Chapter 6
(Part A)

DOMINANT DISCOURSE WITHIN AGED CARE POLICY IN AUSTRALIA 1963–1993 Phases 1–3 (1963–1971)

The state is not simply one of the forms or specific situations of the exercise of power ... in a certain way all forms of power relations must refer to it ... not because they are derived from it ... rather because power relations have come more and more under state control (although this state control has not taken the same form in pedagogical, judicial, economic, or family systems) ... one could say that power relations have been progressively governmentalized, that is to say, elaborated, rationalized, and centralized in the form of, or under the auspices of, state institutions.

(Foucault 1982:224)

INTRODUCTION

The major shifts in aged care policy in Australia over the past 30 years are a reflection of both the political and economic systems in place during that time. This chapter provides a brief overview of the political context within which provision of nursing home care operated in Australia between 1963 and 1993. This chapter is also concerned with the public discourse of aged care where priorities and values are expressed in policy behaviours, in spoken language found in Parliamentary debate and in the written word found in official policy documents. The presence of the dominant medical discourse is also highlighted owing to its powerful influence over the bureaucratic process of government. Six major phases of aged care policy are examined including a discussion of the dominant public discourse during each phase.

Foucault (1980) describes how powerful professional groups are able to talk about and define, sort, classify, categorise and label other groups within society. The discourse reflects the major priorities and values of a certain group and may be

expressed not only in their behaviours but also in their spoken language which may subsequently appear in the written context of official documents. A professional discourse is constructed by the professional group conducting its practice in a particular fashion. The discourse is formed through the legitimation of particular organisations and then is defined through certain need. Professional groups such as doctors, nurses, journalists, administrators and planners, through their various forums, discuss and define the elderly and present views of what they perceive are the needs of the elderly. However, powerful and influential discourse can and should be carefully examined and unpacked in order to uncover some of the social interests which are characteristic of its make-up.

In 1962, the Commonwealth Government introduced the Nursing Home Benefits Scheme which provided the sum of 20 shillings ($2.00) a day to nursing home proprietors for each resident. The Nursing Home Benefit was paid in respect of all residents in all nursing homes throughout Australia, whether the residents were insured or not insured, or whether they were in voluntary, private or state nursing homes. This nursing home subsidy came to provide such a motivational force to welfare organisations, companies and businessmen alike that by 1984, the Senate Select Committee reported there were 74 600 nursing home beds or some 140 beds for every 1000 population aged over 75 years (Senate Select Committee 1984:45). In 1986, the Nursing Homes and Hostels Review reported the number to be 71 503 beds or some 67.2 beds per 1000 population aged over 70 years, and by August 1986, its recommendations in the form of Stage 1 of the Commonwealth's Aged Care Reform Strategy (ACRS) were introduced targeting the reduction of nursing beds to 40 beds per 1000 population aged over 70 years (Commonwealth Department of Health, Housing & Community Services 1991:181). We see by June 1991, half way through the ACRS, the number of nursing home beds was reduced to 73 291 beds or 56.8 beds per 1000 population aged 70 years and over (1991:95).

In order to understand how and why this growth and later reduction of nursing home bed provision occurred and to learn what the consequences were for the quality of care provided to residents living in nursing homes, we will now recall the political and economic context of the period under study in order to explore the major policy shifts which have impacted on the nursing home bed provision.

AUSTRALIAN POLITICAL CONTEXT

Before considering the major policy shifts which have impacted on various aspects of nursing home bed provision within Australia, it is essential to recall the character of the Australian political system in which such provision was operating, in order that the development, legitimation, implementation and evaluation of policy decisions surrounding nursing homes may be understood. The main elements which assist in understanding the major shifts in aged care policy that have impacted on nursing homes in Australia are: firstly, the form of political leadership in place at the time; secondly, the pattern of Commonwealth/State relationships; thirdly, the characteristics of local government; and finally, the involvement of non-government agencies in the supply of welfare services (Parker 1987:5).

Political Leadership

Australia experienced a Labor Government during the period 1941 to the end of 1949, headed first by Curtin and then by Chifley. In 1950, under Menzies, the Liberal coalition won government. Menzies headed five successive Liberal coalition Governments until 1966, when the Liberal coalition Government continued under Holt, then Gorton, and finally McMahon. Many of the aged care policy decisions affecting nursing home provision emerged during this 23 year period of conservative government. These policy decisions were made in the light of an ideological commitment to the private sector, to a society where self-help was of the utmost importance and where government intervention was considered only as a last resort.

During the late 1960s and early 1970s, concern was mounting about the increasing amount of public expenditure surrounding health care provision and the uncoordinated manner in which the health services were being provided. By the end of 1972, the Labor Government was returned to power under Whitlam and as a consequence extensive plans were formulated to undertake a major reorganisation of the health and welfare services. These plans concerned not only the organisation and funding of health care services but also outlined new developments for public social services. Major increases in public expenditure occurred during the early 1970s, but in November 1975, supply legislation was blocked by the Senate. As a consequence, an unprecedented constitutional and financial crisis occurred and, as a result, the Governor General, Sir John Kerr, dismissed the Whitlam Government. The Governor General invited the leader of the Liberal party, Malcolm Fraser, to form a temporary government and at the following election the Liberal coalition party gained power. Australia experienced a conservative administration for the following three elections until March 1983 when the Labor party under Hawke regained power. Since 1983, Australia has experienced 11 years of a Labor administration even though the leadership of the Labor party changed to Keating in 1993.

Therefore, the period prior to this study contained a 23 year period of a Liberal coalition Government, which was only disturbed by three years of Labor administration. This present study pertains to a period which is characterised by 11 years of a Labor Government which, in terms of social policy, has been criticised in some quarters as proceeding more like a conservative government than its Whitlam forerunner twenty years or so earlier.

Commonwealth/State Relationships

Australia has been a federation since 1901, with responsibilities for various areas of government divided constitutionally between the Commonwealth and the six states. The major responsibilities of the Commonwealth rest with areas such as defence,

education, health, economic policy, foreign policy, and aspects of social welfare such as Aboriginal affairs, repatriation affairs, and most social security payments to individuals such as unemployment benefits, pensions, and so on. The Commonwealth raises revenue through income tax and distributes this to the states. The states also have the right to raise revenue through taxes and they do so to a lesser extent through the levy of land tax, petrol tax, road tax, and so on. Local governments are also allowed to raise income and do so through the land rating system; however, their income is minor.

The Constitution allows the Commonwealth to make payments to individuals in cases such as unemployment and sickness. However, state governments carry the responsibility for the provision of individual services such as hospitals, schools, public housing, and local social services. The Commonwealth transfers funds to the states to provide for such services. However, the transfer of Commonwealth funds to the states is generally undertaken in a global fashion and the states may utilise the funds in any particular manner they choose. It is only when the Commonwealth transfers funds via Special Purpose Grants that the states are required to use the monies for specific purposes.

Often, the political party in government at the Commonwealth level can differ to that at the state level and this leads to a situation where the Commonwealth government frequently is required to deal with a number of state governments that are of the opposite political persuasion.

Local Government Involvement in Health and Welfare Services

As the Australian population is spread widely throughout the countryside, vast distances are found between local government councils and, with relatively small population bases in rural towns, the amount of revenue to be earned by local governments is small. Therefore, local government councils have steered away from any major involvement in provision of local health and welfare services, with their major responsibilities tending to be in the maintenance of local roads. Local

government councils are genera ly elected more upon a personality basis rather than on their political party prefere ıce and therefore local government councils have tended to avoid increases in th: taxes as it would bring bad publicity at the next election.

Non-government Welfare Agencies

The practice of government administrations looking to non-government agencies, such as churches and religiou; orders, to provide basic welfare services to the community has a long history. Benevolent organisations have been given support via capital grants and per capit. payments for services provided to people in need. The long history of Libera Government up till 1983 saw conservative administrations advocate pay ments to benevolent organisations rather than supporting government run org anisations due to the self-help ethic. Vast networks of volunteers would raise donations and provide a source of free labour to many welfare services and this is still the case, with organisations raising vast sums of money through donations in orc er to obtain matching government grants.

Therefore, all four of these elements of the Australian political context are important to understand the major shifts in aged care policy that have impacted on nursing homes. These major p olicy shifts are presented later in this chapter in a series of policy phases exhibiting the different economic systems that reflected the values and beliefs which were c entral to the community at the time.

Australia's Market Capi alist Economy

In the real world, economies lie between the extremities of pure capitalism on the one hand and the dictates of a communist economy on the other. The Australian economy while capitalist in ori entation, is generally referred to as a contemporary market capitalist economy or a mixed economy. This acknowledges the fact that government plays an active role in our economy by providing various goods and services which, if the market were left alone, would otherwise be either under produced or not produced at al . This promotes economic stability and growth for

the country. The Australian economy cannot be a pure market economy in which market forces of supply and demand determine the allocation of resources and distribution of production because of the size of government intervention taking place and also because of the establishment of economic power by not only government but also private businesses, unions and various pressure groups within society (Jackson & McConnell 1987:27).

Image of the Aged in a Capitalist Society

Gibb (1990:14) undertook a survey of certain print media from 1986 to 1989 and argues 'the themes which dominated news coverage of aged people represent a prevailing model of ageing within modern capitalist technocratic societies.' She continues: 'These images can be gathered together as concatenations of dominant discourses within this society, that do much to shape the social reality of old people within it' (1990:14). The dominant medical discourse, for example, revolves around diseases and disorders in the elderly person and the doctor, rather than being responsible for old people, is characterised as having responsibility over old people. The dominant bureaucratic discourse more recently has concentrated on economic priorities in service planning. Gibb believes that the contributions of these two discourses form a dominant social or 'market place' discourse where elderly people are not to be trusted with the economic responsibility of their own lives, and where relatives take responsibility for the elderly person. Gibb (1990:15) continues:

> The discourse also states that physical welfare is paramount. Hence it is considered preferable that physical conditions of living be maintained, even at the cost of the quality of psychological wellbeing. The mindset of a technocratic society, where material indicators of wellbeing take precedence over other criteria, fits well the view that nursing-home institutions are the final sanctuary for people no longer economically productive — as defined within the labor market.

Understanding the Australian political and economic system during the period of study allows us to turn to an examination of five major phases of aged care policy within Australia over the last 30 years.

MAJOR PHASES OF AGED CARE POLICY

The history and evolution of aged care policy formation and implementation may be described in major policy phases which may be linked with the ideological approach favoured by the Commonwealth Government in power at the time. These phases of aged care policy are defined by major shifts in policy directions by governments which in turn have impacted on nursing home bed provision (Howe 1990). Laver (1983:110) argues that health as a policy area will tend to be among the things that will change with a change of government. This is true in the Australian nursing home industry where major shifts in policy directions over the last 30 years have impacted on several aspects of nursing home bed provision. There are at least five factors which may be considered. They concern: firstly, the changes in patterns of utilisation; secondly, the rate of growth; thirdly, the balance between public, private and voluntary provision; fourthly, the cost of services; and, finally, the level of quality of care.

The six phases to be considered in discussing the major changes to aged care policy are:

Phase 1	Insurance-based Health Service— *Laissez-faire* Approach	(Prior to 1962)
Phase 2	Minor Subsidy Intervention Approach	(1962 to 1968)
Phase 3	Major Cost-sharing Subsidies, Minor Regulations, Minor Inquiries	(1969 to 1971)
Phase 4	Minor Regulatory Approach	(1972 to 1981)
Phase 5	Major Public Inquiries and Reports	(1981 to 1985)
Phase 6	Major Regulatory Approach— Aged Care Reform Strategy	(1986 to 1993)

Phase 1—Insurance-based Health Service— *Laissez-faire* Approach (Prior to 1962)

Prior to 1962, private voluntary insurance was the linchpin of health services in Australia. Those who could not afford health insurance or were 'bad risks' were

unable to gain access to such benefits. Therefore, during the Second World War, attempts were made by Labor Governments to introduce a free national health service. In 1944, endeavours to introduce the Pharmaceutical Benefits Act were opposed by the medical profession such that a later High Court declared that parts of the new scheme were unconstitutional. The Government held a national referendum seeking to amend the Constitution to allow the Commonwealth to possess power to legislate on various kinds of health and welfare payments. However, the Government failed to achieve a majority of support from the public. In 1946, some two years later, the Government held a further national referendum. However this time included the condition that such benefits be paid to individuals. This referendum was won. New endeavours were put into action to establish a national health scheme and although opposition from the medical profession was still forthcoming, Chifley's Labor Government introduced a National Health Service Act in 1948. Intense opposition continued and very little of the Act was implemented as in December 1949, Menzies' Liberal and Country party coalition won power at the election polls.

In 1950, an editorial in the *Australian Medical Journal* stated that the council of the British Medical Association (Australia) faced not only a new government but also:

> a new minister who is a highly trained medical man with years of experience of practice. The minister says plainly that he wishes to see the point of view of the medical profession (18 February, 1950:235).

The new Liberal coalition's minister was Earle Page, an eminent surgeon, who, not surprisingly, adopted the principle of voluntary private health insurance although he had been a longstanding advocate for compulsory health insurance. Insurance companies constituted the mechanism by which the Government's health insurance scheme would operate. However, the previous problems of the uninsured not being covered for medical and hospital costs were still present.

The first part of the insurance-based health service concentrated on hospitals. Since 1948, the Government had been paying eight shillings (80 cents) a day towards

patients in public wards and approved private hospitals. This was to continue as the 'ordinary benefit' and a further additional 'incentive benefit' of 4 shillings a day was payable for those privately insured patients who received a private benefit of six shillings a day (Commonwealth Department of Health, *Annual Reports of the Director-General of Health,* 1954–1956). The combination of these benefits almost met the normal cost of a public ward. The second part of the insurance-based health service concerned medical service costs. The National Health Act of 1953 provided an extensive list of Commonwealth subsidisation that would cover the costs of general practitioner services. In 1954, the Commonwealth enacted the Aged Persons' Home Act which allowed religious and charitable organisations to build nursing homes.

Overall, this insurance-based health service had not overcome the problem for those who could not afford health insurance, for those who were considered 'bad risks', the elderly and the mentally ill. Hence, in 1951, the Pensioner Medical Service (PMS) was introduced which specifically provided the elderly with free medical services in the community but did not provide them with any benefit for care received in hospitals. Even though those who received the PMS benefit were eligible for the 'ordinary hospital benefit' and the 'incentive benefit', because they were not privately insured, they did not receive the 'private benefit' and therefore still did not have sufficient funds to cover the full costs of hospitalisation.

The distress and suffering of the elderly and the chronically ill who were excluded from full hospital insurance cover were frequently raised not only by journalists but also in Parliamentary Debate and finally in 1959 the Government introduced arrangements which allowed the costs of hospital care for the chronically ill to be paid from a 'special account' by the Commonwealth. However, these new arrangements still did not provide sufficient funding for two other groups, namely, uninsured elderly who were not chronically ill but required hospitalisation and uninsured elderly people who were being cared for in convalescent and rest homes

as well as nursing homes. These institutions were not eligible for even the hospital benefits as they were not classified as hospitals. Therefore, elderly people living in these institutions often relied upon their savings or assistance from their families in order to meet their costs. Even for the elderly who were privately insured, the benefits would cease after 84 days of long-term care. Another cause for concern was the increasing numbers of chronically ill pensioners who were being cared for in hospital beds rather than in more appropriate environments (Parker 1987).

Hence, the arrangements during this period proved increasingly unsatisfactory and the grounds for policy change may be summarised as follows:

(i) Many people who did not qualify for the Pensioner Medical Scheme (PMS) benefit faced increasing costs when requiring lengthy stays in hospitals, if they had not taken out private insurance, or could not afford to.

(ii) Many conditions were required by the health insurance funds such as maximum periods of payment and maximum payments such that extended stays even for insured patients were overly costly.

(iii) People who could not afford long-term hospital care were discharged to convalescent and rest homes which were not recognised for insurance purposes and provided enormously varying standards of care.

(iv) Increasing numbers of chronically ill pensioners were being cared for in hospitals beds rather than in more appropriate environments.

In 1962, these problems came to a head and the Liberal Government finally introduced a nursing home subsidy of 20 shillings ($2) a day for each resident living in a nursing home. This issue is taken up in the next phase of aged care policy.

Dominant Public Discourse of Self-help and Private Enterprise

Throughout this period, the themes which dominated the public discourse revolved around self-help and private enterprise. Prior to 1962, the conservative *laissez-faire* approach of administrations of the Liberal coalition, with their ideology grounded

in self-help, encouraged people to obtain their entitlements to Commonwealth benefits 'by their own efforts' (Commonwealth of Australia, Parliamentary Debates (Representatives) 1962). The Government relied heavily on the private insurance-based funding mechanism for hospital and medical services. However, the major problem for the Government was finding a means of encouraging people to take out health insurance voluntarily rather than requiring them to do so through compulsion. Uninsured people who were deemed 'bad risks' by insurers or who were unable to afford private health insurance experienced many cases of extreme hardship. The uninsured elderly and chronically ill who were excluded from full hospital insurance cover relied heavily on their own savings or called for help from their families if they required long-term care as the full cost was not covered.

During this period, the question of how disadvantaged elderly groups within society could achieve benefit entitlement for long-term care was the principal concern to administrators rather than a concern for the quality of services provided. The concern for the funding of services was paramount. The quality of care which was provided within institutions was not an issue. The mystique held for the technical knowledge of the medical professional prohibited any questioning of the quality of services.

Dominant Medical Discourse of Choice

Sax (1984) explains how the 'strife of interests' in Australia arose as discussion around national health insurance emerged and Dewdney (1984) discusses the long history of obstructionism on the part of the medical profession. During this period, the Australian medical profession had close links with the British Medical Association (BMA). Britain had recently moved to a new national health service and the BMA were very keen not to see Australia go the same way. The influential and powerful medical profession was ardently opposed to the introduction of a free national health service because of perceived threats to control over their private provision of medical services. The Liberal coalition party had provided support to

the medical profession's ideology because of the strong similarities to its own emphasis on deservingness and choice (Crichton 1990:42).

Hence, in 1949, the Labor Government having outlined its plans for a comprehensive national health service was subsequently defeated at the polls. The political power of the medical profession reached its peak between 1946 and 1953 when it not only caused the enacting of the Constitutional Amendment, Section xxiii (A) but also steered the introduction of the conservative Earle Page Plan (Parker 1987). It was seen that doctors were the 'experts' and they had the technical knowledge.

According to Foucault (1972:51) 'medical statements cannot be dissociated from the statutorily defined person who has the right to make them, and to claim for them the power to overcome suffering and death.' A Foucauldian perspective would suggest that the medical profession, while being qualified to make statements about medicine, used their medical status as 'experts' to achieve their own political agenda of supporting private practice rather than a national health service which may have led to a reduction in their independent status and possibly their income capabilities.

The medical profession recognised the plight of the elderly and chronically ill, as in May 1950, the editor of the *Australian Medical Journal* wrote:

> ... we plead for special institutions, which are more than hostels, where they may be nursed and treated ... it is right that we should do this, especially when we find that they occupy beds in which acutely ill patients should be placed (Editorial 1950:601).

Doctors were not concerned with the hardship of the old and chronically ill who did not have entitlements to benefits to cover their long-term care requirements but rather were more concerned with insufficient access for their other patients to acute beds in hospitals.

The medical discourse was extremely influential and powerful during this period. Within the medical discourse, a preference for private interests and choice by doctors resulted in the elderly being used as pawns in an ideological battle. Doctors wanted to be able to choose who they would and would not treat. They did not want to treat the elderly or chronically ill in hospitals. They would not co-operate with the implementation of the National Health Act, 1948 and gave support to the Liberal party move to gain power in order that their own private practices would not be altered.

Phase 2—Minor Subsidy Intervention Approach (1962–1968)

In 1962, the Commonwealth introduced the Nursing Home Benefits Scheme which ensured payment of benefits to the elderly and chronically ill regardless of their pension status or their participation in private health insurance. The introduction of this benefit had a dramatic impact on the pattern of nursing home provision, particularly in the private sector. Between 1963 and 1968, there was a 24 per cent growth in the number of approved nursing home beds with the private sector accounting for 95 per cent of the growth. During the same period, the cost of nursing home benefits rose by 37 per cent. A steady increase in the proportion of expenditure was directed to the private sector which made up nearly 70 per cent of the bed numbers by 1968 (Commonwealth Department of Health, *Annual Reports of the Director-General of Health*, 1963 to 1986).

Earlier private nursing homes were established along the lines of cottage industries. Large older homes were used as convalescent or rest homes and were owned and managed by retired nurses and matrons. With the introduction of the Nursing Home Benefit, the actual size of nursing homes increased as more entrepreneurs entered the market. Only residents in facilities that were specifically approved as nursing homes were paid benefits. The subsequent variation in types of facilities that fell into the nursing home category was due to two major factors. Firstly, many long stay wards of public hospitals and many small private hospitals which really

provided long-term care rather than acute care changed from hospital funding to nursing home funding. Secondly, approval of the facilities was the responsibility of State Governments which allowed for enormous variation from state to state in the definition and types of staffing levels (Howe 1990).

The introduction of the Nursing Home Benefits Scheme impacted on both the supply of and demand for nursing homes throughout Australia. The supply of nursing homes was assured with the introduction of the Nursing Home Benefits Scheme. The nursing home industry came to be viewed by entrepreneurs as a lucrative low risk industry. There was very little risk of bad debts with income assured as Commonwealth benefits were paid directly to nursing homes and, together with the residents' age pension supplementation, proprietors were ensured of a ready supply of applicants who all had the ability to cover the costs of care. There were no conditions, regulations or limitations placed upon proprietors who entered the market and, therefore, if a resident's condition improved there was no incentive for the nursing home to transfer the resident home. Therefore, large waiting lists appeared. During the Parliamentary debate of the 1962 Bill, the opposition spokesman on Health, Allan Fraser, had raised such concerns and argued that: 'the person who most needs attention ... will not get into a nursing home ... because the person who needs the most attention will cost the proprietor ... the most in nursing care' (Commonwealth of Australia, Parliamentary Debates (Representatives) 1962). The availability of Commonwealth benefits also encouraged benevolent groups to enter the market and the number of religious and charitable nursing homes also grew.

With regard to the demand side, Parker (1987:16) provides a number of explanations for the increase in demand for nursing home places during this period. Firstly, between 1961 and 1966, the number of people aged 65 years or more rose by 10 per cent and those of 75 years and over grew by 22 per cent (Australian Bureau of Statistics 1982:5) Secondly, large numbers of patients from State funded

hospitals and mental institutions were moved to the Commonwealth funded nursing homes, thereby transferring responsibility of funding from the States to the Commonwealth. Evidence from the McLeay committee in 1982, reported on the:

> ... concerted action by some states to move busloads of people out of their mental institutions into big boarding houses. They immediately approved these as nursing homes ... this added thousands to the nursing home field (McLeay 1982:13).

Thirdly, increase in demand came from a lack of suitable alternatives within the community which would have enabled some of the elderly to stay in their own homes or be cared for by their families. Other than the home nursing support, little Commonwealth provision was made to encourage the provision of other alternative forms of provision. Fourthly the establishment of 'private' nursing homes lessened the stigma of sending one's relatives to a public nursing home and therefore more people chose to place relatives in nursing homes than previously was the case. Lastly, many doctors had financial interests in nursing homes which may have increased the demand for places in nursing homes. The later McLeay Report (1982:81) viewed doctors who owned nursing homes as having a 'conflict of interest' and recommended:

> Each non-governmental nursing home be required to make publicly available and provide to potential patients the names and addresses and occupations of all substantial beneficial owners of the home and the proportion owned.

As fees in private nursing homes increased, many residents found themselves unable to meet the widening gap between the combined amount of their Commonwealth benefits/pensions and the actual fee charged by proprietors. The arrangements during this period proved increasingly unsatisfactory and the grounds for policy change may be summarised as follows:

(i) Some highly dependent residents were being asked to leave nursing homes when they required more intensive care. Nursing home proprietors found it too costly to provide intensive care as it would reduce their profitability.

(ii) Those residents with limited resources were strongly disadvantaged as they were unable to meet the widening gap between the Commonwealth benefits and pensions paid and the fees charged by the nursing home proprietors.

(iii) There was no control of the amount of fees that could be charged and residents were increasingly being required to rely on their own private savings or the help of families.

(iv) There was a problem of how to prevent the variability of standards of care in differently funded nursing homes. There was no incentive or requirement for proprietors to be concerned with the standards or quality of care provided to residents.

(v) There was also no incentive for rehabilitation as full occupancy of a nursing home was required to maintain a steady flow of income.

(vi) Both residents and proprietors believed the health insurance system to be unjust as those who had paid into hospital health insurance funds for many years were unable to reap the benefits when they required nursing home care as the additional Commonwealth benefits were only paid whilst in hospital.

(vii) Large multi-level aged care complexes were developed which provided accommodation in the form of supervised housing, hostel beds and nursing home beds. Many elderly and chronically ill were required to make substantial donations to these organisations in order to gain entry. Residents would progress through the different levels and therefore the nursing home beds could be accessed only by those who were already part of the overall complex (McLeay 1982:55, 63).

(viii) The need for policy change became increasingly evident due to the pressure of rapidly rising health costs for the Commonwealth.

Dominant Public Discourse: The Elderly as Private Sector Revenue Earners

Within the public discourse, funding priorities to provide health services for the uninsured old and chronically ill resulted in the Government relying on private enterprise to provide long-term care for the aged and thus the elderly and chronically ill came to be regarded by the Government as revenue earners for private enterprise. With the assurance of Commonwealth benefits from a Liberal

Government who was opposed to a comprehensive national health service, entrepreneurs as well as religious/charitable organisations flooded into the nursing home industry.

After the introduction of the Nursing Home Benefits Scheme in 1962, the Government took very little part in other policy development. The Government believed that the self-interest of profit-seeking private entrepreneurs, together with the benevolence of religious/charitable organisations who were entering the nursing home industry, would unconsciously provide sufficient provision of nursing home beds to the community. This *laissez-faire* approach proved increasingly unsatisfactory as it allowed the number of facilities to grow without any control over distribution of facilities or quality and standards of care provision.

Dominant Medical Discourse:
The Elderly as Threats to Hospital Bed Availability

In general, doctors primarily provide medical and surgical services for our society. However, they are also businessmen and businesswomen who are interested in earning an income. The Liberal Government policy which encouraged growth of nursing home provision through the private sector fitted well with the private enterprise basis of the medical profession.

During this period, within the medical discourse, the major priorities of the medical profession were access to hospital beds and the elderly and chronically ill posed a threat to such bed supply. Income was to be made by admitting patients to hospital, and clogging up hospital beds with the elderly and chronically ill who the medical profession could no longer 'cure' meant a threat to doctors' income.

Therefore, doctors became entrepreneurial and moved into partnerships to establish nursing homes. This meant they could move their patients out of hospital to their own nursing homes and be assured of further income because of the flow of Commonwealth benefits to nursing homes. Public perception of private nursing homes was high and they were assured of a steady flow of applicants to keep the

beds and bank accounts filled. There was little public concern for the type of facilities available or where they were situated, or the quality or standard of care provided.

Phase 3—Major Cost-sharing Subsidies, Minor Regulation, Minor Inquiries (1969–1971)

In 1967, the Labor opposition had argued fiercely for a Senate Select Committee to investigate the hospital and medical insurance industry. During a Senate Debate Murphy argued 'it appears that again the burden will fall on the ordinary citizen in a way which is quite contrary to what was envisaged when the scheme was set up' (Commonwealth of Australia, Parliamentary Debates (Senate) 1967).

The Liberal Government responded by setting up an independent review over which Mr Justice Nimmo presided. However, during the third discussion of the health insurance issue in the Senate, the Labor Government was finally successful in winning the motion to establish the Senate Select Committee and it was subsequently established with Dame Ivy Wedgewood, a Liberal member, as its chair. Therefore, during 1963 and 1969 two major inquiries to specifically investigate the hospital and medical insurance industry were undertaken though reported only briefly on issues regarding nursing home provision.

The rapid growth in the number of nursing home beds and the difficulty with nomenclature were major concerns of both the Nimmo (1969) and Wedgewood (1969) committees. In March 1969, the Nimmo committee report extended its comments to include difficulties with the varying standards of nursing homes. Comments included: 'the accommodation is poor, the food unattractive and monotonous, the treatment almost wholly confined to the administration of drugs and a large proportion of patients become prematurely ... bedridden' (Nimmo 1969:57).

Regarding the confusion of nomenclature surrounding nursing homes, some nursing homes were registered by State Governments as hospitals, and therefore

the term 'hospital' took on several different meanings for the various states and the Commonwealth. The Nimmo committee recommended that 'joint remedial action' be undertaken between the Commonwealth/States in order to end the variation of standards of facilities and the confusion with nomenclature (Nimmo 1969:57).

In 1970, the Wedgewood committee although concerned with the rapid growth of nursing home beds continued to support the need to transfer nursing home type patients out of high cost hospitals to lower-cost nursing homes. The committee recommended that Commonwealth grants to the states be expanded to further facilitate the availability of nursing home beds. They also recommended that a nursing home insurance system be established in order to allow people to insure for nursing home cover (Commonwealth of Australia 1970).

Private nursing home proprietors were able to charge whatever fees they liked and the difference between the benefits and pensions residents received and the actual cost of care provided was becoming increasingly wider. Private nursing home proprietors and health insurance funds complained to the Wedgewood committee that many residents were unable to pay their accounts as they could not claim nursing home care from their hospital benefits fund. The Wedgewood committee heard evidence from many pressure groups including the Hospital Benefit Fund of Western Australia, Private Hospitals' Association of South Australia and the Australian Association of Social Workers. Two nursing home matrons provided evidence about the difficulty of accessing beds for pensioners with limited resources and the refusal of some nursing homes to take residents unless they were sufficiently ambulant and independent. Further, the *Annual Report of the Director-General of the Commonwealth Department of Health,* 1968-69 reported on the 'shortage of low-cost nursing home accommodation of acceptable standard' (Commonwealth Department of Health 1968-69:15).

In 1968, the Liberal Government identified both residential care and community-based care solutions to the problems surrounding nursing home bed provision. The

residential care solutions were embodied in two separate pieces of legislation: the National Health (Amendment) Act, 1968 which commenced in 1969 and the States' Grants (Nursing Homes) Act, 1969. The National Health (Amendment) Act, 1968 provided a supplementary nursing home benefit of $3 a day (to the existing $2) for 'intensive' care residents and required a medical practitioner's certificate in support of claims. Lawson (1972), describing the difficulty with estimating the nursing home bed requirements, calculated approximately 25 per cent of nursing home residents at the time did not actually require nursing home care. It was very difficult for the highly dependent to obtain admission to a nursing home bed. Therefore, in order to gain entry, many people sought admission far earlier than was actually necessary. As Parker (1987) pointed out, it was thought that providing an increased subsidy for the elderly requiring 'intensive' care might delay their admission into a nursing home until they were sufficiently dependent to qualify for the extra benefit.

The States' Grants (Nursing Homes) Act, 1969 provided $5 million to the states to encourage additional state-provided nursing home beds. Commonwealth grants were provided over five years on a 50-50 matching basis and contributed to the subsidisation of the capital costs of State nursing homes. During the second reading debate of the Act, Forbes, the then Minister for Health, argued the need for such state-provided places because the sick aged 'were unable to afford the charges made by the more expensive privately run nursing homes' (Commonwealth of Australia, Parliamentary Debates (Representatives) 1969). Thus, these state-provided beds were to be earmarked for those with few financial resources and in genuine need of nursing home care. The Commonwealth believed that the States, by taking up the capital grants would solve the difficult access problems of the highly dependent gaining entry into nursing homes. The 1000 bed target for bed provision was achieved in just three years; however, it did not require the $5 million as earmarked. Only $2.7 million was taken up by the States

(Commonwealth Department o ' Health, *Annual Reports of the Director-Generall of Health*, 1971-75).

The second part of the Liberals' policy strategy was to focus on community-based services through the introduction of both the States' Grants (Home Care) Act, 1969 and the States' Grants (Parame dical Services) Act, 1969. The former Home Care Act provided for housekeeper and home-help services for the frail aged in their own homes, as well as for the development of senior citizens' centres where trained Welfare Officers were available. The States were asked to match the Commonwealth payments by two-thirds for capital with operating funds matched 50-50. The later Paramedical Services Act provided for certain paramedical services such as physiotherapy, chiropody and occupational therapy and were matched 50-50 with Commonwealth funds. Kewley (1973) pointed out that the States were very slow in taking up these Grants. Queensland and South Australia were the first to accept the States' Grants (Home Care) in 1969, with Victoria, New South Wales and Western Aust alia following in 1970. The States were far slower in taking up the States' Grants (Paramedical Services) as only South Australia and Tasmania took up these Grants.

In 1969, the Liberal Government also introduced the Delivered Meals subsidy which was to assist in the provision of the Meals on Wheels service; however, rather than providing funding to the States, the Government delivered the subsidy directly to the voluntary organisations because it 'must have foreseen that the progress of its cost-sharing home-care programme would be uneven and slow' (Parker 1987:27). Brennan (1983) argued that the matched funding incentives were all in the wrong direction. State Governments were discouraged from funding community service projects as the Commonwealth provided too strong a disincentive by fully funding institutional care.

Between the years 1964 and 1968, the number of private nursing home beds rose by 53 per cent. Following policy changes in July 1969, the rate of growth of

nursing home beds increased a further 36 per cent by 1972. The mean annual rate of growth of private nursing homes between 1964–1968 and 1969–1972 rose from 10.6 per cent to 12.1 per cent respectively (Commonwealth Department of Health, *Annual Reports of the Director-General of Health*, 1969–1972). Even though uneven standards of care were a problem for the Liberal Government, the Commonwealth's funding of nursing homes would prove a far greater problem and so the energies of the Government were directed towards reigning in the cost provision at the expense of quality provision. Kewley (1973:537-8) comments:

> The number of nursing home beds per 1000 of the population rose from 2.3 in 1963 to 3.7 by 1971. A consequence was that Australia had the greatest number of people in nursing home beds per head of population in the world. The increase in the number of beds occurred mainly in the private or profit sector and especially in New South Wales.
> There was probably no expectation at the time this benefit was introduced that by 1972 Commonwealth expenditure upon nursing home benefits would be almost three times as much as ... on hospital benefits for insured patients.

By 30 June 1972, there were 47.5 nursing home beds per 1000 population aged 65 years and over, and, more alarmingly, 138.5 nursing home beds for every 1000 people aged 75 years and over. McMahon's Liberal Government remained firmly committed to the private and voluntary sector provision of nursing home beds and was reluctant to move away from that stance. However, the Government was alarmed at the enormous funding implications to them if they were to continue with such a stance. The centre of McMahon's difficulties lay with the unwillingness of the State Governments to take up grants to improve community-based services which would have eased the demand for nursing home places. State Governments were afraid that insufficient funding would be forthcoming from the Commonwealth if they were to undertake such community-based projects as were being encouraged by the several new Acts of 1969. In 1972, these problems came to a head and the Liberal Government finally announced new legislation which endeavoured to bring the escalation of costs and provision of nursing home beds under control.

Dominant Public Discourse:
Economic Incentives to Prevent a Private Sector Retreat

The Nimmo committee (1969:57) specifically alerted the Liberal Government to problems surrounding the varying standards and poor quality of care provided to nursing home residents. However, the Government was reluctant to undertake major intervention into the operation and management of nursing homes, preferring to concentrate on the broader issues of providing capital infrastructure and increasing subsidies. Throughout this period, the themes which dominated the public discourse revolved around economic incentives to prevent a private sector retreat from nursing home bed provision. Funding priorities were the key focus of the Government and resulted in the Liberals relying on increased subsidies and grants to entice proprietors to improve the standard and quality of nursing care within nursing homes rather than initiating regulatory control measures.

The establishment of the two tier system through the 'intensive' nursing care subsidy, gave the Government some breathing space as they were not required to provide increased subsidies to all residents but, rather, only to those who were categorised as requiring 'intensive' care. By making two levels of funding, the Government would only need to increase benefits for a small proportion of the population rather than increase benefits for all residents. Parker (1987) suggests the new $3 per day subsidy to 'intensive' care nursing home residents cost about $15 million per year, whereas if the Government had increased the $3 per day subsidy to all nursing home residents the cost incurred would have been in the order of $35 million per year.

The question of how to ensure that private providers of nursing home beds would remain in the industry was of foremost concern to the Government rather than a concern for the quality and standard of care provided within the nursing homes. If the private sector withdrew its investment in the nursing home industry, the

Government would have required a massive amount of capital funding to inject into the States to establish further nursing homes.

The Government remained focused on providing economic incentives to the private sector to continue nursing home bed provision while leaving the provision of the quality and standards of such provision to the individual proprietors to determine. It was thought that providing the additional supplementary benefits to nursing homes for 'intensive' care residents would give the Commonwealth Government stronger leverage to require nursing home proprietors to employ more highly skilled staff and improve the standard and quality of care. It was hoped that the increase in funding for 'intensive' care residents would stimulate proprietors to increase the overall standards and quality of care provided in nursing homes. However, the major difficulty concerned the lack of control or regulation to ensure this happened. There were no requirements for proprietors to use the money to improve the quality or standards of care and consequently little improvement in the standards or quality occurred.

It was thought that providing capital grants to the States to establish new public nursing home beds for the poor and the needy would improve the quality and standard of facilities available. However, the capital grants encouraged the establishment of a class based system of nursing home bed provision: private and voluntary nursing homes for the rich and state-provided nursing homes for the poor. Therefore, the energies of the Government which were primarily directed towards reigning in the cost of providing care were expended at the expense of adequately ensuring quality care provision.

Dominant Medical Discourse: Fee for Service

Within the medical discourse, financial priorities to ensure residents of private nursing homes were able to meet the cost of fees charged by proprietors, resulted in the medical profession supporting the policy directions of the Government. The

medical profession was reluctar t to come under scrutiny through the imposition of regulatory standards in the nursing home area.

Once entering the nursing home, the destiny of the resident was placed in the hands of the nursing staff and, therefore, both residents and their families were reluctant to complain about the quality or standard of care given by the nursing staff for fear that their stay may be made more difficult or that they may be asked to leave the nursing home. Residents who became too ill were often asked to leave and relatives feared if they complained about the care provided they may also be asked to move their relative to another home This posed an enormous problem for relatives, firstly, because of the initial difficulty in finding a nursing home bed, and, secondly, in the case of a voluntary nursing home, the initial large donation paid to gain entry would be lost.

Chapter 6
(Part B)

DOMINANT DISCOURSE WITHIN AGED CARE POLICY IN AUSTRALIA 1963–1993
Phases 4–6 (1972–1993)

Phase 4—Minor Regulation Approach (1972–1981)

This period commenced with the Liberal Commonwealth Government turning to regulation to curb the difficult problems of rapid growth of beds, escalating expenditure, lack of control over admissions to nursing homes and the dilemma of interstate variations in fees and benefit levels that had developed. In October 1972, with the support of the opposition, McMahon's Liberal Government passed the National Health (Amendment) Act, 1972 which focused on three new areas of supervision to bring the industry under control. Firstly, to lessen the gap between Commonwealth subsidies and fees charged to residents, proprietors were offered increased subsidies only if they agreed to fix the fees charged to residents at the amounts charged at the end of June 1972. Secondly, regulation of the admission of residents into nursing homes was undertaken by requiring a medical practitioner to certify the need for placement. Thirdly, regulation of the approval of the location of new nursing homes was undertaken to provide a better distribution of places throughout the nation (Crichton, 1990). However, in November 1972, the Liberal Government was defeated at the polls and the incoming Whitlam Labor Government was left to implement the Act.

Whitlam's Labor Government was presented with not only an escalating nursing home subsidy bill but also faced a nursing home industry which lacked control over its activities and location. There was no accountability of service providers for

use of Government funds and no responsibility to provide services to local consumers as there was a lack of controls over standards or quality of care provided to residents and a lack of regulations to stipulate where new nursing homes should be established. The average weekly cost of nursing home bed provision differed markedly from state to state; for example, Victorian fees were 28 per cent higher than the average of the other states (Commonwealth of Australia, Parliamentary Debates (Representatives) 1972).

The change to Labor ideology brought with it growing fears amongst private nursing home proprietors and the medical profession of the introduction of increased regulations and controls. The medical profession was especially not keen to have Labor bureaucrats altering their Earle Page Plan. They feared Labor might try to re-introduce nationalised medicine and, in particular, nationalise private nursing homes. During the 1960s, the medical profession had established a strong history of deliberate non co-operation with any Government which tried to implement any policy which was not acceptable to it. Mathews (1974) described the manner in which the medical profession had devised an energetic plan, during 1962, to fight against nationalised medicine.

The new Labor Government had attracted, as Graycar (1976) calls them, 'the conscience lobby' who were largely intellectuals frustrated by the previous ineffective Liberal policies which had failed to solve the many problems of need within the Australian community. Through social research projects, academics proved linkages between poverty, poor education, poor housing, and unemployment with illness and chronic disease as there were still vast numbers of the Australian population in need (Crichton 1990). These Labor organisational reformers were mainly frustrated academics as well as administrators who had been hindered in their attempts to change the organisational design of health and social services in an effort to improve funding and service delivery. The reformers did not belief that the Liberal strategy of reliance on market forces would achieve the

the necessary redistribution required to provide services equitably and efficiently to neglected minorities. The new Labor reform strategy emphasised more universality of service provision while encouraging public administration of facilities.

In an era of reform, the Labor Government sought to encourage community-based services in an attempt to keep the elderly out of nursing homes. However, the States were reluctant to assume responsibility for community-based service provision, and were slow to take up grants. During their three years in power, the Labor Government introduced additional grants under the States' Grants (Home Care) Act, 1973. The former $1 for $1 matched funding was made far more attractive to the States by being increased to a $2 for $1 arrangement and was later raised to $4 for $1. Also, the new Community Health Program was introduced, providing 100 per cent funding for community projects.

The Labor Government endeavoured to shift the balance of nursing home bed provision away from the private sector towards the voluntary sector. In 1974, the Government introduced the Nursing Homes' Assistance Act, 1974 which provided funding for the deficits incurred by voluntary non-profit nursing homes. This deficit-funding also included the costs of transporting the elderly to nursing home centres where physiotherapy, occupational therapy and chiropody were made available. All these services were deficit-financed and, therefore, voluntary nursing homes also became sites for community service provision. Thus, the Commonwealth, by providing funding directly to voluntary nursing homes to supply community services, was able to bypass the states who had been slow to assume responsibility for providing community-based services. Voluntary nursing homes increasingly were able to provide a range of services to those who gained entry, whereas the private sector who only received the Commonwealth subsidy were more restricted in their service provision. Many private proprietors moved out of nursing home provision as they were unable to increase their fees and sustain sufficient profits. The Nursing Homes' Assistance Act, 1974 had freed the

voluntary sector from former requirements under the Aged Persons' Homes Act, 1953 to provide hostel accommodation wherever they provided nursing homes. This left the way open for voluntary organisations to apply for capital grants to purchase these private nursing homes and together with the deficit-financing arrangements were able to provide a range of services to their residents.

The Labor Government thought the voluntary sector with an ethos of benevolence would provide more beds to the poor and needy and would be more conscious of the quality and standard of care provided to residents than their profit-seeking private sector colleagues. Unfortunately, this was not to be the case, as the voluntary sector, with an increased ability to provide extra paramedical services through deficit-funding, continued to attract middle class people of the religious inclination of the organisation who could afford to make an initial sizeable donation upon entry into the nursing home.

Indeed, between 1972 and 1975, the new attempts at regulatory control resulted in a decrease in private sector provision. However, the new arrangements did not have the desired affect of controlling expenditure and growth as intended because they lacked the strong cost controls needed. The new arrangements, when combined with the capital subsidies which were opened up to the voluntary sector, saw more of an increase in provision of beds and payments to the voluntary sector rather than to the private sector (Howe, 1992).

During 1973-1975, the Australian Medical Association (AMA) fought hard to prevent the Labor Medibank proposal from becoming established (Glasner 1978). Glasner (1978) suggests that the AMA was pressured into resistance of the Medibank plan by their right-wing activists who feared that AMA's negotiators were becoming 'too close' to the government's negotiators and would not fully represent their interests. Crichton (1990:74) comments:

> The authority of the core group of the AMA had been challenged by the breakaway of the General Practitioners' Society in Australia when the Nimmo Report was implemented in 1968. In 1973, that agreement

> was up for review and while it was a completely separate issue from Medibank, the two issues coinciding put pressure on the negotiators.

Interestingly, two per cent of the right-wing 'radicals' supported the Community Health Program which most doctors opposed and, therefore, there was a rift even within the right-wing arm of the medical profession. This placed the AMA negotiators in an awkward position. The AMA subsequently renewed old ties with their Liberal party colleagues who held power in the Senate in order to block any legislation that looked to threaten their private enterprise ideology.

During the period 1972 to 1975, the Labor Government, by simply not approving new nursing home applications, reduced the number of beds to a considerable extent, but with the Constitutional crisis, the Liberals were returned to Government in late 1975, and consequently nursing home approvals recommenced and uncontrolled growth resumed. Parker (1987:4) suggests:

> On the face of it, the halt to the growth of the private sector could be attributed entirely to the imposition of the regulations; but there was also a good deal of fear in the private enterprise field that the Whitlam government would take matters further. The nursing home industry felt insecure and unsettled; the future seemed uncertain. Some sold out, and others hesitated to venture new investments. In this respect it is noticeable that, although the controls continued unchanged during the Fraser administration, after 1976, the return of the Liberals heralded renewed growth in private enterprise nursing homes.

In November 1975, the return of the Liberals to power saw the return of conservatism and an ideological commitment to private enterprise and self-help. The Liberals' major objective was to encourage people to take out private health insurance so payment for health care services would come from the health insurance funds rather than from the public purse (Scotton & Ferber 1980:190). The Liberals were vehemently against any form of compulsory national health insurance, such as Labor's Medibank scheme, and, soon after they gained power, a review of Medibank was undertaken. By modifying Medibank, the Liberals allowed people to move out of the scheme if they preferred to be covered by private health insurance; thereby the cost of the health service provision would be paid for

by the health insurance fund rather than from public funds. The medical profession was strongly in favour of dismantling Medibank also, as they believed it worked against the fee-for-service system on which they based their private practice.

In June 1976, Austin Holmes was appointed chair of a committee to examine the co-ordination and integration of programs for the elderly. *The Report of the Committee on Care of the Aged and the Infirm* was published in January 1977 and, not surprisingly, strongly recommended the 'insurance industry' as the major solution to all the problems concerning the aged and infirm (Holmes 1977). The Holmes Committee (1977:102) provided the following four reasons for choosing such a solution:

(i) Insurance was perceived as the only practical way of reducing the overall Commonwealth expenditure on nursing homes.

(ii) The Government's position to negotiate with the states on cost-sharing would improve.

(iii) Private health insurance would encourage self-help and self-reliance.

(iv) Private health insurance was believed to be a popular solution especially with the medical profession.

It is not surprising that the Holmes Committee's recommendations were strongly supported by a Liberal government possessed by a strong ideological commitment to self-reliance. Subsequently, the National Health (Amendment) Act, 1977 was passed requiring private insurance funds to pay a benefit to any insured elderly resident living in a nursing home. The benefit paid to residents was to be the equivalent of that paid to residents by the Commonwealth nursing home subsidy including the supplementary 'intensive' care benefit. As well, the Act included provision to rename the 'intensive' care benefit to 'extensive' care benefit and also fixed the contribution residents were required to make towards their care at 87.5% of a single person's pension.

The 1977 Act was not well received by the health insurance funds as providing insurance cover for the elderly and infirm proved extremely costly. A sizeable campaign was waged in the media and in Parliament concerning the difficulties the new scheme posed for the elderly. Cass, for the Labor opposition, questioned:

> Why should patients take out private insurance when their nursing home benefits are paid by the government anyway? (Commonwealth of Australia, Parliamentary Debates (Representatives) 1977)

Combined with this, even when residents were insured, there were disincentives for private nursing home proprietors to actually seek reimbursements from health insurance funds for their insured residents. It was claimed that the Commonwealth was unnecessarily paying benefits for residents who were actually insured and should have had their costs paid for from the insurance funds (Ministerial Statement 1981:157). The Auditor-General (1981:90) confirmed this when reporting on an efficiency audit of the Commonwealth administration of nursing home programs:

> There is little incentive for nursing home patients to contribute to hospital insurance funds. There is a disadvantage to the proprietor of the non-Government nursing home if patients are insured as it involves extra administrative effort to claim for the fund for that patient and there is usually a longer delay in receiving payment from funds than from the Department of Health.

Even though there were difficulties with the implementation of insurance-based cover for the elderly and infirm, the Commonwealth Government achieved considerable savings from health insurance funds being involved as the Auditor-General reported that only one per cent of residents in nursing homes were incorrectly classified as uninsured and thus paid by the Commonwealth instead of the insurance funds (Auditor-General 1981:91).

The Government experienced considerable pressure from the media, health insurance funds and the opposition. Firstly, the media criticised the inequitable liability placed on the majority of people with health insurance to support the increasing payment of benefits to the elderly; secondly, the health insurance funds

threatened the Government with the need for increases to insurance premiums to pay for the growing demand; and, thirdly, the opposition in Parliament criticised the very need for people to take out health insurance to cover the nursing home care when the Commonwealth would provide the very same service.

Eventually, in September 1981, the Fraser Government was forced to return to the former policy of the Commonwealth, providing nursing home benefits to all residents in nursing homes. As Parker (1987:53) puts it, the Commonwealth Government's 'flirtation with the hospital benefit funds was short-lived'. Parker believes the principal reason for the willingness of the Commonwealth to agree to resume full responsibility for nursing home benefits was not due to pressure group activity as mentioned earlier but rather was the 'price exacted by the hospital insurance funds for collaboration on ... other fronts' (1987:53) as several months earlier the Health Acts Amendment Act, 1981 was introduced rather painlessly. The Act contained a strong commitment to private health insurance and gave increased support to private hospitals. Also, it required private health insurance funds to accept people with 'pre-existing illness' which was previously not the case (Parker 1987:53).

The increased share the Commonwealth was taking in the provision of health services compared with the contribution made by the States and private sector alarmed the Government (Commonwealth Department of Health 1980:18) whose overall objective was to reduce public spending. Therefore, in August 1979, the Fraser Government set up a commission headed by Jamison, to investigate the efficiency and administration of hospitals (Jamison 1981). In 1981, the Jamison Committee reported and found there had been an overall increase in the proportion of expenditure on institutional services. General hospitals accounted for the majority of institutional outlay (64 per cent); however, nursing homes were the second highest proportion (15.5 per cent), then mental hospitals (9 per cent), private hospitals (8.5 per cent) and finally repatriation hospitals (3 per cent)

(Jamison 1981:15). Thus, nursing homes remained high on the Commonwealth agenda. Sax (1993:88) believes:

> Government policy guidelines were too few and too imprecise to influence the implementation of what could have been a carefully specified program. The absence of an integrated approach to long-term care resulted in increasing Commonwealth support being directed towards one limb only of what should have been a comprehensive system of care.

Thus, the major grounds for policy change can be summarised as follows:

(i) Uncontrolled growth of nursing home beds.

(ii) Uncontrolled escalation of costs through deficit-funding.

(iii) Voluntary homes catering for the rich rather than the poor and needy.

(iv) Lack of adequate distribution of nursing homes through the nation.

(v) Varying levels of staffing and nursing standards between States.

(vi) Varying levels of community service support for the elderly between States.

(vii) Varying levels of charges between nursing homes providers.

(viii) Varying levels of charges between States.

Dominant Public Discourse:
Provision Based on Ideological Inclination of the Political Party in Power

Within this discourse, the change in political ideology of the incoming Labor Government in 1972 saw a strong shift away from private sector provision. Labor did not wish to encourage private sector provision of health services and, therefore, in order to increase the stock of nursing home beds, rather than increasing funding to the states to provide further public nursing home beds (which would have been extremely costly to the public purse), Labor chose to subsidise the voluntary sector who were capable of raising donations through their organisational structures. Great priority was given to finding solutions to the funding problems of nursing homes and each political party in power utilised their own ideologically driven funding mechanisms. Ensuring an acceptable quality and standard of care was provided to the aged and infirm within nursing homes did not enter into the ideological equation at the time. The standard and quality of care provided was not

questioned — only the ideology upon which the funding mechanisms provided the care was questioned.

In 1975, with Labor's defeat, the discourse reverted to one of reduced Government spending and an increased commitment to self-reliance via private health insurance funds. Interestingly, the deficit funding to the voluntary sector continued; however, this provision was not afforded to hostels or self-contained accommodation which would have encouraged people to remain in their homes as long as possible. Therefore, we see during this period between 1972 and 1981, even with changes in Government, quality and standards of care were still not an issue. Both political parties avoided the issues of quality and standards of care. They avoided questioning the technical proficiency of the medical profession who were an extremely strong and forceful political lobbying force.

Phase 5—Major Public Inquiries and Reports (1981–1985)

In the early eighties, nursing homes received a barrage of bad publicity and were accused of creating 'misery' and 'horror'. Little, if any, documentation was maintained on residents and the quality of care for residents was finally called into question. A series of inquiries and research projects highlighted the need for change and direction in provision for aged care services. Four major inquiries and reports during this period included:

Feb 1981 *Report of the Auditor-General on an Efficiency Audit: Commonwealth Administration of Nursing Home Programs* (chaired by D.R. Steel Craike);

Oct 1982 *In a Home or at Home: Accommodation and Home Care for the Aged* (known as the McLeay Report);

Oct 1984 *Senate Select Committee on Private Hospitals and Nursing Homes* (known as the Giles Report); and

July 1985 *Cost of Nursing Home and Hostel Care Services* (known as the Coopers & Lybrand WD Scott Report).

Each of these reports will now be discussed in turn.

Report of the Auditor-General on an Efficiency Audit: Commonwealth Administration of Nursing Home Programs (1981)

Because of growing concern about the efficiency and cost of Commonwealth outlays, the Government called upon the Auditor-General to undertake efficiency audits. In 1979, the nursing home industry became the focus of the second such audit and by 1981, the *Report of the Auditor-General on an Efficiency Audit: Commonwealth Administration of Nursing Home Programs* (Auditor-General 1981) was published. It reported extremely critically on the fragmentation of Commonwealth programs which were poorly conceived and lacking in defined guidelines. The report commented on the poor management of the nursing home program and pointed to the 'unnecessary expenditure and a lack of consistency in the distribution of Commonwealth assistance to the aged and infirm' (Auditor-General 1981:v). Several major aspects were of concern to the Auditor-General (1981:v-vi) who stated that a lack of an integrated approach to care of the aged appeared to be leading to:

- increasing Commonwealth financial support to high cost institutional nursing care and to a mismatch between the real care requirements of individual patients and the type of care provided;
- weaknesses in nursing home benefit admission controls and control over classification of patients requiring extensive care and hence, additional benefits;
- inadequacies in Commonwealth guidelines leading to lack of economy in aspects of nursing home care including the number of nursing, paramedical and domestic staff and the size and design of homes;
- weaknesses in controls over expansion in numbers of nursing home beds; and
- looseness in departmental systems for containing Commonwealth expenditure through fees control and deficit financing budget controls.

The Auditor-General examined the following range of problem areas within the nursing home program: central management and evaluation; patient admission and classification; standards of nursing home care; control of numbers of nursing home beds; fees control; determining of benefits; and deficit-financing.

The Auditor-General (1981:7) was cognisant of the difficulties associated with Commonwealth/State responsibilities, arguing:

> Effective interaction between Commonwealth departments (Health, Social Security and Veterans' Affairs) in the planning and evaluation of related programs of care for the aged and the infirm is largely absent, although informal liaison occurs. Commonwealth administration is not adequately integrated. Better value for the Commonwealth's health and welfare expenditure on the aged and the infirm could be obtained if related services were planned for and evaluated jointly.

When suggesting the 'use of assessment teams to establish more accurately patients' nursing requirements' (1981:10) the Auditor-General noted:

> A successful Commonwealth strategy would take account of State priorities and planning processes. Incentives to the States (e.g. part financing of assessment teams) could be considered. The co-operation of State Governments and other Commonwealth departments would be essential, perhaps through the forum provided by the present Commonwealth-State Co-ordinating Committees with a suitable broadened charter (Auditor-General 1981:17).

The Auditor-General (1981:20) also drew attention to the problems of financing the various types of nursing homes:

> Present arrangements for controlling nursing hour costs in deficit financed homes led to a higher level of Commonwealth expenditure and inequity between their patients and those in non-Government participating homes. Furthermore, there are no incentives for operators of deficit financed homes to encourage economies in staffing or penalties to discourage excessive staff levels.

However, the report lacked strength in its suggestions for change, merely saying 'there would be merit in a comprehensive policy review of the strategy implicit in the existing framework of Commonwealth funding of nursing home care' (Auditor-General 1981:24).

When examining standards of nursing home care, the Auditor-General reported on the following issues: nursing care and supervision hours; physical facilities; paramedical services; domestic support services; and inspections; however, only a small six page chapter was devoted to all of these issues. The problem of a

standard number of nursing care hours between States featured highly in the report and a number of major problems were discussed:

(i) the varying levels of funding provided by the Commonwealth to the States;

(ii) the lack of uniformity of hours of nursing care provided in non-government participating (private, National Health Act) homes;

(iii) the higher level of funding provided to deficit financed (Nursing Homes Assistance Act) homes compared to non-government homes;

(vi) the lack of State standards for the numbers on non-registered nursing staff hours per patient although this category of nursing staff made up approximately two-thirds of the nursing staff within nursing homes; and

(v) the lack of guidelines to indicate maximum standards to be funded by the Commonwealth (Auditor-General 1981:11).

The report recommended that the Commonwealth Government should 'establish maximum standards for use by assessors in determining the extent of Commonwealth funding of nursing hours above State minimum requirements' (Auditor-General 1981:12). It further recommended that guidelines and standards should be developed for allied health professionals as well as domestic staff. The Auditor-General noted that the implementation of the suggestions outlined above would 'require some re-ordering of priorities and perhaps staff effort from the Department involving additional assistance at least in the short term when standards are being developed' (1981:12).

The Auditor-General's report was referred to the House of Representatives' Standing Committee on Expenditure (1982b). Efficiency audits were comparatively new to Parliament and during the presentation of the House of Representatives' Standing Committee's Review on Expenditure *Review of the Auditor-General's Efficiency Audit* (1982b) to Parliament, Leo McLeay advised that they should 'ensure that an officer who is a statutory office holder does not

start to exercise more power than this Parliament' (Commonwealth of Australia, Parliamentary Debates (Representatives) 1982).

In a Home or at Home: Accommodation and Home Care for the Aged (1982)

In late 1982, the House of Representatives' Standing Committee on Expenditure released the report *In a Home or at Home: Accommodation and Home Care for the Aged* (known as the McLeay Report) which formed the foundation for policies adopted by the incoming Labor Government in 1983. The McLeay Report's recommendations fell into two major categories. The first category was concerned with the changes to aged care programs based on their financial arrangements and functional responsibilities between the Commonwealth and the States. The recommendations were focused 'at removing major problems and anomalies in the administration and delivery of programs, shifting the imbalance between institutional and home care and directing Commonwealth Government assistance for health and welfare to those in greatest need' (McLeay 1982:ix). The second category of recommendations revolved around the Committee's recommendations concerning transferring the responsibility for the administration, delivery and financing of accommodation and home care programs of the aged from the Commonwealth to the States.

The McLeay Report may be criticised for devoting minimal attention to aspects of quality of care for residents living in nursing homes because its major focus, in relation to nursing homes, concentrated on trying to solve the problem of quantifying the number of nursing hours required to deliver a standardised level of care to residents. However, McLeay did report on the difficulties in relation to staffing standards already established by Hospital and Allied Services Advisory Council (HASAC) specifications because of their relationship to nursing hours only, and because of the absence of the mention of any other paramedical staff, domestic staff or other support staff. The report noted:

> The quality of nursing care is considerably affected by the time spent by nurses in non-nursing tasks and the availability of other therapists. It is possible that a greater provision of nursing staff may be less effective in improving care than attention to support staff. The report noted "a high ratio of nurses to patients but with nurses performing domestic tasks is most inefficient and may result in a lower standard of care than a lower nurse patient ratio with additional support staff (McLeay 1982:72).

The McLeay Report commented, 'the standard of care in private nursing homes will inevitably depend on the fees charged, the level of subsidy, the profits of the proprietors, costs and managerial efficiency.' The report continued, 'in the long run, the return on funds must be similar to the return on funds elsewhere in the economy and costs will reflect managerial views of efficiency and the price of inputs particularly wages' (McLeay 1982:70). Therefore, the report recommended that 'the Commonwealth should fund the number of nursing hours per patient to a uniform standard set by the Commonwealth' (1982:70).

The McLeay Report, while paying little specific attention to quality of care in nursing homes, did make links to quality of care provision and devoted two pages of the 111 page report to the issue of complaints against proprietors. The committee made specific comment that although there were organisations representing the proprietors of nursing homes, there were 'not any specific organisations representing the interests of patients' (McLeay 1982:73). The Department of Health, in evidence to the committee, reported that while there was a number of community organisations that might be expected to become involved in this area, and indeed the Pensioners' Federation had picked up the concern of nursing home residents, it had, as yet, not been done on an effective basis (McLeay 1982:73).

While the Department of Health reported to the committee that the number of complaints to health authorities on standards of care, patient care and quality of care was fairly small, evidence from a representative from the Australian Council on the Ageing suggested that indeed many grievances were never articulated and the

committee was given evidence 'that the management of institutions have very effective ways of containing complaining residents by isolation, by restraint and by just ignoring them' (McLeay 1982:73). The report did not provide any specific recommendations about how the quality of care could be improved. It did, however, articulate well the lack of avenues available to residents or their relatives to make complaints about the way a nursing home was being conducted or operated and subsequently recommended that 'to overcome the lack of channels of complaint against low standard nursing homes, hostels and domiciliary services, an Aged Care Tribunal should be established in each State, to which aged people receiving care or their relatives can take complaints about services' (McLeay 1982:74).

The McLeay Report gave the Federal Government a reprieve by not recommending any strengthening of standards monitoring in nursing homes. It concurred with a submission from the Australian Nursing Homes' Association that self-regulation be on trial on the basis that 'unless the industry delivers the goods within a period of, say, five years of giving it control, this power would be taken away' (McLeay 1982:76).

The Senate Select Committee on Private Hospitals and Nursing Homes (1985)

On 24 September 1981, the Senate appointed a Select Committee on Private Hospitals and Nursing Homes to enquire into and report on a range of issues in profit and non-profit private hospitals and nursing homes. The establishment of the committee reflected the growing concern for the general lack of knowledge about the private health sector and, more specifically, with regard to the nursing homes sector, it reflected concern with the standard of care being received by nursing home residents (which had received considerable attention in the media at the time) (Giles 1985:xiv). The major terms of reference for the committee concerned:

(i) the extent of Government subsidy of such institutions;
(ii) the financial organisation and motivation;

(iii) the type and frequency of services provided;
(iv) variations by State, region, size and type of hospital in relation to bed usage, surgery undertaken and length of patient stay;
(v) staffing arrangements;
(vi) recording, accounting and referral procedures;
(vii) composition of boards emphasising any potential conflicts of interests; and
(viii) present and future roles within the health care delivery system as a whole (Giles 1985:xiii).

By November 1984, the six female Senators of the Select Committee chaired by Senator Patricia Giles presented their report to the President of the Senate, concluding that the rapid growth in numbers of nursing home beds since 1963 had not so much been caused by population change or socioeconomic factors (as was thought to be the case) but rather was a direct result of the specific funding policies of previous successive governments. The Senate Select Committee report specifically rejected the notion of nursing home funding grants being paid directly to the States as recommended earlier by the McLeay Report and concluded in favour of 'program grants' administered by the Commonwealth which would be paid by the Commonwealth directly to individual nursing homes.

Compared to the earlier McLeay Report (1982), the Giles Report (1985) paid serious attention to the standards and quality of care in nursing homes, devoting some 30 pages to the issue and recommended the development of new Commonwealth standards for nursing homes and the establishment of a Commonwealth nursing homes inspectorate. Both of the major areas of standards of care and quality of care will now be discussed in turn.

Standards of care

The Committee focused its attention on nursing care provision, paramedical services, diversional therapy and the physical facilities of nursing homes. The arrangements at the time allowed each State to establish its own standard for nursing hours and consequently the States, by developing different levels of

nursing hours, lacked any uniformity. As a consequence, the Commonwealth, being required to finance the level of care that was decided upon by the individual State, was left funding different States at different levels. The 1975 working party formed by the Hospitals and Allied Services Advisory Council (HASAC) to study the issue of uniform minimum nursing hours provided a uniform minimum number of nursing hours for care to be provided by each State; however, the States were reluctant to adopt the guidelines recommended by the HASAC. The Senate Committee was told that very few nurses employed in nursing homes had appropriate qualifications. A 1978 survey found that only two per cent of registered nurses who worked in geriatric units possessed a postgraduate qualification in the area (Senate Select Committee on Private Hospitals and Nursing Homes, 1985:753). Also, evidence from the Organiser of the New South Wales Nurses' Association outlined the paucity of in-service education available to nurses in nursing homes. Therefore, the Giles Report recommended that:

> more postgraduate courses in geriatric nursing be made available with appropriate accreditation and awards to promote improved and acceptable geriatric nursing care and to develop career path options ... that each State promote the introduction of in-service and training programs in nursing homes ... [and] that program grants be designed to introduce uniform minimum staffing levels progressively throughout Australia (Senate Select Committee 1985:114-118).

With regard to paramedical services, diversional therapy and physical facilities, deficit-financed homes provided a considerably higher level of provision of paramedical services to residents at no additional cost to the resident, whereas very few participating homes or private homes provided such services. Also, each State was able to establish its own standards for physical facilities and enormous variations were evident. Thus, the Giles Report recommended that:

> the Commonwealth develop guidelines to enable a consistent and equitable approach to the availability and cost of paramedical and diversional therapy services ... [and] that the Commonwealth Department of Health introduce a code of physical standards as quickly as possible (Senate Select Committee 1985:119).

Quality of care and quality of life

A comprehensive coverage of the quality of care and quality of life of residents living in nursing homes was provided by the Senate Select Committee who found extensive evidence of sub-standard care in some nursing homes. Graphic pictorial accounts of mistreatment were provided as evidence. Evidence of the difficulty of the inspection system was provided by Mrs R. Oates, a member of the Royal Australian Nursing Federation, who explained that:

> the level of patient care is all-important and that the present system of emphasising physical aspects is very frustrating for those who run good patient care facilities but have to be concerned with the width of doorways and the height of beds. She added that there are nursing homes with very good accommodation facilities that give terrible patient care (Senate Select Committee 1985:120).

The Senate Select Committee (1985:120) reported that 'the ideal nursing home acknowledges the dignity of each individual, and the right to privacy. It provides good physical care, the patients are well nourished, comfortably accommodated and treated with respect. It also provides opportunities to socialise.' The main recommendations of the Senate Select Committee (1985:xxii–xxv) were summarised by the *Nursing Homes and Hostels Review* :

- that the Commonwealth fund pilot studies to examine quality indicators with a view to introducing these indicators in the assessment of quality of patient care and to provide a basis for thorough nursing home inspections;

- that Commonwealth Medical Officers be empowered to carry out full physical examinations of nursing home patients and have access to medical records; and

- that a Commonwealth nursing homes inspectorate section be established within the central office of the Standards and Development Branch of the Commonwealth Department of Health, with regional sections situated in each State's regional office. Some of the proposed functions of the central office section were to:

  (i) formulate uniform guidelines on inspection procedures, and define clearly the role to be undertaken by Commonwealth, State and local government authorities;
  (ii) co-ordinate the Commonwealth's inspection system;
  (iii) prosecute breaches of all standards including quality of patient care; and

(iv) liaise with State and local government authorities concerning the inspection systems and the quality of patient care (Rees 1986:71–73).

Cost of Nursing Home and Hostel Care Services (1985)

The Senate Select Committee recommended the replacement of the existing nursing home benefits system and deficit funding arrangements with a series of 'program grants'. Rather than funds being distributed on a per capita basis, the program grants would be distributed to residents in nursing homes via 'annual grants' based on the amount of care provided to various levels of resident as was agreed to by Government. However, difficulties of not having sufficient information about nursing home costs caused the Government considerable concern and led to the commissioning of Coopers and Lybrand to undertake a study on the *Cost of Nursing Home and Hostel Care Services* (1985). The study was commissioned and undertaken between July and December 1984 (around the same period that the Senate Select Committee Report was being finalised) with the consultants' final report published in July 1985. The overall aim of the study was 'to obtain validated information on the costs of Nursing Homes to enable standards of funding to be set which recognise the different roles and levels of services provided by different nursing homes' (Coopers & Lybrand 1985:3).

Traditionally, two quite distinct methods for calculating standard costs may be used. Either a survey of existing practices may be undertaken with standard costs being attached to the existing practices or, alternatively, a separate standards system may be developed quite independently of existing practices. The fundamental requirement of the former method is the need for consistency of service level across all the providers. Any two providers, having a similar number of residents of similar dependency in a similar location should have strong similarities in their operating costs and therefore, any variance from the expected costs should be easily identifiable.

Coopers and Lybrand commented on the various interpretations and inconsistencies Australia wide of what constituted an adequate level of service and suggested that the Commonwealth Government define what was meant by 'an adequate quality of care, either in terms of the services (inputs) required to achieve this or in terms of an output measure (e.g. comfort and quality of life of the patient)' (Coopers & Lybrand 1985:20). The consultants described the differences in the types of homes and variety and range of homes. They stated:

> If a grants system is to be "per capita" then each home should be treated equally, with the number of beds (or bed-days) and the degree of need of the patients being the only factors influencing the level of the funds provided. However, nursing homes are a mixed group, with a variety of individual characteristics and operating situations which means that they tend to develop individual cost patterns ... The concept of "equal funding" is thereby complicated (Coopers & Lybrand 1985:20).

The consultants were unable to establish a relationship between the extensive care ratio of nursing home residents and costs. They explained 'we are not suggesting that in any one home extensive care patients do not receive more care, we are suggesting that the cost structures of the homes in the sample do not show that extensive care requirements affect costs' (Coopers & Lybrand 1985:71). Their report was summarised as follows:

> It is our strong conclusion that the high variability of costs of individual nursing homes exists because the past system of individual approval of nursing home costs has allowed each nursing home to set its own cost level based on its costs in 1972 and separate annual assessment since then (Coopers & Lybrand 1985:9).

The consultants found that an independently determined model which they called an 'independent point of reference' was more appropriate for the nursing home industry than one based on the current costs (Coopers & Lybrand 1985:67). The 'independent point of reference' model incorporated standards for all nursing home operations and defined the level of inputs required to meet a pre-determined level of output. Where a particular nursing home chose to operate above the level of inputs then that nursing home would bear the subsequent cost themselves. Extra

funds would not be made available from the public purse to cover extra costs. The consultants were quick to point out that such a model of funding would need to be defensible in terms of the adequacy of the level and quality of patient care provided as some nursing home proprietors may be tempted to provide a level of service that required a lower level of inputs in order to achieve higher profit margins.

Coopers and Lybrand (1985:24) recommended the independent approach because throughout their exhaustive search they were unable to substantiate that costs in the nursing home industry showed sufficient consistency for generating standards costs which formed the pre-requisite to 'program grants'. As well, they recommended that future movement in nursing home costs should be monitored against a number of independent indices, namely, various State nursing awards; award rates of ancillary staff and services; and the consumer price indices for food (Coopers & Lybrand 1985:9).

Dominant public discourse

The task of achieving equity of funding between the States as well as between the various types of nursing homes has been a major priority within the public discourse and this is well displayed in the Auditor-General's Report (1981). The Auditor-General's Report saw funding and equity priorities as central to the public discourse on nursing homes with the Government concerned mainly with the problem of equity of nursing hours across the various States rather than looking at the quality and standards of care being provided with these nursing hours. The McLeay Report (1982) also focused centrally on funding priorities, devoting very little attention to the area of quality and standards of care and preferring to concentrate on the issue of transferring the responsibility of funding from the Commonwealth to the States.

The release of the Senate Select Committee (1985) report saw the emergence of a fuller discussion on issues of quality and standards of care in nursing homes with the Government undertaking to establish nursing home accommodation in the

context of an overall plan for providing quality care for the elderly rather than in the piecemeal fashion of previous policy-making. Previously, nursing homes were viewed more as independent operations that provided a separate service to the community with minimal accountability for quality. However, nursing homes were now being seen as but one part of an overall comprehensive, integrated, geriatric service rather than as independent private operations as was formerly the case. A new focus on quality and standards of care began to emerge within the framework of an integrated service provision and planning framework.

Not suprisingly, the release of the Coopers and Lybrand (1985) Report saw funding priorities remain central to the public discourse on nursing homes, with the Government undertaking to establish a standard costing model for nursing homes. However, moves to establish a standard cost model encouraged the establishment of quality control mechanisms. The Government knew that in order to introduce the new control measures, they would have to ensure to their critics that the quality and standards of care to residents within nursing homes would not be jeopardised. Therefore, for the new funding model to be successful, the quality and standards of care priorities gained a high profile. It was not through the action of various interest and pressure groups such as consumers, academics or professionals that saw the item of quality move to the top of the policy agenda, but rather the necessity for the economic rationalists and bureaucrats to legitimise and substantiate their proposed new model of funding which would be based on the 'independent point of reference' method using indices rather than the previous actual current costs of operation. An adequate level and quality of care provided to residents needed to be assured in order that the Government could introduce its new model of funding. So we see the issue of quality and standards piggy-backing on the funding rollercoaster.

Phase 6—Major Regulatory Approach: Aged Care Reform Strategy (1986–1993)

By July 1985, some five years after the Auditor-General's criticism about aged care programs, consensus seemed to have been reached concerning the major problems. The Minister established the *Nursing Homes and Hostels Review* which, by 1986, made some 47 recommendations about the planning context, assessment, standards, recurrent funding and the structures of the new residential program (Nursing Homes and Hostels Review Committee, 1986). A number of these recommendations was later adopted as Commonwealth policy and subsequently formed the Government's new Aged Care Reform Strategy. The major changes proposed by the *Nursing Homes and Hostel Review* (1986) included:

(i) the development of assessment teams to provide advice to elderly people on their care needs and referral to appropriate services;

(ii) controlled growth of nursing homes and hostels accommodation with an emphasis on the provision of greatly expanded hostel accommodation;

(iii) changes in funding arrangements for nursing homes based on a standard of care determined by the Commonwealth;

(iv) adjustment in the subsidies available to hostels to reflect the increasing role which hostels will take on in caring for elderly people;

(v) the need for greater flexibility in program arrangements to cater for special groups including migrants, Aboriginals and dementia sufferers;

(vi) the development of standards of care and quality of life measures for better assessment of the care provided; and

(vii) the strengthening of community care services to ensure a better balance in the provision of care for elderly people.

Before 1986, a submission-driven funding system existed which created marked inequities between regions. Recommendations from the 1986 *Nursing Homes and Hostels Review* sought to produce a more equitable distribution of services across

and within States and Territories by moving to a needs-based planning approach for aged care services. The Aged Care Reform Strategy was introduced as a result of the *Nursing Homes and Hostels Review* (1986). The basic purpose of the Aged Care Reform Strategy has been 'to change the balance between residential care and community services in provision of aged care, and within residential care, to change the balance between nursing home and hostel provision' (Commonwealth Department of Health, Housing & Community Services 1991:334).

Actual residential care provision was 67 nursing home beds and 33 hostel places per 1000 people aged 70 and over at the time of the *Nursing Homes and Hostels Review* (1986). The Review established planning benchmarks for residential services, setting targets of 100 residential places per 1000 people aged 70 years and over, with target ratios of 40 nursing home beds to 60 hostel places (*Nursing Homes and Hostels Review* 1986). In 1987 there was a total of 1486 nursing homes in Australia providing 75 932 beds or 4.7 beds per 1000 population. By 1992, there were 1439 nursing homes providing 74 157 beds or 4.3 beds per 1000 population (see Table 6.1).

Table 6.1
Changes in Nursing Home Bed Provision 1987–1992

	1987	1992
Nursing Homes	1486	1439
Nursing Home Beds	75932	74157
Beds/1000 population aged 70 years and over	4.7	4.3

Source: Commonwealth Department of Health, Housing & Community Services, 1992b, *Nursing Homes for the Aged: A Statistical Overview (1990–1991).*

In the 1991/1992 Budget, Community Aged Care Packages were introduced by establishing a care package target of 5:1000 people aged 70 and over, while at the same time reducing the hostel ratio to 55:1000. Care packages were designed to give hostel level of care to an older frail person remaining in his/her own home. In the 1992/1993 Budget, a further change was announced with the hostel ratio further reduced to 52.5:1000 and the care package ratio increased to 7.5:1000.

(Commonwealth Department of Health, Housing, Local Government & Community Services 1993b:4). By December 1993, the ratio was 53 nursing home beds to 39 hostel beds, and by the year 2001 it is predicted that the provision level will be 41 nursing home beds, 47 hostel places and 7.5 care package places (Commonwealth Department of Health, Housing, Local Government & Community Services 1993b:4-5). Table 6.2 provides details of the changes of ratios from 1986 to 1993.

Table 6.2
Ratios of Nursing Home, Hostel and Community Care Package Provision per 1000 people aged 70 and over 1986–1993

	Nursing Homes	Hostels	Community Care Packages
At time of 1986 Review	67	33	0
Benchmarks of 1986 Review	40	60	0
1991/1992 Budget	40	55	5
1992/1993 Budget	40	52.5	7.5

Source: a. Rees, G. 1986, *Nursing Homes & Hostels Review.*
b. Gregory, B. 1993a:4-5.

Thus, the Aged Care Reform Strategy has been successful in reducing the actual number of nursing homes and beds with a corresponding increase in the number of hostel places. In accord with the overall aged care planning strategy, Table 6.3 shows all States except South Australia have experienced an increase in the ratio of hostel provision with a corresponding reduction in the ratio of nursing home provision.

Table 6.3
Residential Care Provision Nu nbers and Ratios by States/Territories 1985 and 1991

State/ Territory	Hostels 1985	Hostels 1991	Nursing Homes 1985	Nursing Homes 1991	Combines 1985	Combines 1991
(a) Numbers of beds/places						
New South Wales	11158	15162	28322	28931	39480	44093
Victoria	7998	11058	15296	16377	23294	27435
Queensland	6985	9538	11538	11958	18523	21496
South Australia	4523	5334	7298	7144	11821	12478
Western Australia	3282	4348	6245	6087	9527	10435
Tasmania	640	1036	2312	2100	2952	3136
Northern Territory	47	117	95	173	142	290
ACT	252	487	397	521	649	1008
Australia	34885	47080	71503	73291	106388	120371
(b) Ratios per 1000 aged 70 ye ars and over						
New South Wales	29.3	32.9	74.3	62.9	103.6	95.8
Victoria	27.8	33.0	53.2	48.8	81.0	81.8
Queensland	41.6	44.2	68.7	55.5	110.3	99.7
South Australia	44.0	43.1	71.0	57.8	115.0	100.9
Western Australia	38.6	41.1	73.5	57.5	112.1	98.6
Tasmania	20.7	28.5	74.8	57.9	95.5	86.4
Northern Territory	26.1	41.8	72.9	61.8	98.9	103.6
ACT	33.2	46.8	57.9	50.1	91.1	96.9
Australia	32.8	36.5	67.2	56.8	100.0	93.3

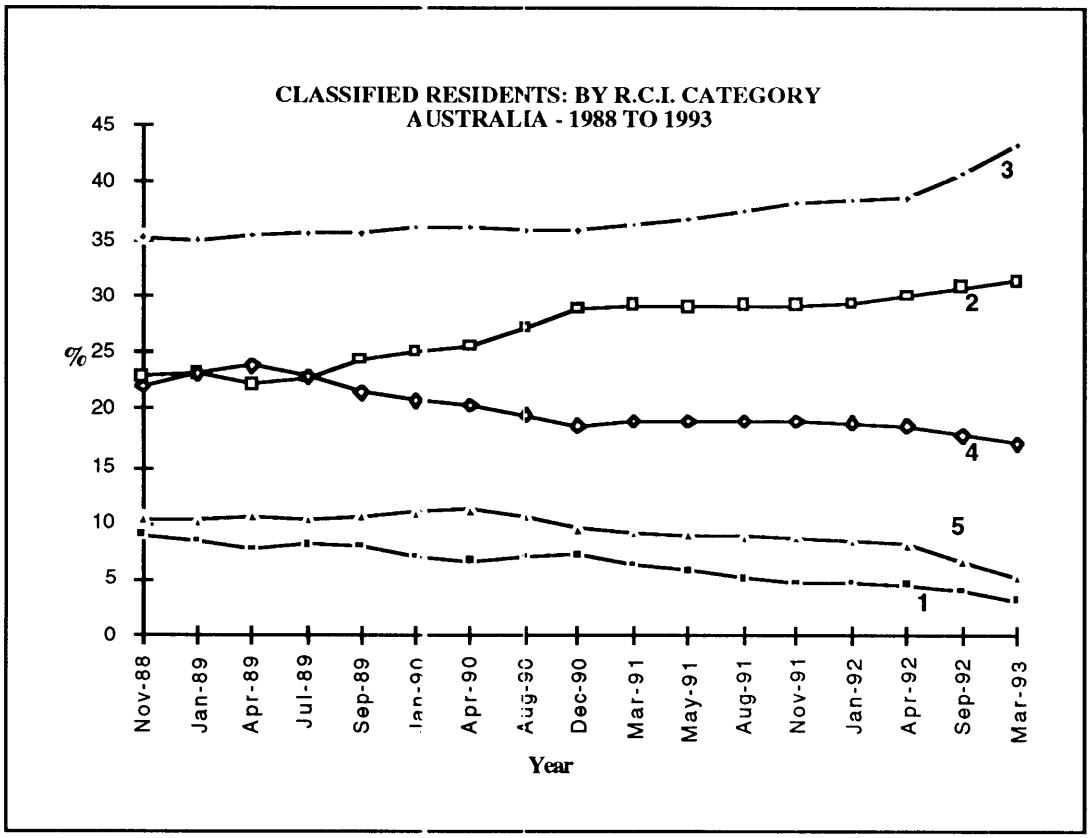
Notes: 1985: From *Nursing Homes & Hostels Review* Table 3.3 (nursing home beds do not include younger disabled).
1991: From DCSH Residential Care Planning Database.

Source: Commonwealth Department of Health, Housing & Community Services, 1991, *Aged Care Reform Strategy Mid-Term Review 1990–1991.*

As well as changes to the balance of provision between nursing homes, hostels and the community, significant changes to the resident mix in nursing homes have occurred over the last six years since the implementation of the recommendations of the N*ursing Homes and Hostels Review*. The percentage of nursing home residents classified in each category of dependency from November 1988 to March 1993 in Australia is presented in Table 6.4. Category 1 (most dependent) can be seen changing from 9.1% of residents to 3.2%, whereas categories 2 and 3 have both increased from 23% to 31 3% and 35.3% to 43.2% respectively. Categories 4 and 5 have both decreased from 22.1% to 17% and 10.4 to 5.3% respectively. Thus, the gradual shift of residents can be seen moving from the more expensively

funded category 1 to the less expensive category 2. Similarly, a shift of resident can be seen moving from the less expensively funded categories 4 and 5 up to category 3. Therefore, the dependency of residents within nursing homes is becoming far greater, placing added stress on staff and limited resources.

Table 6.4
Nursing Home Residents Classified by Resident Classification Instrument Category 1988–1993



Source: Commonwealth Department of Health, Housing, Local Government & Community Services, 1993a, *Residential Care News,* Canberra.

The adoption of recommendations of the *Nursing Homes and Hostels Review* (1986) set in train a number of investigations into various aspects of nursing home provision. These investigations served to assist the Government in the implementation of their overall strategy and included:

1986 *Quality, Staffing and Dependency: Non-government Nursing Homes*
1986 *CAM Review*

1987 *Living in a Nursing Home—Outcome Standards for Australian Nursing Homes*

1989 *Residents' Rights in Nursing Homes and Hostels: Final Report*

1991 *Aged Care Reform Strategy Mid-Term Review*

1992 *Raising the Standard · Resident Centred Nursing Home Regulation in Australia*

1992 *Review of the Structure of Nursing Home Funding Arrangements—Stage 1*

1993 *Resident Classification Instrument Documentation Consultation*

The focus of these investigations centred around three major areas: the method of funding nursing homes; the monitoring of standards and quality of care provided to residents living in nursing homes; and finally the rights of residents living in nursing homes. Each of these three areas will now be discussed with reference to the various investigations mentioned above.

Method of Funding Nursing Homes

A new funding method was introduced into non-government nursing homes as a result of the *Nursing Homes and Hostels Review* (1986); however, the Review based a number of their recommendations on earlier costing work undertaken by the Coopers and Lybrand Report, *Cost of Nursing Home and Hostel Care Services* (1985). The system of funding which was introduced was based on two major components, namely, the Care Aggregated Module (CAM) and the Standard Aggregated Module (SAM), and a minor component of Other Costs Reimbursed Expenditure (OCRE). The Care Aggregated Module aims to fund nursing homes on the basis of the level of care required by their residents rather than the previous cost reimbursement principles which merely funded nursing homes on the amount they spent rather than the service they provided and level of service provided to the residents. The CAM provides an allowance for the personal care requirements of residents and includes all nursing hours (RNs, SENs, and nursing attendants) as well as therapy hours. The SAM component is a standard grant for non-nursing and non-personal care costs which include costs for such items as food, heating, laundry, maintenance, gardening and so on. The OCRE component provides full

reimbursement to the nursing home for costs associated with superannuation, long service leave and insurance costs et cetera.

In order that CAM hours may be calculated, an NH4 Application for Resident Classification Instrument (RCI) is now completed for each resident (see Appendix 6). The RCI consists of a questionnaire which is completed by the Director of Nursing of the nursing home and then forwarded to the Commonwealth Department of Health, Housing and Community Services. Section one of the RCI consists of 14 questions sorted into four major areas of care. These major areas include: firstly, clinical care, which contains questions on continence, maintenance of skin integrity and specialised nursing procedures; secondly, social and emotional support, which contains questions on physical aggression, verbal disruption and behaviour; thirdly, communication and sensory processes, which contains questions on vision, hearing and speech/comprehension; and, finally, activities of daily living, which contains questions on mobility, toiletting, washing and dressing, eating and maintenance of independence. These areas are listed more clearly in Table 6.5. Once a response is determined for each question, a weighting or score is attached to the response. Table 6.6 presents the weightings which apply to each question in the revised RCI.

Table 6.5
Resident Classification Instrument Questions

Clinical Care	Continence Maintenance of skin integrity Specialised nursing procedures
Social and Emotional Support	Physical aggression Verbal disruption Behaviour
Communication and Sensory Processes	Vision Hearing Speech/Comprehension
Activities of Daily Living	Mobility Toiletting Washing and dressing Eating Maintenance of independence

Source: Commonwealth Department of Health, Housing & Community Services, 1992b:21.

Table 6.6
Weightings Applying to Revised RCI

Continence	0.00	3.84	7.69	11.53
Skin Integrity	0.00	3.68	7.37	11.05
Specialised Nursing	0.00	1.19	2.38	3.56
Physical Aggression	0.00	2.02	4.04	6.07
Verbal Disruption	0.00	1.18	2.36	3.54
Behaviour	0.00	1.32	2.64	3.97
Vision	0.00	1.34	2.68	4.02
Hearing	0.00	1.14	2.29	3.43
Speech/Comprehension	0.00	1.72	3.43	5.15
Mobility	0.00	3.48	6.96	10.44
Toiletting	0.00	3.39	6.79	10.18
Washing and Dressing	0.00	5.34	10.69	16.03
Eating	0.00	3.09	6.18	9.26
Independence	0.00	2.01	4.03	6.04

Source: Commonwealth Department of Health, Housing & Community Services, 1992b:8.

All the scores for each of the 14 questions are added together to give an overall score for the resident. A range of scores is used for each funding category to determine whether the resident is assigned to category 1, category 2, category 3, category 4 or category 5. The range of points for each funding category is:

Category 5	0	22.34	(least dependent)
Category 4	22.35	47.66	
Category 3	47.67	73.15	
Category 2	73.16	86.94	
Category 1	86.95	104.29	(most dependent)

The number of hours of care funded for each resident is based on the classification of each resident into one of five categories of dependency — category 1 being the most dependent and category 5 being the least dependent. Nursing home staff are required to validate the RCI rating by maintaining records and documentation for each resident. The actual number of nursing hours per day for each RCI Category (see Table 6.7) is determined by the Commonwealth and is uniform throughout Australia. However, the standard hourly rates for each category differ in each State due to the differences in awards (see Table 6.8). An example of the manner in

which the Resident Classification Instrument data is used by a Director of Nursing to estimate nursing and personal care hours per week in a nursing home is demonstrated in Table 6.9.

Table 6.7
Number of Nursing Hours of Care per Day and per Week for each RCI Category

RCI Classification	Hours of Nursing/Day	Hours of Nursing/Week
Category 1	3.857	27.0
Category 2	3.357	23.5
Category 3	2.786	19.5
Category 4	1.857	13.0
Category 5	1.286	9.0

Source: Commonwealth Department of Health, Housing & Community Services, 1992e, *Commonwealth Government Gazette* No.GN 51, 23 December.

Table 6.8
Standard Hourly Rates for each RCI Category in each State/Territory Effective from 1 January 1995

	CATEGORY				
STATE/ TERRITORY	1 $	2 $	3 $	4 $	5 $
New South Wales	19.40	19.47	19.59	20.39	19.74
Victoria	21.02	21.06	21.12	21.56	21.16
Queensland	16.50	16.57	16.67	17.39	16.83
South Australia	18.08	18.12	18.17	18.55	18.16
Western Australia	19.80	19.85	19.93	20.48	19.99
Tasmania	20.49	20.53	20.16	21.14	20.69
ACT	19.53	19.60	19.71	20.44	19.66
Northern Territory	21.07	21.13	21.21	21.81	N/A

Source: Commonwealth Department of Human Services & Health, 1994b, *Commonwealth Government Gazette* No.GN 94020, 24 December.

Table 6.9
Example of the Calculation of the Nursing and Personal Care Hours

Brodie's Nursing Home Estimated Nursing & Personal Care Hours for Week 1.7.93 to 8.7.93						
RCI Category	No.of Residents	No.of Bed Days	Hours/ Day	Total Hours	SHR NSW	CAM Total
1	2	14	3.857	53.99	19.40	1047.56
2	6	42	3.357	140.99	19.47	2745.15
3	14	98	2.786	273.03	19.59	5348.62
4	7	49	1.857	90.99	19.93	1813.49
5	1	7	1.286	9.00	20.39	183.55
TOTAL	30	210		568.00		$11138.37

A review of CAM was announced in November 1989, 12 months after the CAM funding arrangements had been in operation. Submissions were received from many interest groups and the Review Committee was informed that the RCI was 'a poor predictor of relative service need for particular groups of residents, including residents with dementia, residents from a non-English speaking background, and those who require very intensive service provision or have special communication care needs' (CAM Review, 1990:11). Two major recommendations of the CAM Review Committee were that the Commonwealth Department of Community Services and Health:

> look at its provision of services for people with dementia with a view to achieving a co-ordinated funding approach which recognises a network of services including support in the community and more intensive levels of care in residential age care facilities; and
>
> in consultation with the nursing home industry, develop and trial a classification instrument designed to test a number of approaches aimed at more accurately measuring the range of service needs of all residents (CAM Review 1990:62).

There was considerable dissatisfaction with the RCI, as both proprietors and Directors of Nursing complained about the inadequacy of the RCI to fully represent the needs required by their residents. Following the CAM Review, in 1991 a revised RCI was trialled and a further two questions were added to the questionnaire. Interestingly, however, in 1991 when the *Aged Care Reform Strategy Mid-Term Review* was undertaken, the Review noted that 'the RCI has proved a powerful targeting mechanism in tying the level of Commonwealth benefit directly to the level of nursing and personal care required for an individual resident' (1991:103). From the Government's perspective, the RCI was a solid scientific tool which allowed the Government to distribute funding more equitably than had previously been the case, even though there was considerable dissatisfaction with its accuracy

The aim of the *Aged Care Reform Strategy Mid-Term Review* (1991) was to chart the progress that had been made since the implementation of the *Nursing Homes*

and Hostels Review (1986) recommendations and the Home and Community Care Act (1985) as well as to assess the impact of the various measures which had been implemented. The Review also sought to clarify the future directions to be taken within the overall policy framework in order that aged care services be delivered in the most effective and efficient manner (Commonwealth Department of Health, Housing & Community Services 1991). The terms of reference for the Review were as follows:

(i) assess the extent to which community and residential aged care services are effectively targeted and equitably distributed and the extent to which fees policy impacts on targeting;

(ii) resolve boundary issues between long-term care and acute care of the aged so that the most cost-effective form of care prevails;

(iii) report on the balance of care between residential and community services and identify ways in which the emphasis on community provision can be strengthened, including better linkages between housing services and aged care; and

(iv) assess the impact of the involvement of multiple levels of Government on aged care services and identify ways to remove overlaps and duplication, establish areas of functional responsibility and principles for resource allocations between levels of Government (Commonwealth Department of Health, Housing & Community Services 1991:2).

Overall, the final report focused mainly on the successes of the Aged Care Reform Strategy (ACRS) in reducing the number of nursing home beds and increasing the number of hostel places. It also provided a projection model for the ratio of nursing home beds to hostel beds to Home and Community Care (HACC) funding to the year 2001. This was based on Australian Bureau of Statistics (ABS) population projections, ABS data of the distribution of disability and handicap, data on turnover rates within nursing homes, RCI and hostel subsidy distributions, planned changes in residential provision levels, and characteristics of the HACC population derived from a number of studies and the HACC user data collections (Commonwealth Department of Health, Housing & Community Services 1991:271).

In 1992, taking into account the difficulties regarding the funding of dementia residents as expressed by the earlier CAM Review (1990), the *Aged Care Reform Strategy Mid-Term Review* (1991) was extended to a second stage in order to prepare a *National Action Plan for Dementia Care* (Commonwealth Department of Health, Housing & Community Services, 1992a). The terms of reference relating to the development of the Plan were to:

(i) report on the demographic and social context of dementia care over the next decade;

(ii) consider the policy implications of recent research evaluating approaches to dementia care in residential care and community care, including support for carers;

(iii) review strategies available for community education; and

(iv) identify and assess options for an integrated National Action Plan for Dementia Care covering all elements of aged care programs (Commonwealth Department of Health, Housing & Community Services 1992a:6).

The recommendations provided in the National Action Plan focused primarily on current programs providing residential and community care for frail older people with dementia and support to their carers. The Plan did not recommend the establishment of a separate dementia care program, but rather weaved the various parts of dementia care through the existing fabric of all aged care programs (Commonwealth Department of Health, Housing & Community Services 1992a:17). The overall scope of the Plan was defined at three levels because of the intergovernmental relations and responsibilities for different aged care programs and policies. While the Commonwealth Government has the principal responsibility for residential care programs, covering nursing homes and hostels (with State/Territory Governments having only limited involvement in State/Territory nursing homes). in the Home and Community Care Program area, the Commonwealth Government and the States/Territories share responsibility. Therefore, the Commonwealth Government may take direct action in the major

area of residential care (i.e. nursing homes and hostel). However in community care, it requires agreement with States/Territory Governments before programs can be advanced.

The Plan also made recommendations concerning the role of the Government in supporting applied health services research and bio-medical research and also focused on providing a framework whereby Local Government and non-government agencies could work together towards common goals in care of people suffering from dementia (Commonwealth Deptartment of Health, Housing & Community Services 1992a:17-18). The development of a *National Action Plan for Dementia Care* has provided a useful opportunity to examine critically the aged care system and its impact on people with dementia as well as their caregivers in a comprehensive and integrated fashion (Commonwealth Department of Health, Housing & Community Services 1992a:iii).

In order to correct misconceptions concerning the amount of documentation required to verify resident's classification using the RCI, in 1992, the circular, *Resident Classification Instrument (RCI) — Guidelines of Documentation* (Commonwealth Department of Health, Housing & Community Services 1992d) was developed in consultation with peak industry bodies, representative Directors of Nursing and unions. Although this circular was distributed early in December 1992, there remained residual concerns about the inconsistencies and variations of interpretation of similar data sets across different nursing homes. The then Commonwealth Minister for Health, Peter Staples appointed Sue Macri to investigate and report on Departmental documentation requirements in Commonwealth nursing homes. The subsequent Macri Report (1993) was released in July 1993 and concentrated on the documentation requirements to achieve validation for the RCI category classification which was undertaken during standards monitoring team visits. It focused mainly on the need for nursing home staff to utilise the foundations of the nursing process in order to achieve

documentation requirements rather than undertake intermittent and very lengthy and time consuming documentation techniques that many times served no other purpose than to provide a description about what should have been routinely recorded. In summarising the Report, Macri noted:

> The current RCI validation process is characterised by inconsistencies which generate confusion and animosity in the workplace and non-acceptance of the tool.
>
> It has been clearly identified that over-documentation for nursing home staff detracts from resident care and desired outcomes, and has a negative impact on staff morale. Likewise for CNOs, over documentation makes the tasks at hand (RCI review) much more difficult, often putting the CNO in a conflicting position with nursing home management and staff.
>
> It is costly for both the Government and Industry alike to continue with an ineffective and inefficient system of documentation and review. Much work needs to be done, as under, or poor documentation has also been identified as a major concern.
>
> Much also needs to be done to up-grade the knowledge and skills, not only of nursing staff but also nursing home management in the whole area of documentation and clinical records requirements ... so as to ensure that they carry out their role and function proficiently.
>
> There is a strong foundation for education and training programs designed to address the knowledge gaps in the industry relating to documentation (Macri, 1993:40-41).

More recently, in 1993, a review of funding of nursing homes was undertaken which concentrated on issues of micro economic reform in the nursing home industry. The *Review of the Structure of Nursing Home Funding Arrangements Stage 1*, (Gregory 1993b) identified three options for structural reform to promote efficiency and long-term viability of nursing homes while continuing to emphasise quality of care for residents. Some of the major challenges faced by the Review were as a result of recent industrial relations changes involving enterprise bargaining and multi-skilling. The three options are briefly summarised below.

Option 1—Non-acquitted funding

This first radical option considered the removal of the requirement to acquit CAM funding. As Gregory reported:

> Compared to the existing CAM/SAM system, this would give homes much greater flexibility in their use of staff and remove disincentives for enterprise bargaining and multi-skilling. Proprietors would be able to make a profit or surplus from efficiencies in nursing and personal care budgets (1993b:79).

Non-acquitted funding allows increased profits or surplus to be gained from not only increased efficiency of nursing home operations but also from reductions in the provision of nursing and personal care hours and from reductions in employment of nursing staff. Therefore, Professor Gregory concluded that while non-acquitted funding system would save staff resources on the financial monitoring side, more intense monitoring would be required to maintain the standards monitoring which 'would exacerbate a current source of friction between the Government and nursing homes' (Gregory 1993a:79).

Option 2—moving the border between acquittable and non-acquittable funding from the current CAM/SAM boundary to one which facilitates staff flexibility within the nursing home

Two variations were considered in this option:

(i) to acquit all labour costs and provide a non-acquitted flat grant for non-labour costs; and

(ii) to acquit all costs related to nursing home care other than costs directly related to buildings and land (Gregory 1993b:79).

Under this option, multi-skilling would prove far easier as it would be possible to use staff part-time on domestic duties and part-time on direct care duties. However, the disadvantage of this option is that it replaces the CAM/SAM border with another border — that of labour/non-labour or care/accommodation which inevitably would require detailed Departmental auditing activity. The option would contract the size of the budget within nursing homes where there is an incentive to make efficiencies as well as to make it harder to use SAM staff part-time in an attached hostel.

Option 3—the current CAM/SAM system with modifications

This option outlines a minimum set of reforms:

(i) design a new indexation procedure, not based on award movements, which provides clarity and transparency to the setting of funding levels which are adequate for real cost movements affecting nursing homes, while protecting against cost escalations;

(ii) allow over-award payments, with further consideration to be given to whether any distinction is made between non-award payments embedded in a certified enterprise agreement, or whether all such payments should be accepted;

(iii) clarify and widely promulgate the principles governing the distinction between CAM and SAM costs, with particular attention to areas the industry experiences as ambiguous or uncertain;

(iv) develop clear guidelines on the documentation required to justify the apportionment of staff time between CAM and SAM or between a nursing home and an attached facility such as a hostel (Gregory 1993b:80).

Option three neither increases nor decreases the size of the portion of the nursing home budget where profit or surplus can be made and where direct monetary incentives will drive enterprise bargaining (Gregory 1993b:80). Gregory (ibid) concluded:

> A significant proportion of the burden of administration of the current system should be able to be reduced with full attention given to the minimum set of reforms listed above. It would not remove any area of accountability in its totality, as would the first option, but neither would it add any new kinds of regulation as would be entailed by adoption of that option.

The Report also made a number of other suggestions which could offer some improvement or efficiency gains for the nursing home industry. These are outlined below:

(i) options to reduce the number of RCI classifications needed;

(ii) approaches to reduce the friction associated with Standards Monitoring, including improving industry participation and further use of risk management techniques;

(iii) greater use of risk management in validation of CAM expenditure;

(iv) options to improve the take-up and affordability of respite care;

(v) options to simplify funding arrangements for enteral feeding and continuous oxygen;

(vi) modification of the incentive structure of the CAM reconciliation system to encourage homes to spend their CAM funding;

(vii) the possibility of varying SAM by State; and

(viii) options to improve industry understanding of the funding system (Gregory 1993b:6-7).

At the time of writing, the Commonwealth Government had yet to make any further decisions regarding any changes as a result of the Gregory Report, even though they strongly favoured option three.

Monitoring of Standards and Quality of Care

With the intent of changing the provision, and the methods of funding of residential care for the aged in nursing homes, the Commonwealth Department of Community Services commissioned Dr Catherine Rhys Hearn to obtain relevant background information about the nursing homes which were currently participating in its funding schemes, that is, participating homes and deficit funded homes (Commonwealth Department of Community Services 1986b:137). The specific aims of the study were:

(i) to determine the staffing levels in nursing homes;

(ii) to measure the dependency of the residents;

(iii) to monitor the care given;

(iv) to design measures for quality of care;

(v) to measure the quality of care;

(vi) to assess the environment and facilities within the homes;

(vii) to describe any existing differences between homes of different types and/or in different States;

(viii) to examine/discover any relationships which may exist between any of the important parameters; and

(ix) to investigate any relationships between quality and quantity of care and dependency and staffing values (Commonwealth Department of Community Services 1986b:137).

Dr. Rhys Hearn's Report, *Quality, Staffing and Dependency: Non-government Nursing Homes* was released in October 1986 and noted that it would provide a reference point for the work which would be required in the development of appropriate standards for nursing homes. A number of different parameters was investigated during the study including the quality/relevance of nursing care, Q1, and the general quality score, QC. The former ratio, Q1, describes the 'quality' of direct nursing care and measures the extent to which the care needed by the resident is actually given in practice. The latter, QC, records staff education opportunities, staff facilities, flexibility of policies regarding residents' care regimes, and security, maintenance and safety factors.

The forword of the Report, prepared by the Department of Community Services, noted two particularly important findings of the study, the first being 'the multi-faceted nature of "quality" and relative independence of different measures [and] the second, the wide range of outcomes currently being achieved, often in cases of similar input' (Commonwealth Department of Community Services 1986b:iii). The Department continues:

> The first of these findings implies a need for considerable sensitivity in the establishment of standards, and the adoption of a broad focus which takes into account all of those factors which impact upon the lives of people in nursing homes and the satisfaction of their individual needs and desires.
>
> The second finding endorses a number of the earlier studies which have indicated that **to a significant extent the quality of care provided depends more upon the philosophy and management of the service than the level of resources provided.** [my emphasis in bold]

> In this study, while a link has been found between staffing and the quality and relevance of direct nursing care, it is noted that staffing only partly explains variations in this measure of quality, even when account is taken of the dependency of residents. Further, other measures of quality used in the study have been found to be largely independent of the level of staff resources (Commonwealth Department of Community Services, 1986b:iii).

Dr. Rhys Hearn argued in her findings that 'the quality/relevance of the direct nursing care, Q1, may be seen to have improved in those nursing homes which have higher values for the general quality score, QC, and those which have higher proportions of trained nurses, [the Report underlines these words] both registered and enrolled' (1986b:145). The Report continues that QC issues:

> are all related to staffing, in the sense that it is quite likely that better educated, trained nurses may be designing more imaginative and flexible care policies, and that all these factors are only possible to achieve either with higher staffing-to-dependency ratios, or with more "efficient" use of the staff's time, (that is, a higher proportion of the nurses' time spent on direct care of the residents) (Commonwealth Department of Community Services 1986b:145-146).

The Report further noted 'that "efficiency" goes up with the proportion of trained nurses, the score for QC (staff education, facilities and flexibility in policies), and up with dependency, but down with increased staffing' [the Report underlines these words] (Commonwealth Department of Community Services 1986b:147). The Report concluded as follows:

(i) quality/relevance of nursing care increases mainly with the staffing-to-dependency ratio, but also with the proportion of trained staff, and the education/facilities in the nursing home;

(ii) general quality is largely independent of staffing or dependency;

(iii) probably the most important parameter necessary to characterise a nursing home is the dependency of its residents;

(iv) to predict the quality/relevance of care given, it is necessary to know: the ratio of staffing-to-dependency the proportion of trained staff the QC score (staff education, flexibility of care policy and facilities);

(v) to determine appropriate staffing levels, the dependency of the residents must be known; and

(vi) homeliness is judged largely on care planning, care policies, arrangements for meals, buildings, facilities and amenities (Commonwealth Department of Community Services, 1986b:149).

Soon to follow, in June 1987, the Commonwealth/State Working Party on Nursing Home Standards published the landmark *Living in a Nursing Home: Outcome Standards for Australian Nursing Homes* which heralded the beginning for monitoring the performance of nursing homes. Prior to this, both State and Federal Governments undertook the monitoring of quality in nursing homes in a variety of inspectorial roles, which were all primarily concerned with inputs to service provision, rather than with the outcomes for individual residents (eg fire regulations, food preparation regulations and so forth). On 1 July 1987, the Outcome Standards were implemented and Commonwealth funding to nursing homes became contingent on nursing homes meeting the 31 resident outcome standards. These standards are grouped into seven main categories: Health Care, Social Independence, Freedom of Choice, Home-like Environment, Privacy and Dignity, Variety of Activities, and Safety. A brief explanation of these categories are presented in Table 6.10 (Commonwealth Department of Community Services, 1987a).

Table 6.10
Commonwealth Outcome Standards of Care

1. *Health Care*	Residents' health will be maintained at the optimum level possible.
2. *Social Independence*	Residents will be enabled to achieve a maximum degree of independence as members of society.
3. *Freedom of Choice*	Each resident's right to exercise freedom of choice will be recognised and respected whenever this does not infringe on the rights of other people.
4. *Home-like Environment*	The design, furnishings and routines of the nursing home will resemble the individual's home as far as reasonably possible.

5. *Privacy and Dignity*	The dignity and privacy of nursing home residents will be respected.
6. *Variety of Activities*	Residents will be encouraged and enabled to participate in a wide variety of experiences appropriate to their needs and interests.
7. *Safety*	The nursing home environment and practices will ensure the safety of residents, visitors and staff.

Source: Commonwealth Department of Community Services, 1987a.

In 1993, a four year evaluation of the Commonwealth Government's nursing home outcome standards program was completed and *Raising the Standard: Resident Centred Nursing Home Regulation in Australia* (Braithwaite et al. 1993b), not suprisingly, confirmed the positive contribution of the standards and standards monitoring in improving the quality of care in nursing homes. The 11 major regulatory objectives of the outcome standards process were outlined by Braithwaite (1993b:xi-xvi) as follows:

(i) move from regulation of inputs to an outcome orientation;

(ii) improve the quality of life of nursing home residents;

(iii) minimise the cost of regulation;

(iv) secure industry commitment to the standards and acceptance of the standards monitoring process;

(v) secure public confidence in the regulatory process;

(vi) avoid corruption and regulatory capture;

(vii) strengthen consumer sovereignty and respect for consumer rights;

(viii) give consistent and valid compliance ratings;

(ix) improve program productivity;

(x) improve enforcement effectiveness; and

(xi) respect for procedural justice.

When commenting on the quality of life of nursing home residents, Braithwaite and others in *Raising the Standard* (1993b:xi-xii) go to elaborate lengths to provide a positive affirmation that the standards monitoring program has vastly improved the quality of life of nursing home residents by relying on supportive evidence from the following data:

(i) improvements in compliance scores at follow-up visits;

(ii) objective and subjective data on care planning;

(iii) objective and subjective data on staff participation in training;

(iv) subjective qualitative data on the impact of the standards monitoring process on the motivation of Directors of Nursing and nursing home staff to improve quality of care;

(v) data on the level of participation of residents in nursing home affairs;

(vi) director of Nursing reports and evaluator observations of specific ideas obtained as a result of the standards monitoring process that improved the quality of life for residents;

(vii) observation of the enjoyment and assurance that most residents get from participating in the standards monitoring process itself;

(viii) reports from Directors of Nursing as to whether there had been an increase since 1987 in their commitment to emphasising residents' rights, making the nursing home more home-like, involving staff, relatives and residents in decision-making, emphasising activities programs in service training, allowing residents to take risks, shifts from a task orientation to a resident orientation, changes towards treating a nursing home more as a residents' home and less as an institution than was the case in 1987; and

(ix) perceptions of Directors of Nursing that improvements had been affected in the quality of the residents' lives as a result of the work of standards monitoring teams.

Braithwaite et al. (1993b:xii) acknowledge that 'each of these strands of evidence is rather weak on its own'. They argue, however, that taken together 'these disparate sources of evidence constitute an overwhelming case that the standards monitoring process has been a success in improving the quality of life for nursing home residents' (1993b:xii). However, Braithwaite et al. (1993b:xii) continue further with the following disclaimer:

> the consultants absolutely agree with those nursing home employees, residents and consumer advocates who believe that the **improvements are comparatively minor** compared with what remains to be done. Quality assurance programs in Australia are still at a primitive stage. While care planning has become more sophisticated and participatory, few nursing homes have a routine cycle of care plan review conferences where the resident and all staff involved with the resident attend, and to which relatives receive a written invitation.

Aspects of reliability (internal consistency) and validity (what is supposed to be measured) regarding the standards monitoring program were provided in the Report. The consultants commented that:

> there are many ways that the standards monitoring process could be made more valid by more comprehensive data collection ... however ... they would be expensive to implement (Braithwaite et al. 1993b:72).

For example, inspections of nursing homes in the United States conduct systematic surveys of medications and quite often reveal frightening medication error rates of ten per cent and more. Similarly, in observing treatments given by nurses to residents, especially to residents with decubitis ulcers, the American inspection process regularly uncovers many problems. Braithwaite et al. (1993b:72) admit that:

> this deeper digging in the American process uncovers many problems which remain reliably submerged in the Australian process — Class III ulcers that are documented and treated as Class II, poor infection control practice in the treatment of bedsores and inadequate respect for the privacy or dignity of the resident during this most undignified aspect of nursing home life.

However, *Raising the Standard* (1993) does not recommend adoption of more systematic inspections as is the case in the United States but 'would prefer to see training further expanded for both standards monitors and nursing home staff to help them both to see where deeper digging is required' (Braithwaite et al. 1993b:72). The Report does not recommend the use of guidelines such as the American 'Interpretive Guidelines for Unnecessary Drugs' that apply under American law but advocates to use such guidelines as teaching tools. The Report

also recommends increased training as a resolution to the difficulty with reliability and validity with the following five outcome standards which have proved to be problematic:

- Standard 1.3: All residents are as free from pain as possible;
- Standard 1.5: Residents enabled to maintain continence;
- Standard 1.9: Sensory losses identified and corrected;
- Standard 5.4: Nursing home free from noise; and
- Standard 5.6: Nursing home practices support the resident's right to die with dignity.

Regarding cross-referencing, some standards monitoring teams were reported to fail to allow a single incident to affect ratings on more than one standard. This proved a continuing source of unreliability. As well, inter-state consistency was also a source of unreliability, particularly in New South Wales. The Department had already responded to this criticism (Braithwaite et al. 1993b:76) by undertaking:

(i) Consistency workshops;
(ii) Exchanges of standards monitors between States;
(iii) Standards review days for central office staff;
(iv) TARCRAC dissemination of national interpretations of standards;
(v) Standards monitoring training taken back from State offices and given to TARCRAC; and
(vi) Compliance sheets and standards monitoring reports being reviewed and exchanged inter-state.

Interestingly, inter-state unreliability was not highlighted by a recommendation to follow-up by the Report, even though action was recommended to standards monitoring teams who continued to rate standards as met when they were not met because the team did not want a single incident to affect adversely the rating for more than one standard (Braithwaite et al. 1993b:78).

Residents' Rights

In August 1988, the Hon. Peter Staples, Minister for Housing and Aged Care, commissioned Chris Ronalds to undertake a consultancy in relation to residents' rights in nursing homes and hostels. The Issues Paper, entitled *I'm Still an Individual* was released in February 1989 and feedback on this paper through a series of public consultations, a national phone-in and the receipt of written submissions and letters from interested parties, guided the recommendations and the analysis in Ronald's final Report *Residents' Rights in Nursing Homes and Hostels* (Ronalds, Godwin & Fiebig 1989:11). Subsequently, a strategy of user rights in residential care was developed following publication of the Report which was the final product of this part of stage five of the Government's Aged Care Reform Strategy. The Report consisted of five major components which formed the overall user rights strategy, namely: charter of residents' rights and responsibilities; an agreement between the operator and resident; residents' complaints units; community visitor schemes; and, finally, advocacy services for residents. The *Aged Care Reform Strategy Mid-Term Review* (Commonwealth Department of Health, Housing and Community Services 1991:49) reported that by mid 1991, all five components of the residents' rights strategy had been implemented.

Dominant Public Discourse: Long-Term Strategy to Balance Care Provision

The public discourse on aged care during this period was not so much ideologically driven with short term quick fix-it solutions but rather priorities centred on providing a long-term strategy. This was in order to address the problems of containing costs at the same time as providing quality care in nursing home provision through the formulation of a long-term strategy which included a series of funding and quality outcome mechanisms.

While a long-term approach was being taken, funding priorities continued to remain central in the public discourse of the Commonwealth Government and this is demonstrated through the introduction into non-government nursing homes of the CAM/SAM and OCRE funding mechanism together with the compulsory RCI dependency system for classifying residents into levels of care to provide funding. Although quality care and standards of care priorities have emerged more strongly in the public discourse during this period through the establishment of the Commonwealth Outcome Standards and Standards Monitoring Teams, this quality of care and standards monitoring emphasis is more as a result of the Government seeking to ensure that its funding mechanisms are not abused by nursing home operators rather than because of any adherence to humanitarian or social justice principles.

For example, the Forword prepared by the Department of Community Services (1986b:iii) for Dr. Rhys Hearn's Report, *Quality, Staffing and Dependency: Non-government Nursing Homes* noted 'the focus of this consultancy reflected, in particular, concerns highlighted in the Coopers and Lybrand WD Scott's *Cost of Nursing Home and Hostel Care Services* Report, that costs of providing nursing home care vary widely and that the reasons for this were unclear.' Therefore, the objective of expanding the understanding of what currently occurred in nursing homes and the relationship between factors such as staffing and quality of care provided was strongly being emphasised in this study, not for some humanitarian reason to benefit the aged and chronically ill who were living in nursing homes but rather because the Commonwealth Government continued to have as its major priority the need to clarify why costs varied to such an extent in order that they could bring the funding of nursing homes under control.

Prior to 1986, a submission-driven funding system existed which created marked inequities between regions. The recommendations from the *Nursing Homes and Hostels Review* (1986) which were subsequently taken up in the Aged Care

Reform Strategy saw the move to a needs based planning approach which sought to produce a more equitable distribution of services across and within States and Territories. Therefore, the themes which have dominated the public discourse throughout the Aged Care Reform Strategy have revolved around providing a better balance of services between nursing home and hostel accommodation and community services provision.

Benchmarks for the ratio of nursing home beds to hostel beds were established by the *Nursing Homes and Hostels Review* (1986) and were implemented as part of the Aged Care Reform Strategy in order to control the growth of costly nursing homes. Since 1991, these benchmark ratios were extended to include increased services by way of Community Packages in order to encourage people to remain in their homes rather than move into hostels and nursing homes.

Prior to the introduction of the Outcome Standards requirements, there was very little nursing care planning in existence within nursing homes and due to the lack of knowledge about nursing care planning amongst the staff of nursing homes, the implementation of the Outcome Standards Policy has proved extremely difficult. Sadly, since the introduction of the Outcome Standards Policy, discussion by nursing staff within the nursing home industry has centred around the volume of documentation required to provide care rather than the more important overall issue of how to improve the quality of care and quality of life of the increasingly dependent population of residents now living in nursing homes. That is, very little attention has been given to major issues such as the continuing number of untrained nursing staff working in nursing homes as well as the paucity of gerontologically trained Registered Nurses and Directors of Nursing working in nursing homes both of which can have a major impact on the quality of care provided to residents living in nursing homes (Pearson 1987).

The Commonwealth moved to 'outcomes' standards monitoring of care, while the States continued to monitor various 'input' measures for quality. However, the

actual 'process' through which quality of care was to be delivered was not specifically addressed. The actual process through which nursing home staff were to prepare the documentation required to support the RCI and to support the requirements of monitoring teams was not prescribed by Government circulars in order to allow nursing homes the opportunity to develop their own models of documentation which best suited their individual setting. However, lack of knowledge about nursing care planning amongst nursing staff as well as the fear that if they did not document all the care given then the resident might not be placed in the correct category of care and thus the level of funding for the nursing home would be reduced has seen a huge amount of over documentation taking place within nursing homes.

Some two years after the introduction of the CAM funding, the Commonwealth Government funded the production of a CAM Management Manual to explain the methods through which the CAM/SAM/OCRE process would operate within nursing homes. However, no such manual was prepared to explain the methods through which the Standards Monitoring Team process would operate. It is only recently, with the release of the findings of the Macri Report (1993), that a Documentation and Accountability Manual was commissioned and is due for release in March 1995. Although Government Departments prepare circulars concerning new policies, which are then forwarded to nursing homes for implementation, it would seem there is a serious need to ensure that any future policy changes which affect nursing home staff should automatically have an accompanying manual which not only explains the changes to the nursing home staff but also gives details of the processes which are required to be implemented in order to achieve the desired policy. Because of the high numbers of untrained nursing staff working in nursing homes, it would seem that this is an important point to address in any future policy implementation within the nursing home sector.

Thus, over the last decade, shifts in aged care policy have heralded the beginning of a new era for the nature of nursing home care provision. Previously, nursing homes admitted people of varying dependency levels and nursing home staff cared for a mix of residents. However, today, nursing homes have become places which provide care for only the highly dependent, with less dependent people requiring residential care being directed into less expensive hostel accommodation. Increasingly, nursing staff are required to provide care for highly dependent residents and therefore, the educational needs of nursing home staff need to be addressed.

The regulatory process of establishing standards monitoring teams to monitor nursing homes has been put into place in order to monitor the outcomes of nursing homes. However, I would argue that the Commonwealth Government has not gone far enough in monitoring the outcomes of nursing homes by not sufficiently investigating to ensure that quality treatment and nursing care are really being provided for residents. Difficulties with establishing the process of documentation for the Outcome Standards has distracted attention from the very issue of providing improved quality care to residents. How do residents know when a member of the standards monitoring team asks them if they are being provided with the correct care when they may not know what correct care is? Clinical indicators including the incidence of decubitus ulcers urinary tract infections and skin tears are some simple indicators that could be recorded and compared across various different types of nursing homes in order to provide more information about the care being provided within nursing homes. Such data would provide additional information which would be of enormous benefit to not only potential residents but also to staff in order that they could see how their nursing home was performing in comparison to other nursing homes of similar size, and so on.

While this argument for increasing the monitoring and surveillance of residents using clinical indicators may be somewhat contradictory to the Foucauldian view

espoused earlier that monitoring and surveillance of residents is a form of control which produces docility in residents, and therefore should be avoided, I would argue that the monitoring of clinical indicators of residents well-being for quality purposes would actually be highly beneficial to residents' welfare. The addition of quality clinical indicators to the Outcome Standards Monitoring Process would not only enrich the process but would also provide useful comparative information to prospective residents and their relatives. Measurable and comparable clinical indicators across the nursing home sector would be easily understood by those external to the nursing home arena such as prospective residents and their relatives and therefore would increase their knowledge about the quality of care provided in nursing homes. Such additional information may influence the choice of nursing homes where a resident is placed and from a Foucauldian perspective, the Commonwealth Government, by not collating such data on residents in nursing homes and only relying on the Commonwealth Outcome Standards Monitoring Teams reports to assure the quality of care in nursing homes is in effect denying prospective residents and their relatives and friends measurable objective comparative information about the quality of care provided in nursing homes.

SUMMARY

Parts A and B of this chapter were concerned with the public discourse of aged care where priorities and values are expressed in policy behaviours, in spoken language found in Parliamentary debate and in the written word found in official policy documents. The history and evolution of aged care policy formation and implementation was described through the use of six major policy phases which were linked with the ideological approach favoured by the Commonwealth Government in power at the time. The six major policy phases of aged care policy as described were:

Phase 1—Insurance-based health service: *laissez-faire* approach;

Phase 2—Minor subsidy intervention approach;

Phase 3—Major cost-sharing subsidies, minor regulations, minor inquiries;

Phase 4—Minor regulatory approach;

Phase 5—Major public enquiries and reports; and

Phase 6—Major regulatory approach: aged care reform strategy.

The political and economic context of the period under study was examined in order to understand the major shifts in aged care policy that have impacted on nursing homes. These major policy shifts were found throughout the various policy phases which exhibited the different economic systems that reflected the values and beliefs which were central to the community at the time.

This chapter has attempted to examine and unpack the powerful and influential public discourse in order to uncover some of the social interests which are characteristic of its make-up and these will now be summarised in relation to the above six phases of aged care policy.

Prior to 1962, during the *laissez-faire* period, the major public discourse centred around self-help and private enterprise. This period saw the introduction of the Aged Persons' Home Act in 1954 which allowed religious and charitable organisations to build nursing homes. In 1962, the Commonwealth introduced the Nursing Home Benefits Scheme which ensured payment of benefits to the elderly and chronically ill, regardless of their pension status or their participation in private health insurance. Therefore, between 1962 and 1968, during the period of minor subsidy intervention within the public discourse, funding priorities to provide health services for the uninsured old and chronically ill resulted in the Government relying on private enterprise to provide long-term care for the aged and thus the elderly and chronically ill came to be regarded by the Government as revenue earners for private enterprise. The next period, between 1969 and 1971, was a time of major cost-sharing, minor regulation and enquiries. The Nimmo Committee (1969:57) alerted the Liberal Government to problems surrounding the varying standards and poor quality of care provided to nursing home residents and

subsequently the two-tier system of funding through the 'intensive' nursing care subsidy was established. Throughout this period, the themes which dominated the public discourse revolved around economic incentives to prevent a private sector retreat from nursing home bed provision. Funding priorities remained the key focus of the Government and resulted in the Liberals relying on increased subsidies and grants to entice proprietors to improve the standard and quality of nursing care within nursing homes rather than initiating severe regulatory control measures which would not have been popular with the medical profession.

Between 1972 and 1981, the Liberal Commonwealth Government turned to regulation to curb the difficult problems of uncontrollable rapid growth of nursing home beds, escalating expenditure, lack of control over admissions and the dilemma of interstate variations in fees and benefit levels that had developed. The change in political ideology of the incoming Labor Government in 1972 saw a strong shift from private sector provision to favour the voluntary sector. Greater priority was given to finding solutions to the funding problems of nursing homes and each political party in power utilised their own ideologically driven funding mechansims. The standard and quality of care provided was not a major question — only the ideology upon which the funding mechanism providing the care was questioned. We see during this period between 1972 to 1981, both political parties avoiding the issues of quality and standards of care. They avoided questioning the technical proficiency of the 'expert' medical profession which was an extremely strong and forceful political lobbying force.

In the early eighties, nursing homes received a barrage of bad publicity and a series of enquiries and research projects were set in train which highlighted the need for change and direction in provision for aged care services. This period of major public inquiries and reports between 1981 and 1985 saw the emergence of a fuller discussion on issues of quality and standards of care in nursing homes. However, funding continued to remain the central priority within the public discourse, with

economic rationalists and bureaucrats seeking ways to legitimise and substantiate their proposed new model of funding. Therefore, an adequate level and quality of care provided to residents needed to be assured in order that the Government could introduce its new model of funding.

Thus, by 1986, as a result of the *Nursing Homes and Hostels Review* (1986), the Aged Care Reform Strategy was introduced and consisted of a raft of major regulatory measures which focused not only on funding but also on the standards and quality of care provided to residents. The previous submission driven funding system which created marked inequities between regions was replaced by needs-based planning approach. The public discourse on aged care from 1986 was not so much ideologically driven with short-term quick fix-it solutions but rather priorities centred on providing a long-term strategy. While a long-term approach has been taken, funding priorities continued to remain central in the public discourse of the Commonwealth Government and this is demonstrated through the introduction of the CAM/SAM and OCRE funding mechanisms together with the compulsory RCI dependency system for classifying resident into levels of care to provide funding.

Interestingly, although quality care and standards of care priorities have emerged more strongly in the public discourse over the last decade with the establishment of the Commonwealth Outcome Standards and Standards Monitoring Teams, I would argue this quality of care and standards monitoring emphasis is more as a result of the Government seeking to ensure that its funding mechanisms are not abused by nursing home operators rather than because of any adherence to humanitarian or social justice principles.

Changes introduced as a result of the Aged Care Reform Strategy have greatly affected the role and function of the Director of Nursing and the management practices of nursing homes in Australia. As a result of growing financial constraints, nursing home proprietors increasingly have adopted an economic

approach to management, endeavouring to obtain the highest possible productivity from staff from available resources. The utilisation of a Total Management Package will ensure a more efficient and effective operation of a nursing home, while providing high quality care for residents. Unless legislation is amended to reflect the changing education requirements of Directors of Nursing of nursing homes then the Aged Care Reform Strategy will have difficulty in achieving its desired outcomes.

Chapters Four, Five and Six have examined the discourse of quality of care in nursing homes from the perspective of residents, care providers and the public sector, respectively. The following chapter provides a Foucauldian analysis of the discourse of quality of care for residents in nursing homes.