Chapter 1
Introduction

Introduction

The current climate of aged care encourages a commitment to continuous improvement in standards, quality of care and the processes of accreditation. The delivery of quality care requires an appropriate staffing mix with the skills to provide an acceptable standard of care (Pearson, Hocking, Mott & Riggs 1993). In Australia, the employment of an increasing number of support workers in the delivery of health care has largely gone unnoticed in the public arena. Bulbeck (1993:99) talks of a 'less skilled' category of assistants in nursing (AINs) that exists to assist the registered nurses in the aged care industry. The delivery of care by these 'less skilled' or minimally trained staff, particularly in aged care, has been mostly ignored by managers in pursuit of profit margins, registered nurses preoccupied with the diversification of their own role, and government policy that has encouraged and supported dependency on institutionalised aged care by older people.

This thesis is concerned with the practice of assistants in nursing (AINs) employed in Australian nursing homes. In particular, it identifies and examines AINs' ideas about equality and how this drives decision making in terms of their distribution of resources at the bedside. This issue is important because the majority of employees in nursing homes are AINs. How they distribute resources impacts upon the type and quality of care that is delivered, and the quality of life that older persons experience in nursing homes.

The significance of examining the practice of AINs cannot be understated, for a number of reasons. Firstly, there has been an escalation in the number of AINs employed in private and public health care services, and a significant increase in the

AIN workforce is anticipated in aged care services as demographic changes in Australia see an increase in the number of elderly people requiring nursing home care and hospitalisation. Secondly, little is known about how the practice of AINs affects the care needs of consumers. Thirdly, because AINs are largely an unregulated workforce, monitoring their utilisation and the standards of their work does not occur.

To examine the practice of AINs, and how they distribute their resources at the bedside, interviews were held with AINs employed in nursing homes in the rural health region of New England, New South Wales. Initial contact with the AINs who participated in the study followed consultation with the Director of Nursing at each participating nursing home. The researcher had previously worked as an AIN, and more recently as a registered nurse, in the nursing home sector in the New England region. An awareness that continued employment as a registered nurse within the nursing home sector may result in 'unequal' power relationships between the researcher and participants, and possibly skew the findings of the study, led to a conscious decision by the researcher to not work in the sector for the 30 months' duration of this study.

Background and context

The Assistant in Nursing

Between 1991 and 1996, AINs employed in the aged care sector increased by 27% (Australian Institute of Health & Welfare 1999a:3) and they have traditionally made up the majority, or approximately 57%, of workers in the aged care industry (Workforce Planning Unit 1994). Currently, approximately 25,940 AINs are employed in Australia (Australian Institute of Health & Welfare 1999a:3) and most work in the nursing home industry under the nursing award. Although AINs have contributed to care in the nursing home sector for many years, it is relatively recent that professional nursing associations have officially acknowledged their role. The New South Wales Nurses' Association, for example, adopted a position statement

and an initial draft policy on AINs at its national conference in 1998 (New South Wales Nurses' Association 1998). Other states, although not adopting their own position statements on AINs (personal correspondence with the Australian Nursing Federation state branch secretaries, 2–12 December 2000), all follow the national guidelines set down by the Australian Nursing Federation in March 1999 (Australian Nursing Federation 1999).

These position statements and policies identified the roles and responsibilities of AINs and registered nurses in terms of the delegation of nursing duties. The discussion that occurred about the appropriate role of the AIN was driven by a broader philosophical and professional debate about the appropriateness of skilled versus less skilled staff being directly involved in the care of clients. Although AINs had been part of the nursing unions and workforce 'unofficially', their role and contribution to care had not been acknowledged officially by these associations. The adoption of the policy by the New South Wales Nurses' Association in 1998, followed by the Australian Nurses Federation in 1999, was therefore significant because it not only more clearly defined the role of the AIN by recognising their role 'officially', it also validated the work that AINs performed. However, despite the numbers of AINs employed in aged care facilities and the recent recognition of the role they play in the delivery of care, there exists little research that focuses on their practice (New South Wales Department of Health 1992, 1996). The majority of studies that have examined nursing home practice have focused on the role and contribution of registered nurses, which make up approximately 10% of the aged care workforce (New South Wales Department of Health 1996). To broaden both the current depth and understanding of nursing home practices, this study is aimed specifically at examining the practices of the assistant in nursing.

Delegation of nursing duties

Registered nurses are more formally educated than other classifications of nurses such as AINs and have been traditionally seen as the custodial carers of nursing

home residents. The two dichotomised forms of knowledge, formal educational training at university for registered nurses and primarily experience-based training of AINs or TAFE level three certificate, have led to friction in the delivery of care for nursing home residents. Much of this friction has revolved around the appropriate delegation of nursing duties.

'Delegation' refers to the transfer of authority to another person to perform selected tasks in specific situations. As the scope of nursing has evolved in response to social, economic and technological influences, the traditional role of registered nurses has diversified and delegation of tasks has occurred as a result. In the nursing home industry, nursing tasks involving activities of daily living, such as feeding, showering and dressing, have been delegated by the registered nurse to the AIN. The administration of medications, assessment of clients, documentation of residents' needs and other more complex tasks have remained the domain of registered nurses.

The appropriateness of delegating nursing duties to less-skilled employees has also received attention in similar circumstances overseas. For example, the Nurses' Association of British Columbia and the Central Council for Nursing in London, within similar timeframes, have had similar debate about the inclusion of unlicensed care providers (UCPs) and health care assistants (HCAs), respectively, in providing care for the aged (Francis & Humphreys 1998; Registered Nurses' Association of British Columbia 1999). In other places, such as Nevada, AINs are a very pro-active group which provides journals, educational opportunities and union support for their role (Workman 1996). In Australia, AINs, as a result of official acknowledgment, now have access to formal educational programs. This commonly involves a 260–320 hour course at Certificate Three level under the Australian Qualifications Framework (New South Wales Nurses' Association 2000). Short courses offering education on aspects of their work such as wound observation and

care of the dying are also becoming increasingly available (Australian Bureau of Statistics 1997).

The debate about nursing practice has, in general, revolved around whether nursing should be a practice-based or theory-based profession. Part of this debate relates to whether traditional roles of registered nurses should be delegated to less-skilled nursing staff. This issue certainly warrants careful future analysis. However, although it is arguable that such delegation of duties influences the type of care residents receive, this thesis does not explicitly aim to determine the appropriateness of the delegation of roles. Rather, it is predominantly concerned with examining the practices of AINs from their perspective and identifying the factors that influence how they distribute resources to those in their care.

Significance of the study

Context

The care that people in nursing homes experience on a daily basis is constantly betwixt and between government intervention, in terms of regulation and financial arrangements, on the one hand, and the financial interests of providers on the other. In general, aged care policy is aimed at the provision of a standard of care that is acceptable to society and cost effective to the government. As politicians and providers attempt to balance the social concern of aged care provision against the cost effectiveness of providing such care, the macro-level decisions in this distribution tend to focus on the collective dependency status of residents, the notion of user pays arrangements and the rhetoric of quality of life. Although these macro-level governmental decisions clearly influence the resources available to the AIN, and other staff, their 'trickle down effect' on the quality and type of care delivered to residents at the micro level of the bedside has not been explored. The consumer voice is usually only heard in times of crisis following government inspections of the practices employed in nursing homes and where restrictions to funding, or sanctions, are imposed to prevent certain providers from operating.

The quality of residents' life in nursing homes is inextricably linked with the distribution of available resources on an equal basis to all residents. The intricacies of how this distribution occurs at the bedside can only be understood by the examination of the bedside practices of the particular staff delivering care. In this instance, the staff who deliver most of the care and who have the ability to control the distribution of resources at the bedside are AINs.

An examination of the bedside practices of AINs has become even more relevant since the introduction of the Aged Care Reform Package in 1997 because the reforms have removed the previous strict nurse-to-resident ratios and made staffing issues a major concern for all stakeholders (Gray 2001:96). Opponents of the reforms would argue that this arrangement is a cost driven reform because staffing in high care facilities can consume up to 80% of the budget (Gray 2001:163). Supporters of the reforms, however, would argue that numbers of staff do not ensure quality outcomes for residents, rather, it is the appropriateness of the skills of the staff that ensures quality outcomes. Resolving questions about the appropriateness of staffing mix and quality outcomes for residents relies on determining and understanding the roles and behaviours of the staff involved in the delivery of care.

The 'ageing in place' policy that was introduced with the Aged Care Reform Package in 1997 aims to enable the elderly to remain in the same residential facility despite a potential decline in their health leading to a higher category of care needs. This change in policy is likely to result in the increased employment of AINs to care for the aged in what was previously known as the hostel industry. Such a trend will further increase their numbers in the aged care industry and this strengthens the importance of identifying their practices, and examining the factors that influence the type of care they deliver to elderly residents. By gathering information about a particular phenomenon, the AINs' perception of equality and how this influences

the distribution of resources at the bedside, this study addresses an important shortfall in knowledge about the delivery of care in nursing homes.

The introduction of a user pays system under the Aged Care Reform Package of 1997 has signalled a shift in federal government policy from public funding of aged care services to a greater emphasis on consumer cost sharing arrangements to fund aged care. Under this user pays system residents are categorised as those who are not required to pay an income tested fee and accommodation charge and those who may be required to pay such fees. Hence, under these arrangements residents are now categorised according to the level of care they receive and according to their ability to pay for their care. In addition, some facilities, known as Extra Service Facilities, can offer luxury accommodation and a higher standard of food and services to residents able to pay higher accommodation charges and higher daily care fees (Gray 1999:6). In effect, this means that people with the financial means can, if the facilities are available, access higher quality accommodation and services.

Under the new funding arrangements, the distinction between residents who pay additional fees and those not required to, not only influences the type of accommodation and services residents may access, but it also has the potential to influence the type of care they receive in nursing homes. Hence, the introduction of the user pays system under the Aged Care Reform Package raises important questions about its potential impact on the issues of equity in accessing services and equality in the delivery of care.

During her employment in the nursing home sector the researcher had observed differences in the manner in which staff delivered care to different residents. The desire to examine this phenomenon and the factors that influenced these differences in behaviour resulted in the researcher conducting a small pilot study, which provided the basis for the field of inquiry for this study. The pilot study was conducted in early 1998, following the release of the Aged Care Act in late 1997. This small study was conducted to explore potential influences of a user pays

system on the delivery of care in nursing homes. Details of the pilot study are provided in chapter two.

AINs and resource distribution

It is AINs who are ultimately responsible for distribution of care resources at the micro level of the bedside. It is the individuals within this group of workers who decide which residents will be rushed through the essential activities of daily living so that the required work is accomplished within the regular eight-hour working shift. AINs will, for example, decide whom they will spend more time with when showering, feeding and dressing residents. They will determine the amount of time spent grooming residents and which residents will have their call bells answered expediently.

Few studies have analysed the content of the interaction between registered nurses and patients. Even fewer have examined the interaction between AINs and the residents of nursing homes. Studies that have examined the time registered nurses spend with patients (Armstrong-Esther & Browne 1986; Norton, McClaren & Exton-Smith 1962; Wells 1980) found that the time was limited in duration and was predominantly spent on providing physical care (Davies 1992:583). There is also a considerable amount of literature available on the behaviour of difficult residents and the reason this behaviour occurs (Bepko 1984; Block, Boezkowski, Hanson & Vanderbeck 1987; Ryan, Tanish, Kolodny, Lendrum & Fisher 1988). However, studies which examine the dynamics of interactions between staff and residents and the factors that influence how staff distribute resources are scant.

As AINs are expected to increase in numbers and simultaneously be expected to care for higher-level dependency residents than previously was the case, an examination into their practice is long overdue. Examining the role of AINs who account for the largest percentage of the nursing home workforce will provide a more accurate picture of nursing home practice and the provision of care. By doing so, the development of more comprehensive policies regarding appropriate staffing

in long term residential facilities is possible. Those determining staff ratios must be aware of not only the complex needs of this vulnerable population of elderly people but also the expanding role of the AIN. These issues warrant both examination and analysis by the nursing profession.

Purpose of the study

Aim of the study

As stated earlier, the aim of this study is to examine the practice of AINs and how this impacts on the quality and type of care delivered in nursing homes. To do this, the study focuses on the AINs' ideas about equality and how this transpires into behaviour in terms of their distribution of resources at the bedside.

Objectives

The main objectives of this study are to:

- identify the AINs' perception of equality;
- identify the major influences that maintain and reinforce the AINs' perception of equality;
- identify the resources available to the AIN, the influence these types of resources have on the AINs' perception of equality and the types of care delivered at the bedside; and
- examine how the AINs' distribution of resources influences the types and quality of care residents receive.

Methodological considerations

A qualitative approach

Within the Australian context, the Outcomes Standard Monitoring Program introduced in 1987 sets the precedent for a qualitative approach to examine issues such as equality and quality of care in the nursing home industry. Under this program the measures of outcomes are based on residents' perceptions of the acceptability of outcomes rather than objective tools (Gibson 1998:96). To do so, the monitoring team enters the nursing home and through observation and

conversations with residents, family and key staff, the team gains an overall perception of the quality of care and the residents' quality of life in the facility. In other words, there are no set checklists of empirical measures of inputs and processes. The main focus is placed on whether the standard is *perceived* as being upheld by the resident. For example, Standard 5.1 involves the respect of privacy and dignity of residents by nursing home staff. In this case, the monitoring team is concerned with whether the residents *perceive* that this is occurring rather than which measures or procedures are used to achieve this outcome (Gibson 1998:90-91). In a similar vein, the focus of this study is not on *what* care the residents receive, but rather on *how* the AINs' perceptions of equality influence the quality and type of care they deliver.

The use of a qualitative method, such as grounded theory, is appropriate for this study because it enables the discovery of meaning and interpretation of behaviour in an area about which little is known. Grounded theory does not rely on existing theoretical frameworks, priori assumptions or previous studies (Taylor & Bogdan 1984:126). The method allows the researcher to develop theory from the 'ground up'. That is, theory is teased out of the data gathered from the informants. From the data provided by the informants in this study, the researcher was able to generate theory that helps explain how they distribute their resources to residents in their care.

Grounded theory is a particularly useful method for examining the microcosm, or micro aspects, of action and interaction in a particular setting (Grbich 1999:129). However, to more fully understand a particular phenomenon, macro-level aspects or influences need to be considered. This study, therefore, seeks to take account of the structural influences of the nursing home environment, and broader society, on the behaviour of AINs at the micro level of the bedside.

In-depth interviewing

The use of in-depth interviewing presupposes a certain physical and cognition capacity of the interviewee. Within the nursing home environment, where many residents are highly physically and cognitively impaired, the voice of the residents is small individually and collectively or, at worst, nonexistent. Relying on the residents' perceptions of their care is further complicated by the impact of institutionalisation upon their perceptions. Institutionalised residents are reluctant to criticise the practice of their carers and tend to develop views different to those held by the wider society from which they come (Ellis 1999; Jacelon 1995; Stockwell 1972). An example by Gibson (1998:99) clearly illustrates this later point:

> In one observed instance, female and male residents were showered together in full view of each other. The problem ... was that the residents had come to accept this and did not complain of it, although this would not be regarded by most people as consistent with the privacy and dignity standards. Arguably, this would not have been the view of the residents prior to their perceptions being shaped by a very inflexible regime.

The other groups that may have been able to shed light on the care of these very frail, mostly very old, consumers are family, proprietors and staff. However, although family members would be able to provide their perceptions about the care that their significant others receive, to ask them to comment on the care other residents receive would be unreasonable. Furthermore, some residents have no family. The providers who own and manage the institutions clearly have a conflict of interest when assessing the equality and type of care residents receive in their institutions. The only remaining group with insight into institutionalised care is the staff of such institutions. As outlined earlier, AINs spend the most time with residents and often face the dilemmas of providing equality of care, as they struggle to simultaneously meet the expectations of the provider and the residents in their care. This is a further reason why AINs were chosen as the appropriate informants for this examination of nursing home practices.

Structure of the thesis

Chapter two discusses the methodological framework used in the study. It examines the utility of grounded theory and provides an explanation of the process involved in the data collection and analysis.

Chapter three examines the broader social and political environment in which aged care has developed. It provides a brief overview of the policy approaches to aged care in Australia and the implications of recent aged care reform on contemporary nursing home structures and the emergence of AINs as major providers of aged care.

Chapters four and five provide content analysis of the informants' interviews and present the findings and meanings from the research. Chapter four begins the process by defining the informants' perceptions of equality and examining the factors that maintain these perceptions within the working environment. The behaviour, in terms of equality, that the AINs exhibit during their distribution of resources at the bedside is analysed within the context of contemporary theory of equality. Chapter five identifies the AINs' resources and explores their perceptions of equality in response to their construction of the act of caring. It compares and contrasts the AINs' perceptions of equality and their described behaviour to discover meaning of their bedside practices within the context of nursing home practice. Within these two chapters, categories and themes that emerged from the interview data unfold to identify the core category that provides insight into the factors that influence the AINs' perceptions of equality and their subsequent practice in the distribution of resources at the bedside.

Finally, chapter six provides a summary of the research findings and presents the conclusions drawn from the study. The implications of the findings for nursing home practice are also presented.

Chapter 2
Methodological Framework and Theoretical Approach

Introduction

This chapter discusses the methodological framework used in the analysis of the AINs' perceptions of equality, and how this translates into their distribution of resources in residential aged care. The interpretive framework used for the study is that of grounded theory. This approach is particularly useful for examining the microcosm of action and interaction within particular settings, and exploring the construction of meaning (Grbich 1999:129).

Assigning an appropriate methodological framework to this research project was determined by two essential elements of the study. Firstly, the central question of the research, how the AINs' perceptions of equality influenced their distribution of resources at the bedside, required an approach that would enable the researcher to explore this particular question from the AINs' perspective. Secondly, it was imperative that an appropriate method be selected to explore an area about which very little is known. The ultimate 'fit' of an appropriate methodology with these two elements of the study was quintessential to the findings and subsequent analysis of the data.

Interpretive research enables the researcher to document and interpret the totality of what is being studied, in context, and from the respondent's point of view (Lieninger 1984:3–7). That is, it enables the researcher to explore society, or a subset of society, from the 'emic' point of view or the perspective of the participants in the study (Field & Morse 1985:20).

In this study the grounded theory approach provided the researcher with an appropriate framework and means to focus on the AINs' perceptions of equality and to explore how these perceptions transpired into behaviour at the bedside within the social parameters of nursing home practice. To gain insight into the AINs' perspectives and experiences, the 'emic' point of view, the study used in-depth interviews.

The chapter begins by outlining the major characteristics of grounded theory. A description of the informants involved in the study, and a discussion of the processes involved in the collection of data and the analysis of the information provided by the informants, follows this discussion.

Grounded theory

Background

Interpretive methods of qualitative research share common attributes involved in the examination of phenomena. They employ similar methods used to interprete, describe and understand the world of the person (Stern 1994:213). Grounded theory, as an interpretive method, also provides a way to explore contextual influences within the world of the person if the researcher chooses to utilise it in this way (Hutchinson 1993:193). As these methods share similar ways of data collection and analysis, it is important for researchers to differentiate between the traditional interpretive methods and grounded theory that has evolved out of a partial combination of these methods. Whereas ethnographers are concerned with describing a culture of a given group, and sociologists are interested in exploring the major influences in the social world of the group, phenomenologists are concerned with the relationships between individuals' experiences and the surrounding world at a given point in time (Stern 1994:213). All of these methods employ a multitude of ways to undertake research. When these methods fail to capture what the data are trying to say, however, researchers often 'tinker' in an effort to explain the participant's world and remain true to the data (Stern

1994:213). Two pioneers who became involved in this 'tinkering' with method were Anselm Strauss and Barney Glaser. The method they developed, grounded theory, was used for this study.

Strauss and Glaser created the framework, or method of grounded theory, in 1967, at a school of nursing in San Francisco, by modifying aspects of traditional interpretive methods such as ethnography and phenomenology. Grounded theorists assume that what the participants reveal is true and, as the name suggests, in grounded theory observations and questions are generated in the field, or from the 'ground up'. Whereas the ethnographer concentrates on the ritual, grounded theorists place importance on the participants' constructions of the social reality of the ritual. In this study it was the social reality of the nursing home that AINs created that became important in explaining their interactions with residents in the nursing home environment.

Although grounded theory employs a process of collecting and analysing data and emphasises the importance of day-to-day happenings within a particular context (Grbich 1999:129), descriptions of how to use grounded theory were elusive in the original work of Strauss and Glaser. Stern (1994:221) has argued that Glaser and Strauss had quite different 'modus operandi' when utilising grounded theory. This is evident in the later publications of their writings. Glaser very strongly pointed out in his books, *Theoretical Sensitivity* (1978) and *Emergence Versus Forcing: The Basics of Grounded Theory* (1992), that true grounded theory belonged to the Glaserian school and that Struassians really utilise a framework termed 'conceptual description'.

Glaser suggests (1992:4–5) that grounded theory pivots on two aspects. Firstly, it identifies the question or problem and the variation that may occur within a setting and, secondly, it identifies the connection or comparison between behaviours, incidents and categories. Strauss, conversely, transgressed into a much more analytical process of coding (known as open, axial and selective) in the

development of theory (Grbich 1999:129). This thesis follows the Glaserian school in terms of analysis by 'de-emphasising the fracturing of data through coding in favour of comparisons between incidents and between emerging concepts' (Glaser 1992:102). That is not to say that aspects of grounded theory which have been employed by Strauss (1987) and Strauss and Corbin (1990) are not utilised in this study but, rather, that the emphasis on 'letting the theory emerge' via a Glaserian approach (Stern 1994:221) prevails over the tighter, more prescriptive analytical Straussarian approach.

Grounded theory is a discovery process in which there is a reciprocal relationship between data collection, analysis, and theory. There is often 'a continual blurring and intertwining of all three operations from the beginning of the investigation until its near end' (Glaser & Strauss 1996:57). That is, all three aspects rely on each other simultaneously in the development of theory. The theories are fluid, embrace multiple actors and scenes, and require the researcher to explore each new situation for relevance to emerging themes and concepts. Through a systematic process of sorting and analysing the data, the researcher looks for patterns of incidences to develop a statement of plausible relationships (Hutchinson 1993:182). The approach provides a certain amount of predicability because if there are 'approximate similar conditions, then approximately similar consequences may occur' (Strauss & Corbin 1988:69). In this study the plausible relationships among concepts and sets of concepts in terms of the AINs' distribution of resources in Australian nursing homes are explored. The relationships discovered are described fully in chapters four and five.

When using grounded theory, the researcher begins with a question and investigates it using various methods such as in-depth interviews and/or observation. In-depth interviews are designed to allow people to tell their story because 'ordinary language is in some sense a huge reservoir in which the incredible variety of richness of human experience is deposited' (van Manen 1990:61). Grounded

theorists do not set out to test other theories. Rather, they aim at generating theory (Browne & Sullivan 1999:589) that becomes inherently relevant to the world from which it emerged (Hutchinson 1993:184). In this study, examining the AINs' perceptions of equality that underpin their practice became inherently relevant in creating an understanding of the quality and type of care delivered to nursing home residents.

The initial interviews in this study contained broad global questions such as 'can you tell me a little about yourself?' and 'what things do you like about your work?'. That is, in order to capture which factors influenced the AINs' perceptions of equality at the bedside, a rather large net of inquiry was cast so as to not restrict the boundaries of inquiry, or unnecessarily direct the informants from the researcher's perspective. This approach allowed the informants to reveal much about their practice, the types of structures they worked under, their interaction with residents, and their day-to-day role in caring for residents. An analysis of data provided by the initial informants postulated a modified set of parameters and guided the researcher in the selection of the next group of informants to support or discount emerging themes and concepts, and so on. As the study progressed, the interview questions moved to more specific or particular questions that were guided by the emerging themes. The themes that emerged were related to the informants' perceptions of equality.

The terminology used to refer to the participants during the research reflected the roles and the power relationship that was associated with the research. For example, describing the AINs as 'informants' implied that the researcher was being *informed* of knowledge by the AINs, rather than the researcher creating knowledge by manipulation of behaviour. In addition, to prevent the researcher, or the informants, from having power over each other, particular language or terms were used to define and maintain what Minichiello, Aroni, Timewell and Alexander (1990:25) have termed 'in crowds' and 'out crowds'. In crowds, or insiders, develop

particular language to describe their world (Minichiello, Madison, Hays, Courtney & St John 1999:409). In this study it was essential that the language specific to the culture of nursing and nursing homes was understood and not misinterpreted by the researcher. As the AINs were the focus of the study, it was important that the researcher recognised and learned their language to avoid misunderstanding of their meaning and experience and, in turn, to avoid incorrect analysis (Taylor & Bogdan 1984:51). Hence, throughout the interview process, the researcher had to be conscious of the need to use language belonging to the AINs, not the researcher.

As this study moved through phases over time, connections developed between data and analysis to form a theory about a particular behaviour or group of behaviours. In this instance, the theory involved establishing connections between the AINs' behaviour and its relationship to perceptions of equality. The behaviours that emerged throughout this initial process were grouped together to form categories and subcategories. The use of 'in-vivo' coding (Glaser 1978:70) was adopted so that the categories reflected the actual terminology of the informants rather than traditional labels such as 'toileting' and 'professionalism'. In other words, the categories have been restated directly from the conversation of the AINs and labelled according to their conceptualisation of the particular behaviour in their own words or language, for example, 'bits of yourself'. This is consistent with the idea of Glaser (1978:70) that 'in-vivo' terms are grounded in the perspectives of the actors or within context.

The appropriateness of grounded theory for this study

The primary aim of this study involved gathering information about a particular experience: the practice of AINs in Australian nursing homes. To do this, the study focused on the AINs' ideas of equality and how these transpired into behaviour in terms of distribution of resources at the bedside. As outlined in chapter one, the main objectives of this study were to: identify the AINs' perceptions of equality by exploring AINs' values and beliefs; to examine the influence workplace structures

had on available resources and quality of care; and to explore how the AINs' perceptions of equality impacted on the AINs' distribution of these resources at the bedside.

An interpretive framework, utilising grounded theory method, was especially useful for this study as it has the advantage of being able to gather information about an experience where little is known, such as AINs' perceptions of equality and how these perceptions impact on long term residential care. As pointed out earlier, the grounded theory approach develops from the 'ground up' and does not rely on existing theoretical framework, priori assumptions or previous studies (Taylor & Bogdan 1984:126). Rather, it creates theory by developing concepts and propositions from the data gathered. To avoid influencing the researcher in terms of the interpretation of the data, Strauss has contended that the review of any literature should only occur after all the data are collected, if at all. Glaser has agreed with Strauss to a certain extent. However, Glaser has stated that once the first core category emerges, the literature should be reviewed and the subsequent emergence of categories should guide the literature review for the remainder of the research (Grbich 1999:133). As the Glaserian school of thought guided this study, the literature reviews occurred in this way, sending the researcher back to the literature multiple times in an effort to interpret the informants' world.

It is commonly observed that grounded theory is particularly useful when the minutiae of interaction is the focus of a study (Grbich 1999:129). Hence, it tends to examine the micro rather than the macro aspects of actions and interactions. This is not to suggest that grounded theory is not capable of taking account of the macro issues that impact on the microcosm of the phenomenon under study. Indeed, Glaser (1992) and Strauss and Corbin (1990) have advocated searching for both the action/interaction and structural aspects of a phenomenon and linking the two together. To demonstrate the interaction and interrelatedness of conditions that apply to a given phenomenon, the concept of a conditional matrix is useful.

Figure 2.1 provides an illustration of a conditional matrix modified from Strauss and Corbin (1990:163). The concept of a conditional matrix denotes the 'complex web of interrelated conditions, actions/interaction, and consequences that pertain to a given phenomenon' (Strauss & Corbin 1990:161). In Strauss and Corbin's (1990:162–164) view, it is important to acknowledge the impact relevant macro-level variables on the actions/interactions under study, such as: international or national politics, government regulations, economics, and values; organisational and institutional level structures and rules; and sub-organisational and sub-institutional structures and rules; and sub-organisational and sub-institutional structures and rules.

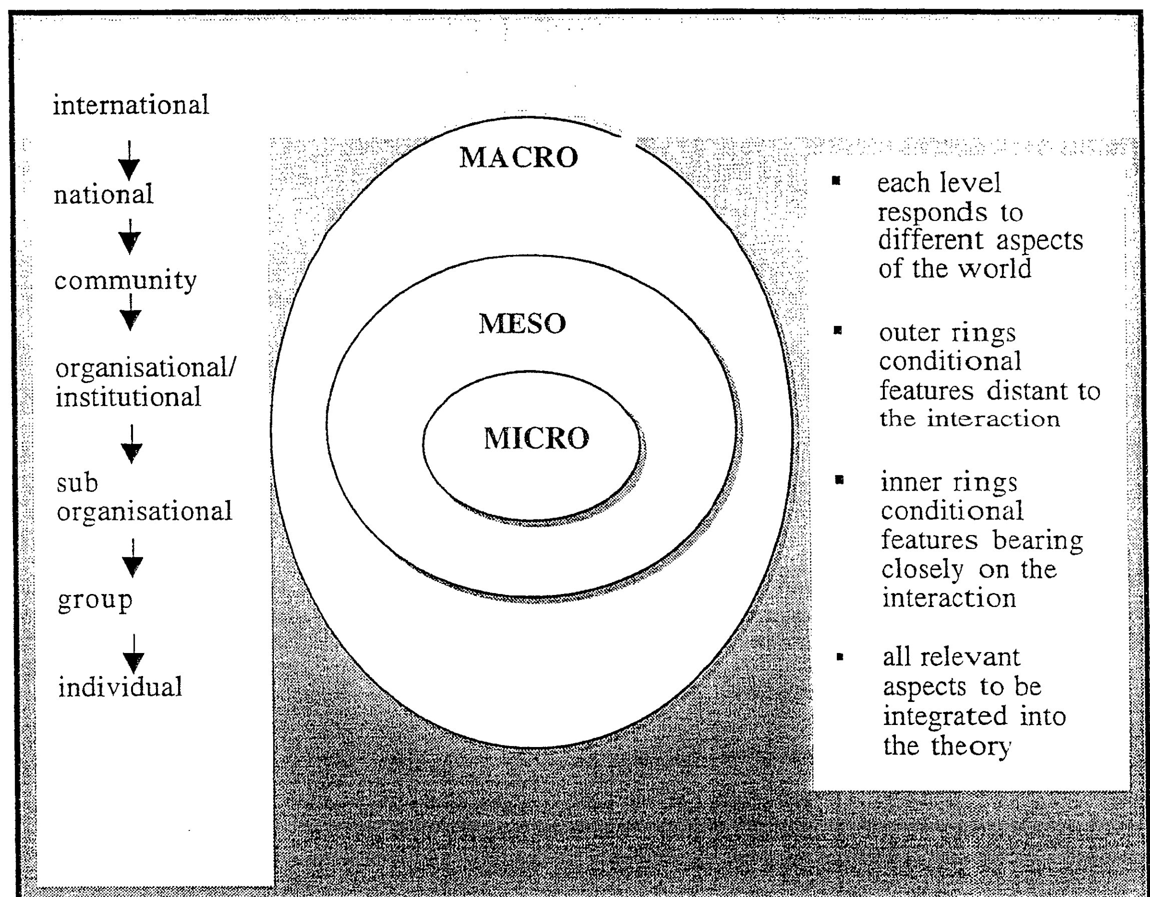

Figure 2.1: Conditional matrix (adapted from Strauss & Corbin 1990:163)

However, although grounded theory is claimed to have the capacity to address these broader macro-level influences, most grounded theory studies in nursing have

tended to focus on micro-analysis of social processes, and have failed to address the potential impact of macro-level variables on these processes (Hutchinson 1993:193). By examining macro-level issues relevant to the delivery of aged care in Australia, this study seeks to take account of the broader structural influences that have impacted on the structure and organisation of the nursing home industry, and the AINs' distribution of resources.

Method

The pilot study

The pilot study was conducted in early 1998 to explore the influences of the introduction of a user pays system under the Aged Care Reform Structural Package on the delivery of care at the bedside in nursing homes. The findings of the pilot study provided the impetus for this research.

The pilot study utilised in-depth interviewing, theoretical sampling and grounded theory methods of analysis to explore the experience of the participants in their delivery of care in nursing homes. The informants chosen consisted of two registered nurses and two AINs. A mix of gender, age, experience and educational level was purposely sought to give this small study added diversity. The duration of each interview ranged from 30 to 60 minutes.

Three common themes relating to the equality of care delivered to residents arose from the data of the pilot study. These themes were examined to determine their influence, from the perspective of the staff, on the level and type of care they delivered to residents. The findings of the pilot study suggested that the residents' level of verbal articulation, the degree of family involvement in the lives of residents, and the judgements by staff of the residents' financial means may lead to inequality in the delivery of care. These findings provided the researcher with valuable insight into the complex interplay between the perceptions of staff about the meaning of equality, their perceptions about the socioeconomic status of residents, and the influence these factors may have on the care they deliver. During

the pilot study, the researcher was able to clearly identify the group of staff that contributed most to the bedside care of residents and gained ideas about the types of questions needed to explore the relationship between perceptions of equality and the delivery of care. This enabled the researcher to determine the appropriate sample group for the purpose of this study and provided assistance in the development and refinement of interview questions.

In addition, the pilot study enabled the researcher to allay fears, within the participating institutions, about a recurrence of negative publicity that had followed previous research which they felt had unfairly criticised their practice. This proved to be extremely important because the 'gate keepers' to accessing the informants for this study were the Directors of Nursing. By providing the details and intent of the pilot study, and subsequently the results of the study, the researcher was able to establish a working relationship with leaders within the nursing homes, which in turn facilitated access to the informants involved in this study.

The experience of conducting the pilot study and the findings it yielded therefore proved very useful in the undertaking of the research presented in this thesis. It provided the basis for this study which involves a more complex analysis of how the AINs' perceptions of equality influence their delivery of care to residents.

Data collection

In-depth interviewing

Henderson (1966, cited in Robinson & Vaughan 1992:13) describes qualitative nursing research in the context of 'getting inside someone's skin to try and see the world as they view it'. To 'get inside' the experience of nursing home practice, this study has used in-depth interviewing of the informants as the tool for data collection. In-depth interviews with the informants were used to gather an understanding of experiences of the participants, that forms part of a social system, in this case the institution of nursing homes. In this particular social system, AINs play a role in a subsystem of that society. The interview focused on the 'emic', or

the 'insider's', point of view in an attempt to 'develop an explanation about the development, maintenance and salience of certain social processes' (Kellehear 1993:21) such as the informants' perceptions of equality and their influence on their behaviour.

The informants participated in the study voluntarily and were interviewed for approximately 30 to 60 minutes. The interviews commenced following ethics approval from the University of New England Ethics Committee and approval from the Directors of Nursing of the participating nursing homes. They were conducted in a setting outside the work environment chosen by the informant, and were tape-recorded. Prior to the interview, each informant was supplied with a plain language statement which outlined the aim and purpose of the research, expectations of the participants, the type of information to be collected and the manner of collection, and the contact details of the researcher. A signed informed consent form was obtained prior to the commencement of the interviews. All informants were informed of their right to withdraw from the study at any time, for any reason, without prejudice. To provide consistency and, hence, strengthen validity, the same researcher carried out all the interviews. A general conversational style regarding their work in nursing homes was the theme, with a particular focus on the AINs' perceptions of equality of care and the distribution of resources identified by them.

In keeping with the principles of grounded theory (Lieninger 1984:9), it was the AINs' points of view, and their interpretations and meanings that were important in this study. Although the numbers of informants involved were small, the strength of the findings in this study came from the diversity of the AINs interviewed and the similarities of their experiences when related to the same sorts of phenomena. Although as a methodology, grounded theory uses a smaller sample size than quantitative methods, the data that are gathered are abstract, have multiple foci and are enormous in size. In this study, the interviews of nine informants who

participated yielded in excess of 400 A4 pages of transcripts, in addition to the researcher's field notes and interpretive notes.

The categories identified in the study emerged as the informants told their stories. Each AIN brought to their encounters with residents their own beliefs, expectations, emotional state and past experiences. All of these individual aspects underpinned the AIN's perception of equality of care and determined how the AIN behaved in the workplace. However, other emerging categories suggested that the residents, other staff and the structure of the nursing home environment, at particular points in time could modify this behaviour. From these categories, themes were developed to describe the content and shape of the experiences described by the AINs. As explained by van Manen (1990:90), 'themes are more like knots in the webs of our experiences, around which certain lived experiences are spun and thus lived through as meaningful wholes'. Themes became the experience of meaning rather than isolating objects and were inter-woven to formulate theories regarding the practice of AINs. They explained the *how*, *why* and *when*, of the major categories and become important in understanding the AINs' decision making process in terms of distribution of resources at the bedside.

The informants

In Australian nursing homes the staffing mix is varied, ranging from the Directors of Nursing to Diversional Therapists to Assistants in Nursing. The choice of AINs for the purpose of this study was twofold. Firstly, because this group of workers provides the majority of care for residents, in what has been described as 'bed and body work' (Gurbrium 1975), examining their behaviour provides insight into how perceptions of equality affect the care residents receive. Showering, feeding, toileting, dressing, pressure area care, mobility and location changes are usually performed by the AINs (New South Wales Health Department 1996:17–18). Hence, because this group is involved in most of the activities concerned with the quality of daily life for residents, it is the most appropriate group to study when

exploring how perceptions of equality influence the bedside care delivered in high dependency nursing homes. Secondly, focusing on the behaviour of this group provides a broader perspective in which to examine quality of care issues in existing nursing home structures. AINs are closely connected to the residents through involvement in their care and often face dilemmas of providing equality of care as they struggle to meet the expectations of the provider and simultaneously attend to the perceived needs of the residents in their care.

Because the selection of informants was 'guided by a search for contrast' (Llewellyn, Sullivan & Minichiello 1999:181), obtaining a relevant sample for the study was complex, intense, and time consuming. The researcher met with potential informants, with the permission of the Directors of Nursing, during routine staff meetings to explain the purpose of the research and the expectations that would be placed on those who agreed to participate. Flyers detailing the purpose of the study and the contact numbers of the researcher were left at each participating nursing home and potential informants were invited to contact the researcher directly. To ensure the anonymity of informants, the researcher undertook to have no contact with any informant at their place of work.

Following the initial contact, 25 informants volunteered to be available for the study. All filled in demographic sheets covering areas such as age, gender, ethnicity, socioeconomic status, educational status, terms of employment and experience in nursing homes. This enabled the researcher to purposely select a diverse group of AINs that in turn would add strength, in terms of validity, to the research. The sampling of informants for the study was an ongoing, staged process. As with true grounded theory, data collection, analysis and sampling were intimately interrelated and occurred at the same time (Llewellyn et al. 1999:177). A deliberate sample of maximum variation was sought, as little is known or published about the practice of AINs (Pearson et al. 1993; New South Wales Department of Health 1992, 1996).

During the interview phase of this study, establishing some kind of rapport was essential to ensure the informants were relaxed and able to express their views openly. The researcher had anticipated that developing trust between herself (as the interviewer/registered nurse) and the AINs (interviewees) was going to be a major hurdle as most AINs in the workplace seem to experience a lack of confidence about discussing nursing home practice. The AINs saw the workplace as an environment where they typically held a low position in the social order. Being asked to participate in a nursing home study was therefore an uncommon and confronting experience to which they were not accustomed.

Theoretical sampling

For the purpose of this study, a diversity of sample demographics within the same setting was sought (Hutchinson 1993:188). This is referred to as theoretical sampling and allows the researcher to gain the most diverse sample possible. Maximum variation sampling (Patton 1990), which allowed the researcher to vary the sample to gain an understanding of the depth and breadth of the experience under exploration, was used to obtain a true picture of the interaction and practices of AINs.

As pointed out above, each informant completed a demographic form detailing their age, gender, ethnicity, educational status, years of experience in aged care, hours of employment and their perceived socioeconomic status. That is, the socioeconomic status of the informants was self-defined and not assigned by the researcher. The demographic details of the nine informants who participated in the study are provided in Tables 2.1–2.5. All of the informants identified as Australian, and were aged between 17 and 45 years. In keeping with the normal demographic profile of people employed in nursing work, the majority of the informants were female (i.e. six out of a total of nine were female). The majority had some training at a TAFE institution and they had varying lengths of work experience in aged care. Most of the informants were employed on a part-time or casual basis. Their normal hours of

employment ranged from 20 to 30 hours per week. The difference between permanent part-time and casual employees was that the management could, under the industrial award, alter the latter group's hours of employment at any time. Two of the informants stated that they perceived themselves to be of a high socioeconomic background, even though as an AIN they were working for a relatively low wage. Their perception of themselves as having a high socioeconomic background related to their private school education background, their partner's type of work, and their social networks outside the work environment. The remaining seven informants perceived themselves to be of low socioeconomic status within the similar parameters of educational background and social networks of family and friends. The small number of informants who self-identified as having a high socioeconomic status (i.e. two) became problematic in terms of theoretical sampling, but this is not surprising, given the low status accorded to AINs and their financial remuneration.

Table 2.1: Demographics of informants

females	males	Australian	other
6	3	9	0

Table 2.2: Educational status of informants

TAFE	secondary	university	industry	other
5	3	1	0	0

Table 2.3: Informants' length of experience in the aged care industry

<1year	1–2 years	2–3 years	3–4 years	>5 years
1	2	2	2	2

Table 2.4: Employment status of informants

Perm full time	Perm part time	Casual
1	3	5

Table 2.5: Self perceived socioeconomic status of informants

High SES	Low SES
2	7

In keeping with theoretical sampling, the choice of informants in this study was based on their relevance to emerging themes of the study and was intimately related to data collection (Llewellyn et al. 1999:177). In this respect, the demographic features of the potential AINs became the criteria for selection. The following example demonstrates this point. If the informants, up to a certain point in the study, were female, possessed a TAFE education and were over the age of 35, then the selection of an informant possessing different demographic characteristics, for example, male, under the age of 35, with no TAFE education, would be used to validate or negate any arising themes. If the informants related similarly to a common behaviour or context, then a certain amount of validity was assumed.

The contexts or situations of the study were also chosen via theoretical sampling, again depending upon their relevance to emerging themes. This process of selection was based on the search for contrast (Llewellyn et al. 1999:179–181). For example, if a particular behaviour or interaction occurred under a particular circumstance, then the researcher needed to determine under what circumstances it did *not* occur and why. This would then account for observed differences and hence add breadth and depth to subsequent understanding (Field & Morse 1996:95). When the researcher had explored many 'negative cases' or varying samples of the population and the emergence of new themes and concepts did not occur, then the study had reached what is termed 'saturation'. Saturation, according to Strauss and Corbin (1990:193), occurs when no new relevant data appear, when all elements of a category are accounted for, and when relationships between the categories are established and validated. Using this method of theoretical sampling, this study resulted in nine AINs being interviewed from the New England health region of New South Wales as saturation of data surrounding common themes occurred at this point.

Analysis

Process

Interpretive methods are used extensively in contemporary research. The actual process of analysis, however, is poorly defined. It is how the methods are focused, sequenced, targeted and employed that differentiates the various methods of qualitative research. Within interpretive frameworks, such as the grounded theory method, theory is not fact, but merely a 'best guess' to guide investigation or understanding of a phenomenon (Morse 1994:32).

In discovering theory, different methods of data collection and data analysis exist. One of the most fundamental differences between quantitative and qualitative methodologies lies within data collection and data analysis. Consistent with true grounded theory (Chientz & Swanson 1986; Miller & Crabtree 1992; Hutchinson 1993; van Manen 1990), this study involved simultaneous data collection and analysis which resulted in the researcher being immersed in the data over a period of 30 months. In other words, in contrast to quantitative methods the data in this study were not collected at one point in time and then analysed by the researcher.

The interviews were conducted during the period late 1998 to late 1999. The researcher transcribed the taped interviews and content analysis of the interviews was conducted. The analysis took two forms, latent analysis and manifest analysis (Field & Morse 1985:103). Latent analysis involves the review of sections or passages of the interviews within the context of the entire interview. This enables the researcher to identify the major intent of the sections and discover underlying meanings. The purpose of manifest analysis is to quantify, or enumerate the frequency, in which specific concepts are discussed and when they are not. This type of analysis was used to survey the interview transcripts for words, phrases and themes central to the research. Through this process of latent and manifest analysis the researcher was able to identify major categories and themes important to the

interpretation of the experience or phenomena under investigation (Miller & Crabtree 1992).

For the purpose of this study, the parameters of the research were initially loosely defined. Three informants were interviewed before the first formal analysis occurred. Analysis occurred following each subsequent interview. The interview questions were modified in each case, as the direction of the research took on new meaning based on the informant's knowledge. This provided the researcher with the ability to propose questions and examine propositions or themes that arose from the data collection. This approach is consistent with the idea of Field and Morse (1985:12–14) that a general theme of which direction the research is going is all that is appropriate in the beginning. The methodology utilised in this study is also consistent with Glaser and Strauss' (1967:58–59) partial analysis that tests 'each step of the way' through a process of selecting and talking to informants in order to explore the nature of the experience.

In this study, the researcher became the tool for data collection and gathered information through observation and in-depth interviews. Following the process described by Hutchinson (1993:194–197), by listening, reading and re-reading transcripts, the relationships and comparisons led the researcher to the formulation of theory. The taped in-depth interviews were transcribed and these provided the basis for a content analysis of the informants' experiences (Field & Morse 1996). The transcripts and field notes of each interview were analysed and reviewed in depth and the emerging themes and concepts were noted separately. Common links between the categories involving the perceived level and equality of care were developed, and assumptions linking the categories were utilised to support, refute or create theory in relation to AINs' perceptions of equality and their behaviour. The use of assumptions about a particular behaviour or event was useful in determining data questioning, sampling and the eventual saturation of data. The categories identified were linked together under a core category to provide an interpretation of

the data. By identifying themes and issues, a conceptual theory relating to the effects of the perception of equality on the practice of AINs at the bedside in Australian nursing homes developed.

Limitations

The limitation of grounded theory, in general, can be seen through its utilisation as a method. According to Glaser (1978:69–72), there is a great risk of diffusing the meanings of the data, as researchers tend to focus on coding rather than on the process of conceptualising themes and contexts. It is the concepts, their relationship to each other and subsequent theory, that is important in grounded theory analysis, not the multitude of acontextual codes extrapolated and dissected into less than meaningful groups. Comparing and conceptualising category data is essential for meaningful interpretation of the informants' experiences (Glaser 1978:72).

Grounded theory recognises that reality is not fixed but, rather, has multiple foci dependent upon the context at a particular point in time (Taylor & Bogdan 1984: 1–2). Based on the argument of multiple reality, grounded theory also acknowledges that people experience things differently at different points in time (Glaser & Strauss 1967:61). The findings of this study, therefore, represent a small glimpse of the practice of AINs in Australian nursing homes. Experiences of other groups of AINs may be different or similar, again dependent on the experiences and contexts of the people in the respective groups. Quantitative researchers would consider this a severe limitation, whereas qualitative researchers, such as grounded theorists, regard discovering the 'emic' point of view as a unique strength in trying to understand or interpret an experience.

Reliability and validity

To determine the reliability and validity of research, traditional aspects such as the tools, design type and size of sample are usually assessed. These traditional, or quantitative, measures of validity and reliability cannot be utilised in qualitative methodology (LoBiondo-Wood & Haber 1998:218–220). The reliability of

grounded theory method hinges on the emergence of recurrent themes, patterns, lifestyles and behaviour rather than the size of the sample (LoBiondo-Wood & Haber 1998:218–220). Hence, in this study, the 'truth' of the informants' world came from informants determining the direction and focus of the study through their descriptions of phenomena, and its strength came from the diversity of sample obtained via theoretical sampling. Saturation of data was considered to be of far greater importance than the number or size of the sample. This study did not aim for generalisability and replicability of the research findings, as required in traditional quantitative research. Rather, it aimed to generate theory that offered a new perspective and useful ways of understanding the practices of the AIN, and the world of nursing home practice.

To ensure validity, review of taped interviews occurred within a 24 hour period. The same researcher undertook all interviews and transcript analysis to provide consistency. Validity and reliability also became established through an inquiry audit as utilised by Lincoln and Guba (1985). In this instance, the research supervisors became the auditors for this investigation as they critiqued the research design, its implementation, data analysis and interpretation of findings as the research progressed. The confirmability of the 'audit trail' is evidenced by audio-tapes, verbatim transcription, and by the documentation of data analysis. Therefore, other researchers may audit the process.

Summary

This chapter has examined the methodological framework that has guided this study of the relationship between the AINs' perceptions of equality and their behaviour in terms of resource distribution at the bedside. Grounded theory was particularly appropriate for this study because of its capacity to interpret the totality of what is being studied in context and from the participants' points of view. Because the approach develops theory from the 'ground up', and does not rely on existing

theory or priori assumptions, its use enabled the researcher to examine a phenomenon about which very little is known.

Although it is claimed that grounded theory has the capacity to incorporate the influence of macro-level variables and structural aspects in its analysis of a given phenomenon, the approach is criticised for not paying sufficient attention to these factors. This study seeks to address this criticism by taking account of macro-level influences on the delivery of residential aged care. Although these macro-level influences are referred to throughout the thesis, chapter three details the broader social, political and institutional factors that have impacted on the organisation and structures of the aged care industry, the delivery of institutionalised care to the aged and the emergence of the AIN as the dominant provider of bedside care to residents in nursing homes.

Chapter 3
Aged Care in Context: The Broader Political and Social Environment

Introduction

There have been marked shifts in aged care policy in Australia over the past 40 years. These changes in policy have had a profound effect on the structure and organisation of the aged care sector, workforce arrangements within the industry, and the delivery of residential care for the elderly. Because macro-level decisions at the governmental level influence the organisation and structure of institutional care, and the mix of staff employed in residential care facilities, they have the potential to have an important impact on the quality and type of care that elderly people receive in residential care. In addition, the changes that have occurred to government policies, particularly those related to the funding of aged care, can largely explain the emergence of AINs in such large numbers in the aged care workforce.

This chapter provides an overview of the broader context in which the aged care sector has developed. It seeks to address the criticism of studies based on grounded theory method that they pay insufficient attention to the influence of macro-level structures and processes on action and interaction at the micro-level. The chapter commences with a brief outline of the demographics of Australia's ageing population and workforce issues. It then provides an overview of the changes that have occurred in aged care policies since the 1940s. This is provided because these policy decisions have had an important effect on the contemporary structure and organisation of the aged care sector and staffing mix within residential care facilities. The final section of the chapter outlines the structure and organisation of the nursing home industry and the aged care workforce. All these factors have had

an important impact on the ways in which AINs organise their work and distribute their resources.

The ageing dilemma

Currently, limited resources are available for distribution to meet a projected insatiable demand for aged care in Australia. In 1998, there were 2.3 million people aged 65 years and over, and it is projected that by the year 2021, people aged 65 years and over will number four million and constitute 18% of the population. Those over the age of 80 years will number 800,000 (Gray 2001:1). This rapid ageing of Australia's population has been attributed to three main factors: the high birth rate in the decade following World War II; increased life expectancy; and the number of post World War II immigrants reaching old age (Sax 1993:13–14). In 1996 in the New England region, where this study took place, people aged 65 years and over numbered 174,975 or 12.53% of the population (New England Public Health Unit 1998).

The dilemma for those responsible for the distribution of the health dollar is to decide how much, and to which groups, certain allocations will go. Common perceptions and stereotypical beliefs held in society have centred on the notion that as people age they become dependent and require nursing home care. There has been growing concern, therefore, that increasing numbers of elderly people could place considerable strain on government budgets and increase the tax burden for the remaining population (Commonwealth Department of Health & Aged Care 2000a:1). Dependency ratios, which define the number of persons retired to those working, have projected that in 2050 there will be 60 retired persons to every 100 working persons in Australia (Bacon & Gallagher 1996, cited in Commonwealth Department of Health & Aged Care 2000a:11). This projection of an ageing population has resulted in a mindset among policy makers and the public that a large proportion of health care resources will need to be distributed to the care of an increasing number of older people. However, the reality is that the increase in the

older population does not necessarily equate with an increase in expenditure on health care, or that elderly persons will become a larger drain on the health care dollar than other sections of the population. As stated by the Productivity Commission in their report on the economic implications of Australia's ageing population (Commonwealth Department of Health & Aged Care 2000a:3):

> ... the impact of population ageing has been overstated by many commentators, particularly by demographers. Some commentators have verged on the hysterical ... We say that the implications of ageing are well within the capacity of the economy to absorb and need not involve any significant hardships for the general population or for the aged ...

Currently only 4% of people over 65 years of age require nursing home care in Australia. Nonetheless, between 1993 and 1994, health expenditure on the 65 years and over group was 4.1 times greater than the expenditure on the under 65 age group (Australian Institute of Health & Welfare 1999b:34). Of this expenditure, however, a sizeable amount was spent on food and accommodation in nursing homes but was still classified as health expenditure. The inclusion of these costs in health expenditure creates a statistical illusion in terms of health expenditure on the aged. For example, between 1983 and 1995, real health care expenditure per person grew by 2.9% annually but only 0.6% of this can be attributed to costs associated with an ageing population (Australian Institute of Health & Welfare 1999b:34).

The largest increase in health care costs occurs in the two years prior to a person's death. Therefore, it is only when a large proportion of the population ages and enters this bracket that a large increase in health care expenditure can be expected (Goss 1992). Two factors will offset the impact of increases in older Australians. Firstly, the decreasing numbers of younger dependants will enable resources to be distributed equitably and, secondly, in contrast to the experience in other countries, the proportion of persons of working age will not change significantly (Commonwealth Department of Health & Aged Care 2000a:13). Nonetheless, the projected growth in the numbers of aged people in Australia, and the associated escalation in costs, has raised concerns among policy makers that the aged care

system will not be able to meet future needs adequately. Overstated claims about increasing numbers of aged people requiring care has led to contemporary government policies that aim to decrease government expenditure by increasing costs to individuals and the private sector (Commonwealth Department of Health & Aged Care 2000a:2). This trend has occurred despite the observation of the Productivity Commission that an ageing population does not translate into an increasing burden for society (Commonwealth Department of Health & Aged Care 2000a:4).

In terms of staffing aged care services, the lack of status for workers in aged care, and the absence of incentives to attract skilled staff to work in the area will continue to see few registered nurses entering, or remaining, in aged care (New South Wales Department of Health 2001). For example, registered nurses currently working in aged care attract 15% less wages than registered nurses employed in the public sector (New South Wales Nurses Association 2000). The issues of retention of registered nurses in aged care, combined with the high numbers of staff required for the intensive support associated with the care of this group, particularly in nursing homes, have been used to justify the employment of large numbers of support workers such as AINs. However, despite the Australian Nursing Federation's (1999) recent adoption of policies related to AINs, they still remain an unregulated workforce about which little is known. The majority of research into the practice of nursing homes has involved registered nurses (e.g. Courtney 1996; McMinn 1996; Milne & McWilliam 1996; Nay 1993; Nolan & Grant 1993; Salmon 1993), which only comprise 10% of the aged care workforce. Hence, the largest proportion of care workers employed in Australian nursing homes, AINs, have been largely ignored by policy makers and researchers. It is important to note this failure to pay sufficient attention to the roles and practices of AINs because decisions about how resources should be distributed at the bedside lie most critically with bedside carers such as AINs. It is individuals within this group of workers that ultimately decide, whether overtly or covertly, how available resources are going to be allocated to

those in their care, and the manner in which they will be distributed. Therefore, an examination of how AINs distribute available resources, and the factors that influence their decisions about resource distribution, can provide valuable insight into the type of care delivered and, moreover, the quality of life experienced by people in residential care. The identification of the major factors that influence micro resource distribution decisions by AINs at the bedside may help alter practices and improve the quality of the daily lives of elderly residents.

Nonetheless, macro-level decisions at a governmental level provide the framework that influences the structure and organisation of the aged care sector, how aged care is funded and staffed and, in turn, the delivery of care to residents. The following discussion provides a broad overview of aged care policy and reform that has led to the current structures and practices seen in Australian nursing homes and outlines the context in which AINs emerged as the major providers of care for the aged.

Aged care policy in Australia

Background and context

The volume of literature that has analysed the development of policy related to nursing homes in Australia was minimal prior to the 1980s. Since the 1980s, demographic changes in the Australian population have caused fear of massive increases in expenditure for the provision of long-term institutionalised care, and resulted in the commissioning of multiple reports by the Federal government. The reports have encompassed such areas as funding, planning strategies and equity of care (Grant & Lapsley 1993:197). They have all claimed that nursing home policy has been piecemeal, disorganised and lacked any clear direction in the provision of services and planning for aged care.

In terms of examining staffing issues, most reports have focused on the role and utilisation of registered nurses in nursing homes. Little attention has been given to the bedside practices of AINs and their influences on the quality of care residents receive. Two government reports commissioned by the New South Wales

Department of Health have been the only real attempt to explore the roles and functions of the AIN (New South Wales Department of Health 1992, 1996).

The first of these reports, in 1992, examined the role and utilisation of AINs, and the second, in 1996, progressed into an examination of the educational needs of this group. Oddly enough, these reports did not develop out of government or industry concern, but rather from an impetus within the New South Wales Nurses' Union by its enrolled nurse (EN) membership. Enrolled nurses receive one year of training and, given their lower level of preparation, have traditionally worked under the direction of registered nurses in the private and public sectors. They had found that they were increasingly competing for jobs with AINs, particularly in the nursing home sector (New South Wales Department of Health 1992). The identification of the utility of AINs in the workplace (New South Wales Department of Health 1992, 1996), and their acceptance as a legitimate part of the nursing workforce did not improve the enrolled nurses' plight. Recognition of the AINs' role actually increased their employment in nursing homes and led to the initiation of courses to meet their educational needs (New South Wales Department of Health 1992, 1996; New South Wales Nurses' Association 2001). The result of these developments was that enrolled nurses were often forced to accept employment as AINs and, as such, were paid at a lower rate.

The early years: 1940s–1980s

The provision of government subsidies for nursing homes first appeared on the Australian political agenda following an amendment to the Constitution in 1946. This amendment enabled the Federal government to provide financial benefits for social services, including assistance for medical services, hospitals, pharmaceuticals and nursing home services (Sax 1993:86). In 1954, the Federal government introduced the *Aged Persons Act* which provided matching funds, for couples only, to non-government organisations, such as religious and charitable bodies, which offered accommodation to the elderly (Sax 1993:27). Under the scheme,

government funding expanded to hostels, nursing homes and community care (known as independent living). The availability of government subsidies and a 'pool of old people' large enough to ensure high occupancy rates in institutions led to increased involvement of the commercial sector, with an inherent interest in profit margins, in the provision of aged care accommodation (Sax 1993:28).

Although the 1954 Act had intended to increase the housing available to the poor elderly, the effect in following years was an oversupply of nursing home beds and insufficient home and community services (Gibson 1998:29). Subsequent incremental shifts in aged care policy favoured the provision of increasing numbers of nursing home beds. The *Nursing Home Benefits Scheme*, introduced by the Federal government in 1963, and the extension of the capital subsidy scheme to include nursing home beds in the mid 1960s, served to increase the financial attractiveness of providing nursing home beds. Hence, throughout the 1960s and 1970s the financial incentives of high profit margins, and lack of government regulations, attracted further entrepreneurs into the aged care sector and led to a rapid expansion of the nursing home industry (Gibson 1998:29–30). In addition, large numbers of elderly people were transferred from State funded hospitals and psychiatric institutions to federal government funded nursing homes (Sax 1993:90). This increased the number of nursing home beds provided and clearly demonstrates how the financial incentives offered by the Federal government contributed to the growth in the nursing home sector during this period (Sax 1993:90).

The financial advantages of caring for a large pool of people in an institutional setting, combined with a lack of government intervention, saw this quasi-segregation of older people escalate and created the dominance of institutionalised care over community care that remains in existence today. Australia soon became the 'world leader' in having more nursing home beds per head of population and the lowest coverage of domiciliary nursing per head of population (Grimes 1987:2). For example, between 1963 and 1985, nursing home beds tripled from 25,535 to

75,281, which amounted to a total of 67.2 beds per 1,000 persons aged over 70 years (Commonwealth Department of Health, Housing & Community Services 1991a & b).

The Federal government's approach to aged care throughout the 1960s and 1970s not only laid the foundation of the dominance of institutional care over community care, but also the dominance of the voluntary and private sector in the ownership and administration of institutional care. Throughout this period, federal funding was provided on the basis of agency submission rather than on assessed need. This meant that the owners and providers of residential care facilities could propose to the government how much funding they would require to house, feed and care for the number of persons in their facility. That is, the providers were able to decide how much funding they required and how it would be expended. No independent body assessed funding requirements on the basis of the care needs of people in residential care. Hence, the industry perspective of the perceived 'wishes' of elderly people, rather than consumer needs or demands, drove the types of care provided during this period. This lack of a consumer perspective in the organisation of aged care remained a feature of aged care policy until 1983 (Russell & Schofield 1995:48). In addition, there were no requirements for the proprietors of nursing homes to use government monies to improve standards or employ skilled staff in nursing homes (Courtney 1996:159). Little attention was paid to standards of care and identification and consideration of the characteristics of an appropriate workforce to care for elderly people in institutions.

Regulation of the number of new beds approved by the Federal government in the early 1970s reduced the number of beds available; however, a change in government in the mid 1970s saw the resumption of uncontrolled growth in bed numbers and government expenditure (Courtney & Price 1995:525). The introduction of a more directed and integrated policy in aged care funding did not begin until the release of the McLeahy Report in 1982 (Sax 1993:91). This report

described previous policies and planning as a total mismanagement of service provision and it questioned the appropriateness of the level of expenditure devoted to institutionalised care. The expenditure of $100 million on 7% of the population living in institutionalised care compared to $100 million on 93% of the population living in the community reflected an inversely related expenditure on Australia's elderly population (Grimes 1987:2). The National Health and Medical Research Council (1976:17) also criticised government expenditure on the ageing population by pointing out that much of the money spent on the 'affluent elderly' would have been better spent on providing care in the home. Although changes in aged care policy have occurred, as outlined below, the number of nursing home beds per head of population and federal government spending on institutionalised care has remained high. For example, in the 1998–89 Federal government budget, $2.9 billion were allocated to institutionalised care, 76% of which went to nursing homes (Commonwealth Department of Health & Aged Care 2000a:18). By 1998, the provision of nursing home beds in metropolitan areas was 89.9 beds per 1,000 persons and in rural areas 81.7 beds per 1,000 persons (Australian Institute of Health & Welfare 1999c). The highest numbers of residential care beds were in the Northern Territory (112 per 1,000 persons) and Queensland (95 per 1,000 persons) (Australian Institute of Health & Welfare 1998). In the New England region, the setting for this study, there continues to be an oversupply of nursing home beds per head of population (New England Public Health Unit 1998).

The middle years 1980s–1990s

Negative publicity about the care provided in nursing homes during the early 1980s led to a series of reports and reviews that highlighted the need for change in the provision of aged care in Australia. In 1981, the *Report of the Auditor General on an Efficiency Audit: Commonwealth Administration of Nursing Home Programs* commented on, among other things, the poor management of the nursing home program, increasing federal government expenditure on high cost institutional care, the mismatch between the care needs of residents and the care they received, and the

inadequacy of federal guidelines on the number and type of staff employed in nursing homes (Auditor-General 1981, cited in Courtney 1996:171). The report noted that although around two-thirds of the 'nursing' staff working in nursing homes consisted of non-registered nurses, there was a lack of uniform standards for the number of nursing hours per resident this category of staff performed (Courtney 1996:173).

In late 1982, the report *In a Home or at Home: Accommodation and Home Care for the Aged* (known as the McLeay Report) was released. The major focus of this report, in terms of nursing homes, concentrated on the number of beds available and funding arrangements for aged care (Sax 1993:91–93). In terms of staffing arrangements in nursing homes, its main focus was on the need to provide staff to perform non-nursing tasks to relieve nurses of performing such duties (McLeay 1982:72). Although it considered the number of nursing hours required to deliver a standardised level of residential care, it did not address the appropriate skills mix of nursing staff to provide that care.

The main recommendations of the McLeay report (1982) revolved around the need to limit the growth of nursing homes, and the need to provide additional financial assistance to enable aged care assessment teams (ACATs) to determine whether the frail elderly should enter nursing homes or receive services to enable them to remain in the community. The report also noted the lack of avenues available to residents and their families to make complaints about the quality of care provision and recommended that a tribunal be established in each state to receive complaints about aged care services. The recommendations of the McLeay report provided the foundation for the policies the Federal Labor government adopted when it came to power in 1983.

The 1984 *Senate Select Committee on Private Hospitals and Nursing Homes* (known as the Giles Report) also had a significant impact on the restructuring of long term residential care for the elderly (Sax 1993:93). This report concluded that

the rapid growth in the numbers of nursing home beds since the early 1960s had resulted from the funding policies of successive governments and not, as thought to be the case, demographic changes or socioeconomic factors. It also highlighted the poor standards and quality of care provided in nursing homes, the lack of uniform staffing levels across states, and the need to fund care based on the amount of care provided to different levels of residents. In response to the observed lack of appropriate aged care qualifications among registered nurses, and the paucity of in-service education for nurses working in nursing homes, the report recommended increased postgraduate courses in geriatric nursing and the introduction of in-service and training programs in nursing homes (Giles Report 1984:114–118). Although the Giles Report focused more attention on the need to emphasise quality and standards of care, and the need to address the educational needs of nurses employed in nursing homes, its recommendations focused predominantly on the educational needs of registered nurses.

Major structural and funding changes to residential care for the elderly occurred following the release of the *Nursing Home and Hostels Review* in 1986 (Commonwealth Department of Community Services & Health 1986). The major policy changes included: the development of assessment teams (ACATs) to advise the elderly on their care needs; the expansion of home and community care services; changes to funding arrangements for nursing homes based on a standard of care set by the Federal government; the development of standards of care and quality of life measures for the assessment of care provided; and adjustment to government schedules for hostels to enable them to also provide services for the frail elderly (Courtney & Price 1995:527; Sax 1993:94). The introduction of standards of care and quality of life measures in 1986 led to an examination of quality of care in a real sense for the first time. However, the review did not include an examination of the staffing mix in nursing homes or the skills required to appropriately care for elderly people. An examination of the knowledge and skills of the staff delivering most of

the care, such as AINs, did not come until some ten years later (New South Wales Department of Health 1996).

A number of the recommendations of the *Nursing Home and Hostels Review* formed the basis for the Federal government's Aged Care Reform Strategy. In 1988 the review's recommendation on a national uniform nursing and personnel care standards was adopted and a new funding system replaced the cost reimbursement funding arrangements that had been in place since the introduction of the nursing home benefit in 1963. As pointed out earlier, these previous arrangements had merely based the funding of nursing homes on the amount they spent rather than on the level of services they needed to provide. The new funding arrangement, which funded nursing homes according to the level of care residents required, was based on two major components: the Care Aggregate Module (CAM) and the Standard Aggregate Module (SAM). CAM covered the costs of providing personal care staff and SAM covered non-nursing and non-personal care costs such as laundry, food, heating and maintenance (Courtney & Price 1995:527).

In order to assess and calculate the care needs of residents, the CAM hours, an instrument referred to as the Resident Classification Instrument (RCI), was introduced. This instrument divided resident types into five categories of dependency. Category 1 was the most dependent and category 5 the least dependent. The number of hours funded for the care of each of the residents was based on their classification into one of the five categories. The areas of care covered by the RCI were clinical care needs, emotional and behavioural support, communication and sensory difficulties, and activities of daily living (Courtney & Price 1995:533). The higher the physical dependency of residents, the higher the level of government funding the nursing home received.

Many of the care needs of residents related to an inability to walk, eat or attend to personal hygiene independently. The communication and sensory needs related to physical impairments, and the social and emotional support category involved the

management of physical aggression, verbal disruption and problematic behaviour. The employment of AINs to perform tasks to care for these predominantly physical needs offered a cost effective means to deliver residential care. Registered nurses were employed to carry out the more 'complex' tasks such as administering medication, providing wound care and attending to documentation requirements.

There was insufficient provision in the funding arrangements to allocate nursing hours to aspects of care not based on physical need. The CAM system has consequently been criticised for its failure to adequately recognise the dependency levels of physically able but mentally impaired residents such as those with dementia, and residents with special communication needs, and for its tendency to discriminate against the rehabilitation of residents to increase their mobility levels (Courtney, Minichiello & Waite 1997). Overall, within the industry there was considerable dissatisfaction with the RCI's adequacy to accurately represent the real care needs of residents (Courtney 1996:193).

Nonetheless, despite criticisms about the RCI's ability to fully assess residents' care needs, the tool is claimed to have successfully tied the level of federal government expenditure directly to the level of nursing and personal care required by residents (Commonwealth Department of Health, Housing & Community Services 1991a:103). The different levels of benefits under the RCI provided incentives for highly dependent people to be admitted to nursing homes. As a result, there was a decline in the number of residents in the least funded, least dependent, categories being placed in nursing homes (Sax 1993:96–97). Thus, overall, the average dependency of residents in nursing homes increased and this increased the demands on the resources of staff.

The introduction of the CAM/SAM funding mechanisms and the RCI dependency system for classifying residents into levels of care to determine funding demonstrates that funding priorities continued to remain central to government policy. However, under the CAM system, the allocation of funds for nursing care

hours also clearly highlighted the Federal government's increasing emphasis on the quality and standard of care provided in nursing homes. Under this system the employment of staff was directly proportional to the funding levels proprietors received. However, determination of the 'skills mix' within the staffing arrangements was left to the industry.

On the surface, the employment of increasing numbers of AINs to care for residents with increasing levels of dependency appeared congruent with the government's desire to improve quality of care. However, the determination of the actual care needs of the residents remained focused largely on residents' physical needs. A general acceptance of AINs as being the appropriate staff to deliver this care developed to the extent that by 1994, AINs comprised 57% of the aged care workforce (Workforce Planning Unit 1994). This increase in the employment of AINs has continued to occur, despite the latest policy shift away from government funding being based solely on the care of the physical needs of residents and their behavioural problems.

Aged care structural reform 1997

The Aged Care Structural Reform Package was introduced with the Aged Care Act by the Federal coalition government in 1997 (Gray 1999:4). The changes in government policy followed the release of two reports, the *Aged Care Reform Strategy Mid-Term Review* (1991) and the *Review of the Structure of Nursing Home Funding Arrangements Stage 1* in 1993 (known as the Gregory Report). The 1991 review examined the progress that had been achieved following the 1986 *Nursing Home and Hostel Review*, assessed the impact of various measures that had been introduced, and examined future directions for the delivery of aged care services in an efficient and effective manner. Overall, the 1991 report concluded the Aged Care Reform Strategy had succeeded in reducing the number of nursing home beds and increasing the number of hostel places. The 1993 Gregory Report concentrated on structural reform to promote the efficiency and long term viability

of nursing homes, while continuing to maintain an emphasis on quality of care for residents, and the consolidation of the funding relationship between nursing homes and hostels (Gregory 1993).

Initially, the largest impact of the 1997 reform package came from the change in funding arrangements to hostels and nursing homes. The government abandoned the separate RCI funding for nursing homes, the Personal Care Assessment Instrument (PCAI) funding for hostels and the CAM/SAM nursing and building funding, and introduced one funding subsidy, known as the Resident Classification Scale (RCS), for both nursing homes and hostels (Palmer & Short 2000:115). That is, the new funding system introduced a single instrument to cover both nursing homes and hostels and, unlike the previous system, the funding was not directed to any specific areas such as catering or staffing. Under the new system, decisions about where funds should be distributed were left to the managers of residential care, rather than being government directed. The government also injected $10M annually to rural and special needs facilities, and $20M into capital works of residential facilities (Gray 1999:4).

The RCS provided, for the first time, a tool to measure and fund not only the physical care needs of residents and their behavioural problems, but also their emotional, lifestyle and spiritual needs. Under the new funding arrangements aged care providers could receive funds to care for emotional and social support, leisure interests and activities and measures to encourage independence. Supporters of the reform had hoped that by extending funding to a broader range of care, and allowing providers to determine funding priorities, the 'full' care needs of the residents would be met. However, although the employment of staff such as recreational therapists to carry out life style programs for residents and other allied health workers such as speech, dietary and physical therapists, was initiated, there was actually minimal movement away from the traditional skills mix among staff (Gray 2001:94–96). The employment of staff remained focused on providing staff

to care for the physical needs of residents. As a result, the RCS funding has not provided a marked change in the experience of residential care or the quality of care delivered. There has also remained within the industry a general acceptance of the appropriateness of utilising AINs as the major carers of the elderly.

The introduction of the Aged Care Reform Package saw a marked change in the Federal government's expectations of the individual's responsibility for his or her own aged care. Following the recommendations of a third report, the *National Commission of Audit* (1996), the 1997 Aged Care Act introduced a user pays system based on the notion of self-reliance for aged care funding. The report had predicted large increases in federal subsidies for nursing homes to meet the needs of an ageing population and recommended the introduction of means testing care fees and increased user pay charges (Palmer & Short 2000:116) to curb government funding of long term institutional care for dependent residents. Although the predicted negative effects of an ageing population on health services and government budgets have been shown to be misleading (Palmer & Short 2000:116), the newly elected coalition government saw an opportunity to make large, short term cost saving, by introducing user pays arrangements to nursing homes. As Palmer and Short (2000:345) point out, dire predictions about the impact of an ageing population have been commonly used to argue for policies that reduce government expenditure on aged care and place greater responsibilities on individuals and the private sector. Projections of the potential cost of aged care have also added weight to the arguments of those supportive of employing the lowest paid and lesser skilled workers, such as AINs, to care for elderly people.

A user pays system

The proposal to introduce a user pays system in nursing homes created intense media debate and public opposition. The most controversial element of the original policy proposed by the government was the introduction of a means tested entry contribution, or accommodation bond, for people entering nursing homes. In effect,

this scheme would have provided the owners of nursing homes with interest free loans to support capital developments of their institutions (Palmer & Short 2000:116). A similar scheme, which has been in place in the aged care hostel industry since 1991 in Australia, has been successful in withdrawing government subsidies to hostels for the care of those who can afford to pay for their own care (Sax 1993:109). The policy to withdraw government subsidies for elderly residents with the means to pay for their own care in hostels (Sax 1993:100) was introduced essentially without much opposition, possibly because hostels were likened to retirement villages, rather than care facilities. However, a similar proposal for nursing homes created intense public criticism. It seems, as Gibson (1996a:411) states, society has developed a 'notion of protecting the interests of the powerless (high dependency residents) against the potential abuse of the powerful (the providers of such care)'.

The media coverage of the Federal government's proposed changes to nursing home funding gave close attention to the issue of pensioners having to sell their homes to pay an accommodation bond. Sensationalised headlines in the *Sydney Morning Herald*, for example, highlighted the financial burden for the elderly and their families. For example, 'Nursing homes say elderly will have to sell up,' 'Nursing homes: The policy that grew into a monster' and '45,000 elderly face new daily fees' (Brough 1997a; Horin 1997; Jopson 1997). This type of reporting reflected the intense public opposition to the government's plan for a user pays system in nursing homes. Throughout the heated public debate, the aged care industry managed to avoid any hint that mismanagement on its part, or its lack of investment in capital stock, had contributed greatly to the increased costs of providing nursing home care. Instead, the media coverage portrayed members of the Federal government as uncaring economic rationalists whose prime aim was to cut government funding to aged care. The media's coverage of the issues had suggested the government wanted all individuals, including pensioners, to fund their own aged care.

The public's vehement opposition to the Federal government's aged care reforms translated into 13 changes to the legislation in 1997. The government altered its original proposal by abandoning the lump sum contribution payment for entry into high care nursing homes and put in place a daily accommodation fee subject to a means test. In effect residents who could afford to pay for care still did so, but through a daily charge rather than providing a lump sum in the form of an accommodation bond to the provider. This fee became a key element in the restructuring of the funding between high and low band residential services.

Although the changes to key elements of the policy were welcomed, the industry and the media portrayed them as a back down by the Federal government. Newspaper headlines continued to report the dilemma of funding the care of nursing home residents: 'PM bows to aged on care fees', 'Aged care back down', 'Aged care in the 21st century' (Brough 1997b; Heinrich 1997; *Sydney Morning Herald*, 7 Nov, 1997). The volatile atmosphere created by the government's reform can be further illustrated by noting that three ministers were appointed to the aged care portfolio in the two years following the introduction of the Aged Care Act. Cabinet ministers, Judy Moylan, Warrick Smith and the current minister, Bronwyn Bishop, have all faced extreme political pressure and public criticism over the implementation of the user pays elements of this legislation. Nonetheless, despite widespread criticism, the user pays system, or cost sharing arrangements, in a more palatable electoral form, remains current government policy.

Income testing

Under the user pays system, government subsidies to providers are means tested by imposing an income-tested fee on private income over and above the full pension (Gray 1999:4). Since 1 March 1998, the income-tested fee has been applicable to all residents of nursing homes. The fee is indexed to the consumer price index (CPI) on July 1 each year (Commonwealth Department of Health & Aged Care 2000b:5).

The fees residents pay to high level care facilities, such as nursing homes, consist of two components, a basic daily care fee and an accommodation charge. The maximum resident payments are specified by the Federal government and depend on the resident's income (for daily care charges) and assets (for an accommodation payment). Facilities able to provide a higher level, or luxury level, accommodation are exempt from the specified maximum resident contribution (Duckett 2000:214). The fees charged for the provision of these services are determined by an arrangement between the provider and consumers.

The maximum fees charged for care differentiate between the residents' levels of income. The maximum basic daily care fee for full pensioners was set at 87.5% of the pension, currently $23.96 per day (Commonwealth Department of Health & Aged Care 2001b). This basic care fee contributes to the cost of nursing care, living expenses such as meals, cleaning, laundry, heating and cooling, and other requirements such as recreation and social activities (Commonwealth Department of Health & Family Services 1998). Part pensioners and non-pensioners (self-funded retirees) also pay the basic daily care fee but, in addition, they may be asked to pay a further daily income-tested fee currently set by the Federal government at a maximum of $28.91 per day (Commonwealth Department of Health & Aged Care 2001b). Full pensioners do not pay any income-tested care fee (Duckett 2000:214).

In addition to the daily care fee, residents may be required to pay an accommodation charge, subject to an assets test. This charge provides the proprietors of nursing homes with additional working capital and is, in effect, a contribution to the capital costs of the facility (Duckett 2000:214). The maximum accommodation charge is set on a sliding scale for residents with assets, usually their home, in excess of a level stipulated by the Federal government, and it can be levied for a maximum of five years (Commonwealth Department of Health & Family Services 1998).

Under the current reforms, Extra Service Facilities, previously known as Exempt Nursing Homes, can offer residents luxury accommodation and higher standards of

food and services. In return, they may charge residents higher accommodation charges and higher daily fees (Gray 1999:6). In effect, this means that people from higher socioeconomic backgrounds with the means to pay for extra services are in a position to access higher quality accommodation and services.

With the introduction of income tested fees and accommodation charges, the Federal government's aged care legislation sought to identify particular vulnerable groups in aged care services and address socioeconomic issues such as an inability to pay. It also emphasised strategies to ensure that discrimination of these groups did not occur. Under the legislation there is a requirement that a certain number of places in nursing homes, currently 18.3% in the New England region (Commonwealth Department of Health & Aged Care 1999), must be preserved for financially disadvantaged persons who can not afford to pay extra fees or accommodation charges (concessional residents). Through a viability supplement, the Federal government has also provided extra funding for facilities in rural and remote areas. However, although the social justice initiatives underpinning the legislation are aimed at ensuring that people who are financially disadvantaged are 'treated fairly and justly, have control over their day-to-day lives and have real choices' (Australian Law Reform Commission 1995:71), the choice residents actually have in terms of choosing the level of care they receive, and *who* delivers that care, are indeed limited. In order to purchase superior services, if they are available, residents must have the financial means to do so and, given that one group of workers, AINs, delivers most of the care in nursing homes, the residents' choice of carer is limited.

Implications of a user pays system

The introduction of a user pays system, through means testing of government subsidies and asset tested daily accommodation charges, signalled a shift in policy from public funding of aged care services to a greater emphasis on consumer cost sharing to meet the increasing demands in aged care. The adoption of a user pays

system for funding nursing homes was consistent with the broader market-dominated reform agenda of successive Australian governments. These reforms have drawn on the paradigm of economic rationalism, which closely identifies with libertarian views and a belief in competition, individualism and a limited role for the state. In this approach, health services are treated as commodities to be bought and sold in a market-oriented system, and charity is seen as the proper means to relieve the hardship of those unable to participate (Sax 1993:91).

Those who have the financial means to overcome the structural barriers of a market driven system usually subscribe well to its values (Najman & Lupton 1995:414). However, restricted access to services and goods based on an ability to pay raises the notion of 'worthy' and 'unworthy' individuals. People without the financial means to participate in a user pays system are forced to accept restrictions on their social, intellectual and emotional needs, and the choices available to them. Hence, those unable to participate fully in a user pays system may become socialised into accepting limitations on their choices and thinking they should be grateful for what they receive (Najman & Lupton 1995:420).

As outlined in the previous section, the introduction of a user pays system has resulted in the categorisation of residents as those who are not required to pay an income tested fee and accommodation charge (full pensioners), and those who may be required to pay such fees (part pensioners and non-pensioners). In other words, residents are now categorised according to the level of care they need and according to their ability to pay for that care. Hence, residents with financial means may have access to higher quality accommodation and services and those without these means are limited in their choices.

The distinction between fee-paying residents and non-fee-paying residents not only influences the level of accommodation and services residents may access but it also has the potential to influence the type of care they receive in nursing homes. Given the high visibility of the government's reforms in the press, and the intense public

interest in the reforms, people working in aged care facilities have been made very aware of the cost sharing arrangements. The staff's awareness of the user pays system and their perceptions of the residents' socioeconomic status and ability to pay for services has the potential to influence the type of care they deliver. The issues of equality and equity in the delivery of care have, therefore, become of increasing importance under the new funding arrangements for nursing homes. Through an examination of the practices of AINs, this study explores the potential influence a user pays system may have on the delivery of care in nursing homes.

Funding and the integration of nursing homes and hostels

The introduction of the single funding instrument, the RCS, was intended to integrate nursing home and hostel care and facilitate 'ageing in place' within aged care institutions. As a single funding tool, it was designed to cover the full spectrum of residential care needs, not just physical care needs, and to enable appropriate funding to be directed to all residents, regardless of whether they were located in nursing homes or hostels. Its introduction removed the distinction between nursing homes and hostels by referring to both types of institutions as residential aged care facilities. However, for the purpose of this study, the terms 'nursing homes' and 'hostels' have been retained to more clearly identify and describe the different structures, staffing arrangements and staffing mix within different sections of the aged care industry.

By introducing the RCS, the government was encouraging documentation of the wholistic needs of residents by linking those needs to the funding facilities received. Within the industry, the RCS was generally disliked because it comprised 21 questions that were difficult to define, rather than the previous eight easy to define questions about physical dependency. The new tool has required staff to document, for each resident, 20 categories ranging from clinical needs such as pressure care, toileting and hygiene, through to human and social needs. Each category was assigned points that ranged from A to D, with D being the highest score

(Cuthbertson, Linsay-Smith & Rosewarne 1998:206). The points are then totalled to provide a final score that reflects the overall dependency level for each resident which, in turn, determines the level of funding the proprietor receives for each resident. Although the funding aimed to address more than the physical care needs of residents (Cuthbertson, Lindsay-Smith & Rosewarne 1998:4), the introduction of the RCS has not changed the staffing ratios within nursing homes, or the level of the expertise of carers at the bedside (Gray 2001:94-96).

The RCS did, however, introduce a measure of competition that had not previously existed in aged care and, through subsidies to residential facilities, it enabled residents with similar needs to receive similar funding from the Federal government, regardless of whether they were living in a nursing home or hostel (Cuthbertson et al. 1998:4). By establishing the notion of integrated care, the introduction of the RCS meant in theory that, for the first time, people entering residential care could remain in the same facility for as long as they wished, despite the potential of their declining health leading to a higher category of care needs. This 'ageing in place' was aimed at minimising disruption to the lives of elderly people requiring residential care. It has also provided a means for couples to remain together, even if the health status of one partner declines. In other words, as a uniform tool, the RSC more accurately measures the care requirements of residents in all aged care facilities. Prior to its introduction, nursing homes provided care for residents who were very dependent, and hostels provided care for mildly dependent residents. Under the new funding arrangements, hostels can provide care for residents with high dependency levels and nursing homes can provide care for residents with lower dependency levels.

In reality, however, the physical and behavioural care needs of residents with high levels of dependency remain unmet by the traditional low band facilities such as hostels. Although there seems to have been a general acceptance of the importance of 'ageing in place', in practice, some providers have considered the staffing

implications, the need to employ nursing staff to care for residents with high dependency levels, as a disincentive to offering 'ageing in place' (Gray 2001:194–195). Hence, although the government has succeeded in making the funding subsidies to residential care facilities uniform, the staffing arrangements and costs within nursing homes and hostels have remained quite different. Nursing homes operate under a nursing structure and award, which involves the employment of Directors of Nursing, registered nurses, enrolled nurses and assistants in nursing. The delivery of care in these facilities is tightly regulated and care by qualified registered and enrolled nurses is offered on a 24-hour basis. The associated costs of employing qualified nursing staff under the Nursing Home Award constitutes a large proportion of the overall expenditure of nursing homes. The high cost of staff in these institutions has been used to justify the employment of AINs to carry out most of the care required by residents. Registered nurses are employed in lesser numbers to provide more complex care, administer medications, and attend to documentation requirements.

The hostel industry operates under the Charitable Sector Award, which covers managers and personal care assistants (PCAs) or care service employees (CSEs). This group of workers is represented by the Health and Research Education Association (HAREA). The important distinction between AINs, PCAs and CSEs is that, unlike AINs, the latter two groups are permitted to administer medications under the charitable sector award. This dispenses with the need to employ more expensive registered nursing staff to perform this task. Unlike nursing homes, the delivery of care in hostels is loosely regulated and 24-hour care by registered nurses is often not available. Even in facilities that offer higher levels of care, the employment of registered nursing staff is rare (Gray 2001:95). Those in the industry claim that hostels focus on homelike environments and, therefore, do not require qualified nursing staff to provide care. Many of the managers of these facilities are in fact registered nurses, but they have not been employed as such (Aged Service Association Workforce Survey 1999). Most have been employed as

managers under the Charitable Sector Award and therefore the overall expenditure on staff has been much less for the hostel industry.

Disparities in the cost of staffing the different institutions under the single funding instrument have created friction and dissatisfaction within the aged care industry. Nursing homes spend greater proportions of their government subsidies on the employment of nursing staff than do hostels, although the latter receive the same amount of subsidies for the same categories of resident (Gray 2001:94). The Aged Care Act attempted to address this problem by defining a nursing ratio for high band residents. The initial requirements of the Act include 24-hour, on-site, qualified nursing staff in institutions where there were eight or more high band residents, and consideration of providing nursing coverage when there were 4–7 high band residents (Gray 2001:94). This effectively meant that nursing staff had to be employed to work at night, and not just sleepover, as had previously been permitted under the Charitable Sector Award of hostels. However, these requirements did not work as the Act intended. Proprietors merely adjusted the numbers of high band residents to avoid requirements to employ registered nurses and provide overnight nursing staff (Gray 2001:95). An amendment to the legislation in 1998 subsequently replaced the nursing ratio specifications with the requirement that nursing procedures had to be carried out by nursing staff, irrespective of the number of residents requiring those procedures (Gray 2001:95). Hence, although there has been a general recognition that the employment of appropriately skilled and qualified staff is needed to adequately care for the aged, legislation has usually been required to ensure that this occurs.

The funding arrangements under the uniform system of the RCS, have provided managers of aged care services with greater flexibility in terms of how they meet the care needs of residents, and there are strong indications that the arrangements have enabled providers to invest large proportions of budget into capital improvements (Gray 2001:83). Some hostels have begun to employ registered nurses in their

facilities, particularly where the majority of their residents are progressing into high band care. In some hostels, registered nurses previously employed as managers have been reclassified as Directors of Nursing. These nursing staff, although paid by the charitable sector, are employed under the same nursing award and wage structure as those in the nursing home industry.

However, the effects on the overall level of staff for residential aged care and the hours devoted to direct care are not clear. Submissions to the *Two Year Review of Aged Care Reform* (Gray 2001:96) have suggested that the reforms have brought an overall reduction in the number of staff and a negative change to the skills mix of staff. Concern has been expressed that providers, under the new funding arrangements, have sought to cut costs by employing staff who do not have the appropriate skills or qualifications to carry out the care required. If this is the case, then it is clear that a mere increase in funding to aged care facilities will not necessarily result in improved levels of staffing, an appropriate skills mix among staff, or improved quality of care at the bedside. The New South Wales Nurses' Association has attempted to address this issue by calling for a return to a system where nursing home providers received designated funding to employ an appropriate mix of staff to match the needs of residents (New South Wales Nurses' Association 2001). As pointed out previously, prior to the reforms in the late 1990s, all nursing homes received funding for nursing care under the Care Aggregated Module (CAM).

To date, the majority of changes that have occurred to staffing arrangements under the aged care reforms have involved registered nurses and the reclassification of managers, rather than workers at the bedside. An increased emphasis on accountability, documentation requirements and the monitoring of competencies (Gray 2001:136), combined with requirements to supervise less qualified staff, has placed greater demands on registered nurses and managers and has resulted in resources being utilised to support a top-heavy management structure. However, as

the aged care industry moves to more fully embrace the government's 'ageing in place' policy, further changes to staffing arrangements within the industry will be required. 'Ageing in place', according to Gray (1999:5), is 'changing the character of them [hostels] to that akin to nursing homes'.

Hostels providing high levels of care will be required to employ more registered nurses to provide 24-hour care to residents with higher dependency levels. The increased employment of registered nurses to provide more complex care and administer medications will remove the need, and incentive, to employ PCAs and CSEs to perform such tasks. The 'ageing in place' trend has, therefore, the potential to considerably alter the skills mix and qualifications of staff employed in the aged care industry. Figures 3.1 and 3.2 compare and contrast staffing arrangements under the traditional high band nursing home care arrangements and the previous hostel low band care arrangements, and the structures that are emerging as a result of the Aged Care Structural Reform Package.

As illustrated in Figure 3.2, the current trends are seeing the movement of registered nurses into the hostel industry as a result of high band care recipients 'ageing in place'. Over the past four years, the traditional nursing structures have been replacing the previous structures in hostels with the result that there has been a decline in the number of non-nursing staff such as PCAs and CSEs. Legislative changes requiring the employment of registered nurses to care for high dependency residents will make the previous cost benefit practice of employing PCAs/CSEs to administer medications and document care needs obsolete. As this occurs, it is likely that the lower paid workers, AINs, will replace the PCAs/CSEs as the primary care providers. Recent changes to the awards (New South Wales Nurses' Association 2000) have already enabled hostels and nursing homes greater flexibility to employ AINs or CSEs/PCAs as their 'generic care worker'. Furthermore, in New South Wales, undergraduate nursing students are employed

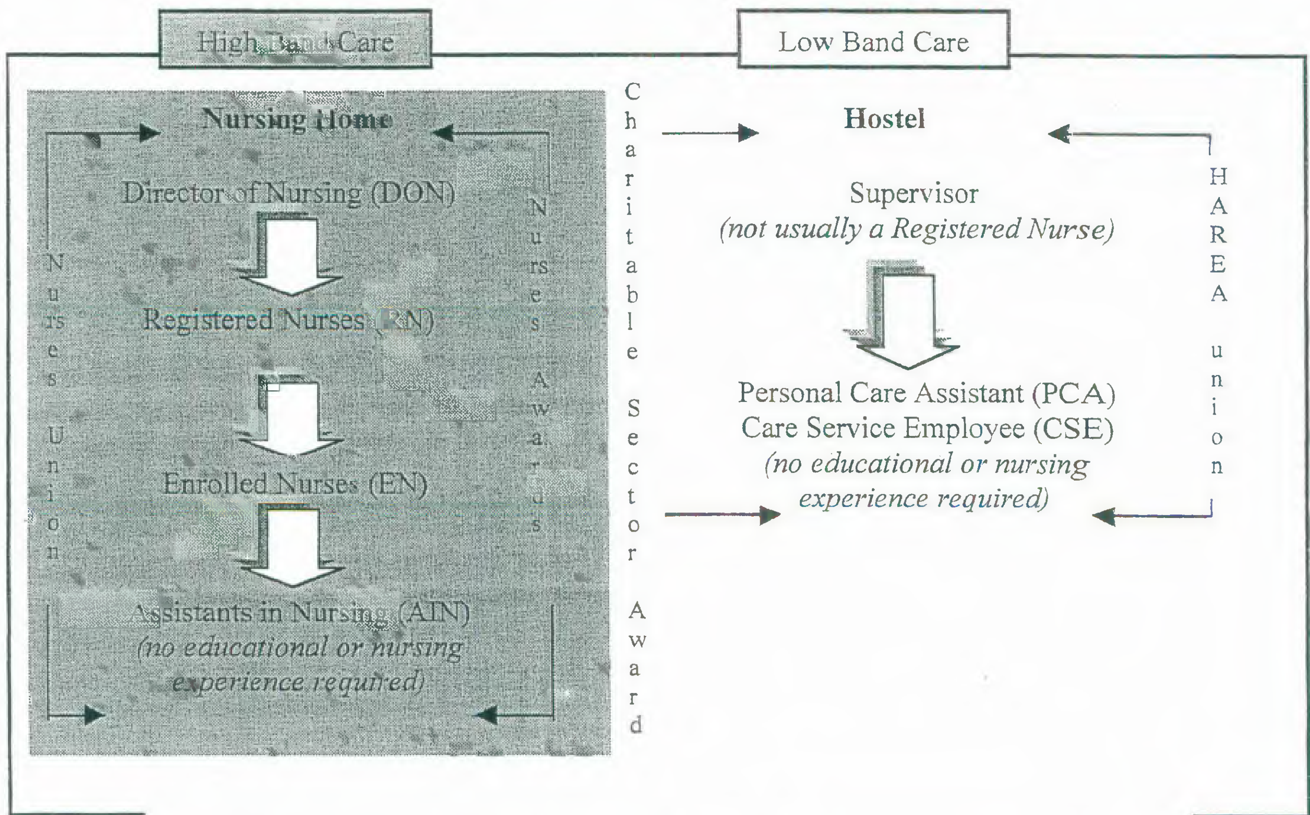

Figure 3.1: Traditional structure: Pre aged care structural reform 1997

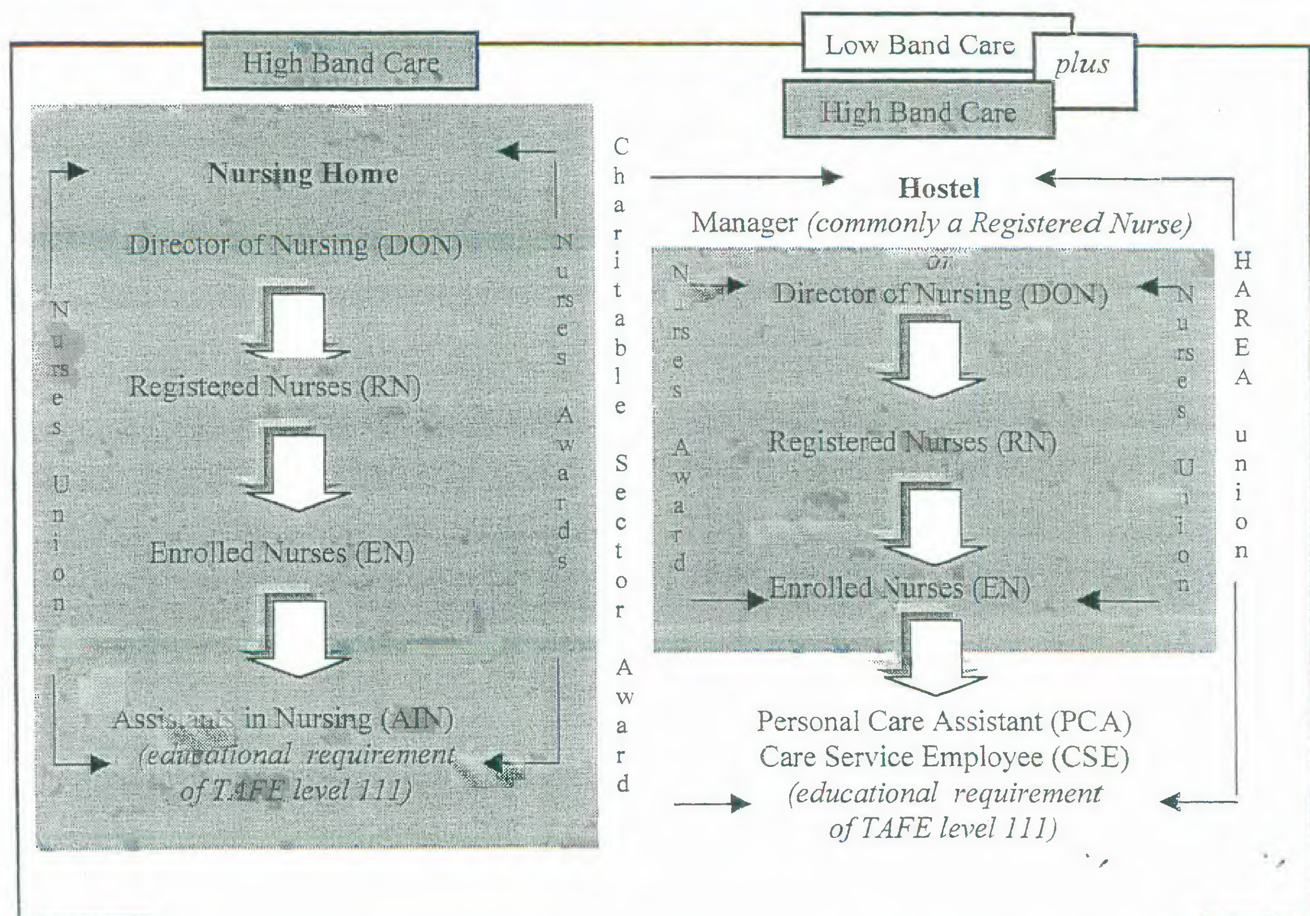

Figure 3.2: Emerging structure: Post aged care structural reform 1997

as AINs in the public health system (New South Wales Department of Health 2001).

The employment of AINs in place of PCAs/CSEs will further boost the numbers of AINs employed in the aged care industry. Such a trend is significant and further strengthens the importance of identifying and studying the practice of AINs. By identifying the practices of AINs and the type of care they deliver at the bedside, this study will provide some insight into the influence of this group of carers on the daily lives of residents.

The contemporary nursing home industry

In Australia, the majority of nursing homes are owned and managed by the private sector and are licensed by state and territory governments. The Federal government determines the level of fees that providers may charge residents and it funds the majority of these charges through subsidies and social security benefits (Australian Institute of Health & Welfare 1999b:31).

At present, the provision of nursing home care consists of three tiers. Forty-eight per cent are managed by private-for-profit groups, 38% are managed by private not-for-profit groups, and only 14% are managed by state governments (Australian Institute of Health & Welfare 1999b:31). As pointed out above, nursing homes have traditionally been the providers of high level care and hostels the providers of low level care (Australian Institute of Health & Welfare 1999b:31). Within the aged care industry, management strategies have had a dominant economic rationalist bias towards providing cost effective care. Little consideration has been paid to qualitatively researching the views of consumers and nurses about aged care policy. Given that these groups are the front line people involved in the receipt and delivery of care, it seems logical that their views should be considered in the development of policy that impacts on resource distribution and the type of care residents experience.

Within the literature, the views of nurses regarding aged care policy are indeed scant. There are multiple studies that examine nurses' attitudes to the elderly, and the types of care they deliver (Fenwick 1984; McMinn 1996; Nay 1994; Patterson 1995; Pearson, Hocking, Mott & Riggs 1993), but in relation to policy and politics it appears that nurses perceive 'that they have nothing to say that is politically significant, that they are politically powerless, and that they are safe to remain in a state of political naivety' (Holmes 1991:441). However, nurses are in a key position to provide information and insight into the dilemmas facing providers and consumers of long term institutional care. Whilst a focus on consumer groups is starting to filter through the literature (e.g. Gibson 1996b; Howe 1992; Russell & Schofield 1995; Sax 1990), nurses' views on funding arrangements, maintaining equality of care and ascertaining the needs of the nursing home community are unfortunately lacking. Studies on AINs and their role in the delivery of care are even fewer and this research will begin to address the shortfall of knowledge in this area.

In relation to policy development within the context of nursing homes themselves, the majority of Directors of Nursing have little experience or qualifications in managerial/financial skills or gerontological areas (Pearson et al. 1993; Courtney 1996). Their nursing experience is largely task orientated, which is reflective of their age and the hospital based nursing culture of which they are a product. The lack of postgraduate or undergraduate qualifications among registered nurses working in aged care is reflected in their lack of documentation skills, lack of grant submission skills and poor client focused research ability. The ability to comprehend government initiatives and reports, and the degree of commitment by Directors of Nursing to implement changes in aged care is limited (Courtney 1996; Courtney et al. 1997). Their increasing utilisation of AINs as primary carers reflects a resistance to the suggestion that a higher level of skills may be required to deliver bedside practices that ensure quality of care. However, as public scrutiny and

government regulation of the industry increases, the demands on providers to fund more qualified nursing staff in greater numbers will increase. The documentation required to ensure adequate funding for increasingly high dependency residents, categorised one and two under the RCS, will increase the demands on registered nurses and managers. Education and training of all staff to assist in this process will be required to curb the prospect of income losses and litigation (Courtney 1996).

Nursing home characteristics

In Australian nursing homes, the staffing mix varies and is hierarchical. At the apex of the hierarchy are the Directors of Nursing (DONs) followed by Deputy Directors of Nursing, Registered Nurses (RNs), Enrolled Nurses (ENs) and Assistants in Nursing (AINs). Figure 3.3 depicts the hierarchical structure of the staffing mix in a 64 bed nursing home examined in this study. This hierarchical nature of staffing arrangements is typical of nursing homes in Australia. As the figure demonstrates, the majority of the workforce consists of AINs.

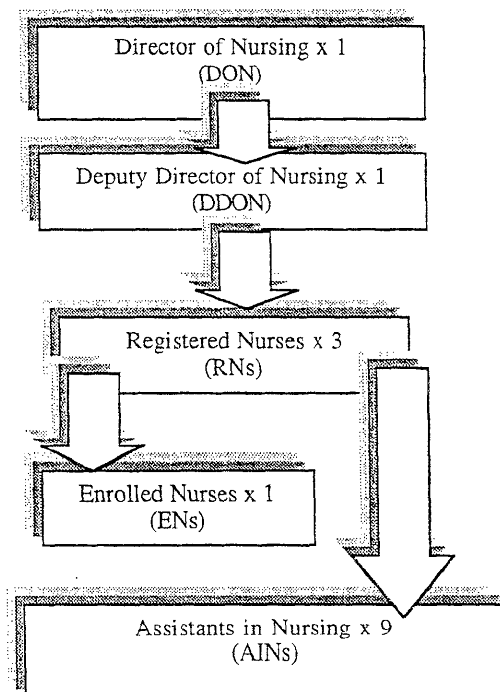

Figure 3.3: Nursing home hierarchy

Nursing home hierarchy using a 64 bed staffing ratio, where x = number of staff on a morning shift. This staffing ratio is the largest within any 24-hour period. Less staff are employed over the evening and night shifts (12 and four respectively).

Within the nursing home structure, the assessment of residents' needs and delegation of tasks must always be performed by a registered nurse (New South Wales Nurses' Association 1998). The registered nurse delegates to the AIN care that involves tasks that assist, comfort and support residents in their activities of daily living. The delegation of care is based upon the characteristics of the person requiring care and the types of activities to be performed. AINs are expected to report, verbally, any changes observed in the residents' behaviour or health status. Documentation of these changes, however, remains the realm of the registered nurses, as any written form of documentation by AINs is perceived to be a breach of the roles within the nursing home structure. Street (1992:268) describes this 'oral versus written culture' as a tool for perpetuating dominance. It separates the 'doers' (AINs) from the 'thinkers' (registered nurses), thus maintaining the hierarchical laden structures of nursing home society. That is, the assignment of defined roles to staff, and the expectation that AINs will comply to their role, maintains the traditional hierarchical structure of the nursing home. The position of AINs in this structure parallels with Nightingale's 'mission women' recruited from the 'handywomen' class. They could not be trusted to work on their own and were supervised at all times (Edwards 1997:239). In the nursing homes examined in this study the ratio of AINs to residents was 1:12 and the ratio of AINs to registered nurses was 3:1. The delegation of care to the AINs occurred at the discretion of the registered nurses.

The emergence of Assistants in Nursing

The popular images of nursing rarely identify the unqualified or lesser skilled workers. Even though the role of the registered nurse has evolved enormously since Florence Nightingale's era, the traditional images of a nurse as the 'lady with the lamp' still remain today. Under Nightingale's direction, the majority of the work was done by what was referred to as 'untrained handywomen' (Edwards 1997:237). These handywomen, or lesser skilled women, belonged to the lower classes. In the Nightingale scheme probationer, or student, nurses did not wash or

feed patients, the 'handywomen' did. In today's aged care facilities, a parallel with the undernurse has existed for many years — the assistant in nursing (AIN).

Historically, lesser skilled staff has been drawn from the lower classes to care for the poor sick in institutions. This dependence on lesser skilled staff has remained a feature of institutionalised care worldwide, particularly in nursing homes (Davies 1992). In Australia, alarming claims about demographic changes leading to increases in the frail elderly with chronic illness have created concern about increasing costs of employing registered nurses to care for the aged. These fears have seen a steady utilisation of relatively less skilled staff in the institutionalised care of elderly people, both in the private and public sectors. In 1996 the workforce employed in the nursing home industry numbered 80,564 persons (Australian Institute of Health & Welfare 1998:182). Of this, the overall percentage of AINs is difficult to determine as they are unregulated and employed under various awards and nomenclature (personal correspondence with officers of the Commonwealth Department of Health, secretaries of the Federal and State branches of the Australian Nurses' Federation, secretaries of the New South Wales Nurses' Association and the Australian Nursing Homes and Extended Care Association, representatives of 'Geriaction Inc.', 3–9 December 2000). The number of AINs employed in nursing homes is, however, known to be large. In nursing homes, in 1994, AINs represented 57% of the aged care industry workforce (Workforce Planning Unit 1994), and between 1991 and 1996 their numbers increased by 27%, from 20,402 to number 25,942 (Australian Institute of Health & Welfare 1999a:3).

Assistants in nursing belong to a particular group of employees, called support workers, that exist throughout many Western countries. The British system incorporates this notion of the support worker, the unlicensed care provider (UCP), and other countries also have a similar worker, referred to as a health care assistant (HCA) (Registered Nurses' Association of British Columbia 1999; Francis &

Humphreys 1998). Nevada, in particular, has been quite pro-active in the registration and regulation of the lesser skilled support worker (Workman 1996).

The varying nomenclature of the AIN within different spheres of the health, or caring, industry has seen a marked reluctance to use the term 'nursing' within the title, although it has been recognised that AINs perform nursing duties (New South Wales Nurses' Association 1998). In Britain, for example, workers similar to AINs are referred to as HCAs (Health Care Assistants), in Australian hostels they are known as PCAs (Personal Care Assistants) or CSEs (Care Service Employees), and in the hospital system they have been classified as CSEs, or more recently AINs. The abstinence or removal of nurse or nursing from the title, according to Edwards (1997:235), reflects the nursing profession's unwillingness to acknowledge historical, present or future contributions of the lesser skilled nurse in direct patient care. The Australian Nursing Federation (ANF) identifies the AIN by job description, rather than title. It acknowledges this in its draft policy *Assistants in Nursing and other Unlicensed Workers Providing Care* by stating 'the term Assistant in Nursing, *however titled*, means a person who assists registered and enrolled nurses in the delivery of nursing care' (Australian Nursing Federation 1999). This reluctance to recognise the utilisation of the AIN in the delivery of care is reflected in the dearth of research devoted to this group of employees.

Support workers, regardless of title, have been utilised internationally to overcome shortages of registered nurses in the workforce. In Australia, registered nurses employed in private and public nursing homes decreased by 6% and 22.1% respectively between 1993 and 1996 (Australian Institute of Health & Welfare 1999a:41). Because of their lower rate of pay, the utilisation of AINs provides a cost effective management strategy for labour intensive areas such as nursing homes. The current rate of pay for an AIN during their first year of employment in New South Wales is $9.74 per hour. This rate reaches a maximum of $10.58 per hour in the third year of employment (Public Hospitals Nurses' (State) Award

2000). By contrast, the hourly rate of pay for a registered nurse in the first year of employment is $15.99. This rate increases to $17.73 per hour by the third year of employment, and by the eighth year it is double that of the AIN's maximum hourly rate (Public Hospitals Nurses' (State) Award 2000).

It is commonly argued that the employment of workers such as AINs frees up the registered nurse to carrying out more complex procedures. The increase in technologies, throughput of patients, and increased number of elderly patients and consumer awareness, has put more pressure on registered nurses and managers in the public and private sectors where the advent of support workers is seen as a re-emergence rather than a new phenomenon (Chang 1995:70). However, some (e.g. Nay 1994) argue that the employment of support workers such as AINs erodes the very nature of the nursing profession and suggest that if managers were more creative in their approach, then all the care could be performed by registered nurses without the need for AINs.

Divisions of labour appear to persist within the health care arena and three tiers of nursing almost always re-emerge in Australia, despite restructuring of the profession, titles and roles. New forms of the division of labour tend to emerge as the social pressures and demands for particular services evolve, as is demonstrated by the increasing numbers of AINs in aged care. For example, wound dressing and urinalysis were once the domain of the doctors in Victorian hospitals and have since been delegated to the registered nurse (Edwards 1997:238). In turn, these skills will be guarded jealously by members of the nursing profession, just as they were by medical practitioners, until such times as their roles begin to change. In contemporary health care and in the current climate of Australian nursing homes this division of labour, underpinned by a desire to restrain expenditure, creates a situation where lesser skilled staff may provide the majority of direct care (Davies 1992:582). Whether the diversity and demands placed upon the role of the registered nurse will continue to see an erosion of the professional nurse as the

familiar 'hands on' practitioner, or whether nurses can preserve the core of what makes nursing an interpersonal role, is yet to be determined.

For aged care research to ignore such a sizeable proportion of care-givers, such as AINs, appears incongruent with the contemporary quest for quality assurance and standards of care. This study does not seek to determine whether AINs should be employed to care for the aged. Rather, it aims to examine how AINs deliver their care and to identify the factors that influence the type of care they deliver. Nonetheless, by exploring the practice of AINs and the values and perceptions that influence their practice, the study will shed some light on the appropriateness of the AIN's role in the delivery of quality care to the aged.

Summary

Australia has had an oversupply of nursing home beds, with the result that many people have received higher levels of care than that required by their level of dependency. The growth in bed numbers between the 1960s and the 1980s was not due to changing demographics but, rather, the funding policies of the Federal government during this period. Hence, macro-level governmental decisions have had an important influence on the structure and organisation of aged care and the lives of people in residential care. The aged care reform strategy that was introduced in the 1980s was successful in reducing the number of nursing home beds and the numbers of the least dependent aged in institutionalised care. Nonetheless, the potential drain of an ageing population on public resources has remained a concern to policy makers. The more recent changes to aged care policy introduced in the mid 1990s have sought to further reduce the number of least dependent aged persons in institutionalised care by matching funding of residents' care to their level of dependency, reduce government expenditure on institutionalised care and promote 'ageing in place'. An important development in these changes has been the introduction of a user pays system via income tested care fees and accommodation charges. The introduction of these fees is designed to reduce federal government

payments to aged care providers by increasing consumer payments for their own care.

Although the fees charged by nursing homes are subject to income testing, and the government does provide a concessional supplement for financially disadvantaged residents, the introduction of a user pays model raises questions about its potential impact on equity in access, and equality, in relation to the provision of care. The staff's awareness of the residents' socioeconomic status and, hence, ability to pay for services, may have an important impact on the types of services and care that residents receive.

The staffing mix within nursing homes has also had an economic basis. The employment of staff who are less skilled and less well paid than registered nurses has been financially attractive to aged care providers. Given the increasing number of AINs in the aged care industry, and their predominance in the delivery of care, an examination of their practices and how they distribute resources at the bedside is long overdue. In its examination of the factors that influence how AINs distribute resources to residents, this study explores the potential impact a user pays system may have on the care delivered in aged care institutions. In doing so, it attempts to identify the influence that the AINs' perceptions of the meaning of equality has on the care they deliver and the extent to which this is modified by influences such as the perceived socioeconomic status of residents and their ability to pay for care and services. The AINs' perceptions about the meaning of equality and the factors that maintain and reinforce these perceptions is explored in the following chapter.