REVIEW ARTICLE

Regulation and Quality in Aged Care: a Cross-National Perspective

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Abstract. The objective of this article is to assess critically the regulatory foundations required for continuous improvement in the quality of nursing home care. Data from observation of nursing home inspections in Australia and other nations (particularly the US) are used to illuminate this assessment. Conclusions are:

- The quality of regulatory dialogue affects care outcomes: disrespectful dialogue and tolerance of law-breaking make things worse.

- Trustful dialogue, praise, reintegrative shaming and building the self-efficacy of managers improves compliance.

- A useful policy framework is a regulatory pyramid that tries dialogue first and then escalates to more sanction-based strategies when dialogue fails.

- Attempts to pursue consistency in regulatory decisions by rendering rules more specific and disciplining them with scientific protocols is counterproductive because of the operation of a 'reliability paradox'.

INTRODUCTION

After many years of essentially input-oriented state government regulation of nursing homes an Australian national outcome-oriented Standards Monitoring Process was introduced in 1988. Since 1987, Valerie Braithwaite, Diane Gibson, Toni Makkai, Ann Jenkins and I have been evaluating the Australian Standards Monitoring Process and comparing it to regulation in other nations with funding from the Australian Commonwealth Government and the American Bar Foundation. Our conclusion is that the Australian process has been a success compared to the regulatory regimes we have studied in other countries and compared to other areas of regulation in Australia. Perhaps this is why the nursing home industry successfully lobbied the Howard Government (which came to power in 1996) to abolish it; it will be replaced soon by an accreditation regime in which industry has a stronger voice.

The nature of our data is quantitative information based on interviews and records at 410 Australian nursing homes and observation of more than 150 nursing home inspections in Australia, the US, the UK, Canada and Japan between 1988 and 1992. All the conclusions in this presentation relate only to that time period. The findings have been presented in reports to the Commonwealth [1-3] and other publications [4-13] though more analysis remains to be done.

QUALITY OF REGULATORY DIALOGUE

A key variable our research group has identified

in the success and failure of nursing home regulation is the quality of the regulatory dialogue. Often enough Australian nursing home regulation not only fails to improve quality of care, but actually makes it worse. When it does, we find this counterproductivity related to the nature of the regulatory dialogue that occurs.

One problem is inspectors who believe in being nice to nursing homes; when they find that the standards have not been met, they make excuses on behalf of the home; they don't disapprove. These inspectors are popular with the industry, but after they visit a nursing home, its standards decline over

Figure 1: Mean improvement in compliance for nursing homes where inspectors used high disapproval and high reintegration styles; high disapproval and low reintegration styles; low disapproval and high reintegration styles (N=129; F-Value=3.58; p=.03)
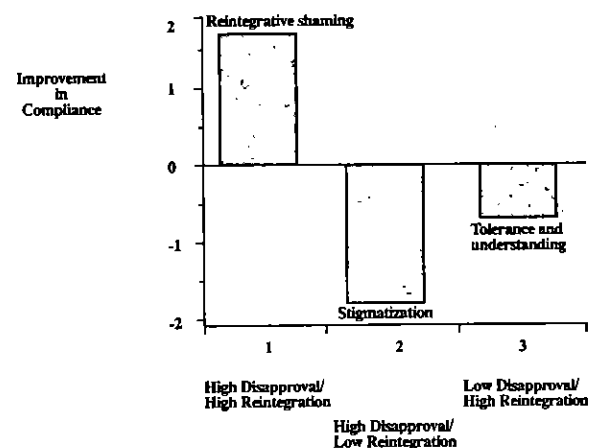
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the subsequent two years as the right hand bar of Figure 1 shows. Standards decline even more after facilities are inspected by inspectors who do disapprove of failures to meet the standards, but disapprove in a stigmatising way [9]. This means they disapprove disrespectfully. They label management and proprietors as heartless, as putting profits ahead of people. This regulatory style produces defiance or disengagement from the regulatory game. The regulatory philosophy that works in improving compliance (by 39 per cent in Figure 1) is reintegrative shaming - disapproval within a continuum of respect for nursing home management.

Respect is communicated in part by giving nursing home management a degree of process control during the dialogue about what is to be done, treating them with procedural fairness [12]. Respect is also communicated by trust. When chief executives of nursing homes believed that they were treated as trustworthy by inspectors, their homes experienced a significant improvement in compliance with standards during the two years following that inspection [7]. These were chief executives who agreed with the attitude statement: "The Standards Monitoring Team treated me as a person who could be trusted to do the right thing". Conversely, when chief executives agreed that "The Standards Monitoring Team treated me as someone who would only do the right thing when forced to", compliance with the standards fall.

We also found that informal praise from inspectors when standards improve increased subsequent quality of care [5]. However, we did not find that perceived severity and certainty of punishment for non-compliance with the standards increased compliance [4]. In some contexts it did, in other contexts threat made things worse [10].

Anne Jenkins from the Australian Institute of Health and Welfare completed a wonderful study of the importance of the self-efficacy of Directors of Nursing (DONs) in specifying when regulation succeeds and fails. Jenkins [8, 14] shows consistently that when DONs have a high level of belief in their own ability to meet the standards, they do indeed perform better at meeting them. This is a much better predictor than qualifications or experience, which are not good predictors at all.

The deterrence-self-efficacy interaction is interesting in Jenkins' work. She finds that when DONs with low self-efficacy are concerned about legal sanctions, this seems to cause them to drop their bundle. But high self-efficacy DONs who are concerned about legal threats seem to respond to the challenge; they have high compliance. Similarly, low self-efficacy DONs are discouraged by procedural injustice. High self-efficacy DONs are not: in fact, "when they believed the regulator was moving the goalposts they just kicked the ball further" [14]. On a number of dimensions, Jenkins showed high self-efficacy to compensate for the adversities and obstacles that caused poor quality of care in homes run by low self-efficacy managers.

Figure 2: Three types of actors and three strategies in a regulatory pyramid
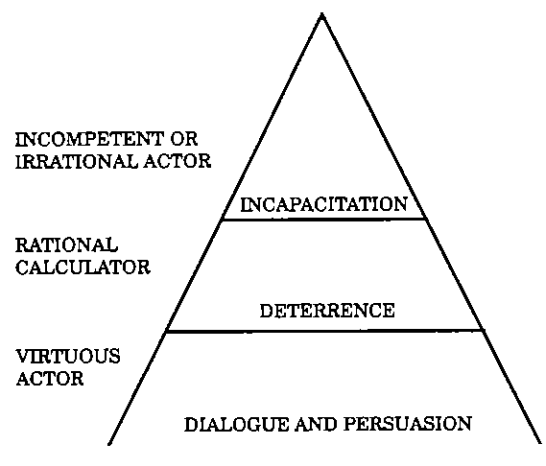
The requirement that comes out of this relationship is for a regulatory dialogue that sustains managerial self-efficacy. Perhaps this is one reason why we found that praise by inspectors for good performance improves quality of care. None of this sustains a policy framework that sees distrust and deterrence as never needed. What we favour is an enforcement pyramid, as in Figure 2, that tries dialogue as the preferred strategy, then tries deterrence when dialogue fails, then tries incapacitation (eg. shutting the home) when deterrence fails.

Overall, we think that getting the dialogue right is more important than getting the sanctions right or even getting the rules right. In fact the rest of this paper will be devoted to showing that getting the regulatory dialogue right is the best way to get the standards right.

THE RELIABILITY PARADOX

Most countries get their aged care regulatory standards wrong because they are more concerned about consistency of enforcement or reliability than they ought to be. Ironically, our Minister tells us inconsistency is one reason the Standards Monitoring Process should be abandoned. Valerie Braithwaite and I [11] propose a reliability paradox: reliability is more likely to be achieved when reliability is not the central objective of public policy. When we make another objective our central concern - designing standards which best foster a regulatory dialogue about how aged care can improve quality of life outcomes - an indirect effect may be better reliability of the rating achieved.

On a quota sample of 50 Australian nursing home inspections we put our own independent rater of compliance in the home at the same time as a government Standards Monitoring Team. Across the 31 standards, inter-rater agreement ranged from 78% to 98%. For total compliance scores obtained by adding ratings on all standards, the inter-rater reliability coefficients ranged from .93 to .96. This extraordinarily high level of

reliability contrasts with extraordinarily low reliabilities obtained in American studies which have been reviewed elsewhere [1, 11].

I want to advance the hypothesis that Australian standards are more reliably or consistently rated than US standards because they are broad, vague, subjective and undefined with regard to protocols. Examples of some of these broad and vague standards are detailed in Table 1, together with examples of more specified US standards from the same domain, though the table understates the difference because of the absence of protocols and guidelines associated with the US standards and of the large numbers of more specific US state government standards used to flesh out the federal rules.

Historically, what has happened in the US and what I fear will happen here is that key political players in the nursing home regulatory game came to be critical of broad, vaguely defined standards. The industry has been at the forefront of this criticism. When nursing home X gets a "not met" rating on a broad standard on which nursing home Y in similar circumstances gets a "met" rating, home X screams about inconsistency. An industry association complains on its behalf about the vagueness of the standard leading to "subjective" and "unfair" judgements by inspectors. Consumer groups, lawyers and lawmakers agree with these pleas for the standard to be tightened up, but for different reasons. They are concerned that vague standards are unenforcible, and leave too much discretion with inspectors they do not trust to clean up the industry. Finally, certain gerontologists who advise the lawmakers believe in tight protocols to ensure that the same things are being assessed in exactly the same way using precisely defined criteria.

Hence, one of the few things agreed among the key players of the American regulatory game has been that broad standards which are not tightly specified must be narrowed. The consequence has been an historical process of all these constituencies succeeding in having one broad standard broken down into two or three narrower

Table 1: Examples of some broad, vague, Australian nursing home standards and more specific US standards

Australian	US
1.5 Residents are enabled to maintain continence.	F321 (1) A resident who enters the faculty without an indwelling catheter is not cathetarized unless the resident's clinical condition demonstrates that catheterization was necessary; and
	F322 (2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.
4.2 The nursing home has policies which enable residents to feel secure in their accommodation.	F208 (2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.
5.1 The dignity of residents is respected by nursing home staff.	F460 (2) (ii) Bedrooms must measure at least 80 square feet per resident... [etc.].
6.1 Residents are enabled to participate in a wide range of activities appropriate to their interests and capacities.	F256 (2) The activities program must be directed by a qualified professional who- (i) Is a qualified therapeutic recreation specialist or an activities professional who- (A) Is licensed or registered, if applicable, by the State in which practicing; and (B) Is eligible for certification as a therapeutic recreation specialist...

standards, later to be subdivided again. By the 1980s, the upshot was that in most states, US inspectors were surveying about a thousand federal and state standards.

How do they cope with such a daunting task? The answer is that they do not. Some of the standards are completely forgotten, not suppressed by any malevolent or captured political motive, just plain forgotten. As one Midwestern inspector said to me: "We use 10 per cent of them repeatedly. You get into the habit of citing the same ones. Even though possibly you could use others [for the same offence]. Most are never used."

When inspectors have an impossible number of standards to check, our ethnographic work has documented the arbitrary factors that cause particular standards to be checked in some homes, neglected in others. At its best, the US process between 1988 and 1992 worked in the following way.

The inspectors meet at the conclusion of their information-gathering to share the problems they have found. When a number of negative findings are judged to constitute a pattern of non-compliance, a search begins for a standard which can be written up as "not met". Once all the problems have been agreed and standard numbers found to write "not mets" for them, the team leader ticks "met" for all the remaining standards. As she does so, she does not read them or think about them and she certainly does not check with her colleagues the possibility that the same pattern of conduct that caused one standard to be rated "not met" should also cause several other standards to be out of compliance. In other words, she makes one valid "not met" rating and several invalid "met" ratings as a result of this strategy.

What is the relevant contrast with the Australian process in this regard? While it is not easy for Australian Standards Monitoring Teams to keep 31 standards in their heads, they can make a fist of it. After their visit the Team can (and generally does) sit down to discuss, standard by standard, the evidence collected by all team members relevant to each one. Sometimes as they systematically discuss the 31 standards, they will find they have not collected the data necessary to reach a reliable rating on a standard. They must then take steps to collect the extra information. There is no escape from this because the Team is required to sit down with management of the nursing home to summarise positives and negatives on each standard and give reasons for each final rating. Again the American exit conference is different in that the requirement there is only to give negative reasons on that subset of standards that are not met. Nothing is said about each standard that is ticked "met". It would be difficult to do so since the team has neither debated compliance with them nor assured themselves that they have collected the data relevant to them.

The end result of American demands for more specific standards with more clearly defined protocols that cover all the things judged to be important is an inspection package that is structurally unreliable. The pursuit of reliability of parts causes the unreliability of the whole.

When American inspectors cannot keep all the standards in their heads, what does our ethnographic research reveal to be their cognitive coping strategy? They have gestalts of quality care that they see as underlying the hundreds of specific regulations. In other words, what they have in their heads is something rather like the 31 Australian outcome standards. So when they observe a breach of their tacit privacy standard, for example, they search for an appropriate regulation under which to cite it.

The question that must be confronted is that if this is the empirical reality of what inspectors do and must do, why not design a regulatory system that can work well in the face of that reality? Perhaps it is shockingly chauvinistic to suggest that Australia's current nursing home regulatory system is such a system. But I hardly think so when we are foolish enough to be in the process of abolishing that system.

After explaining to a number of US inspectors the above interpretation based on our observations of how they coped, they agreed that this was basically how they did it. When we pointed out that the most troubling implication of this process from the point of view of reliability was that, depending on how hard they searched through the standards, they might find one or two or three deficiencies to write, one of them said, tellingly: "Or they might find none at all and have to mush it in".

THE PARADOX OF DISCRETION

Hence, hand in hand with a paradox of reliability is a paradox of discretion. More and more specific standards are written by lawmakers in the misplaced belief that this narrows the discretion of inspectors. The opposite is the truth: the larger the smorgasbord of standards, the greater the discretion of regulators to pick and choose an enforcement cocktail to meet their own objective. A proliferation of more specific laws is a resource to expand discretion, not a limitation upon it [15].

Similar problems arise with highly specified protocols for standards. Protocols can work well in practice because in the evaluation study the protocol does not have to compete for limited time with 30 other protocols. There are other reasons, however. An evaluation might show that a protocol of putting a tick in a box for the name of every resident who participates in an activity can be done reliably. Moreover, scores from following the protocol are validated against more sophisticated detailed assessments of the effectiveness of activities programs. Unfortunately, however, what was valid at the evaluation stage quickly becomes invalid at the implementation stage.

Administrators are quick learners in the business of getting good inspection results. If ticks in activities boxes are what count, droves of sleeping residents will be wheeled into activities programs to get the numbers up. Never mind that the quality of the activities program will be compromised by the clutter of sleeping residents;

it's beating the protocol that counts. This is why nursing home administrators love protocols: "Give us the rules and we'll play the game" is what they say. A subjective resident-centred regulatory dialogue oriented to broad outcomes make it harder for the 'efficient' administrator to beat the system.

A logic of protocols can be replaced with a logic of the good detective. We argue that when a resident is being seriously neglected, two different nurses with free reign to follow whatever evidentiary trail they pick up are both more likely to detect what they agree to be neglect than two nurses who we ask to be automatons following a standard protocol.

RULE BOOKS AND STORY BOOKS

Criminologists have come to understand during the past decade that police culture is not a rule book; it is a story book. It is story-telling not rules that generates the operational sensibility that succeeds or fails in delivering a consistent rule of law [16].

This leap of understanding has a lot of implications. Consider the following fairly typical quote from a regulator: "There are some things that the process cannot do reliably. So you don't do them." Examples are: "Are the staff pleasant? Is the room tastefully decorated?" When we hear them say this, we should consider that this is not a position the Hyatt Hotel group can afford to adopt. They accomplish staff civility and pleasant decor not through decor rules or protocols but through a regulatory dialogue that accomplishes the relevant sensibilities and through sharing stories about how one person's pleasantry was another's bad manners.

Aged care regulatory cultures are story books rather than rules books in ways not dissimilar to police culture and Hyatt Hotel regulatory cultures.

In conclusion, my fundamental message here is that we should not heed pleas from the aged care industry to "Give us the rules and we'll play the game". As Max Weber [17] taught us: "The more formal and complex the body of law becomes, the more it will operate in favour of formal rational bureaucratic groups such as corporations" [18]. There is an alternative and that is one that rejects rule-based game-playing in favour of regulatory dialogue that nurtures sensibilities. If trustful dialogue gets self-efficacy about these sensibilities right, continuous improvement in aged care will follow from those sensibilities. Aged care regulatory cultures will transform the circumstances of the aged when they are story books of how continuous improvement has been secured. We can only hope that as the next chapter in Australian nursing home regulation is written, a regulatory culture can be preserved that enriches our stories of and sensibilities to continuous improvement.

ACKNOWLEDGMENT

REFERENCES

1 Braithwaite J, Braithwaite V, Gibson D, Landau M, Makkai T. The reliability and validity of nursing home standards. Canberra: Australian Government Publishing Service, 1992.

2 Braithwaite J, Makkai T, Braithwaite V, Gibson D. Raising the standard: resident centred nursing home regulation in Australia. Canberra: Australian Government Publishing Service, 1993.

3 Braithwaite V, Braithwaite J, Gibson D, Makkai T. Progress in assessing the quality of Australian nursing home care. Australian Journal of Public Health 1991; 16:89-97.

4 Braithwaite J, Makkai T. Testing an expected utility model of corporate deterrence. Law and Society Review 1991; 25:7-40.

5 Makkai T, Braithwaite J. Praise, pride and corporate compliance. International Journal of the Sociology of Law 1992; 21:73-91.

6 Braithwaite V, Braithwaite J, Gibson D and Makkai T. Regulatory styles, motivational postures and nursing home compliance. Law and Policy 1994; 16:363-94.

7 Braithwaite J, Makkai T. Trust and compliance. Policing and Society 1994; 4:1-12.

8 Jenkins, A. The role of managerial self-efficiacy in corporate compliance with the law. Law and Human Behaviour 1994; 18:71-88.

9 Makkai T, Braithwaite J. Reintegrative shaming and regulatory compliance. Criminology 1994; 32:361-85.

10 Makkai T, Braithwaite J. The dialectics of corporate deterrence. Journal of Research in Crime and Delinquency 1994; 31:347-73.

11 Braithwaite J, Braithwaite V. Rules versus standards: the reliability paradox in regulation. Social and Legal Studies 1995; 4:307-41.

12 Makkai T, Braithwaite J. Procedural justice and regulatory compliance. Law and Human Behavior 1995; 20:83-98.

13 Gibson, D. Aged Care: Old Policies, New Problems. Cambridge: Cambridge University Press, 1998.

14 Jenkins, A. The role of managerial self-efficacy in corporate compliance with regulatory standards. Unpublished PhD Dissertation, Australian National University.

15 Baldwin R, Hawkins K. Discretionary justice: Davis reconsidered. Public Law 1984; 570-89.

16 Shearing CD, Ericson RV. Towards a figurative conception of action. British Journal of Sociology 1991; 42:481-506.

17 Weber M. On law in economics and society. New York: Clarion, 1954.

18 Sutton A, Wild R. Corporate crime and social structure. In Wilson PR, Braithwaite J. eds. Two faces of deviance. Brisbane: University of Queensland, 1978.