size and resident mix were associated with deficiencies
Statistical controls	Resident acuity levels and year effects were controlled for	Spearman's rank-based method to estimate correlation plus multiple linear regression for some associations	Control variables included facility size, occupancy, resident characteristics and market competition
Conclusions	Larger facilities are more likely to be sued in legal courts	Larger nursing homes had higher rates of incidents, reports and validations of abuse	Larger facilities operated by top for-profit chains have more quality deficiencies and serious deficiencies
Notes and LOE	An outlier as 'one off' dependent variable used 2b	2b	2b

(Kane et al. 2007) USA	(Kane et al. 2004)	(Kamimura et al. 2007) USA §	Author
Two-year longitudinal quasi-experimental study	Cross-sectional exploratory study	Cross-sectional study	Study design
Traditional and small -scale care settings and demographic factors	Facility characteristics - % priv. rooms, location and size (small <109 beds) - resident characteristics	Organisational, staff training, clinical & business practices, protocols, policies	Independent variables
Scales for 11 domains of resident quality of life and quality of care was indicators	Estimated score for QOL for facilities based on cumulative scores for residents	1. Deficiencies against standards, 2. ulcers	Dependant variables
140 residents	An unrepresentative sample (private/not-for-profit mix) of 40 voluntarily participating nursing homes	40% response rate to a survey of chain-owned nursing homes merged with secondary data	Sample selection
6	40	203	Sample size (facilities)
29495.00	49-287	n/a	Size range (beds)
n/a	128	114	Mean no. of beds
n/a	n/a	P=.001	Significance
n/a	n/a	42	SD of the mean
Outcomes data were analysed using multivariate panel regression analyses using the random-effects regression models	Estimation of impact of facility element on quality of life was adjusted for resident characteristics using the Univariate General Linear Model and Variance Components procedures	Descriptive statistics, bivariate correlations and multivariate regression analyses to estimate the effects of standardisation and control variables on deficiencies and ulcers	Nature of analysis
The QOL and QOC results strongly favoured the residents in small-scale setting compared with traditional settings	The facility-based QOL indicator differentiated between facilities with a degree of consistency. Few facility characteristics were significantly related to AoL scores	Standardisation lowered the total number of health deficiencies significantly but did not affect pressure ulcer prevalence. Clinical staff training lowered the incidence of ulcers. Facility size was highly correlated in all of the statistical models	Reported findings
Selection effects were examined by comparing baseline characteristics and outcomes were controlled for demographic and baseline assessment using Tobit modelling	n/a	Control variable included number of beds, ownership, staffing levels, case mix, ownership type, degree of corporate oversight	Statistical controls
Residents in small-scale GREEN HOUSE units have more favourable outcomes compared with residents in traditional size facilities	Did not find the size of facilities to be significant with respect to the studied components of QOL	Larger facilities (>100 beds) have more deficiencies against quality standards and more resident pressure ulcers	Conclusions
Lack of specifics of bed size prevents comparison with other studies	As sample not representative as they volunteered, no generalisability outside sample	2b	Notes and LOE
1b	2b		

(McGregor et al. 2005) Canada	(Li et al. 1996) USA §	(Leroi et al. 2007) USA	Author
Cross-sectional study	Randomly cases matched with two comparators	Cross-sectional study	Study design
Nursing staffing hours, organisational characteristics,	Resident status, organisational characteristics, infection control programs and procedures	Resident and facility characteristics, dementia and psychiatric indicators	Independent variables
Hours of care per resident	Infections rates	Care and safety procedures, nutrition, accident record and activities for residents	Dependant variables
All facilities in British Columbia for which staffing data was available	Cases were homes with notifiable infectious disease matched with non-infected homes	Stratified random sample	Sample selection
167	171	22	Sample size (facilities)
n/a	20-889	30-120	Size range (beds)
87	n/a	50.5 (median)	Mean no. of beds
p =.43	P=.05	<p=.05	Significance
53	n/a	n/a	SD of the mean
One-way analysis of variance and univariate linear regression, two-way analysis of variance and covariance to calculate estimates and 95% confidence intervals	Logistic regression analysis following univariate analysis of association between variables	Descriptive univariate statistics were used to compare the various characteristics of the two facility types	Nature of analysis
The mean number of hours per resident-day was higher in the not-for-profit facilities than in the for-profit facilities	Facility size was significantly associated with infections. Other factors with weaker associations were paid sick leave for staff and shared staff between units	Smaller homes had higher rates of dementia and psychiatrically disturbed residents. Statistical significant differences were identified for falls, safety device use and structured activities	Reported findings
Facility characteristics were controlled for in estimations of outcome variables of hours of care	Regression controlled for infection control programs and laboratory checks but low power prevented examination of interactions with other variables	Small exploratory study therefore multivariate, statistics were not used to determine correlations between variables	Statistical controls
No significant association between facility size and hours of care per resident	Larger size is significantly associated with resident respiratory or gastrointestinal disease outbreaks	Small units (3-15 beds) had more impaired residents and greater use of safety devices but fewer falls, while larger units had more structured activities	Conclusions
2b	Li reported results significant increase in risk for each 100 beds; hence less than 100 beds is favourable 1c	Small sample size limits generalisation, other factors such as facility size need to be taken into consideration. 2b	Notes and LOE

(Pearson et al. 1992) Australia §	(O'Neill et al. 2003) USA §	(McGregor et al. 2006) Canada §	Author
Cross-sectional study with data collected by survey	Cross-sectional study	Retrospective cohort study	Study design
Staff and facility characteristics, leadership style, size, ownership, location, resident dependency	Resident characteristics, facility characteristics, competition, costs	Ownership type, structure and size, resident characteristics	Independent variables
Health status and quality of life	Deficiencies against standards	Pneumonia, ulcers and deaths	Dependant variables
Random stratified sample across 4 states	All facilities with data recorded with the OSCAR in California	All 43,000 residents of nursing homes between 1996 and 1999 classified intermediate or extended care	Sample selection
200	1,098	301	Sample size (facilities)
20-150	19–391	20-300	Size range (beds)
n/a	n/a	n/a	Mean no. of beds
P=.01	P=.05	P=.01	Significance
n/a	49	n/a	SD of the mean
Regression analysis of 9 independent and 7 dependent variables	Tobit multivariate techniques with 4 types of sensitivity analyses	Cox proportional hazard regression analyses based on crude hospitalisation and diagnostic rates and adjusted for age, sex, level of care, hospitalisation rate, facility size	Nature of analysis
Positive significant relationship found between size and 'freedom of choice', 'variety of experience', 'social independence' and 'safety'	For-profit and chain-owned facilities had higher total number of deficiencies, with those with the highest profit having higher deficiencies	A positive significant relationship using crude rates and adjusted risk ratios between 'large facility size' and hospitalisation related to 2 out of 4 reasons for hospitalisation	Reported findings
n/a	Tobit analysis controlled for resident characteristics, market characteristics and financial variables	No control of variables correlational scores only reported	Statistical controls
Medium sized homes (41-60 beds) have better resident outcomes	Larger facilities have significantly more quality deficiencies	Larger size (>71 beds) have higher crude rates for pneumonia, ulcers and death in residents	Conclusions
2b	2b	Range and mean have been estimated from the data on British Columbia homes cited in (McGregor et al. 2005)	Notes and LOE

(Rantz et al. 2004) USA §	(Phillips et al. 2005) USA §	(Phillips & Guo 2011) USA §	Author
Three-group exploratory study design	Cross-sectional study	Exploratory/ descriptive 2-group design	Study design
Nursing leadership, team processes, ownership type, facility size, cost, staff mix, staff hours.	Resident and facility characteristics, medical and hospital utilisation	Resident and facility characteristics	Independent variables
Multiple outcome indicators derived from the Minimum Data Set	Medicare expenditure	Content analysis of complaints and substantiated allegations to government authorities	Dependant variables
Random allocation of 443 facilities into three equal groups based on quality indicators scores (good, average, poor)	A stratified, three-stage sampling design included 1,200 residents	All assisted living facilities services in Arizona in 2007-08	Sample selection
92	293	454	Sample size (facilities)
30-200	11-100	<11->100	Size range (beds)
97	73	44.75	Mean no. of beds
P=.006	p=.01	p=.001	Significance
n/a	5.3	n/a	SD of the mean
Percentages of median values as appropriate for the type of data; Wilcoxon rank sum test for group differences	Logistic regression and ordinary least squares (OLS) regression	Chi-squared	Nature of analysis
Facility size was consistent and the only statistically significant difference among a range of demographic and structural variables	Individuals from ALFs of smaller size had lower Medicare expenditures than residents residing in larger ALFs	There were significant differences in size, nature of abuse, ownership between the complaint group and the non-complaint group	Reported findings
There was no significant difference between the matched groups based on staff mix, case mix on admission, cost of care or source of income. Leadership and care differences were shown between the facilities based on outcomes	Not described but implied in the use of logistic regression and OLS software	No multivariate analysis estimated	Statistical controls
Smaller facilities (30-60 beds) have better resident outcomes	Larger facilities (>73 beds) had higher Medicare expenditure indicating poorer health management	Larger facilities (>55 Beds) had significantly more complaints than smaller facilities.	Conclusions
The range and mean have been estimated from the data in the article as it is not directly reported.	2b	2b	Notes and LOE
2b			

(Sikorska-Simmons 2008) USA §	(Samus et al. 2005) USA	(Rao, Coelli & O'Donnell 2003) Australia §	Author
Cross-sectional study	Cross-sectional exploratory study	Cross-sectional study	Study design
Organisational characteristics and resident mix	Resident and facility characteristics, especially dementia and psychiatric indicators	Ownership types, size, location	Independent variables
Measures of organisational culture using a valid instrument (Organizational Culture Survey)	QOL indicators (and a scale to measure homelike quality of facility)	Financial performance	Dependant variables
294 staff of ALFs in Maryland USA	134 residents	A 40% return to a survey of all residential aged care services in Australia	Sample selection
52	22 (large facilities had more than 16 beds)	787 reduced to 488 for full analysis	Sample size (facilities)
6-129	12-?	<30->100	Size range (beds)
35	n/a	n/a	Mean no. of beds
0.016	n/a	n/a	Significance
24	n/a	n/a	SD of the mean
Zero-order correlations were used to estimate relationship between organisational factors followed by a Level 2 intercept-as-outcome hierarchical regression model	Linear regression analyses were used to estimate the relationship of neuropsychiatric symptoms and homelike climate with QOL	DEA, Stochastic Frontier Analysis Cost Function and Distance Functions.	Nature of analysis
Facility size emerged as the second strongest predictor of staff-supportive organisational culture (t = –2.52, p = 0.016)	Agitation, depression, apathy and irritability were significant predictors of QOL, explaining 29% of the variance	Average technical efficiency was calculated to be 0.83 with variation between states and location, organisational types (for-profit are higher), chain membership and size	Reported findings
Factors on staff-supportive organisational culture were assessed using two-level hierarchical linear modelling	Controlling for socio-demographics, cognition, functional dependence, and physical health	Control variable used and found to be non-significant included resident mix, income, complaints	Statistical controls
Smaller facility size was predictive of more staff-supportive organisational culture	Neither facility size nor homelike environment was significantly associated with QOL in univariate analyses. Size of facility moderated the relationship between agitation and quality of life	Facilities with 30 to 60 beds are the most efficient	Conclusions
Because of small size and unique measure not included in comparative chart	Because of small size and unique measure not included in comparative chart	2b	Notes and LOE
2b	2b		

Author	(Sloane et al. 2002) USA	(te Boekhorst et al. 2009) Netherlands	(Unroe et al. 2012) USA §
Study design	Cross-sectional study	Quast experimental longitudinal study	Cross-sectional study
Independent variables	Facility and resident characteristics	Traditional and small-scale care settings and demographic factors	Nursing Home Compare star ratings, resident characteristics and organisational characteristics
Dependant variables	Use of inappropriate medications	Functional and QOL indicators	90-day readmission and mortality rates for Medicare residents
Sample selection	2,078 residents in a stratified random sample of residential care/ ALFs in 4 states	164 residents	All Medicare residents discharged to a nursing home between 1 January 2006 and 31 December 2007
Sample size (facilities)	193	19 group living units and 7 traditional nursing homes	13,619
Size range (beds)	<16 (58%) >16 (42%)	6-n/a	51->200
Mean no. of beds	27.9	n/a	75-120 (104 estimated)
Significance	adjusted odds ratio 0.981	various	p=<.001
SD of the mean	34.9	n/a	n/a
Nature of analysis	Multivariate regression, using generalised estimating equations, analyses were performed using PROC GENMOD in Statistical Analysis Systems	Chi-square tests and multilevel univariate and multivariate linear and logistic regression analyses were used	Cox proportional hazard regression analyses for relationships between independent and dependent variables
Reported findings	Inappropriate prescription medication (IPM) use was associated with the number of medications received, smaller facility bed size, moderate licensed practical nurse turnover, absence of dementia, low monthly fees, and absence of weekly physician visits	While there were no differences in behavioural problems or social engagement, residents of group living homes had a better cognitive status and needed less assistance with ADLs	Residents in facilities with more than 133 beds had a 7% higher risk of readmissions and 7% risk of readmission than those in smaller facilities
Statistical controls	The generalised estimating equations controlled for the clustering effects of the study sample	Multivariate regression coefficients were adjusted for baseline scores	Facility characteristics were used as controls for readmission and mortality rates based on star ratings, with some categories of size and ownership showing significant effect on risk of readmission and mortality
Conclusions	Smaller bed size (<16 beds) was associated with increased probability of IPM	Small (<6 residents) group living homes have some beneficial effects on residents in relation to ADLs and social engagement but not for cognitive status, behaviour, QOL indicators and use of medications	Residents in facilities with more than 133 beds (second quartile) have a 7% increased risk of readmission for heart failure and a 7% higher mortality rate
Notes and LOE	as proxies for resources such as nursing oversight. Insufficient information on range of bed sizes to include in comparative chart.	Small study and does not report number of beds 1b	2b

Author	(Verbeek et al. 2010) Netherlands	(Wagner et al. 2006) Netherlands §	(Weech-Maldonado et al. 2012) USA §
Study design	Quasi-experimental study	Cross-sectional study	Cross-sectional study
Independent variables	Traditional and small-scale care settings and demographic factors	Organisational size and occupancy, characteristics and functional status score of 12,377 residents	Ownership/ chain affiliation combinations and not-for-profit independent
Dependant variables	Quality of life (QUALIDEM), neuropsychiatric symptoms, and agitation, perceived burden, satisfaction, and involvement with care, job satisfaction and motivation	Outcome indicator score based on incontinence, ulcers, constraint, behaviour	Financial performance
Sample selection	259 residents, 229 family caregivers and 305 staff	Randomly selected homes from all homes in the Netherlands were surveyed and compared using secondary data	OSCAR data on all certified USA facilities for 5 years
Sample size (facilities)	49 (28 small-scale units and 21 traditional nursing homes)	65	11,236
Size range (beds)	<8 - >20	n/a	n/a
Mean no. of beds	n/a	193	120 (est.)
Significance	n/a	P=.05	P=.001
SD of the mean	n/a	77	n/a
Nature of analysis	Differences were tested with x^2-tests for categorical variables, individual sample t tests for normally distributed continuous variables, and Kruskal-Wallis tests for continuous variables	Logistic multi-level analysis for the effects of home characteristics on outcome. Linear regression multi-level analysis on quality activities and outcomes	Least square regressions
Reported findings	No significant group by time interaction effects were found for all subscales and the total score of QUALIDEM. Small significant effects were found in favour of small facilities by family members. No differences were detected for staff	While resident characteristics explained most of the variance, there was a significant relationship between size and pressure ulcers	For-profit nursing homes delivered better financial performance than not-for-profit facilities across both operating and total margins; the relationship between chain affiliation and financial performance was more nuanced
Statistical controls	All socio-demographic characteristics of participants were included as covariates in the model. Fixed effects for group by time interaction were tested for significance	Even allowing for the effect of resident characteristics, quality procedures and governance practices the effect of size is still significant	Autocorrelation and heteroscedasticity were addressed and state fixed effects and year fixed effects controlled for the effect of time; predicted values adjusting for the control variables
Conclusions	No size effects were found for residents' total QOL, neuropsychiatric symptoms, and agitation. Family caregivers were more satisfied. No difference in staff indicators	Residents in larger nursing homes have fewer pressure ulcers but no difference for other outcomes	Larger facilities have better financial performance
Notes and LOE	1b	An outlier study due to the much larger size of the facilities compared with other studies 2b	2b

Author	(Zinn et al. 2009) USA §	(Zimmerman et al. 2005) USA	(Weech-Maldonado, Neff & Mor 2003) USA §
Study design	Cross-sectional study	Cross-sectional exploratory study	Cross-sectional study
Independent variables	Structural and peripheral change, financial and quality performance, size and environmental shock	Resident and facility characteristics, especially dementia and psychiatric indicators	Organisational characteristics, resident mix, income mix, location
Dependant variables	Government penalties imposed	QOL indicators and QOC indicators and 2 developed scales	Financial performance, cognitive decline, mood decline, pressure ulcers
Sample selection	OSCAR data on all certified USA facilities over 10 years	Stratified purposive sample	Homes in 5 USA states
Sample size (facilities)	10,901	421 residents in 45 facilities	781
Size range (beds)	<100->200	n/a	n/a
Mean no. of beds	> 100	n/a	n/a
Significance	P=.001	n/a	p=.10
SD of the mean	n/a	n/a	n/a
Nature of analysis	Cross-sectional time series generalised estimating equation (GEE) model with a logit link function to predict termination from public program participation	Mixed including: simple descriptive methods, generalised estimating equations applied to linear or logistic models, partial Pearson correlation coefficients	Structural equation modelling
Reported findings	Poor prior financial and quality performance, and environmental changes, increases the risk of failure, larger size is protective, decreasing the likelihood of performance failure	This study did not find any statistically significantly relationship between size and QOL except for better quality in ALF compared with nursing homes	Homes that produce high quality care do so at lower cost and higher financial performance
Statistical controls	Control variables were included in a cross-sectional time series generalised estimating equation logistic regression model	Adjusted the standard errors for clustering using Taylor series expansion methods	Feedback loops were built into the modelling to test for potential endogeneity of quality and financial performance
Conclusions	Larger facilities are least likely to have government sanctions imposed for quality standards	Large small divide not consistent with other studies	Weak association between size and profit but none with quality
Notes and LOE	2b	Specific bed sizes not provided 2b	2b

Levels of evidence

To following table describes the grades of recommendation developed by the Oxford Centre for Evidence-based Medicine Levels of Evidence (Phillips et al. 2001) and which were used to select and classified papers reviewed for this study.

Table 3 Centre for Evidence-based Medicine Grades of Recommendation

Level	Therapy/Prevention, Aetiology/Harm	Prognosis	Diagnosis	Differential diagnosis/symptom prevalence study	Economic and decision analyses
1a	SR (with homogeneity*) of RCTs	SR (with homogeneity*) of inception cohort studies; CDR† validated in different populations	SR (with homogeneity*) of Level 1 diagnostic studies; CDR† with 1b studies from different clinical centres	SR (with homogeneity*) of prospective cohort studies	SR (with homogeneity*) of Level 1 economic studies
1b	Individual RCT (with narrow Confidence Interval‡)	Individual inception cohort study with ≥ 80% follow-up; CDR† validated in a single population	Validating** cohort study with good††† reference standards; or CDR† tested within one clinical centre	Prospective cohort study with good follow-up****	Analysis based on clinically sensible costs or alternatives; systematic review(s) of the evidence; and including multi-way sensitivity analyses
1c	All or none§	All or none case-series	Absolute SpPins and SnNouts††	All or none case-series	Absolute better-value or worse-value analyses ††††
2a	SR (with homogeneity*) of cohort studies	SR (with homogeneity*) of either retrospective cohort studies or untreated control groups in RCTs	SR (with homogeneity*) of Level >2 diagnostic studies	SR (with homogeneity*) of 2b and better studies	SR (with homogeneity*) of Level >2 economic studies
2b	Individual cohort study (including low quality RCT; e.g., <80% follow-up)	Retrospective cohort study or follow-up of untreated control patients in an RCT; Derivation of CDR† or validated on split-sample§§§ only	Exploratory** cohort study with good†††reference standards; CDR† after derivation, or validated only on split-sample§§§ or databases	Retrospective cohort study, or poor follow-up	Analysis based on clinically sensible costs or alternatives; limited review(s) of the evidence, or single studies; and including multi-way sensitivity analyses
2c	"Outcomes" Research; Ecological studies	"Outcomes" Research		Ecological studies	Audit or outcomes research
3a	SR (with homogeneity*) of case-control studies		SR (with homogeneity*) of 3b and better studies	SR (with homogeneity*) of 3b and better studies	SR (with homogeneity*) of 3b and better studies
3b	Individual Case-Control Study		Non-consecutive study; or without consistently applied reference standards	Non-consecutive cohort study, or very limited population	Analysis based on limited alternatives or costs, poor quality estimates of data, but including sensitivity analyses incorporating clinically sensible variations.
4	Case-series (and poor quality cohort and case-control studies§§)	Case-series (and poor quality prognostic cohort	Case-control study, poor or non-independent	Case-series or superseded reference standards	Analysis with no sensitivity analysis

Level	Therapy/Prevention, Aetiology/Harm	Prognosis	Diagnosis	Differential diagnosis/symptom prevalence study	Economic and decision analyses
		studies***)	reference standard		
5	Expert opinion without explicit critical appraisal, or based on physiology, bench research or "first principles"	Expert opinion without explicit critical appraisal, or based on physiology, bench research or "first principles"	Expert opinion without explicit critical appraisal, or based on physiology, bench research or "first principles"	Expert opinion without explicit critical appraisal, or based on physiology, bench research or "first principles"	Expert opinion without explicit critical appraisal, or based on economic theory or "first principles"

Notes on levels of evidence

Users can add a minus-sign "-" to denote the level of that fails to provide a conclusive answer because of:

- EITHER a single result with a wide Confidence Interval (such that, for example, an ARR in an RCT is not statistically significant but whose confidence intervals fail to exclude clinically important benefit or harm)
- OR a Systematic Review with troublesome (and statistically significant) heterogeneity.
- Such evidence is inconclusive, and therefore can only generate Grade D recommendations.

*	By homogeneity we mean a systematic review that is free of worrisome variations (heterogeneity) in the directions and degrees of results between individual studies. Not all systematic reviews with statistically significant heterogeneity need be worrisome, and not all worrisome heterogeneity need be statistically significant. As noted above, studies displaying worrisome heterogeneity should be tagged with a "-" at the end of their designated level.
†	Clinical Decision Rule. (These are algorithms or scoring systems which lead to a prognostic estimation or a diagnostic category.)
‡	See note #2 for advice on how to understand, rate and use trials or other studies with wide confidence intervals.
§	Met when all patients died before the Rx became available, but some now survive on it; or when some patients died before the Rx became available, but none now die on it.
§§	By poor quality cohort study we mean one that failed to clearly define comparison groups and/or failed to measure exposures and outcomes in the same (preferably blinded), objective way in both exposed and non-exposed individuals and/or failed to identify or appropriately control known confounders and/or failed to carry out a sufficiently long and complete follow-up of patients. By poor quality case-control study we mean one that failed to clearly define comparison groups and/or failed to measure exposures and outcomes in the same (preferably blinded), objective way in both cases and controls and/or failed to identify or appropriately control known confounders.
§§§	Split-sample validation is achieved by collecting all the information in a single tranche, then artificially dividing this into "derivation" and "validation" samples.
††	An "Absolute SpPin" is a diagnostic finding whose Specificity is so high that a Positive result rules-in the diagnosis. An "Absolute SnNout" is a diagnostic finding whose Sensitivity is so high that a Negative result rules-out the diagnosis.
‡‡	Good, better, bad and worse refer to the comparisons between treatments in terms of their clinical risks and benefits.
†††	Good reference standards are independent of the test, and applied blindly or objectively to applied to all patients. Poor reference standards are haphazardly applied, but still independent of the test. Use of a non-independent reference standard (where the 'test' is included in the 'reference', or where the 'testing' affects the 'reference') implies a level 4 study.
††††	Better-value treatments are clearly as good but cheaper, or better at the same or reduced cost. Worse-value treatments are as good and more expensive, or worse and the equally or more expensive.
**	Validating studies test the quality of a specific diagnostic test, based on prior evidence. An exploratory study collects information and trawls the data (e.g. using a regression analysis) to find which factors are 'significant'.
***	By poor quality prognostic cohort study we mean one in which sampling was biased in favour of patients who already had the target outcome, or the measurement of outcomes was accomplished in <80% of study patients, or outcomes were determined in an unblinded, non-objective way, or there was no correction for confounding factors.
****	Good follow-up in a differential diagnosis study is >80%, with adequate time for alternative diagnoses to emerge (eg 1-6 months acute, 1 - 5 years chronic)

Appendix C – Copy of consent form and participant information

Faculty of Health,
University of Technology Sydney
PO Box 123, Broadway, NSW, 2007
[Date] 2013

Dear.

Re: Research into trends in the residential aged care industry in Australia[1]
Thank you for agreeing to participate in this important study being conducted at the University of Technology, Sydney. The research focuses on the current and future trends in the residential aged care industry. It is hoped that an improved understanding of these relationships will assist in planning the expansion of the industry.
The interview will take no more than an hour.
Attached are an information sheet, which provides further details on your involvement with the study, and a consent form that I will ask you to sign if you agree to participate.
I look forward to meeting you on [date] 2013.

Yours sincerely,

Production Note:
Signature removed
prior to publication.

Richard Baldwin
PhD candidate
Faculty of Health, UTS
Mob: [redacted]
email Richard.baldwin@uts.edu.au

[1] This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au), and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

PARTICIPANT INFORMATION SHEET

Trends in the residential aged care services in Australia (UTS HREC approval number 2012000366)

WHAT AM I BEING ASKED TO PARTICIPATE IN?

You are being invited to participate into a research study conducted through the Faculty of Health at UTS examining the future shape of the residential aged care industry in Australia.

WHO IS DOING THE RESEARCH?

My name is Richard Baldwin and this research is part of my PhD. My supervisors are Professor Lynn Chenoweth (9514 5710) and Dr Marie dela Rama (9524 3635).

WHAT IS THIS RESEARCH ABOUT?

The purpose of this study is to increase understanding of the current and future trends in the residential aged care industry in Australia. An improved understanding of these trends will assist in planning the expansion of the industry to meet predicted future needs.

WHY AM I BEING ASKED TO PARTICIPATE?

You are being asked to participate because you are a key person in a policy, advocacy, research or senior management role with knowledge of and/or experience in the residential aged care industry. This experience provides you with a national perspective on the industry.

IF I SAY YES, WHAT WILL IT INVOLVE?

Participation will involve a one hour interview at a time of your choice about your views on current and future trends in the residential aged care industry. The interview is designed to be conversational. You will not be asked any questions of a personal nature or a particular nature about your organisation. You will be asked to agree to the interview being recorded.

ARE THERE ANY RISKS OR INCONVENIENCES?

All information you provide will be treated confidentially and stored securely in accordance with UTS policies on human research. No material will be published that will enable any individual participants or organisations to be identified. You will be provided with a transcript of the interview. You may clarify, modify your responses or request that particular comments not be used in the analysis.

HOW WILL INFORMATION I PROVIDE BE USED?

The information you provide will be analysed as part of the thesis. It may also be included in some publications or conference presentations.

DO I HAVE TO SAY YES?

Participation is voluntary and there will be no further approaches from me in relation to this research if you do not wish to be interviewed. Individuals who declined to participate in the study are not identified.

IF I SAY YES, CAN I CHANGE MY MIND LATER?

You can change your mind at any time during the interview or after it is completed. Should you revoke your consent using the copy of the consent form left with you, the record of the interview will be destroyed and no details of it will be used in the research.

HOW IS THE RESEARCH FUNDED?

A University of Technology student scholarship is the only source of financial support for this research.

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have questions about the research please feel free to contact Richard Baldwin on 0402894427. If you would like to talk to someone who is not connected with the research, you may contact the Research Ethics Officer on 02 9514 9772, and quote this number 2012000366.

Faculty of Health,
University of Technology Sydney
PO Box 123, Broadway, NSW, 2007

PARTICIPANT CONSENT FORM
TRENDS IN THE RESIDENTIAL AGED CARE SERVICES IN AUSTRALIA[2]

I _____ *(participant's name)* agree to participate in the research project named above *(UTS HREC approval reference number 2012000366)* being conducted by Richard Baldwin, a PhD student of the University of Technology, Sydney (contact number [redacted]).

Funding for this research has been provided by the University of Technology, Sydney.

I understand that

- the purpose of this study is to increase understanding of the current trends in the residential aged care industry in Australia
- I have been asked to participate in this research because of my knowledge and experience in and understanding of the residential aged care industry in Australia
- my participation in this research will involve an interview with the researcher of up to one hour, which will be recorded
- the recordings and other records of my interview will be stored securely in accordance with the policies of the University
- I am free to withdraw my participation from this research project at any time I wish, without consequences, and without giving a reason.

I agree that Richard Baldwin has answered all my questions fully and clearly and I am aware that I can contact him or his supervisor(s) Professor Lynn Chenoweth and Dr Marie dela Rama if I have any concerns about the research.

I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

_____ ____/____/____
Signature (participant) [date]

_____ ____/____/____
Signature (researcher or delegate) [date]

Faculty of Health,

[2] This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

University of Technology Sydney
PO Box 123, Broadway, NSW, 2007

REVOCATION OF PARTICIPANT CONSENT FORM

TRENDS IN THE RESIDENTIAL AGED CARE SERVICES IN AUSTRALIA[3]

I hereby wish to withdraw my consent to participate in this research whose title appears above and understand that any information I have provided will not be used in the research and that the records of my participation will be destroyed. I understand that my withdrawal will not jeopardise my relationship with the University of Technology Sydney in any way.

_____ ____/____/____

Signature (participant) [date]

This section for the Revocation of Consent should be sent to Richard Baldwin, Faculty of Health, University of Technology, Sydney, Level 7, Building 10, PO Box 123, Broadway, 2007, NSW.

[3] This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Appendix D – NVivo Code Book

This Code Book provides details of identified nodes following completion of the coding of the transcripts. It describes the Parent Nodes, subordinate nodes, the description of the nodes the number of references and the number of sources coded to that node.

Table 4 NVivo Code Book

Parent Node Name	Name of node	Description of nodes	No. of Coding References	No. of Source Coded
Top level nodes (details of subordinate nodes are provided below)	Approach to business	Approaches to business for both individual providers and types of providers, including by size and FP & NFP	0	0
	Capital	A range of views on the planning for, sources of, access to and future need for capital investment in RAC	0	0
	Financial performance	Financial performance in the past and currently generally. Does not include anticipated financial performance as a consequence of LLLB	0	0
	Future	Comments on the future of the industry	0	0
	Information management and information technology	Views on information management, data collection, information systems, and information technology	0	0
	LLLB Reforms	Comments related to the LLLB reforms announced by the Australian government	0	0
	Locality	views expressed on the impact that locality has on services and policies related to locality	0	0
	Neo-liberalism	Concepts related to market forces and the principles of the market and market-based reforms	0	0
	Participants	Participants interviewed and potential participants	0	0
	Policy process	The process used by the government in the consultation regarding its reforms and by the stakeholders in influencing the government thinking and decisions	0	0
	Providers & org type	Difference between provider types on the impact of the LLLB and other aspects of the RAC system	0	0

Parent Node Name	Name of node	Description of nodes	No. of Coding References	No. of Source Coded
	Quality - achievement and measurement	How quality is measured and assessed including the reviews and assessments by the Agency	0	0
	Size - significance of	The significance of size in relation to the future of facilities, size of organisations and providers, relationship between size and performance	0	0
	Society relationships	Views of the relationships of providers and homes with the local community and with society	0	0
	Staff	Views on staffing and workforce	0	0
	Thesis, questions and interview	Comments on the nature of the enquiry and the questions asked during the interview	1	1
Nodes\\Approach to business	Business strategy	Comments on business strategy and approaches to strategic and corporate decisions	35	8
Nodes\\Capital	Capital and provider type	Difference in the need for capital based on provider type and the different capacity for capital generation by provider type	4	3
	Capital funds - access to	The capacity of different groups to access capital, the importance of access to capital, sources of access to capital by different groups	25	10
	Deficiency in investment in the past	Comments on the problems facing the sector in the past in relation to its ability to attract investment funds and how investments in the past have been used	8	4
	Future Investment needs	Views on the needs of the RAC sector in the future for investment funding	5	4
	Licences ~ value of approved place	Comments on the value of approved aged places and the significance of the licensing system currently	2	2
	New investment opportunities	Comments on new investment opportunities for the sector	3	2
	Planning horizon in years for investment planning	Number of years used in planning for investment decisions, e.g.net Present Value, IRR, WACC etc.	8	4
Nodes\\Capital\Future Investment needs	Capital investment	a range of issues related to the future access to capital by different groups, investment needs, lack of investment in the past, opportunities and planning horizons	5	2

Parent Node Name	Name of node	Description of nodes	No. of Coding References	No. of Source Coded
Nodes\\Financial Performance	ACFI	ACFI suitability and impact on financial performance	5	3
	Financial performance by provider type	Discussions on the relationship between financial performance and provider type/	8	3
	Financial performance in the past	Financial performance in the light of policy parameters	11	3
	Occupancy rate significance of	Significance of occupancy rate for financial and operational performance and competition	4	2
Nodes\\Future	ACATs	Comments on Aged Care Assessment Teams and their current and future role in aged care	6	3
	Access to care	Current and future access to care either through geographical distribution or co-payments or other barriers or enhancers to access; see also ACATS	8	5
	Demand	Comments about how the participants see the future demand for aged care	16	9
	Deregulation	Comments of the possibility and impact of deregulation in the future	6	2
	Design of RAC facilities	What RAC facilities will look like in the future	27	9
	FP and NFP mix of services	The proportion of organisational type of providers in the future shape of the industry	28	12
	Future of your organisation	View of how the participants' organisation sees the future	7	3
	Housing in the future	Views of how housing for the aged will be organised, financed and provided in the future	2	2
	Innovative models	Innovative models of aged care	3	1
	Long term care insurance	The possibility of long term care insurance covering the cost of aged care in the future	1	1
Nodes\\Future	Private equity investment	Future potential for private equity investment in RAC	2	2
	Private market for aged care	Observations and views on the future of the private market for aged care in Australia	1	1

Parent Node Name	Name of node	Description of nodes	No. of Coding References	No. of Source Coded
	RAC in the future	What the future is for the residential aged care sector	4	4
	Shape of industry in future	The shape of the industry in the future in terms of the mix of high care and low care, the nature and role of RAC services	31	13
Nodes\\Future\Design of RAC facilities	High rise residential care	Possibility of high rise RAC or adoption of European models	3	1
	Integrated campuses - villages & RAC	The possibility that the future will see an expansion of campuses operated by a single provider where there are multiple accommodation types	17	7
	Rooms - one bed and more than one bed rooms	The debates around the value and quality of one bed rooms and more than one bed rooms	2	2
Nodes\\IMIT	Information management	Views on the need for information, current information collection, limitation or lack of information	10	2
	IT	Views on investment in, issues with, preference for, barriers to use	1	1
Nodes\\LLLB Reforms	2017 review	Comments on the planned review of the system in 2017	10	5
	ACAR process	Views on the annual round of allocations of new community and residential places by the federal government administered by the Department	6	2
	Accommodation payments	Reforms to the way in which residents pay for accommodation - RADS and DAPs	0	0
	Aged Care Financing Authority	Comments on the role and performance of the ACFA	9	6
Nodes\\LLLB Reforms	Ageing in place	Comments on the practice of providers accepting residents who are low care and then progress to high care in the same facility	3	3
	AIHW role in data management	Comments on the new role for the AIHW in managing and making available data on the aged care system	3	2
	Assessment of LLLB reforms overall	Broad comments on the overall LLLB package and whether it was productive, beneficial etc.,	21	11
	CDC	Comments on consumer-directed care initiative in both community and residential care	11	4

Parent Node Name	Name of node	Description of nodes	No. of Coding References	No. of Source Coded
	Community care	The future of community care, subcontracting in community care and in RAC, the notion of community care in suites in RAC and the future of HACC	0	0
	Consumer co-payment	Impact on consumer co-payment by the LLLB reforms	4	4
	Consumer voice	The impact of consumer preferences on the reforms	3	3
	Disappointments	Lost opportunities, impressions that the reforms could have gone further	9	4
	Entitlement	Entitlement, what it means, what the PC intended, government attitude	5	4
	Financial viability and reform	LLLB impact on financial performance and capital raising	11	8
	Gateway	Establishment of the gateway as recommended by the PC and efforts and issues related to access to care	12	4
	Groups affected	Which groups benefit and which groups do not benefit from the reforms	4	3
	Home equity	Equity in the family home that could be used to meet the payments for aged care accommodation in some way	4	2
	PC recommendations not implemented	Views on the recommendation of the PC that were not accepted by the government	4	3
	Quality and agency	Impact that the LLLB reforms will have on the quality of the sector and the regulation of quality, and the move of the agency to the Department	5	4
Nodes\\LLLB Reforms	Retention amount & periodic payments	Comments on the loss of the retention amount by the provider with the new reforms and the introduction of periodic payments as an alternative that must be offered to residents as an alternative to paying a RAD	6	5
	Supply - control on by government	Possibility of a future government relaxing controls on supply, comments on the failure of the previous reform to address this issue	10	5
	Time to implement PC reforms	Comments of the time that will need to be taken to implement all the reforms recommended by the PC and the LLLB	1	1
	Workforce supplement	Views on the workforce supplement and its requirements	2	2
Nodes\\LLLB Reforms\Accommodation	Daily accommodation charges	Views on accommodation charges in residential care and the move and balance between bonds and daily payments and the impact that will have	17	6

Parent Node Name	Name of node	Description of nodes	No. of Coding References	No. of Source Coded
	RADs in high care	Comments on the government reform decision to allow bonds to be paid as RADs by high care residents	20	7
Nodes\\LLLB Reforms\CDC	CDC cost of administration	Views on the administrative burden that will accompany the introduction of CDC particularly around the production of monthly accounts and reports for consumers	2	2
	Community care provider margin	The provider margin that providers can take from the package of community care - how it is estimated and retained	1	1
	Community care reforms	Views on the introduction of CDC into community care	11	6
	Cross-subsidisation	Comments on the impact of cross-subsidisation by CDC	14	5
Nodes\\LLLB Reforms\Community Care	Community - care future	The future of community care	10	7
Nodes\\LLLB Reforms\Community Care	Community care - subcontracting	Issues related to subcontracting of community care places to another organisation	3	2
	Community care in a residential setting	The issue of allowing a person with a community care package to occupy a suite in a residential facility to be close to a relative. This person is eligible for community care but not residential care - not allowed under the current arrangements	3	1
	HACC	Comments on the operation of the HACC program	1	1
Nodes\\Locality	MPSs	Views on MPSs	7	3
	Rural and remote	Comments on the impact of the reforms on rural and remote services and the particular issues they face	43	14
	State and territory differences	Difference in performance and mix of services between states and territories	9	6
Nodes\\Neo-liberalism	Choice	Concepts of choice as a element in RAC and the impact of the reforms on choice	22	9
	Competition	Attitudes towards the impact of competition or the expected impact will have on choice and provider behaviour	20	9

Parent Node Name	Name of node	Description of nodes	No. of Coding References	No. of Source Coded
	Market forces	How the impact of market forces will influence the supply of places and also how the market works in relation to RAC or will work under the reforms	28	11
	Retention of controls on supply	Comments on the decision of the government not to remove the controls on the supply of places	8	4
	Transparent prices	Comments on the new requirements for providers to publish the value of the RADs they charge	8	3
Nodes\\Participants	Participants - potential other people to interview	People recommended by the participants interviewed that may be also useful to interview	81	15
	Participants interviewed	Participants interviewed for the research	0	0
Nodes\\Policy Process	Before reforms	What the future looked like before the reforms	5	5
	Department - role of in public policy	The role of the Department and the public service in influencing government approach to policy and reform	6	6
	Govt approach to reform	Comments on the government's, past and current, approach to form process	39	15
	Govt attitude to PC recommendations	Comments refer to the government adoption or failure to adopt the recommendations of the PC	9	4
	Incrementalism as a policy process	Descriptions of incremental decision-making in the past and the present in relation to policy changes by successive governments and as a preferred approach to policymaking in the aged care area	14	8
	LLLB policy process	Comments concerning the nature of the LLLB reforms and how significant they were, and what the process was, incremental change or big bang	13	7
	Minister - importance of	Views on how the different Ministers with responsibility for ageing policy worked and what influence the Minister has on policy and program development and how the Minister related to other stakeholders	11	6
	Most influential groups and individuals	Most influential groups in guiding and influencing the government's thinking, stakeholders close to government and how they worked, how governments worked with stakeholders	33	14

Parent Node Name	Name of node	Description of nodes	No. of Coding References	No. of Source Coded
Nodes\\Policy Process	NACA	NACA, views on the way it worked and how the groups developed a consensus on a range of policy options and relationships with governments	2	1
	Policy of provider type	Policies related to a preference for one type of provider over another	14	9
	Policy on size	Comments on government policy on the size of facilities and size of organisations	4	1
	Political parties - different approaches	The different approaches to aged care between the two main political parties	17	10
	Politics and policy options and debate	Views on the debates around possible approaches to aged care policy and programs and how the debates have transpired, how the different parties view aged care policy	13	4
	Two-tier system	Possibility of heading for a two-tier system of city and rural	5	2
Nodes\\Policy Process\NACA	NACA policy positions	Views on the policy positions and preferences of the NACA and it members	4	1
	NACA policy process	The process used by the government in the consultation regarding its reforms and by the stakeholders in influencing the government thinking and decisions	12	4
	National Aged Care Alliance	Views on the value and performance of the National Aged Care Alliance in establishing a consensus view within the industry and in negotiating with governments	9	5
Nodes\\Providers & org type	Consolidation - estimate of future number of providers	Views on the number of individual providers of RAC in the future and moves and patterns of consolidation in the industry	30	13
	Difference between FP & NFP	Attitudes towards the difference in the services provided by the two sectors and how the two different sectors perform	44	13
	International comparisons	Views on how Australia compares with other countries and aged care systems and the relevance and importance of comparing systems	9	3
	Management skills - importance of	Views on the importance of management skills in relation to quality and performance	17	7
Nodes\\Providers & org type	Provider groups influence	Influence of the different provider groups with government, provider groups acting together, providers acting together	12	7

Parent Node Name	Name of node	Description of nodes	No. of Coding References	No. of Source Coded
	Provider mix	Mix of FP, government and NFP providers both in the past and currently	16	11
	Providers and LLB reforms	Which providers will be affected by the LLLB reforms and how different types of providers view the LLLB reforms	10	5
	Retirement villages and RAC	Current and past approaches to the multiple accommodation type campus	7	4
	Transition Care	References to transition care services	2	2
Nodes\\Quality - achievement and measurement	Accreditation	Process of accreditation and the accreditation system, how well it works and what it is	10	5
	Quality	How quality is measured and assessed including the reviews and assessments by the agency	12	5
	Quality and size or ownership	Views on the relationship between facility size and quality and facility ownership and quality	16	7
	Quality measurement and rating	Views on how quality is measured and rated within the system, how it should be measured and where we should go with quality	43	11
	Quality of life	Comments on the issue of quality of life as separate to the quality of care or outcomes for residents	1	1
	Research in aged care	Views on the research in aged care, how relevant and how research is used	2	2
	Resident's perceptions	Views expressed on the perceptions of residents and their perceived needs and preferences	5	1
	Sanctions and notices of non-compliance	Comments on sanctions and notices of non-compliance and how useful this system is and what it means	8	5
Nodes\\Size - significance of	Organisational size in future	What will be the size of provider organisations in the future	13	8
Nodes\\Size - significance of	Size of community providers	Comments on the likely impact of services by the size of the provider of community services	1	1
	Size of facilities & performance	Views on the relationship between size of facilities and performance other than quality	43	16
	Size of residential providers	Impact of the size of providers of RAC on performance and quality	11	6

Parent Node Name	Name of node	Description of nodes	No. of Coding References	No. of Source Coded
Nodes\\Society relationships	Age friendly society	Ideas on the concept of age friendly society	1	1
	Community involvement	Involvement of the aged care provider in the local community	2	1
	Religious-based services	Origins and motivations of church-based aged care services	4	1
	Social inclusion initiatives	Strategies that providers are using currently to provide some policies for social inclusion and their relationships with the community	3	1
	Social responsibility	The notion that aged care providers, because they receive government funding, have some social responsibility towards the community and not simply to deliver purchased services	3	2
Nodes\\Staff	Staffing	Impact of staffing on quality and performance	4	3
	Volunteers	The place of volunteers in the provision of service and contribution to quality and performance	1	1
	Workforce	Staffing issues, staff development, strategic workforce approaches	6	3

Appendix E – Methods used to prepare census data

A number of adjustments were made to the available data to create a unique database without duplicate codes for the same service or approved providers. The following tables list the amendments made in correctly allocating specific services to providers and in giving a unique code to provider services.

Table 5 Data cleaning; original names and database name for the purpose of analysis

Changed from	year	Changed to
Alcheringa Hostel (Point Clare)	2003 +	Alcheringa
Alkira Hostel for the Frail & Aged	2003 +	Blue Care Brisbane Valley Community Care CACP
Amaroo Lodge Nursing Home	2003 +	Amaroo Aged Care Facility
Aminya Nursing Home (Baulkham Hills)	2003 +	Aminya Centre for Aged Care
Australian Chinese Community Association of NSW	2003 +	Australian Chinese Community Association South East Sydney CACPs
Australian Chinese Community Association of NSW (postcode 2010)	2003 +	Australian Chinese Community Association South East Sydney CACPs
Berriquin Nursing Home	2003-10	Finley Regional Care (from 2011)
Bethany Hostel (Camberwell)	2003-07	Lynden Aged Care
Bethany Nursing Home	2003-07	Camberwell Gardens
Blind Welfare Association Hostel	2003	Rose Court Hostel
Blind Welfare Nursing Home	2003	Rose Court Nursing Home
Bribie Island Retirement Village	2003-2010	Bribie Island Retirement Village (community) Bribie Island Retirement Village (innovative) Bribie Island Retirement Village
C A S A Program (Italian Senior Citizens Association of WA)	2004	Deleted as only appears one year and cannot be traced
Canossa Nursing Home	2003-10	Canossa Nursing Home Trebonne
Catherine McAuley Community Aged Care Packages	2003-10	Catherine McAuley Community Aged Care Packages Wembley
Cooinda Hostel (operated by Calvary)	2003-10	Cooinda Hostel Calvary
Elanora (Vic)	2012	Elanora (Vic)
Harley Nursing Home (operated by Thompsons at Cremorne)		Harley Nursing Home Cremorne
Hillcrest Nursing Home	2003-07	Regis Hillcrest
Juninga Centre	2003-2008	The Juninga Centre
Karingal Care Services	2003-08	Karingal Care Service
Leighton Nursing Home	2003-04	deleted
Loddon Mallee Aged & Disability Consortium	2005 +	Loddon Mallee Region EACH Program
Loddon Mallee Local Government Aged & Disability Consortium	2005 +	Local Government Loddon Mallee Region Community Services Officers Consortium
Lourdes Nursing Home at Port Macquarie	2003-2010	Lourdes Nursing Home Emmaus
Mary Potter Nursing Home at Ryde	2003-12	Mary Potter Nursing Home (Ryde)
Mary Potter Nursing Home at Woree	2005-12	Mary Potter Nursing Home (Woree)
Nazareth House in Qld	2003 +	Nazareth House (Qld)
Nazareth House Nursing Home in NSW	2004 +	Nazareth House Nursing Home (NSW)
Nazareth House Nursing Home in Qld	2004 +	Nazareth House Nursing Home (Qld)
Ningana Hostel at Dalby	2003 - 2005	Ningana Retirement Village
Pam Corker House community care	2003-12	deleted
Pioneer lodge in Queensland	2009-12	Pioneer Lodge (Qld)
Roseneath Nursing Home	2003 +	Deleted could not be matched with a facility in a

Changed from	year	Changed to
		later year
St Annes Nursing Home in Victoria	2003 +	Deleted could not be matched with a facility in a later year
St Basil's Nursing Home in Victoria	2003 - 06	St Basil's Homes for the Aged in Victoria
St Catherine's Nursing Home at South Brighton in SA	2003-05	Brighton Aged Care
St Francis Aged Care in Grafton	2010-12	St Francis Aged Care (Grafton)
St Francis Aged Care in WA	2010-12	St Francis Aged Care (WA)
St Joseph's Hostel in Coffs Harbour	2003 +	St Joseph's Hostel (Coffs)
St Joseph's Nursing Home at Lismore	2003-2012	St Joseph's Nursing Home (Lismore)
St Luke's Nursing Home at Subiaco		St Luke's Nursing Home (Subiaco)
St Martin's Nursing Home	2003-06	St Martin's Nursing Home (QLD)
St Michael's Nursing Home in WA	2003-04	St Michael's Nursing Home (WA)
St Paul's Lutheran Hostel in QLD	2004-05	St Paul's Lutheran Hostel (QLD)
Strathdon Community providing residential care	2003-2005	Uniting Aged Care - Strathdon Community
Transition Care Services operated by ACT Health	2006 +	Deleted as there is insufficient data to include in the analysis
Villa Maria Centre in Ipswich	2010-12	Villa Maria Centre (Ipswich)
Villa Maria Centre in NSW	2010-12	Villa Maria Centre (NSW)
Waratah Lodge operated by Benevolent Society in Allambie	2003-2008	Waratah lodge (NSW)

Table 6 Actions taken to allocate providers a unique code in the data base.

Issue identified	Action taken with database
Aged Care Deloraine INC is owned by St Marks Homes Inc, an organisation of the Anglican Diocese of Tasmania.	The code of ownership category for aged care Deloraine INC was changed to religious and for ownership to St Marks Homes
Aged Care Services Australia operates several facilities as 'Aged Care Services (number) (name of facility) and is a subsidiary of Japara Holdings Pty Ltd see http://investing.businessweek.com/research/stocks/private/snapshot.asp?privcapId=41355842 They sold out of WA in 2009-10	Japara trading as Aged Care Services Australia Group chooses to list each service under a different approved provider name. To overcome this the ID of each of their facilities was amended to the ID for Aged Care Services Australia Pty Ltd - 65
Heritage Lakes is listed by DoHA in 2012 with Aged Services Victoria Pty Ltd as the approved provider but by the ACSAA as Markham Care Pty Ltd as the approved provider in 2011	Leave as is – not material to the analysis
NB. Apex Software Pty Limited owns two facilities Gymea Bay and Lark Ellen Aged Care at Sutherland but there is little public knowledge on who the owner is	Noted
Australian Retirement Homes (No.2) Pty Ltd and Australian Retirement Homes Limited sound similar but there is no information on either of them to determine if they are the same company	Each has only one facility and is classified as private incorporated. As one is in Victoria and one in NSW unlikely they are the same company – leave as is as not material to the analysis
Hall and Prior Residential Health & Aged Care organisation – NSW division is Fresh Fields Aged Care (NSW) no1 Pty Ltd	All RACs owned by Hall and Prior are operated through five companies. It would appear that Hall and Prior have been in operation since 1993. All these facilities were identified for each year from 2003 to 2012 and were coded with the ID code for Varna Pty Ltd (ID 2198) as this company is consistent across the years. The

Issue identified	Action taken with database
	names of the individual companies in the Hall and Prior group were left as supplied on the master census sheet. The companies in the Hall and Prior group are Danvero Pty, Fresh Fields, Fresh Fields Aged Care Pty Ltd, Fresh Fields Aged Care (NW) – No 1 Pty Ltd, Hamersley Nursing Home (WA) Pty Ltd, Varna Pty Ltd.
Georgose Care Pty Ltd and Georgose Pty Ltd look like the same people	Georgose Pty Ltd is changed to Georgose Care Pty Ltd
Regis Aged Care Pty Ltd and Regis Group Pty Ltd	Regis Aged Care changed to Regis Group Pty Ltd
The Trustees of the Roman Catholic Church for the Diocese of Lismore looks like the The Trustees of the Roman Catholic Church for the Diocese of Lismore Sawtell Catholic Care of the Aged Committee	Changed to The Trustees of the Roman Catholic Church for the Diocese of Lismore
Retirement Care Australia Pty Ltd proposed acquisition of aged care facilities from the Moran Group of Companies in 2005. RCA is a wholly owned subsidiary of the Macquarie Capital Alliance Group	Information on the link between Macquarie Capital Alliance Group, Retirement Care Australia and Regis is available from http://www.uow.edu.au/~bmartin/dissent/documents/health/nh_RCA.html#Structure Retirement Care Australia first appears as an approved provider in 2005 and is listed under the following approved provider names • Retirement Care Australia (Inala) Pty Ltd • Retirement Care Australia (Alton Court) Pty Ltd • Retirement Care Australia (Bethany) Pty Ltd • Retirement Care Australia (Darwin) Pty Ltd • Retirement Care Australia (Edenfield) Pty Ltd • Retirement Care Australia (Gilgunya) Pty Ltd • Retirement Care Australia (Hillcrest) Pty Ltd • Retirement Care Australia (Kardinia) Pty Ltd • Retirement Care Australia (Levenbank) Pty Ltd • Retirement Care Australia (Inala) Pty Ltd • Retirement Care Australia (Parklyn) Pty Ltd • Retirement Care Australia (Sunset) Pty Ltd • Retirement Care Australia (Tyler Village) Pty Ltd • Retirement Care Australia (Weeroona) Pty Ltd • Retirement Care Australia (Hollywood) Pty Ltd For the purpose of analysis these approved providers have been given the same Provider ID (Retirement Care Australia (Inala) Pty Ltd) although their individual names have been retained in the master database Facilities listed by Regis on their website and where the approved provider name commencing with the name 'Retirement Care Australia' in 2012 were changed to Regis Group Pty Ltd to reflect the recent list of approved providers.
Chelsea Manor has changed owners from Desilva Health Care Pty Ltd in 2009 to Retirement Aged Care Management Pty Ltd in 2012 - check if Retirement Aged Care Management Pty Ltd is actually Regis	Chelsea is not listed by Regis in 2012 and left as Retirement Aged Care Management Pty Ltd
Facilities in the Tricare Group were listed as having different approved provider names although all were listed as under the same operation as Tricare	All Tricare facilities with different approved provider names • Tricare (Annerley) Pty Ltd • Tricare (Country) Pty Ltd • Tricare (Hostels) Pty Ltd • Tricare (Kawana Waters) Pty Ltd • TriCare (Mermaid Beach) Pty Ltd • Tricare (Stafford Hts) Pty Ltd They were listed with the same Approved Provider ID as Tricare Ltd
Arcare Pty Ltd and K & M Healthcare Pty Ltd are operated by the same management	K & M Healthcare amended to read Arcare

Issue identified	Action taken with database
team at Arcare	
Two different names listed by Regis Group as approved providers	All the facilities with the name Regis Aged Care Pty Ltd and Regis Group Pty Ltd were all changed to Regis Group Pty Ltd to reflect the single listing on the website.
Three organisations have similar names Blue Cross Community Care, Blue Cross Community Care Services (Ballarat) Pty Ltd, and Blue Cross Community Care Services (Toorak) Pty Ltd	All facilities are listed on the Blue Cross website as under the same management so all were given the same Approved Provider ID as Blue Cross Community Care Services Group Pty Ltd - 294
NB In Victoria prior to 2006 individual hospitals were listed separately as the approved provider rather than the state government	
Assessment was made if • Calvary Health Care ACT Limited • Calvary Home Care Services Ltd • Calvary Retirement Communities Hunter-Manning Ltd • Calvary Retirement Community Canberra Limited • Calvary Retirement Community Cessnock Limited • Calvary Retirement Community Ryde Limited Should be listed as the same approved provider	As Calvary Retirement Community Ryde Ltd and Calvary Retirement Community Canberra constitute only one facility they have been listed separately as there is no clear evidence they are operated as one chain Calvary Retirement Community Cessnock Limited name changed to Calvary Retirement Communities Hunter-Manning Ltd in 2011
It was noted that Country Health SA Hospital Incorporated, Country Health SA Inc, Country Health SA Local Health Network Incorporated are all provided by SA Health and should be changed to the same organisation	They are the same organisation – SA Country Health. The name SA Country Health Hospital Incorporated was introduced in 2009 and changed the network in 2011. However name not changed as all services consistent as to approved provider type and can be analysed within state
There are several facilities listed by the Domain Principal Group as under their operation	All of the facilities with the approved provider name from 2008 to 2012 of • DPG Services Pty Ltd • Baystar Pty Ltd • Domain Aged Care (Inverloch) Pty Ltd • Domain Aged Care (Kirra Beach) Pty Ltd • Domain Aged Care (Operations) Pty Ltd • Domain Aged Care (Parklands) Pty Ltd • Domain Aged Care (Services) Pty Ltd • Domain Aged Care (Victoria) Pty Ltd • Domain Aged Care No.2 Pty Ltd • Domain Aged Care Pty Ltd • Domain Annex Pty Ltd • Principal Healthcare Finance No 3 Pty Limited and all facilities in the Domain group prior to 2008 were given the same approved provider ID as DPG Services Pty Ltd – ID =633
IBIS providers are listed with several provider names	All the IBIS facilities were given the same number as IBIS (No 2) Pty Ltd • IBIS Care (No 4) Pty Ltd • IBIS Care Edenfield Pty Ltd • IBIS Care Pty Ltd • IBIS No 3 Pty Limited

Appendix F – Methods used to prepare sanctions data

Interpreting the number of sanctions imposed from the Department's records

The following table provides examples of the variation in the descriptors used to denote whether there was one sanction imposed or more than one. For consistency with the reporting style shown in example 2, the sanctions reported in example 1 were recorded as four separate sanctions.

Table 7 Examples of different test reporting sanctions

Example 1	Example 2
'Sanctions 1 Applied - Approval as an Approved Provider of aged care services revoked unless an (aged care) administrator appointed. No Commonwealth funding for new residents for a period of six months. No further allocation of places for a period of 12 months. Sanctions 2 Applied Approval as a provider of aged care services and all places allocated, revoked.' (Australian Government Department of Health and Ageing 2012a) [Riverside Nursing Home 1999/2000]	'Sanction 1 Approval as an approved provider of aged care services revoked unless an adviser is appointed for a period of 6 months. Sanction 2 No Australian Government funding for new care recipients for a period of 6 months.' (Australian Government Department of Health and Ageing 2012a) [Radford Private Nursing Home 2009/2010]

Interpreting the different sanction types

The following table identifies the variations in the words used by the Department to describe what appears to be the same sanction. These two sanctions were coded as the same type of sanction.

Table 8 Examples of different text describing the same sanction

Example 1	Example 2
'Approval as an approved provider of aged care services revoked unless the approved provider provides behavioural management training' (Australian Government Department of Health and Ageing 2007b) (Regency Green Multi-Cultural Aged Care Service)	'Sanction 1 - Provide behavioural management training.' (Australian Government Department of Health and Ageing 2012a) (Regency Green Multi-Cultural Aged Care Service).

Classifying sanction types

Initially 19 sanction types were identified and coded in the data set. Preliminary analysis indicated that the frequency of occurrence of the sanctions ranged between 1 and 145 times. The number of sanction types was reduced to 6 by combining similar sanction types,[4] as indicated in the following table with the frequency of occurrence ranging from 14 to 166.

Table 9 'Initial sanction types' and 'new types' for purposes of analysis; (n=420)

Initial sanction types	Frequency of initial types	'New' types	Frequency of new types	SPSS code
Appoint administrator for 6 months	42	Appoint Administrator	44	1
Appoint administrator for 12 months	2	Appoint Administrator		
Appoint Nurse advisor 6 months	134	Appoint Nurse advisor	134	4
Extra serv. removed	1	Restrict funding		
No Bonds 6 months	5	Restrict funding		
No new funding	4	Restrict funding		
No new funding 12 months	5	Restrict funding	171	2
No new funding 3 months	10	Restrict funding		
No new funding 6 months	145	Restrict funding		
No new funding 9 months	1	Restrict funding		
No new places	4	Restrict new places		
No new places 12 months	5	Restrict new places	17	3
No new places 3 months	2	Restrict new places		
No new places 6 months	6	Restrict new places		
Provide training	26	Provide training	42	5
Provide training 6 months	16	Provide training		
Revocation 2 months	2	Revocation of approval		
Revocation of approval	8	Revocation of approval	12	6
Revocation places	2	Revocation of approval		
Total	420		420	6

[4] For example, 'no new funding', 'no new funding 3 months', 'no new funding 6 months' and 'no new funding 9 months' were combined into the new type of 'restrict funding'.

Appendix G – Copy of published paper on quality failures

This paper, (Baldwin et al. 2014), is based on the findings of this study that are reported in Chapter 5. On this page is displayed the first page of the printed article and the following pages provide the full text of the submitted paper.

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Australasian Journal on Ageing

Research

Quality failures in residential aged care in Australia: The relationship between structural factors and regulation imposed sanctions

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Aim: *To examine the relationship between structural factors and the imposition of sanctions on residential aged care services across Australia for regulatory compliance failure.*
Methods: *Poisson Regression analysis was used to examine the association between the number of sanctions imposed and the structural characteristics of residential aged care services in Australia.*
Results: *Residential aged care services that have a greater likelihood of having government sanctions imposed on them are operated by for-profit providers and located in remote locations and in Victoria, Queensland, South Australia, Northern Territory and the Australian Capital Territory.*
Conclusion: *The findings confirm the international literature on the relationship between residential aged care service location, ownership type and the likelihood of sanctions. In the light of the predicted expansion of residential aged care services, policy makers should give consideration to structural elements most likely to be associated with a failure to meet and maintain service standards.*

Key words: *nursing home, public policy, quality control, regulation, standards.*

Introduction

The Australian Aged Care Financing Authority [1] in 2013 reported that an additional 74 000 residential aged care beds will be needed across Australia over the next decade; a 40% increase on the 184 000 beds available in 2012 [2]. If recent trends in the residential aged care industry continue these additional beds will be provided in larger facilities than in the past and a higher percentage will be operated by for-profit providers for residents with higher dependency [3]. Aged care services will also have to be built in all jurisdictions and locations. The challenge for the Australian Government is to establish a regulatory environment that fosters the development of services that achieve and maintain agreed minimum standards for care and resident outcomes. One aspect of this challenge as the industry expands is to monitor those structural factors over which the Government has control, including the size of services, location and ownership. In the absence of a single national data base on the residential aged care industry, an examination of the structural characteristics of aged care services that have failed to achieve compliance standards may identify structural factors associated with poor quality, towards which regulatory attention should be focused.

Background

When assessing the performance of the residential aged care industry and individual service providers the Australian Government relies primarily on the aged care accreditation system (administered by the Aged Care Standards and Accreditation Agency – the 'Agency') and on the complaints handing processes (the Aged Care Complaints Scheme administered through the Australian Government Department of Social Services – formerly the Department of Health and Ageing – the 'Department') [2]. This regulatory system meets the framework of a 'regulatory pyramid' as described by Braithwaite [4] and Gilligan, Bird and Ramsay [5]. It aims to persuade, educate and encourage quality standards through the accreditation process and also to detect and rectify situations where there are failures to achieve minimum standards. During 2011–2012, the Agency conducted 1491 site audits to assess if services were compliant with regulatory framework and identified 229 homes (8.4%) as not having met one or more standards. Also during 2011–2012 the Department received 3722 complaints relating to residential aged care services [2].

Achievement and maintenance of the minimum standards are necessary for residential aged care services to receive the Australian Government subsidy towards the care of residents. Where serious issues are identified by either the Agency, or the Department, the regulatory system provides for the imposition of sanctions on residential aged care providers when those providers have breached their responsibilities under the Act, or failed to implement necessary

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Quality failures in residential aged care in Australia: the relationship between structural factors and regulation imposed sanctions

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ABSTRACT

Aim

To examine the relationship between structural factors and the imposition of sanctions on residential aged care services across Australia for regulatory compliance failure.

Methods

Poisson Regression analysis was used to examine the association between the number of sanctions imposed and the structural characteristics of residential aged care services in Australia.

Results

Residential aged care services that have a greater likelihood of having government sanctions imposed on them are operated by for-profit providers and located in remote locations and in Victoria, Queensland, South Australia, Northern Territory and the Australian Capital Territory.

Conclusion

The findings confirm the international literature on the relationship between residential aged care service location, ownership type and the likelihood of sanctions. In the light of the predicted expansion of residential aged care services, policy makers should give consideration to structural elements most likely to be associated with a failure to meet and maintain service standards.

Key words,

nursing homes, public policy, quality control, regulation, standards

Introduction

The Australian Aged Care Financing Authority (2013) in 2013 reported that an additional 74,000 residential aged care beds will be needed across Australia over the next decade; a 40% increase on the 184,000 beds available in 2012 (Australian Government Department of Health and Ageing 2012d). If recent trends in the residential aged care industry continue these additional beds will be provided in larger facilities than in the past and a higher percentage will be operated by for-profit providers for residents with higher dependency (KPMG 2013). Aged care services will also have to be built in all jurisdictions and locations. The challenge for the Australian Government is to establish a regulatory environment that fosters the development of services that achieve and maintain agreed minimum standards for care and resident outcomes. One aspect of this challenge as the industry expands is to monitor those structural factors over which the Government has control, including the size of services, location and ownership. In the absence of a single national data base on the residential aged care industry, an examination of the structural characteristics of aged care services that have failed to achieve compliance standards may identify structural factors associated with poor quality, towards which regulatory attention should be focused.

Background

When assessing the performance of the residential aged care industry and individual service providers the Australian Government relies primarily on the aged care accreditation system (administered by the Aged Care Standards and Accreditation Agency - the 'Agency') and on the complaints handing processes (the Aged Care Complaints Scheme administered through the Australian Government Department of Social Services – formerly the Department of Health and Ageing – the 'Department') (Australian Government Department of Health and Ageing

2012d). This regulatory system meets the framework of a 'regulatory pyramid' as described by Braithwaite (1998) and Gilligan, Bird and Ramsay (1999). It aims to persuade, educate and encourage quality standards through the accreditation process and also to detect and rectify situations where there are failures to achieve minimum standards. During 2011–12, the Agency conducted 1,491 site audits to assess if services were compliant with regulatory framework and identified 229 homes (8.4%) as not having met one or more standards. Also during 2011-12 the Department received 3,722 complaints relating to residential aged care services (Australian Government Department of Health and Ageing 2012d).

Achievement and maintenance of the minimum standards are necessary for residential aged care services to receive the Australian Government subsidy towards the care of residents. Where serious issues are identified by either the Agency, or the Department, the regulatory system provides for the imposition of sanctions on residential aged care providers when those providers have breached their responsibilities under the Act, or failed to implement necessary improvements (Productivity Commission 2011). During 2011-12 the Australian Government Department of Health and Ageing imposed sanctions in 16 services that did not meet their responsibilities under the Act (Australian Government Department of Health and Ageing 2012d, p. 106). Sanctions impose income restrictions and/or require the aged care provider to undertake actions to remedy non-compliance in identified areas of service (Australian Government Department of Health and Ageing 2012d).

The current aged care quality monitoring system has been operating since 1999, with the Government making available a continuous record of those facilities which have failed to achieve compliance with the regulatory system. Previous analyses of available international and Australian aged care regulatory compliance data have identified similar structural factors associated with compliance failure by residential aged care providers. The factors associated

with services that fail to meet minimum standards include facility size, staffing levels, ownership type, organisational size and location. Zinn found performance failure (loss of government subsidy) associated with structural and environmental factors including ownership and ownership change, size and income (Zinn et al. 2009). Harrington and colleagues (2011; 2008) found that low occupancy rates, larger facilities, for profit ownership and facilities operated by larger organisations were more often associated with higher rates of failure against standards. Similar findings were identified for English (Gage et al. 2009), Israeli (Clarfield et al. 2009) and Australian (Ellis & Howe 2010) aged care services. Ellis and Howe examined data on residential aged care facilities in Australia that had sanctions imposed between 1999 and 2008 and found that these were more likely to occur in certain jurisdictions, in for-profit services, in both small and large categories and in high care-only facilities.

Aim

The purpose of this study was to identify whether structural factors are associated with failures by Australian residential aged care service providers to meet their responsibilities under the Aged Care Act 1997 and to identify where these failures have resulted in the imposition of sanctions.

Ethics, conflict of interest and funding

This research was approved by the University of Technology, Sydney Human Research Ethics Committee in December 2012 (no. 2012000366). The authors affirm that they have no conflict of interest to declare in relation to this research and no funding was provided for this research.

Method

Data collection

Data were extracted from four sources, listed in Table 1. Ten files, made available by the Department, were merged. The files contained the census on all RAC services across Australia at 30 June for each year between 2003 and 2012. The details of sanctions published by the Department in the annual Report on the Operational of the Aged Care Act 1997 were extracted from each of the reports covering the years 1999-2000 to 2011-2012 and these data were checked for consistency and completeness with the details, where available, on the Department's website. A complete list of sanctioned services over the period 2000 to 2013, provided by the Department, was used to validate the previously compiled details on sanctions. The census and the sanctions data were then merged to create a single database containing the characteristics of all residential aged care service between 2003 and 2012 and all sanctions imposed since the commencement of the current accreditation and sanctions system in 1999 and 30 June 2012.

Table 1 Sources of data and selection criteria

Description	Source of data	Data selected
Census data on all RAC services at 30 June each year 2003 to 2012	**Website of the Department of Health and Ageing**	**Size, ownership type, nature of beds, location**
List of sanctions imposed for each year	**Annual Report of the Operations of the Aged Care Act 1997 for each year 2000 to 2012**	**Names of services and approved providers, description of sanctions**
Details of sanctions and NNC	**Website of and a data file supplied by the Department of Health and Ageing**	**Name of services, approved providers, sanction types, reasons for sanctions, date imposed and duration of sanctions and NNC**
Characteristics of pre 2003 services	**Website searches and archived data**	**Ownership type, location, size of services**

Data analysis

Poisson regression models were used to explore the time trend of sanction event rate (number of sanction events divided by total service years of exposure) and the association between structural characteristics and the sanction event rate were examined. Univariate analysis was conducted, followed by multiple Poisson regression with backward model selection to obtain the final model. Chi-square test was used to investigate the association between sanction type/reason and structure characteristics. Statistical analysis was conducted using SAS 9.2 (SAS Institute Inc. 2010).

Findings

In taking action over compliance failure the Department may impose one or more sanctions on an individual service at the same time. This action by the Department was labelled as a 'sanction event'. Over the 13 year period a small number of services experienced more than one sanction event at different times; mostly in different years. The analysis extracted the following variables related to the imposition of sanctions; the number of services which experienced a sanction event, the number of sanction events, the number of individual sanctions and the size, geographic and jurisdictional location and ownership type of sanctioned services. As **Error! Reference source not found.** illustrates between 1 July 1999 to 30 June 2012 sanctions were imposed on 176 services through 205 sanction events. Up to four sanctions were imposed during any one sanction event. In total 412 separate sanctions were imposed. Six services were sanctioned on three different occasions and while the majority of services that were sanctioned received one or two sanctions, one service received a total of eight sanctions during this period.

Table 2 Number of services that were sanctioned, number of sanction events and total number of sanctions for each year 2000 to 2012 in Australia

Year	Sanction events imposed					No. of services sanctioned	Total No. of sanctions imposed
	No. of services with 1 sanction imposed	No. of services with 2 sanction imposed	No. of services with 3 sanction imposed	No. of services with 4 sanction imposed	Total No. of Sanction events		
1999	5	3	0	2	10	8	19
2000	7	15	3	0	25	24	46
2001	5	8	1	0	14	13	24
2002	5	6	3	0	14	12	26
2003	5	13	1	0	19	19	34
2004	4	7	0	0	11	10	18
2005	3	7	1	0	11	11	20
2006	7	12	2	0	21	18	37
2007	3	8	3	0	14	11	28
2008	4	19	7	0	30	24	63
2009	2	5	0	0	7	6	12
2010	3	2	5	1	11	6	26
2011	1	0	6	7	14	10	47
2012	1	0	1	2	4	4	12
Total	55	105	33	12	205	176	412

The frequency of sanction events imposed in a year and the types of sanctions imposed varied across the period between 11 sanctions events imposed in 2004/05 and 30 in 2008/09. No significant linear time trend in sanction rate was detected over this period (P=0.08). This may be related to the three yearly cycles of assessments where more Agency visits occur in assessment years and this cycle may give rise to more services sanctioned in those years.

Analysis of the text explanations provided by the Department in the annual reports and on the website identified six sanction types within the 412 individual sanctions imposed and three reasons for imposing sanctions. As illustrated in Table 3 the sanction most frequently imposed ('restrict funding') was imposed 41 per cent of the time. This sanction denies Australian Government funding for new residents admitted to the sanctioned service for a determined

period, most frequently six months. The appointment of a nurse advisor, at the services expense and for a fixed period of generally six months, was the second most frequent sanction and was imposed 32 per cent of the time. 'Non-compliance with standards and principles' was the most frequent reason given by the Department (45 per cent of all reasons); followed by 'immediate and severe risk' (31% of the time) and 'serious risk' (24% of the time'). Analysis of the relationship between type of sanction and the reason was inhibited by the practice of the Department in reporting reasons to sanction events and not to individual sanctions. There was no significant association detected between sanction type/reason and structure characteristics, including those services with the highest number sanctions, in part due to the small number of observations.

Table 3 Description and frequency of the type of sanctions imposed on residential aged care services across Australia 2000-2012 (n=412)

Description of sanction	Frequency
Appointment administrator	**10%**
Restrict funding for new places	**41%**
Restrict allocation of new places	**4%**
Appointment of a nurse advisor	**32%**
Revoke approval	**3%**
Provide training	**10%**
	100%

Table shows the frequency of sanction events within the total of all service years between jurisdictions, ownership type, location and size of service. NSW was the jurisdiction with the lowest rate of sanction events and the Northern Territory had the highest, although based on only 15 services. For-profit services experienced sanction events at a higher rate than not-for-profit and government-owned services. Services in remote locations had sanctions imposed at a higher rate than those in major cities and regional locations. Larger services (number of beds) had fewer sanction events.

Table 4 Number of service/years (2003-2012), frequency of sanction events and services sanctioned by jurisdiction, location, ownership type and size

		Service years	No. of sanction events	No. of services sanctioned
Jurisdiction	ACT	240	3	2
	NT	129	5	2
	QLD	4755	37	29
	SA	2750	18	16
	TAS	790	1	1
	VIC	7930	52	45
	WA	2504	8	7
	NSW	9078	18	17
		28176	**142**	**119**
Ownership type	FP	7978	72	61
	Govt. ‡	3185	9	5
	NFP	17013	61	53
		28176	**142**	**119**
Location	Major City	17172	90	77
	Regional †	10433	34	32
	Remote §	571	18	10
		28176	**142**	**119**
Size in beds	<= 20.00	2065	12	6
	21.00 - 40.00	7270	37	31
	41.00 - 60.00	8424	45	38
	61.00 - 80.00	4597	24	20
	81.00 - 100.00	2596	8	8
	101.00+	3224	16	16

‡ includes both local government and state government; † includes inner regional and outer regional locations; § includes remote and very remote locations

Multiple Poisson regression included all the factors listed in Table 4. This analysis demonstrates that jurisdictions ($X^2[7]=38.07$, P<.0001), ownership type ($X^2[2]=36.06$, P<.0001), and location ($X^2[2]=36.91$, P<.0001) are significant predictors for sanction. The association between size of service and sanction was insignificant ($X^2[5] =2.76$, P=0.74). As shown in Table 5, five jurisdictions were more likely to experience a sanction event than NSW; services in ACT were 6.99 (95% CI 2.04, 23.92) times more likely; NT was 4.63 (95%CI 1.49, 14.44) times more likely; QLD was 3.43 (95% CI 1.93, 6.08) times more likely; SA was 2.43 times (95% CI 1.78, 6.60) more likely, and VIC was 3.11 (95% CI 1.80, 5.36) more likely. Services in remote area were 9.35 (95% CI 4.96, 17.63) times more likely to experience sanction event comparing to

those in a major city. For-profit services were 2.79 (95% CI 1.91, 4.07) times more likely to have sanction event than not-for-profit services.

Table 5 Relative risk of experiencing a sanctions event by jurisdiction, location and ownership type

Structural factor		Relative risk of a sanction event	95% confidence interval (CI)	P-value
Jurisdiction	ACT	6.99	2.04, 23.92	0.002
	NT	4.63	1.49, 14.44	0.008
	QLD	3.43	1.93, 6.08	<.0001
	SA	2.43	1.78, 6.60	0.0002
	TAS	0.62	0.08, 4.70	0.64
	VIC	3.11	1.80, 5.36	<.0001
	WA	1.37	0.59, 3.16	0.46
	NSW	1	--	
Location	Regional	0.96	0.63, 1.47	0.85
	remote	9.35	4.96, 17.63	<.0001
	City	1	--	
Type	FP	2.79	1.91, 4.07	<.0001
	Govt.	0.58	0.28, 1.22	0.15
	NFP	1	--	

Discussion

The differences in the rate and likelihood of sanctions due to aged care service location, jurisdiction and ownership type supports the findings of the earlier Australian study by Ellis and Howe (2010). However this study was unable to confirm the earlier finding of an association between service size and the likelihood of a sanction being imposed. Ellis and Howe (Ellis & Howe 2010) reported a statistically significant higher rate of sanctions imposed on facilities with fewer than 60 beds for 2008. Because there has been a noticeable change in the size of services across Australia between 2003 and 2012 (Australian Institute of Health and Welfare 2012 Table A1.3) we estimated the likelihood of sanctions imposed by service size using the proportion of the size of all services across this time period. In contrast to previous

research, no significant difference was found for the likelihood of a service having a sanction imposed based on service size.

Consistent with the findings of Ellis and Howe (2010), however, the rate of sanctions imposed on services in the Northern Territory was the highest among the jurisdictions. Services in remote locations, irrespective of jurisdiction, have a significantly higher likelihood of sanctions imposed than services in regional locations and major cities. Although we did not find that size was a significant variable, the higher likelihood of sanctions occurring in services in remote locations may reflect the reduced financial capacity of these, mostly small, remote services to maintain standards at a level endorsed by the Department.

There was a statistically significant higher rate of sanctions in Victoria compared with NSW, which have similar sized populations and economies. One significant structural difference in Victoria is that in 2011 40% of all residential aged care services in that state were provided by for-profit providers, 25 per cent by state and local governments with only 36 per cent provided by not-for-profit providers. During this same period in NSW, 28 per cent of all services were operated by for-profit providers, four per cent by governments and 68 per cent not-for-profit providers (Australian Institute of Health and Welfare 2012). This pattern of ownership type may explain why Victoria had a higher rate of sanctions than NSW in 2011.

Similar findings were identified in relation to ownership type and the likelihood of sanctions, as reported by Ellis and Howe (Ellis & Howe 2010) and researchers in other countries (Castle & Engberg 2006; Gage et al. 2009; Harrington, Hauser, et al. 2011). These researchers also found that for-profit organisations have a higher rate of a failure to meet standards than not-for-profit or government operated residential aged care services. Unlike Ellis and Howe's (13) study we did not investigate any difference between low, mixed and high care services as this distinction is diminishing in the Australian aged care industry. The sanction data extracted for

these analyses suggest that the imposition of sanctions remains a relatively rare event in Australian aged care services, as has been previously reported (Ellis & Howe 2010).

This research reveals that there are continuing patterns of concern in relation to some structural features associated with quality failures in residential aged care facilities in Australia. Structural factors and their relationship with quality failures were selected for analysis as they are publicly available data in Australia. Other factors such as staffing levels, staffing qualifications, resident characteristics and income have also been associated with regulatory failure in overseas studies (Castle 2011; Clarfield et al. 2009; Comondore et al. 2009; Harrington, Carrillo, et al. 2011; Phillips & Guo 2011) and may be applicable in the Australian context. These factors have been found to be correlated with the structural variables identified in this study; for example, staffing levels with ownership type (Castle & Engberg 2007; Spilsbury et al. 2011), ownership type and income (Zinn et al. 2009), location and staffing levels (Harrington & Swan 2003) location and income (Hogan 2004).

This study adds to the relatively small volume of research on the relationship between input variables and the quality of the residential aged care industry across Australia and contributes to the expanding research from comparable countries. It also identifies areas where policy makers may focus their effort to maintain, or improve quality, as the industry undergoes a period of rapid expansion. These findings also suggest that further research is needed in Australia on the relationship between a broad range of factors that may be associated with quality such as staffing levels, resident mix, facility income, ownership type, provider size and location across the Australian residential aged care industry. Consideration could also be given to a more detailed and systematic reporting of the reasons for the imposition of sanctions, such as is reported in other countries, for example, restraint use (Castle 2000, 2002), professional standards, care plans, poor clinical records, and failure to prevent pressure sores

(Harrington, Carrillo, et al. 2011). Finally this research suggests that the structural characteristics of ownership and location of services, as well as jurisdictional differences, ought to be taken into consideration by Australian governments and key stakeholders when planning future services.

Limitations of this research

This research analysed secondary data on the sanction decisions of the Australian Government's Department of Health and Ageing. These data were obtained from inspection reports of the Aged Care Accreditation and Standards Agency and from complaints and subsequent investigations by Department officers. The consistency, validity and reliability of the inspection reports by the Agency and the Department's sanction decisions were not analysed when interpreting these data, however, it reasonable to assume that the Department's determination to impose a sanction is taken only after considerable reflection on all relevant factors, given the significant consequences for a residential aged care provider on which a sanction is imposed. For this reason, we believe that the risk of a type 1 error (imposing a sanction inappropriately) is considered less likely than a type 2 error (a failure to impose a sanction). Consequently, the number of sanctions reported is likely to be an underestimate of the number of services failing to achieve minimum standards, rather than an overestimate. Finally, the number of sanctions is small and within some variables this has limited the tests for significance.

Conclusion

The imposition of sanctions on residential aged care services that have failed regulatory compliance continues to be a part of the accreditation system within the Australian residential aged care industry. Imposing a sanction is a significant but relatively rare event. While there is variation in the number of sanctions from year to year there does not appear to be a significant diminution in the frequency of their occurrence over the 13 years to 2012. Sanctions are more likely to be imposed on services operated by for-profit organisations, on services in remote locations and services in the states of Victoria, Queensland and South Australia and in the Northern Territory and the Australian Capital Territory. In contrast to previous reports, the effect of service size was not found to be significant. However, since services in remote locations are smaller and more likely to receive sanctions, an examination of regulatory policy and practices occurring in these services and in some other jurisdictions is needed. As the residential aged care industry is anticipated to expand rapidly over the coming decade, this research suggests that the structural characteristics of ownership and location of services, as well as the jurisdictional differences, need to be taken into consideration by Australian governments and key stakeholders when planning reforms to their funding and regulation.

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Key points

1. The imposition of sanctions on residential aged care services for failing to meet regulatory compliance remains an active component of the Australian Government's regulatory framework of the industry.
2. The Australian Government uses only three reasons to decide to impose sanctions and imposes six different types of sanctions, however there is no statistical association between the reasons found, the types of sanctions imposed, or different categories of services.
3. Services that are operated by for-profit providers, in some states and territories and in remote locations, are more likely to have sanctions imposed than not-for-profit and government operated services, services in NSW, WA and Tasmania and in major cities
4. These finding are consistent with previous Australian and international research and suggest that policy makers should be mindful of the relationships between some service characteristics and a failure to meet standards as the industry expands rapidly.

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Appendix H – Table of participant recommendations made and received

Table 10 Recommendations received (rows) and recommendations made by interviewed participants (columns)[5]

	Columns is recommendations made																													
Recommendations. received in Rows	RB	CEOMP1	CEOMP2	CEOMP3	CEOMP4	CEOMP5	CEOMP6	CEOMP8	CEOPB1	CEOPB2	CEOPB3	CEOPB4	CEOPB5	CEOPB6	DIrGov1	DirGov2	DirGov3	DirGov4	DirGov5	DirMP1	DirMP2	DirMP4	DirCon1	DirCon2	DirCon3	DirCon4	DirCon5		
CEOMP1	●													●															2
CEOMP2		●								●						●					●		●						5
CEOMP3										●		●																	2
CEOMP4															●		●			●				●		●			5
CEOMP5							●		●	●												●		●		●			6
CEOMP6																				●				●		●			3
CEOMP8									●	●			●	●		●			●										6
CEOPB1	●	●									●										●								4
CEOPB2											●			●															2
CEOPB3									●	●							●				●				●				5
CEOPB4											●				●						●								3
CEOPB5		●															●		●						●				4
CEOPB6											●						●												2
DIrGov1	●													●															2
DirGov2		●								●									●										3
DirGov3		●																	●						●				3

[5] The recommendations received by participants are indicated by the dot (●) in the rows, and the recommendations made by participants can be read in the columns. The second column indicates those participants who I initially selected.

Columns is recommendations made																													
Recommendations. received in Rows	RB	CEOMP1	CEOMP2	CEOMP3	CEOMP4	CEOMP5	CEOMP6	CEOMP8	CEOPB1	CEOPB2	CEOPB3	CEOPB4	CEOPB5	CEOPB6	DIrGov1	DirGov2	DirGov3	DirGov4	DirGov5	DirMP1	DirMP2	DirMP4	DirCon1	DirCon2	DirCon3	DirCon4	DirCon5	
DirGov4	●																												1
DirGov5									●				●											●		●			4
DirMP1							●								●							●							3
DirMP2		●							●	●			●		●					●									6
DirMP4																				●				●		●			3
DirCon1						●																			●				2
DirCon2							●		●																				3
DirCon3											●			●			●	●	●				●						6
DirCon4							●		●															●					3
DirCon5						●						●	●					●											4
Total referrals	4	6	0	0	0	2	4	0	7	7	4	2	5	5	4	2	5	2	5	5	4	0	2	6	4	5	0		

References

The references below correspond to all the citations in Appendices A, B and G. Some of the sources cited in Appendix A also appear in the Chapters and therefore these references are also listed with the references in the volume containing the Chapters. Sources that are cited in Appendix B are all included in the Chapters and also appear in the reference list in the volume containing the Chapters.

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