Impact of Australia's aged care reforms on governance, operations, and recipients of residential aged care in Australia: A qualitative study

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Statement of originality

This is to certify that to the best of my knowledge, the content of this thesis is my own work. This thesis has not been submitted for any degree or other purposes. I certify that the intellectual content of this thesis is the product of my own work and that all the assistance received in preparing this thesis and sources have been acknowledged.

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In addition to the statements above, in cases where I am not the corresponding author of a published item, permission to include the published material has been granted by the corresponding author.

Cathy T Monro

Conferences

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Ethics

The Human Research Ethics Committee of the University of Sydney approved the research reported in this thesis. Approval number is 2017/881.

Thesis abstract

Australia's ongoing aged care reforms have re-focused service provisions from a provider-oriented policy approach to a consumer-directed care focus. This directional change has meant that the funding focus and reform initiatives have been geared towards enabling older Australians to stay in their own homes for as long as possible by increasing homecare and community supported services. The consumer-directed care policy focus is also intended to empower older Australians to exercise choice and control over care service design and delivery. Older Australians generally prefer to continue living in their own homes and in the community and as they age. As a result, they enter residential aged care at a much later stage in life with less mobility and increased frailty, requiring a higher level of care. Amid the reform changes, residential aged care providers face the challenges of finding new ways of delivering services that meet the increasing care needs and expectations of their residents and families while ensuring financial viability of their organisations.

Government reviews of the aged care reforms have centred on assessing the progress and effectiveness of implementing reform initiatives. Research examining various aspects of residential aged care during the reform implementation period have focused on elements of service delivery from the perspectives of aged care workers and/or residents. There is a limited focus on a more comprehensive understanding of the experiences inclusive of provider organisations, aged care workforce and client and family perspectives in the reform environment.

The purpose of this thesis study is to adopt a holistic approach and to explore the impact of the reforms on residential aged care services at the levels of organisational governance, operations, and clients and families within residential aged care. It aims to

provide a snapshot of the various dimensions of reform impact on residential care delivery and contributes to building the body of research that examines the impact of aged care reforms through experiences of service providers and users of residential aged care.

This thesis study focused on uncovering the impact on residential care delivery during the aged care reform implementation process. More specifically, what aspects of residential care delivery have been impacted under the reform conditions. In addition, what the experiences of residents and their families as users of residential aged care services were as a result of the reform changes. The following subset of questions assisted to explore the areas of focus of this thesis study:

- What and how have organisational strategies and processes in residential care facilities changed in response to the reform changes?
- What are the experiences of aged care workers at the operational level of the residential care facilities as a result of adapting to the reforms?
- What are the experiences of residents and their families as users of residential care services amid the reform changes?

The findings of this thesis study illustrate the cascading effects of policy directional changes at governance and operations levels of residential care provider organisations. The outcomes of activities of these structural levels are reflected in how care recipients experience the provision for their care needs. The insights provided by this thesis study demonstrate the interconnectedness between different components in delivering residential aged care and how they reflect policy outcomes. These insights contribute to a deeper understanding between key stakeholders of residential aged care and highlight the importance of anticipating potential consequences of policy outcomes.

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Abbreviations

AC	ACFI Coordinator
ACFI	Aged Care Funding Instrument
ADL	Activities of daily living
AIN	Assistant in Nursing
ALP	Australian Labor Party
AN-ACC	Australian National Aged Care Classification
APHA	Aged Persons Homes Act
BEH	Cognition and behaviour
CDC	Consumer-Directed Care
CHC	Complex health care
CW	Care Worker
DAP	Daily accommodation payment
DON	Director of Nursing
DT	Diversional Therapist
ECM	Executive Care Manager
EEPC	European Economic Policy Committee
EO	Education Officer
GDP	Gross Domestic Product

HACC	Home and Community Care
LLLB	Living Longer Living Better
OECD	Organisation for Economic Co-operation and Development
PCC	Participants, concept and context
PRISMA-ScR	Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Review
RAD	Refundable accommodation contribution
RN	Registered Nurse
WIN	Aged Care Workforce Innovation Network

Glossary of terms

Aged & Community Services Australia

The national peak body that supports not-for-profit church, charitable and for purpose providers of retirement living, community, home and residential care for older Australians (Australian Charities and Not-for-profits Commission, 2023).

Aged Care Act 1997

An Act of the Parliament of Australia that regulates government-funded aged care (Department of Health and Aged Care, 2022a).

Aged Care Funding Instrument

A funding model whereby the amount of subsidy is paid on the basis of assessed care needs in specified categories including activities of daily living (ADL), cognition and behaviour (BEH), and complex health care (CHC). It was used until 30 September 2022 when it was replaced by the new Australian National Aged Care Classification (AN-ACC) (Aged Care Financing Authority, 2021; Department of Health and Aged Care, 2021a, 2022b).

Aged Care (Living Longer Living Better) Act 2013

A legislation that gave effect to the Living Longer Living Better aged care reform package announced by the government in April 2012 (De Boer & Yeend, 2013).

Aged Care Quality Standards

Introduced in 2019 to measure the level of care and services provided by organisations delivering Commonwealth subsidised aged care services. It has been under review by the Commonwealth government in response to the Royal Commission into

Aged Care Quality and Safety recommendations (Department of Health and Aged Care, 2022h).

Aged Care Standards and Accreditation Agency

An independent company established by the Commonwealth government under the Aged Care Act 1997 as the accreditation body for residential care services (Senate Standing Committee on Community Affairs, 2004).

Aged Care Workforce Action Plan 2022-2025

It outlines the government's plan to "grow, skill and enable an aged care workforce that delivers safe, high quality care", and is a part of the government's 2022-23 Budget (Department of Health, 2022, p. 4).

Aged Persons Hostels Act 1972

A legislation that enabled the Commonwealth government to make grants to eligible organisations and particularly to encourage not-for-profit organisations to build more hostel-type accommodation as a provision of alternative accommodation to nursing homes (Parliament of Australia, 1972).

Aged Persons Homes Act 1954 and 1957

A legislation enacted to enable the Commonwealth government to make grant on a £1 for £1 basis towards the capital costs of approved nursing homes that were largely operated by religious and other voluntary organisations (Kewley, 1973). This amount was doubled to £2 under the Aged Care Homes Act 1957 (Parliament of Australia, 1957).

Aged Care Workforce Innovation Network

A mechanism developed to provide opportunity for providers with subsidised business advisory services to redesign their business models and skills mix in transition to the reform environment (Department of Health and Aged Care, 2013).

Australian National Aged Care Classification

A new residential aged care funding model intended to better reflect CDC approaches in delivering consumer-centric care, including mandating care minutes and setting minimum staffing requirements (Department of Health and Aged Care, 2022b).

Commonwealth and State Housing Agreement

A system of joint financial responsibility between Commonwealth and State governments for providing public housing (McIntosh & Phillips, 2001).

Consumer, clients, residents and families, care recipients

These terms are used interchangeably in this thesis. Consumer is commonly used in government websites and publications as a more general description of users of aged care services. In this thesis, care recipients, clients, residents and families represent older Australians in residential aged care or families of older Australians in residential aged care.

Consumer-Directed Care

It is defined as an approach in care planning and management. It is aimed to provide consumers and carers with choice and control over the design and delivery of care services to meet their needs and preferences (Department of Health, 2012).

Consumer-oriented, consumer-focused, consumer-centric

These terms are used interchangeably in this thesis. They reflect the nature of consumer-directed care approach that essentially is about focusing on the needs of consumers of aged care services.

Domiciliary Nursing Care Benefit

A form of carer allowance introduced in 1972 to encourage home-based care (Eagar et al., 2001).

Historical framework

A historical theory-based flexible framework to assist analysing and understanding historical information (Partner, 2013).

Home and Community Care (HACC)

A program introduced in 1986 by the Hawke Labor Government to provide a range of home and community-based services for older Australians, aiming to delay entry into residential aged care (Courtney et al., 1997; Kennedy, 1989).

Home Nursing Subsidy Act 1956

A legislation established to enable Home Nursing organisations, that is, nursing services for people at home, to receive Commonwealth government subsidy for the cost of employing registered nurses (Australian Bureau of Statistics, 1985).

Invalid and Old Age Pensions Act

A legislation introduced to provide a means-tested pension to older people and people with disabilities (National Archives of Australia, 1909).

Legislated Review of Aged Care

A government review at the five-year mark of the reform implementation to assess progress of the first phase of the LLLB reforms (Department of Health, 2017a).

My Aged Care online portal

A website created to provide a centralised point of entry to information about the aged care system (Department of Health, 2012).

National Health Act 1953

A legislation consolidating general medical, hospital and pharmaceutical provisions, and specific pensioner medical services (Eagar et al., 2001; Kewley, 1973).

Outcome Standards for Australian Nursing Homes

Uniform national standards established in 1987 focused on 31 outcomes that aimed at driving high quality of care and high quality of life for residents of nursing homes (Le Guen, 1993).

Personal Care Subsidy 1969

This was designed to subsidise personal care for residents aged over 80 years who lived in hostels (Gibson, 1998).

Policy cycle framework

A staged process for policy analysis that includes problem identification, policy formulation, policy implementation and policy evaluation (Howlett et al., 2009).

Productivity Commission

An independent agency that advises Australian government on microeconomic policy and regulations.

Reflexivity

A reflective process by researchers to actively prioritise voices of study participants for the purpose of ensuring research integrity and rigour (Bishop & Shepherd, 2011).

Researcher positioning

Personal characteristics such as age, gender, beliefs, preferences, personal experiences, and professional experiences that may impact the research (Berger, 2013).

Royal Commission into Aged Care Quality and Safety

Established in October 2018 by the Governor-General of the Commonwealth government to inquire into the quality and safety of aged care in Australia. It delivered an interim report in October 2019, a special report on COVID-19 and aged care in October 2020, and a final report with recommendations in February 2021 (Royal Commission into Aged Care Quality and Safety, 2019, 2020, 2021).

The Rural and Regional Building Fund

One of the two capital grants programs from Commonwealth to assist organisations that cannot raise funds through commercial avenues to provide aged care services (Department of Health, 2012).

The Rural, Regional and Other Special Needs Building Fund

A funding strategy that combined two existing capital grants programs, Residential Care (Capital) Grants and the Rural and Regional Building Fund (Department of Health, 2012).

State Grants (Dwellings for Pensioners) Act 1969

An Act to grant financial assistance to the states with respect to the provision of self-contained homes for aged pensioners (Commonwealth of Australia, 1969).

The McLeay Report

A report from the House of Representatives Standing Committee on Expenditure that conducted an inquiry into the increased cost of residential aged care and identified imbalance between residential and home care with respect to expense and mismatch of services (House of Representatives Standing Committee on Expenditure, 1982).

The Workforce Compact

Additional funding as a part of the LLLB aged care reforms aimed at increasing wages of the aged care workforce particularly in regional, rural and remote areas (Department of Health, 2012).

Chapter 1

Introduction

This introductory chapter sets out the structural framework for the research project presented in this thesis. It provides the contextual background to the research focus, followed by presenting the research aims and research questions. It then outlines the conceptualisation process of conducting this thesis research, followed by a summary of the chapters in this thesis.

1.1 Background

Australia has been undergoing major structural changes to its aged care system since 2012 as the policy response to the projected exponential increase of population ageing and the concerns for sustainability, both in meeting the changing needs of the ageing population and easing fiscal pressures (Department of Health, 2012; Productivity Commission, 2005, 2011; Treasury, 2021). The overall aged care system, consisted of residential aged care, home and community-supported care, had been regarded as fragmented with Commonwealth, state and local governments responsible for funding and provision of different elements of aged care services (Department of Health, 2012; Productivity Commission, 2011). More specifically, residential aged care was the responsibility of Commonwealth government while home and community-supported care services were a joint responsibility between Commonwealth, state and local governments (Courtney et al., 1997). The legislated structural reforms, namely the Aged Care (Living Longer Living Better) Act 2013 (hereafter LLLB), essentially refocused the national aged care policy direction from a historically residential aged care oriented and provider-driven (Borowski et al., 1997; Kendig & Duckett, 2001; Nay et al., 2014), to one

based on Consumer-Directed-Care (CDC) principles (Department of Health, 2012; Gillard & Butler, 2012). This was intended to satisfy older Australians' preference for staying in their own homes for as long as possible, and to empower older Australians to have control over the types of services and providers that meet their particular care needs (Department of Health, 2012; Moore, 2021; O'Loughlin et al., 2017). Further, the LLLB reforms aimed to address the fragmentation issue in the aged care system by centralising the funding and provision of residential, home and community-supported aged care services to the national level, which included unified Aged Care Quality Standards that applied to all residential care, homecare and community-supported care services, and the My Aged Care Website as a centralised platform providing a "principal entry point to the aged care system" (Department of Health, 2012, p. 85; Department of Health and Aged Care, 2022h).

As concerns over the impact of population ageing have focused on economic sustainability globally (Bloom et al., 2015; UNDESA Population Division, 2019), the LLLB reforms also aimed to relieve fiscal pressure for government expenditure on aged care, which had increased by more than 40% in the previous decade (Treasury, 2021). The percentage of the Australian population aged 65 and over has increased rapidly and is projected to reach 25% of total population by 2056 (Australian Bureau of Statistics, 2013). Australian life expectancy is one of the highest in the world with average of 81.2 years (OECD, 2023). Prior to the LLLB aged care reforms, approximately three million Australians were over the age of 65, representing 14% of the total population (Australian Bureau of Statistics, 2011b), with age related health expenditure projected to increase to almost 15% of gross domestic product (GDP) by 2050 (Productivity Commission, 2011). Residential aged care had been a more costly component in aged care services related expenditure for the government, and almost 2.5 times the amount spent on home-based

care and support (Australian Institute of Health and Welfare, 2022b). More specifically, government expenditure on aged care services for the 2009/2010 financial year was $11 billion, and by 2016/2017 financial year, it had increased to $17 billion. Of these figures, $7.1 billion was spent on residential aged care in 2010, and reaching $12.1 billion by 2017 (Australian Institute of Health and Welfare, 2011, 2022b). At the commencement of the LLLB reforms, 70% of government funding for aged care services were in residential aged care (Department of Health, 2012). Demand for residential aged care places continued to increase. The number of older Australians entering residential care has increased by 15% over the last 10 years with the median age of 86 years and presenting with the need for more care due to increased frailty and complex health conditions (Aged Care Financing Authority, 2021; Australian Institute of Health and Welfare, 2023; Borotkanics et al., 2017).

The LLLB as a reform process aimed to serve the purposes of improving the performance of the aged care system, ensuring efficient and equitable responses to the challenges of population ageing, and for the government to (re)direct public resources to realise the particular areas for reform (Palmer & Short, 2014). The directional change from a residential care-oriented and provider-focused to a CDC policy approach has meant that the funding focus and reform initiatives have been directed towards supporting older people's desire to remain living in the community for as long as possible with increased homecare and community-supported services (Department of Health, 2012; Kendig, 2017; McClelland et al., 2021). Similar to countries such as the United States, United Kingdom, Germany, France and Japan that have long adopted the CDC model (Christensen & Pilling, 2018; Lewis & West, 2013; Lyn Phillipson et al., 2019; Prgomet et al., 2017), the intention of the LLLB reforms was to provide control for older people over their care requirements and choice of service providers (Gill et al., 2017; Low et al., 2012).

In particular, individual budgets were introduced to enable self-directed support, thus giving individuals the responsibility of deciding what services and support they needed (Prgomet et al., 2017). The CDC model has been embedded into funding home and community-supported care although not fully implemented in residential aged care settings. Funding for residential aged care during the reform implementation process remained under the previous Aged Care Funding Instrument (ACFI) whereby residential care service providers claimed care subsidies through a care task-based appraisal process (Department of Health, 2017b; Gill et al., 2017).

At the time of the 2012 announcement of the LLLB reforms, there were 185,482 available residential aged care places compared to 57,922 available home-based care packages, indicating the markedly greater supply of residential care over homecare services despite majority of older Australians preferred to stay in their own homes (Australian Institute of Health and Welfare, 2012; O'Loughlin et al., 2017). In response to the changing needs and expectations of older Australians desiring to remain in their own homes, the LLLB reforms refocused the national policy direction from a residential aged care-oriented and service provider-driven to a consumer-focused, home and community-supported care provision approach (Productivity Commission, 2011). As one of the measures to support the reform objective in increasing home and community-supported care, the government planned to save approximately $1.6 billion of residential care subsidies (i.e. ACFI) over five years (2012-2017) by modifying care subsidy categories and restricting eligibility of ACFI subsidy claims by residential care providers. This was as a result of addressing subsidy claim behaviour, and redirecting the funds to increase homecare packages and to help train the overall aged care workforce (Department of Health, 2012). Although the CDC funding model did not apply in the residential aged care setting, the reform measure of generating funding savings from residential aged care to

support the reform objective of increasing home and community-supported care warranted examination on how care delivery in residential aged care may be impacted.

As the nature of national aged care policies had historically been residential aged care-oriented and service provider-driven, there had been a culture of government-funding-dependent and regulatory-compliant organisational approaches to service provision (Gibson, 1998). Redirecting residential care subsidies to support other reform objectives presented challenges for residential care providers to maintain service delivery, particularly with the increasing demand for residential aged care and declining numbers of providers (Aged Care Financing Authority, 2021). For instance, government reports have shown that there were 1,054 residential aged care providers at the start of the LLLB reforms and by the end of 2022 the number had reduced to 805 (Aged Care Financing Authority, 2013; Department of Health and Aged Care, 2023c). Industry reports have also highlighted the vulnerable financial position of residential aged care providers and the issue of sustainability (StewartBrown, 2022). With respect to the allocated funding for aged care workforce training from redirected residential care subsidies, it was not implemented as planned when there was a change of government, with the funding put to general use rather than designated to training the aged care workforce (McClelland & Marston, 2021).

The issue of financial risks for residential care service providers as a result of funding redirection (i.e. ACFI reduction) was raised during parliamentary debates over the LLLB reform legislation however, the impact of this funding reduction on residential care delivery was not fully addressed (Carnell & Paterson, 2017; Department of Health, 2017a; Parliament of Australia, 2013b, 2013d). Government reviews of the reforms such as that of the Legislated Review of Aged Care have largely focused on the effectiveness of

the reforms with respect to fiscal sustainability, improvement on efficiency of service provisions and whether the original reform objectives including the number of homecare packages are to be maintained, rather than the impact on residential care delivery (Aged Care Financing Authority, 2013, 2014, 2017, 2018; Aged Care Sector Committee, 2015; Department of Health, 2017a). The recent findings from the Royal Commission into Aged Care Quality and Safety have highlighted the demands on service providers because of the reforms, and in particular, the neglect of older Australians in care (Royal Commission into Aged Care Quality and Safety, 2019, 2021), hence indicating the importance of considering the consequential effects of reform changes on care delivery.

Studies concerned with the impact of LLLB reforms relating to residential aged care have provided insights into elements of workforce (Davis et al., 2016; Henderson, Willis, Xiao, & Blackman, 2016; Henderson, Willis, Xiao, Toffoli, et al., 2016; Xiao et al., 2021), technological development in residential care facilities (Jiang et al., 2016; Loi et al., 2017), consumer experiences of residential aged care (Jeon et al., 2019; Rees, 2014; Zizzo et al., 2020), and issues of clinical care in residential facilities (Ostaszkiewicz et al., 2016; Tynan et al., 2018). However, more comprehensive assessment of the reform impact on service delivery through different experiences inclusive of service provider organisations, their workforce and client perspectives are limited (Gill et al., 2017). Given the LLLB reforms refocusing funding and provisions of aged care services from residential aged care and provider-oriented to home and community-supported care and consumer-focused, it is important to explore how residential aged care has been delivered during the rollout of the reforms. This includes the impact on providers operating the facilities that deliver services and the impact on the care received by their residents and families of the residents.

1.2 Research aims and research questions

The purpose of this thesis study was to adopt a holistic approach to investigate the impact of LLLB reforms on residential aged care by exploring the experiences of residential care services including provider organisations, their operations in delivering care, and the clients and families as end-users of residential aged care. This thesis study aimed to provide a snapshot of the various dimensions of residential care delivery during the LLLB reform implementation process, and to highlight the structural complexity of the aged care system and the perspectives of various players within that system in the residential care setting.

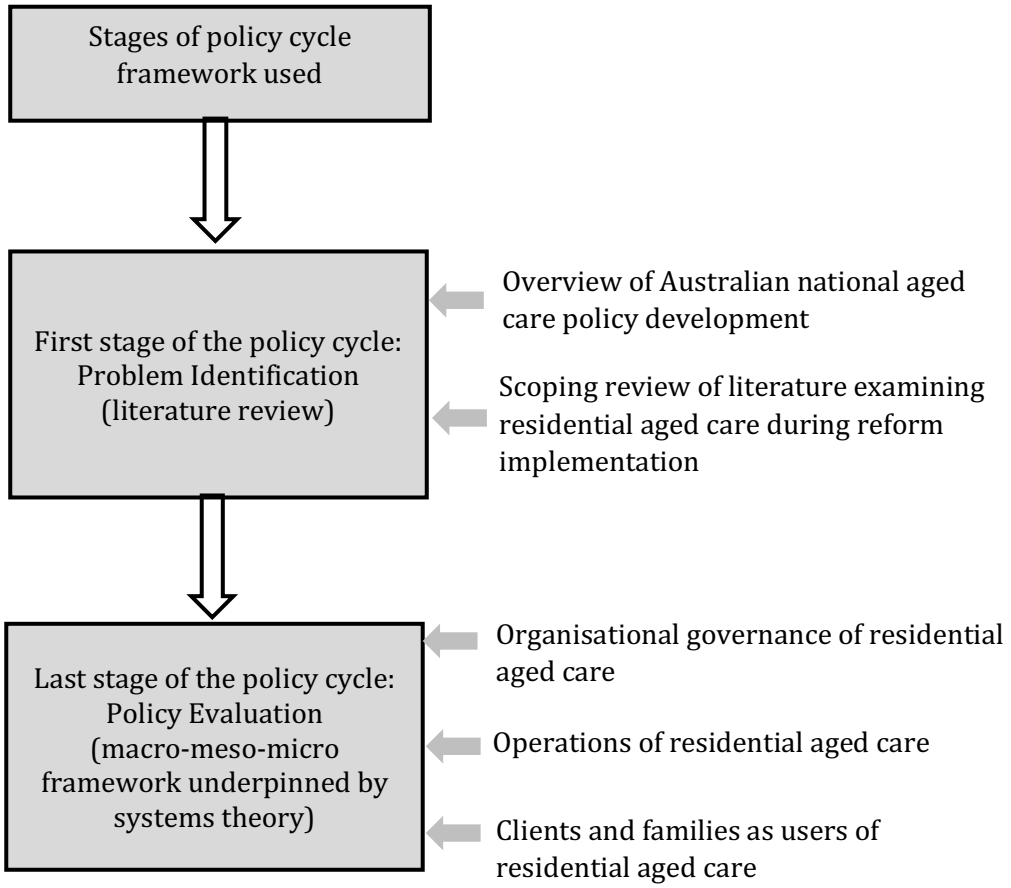
The overarching research question was how the LLLB reform implementation impacted on residential aged care delivery processes and related outcomes. More specifically, what aspects of residential care delivery were impacted under the reform conditions and what the experiences of residents and their families as users of residential care services were under the reform changes. These aspects were examined through the following subset of questions aiming to provide a rich description of the experiences of both the service provider and service consumer perspectives.

- What and how have organisational strategies and processes in residential care facilities changed in response to the reform changes?
- What are the experiences of aged care workers at the operational level of the residential care facilities as a result of adapting to the reforms?
- What are the experiences of residents and their families as users of residential care services amid the reform changes?

1.3 Conceptual flow of the thesis research process

The policy cycle framework provides a useful explanatory tool to explore the impact of the LLLB reform implementation on the various levels of residential aged care delivery process (Howlett et al., 2009). As such, it broadly guides this thesis study in terms of the conceptual flow of the research process. This will be discussed in Chapter Four in more detail. While the policy cycle framework is a staged process that includes problem identification, policy formulation, policy implementation and policy evaluation (Brewer & DeLeon, 1983; Bridgman & Davis, 2004; Howlett et al., 2009), the aims of this thesis study indicate a focus on the impact of policy outputs as part of the policy evaluation stage rather than exploring the full cycle of policy process (Jann & Wegrich, 2007). To identify the policy problem and understand the context of the LLLB reforms, it is important to explore how Australia has arrived at the LLLB reforms where the policy approach shifted from residential care provider-oriented to consumer-focused aged care funding and service provision. Therefore, examining the development of national aged care policy will form one component of the literature review, reported in Chapter Two. Also important in informing the research design of this thesis study, is exploring aspects of the reform impact on care delivery in the residential care setting and the extent of existing research on the subject in the LLLB reform context. A scoping review supports this objective because it addresses the exploratory research questions with a systematic approach to identify gaps in related research (Colquhoun et al., 2014; Peterson et al., 2017). The scoping review will form the other component of the literature review, reported in Chapter Three. Figure 1.1 below presents the overall conceptual flow of this thesis study.

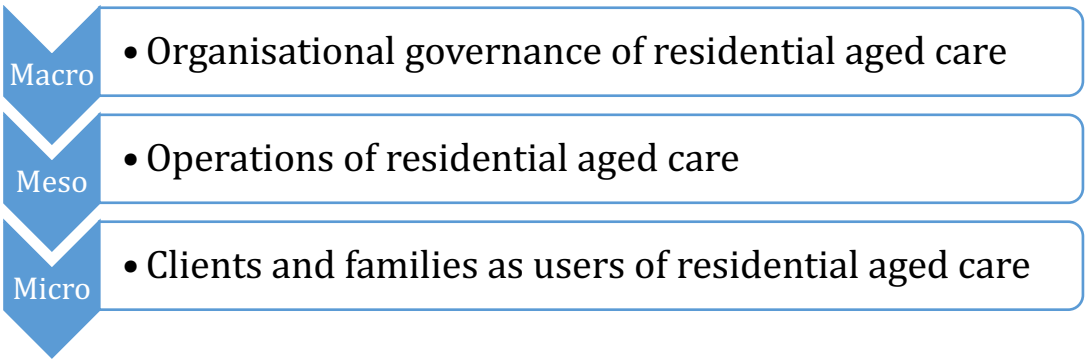
Figure 1.1 Conceptual flow of this thesis study



There is a structural process within provider organisations for implementing government policies. More specifically, organisational structures consist of a governing body such as Boards of Directors and Chief Executive Officers (CEOs) with the organisation's decision-making or governance responsibilities of implementing government policies, and operational functions that consequently reflect decisions made by the governing body (Considine et al., 2014; Cooper, 2005). In this sense, there is a cascading impact of government policy changes on various levels of the provider organisation, with the outcomes of activities of these structural levels reflected at the care

recipient level, that is, how care recipients are experiencing the provisions for their care needs. Overall, these experiences reflect the consequences of policy outputs, that is, consequences for residential aged care provider organisations, for their operational functions and responsibilities, and for residents and families using their residential care services (Pennock, 2011). How each of the governance, operations and consumer levels has been impacted by the LLLB reform implementation could be explored and explained using a macro-meso-micro analytic framework. This is inspired by the UK case study on the impact of implementing its Collaboration for Leadership in Applied Health Research and Care (CLAHRC) whereby the national policy framework was considered as the macro level, with program implementation at the meso level and a case study in practice at the micro level (Caldwell & Mays, 2012). The macro-meso-micro framework is underpinned by systems theory which supports analysis of complex and multidimensional social reality involving various components and their relations (Costa, 2023; Schirmer & Michailakis, 2019). This approach fits the research aims of this thesis study in that, organisational governance, operations and consumers of residential aged care are at the consequential points in the reform implementation or the policy output process. They represent the critical points within the system of residential aged care delivery in the reform environment. Each of these components may have various respective dimensions that reflect reform impact in a different way, and present a (inter-)connectedness when looking at the three components as a whole in examining the impact of the LLLB reforms on residential aged care (Figure 1.2).

Figure 1.2 Macro-meso-micro framework exploring reform impact on residential aged care



1.4 Significance of this thesis study

This thesis study provides a snapshot of the critical elements of residential aged care delivery and the outcomes for clients and families as end-users of residential care in the aged care reform environment. It demonstrates a government policy-provider-consumer flow in a tangible way through exploring the effects of the reform transition process on residential aged care delivery at the levels of organisational governance and operations, and the ultimate outcome of the impact on clients and families in relation to the extent of care received. This also serves the objective of the LLLB reforms for additional research to improve the evidence base (Gillard & Butler, 2012). Considering the recent findings and extensive recommendations of the Royal Commission into Aged Care Quality and Safety (2019, 2021), and the additional challenges of managing COVID-19 outbreaks in residential aged care (Royal Commission into Aged Care Quality and Safety, 2020), this thesis study provides critical insights into the different dimensions of care delivery particularly in the context of responses to the Royal Commission recommendations and to future challenges of sustaining residential aged care. As Australia continues to undertake significant aged care reforms including residential aged care (Department of Health and Aged Care, 2022f), this thesis study encourages a more

comprehensive examination of the impact of reforms on aged care delivery thus informing strategies to ensure the reform objectives are met and to minimise the risk of unintended consequences for older Australians that need care.

1.5 Overview of chapters

This thesis study consists of eight chapters. Following this introductory chapter, Chapter Two presents a historical overview of aged care provisions in Australia and the national aged care policy development over time. This chapter aims to track the policy directional shift from a provider-focused and residential aged care-oriented to a consumer-directed, home and community-supported care focus. It draws on academic literature such as Borowski et al. (1997); Kendig and Duckett (2001); Kennedy (1989); Kewley (1973); O'Loughlin et al. (2017), and government publications including parliamentary debates to chart major national aged care policy development from Federation in 1901 to the LLLB reforms legislated in 2013. This highlights the trajectory of policy orientation and implications relating to residential aged care. It also presents the LLLB reform objectives related to residential aged care and identifies any gaps in policy consideration for residential aged care delivery during the reform implementation and transition period.

Chapter Three reports on a scoping review exploring the nature and extent of existing literature ranging from 2012 when the LLLB reform package was introduced to February 2022 that examined residential aged care provision in the context of LLLB reforms. It reveals a lack of research attention on perspectives from residents and families using residential aged care services in the reform implementation process, and on the critical role provider organisations play in adapting to reform changes and related

implications. It highlights a research gap in a more comprehensive approach to exploring the different facets of the impact on residential aged care of reform implementation. The content of this chapter has been submitted for publication and is currently in peer-review process. This chapter will be presented in the form of a manuscript.

Chapter Four outlines the research design and methodology. It provides the rationale for the chosen qualitative research design and methodological approaches in conducting this thesis study. It states researcher positioning and reflexivity, details the methods of data collection including sampling strategy, participants recruitment, and data analysis. It also considers research integrity, rigour and ethics.

Chapter Five presents the provider organisational governance perspective as the macro-level analysis. It draws on the individual in-depth semi-structured interviews of key informants to explore the strategic responses to reform changes from provider organisations and the resulting overall operational emphasis changing from care service provision to financial sustainability at the organisational governance level. The content of this chapter is presented in the form of a published article: **Monro, C., Mackenzie, L., Du Toit, S., O'Loughlin, K., & Low, L.-F. (2023). A preliminary exploration of the impact of aged care reforms on the governance of two Australian residential care facilities.** ***Gerontology & Geriatric Medicine, 9*****, 1-10.**

Chapter Six reports the meso-level analysis of residential aged care operations in the LLLB reform environment from the perspective of staff at various levels of operational responsibility in residential care facilities. It provides insights into how and why operational issues have informed the findings of the Royal Commission into Aged Care Quality and Safety. The experiences of operational staff explored in this chapter demonstrate the impact of organisational adaptation to reform conditions constraining

the capacity of staff to deliver the level of quality care that not only met the needs of their residents but also was preferred by staff themselves. The content of this chapter is presented in the form of a published article: **Monro, C., Mackenzie, L., O'Loughlin, K., & Low, L.-F. (2021). Perspectives of operational staff working in residential care and aged care reforms.** ***Nursing & Health Sciences, 23*****(4), 948-956.**

Chapter Seven reports the micro-level analysis of lived experiences of residents and families in residential aged care facilities amid the reform implementation process. It presents the expectations and experiences of both the resident and family cohorts and illustrates the different areas of expected care needs respectively. It identifies that high-quality care requires some sense of consumer choice and control in meeting all assessed care needs including adequately addressing the relational and interpersonal elements of residential care delivery. The content of this chapter is presented in the form of a published article: **Monro, C., Mackenzie, L., O'Loughlin, K., Low, L.-F., & du Toit, S. H. J. (2022). 'I could no longer cope at home': Experiences of clients and families in residential aged care within the context of Australia's aged care reforms.** ***Australasian Journal on Ageing, 00,*** **1-11.**

Chapter Eight presents an in-depth discussion drawing together the findings at each of the macro (organisational governance), meso (operations), and micro (client and family) levels along with comparative analyses between the three-level participant cohorts where applicable. This adds extra dimensions to the specific levels of governance, operations and care recipient data reported in Chapters Five, Six and Seven respectively. Given the ongoing changes to residential aged care including funding structure and quality standards since this thesis study was conducted, this chapter will also discuss key issues identified in this thesis study in the current context. It concludes with

recommendations for policy consideration and future research needed to contribute to the empowerment of older Australians to direct their care needs.

Chapter 2

Overview of Australia's national aged care policy - from residential age care-dominated and provider-focused to a consumer-centric direction

The introductory chapter highlighted the fundamental change in funding and provision of aged care inherent in the LLLB reform agenda. Services were transitioned from a provider-focused, residential aged care-dominated policy approach to a consumer-directed, home and community-supported care policy focus. To understand this critical shift in policy direction, it is important to examine the development of Australia's national aged care policy directions over time because policy changes are generally influenced by historical context or experience (Allen et al., 2008; McClelland & Marston, 2021). A historical framework provides a flexible analytic tool for understanding historical knowledge which supports a narrative form that help present the development journey of Australian's national aged care policy (Partner, 2013). Therefore, this chapter uses historical framework, and draws on academic literature (Borowski et al., 1997; Kendig & Duckett, 2001; Kennedy, 1989; Kewley, 1973; O'Loughlin et al., 2017), and government publications such as parliamentary debates to chart major aged care policy development in Australia. Four time periods present significant milestones in policy directions: 1901 to 1953, 1954 to 1971, 1972 to 1995 and 1996 to 2013 (see Table 2.1). The use of parliamentary debates provides a broad and comparable picture of public debates from which to examine how public concerns relating to residential aged care were framed and addressed (Bacchi, 2016; Dargavel & Kendig, 1986). This chapter concludes with an overview of LLLB reform objectives and initiatives relating to residential aged care and

identifies gaps in policy consideration for residential aged care delivery during the reform implementation and transition period.

2.1 Background

While the LLLB reforms have been the current policy response to population ageing in Australia, the demographic pressure of population ageing has been an important national priority for Australia when deciding how to maintain support for older people financially, and through care provision (Kendig et al., 2016). Concerns over the implications of future growth of an ageing population became the focus of government policy discussions from the early 1980s (Hemer, 1983). As population ageing became a global phenomenon, country-specific governments such as the United Kingdom, United States and New Zealand, as well as the Organisation for Economic Co-operation and Development (OECD) and the European Economic Policy Committee (EEPC) began focusing on long-term sustainability of public finances (Treasury, 2002). In Australia, the fiscal pressures on the Commonwealth government due to population ageing were outlined at regular intervals through successive Intergenerational Reports (Treasury, 2007, 2010, 2015, 2021). In addition, the Productivity Commission, an independent agency that advises Australian government on microeconomic policy and regulations consistently highlighted the impact of population ageing and its far-reaching social and economic implications (Productivity Commission, 2005, 2011, 2013). These reports called for an incremental restructure of the aged care system over time rather than allowing it to reach a crisis point that required drastic adjustments and fundamental changes (Productivity Commission, 2005; Treasury, 2007).

However, Australia did arrive at an aged care policy directional point with the introduction of the LLLB aged care reform package by the Gillard Labor Government (2010-2013) in 2012 (Department of Health, 2012; Productivity Commission, 2013; Treasury, 2015). The LLLB reforms required a major shift in mindset for all aged care stakeholders as what had historically been a policy focus on provider-oriented residential aged care services was transformed into a consumer-directed, home and community-supported care model wherein residential care was categorised as a "dedicated extra service" (Aged Care Sector Committee, 2016, p. 1837; Butler, 2015).

Interestingly, while Australia moved to a consumer-oriented aged care policy direction, similar models had been the mainstay for decades in other developed countries (e.g. US, UK, Germany, France, Japan), although with mixed outcomes particularly the level of self-management that challenged the capacity of older people to manage (Christensen & Pilling, 2018; Lewis & West, 2013; Lyn Phillipson et al., 2019). So, how did Australia arrive at this point of its national aged care policy development?

2.2 A narrative of the national aged care policy development

The nature of caring for older people in colonial and post-colonial Australia has changed from that of religious and charitable organisations taking responsibility through a compassionate response to looking after their own members (UnitingCare NSW.ACT Ageing & Disability Service, 2001), to the government overseeing care delivery and safeguarding the use of public money through policy and fiscal mechanisms such as the former Aged Care Funding Instrument (ACFI) for residential aged care (Department of Health and Aged Care, 2021a). Table 2.1 presents a summary of the significant milestones in aged care policy development.

Table 2.1 National aged care policy development milestones

Time Period	Aged Care System	Service Provision Characteristics	Forms of National Funding & Focus	Aged Care as Public Policy
1901-1953	• Compassion-based and voluntary relief system • Accommodation and necessary residential care	• Churches and charitable organisations • Residents were vulnerable, poor and destitute	• The Age Pension • No aged care specific funding	• Absent
1954-1971	• Nursing homes • Hostels	• Existing charitable residential aged care providers • War veteran pensioners and families as additional cohort of people in need	• Capital subsidies to charitable residential aged care providers • Subsidies for nursing care in residential setting	• Aged Persons Homes Act 1954 • Home Nursing Subsidy Act 1956 • Of assistive and non-interference (self-regulated) nature
1972-1995	• Oversupply of nursing home beds • Development of home-based care, and community health program by State governments	• Increasing provider organisations including for-profit providers entering aged care sector	• Focus of capital funding emphasising residential aged care in remote areas • Introduction of Domiciliary Nursing Care Benefit • Joint funding of Home and Community Care with State governments	• Nursing home admission control • Price control • Commonwealth government taking over nursing home regulation from State governments • Funding to residential aged care contingent on regulatory compliance
1996-2013	• Residential aged care facilities • Increasing range of home and community-based services by State governments	• Private individual aged care service operators entering into aged care sector	• Funding directed to private aged care service operators	• Aged Care Act 1997 • Emphasising consumer responsibility • Stringent regulatory regime for residential aged care

2.2.1 The national aged care policy gap (1901 to 1953)

The Australian federated system of government consists of a national parliament and six States and two Territory parliaments. While the States and Territories have their own constitutions, laws and governments, they operate on the principal of a bicameral (i.e. two chambers) parliament, with the exception of the State of Queensland, Australian Capital Territory and Northern Territory with unicameral (i.e. single chamber) parliaments (Access Canberra, 2023; Legislative Assembly of the Northern Territory, 2023; Queensland Government, 2020). There are different areas of responsibilities for the levels of government. However, there are overlapping areas such as health where the Commonwealth government provides a significant portion of funding and State governments carry out relevant responsibilities including service delivery (Parliament of New South Wales, 2020).

At the time of Federation in 1901, the provision of aged care services was not recognised in public policy, and care and companionship of older people had been considered as private responsibilities of the families (Fine, 2007). Older people that were poor and destitute without any family support were largely sheltered and cared for by religious and charitable organisations (Fine, 2007; Gibson, 1998; Lake, 2013; Parliament of Australia, 1957; Rathbone, 1994). This was informed by the beliefs and values of these organisations that underpinned their compassion and desire to take care of their members as it was in the era when majority of the population in Australia claimed some form of membership to religious institutions or mutual associations such as Friendly Societies (UnitingCare NSW.ACT Ageing & Disability Service, 2001). More importantly, in the absence of official institutions to accommodate destitute older people, these voluntary organisations provided a relief system for those in need (Kewley, 1973). This was

acknowledged by the then Minister for Social Services, William McMahon, stating that the churches and other voluntary organisations had devoted their time and energy over many years to provide care to older Australians in need (Parliament of Australia, 1954a, p. 2553).

These provisions, together with lower life expectancy, meant that the issue of aged care was not of particular policy concern to successive governments during this period (Australian Bureau of Statistics, 2011a; Gong & Kendig, 2016). More specifically, the concept of aged care had not entered the public consciousness (Fine, 2007). With respect to social policy concerns related to an ageing population, Australia was one of the first countries in the Western world to introduce an age pension for people over the age of 65 (Kaplan, 1989). However, with the outbreak of World War I, followed by the Great Depression and World War II, successive Commonwealth governments had to focus on other social welfare provisions for the general population such as employment, housing and living standards in their policy considerations (Kewley, 1973). In other words, caring for vulnerable older Australians did not receive public policy attention as it was deemed to be a family concern or up to the charitable organisations to respond to, rather than a government responsibility.

Politically, the parliamentary system in Australia was in its infancy at the time of Federation due to lack of unified, coherent electoral laws and practices (Barber & Johnson, 2014). Consequently, political entities within elected governments continued to evolve and consolidate, ultimately producing the Australian Labor Party (ALP) as a trade union-based party representative of industrial workers' interest, and the Nationalist-Country Party Coalition representing landholder and employer interests (Rickard, 2017). Ideologically, the ALP had been identified as the party of reform since it first formed a

majority Commonwealth government in 1910, and regained office in 1929 with an emphasis on improving worker's rights (Louis, 1982; Markey, 1982). The Nationalist-Country Party Coalition, later evolved into the Liberal-Country Party Coalition, focused primarily on economic prosperity along with incorporating values of Britain as the "Mother Country", and emphasising the family unit as the basis of society within which individuals were expected to take responsibility for their own welfare including caring for older family members (Kewley, 1973; Parliament of Australia, 1954b, p. 2896; Rickard, 2017). The economic-focus of the Coalition and the industrial citizenship rights-focus of the ALP continued to manifest in their respective policy directions including around aged care as evidenced in the parliamentary debates examined below.

The fragmentation in the early years of the political establishment reflected the Commonwealth and State governments' policy directions and considerations with respect to social policies relating to older Australians. In particular, the Commonwealth government did not possess full constitutional power for social service provisions until 1908. As a result, relevant provisions were established at the time of Federation by individual States with Commonwealth schemes enacted at various subsequent intervals as replacement provisions or parallel to State provisions (Australian Bureau of Statistics, 1988). For instance, the New South Wales government enacted the Old Age Pension first in September 1900 with Victoria following suit in January 1901. The newly formed Commonwealth government enacted the national Old Age Pension, along with the Invalid Pensions Scheme in 1908 (Kewley, 1973; Markey, 1982). Effects of World War I and the Great Depression exacerbated the fragmentation in social welfare provision with much political dissent over policies to manage the economic and social impact (Barber & Johnson, 2014). In the meantime, religious and voluntary organisations continued their

long-standing form of charitable relief systems in all States, including caring for older people (Kewley, 1973).

The outbreak of World War II caused further structural dislocation to Australia's economic and social landscape. Construction during the war years ceased almost entirely and the primary legislative focus was on war preparation and national security, resulting in a widespread housing shortage which particularly impacted on older Australians (Department of Infrastructure and Regional Development, 2014; Rickard, 2017; The Institute of Public Affairs, 1966). Consequently, on the recommendation of the Joint Parliamentary Committee on Social Security for the Commonwealth government to accept some responsibility of providing suitable means of accommodation for older people, the 1945 Commonwealth and State Housing Agreement was established as a system of joint financial responsibility between Commonwealth and State governments for providing public housing (McIntosh & Phillips, 2001).

Post-World War II saw a period of political stability within which public attention turned to economic growth with demands for full employment, improved living standards, and widely distributed welfare and education opportunities (Australian Bureau of Statistics, 2001; Department of Infrastructure and Regional Development, 2014; Louis, 1982; The Institute of Public Affairs, 1966). The Commonwealth government gained constitutional power over a number of social and health benefits in 1946, and subsequently consolidated general medical, hospital and pharmaceutical provisions and specific pensioner medical services through the National Health Act 1953. This effectively enabled a more comprehensive national focus on consideration for providing care services to older Australians (Eagar et al., 2001; Kewley, 1973; Sidorenko, 2007).

However, aged care remained outside of the public policy agenda until the Aged Persons Homes Act (APHA) 1954, the inaugural national aged care policy.

2.2.2 Assistive approach to funding and provision of aged care services (1954 to 1971)

The APHA 1954 ushered in the era of Commonwealth government taking responsibility for aged care in the form of capital contributions to the provision of accommodation and care for older Australians. It set the basic foundation and benchmarks for subsequent policy developments in aged care (Dargavel & Kendig, 1986). That is, the policy focus was to provide financial assistance and foster a self-regulatory approach primarily to sustain existing faith-based and voluntary organisations to meet the growing demand for residential aged care (Gibson, 1998, p. 2556; Parliament of Australia, 1954a). This initial Commonwealth grant was on a £1 for £1 basis towards the capital costs of approved homes for older Australians largely operated by religious and other voluntary organisations that were using privately raised funds to provide accommodation and personal or nursing care (Kewley, 1973). This approach signified a change in the nature of the aged care funding structure from one of privately raised funds to that of a partnership with the Commonwealth government to assist and sustain existing providers by contributing to the cost of building more facilities for older Australians in need. Provision of care services remained the domain of religious and other voluntary organisations. Of note was the Commonwealth government acknowledging the inadequacy of considering the wellbeing of older people only in monetary terms. According to the then Minister for Social Services, William McMahon, simply increasing the Age Pension would not solve all the social and health problems such as loneliness and feelings of decreased self-worth of the older population (Parliament of Australia, 1954a).

In other words, the Commonwealth government's perception of the care needs of older people included elements of social interaction and emotional wellbeing, and that these elements be organised into effective action (Parliament of Australia, 1954b, p. 2881).

The subsequent Home Nursing Subsidy Act 1956 broadened the Commonwealth government's focus on its role in aged care provision and the continuation of financial partnership strategies. It expanded the Commonwealth capital grant from providing accommodation for older Australians into providing home-nursing services to approved providers (Cameron, 1956). Further, the Aged Persons Homes Act (APHA) 1957 doubled the Commonwealth government's financial assistance to religious, charitable and other approved organisations in providing homes for older Australians to £2 for every £1 of private contribution (Parliament of Australia, 1957). This was followed by the Commonwealth government extending assistance in 1963 by paying benefits on behalf of people in nursing home beds (Gibson, 1998). This indicated a stronger focus on residential aged care and its providers, representing a turning point in embedding a funding structure into the delivery of aged care services.

The introduction of the Personal Care Subsidy and the States Grants (Dwellings for Pensioners) Act in 1969 reflected the Commonwealth government's objectives in re-examining traditional attitudes and policies in aged care and in developing a more comprehensive programme to assist frail older people (Borowski et al., 1997). The Personal Care Subsidy was designed for residents aged 80 years and over who were living in hostels while the States Grants Act aimed to assist State Housing Authorities to construct self-contained units for single aged or Defence Force pensioners that were eligible for Supplementary Assistance (for non-home owners) (Dargavel & Kendig, 1986; Gibson, 1998). This marked the beginning of the Commonwealth government broadening

policy considerations to include hostel care and home based community care while its funding focus remained on residential aged care (Kennedy, 1982).

2.2.3 Increasing regulatory control over aged care provisions (1972 to 1995)

The Commonwealth provision of capital grants and nursing care subsidies significantly stimulated the supply of nursing home beds. By 1981, the proportion of approved nursing home beds had increased by 50%, which, compounded by a underdeveloped community care sector, resulted in an increasing reliance on nursing home beds (Gibson, 1998, 2009). Commonwealth expenditure on nursing home benefits increased three-fold and the growth mainly occurred in the private sector with 51% growth compared to 27% growth in voluntary organisations (Le Guen, 1993). The Aged Persons Hostels Act 1972 created a distinction between nursing homes and hostels that distinguished higher and lower levels of care needs respectively, with the Domiciliary Nursing Care Benefit introduced to encourage home-based care. However, the growth of nursing homes raised a policy concern over the rising costs, with the McMahon Liberal-Country Coalition Government (1971-1972) beginning to control the number of nursing home admissions, followed by the Whitlam Labor Government (1972-1975) developing community health programs to address the concern over public resource distribution (Eagar et al., 2001). These measures indicated a shift away from residential aged care as the dominant provision structure and marked the first experience of reforms by the aged care industry (Courtney et al., 1997; Le Guen, 1993).

Despite the governments' intention to curb the growth of nursing homes, the dominance of this type of institutional care and inadequate supply of home and community-based care services remained a policy concern (Gibson, 1998; Le Guen, 1993). More specifically, the 1982 government report, known as *The McLeay Report*, identified a

major imbalance between institutional and domiciliary care and found significant inadequacies, expense and mismatch of services (House of Representatives Standing Committee on Expenditure, 1982). It recommended the Nursing Home Care Program to control admissions to nursing homes (Hemer, 1983). Furthermore, the Hawke Labor Government (1983-1991) established the Home and Community Care (HACC) program in 1986 to provide a range of home and community-based services for older Australians, aiming at delaying entry into residential aged care thus stemming the growth of nursing home beds (Courtney et al., 1997; Department of Health and Aged Care, 2006; Kennedy, 1989). Funding commitment for the HACC program consisted of 60% from Commonwealth and 40% from the State governments (Courtney et al., 1997).

By 1987, the Commonwealth government had ended its previously shared responsibilities of monitoring residential care facilities with the State governments by taking regulatory control over nursing home regulations including quality inspections (Braithwaite et al., 2007; Courtney et al., 1997). More specifically, the release of the *Outcome Standards for Australian Nursing Homes* made Commonwealth funding to nursing homes contingent on care facilities meeting the 31 resident outcome standards (Le Guen, 1993). This regulatory control was expanded in the early 1990s to cover nursing homes, hostels and community aged care packages, including respite care and dementia care services (Le Guen, 1993). This indicated the Commonwealth government's aged care policy direction broadening from simply providing financial assistance to sustain service providers, to including a regulatory approach through monitoring quality standards of service delivery. Therefore, funding from the Commonwealth government for aged care services became depended on regulatory compliance by service providers. This policy direction fostered a regulatory-compliant and funding-dependent business operational mentality for residential aged care providers. As a result, residential aged care providers

restructured their organisational governance and operational approach to care delivery to meet these requirements (Gibson, 1998).

2.2.4 Deregulatory agenda and the shift to a CDC policy approach (1996 to 2013)

The Howard Liberal-National Coalition Government (1996-2007) brought about an economic imperative-driven deregulatory agenda in policy approach, which included the rationale of containing national health expenditure that was projected to grow rapidly, particularly with regard to ageing-related spending (Cochrane et al., 2021; Treasury, 2010). In the liberal tradition of emphasising individuals and their family units being the basis of society (Parliament of Australia, 1954b), the new legislation – the Aged Care Act 1997 – encouraged the concept of consumers assuming responsibility for their own welfare with a user-pays system, ultimately minimising labour costs and diminishing the element of social care responsibility in meeting the needs of older Australians (Angus & Nay, 2003). The HACC program was enhanced with the objective of improving consumer choice by enabling private aged care service operators to receive government funding thus providing consumer choice of service providers (Angus & Nay, 2003). The Aged Care Act 1997 enabled an accreditation-based quality assurance system to promote consumer rights and service accountability with a view to ensuring that quality standards would meet the increasing expectations of consumers (Bishop, 2000; Department of Health and Aged Care, 2006). In the context of residential aged care, provider responsibility and accountability were enforced by the Aged Care Standards and Accreditation Agency that assessed performance of residential care facilities in the areas of provider management system, resident care, lifestyle and physical environment in the facilities (Senate Standing Committee on Community Affairs, 2004). Services that were not accredited by the Aged Care Standards and Accreditation Agency from January 2001 were not eligible for

government funding (Department of Health and Aged Care, 2006). This approach reinforced the policy direction of government funding eligibility being contingent on regulatory compliance, thus further inducing aged care service providers into compliance-focused business and operational practices.

The Gillard Labor Government (2010-2013) launched the Consumer Directed Care (CDC) initiative in 2010, trialling 1,000 temporary flexible care packages intended to provide community-dwelling aged care service consumers with greater control over their assessed care needs as well as access to required types of care services (KPMG, 2012; Low et al., 2012). This indicated an increased focus on consumer-oriented policy considerations. The LLLB aged care reform package, introduced in 2012, was intended to address issues arising out of an aged care system that was deemed complex and fragmented, with consumers lacking in choice and control over the services they receive as their needs and expectations changed (Department of Health, 2012; Gillard & Butler, 2012; Parliament of Australia, 2013a; Productivity Commission, 2011). This consumer-oriented policy direction shifted the funding focus from residential aged care to home and community-supported care, and broadened the co-contribution regime across the aged care system (Gillard & Butler, 2012; Parliament of Australia, 2013a). More specifically, residential aged care became a "dedicated extra service" (Parliament of Australia, 2013a, p. 1837). This was a marked departure from previous approaches to aged care provisions where, although home and community-supported care had been consistently strengthened, residential aged care had remained the focal point in Commonwealth government's policy approach. In sum, the LLLB reforms refocused national aged care policy direction from a provider-focused and residential aged care-dominated approach to a more consumer-centric orientation. Therefore, the prospects for residential aged care,

given its entrenched government funding and compliance driven business structure and practices, need to be understood in the context of the reform implementation.

2.3 LLLB reform objectives and implementation measures relating to residential aged care

Table 2.2 presents sustainability, consumer choice and control, and workforce capability as areas of LLLB reform objectives with residential aged care related implementation measures (Department of Health, 2012; Gillard & Butler, 2012). The residential care related reform initiatives included capital funding in the form of increasing the maximum accommodation supplement to encourage building residential care facilities, or refurbishment to improve facilities. The viability supplement provided to residential aged care providers over five years focused on services in regional, rural and remote areas by combining general residential care capital grants and grants for the Rural and Regional Building Fund into a single funding category, that is, the Rural, Regional and Other Special Needs Building Fund.

Funding to support other elements of reforms came from cost saving measures implemented in residential aged care such as means testing to increase consumer contribution to residential care costs, and limiting ACFI claims by residential care providers. Protection of financial interests for consumers was in the form of capped annual care fees, a cooling off period for payment options for accommodation costs determined by the new Aged Care Financing Authority and the insurance requirement of residential care providers for accommodation bonds. The element of consumer choice and control was reflected in the flexibility in payment options and the ability to purchase extra services such as more expensive food and entertainment options (Myagedcare,

2023). Payment options included a refundable accommodation deposit (RAD), which is a lump-sum payment for a room in a residential aged care facility; or a means-tested daily accommodation payment (DAP), which is a rental-style daily charge instead of a lump-sum payment for a room in a residential care facility (IHACPA, 2023). Moreover, RAD is set by residential care providers for older people entering aged care facilities who are not eligible for Commonwealth government assistance, whereas DAP is set by Commonwealth government and is supplemented by government funding for older Australians who are eligible for government assistance in entering care facilities (IHACPA, 2023). The My Aged Care website and a national call centre provided consumers with a centralised point of information access. The Workforce Compact, designed as a form of supplement to service providers for improving wages and training for aged care workers, focused on addressing aged care workforce issues in regional, rural and remote areas rather than the overall aged care workforce across the sector.

The reform objectives in relation to residential aged care were focused on consumers. Measures to address issues of sustainability were largely oriented towards easing fiscal pressure on government funding for residential aged care and to protect the financial interests of consumers. More specifically, means-testing measures were introduced to reduce government contributions towards accommodation and care (Gillard & Butler, 2012). The focus of the viability of residential care services was on regional, rural and remote areas and residential care subsidy (i.e. ACFI) saving measures applied to all residential care providers across the sector. While there were initiatives intended to protect consumers' financial interests, there was a limited focus on the capacity of service providers to maintain care provision in the reform implementation process. This was especially relevant considering the need for quality residential care when home care was no longer an option for older Australians (Gillard & Butler, 2012).

More importantly, industry reports in the early phase of the LLLB reforms indicated that financial vulnerability particularly of the not-for-profit providers was an ongoing concern (StewartBrown, 2017), and that 60% of residential aged care beds were operated by not-for-profit organisations such as religious, charitable and community based groups (Grant Thornton Australia, 2015).

While reform objectives for sustainability issues focused on consumer protection and easing fiscal pressure on the government, examination of parliamentary debates of the reform legislation, discussed below, revealed different perspectives about the financial viability of residential aged care. The projected reduction in ACFI and the ongoing compliance burden on residential aged care providers were highlighted as challenging viability issues of residential care providers by the Liberal Party in opposition (Parliament of Australia, 2013b, pp. 3050-3051). More specifically, an estimated 80% of providers suffered "irrecoverable losses of revenue under the ACFI changes" with some "facing revenue shortfalls up to $560,000" (Parliament of Australia, 2013b, p. 3058; 2013c, p. 3490). Conversely, the Labor government's articulation of sustaining the aged care sector focused on providers of home and community-based care services, citing that the ACFI reduction to residential aged care would ensure additional funding for home care services (Parliament of Australia, 2013d, p. 3709). Although financial risks and the issue of viability for residential care providers were well represented in the parliamentary debates, the potential impact on older Australians receiving residential aged care in the reform environment was not fully considered and addressed.

Table 2.2 LLLB reform objectives and measures relating to residential aged care

Reform objectives relating to residential aged care	Reform measures and implementation
Sustainability in the aged care sector with respect to financing affordability and strengthening residential aged care	Increasing the maximum level of accommodation supplement for aged care providers from $32.58 to $52.84 per residential aged care bed in respect of residents who were unable to meet all of their own accommodation costs
	Combining general residential care capital grants and grants for the Rural and Regional Building Fund into one funding category, namely Rural, Regional and Other Special Needs Building Fund - providing $315.8 million viability supplement over five years (2012-2017) to ensure sustainability of residential care services in regional, rural and remote areas
	Saving measures in residential aged care to support other elements of the reforms: • Means testing arrangement projected to deliver $378 million savings over five years, • Curbing ACFI claims projected to deliver savings up to $1.6 billion over five years
	Consumer protection measures in terms of affordability: • Capped annual care fees, • Cooling off period to decide on payment options for accommodation costs, • Payment options approved by the new reform-established Aged Care Financing Authority and requirement for residential care providers to insure the lump sum accommodation bonds to protect consumers' financial interests
Greater consumer choice and control, and access to information	Clients and families of residential care could purchase extras over and above basic specified care and services (e.g. more expensive food and entertainment options)
	• My Aged Care website created as a principal entry point to the aged care systems • National call centre for older Australians and their families to access aged care information and services
Workforce capability	A Workforce Compact budgeted at $1.2 billion over four years (2013-2017) to improve: • Wages, • Career structure and development, • Training and education opportunities, • Work practices and workforce planning, • Workforce pressures in regional, rural and remote areas. Service providers were encouraged to sign up to the Workforce Compact with conditional extra funding but were expected to contribute to the implementation of the Compact

Sources: adapted from LLLB reform package (Department of Health, 2012), full official press release with fact sheet of reform elements (Gillard & Butler, 2012), and government information booklet on LLLB reform package (Department of Health and Ageing, 2012)

The senate inquiry into the proposed reform legislation identified transitional financial issues for residential aged care at a facility or provider level (The Senate Community Affairs Legislation Committee, 2013, p. 61). In particular, the reform changes in offering consumer choice for payment options, while providing transparency and equity within the residential aged care setting for consumers, would necessitate changes to the existing business models of providers (The Senate Community Affairs Legislation Committee, 2013, p. 62). However, responses to viability concerns were largely related to "rural, regional and remote services and providers" rather than across the residential aged care sector (Department of Health and Aged Care, 2013, p. 4). Further, the government's response to supporting residential aged care in adapting to reform changes was in the form of subsidised business advisory services for residential care providers over three years. In addition, providers were encouraged to access assistance through mechanisms such as the Aged Care Workforce Innovation Network (WIN) which was developed to provide an opportunity for providers to redesign their business models and skills mix in transition to the reform environment. This funding was sourced through Department of Industry, Innovation, Climate Change, Science, Research and Tertiary Education, and anticipated partnership between providers and aged care peak bodies such as Aged and Community Services Australia (Department of Health and Aged Care, 2013).

Reform initiatives in addressing aged care workforce capability also had a strong focus on workforce issues related to regional, rural and remote areas rather than the overall residential aged care sector. In general, there appeared to be a lack of dedicated funding and support for the overall residential aged care sector during the reform implementation process (Royal Commission into Aged Care Quality and Safety, 2019). The legislated review of LLLB reforms focused on effectiveness of the reform objectives.

Review elements relating to residential aged care included assessing whether unmet demand for residential aged care places had reduced, whether further steps were needed to change residential aged care from a supply driven model to a consumer demand focused model, as well as the effectiveness of regulating residential care places and prices that meet consumer needs for services and protection (Commonweath of Australia, 2013; Department of Health, 2017a). More importantly, the legislated review did not include the ACFI and quality and safety issues on its scope (Department of Health, 2017a). Other reviews by the government such as that of Carnell and Paterson (2017) that examined the effectiveness of the reforms did not adequately address the issues related to the ACFI changes and their impact on older Australians in residential aged care.

2.4 Conclusion

The Commonwealth government's aged care policy development journey began with assisting and sustaining religious and charitable organisations in service provision to older Australians in need. It continued a supply-driven and provider-focused policy direction fostering a culture of funding and compliance-oriented organisational approach to service provision privileging residential aged care (Fine & Davidson, 2018; Gibson, 1998). The LLLB reforms brought a fundamental shift in the national aged care policy focus away from providers to a more consumer-oriented approach. While this policy shift intended to reflect the preferences of older people to age in their homes and in the wider community, it is important to recognise the government's fiscal decision underpinning this consumer-oriented policy approach, which has equated to savings for the government (Duckett & Stobart, 2021). Table 2.2 presented cost-saving measures by the government in residential aged care to support the policy shift. As mentioned earlier, the Aged Care Act 1997 was legislated based on the liberal tradition that focused on economic

imperative in policy approach and on the responsibility of the individuals for their own welfare. It encouraged the concept of consumer being applied to older Australians, and the aged care services being marketable commodities (Angus & Nay, 2003; Fine & Davison, 2018).

The limited policy attention to the issue of financial viability of residential aged care providers and potential impact on consumers of residential care services during the reform implementation process warrants closer examination of residential care delivery in the reform environment. Also of note was that earlier perceptions and experiences of CDC initiative indicated that the industry regulation and practices had established a service model which made fulfilling CDC objectives difficult (Gill et al., 2017). Although ACFI has been recently replaced by the new Australian National Aged Care Classification (AN-ACC) residential care funding model intended to better reflect CDC principles in delivering consumer-centric care (Department of Health and Aged Care, 2022f), the effects of ACFI reduction as part of the LLLB reforms' consumer-oriented objectives on residential aged care services remained areas for consideration. Chapter Three will report on a scoping review of literature exploring the nature and extent of existing research since 2012 when the LLLB reform package was first introduced that examined residential aged care provision in the context of LLLB reforms.

Chapter 3

A scoping review of existing literature examining residential aged care provision in the context of LLLB reforms

3.1 Scoping review presented in the manuscript form

Chapter Two highlighted a historical trajectory of a supply-driven and provider-focused policy direction fostering a culture of funding and compliance-oriented organisational approach to service provision that privileged residential aged care. It identified a limited policy attention to the issue of financial viability of residential aged care providers in the LLLB reform environment with a fundamental shift away from residential aged care and providers to a more consumer-oriented policy focus on home and community-supported care. This third chapter reports on a scoping review exploring the nature and extent of existing literature from 2012 when the LLLB reform package was introduced, to February 2022 towards the end of the planned 10-year rollout of the LLLB reforms that examined residential care delivery during the reform implementation process.

This chapter is presented below in the form of the manuscript, **Monro, C.**, Mackenzie, L., & Du Toit, S., (2023). Australian aged care reforms and the quality of residential aged care: A scoping review. This manuscript was submitted to the *Australian Journal of Social Issues* on 7 March 2023 and is currently under review.

References presented at the end of this manuscript have also been incorporated into the main reference list of this thesis. However, references specific to this manuscript incorporated into the main reference list have been altered to be consistent with the

referencing style presented in this thesis study. The numeric sequence of the figures and tables included in this manuscript does not follow the format of this thesis, and is excluded from the main lists of tables and figures of this thesis.

3.2 Australian aged care reforms and the quality of residential aged care: A scoping review

Australian aged care reforms and the quality of residential aged care:

A scoping review

Abstract

Australia has been undergoing a major aged care reform process since 2012. The reforms intended to refocus funding and service provision from a residential aged care oriented and provider-driven approach to a more consumer-focused model of funding and service to support ageing-in-place, as older Australians desire to remain in their own homes for as long as possible. Given this policy directional change towards consumer-oriented home and community-supported care, this scoping review aimed to examine the extent that existing literature explored the impact of the reforms on residential care delivery. It followed a five-stage scoping review framework and searched five databases for articles published between 2012 and February 2022. Initial searches identified 495 articles. Articles were imported to Covidence™ for title, abstract and full-text screening. Consequently 20 articles were identified for full review. The majority of the articles (n=12) focused on the workforce perspectives within residential aged care. This review revealed attention paid to workforce issues and a limited focus on consumer expectations. The latter highlighting that there is a need for an evaluation of the reforms as a vehicle for promoting consumer empowerment. Many contributing factors and unintended consequences contrary to the intended objectives of the reforms warrant closer attention.

Keywords

Aged care, health care reform, quality of care, residential care, service delivery

1 | INTRODUCTION

The recent Australian Royal Commission into Aged Care Quality and Safety revealed significant areas of concern particularly with respect to delivering quality care that meet the needs of older Australians (Royal Commission into Aged Care Quality and Safety, 2019, 2021). The Royal Commission highlighted the rigidity of the aged care system that operated around "funding mechanisms, processes and procedures" rather than focusing on the older people being dependent on the system for care and support (Royal Commission into Aged Care Quality and Safety, 2019, p. 1). This was despite the Royal Commission being conducted at the beginning of 2019, over five years after the introduction of legislation to facilitate major reforms within the age care system, namely the Aged Care (Living Longer Living Better) Act 2013 (LLLB hereafter), formulated to ensure a more socially just, consumer-oriented aged care policy approach in providing care.

The LLLB reforms were designed to refocus funding and service provision from a residential aged care oriented and provider-driven approach to a consumer-directed model of funding and service to support ageing-in-place by providing care in the home and community (Department of Health, 2012). This was in response to population ageing that continued to put fiscal pressure on government spending, as well as to support older Australians' preference to remain living in their own homes for as long as possible (Kendig et al., 2017; Treasury, 2021). Although other developed countries have previously adopted similar models (Christensen & Pilling, 2018; Prgomet et al., 2017), the LLLB reforms were the first such policy direction nationally in Australia (Moore, 2021). In residential aged care, this shift in policy focus resulted in government subsidies

reduction for residential care to increase support for home and community-based care (Department of Health, 2012).

Under LLLB reforms, the means-tested individual budgets given to older Australians based on their assessed care needs, only applied to homecare packages and community-supported care. Funding for residential care remained under the model whereby service providers claimed government care subsidies using the Aged Care Funding Instrument (ACFI) in specified categories including activities of daily living (ADL), cognition and behaviour (BEH) and complex health care (CHC) (Aged Care Financing Authority, 2021; Department of Health, 2012). More specifically, A$1.6 billion ACFI was planned to be redirected over five years (2012-2017) to increase homecare packages and training the aged care workforce. This ACFI reduction was to be achieved through restricting growth in subsidy claims made by residential providers for high and medium care including pain management interventions covered under the CHC category (Department of Health, 2012, 2017c). The ACFI has recently been replaced by the new Australian National Aged Care Classification (AN-ACC) residential aged care funding model, with measures such as mandating an average of 200 minutes of care per resident to better reflect the consumer-focused reform objectives (Department of Health and Aged Care, 2022b).

Older Australians enter residential care at a median age of 86 years and often with increased frailty and complex care needs (Borotkanics et al., 2017; Wells et al., 2019). Government reviews of LLLB reforms have largely focused on aspects of reform objectives rather than the impact of reform measures such as care subsidies (i.e. ACFI) reduction on older Australians receiving residential care. In particular, the legislated review of LLLB reforms excluded the quality and safety issues and the ACFI in its scope (Department of

Health, 2017a), despite the objectives of the reforms that included improving the quality of residential aged care (Carnell & Paterson, 2017).

Quality of care is a multidimensional concept requiring consideration of nursing care and interpersonal care which relates to meeting individual preferences and expectations (Jeon et al., 2019; Rolland et al., 2011). The Royal Commission into Aged Care Quality and Safety (2021) emphasized high quality of care being the foundation of aged care. It is therefore important to map out the various facets of the impact on residential aged care in the LLLB reform environment. There is a limited focus on systematic literature reviews of the impact of policy reforms on residential aged care delivery particularly in the context of LLLB reform implementation in Australia. For instance, Kim and Park (2017) investigated the effectiveness of person-centred-care on people with dementia and they included three articles related to residential aged care in Australia that did not focus on the LLLB reforms.

Given the reform changes in funding and service provision that focus on consumer-oriented home and community supported care, the objective of this review was to explore the impact on residential care delivery due to the LLLB reforms. This review aimed to (i) determine the nature and extent of existing literature examining the impact of Australia's aged care reforms on residential aged care and the impact of care subsidies on providing quality residential care; (ii) summarise and present the available evidence; and (iii) identify any gaps in existing literature.

2 | METHODS

A scoping review supported our assessment of emerging evidence as it addressed exploratory research questions with a systematic approach to identify gaps in related research (Colquhoun et al., 2014; Peterson et al., 2017). The protocol for conducting this

review was guided by the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Review (PRISMA-ScR) Checklist (Tricco et al., 2018). The review process followed the 5-stage framework of Arksey and O'Malley (2005): (1) identifying the research question; (2) identifying relevant studies; (3) study selection; (4) charting the data; and (5) collating, summarising and reporting the results.

2.1 | Stage 1: Identifying the research question

The overall research question was "What are the implications of Australia's aged care reforms on the quality of care in Australian residential aged care facilities?"

2.2 | Stage 2: Identifying relevant studies

The search strategy including development of keywords and determining relevant databases was devised in consultation with a university health sciences librarian. Medline was used to conduct a pilot exercise for identifying key concepts. For instance, the term "aged care" generally used in Australia was referred to as long-term care or gerontologic care in other countries, and the term "residential aged care" was referred to as nursing homes or homes for the aged.

Due to their broad coverage of multidisciplinary approaches in health, nursing, ageing and gerontological studies, Scopus, Medline, Embase, Cinahl and Ageline served as the five databases to search for relevant studies. Table 1 presents the search terms used in these databases to identify relevant publications.

Table 1 Database searches

Search term	Database(s)
("nursing home*" OR "old age home*" OR "home* for the aged" OR "residential facilit*" OR "aged care" OR "long term care" OR "gerontologic care" OR "senior care" OR "elderly care") AND ("aged care polic*" OR "aged care legislation*" OR "care standards" OR "aged care qualit*" OR "aged care deliver*" OR "aged care reform*")	Scopus
("nursing homes" OR "homes for the aged" OR "old age home" OR "residential facilities" OR "long term care" OR "senior care" OR "gerontologic care" OR "elderly care" OR "aged care") AND ("aged care policy" OR "aged care reform" OR "aged care legislation" OR "aged care regulation" OR "care standards") AND ("quality of life" OR "quality of healthcare" OR "healthcare delivery" OR "health services for the aged")	Ageline
("residential facilities" OR "nursing homes" OR "homes for the aged" OR "old age homes" OR "long-term care" OR "senior care" OR "elderly care" OR "gerontologic care") AND ("aged care reform" OR "aged care policy" OR "aged care legislation" OR "aged care regulation" OR "care standards") AND ("quality of life" OR "health services for the aged" OR "quality of health care" OR "quality of nursing care" OR "health care delivery")	Cinahl
("residential facilities" OR "nursing homes" OR "homes for the aged" OR "old age homes" OR "long-term care" OR "senior care" OR "elderly care" OR "gerontologic care") AND ("aged care reform" OR "aged care policy" OR "aged care legislation" OR "aged care regulation" OR "care standards") AND ("quality of life" OR "health services for the aged" OR "quality of health care" OR "delivery of health care")	Medline, Embase

Eligibility criteria followed the participants, concept and context (PCC) framework (Peters et al., 2021). Studies were included if related to residential aged care including care facilities; aged care reform related policy and regulatory category as well as elements representing care service delivery such as care quality and quality of life; and peer-reviewed empirical research of developed countries in English between 2012 and February 2022. The time period from 2012 was selected due to the CDC approach of LLLB reforms being published in 2012. All types of study designs were considered eligible to

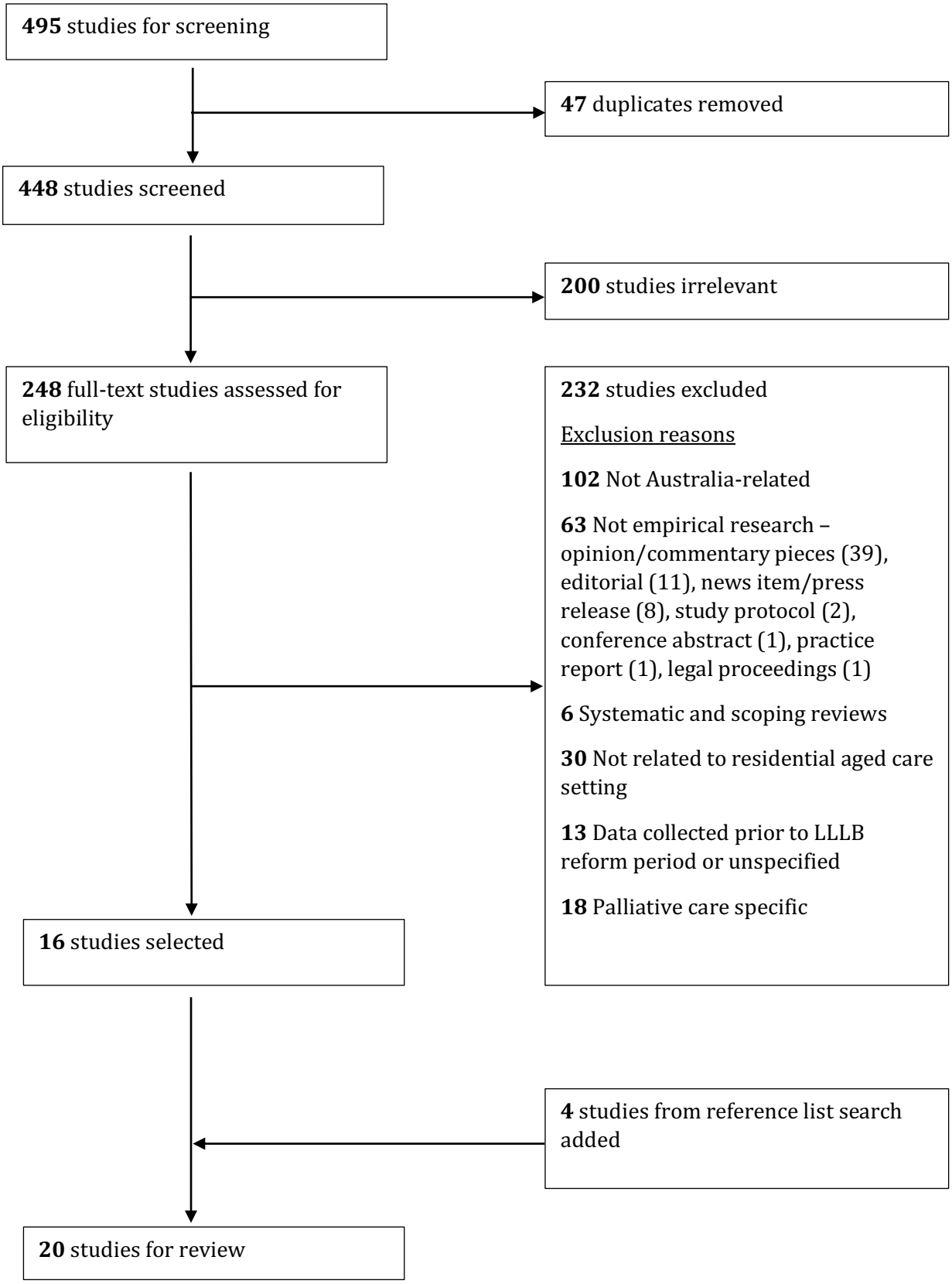
gauge the range of aspects relating to service delivery in residential aged care settings. Studies related to palliative care within residential setting were excluded due to it being classified as "the schedule of specified care and services" as a designated area under ACFI subsidy structure (Australian Institute of Health and Welfare, 2022a, p. 2).

2.3 | Stage 3: Study selection

The database searches resulted in 495 studies being imported from Endnote into Covidence. After duplicates were removed, a total of 448 studies were included for the selection process. Two authors screened the titles and abstracts of all 448 articles independently. Conflicts were discussed and resolved at subsequent meetings of all authors, resulting in 248 studies that related broadly to aged care or in a residential aged care setting being included for full-text review. Two authors assessed all 248 full-text articles independently and resolved further conflicts with a third author. Excluded full-text articles were re-examined to ensure accuracy in adhering to the selection criteria.

Further refinement resulted in excluding studies that did not specify their data collection time given our review objectives being specific to the LLLB reform implementation period. Systematic and scoping reviews were also excluded although their reference lists were hand searched to identify additional articles relating to the objectives of this review (Peters et al., 2020; Tricco et al., 2018). Figure 1 presents the selection process and reasons for exclusion.

Figure 1: Study selection process (using Covidence™ flow chart)



2.4 | Stage 4: Charting the data

Authors met regularly during the data charting process to discuss and refine elements of data extraction to include the following: (a) authors and study focus; (b) study location and data collection period; (c) study design and participants; and (d) key findings related to aspects of residential care and care delivery implications. Specifying key findings that related to aspects of delivering care in residential setting was important in presenting the relevance of data extraction information to the research question. The categorising elements were piloted by the first author using five articles (Peters et al., 2020).

2.5 | Stage 5: Collating, summarizing and reporting the results

Using the data extraction form, relevant data were collated and summarized (see Table 2) and regular meetings between co-authors assisted to ensure consistency and data integrity as advocated by (Braun & Clarke, 2006).

3 | RESULTS

3.1 | Selection of sources of evidence

A total of 20 studies (see Table 2), published between 2015 and February 2022, were included in the final analysis.

Table 2 Characteristics of studies included in the review

Authors and study focus	Study location and data collection period	Study design, participants	Key findings related to aspects of residential care/care delivery implications
Abbey et al. (2015) *Menu planning in residential aged care*	Australia-wide survey. Facility sites in NSW and South Australia Data range: 2010-2013	Mixed method study • National Menu Survey (n=247) • Menus (n=161) • Site observation (n=36)	Relevant key findings: • Low level of food choice for residents, particularly when on texture modified diets • Reliance on tray delivery of meals decrease flexibility for residents
Austin et al. (2021) *The adequacy of residential care services*	NSW Data range: 30 June 2019 - 2029	Quantitative study • Aged Care Services list • Annual population predictive data	Relevant key findings: • NSW fell below target for residential aged care services to meet demand • Nationally one new 140-bed residential care facility needed every week from 2013 to 2023 to meet demands
Borotkanics et al. (2017) *Change in the profile of Australians in residential care facilities*	NSW and ACT Data range: 1 July 2011 - 30 June 2014	Descriptive statistical analyses • Residents (n=9398)	Relevant key findings: • Consistent median age at admission is 86 years • One-third of permanent residents lived in residential care for 3 years or more

Davis et al. (2016) *Factors impacting role of nurses working in residential aged care*	VIC Data collected in 2014	Qualitative descriptive study • Individual interviews (n=11 registered nurse; n=3 enrolled nurses)	Relevant key findings: • De-skilling of nurses due to added responsibilities outside nursing skills and outsourcing of nursing-related services • General Practitioners, hospitals and the community lacking understanding of the complexity of aged care • Quality standards structured in medical model of care, contradicting the person-centred policy approach • Regulatory compliance culture hinders the consumer rights in decision-making
Forder et al. (2022) *Measures of consumer satisfaction in residential aged care*	QLD and NSW Data range: September 2018 - December 2019	Mixed methods validation study • Residential Aged Care Consumer Experience Survey (n=1504)	Relevant key findings: • Experience, care, environment, lifestyle and meals are coherent measures of consumer satisfaction over quality of care and align with the Australian Aged Care Quality Standards
Gao et al. (2015) *Factors influencing employment intentions*	An urban area in Queensland Data range: June - September 2013	Qualitative descriptive study • Individual interviews (n=10 nursing assistants; n=6 nurses)	Relevant key findings: • Level of remuneration, physically and psychologically demanding nature of care work, work schedules and management of cultural diversity • Availability of organisational resources for professional, collegial and workload support • Building meaningful relationship with residents and their families giving meaning to care work

Goh et al. (2017) *Using Touchscreen Technology with residents with dementia*	Melbourne Data range: July - August 2015	Quantitative cross-sectional study • Questionnaire of before-and-after training sessions (n=17 staff)	Relevant key findings: • Using Touchscreen Technology is an important skill for staff to improve the care of residents with dementia and requires training to increase confidence of staff
Henderson et al. (2018) *Facility ownership and missed nursing care and reasons for missed care*	Australia Data range: December 2015 - February 2016	Mixed methods cross-sectional study • Modified MISSCARE Survey (n=3206 direct aged care workers)	Relevant key findings: • Not-for-profit facilities had the highest staff-resident ratios across all occupational group followed by for-profit facilities, with government owned facilities having the lowest ratios • Missed care often related to ACFI's activities of daily living (ADL) • The least likely missed care related to complex healthcare (CHC)
Henderson et al. (2016a) *Frequency and causes of missed care in residential care*	NSW, VIC and SA Data range: 2012 - 2015	Mixed methods study • Surveys (n=922 nurses and personal care assistants)	Relevant key findings: • Tasks most frequently missed were additional unplanned care such as toileting residents within 5 minutes of request • Main reasons being lack of staffing and increasing resident frailty
Henderson et al. (2016b) *Nurses' perceptions of the impact of the aged care reform on care and services in rural areas*	SA Data collected in 2014	Qualitative study • Semi-structured phone interviews of registered and enrolled nurses from residential care facilities (n=4) and multi-purpose services (n=7)	Relevant key findings: • Shortfalls in nursing and care staff as result of ACFI reduction • High-dependency residents prioritised for admission to maximise ACFI funding • Level of staff experience incompatible to level of high care needs

Jeon et al. (2019) *Associations between ACFI classification, consumer/staff satisfaction and clinical outcomes*	Australia Data range: January 2014 - May 2016	Retrospective statistical analysis • National audit data and satisfaction surveys (n=426 residential care facilities)	Relevant key findings: • Aged care homes with higher proportions of high-ACFI residents had higher occurrences of all clinical outcomes except pressure injury • Lower incidence rates of falls without injury and pressure injuries were associated with higher scores for communication, continuous quality improvement, job satisfaction, resident care and services
Loi et al. (2017) *Experiences and perceptions of staff using touchscreen technology to engage residents*	Melbourne Data range: February - December 2015	Quantitative statistical analysis • Questionnaires (n=60 nurses and personal care attendants)	Relevant key findings: • Engaging residents with touchscreen technology contributed to more effective care for residents
Monro et al. (2021) *Perspectives of operational staff in residential care in the context of aged care reforms*	NSW Data collected in 2018	Qualitative description study • Individual interviews (n=9 staff in different roles)	Relevant key findings: • ACFI funding structure and reduction constrained staff's capacity to provide quality care that met the complex needs of residents and families • Areas of available training inadequate to meet complex demands for care
Montalto et al. (2015) *Evaluating a mobile X-ray service for residents of care facilities*	Melbourne Data range: July 2012 - June 2014	Quantitative study • Before-and-after cohort approach (n=30 residential care facilities)	Relevant key findings: • High demand for the mobile X-ray service among older and immobile residents of aged care facilities

Nichols et al. (2015) *Needs of a multicultural workforce working with residents with dementia*	Perth Data range: July - October 2012	Qualitative exploratory methodology • Semi-structured interviews (n=53 staff; n=5 family members of residents)	Relevant key findings: • CALD staff lacking knowledge and experience of dementia • Residents with dementia not easily accepting care from CALD staff • Tension between CALD and non-CALD staff due to different cultural understandings • Effective communication is critical in care delivery
Seah et al. (2021) *Assess person-centered care practices from the perspectives of residents, their family members and staff*	Sydney Data range: May - August 2019	Qualitative study • Individual semi-structured interviews (n=12 residents; n=15 family members; n=18 staff)	Relevant key findings: • While residential aged care facilities aspired to make services more focused on resident outcomes, few fully appreciated the requirements of a system-wide person-centred aged care service
Sutton et al. (2021) *Compare staffing levels and characteristics of residential care facilities against the new national minimum staffing standards*	Australia-wide Data range: 2016 - 2019	Quantitative study • Data from the Royal Commission into Aged Care Quality and Safety (n=1705 residential care facilities)	Relevant key findings: • 3.8% of facilities have staffing levels at or above all three mandatory staffing requirements • Few have staffing levels above minimum care requirements per resident per day • Most facilities meet the requirement to have a registered nurse on-site

Willis et al. (2018) *Organisational ethics of not-for-profit providers supporting CALD staff*	SA Data collected in 2015	Qualitative interpretive study • CALD staff (n=16)	Relevant key findings: • Organisational commitment to practicing valuing diversity enabled supportive human resources and peer worker strategies in place • CALD staff allowed to develop their own positive approaches to care relative to mutual cultural understanding between them and the residents
Xiao et al. (2021) *Reasons why workers enter, stay or leave the aged care workforce*	SA Data range: January - May 2017	Qualitative description study • Face-to-face semi-structured interviews (n=32 staff)	Relevant key findings: • Entering aged care workforce because of passion for the job • Aged care being the only employment option • Preference for working in residential facilities over home and community-based care
Zizzo et al. (2020) *Impact of transition from home to residential aged care*	SA Data range: September 2016 - January 2017	Qualitative study • Focus groups (n=13 residents; n=14 carer-relatives; n=28 staff)	Relevant key findings: • Entering residential aged care is a difficult decision particularly for carer-relatives • Less engaged, rushed or uninformed decision-making process contributes to a sense of loss and grief • Families transfer their sense of loss and grief through complaints, negativity, and aggression toward care staff

3.2 | Characteristics of sources of evidence

Table 2 outlines the key characteristics of the studies included in the review. The selected studies had evenly balanced methodological approaches between quantitative and qualitative study designs. Four studies used mixed methods (Abbey et al., 2015; Forder et al., 2022; Henderson et al., 2018; Henderson, Willis, Xiao, & Blackman, 2016), seven used quantitative methods (Austin et al., 2022; Borotkanics et al., 2017; Goh et al., 2017; Jeon et al., 2019; Loi et al., 2017; Montalto et al., 2015; Sutton et al., 2022) and nine studies used a qualitative methodology in examining various aspects of residential aged care. Most of the qualitative study designs used individual semi-structured interviews (Davis et al., 2016; Gao et al., 2015; Henderson, Willis, Xiao, Toffoli, et al., 2016; Monro et al., 2021; Nichols et al., 2015; Seah et al., 2021; Willis et al., 2018; Xiao et al., 2021; Zizzo et al., 2020).

3.2.1 | Participants across the studies

Residential aged care staff were the primary focus of the studies (n=15) included in the review. Eight of these 15 studies focused on nurses and care workers (Gao et al., 2015; Henderson et al., 2018; Henderson, Willis, Xiao, & Blackman, 2016; Henderson, Willis, Xiao, Toffoli, et al., 2016; Loi et al., 2017; Xiao et al., 2021) including staff of Culturally and Linguistically Diverse (CALD) backgrounds (Nichols et al., 2015; Willis et al., 2018). Three studies included a range of personnel at various levels of operations as well as allied health practitioners (Davis et al., 2016; Goh et al., 2017; Monro et al., 2021). Four studies included residents and family members along with staff as study participants (Abbey et al., 2015; Jeon et al., 2019; Seah et al., 2021; Zizzo et al., 2020). The remaining five included articles focused on residents (n=2) (Borotkanics et al., 2017; Forder et al., 2022) and on residential aged care facility trends (n=3) (Austin et al., 2022; Montalto et al., 2015; Sutton et al., 2022).

3.2.2 | Context of selected studies

Locality in major states of Australia such as New South Wales, Victoria, Queensland and South Australia were strongly represented in the studies included in the review with four studies having a national focus (Henderson et al., 2018; Jeon et al., 2019; Sutton et al., 2022) including one using national data as a component of data collection (Abbey et al., 2015). While seven studies did not specify locations of data collection within their respective states (Borotkanics et al., 2017; Davis et al., 2016; Forder et al., 2022; Henderson, Willis, Xiao, & Blackman, 2016; Willis et al., 2018; Xiao et al., 2021; Zizzo et al., 2020), six studies focused on urban areas (Gao et al., 2015; Goh et al., 2017; Loi et al., 2017; Montalto et al., 2015; Nichols et al., 2015; Seah et al., 2021), and one focused on a rural area (Henderson, Willis, Xiao, Toffoli, et al., 2016).

Over 65% of the studies examined the early implementation period of LLLB reforms from 2012 to 2016 (Abbey et al., 2015; Borotkanics et al., 2017; Davis et al., 2016; Gao et al., 2015; Goh et al., 2017; Henderson et al., 2018; Henderson, Willis, Xiao, & Blackman, 2016; Henderson, Willis, Xiao, Toffoli, et al., 2016; Jeon et al., 2019; Loi et al., 2017; Montalto et al., 2015; Nichols et al., 2015; Willis et al., 2018; Zizzo et al., 2020). Three studies concentrated on periods across the midway of the 10-year LLLB reform implementation plan (Monro et al., 2021; Sutton et al., 2022; Xiao et al., 2021); two focused on the later stage of the reform implementation period (Forder et al., 2022; Seah et al., 2021) and one used predictive data for future projections of residential aged care provision (Austin et al., 2022).

3.2.3 | Concepts encompassed in the selected studies

Studies on the profile of residents (Borotkanics et al., 2017), impact of older people transitioning from home to residential care (Zizzo et al., 2020), adequacy of residential

aged care services (Austin et al., 2022) and current staffing levels and characteristics (Sutton et al., 2022) illustrate a holistic overview of the residential aged care sector. A strong feature was on quality of care experienced by older people in measuring consumer satisfaction about residential quality of care (Forder et al., 2022), the association between ACFI classification, consumer and staff satisfaction and clinical outcomes (Jeon et al., 2019), as well as meal choices and flexibility (Abbey et al., 2015). Additionally, two studies focused on areas of missed care in the residential setting such as toileting residents within five minutes of request and related causes including low staffing levels (Henderson et al., 2018; Henderson, Willis, Xiao, & Blackman, 2016).

With respect to the aged care workforce, three studies presented the perspectives of staff on the impact of the changing policy and consumer environment and the demands of residential care services on the workforce in the reform environment (Davis et al., 2016; Henderson, Willis, Xiao, Toffoli, et al., 2016; Monro et al., 2021). These included funding and regulatory requirements that were not responsive to fostering consumer-focused care delivery, and the insufficient level of staff skill mix unable to meet increasingly complex care needs of the residents. Two studies examined the employment intentions among aged care workers such as satisfaction in meaning of care work albeit its physically and psychologically demanding nature (Gao et al., 2015; Xiao et al., 2021). One study presented the benefits and challenges of a multicultural workforce working with residents with dementia (Nichols et al., 2015). Two studies focused on technological skills and training required for staff working with residents with dementia such as using touchscreen technology to encourage social interaction and improve quality of care (Goh et al., 2017; Loi et al., 2017). One study demonstrated the way in which organisational ethics supported staff of CALD backgrounds to enhance quality care delivery for residents (Willis et al., 2018).

3.3 | Focus areas of impacted aged care provision

Findings revealed three areas of main concern due to policy changes (see Table 3), namely: 1. workforce related issues such as structural challenges and employment intentions of aged care workers; 2. the residential aged care environment including resident profile and the supply-demand issue; 3. areas of care needs and challenges to quality care delivery.

Table 3 Summary of focus areas

Focus areas	Summary
Workforce-related issues	• Mismatch between care subsidies, existing training system and skills and resources required to meet increasing care needs • Compliance culture within aged care • Employment intentions of aged care workers • Benefits and challenges of an increasingly multicultural workforce
The residential aged care environment	• Resident profile • Supply and demand for residential aged care
Areas of care needs and challenges to quality care delivery	• Unmet needs • ACFI reduction impact on staffing level • Structural constraints to delivering quality care

3.3.1 | Workforce related issues

Workforce issues featured prominently among the included studies in that 75% of the studies (n=15) focused on staff in residential care and discussed the challenges faced by aged care workers in delivering quality care. The mismatch between staffing levels determined by available funding and the increasing care needs of the residents represented structural challenges (Henderson, Willis, Xiao, & Blackman, 2016). In terms of staff-resident ratios, Henderson et al. (2018) reported that not-for-profit facilities had

the highest ratios across all occupational groups compared to for-profit and government-owned facilities. Moreover, staff in residential care were faced with a compliance culture as result of the sector being heavily regulated which also impinged on consumer rights in the care-related decision-making process (Davis et al., 2016).

Some studies (n=5) found that staff lacked the level of skills and knowledge required to deliver the care that met the needs of residents with increasing care requirements and complex health conditions (Henderson, Willis, Xiao, Toffoli, et al., 2016). Monro et al. (2021) attributed this to the inadequacy of existing training systems in equipping aged care workers to meet the complex demands for care. Davis et al. (2016) argued that appropriate nursing skills were important but had been pressured by the increased scope of responsibilities for nurses such as maintaining and documenting accreditation standards and compounded by outsourcing of nursing-related services. The complexities of care delivery were also reflected by families of the residents requiring emotional support from care workers because of their own distress. For instance, at times of transitioning their loved ones from home to residential care where they were confronted with complex and burdensome aged care system and processes (Zizzo et al., 2020). Technological skills such as the ability to use touchscreen technology in dementia aged care added another dimension to the care workers' scope of experience when working with residents with dementia (Goh et al., 2017).

The nature of aged care work was highlighted as being physically and psychologically demanding (Gao et al., 2015). While entering the aged care workforce may be the only employment option for some, others had particular passion for the care work, and some preferred working in residential aged care over home and community-based care (Xiao et al., 2021). Several studies (n=4) presented elements of an aged care

workforce with staff of CALD backgrounds. Nichols et al. (2015) reported tension between CALD and non-CALD staff because of their diverse cultural understandings on ageing and approaches to care including caring for residents with dementia. Willis et al. (2018) highlighted potential benefits for non-CALD staff gaining insights from practices of their CALD colleagues' own culture that may enhance quality care delivery for residents. Organisational commitment and support were advocated for sustaining an increasingly multicultural aged care workforce (Gao et al., 2015; Nichols et al., 2015; Xiao et al., 2021).

3.3.2 | The residential aged care environment

In profiling older Australians in residential aged care, Borotkanics et al. (2017) reported the median age at admission to be constant at 86 years and only one-third of permanent residents lived in residential care for three years or more. Jeon et al. (2019) found that residential aged care facilities with higher proportions of high-ACFI residents had higher occurrences of clinical outcomes such as falls and unplanned weight loss. The increasing frailty of residents was highlighted as leading to unplanned care such as call bells and frequent or urgent toileting requests (Henderson, Willis, Xiao, & Blackman, 2016).

Austin et al. (2022) used the shortage of residential aged care beds in New South Wales to emphasise a national supply and demand issue for residential aged care. They calculated that one new 50-bed residential care facility was needed every week in New South Wales from 2020 to 2029 to meet predicted demand, and that nationally, one new 140-bed facility every week needed to be built between 2013 and 2023 to meet the ongoing demand.

3.3.3 | Areas of care needs and challenges to quality care delivery

Areas of unmet needs have been highlighted by several studies. Choice and quality of meals was reported as among the domains that consumers measured quality of care (Forder et al., 2022). However, the study conducted by Abbey et al. (2015) found a general low level of food choice for residents particularly for those with texture modified diets, and reliance on tray-delivery of meals restricted flexibility for residents. Montalto et al. (2015) demonstrated the mobile X-ray service offered to residents by a hospital as an innovation to fill the service gap in unmet needs. Henderson, Willis, Xiao and Blackman (2016) specified additional unplanned care such as call bells and frequent or urgent toileting requests being met within five minutes to be the most frequently missed care tasks in residential facilities. The study conducted by Loi et al. (2017) identified that using technology as part of care delivery to engage residents with psychiatric disorder provided psychosocial benefits to this cohort of residents. With respect to residents with dementia, Nichols et al. (2015) mentioned the challenges for them to accept care from staff of CALD background because of memories of past experience such as war.

The impact of ACFI reduction on staffing levels was highlighted as a challenge to offering quality of care to residents. Studies used the examples of missed care tasks such as moving immobile residents from bed to chair, oral care and wound dressing, which were under ACFI's ADL funding category, to emphasise the influences of ACFI on staffing levels and care provision in residential facilities (Henderson et al., 2018; Henderson, Willis, Xiao, & Blackman, 2016; Henderson, Willis, Xiao, Toffoli, et al., 2016). Following the mandatory staffing requirements recommended by the Royal Commission, Sutton et al. (2022) have reported that only 3.8% of the 1705 residential care facilities in their study were at or above the mandatory staffing requirements, further highlighting the issue of

low staffing levels. A point to note was that staff found meaning in care work if they were able to build relationships with residents and their families which ultimately increased quality of care (Gao et al., 2015).

In addition, according to Jeon et al. (2019), the ACFI funding classification did not lead to or reflect positive health outcomes for consumers. Monro et al. (2021) argued that the ACFI funding structure was task-oriented and constrained staff capacity to provide quality care that met the increasing and complex needs of residents and families, particularly with respect to the practice of relational approaches to care. The regulatory framework such as the aged care quality standards was found to be structured in a medical model of care akin to that of the hospital setting rather than adhering to the consumer-focused reform objectives (Davis et al., 2016). Further, the regulatory framework neglected to include practical guideline for implementation (Abbey et al., 2015; Seah et al., 2021).

4 | DISCUSSION

This scoping review aimed to determine the nature and extent of literature from 2012 to February 2022 examining the impact of Australia's aged care reforms on residential care. Many of the findings from this review have been confirmed by other studies that were not part of this review. In particular, this review identified a strong focus on aged care workforce perspective and a lack of consumer perspective in the process of quality delivery which has also been advocated by other studies (Dow et al., 2013; Walker & Paliadelis, 2016). Given residents' increasing frailty and complex care needs required higher level of understanding and corresponding care delivery (Borotkanics et al., 2017; Henderson, Willis, Xiao, & Blackman, 2016), it is critical to raise awareness of consumer perspective and expectations. From a social justice perspective, consumer empowerment

should include anticipating the needs of residents and their families and how these needs could be met in the reform implementation process (Zizzo et al., 2020).

In line with other research, this review revealed a misalignment between the consumer-focused reform objectives and the funding and regulatory frameworks (Kalaitzidis & Harrington, 2018; Ostaszkiewicz et al., 2016). Given the increasing complexity in providing residential care, the overall change in funding focus away from providers impacted on their sustainability and capacity to deliver care services that met the increasing consumer needs (Monro et al., 2021). There is a demonstrated trend of provider consolidation and reduction in residential aged care providers highlighting an inadequate supply of residential care to meet the demand (Austin et al., 2022; Duckett & Stobart, 2021). This is particularly critical for older people living in rural and remote areas where available services were further limited due to staff shortage as result of ACFI funding shortfall (Henderson, Willis, Xiao, Toffoli, et al., 2016).

Regulatory frameworks such as the new Aged Care Quality Standards did not reflect the importance of choices as part of quality care in line with the consumer-oriented reform approach (Abbey et al., 2015). Moreover, the ACFI data presented level of care needs rather than outcomes of care provided (Jeon et al., 2019). The newly implemented AN-ACC residential care funding model has replaced the ACFI to better reflect the consumer-oriented reform approach in delivering care. However, the focal elements of nursing care tasks remained prominent over interpersonal and relational aspects of consumer needs (Department of Health and Aged Care, 2022f), and early evaluations suggest that this may not meet the needs of residents with dementia (Wesson et al., 2023). Overall, funding models and regulatory frameworks are considered as barriers to quality care delivery because they foster a focus on compliance and funding security rather than

a more personalised approach to providing care (McNamee et al., 2017; Monro et al., 2021; Ostaszkiewicz et al., 2016).

Significant attention was paid to workforce issues from the studies in this review. Of note is employment intention of aged care workers, that entering the aged care workforce was either because the nature of providing care ignited passion for the work, or because the aged care sector was the only employment option (Xiao et al., 2021). This difference in mindset among aged care workers may impact on the quality of care provided and health outcomes for residents. Moreover, given the preference for working in residential care over home and community-based care (Xiao et al., 2021), the challenge may be in attracting more workers to the homecare setting particularly as the reform objective being to enable older people to remain in their own homes. Conversely, the reform environment may present opportunities for innovation in developing the aged care workforce to optimise care provision and health outcomes for residents and their families while achieving professional satisfaction for workers (Davis et al., 2016; Jeon et al., 2019). Innovations such as collaboration between primary healthcare and aged care facilities could fill some of the unmet needs of residents (Montalto et al., 2015).

Organisational commitment to equipping and supporting their aged care workers is critical in enabling a sustainable workforce. Additional training in interpersonal, pastoral care and technological skills would contribute to increasing care quality for residents (Goh et al., 2017; Monro et al., 2021). The needs of aged care workers to deliver care that meets the increasing and complex care needs also require consideration and support, particularly for the multicultural aged care workforce (Nichols et al., 2015). Provider organisations need to have the structure and resources in place to maintain

professional, collegial and workload support to meet the needs of their workers (Gao et al., 2015; Willis et al., 2018).

5 | LIMITATIONS

This review offers a systematic overview of the existing literature examining residential aged care delivery in Australia within the context of Australia's aged care reforms. A broader review including other countries comparable to Australia may present different perspectives of issues relating to quality care delivery. The number of non-empirical research articles (n=63) excluded from this review signified the topic of aged care reform impact being widely discussed although not widely researched. For instance, commentary pieces such as that of Agnew (2013) discussing the implications of low staffing levels creating a culture of 'accepted indignity' in residential care facilities highlights a contributing factor to the misalignment between funding structure and health outcomes. Further, studies included in this review such as that of Henderson et al. (2018) made no reference to the LLLB reforms although its findings on missed care related to ACFI and indicated the impact of ACFI reduction on areas of care provision.

6 | CONCLUSION

In examining the areas of focus in the existing literature on residential care delivery in the reform context in Australia, this review identified a limited focus on consumer expectations and experiences of residential care in the reform implementation process. More representation of the consumer voice is needed in research to enhance awareness and understanding of consumer perspectives to optimise the consumer-focused reform policy outcomes. Increased awareness of consumer perspectives provides care workers with a deeper understanding of the multidimensional nature of care needs for residents. This would equip care workers to better deliver consumer-focused and more

personalised models of care. Contributing factors to unintended consequences such as unmet care needs as a result of funding and regulatory constraints that are contrary to the intended objectives of the reforms warrant more attention so that mitigating strategies may be formulated. How provider organisational structure plays a role in effective implementation of aged care policy reforms that may yield desired reform outcomes also requires further research.

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3.3 Chapter summary and the connection to the next chapter

The scoping review reported in this manuscript, together with the overview of Australia's national aged care policy development presented in Chapter Two form the two components of literature review. Chapter Two provided historical context to conducting this thesis study by demonstrating how significant the conceptual and financial shifts resulting from the LLLB reforms were for the residential aged care sector. In examining existing literature that have focused on the delivery of residential aged care in Australia since the introduction of the LLLB reforms, this scoping review has highlighted a limited research focus on a more comprehensive assessment of reform impact on residential aged care particularly at various levels of care provision process including organisational governance and operations, and the potential flow on effects along these process levels. More importantly, the voices of older Australians residing in aged care facilities during the reform implementation process have not been adequately represented. The next chapter (Chapter Four) provides the rationale to the research design and methodological approaches in conducting this thesis study.

Chapter 4

Methods

The introductory chapter provided an overview of the conceptual frameworks guiding the research processes of this thesis study (see Figure 1.1). Chapter Two highlighted the long-established funding-compliance-focused business structure within residential aged care and indicated gaps in policy considerations for residential aged care delivery during the reform implementation and transition period. The scoping review reported in Chapter Three investigated the nature and extent of literature examining residential aged care between 2012 when the LLLB reform measures relating to residential aged care began to be implemented, and February 2022 towards the end of the planned 10-year rollout of the LLLB reforms (Department of Health, 2012). This review highlighted that research related to residential aged care conducted during the reform implementation period largely focused on the workforce perspective and that more in-depth consumer perspectives were needed. More importantly, a gap also existed in the knowledge regarding governance related to aged care (Hough, 2021). Articles included in the scoping review reported in Chapter Three did not focus on a holistic exploration of reform impact on the various functions in the residential aged care service delivery inclusive of governance, operations and consumer perspectives as proposed by this thesis study. The design of this thesis study aimed to provide a more comprehensive understanding of the multi-level and multi-dimensional nature of reform impact on residential aged care (Cerna, 2013). This chapter explains the selection of qualitative research approaches and processes that were used to answer the research questions presented in the introductory chapter.

4.1 Researcher positioning and reflexivity

Decisions around the use of research methods for this thesis study were influenced by my experiences as a Board Director in a residential aged care provider organisation, and as a family member of a resident in a residential aged care facility. As a Board Director, I understand the governing responsibilities of a provider organisation to comply with government policy changes through the operational functions of the organisation, and what is required of the operational staff in the compliance processes as a result. Therefore, I was attuned to looking at how organisational directions, strategies and operations may be impacted by the LLLB reform changes; and how these changes may affect the operational level of residential aged care delivery. My role as a family member of a resident contributed to a desire to investigate consumer experiences of residential aged care during the LLLB reform implementation period. These experiences have influenced my approaches to this thesis study in that they have indicated connections or relationships between various components within residential aged care delivery processes. As a Board Director, I had the responsibility of ensuring the organisation be financially viable and that it would not reach insolvency. Director responsibilities also included monitoring that the organisation operated within regulatory frameworks and the changes made within the frameworks at any one time. As a family member of a resident in a facility, I had some knowledge of the user-experience that reflected the health outcomes within the organisational environment that required a focus on financial viability under regulatory frameworks. This knowledge included witnessing the work environment within which the facility staff delivered care to residents. It is important to acknowledge the relationships between various components in the residential aged care delivery process and examine how they are impacted by government policy reforms,

including older Australian who are at the receiving end of residential care delivery. As a result, I have drawn on the elements of organisational governance, operations and consumer experiences from which to explore the impact of the LLLB reforms implementation and to attempt a more comprehensive analysis of the impact of the reforms on residential aged care.

4.2 Conceptual frameworks guiding the research

The policy cycle framework and systems theory, indicated in the introductory chapter guide the conceptual flow of this thesis study (Howlett et al., 2009). They provide useful explanatory tools to explore the impact of the LLLB reforms implementation on the various levels of residential aged care delivery process. Generally, the policy cycle framework is a staged process for policy analysis and includes problem identification, policy formulating, policy implementation and policy evaluation (Brewer & DeLeon, 1983; Bridgman & Davis, 2004; Howlett et al., 2009). However, policy research often focuses on particular stages of the policy process rather than the full cycle (Jann & Wegrich, 2007). As indicated in the introductory chapter, the aims of this thesis study orient towards the outcomes of the LLLB reforms reflected in the service delivery and users of residential aged care. As such, the policy evaluation stage of the policy cycle framework is particularly applicable because it gauges the effectiveness of implementation and program delivery. In other words, this stage of the policy cycle is concerned with the study of the impact of policy outputs, which essentially asks how the conditions of the environment or the lives of the individuals were changed by particular policy outputs (Barraclough & Gardner, 2008; Nachmias, 1980). As mentioned in the introductory chapter, government reviews of the effectiveness of the LLLB reforms have focused on validating the LLLB reform objectives such as increasing the number of homecare packages rather than evaluating

the reform outcomes for service delivery to older Australians (Dye, 1976; Nachmias, 1980). Policy evaluation is the phase in the policy cycle that primarily considers social actors such as organisations and individuals rather than government, and pays attention to consequences of policy outputs (Barraclough & Gardner, 2008; Walt & Gilson, 1994).

This thesis study considers experiences of residential aged care providers' organisational governance and operations, as well as clients and their families respectively, as these represent critical points of the LLLB reform implementation process (Howe, 2013; McClelland & Smyth, 2014). These experiences also reflect the consequences of policy outputs as part of the policy evaluation process (Kraft & Furlong, 2018; Nachmias, 1980; Pennock, 2011). There is a relationship between the LLLB reform initiatives related to residential aged care and the outcomes of operationalising these initiatives within residential care. These operational outcomes of the reform initiatives have an impact on residential aged care providers that deliver the care, and on older Australians and their families that receive residential care (Walt & Gilson, 1994).

As indicated in the introductory chapter, systems theory provides the theoretical basis to a macro-meso-micro analytic framework that assists with understanding the operational outflow of the LLLB reforms at each of the governance-operations-consumer points in the residential aged care delivery process. Health services provision is considered a social system within which a number of elements reside and have relationships between them (Costa, 2023). It is a complex social reality that exists within the health system (WHO, 2000; Van Ewijk, 2018). The intention of systems theory is to provide a unifying vision of a particular health system and the interconnectedness therein (Costa, 2023; Schirmer & Michailakis, 2019). Further, systems can also exist on any levels within that system, therefore the relationships exist not only between the elements within

the various levels, but also between the levels within that system (Schirmer & Michailakis, 2019). In this sense, residential aged care delivery represents a system within which organisational governance, operations, residents and families of residents are different components or elements. Each of these components may have various respective dimensions that reflect reform impact in a different way and present a (inter-)connectedness when looking at the three components as a whole, while examining the impact of the LLLB reforms on residential aged care. Therefore, systems theory provides a foundation for examining this multi-layered system because it appreciates both the inter-connected of levels and their permeable boundaries, which contextualises this thesis study within the complexity of the social and political environment as demonstrated in Chapter Two. As systems theory is situated on a high level of abstraction (Schirmer & Michailakis, 2019), a macro-meso-micro framework was used to facilitate the analysis of this thesis study. Using the UK case study on the impact of implementing its new Collaboration for Leadership in Applied Health Research and Care (CLAHRC) as an example, whereby the national policy framework was considered as the macro level, with program implementation at the meso level and a case study in practice at the micro level (Caldwell & Mays, 2012), this thesis study considers organisational governance at the macro level, operations at the meso level, and consumers at the micro level of residential aged care services provision system.

As mentioned in the introductory chapter, it is important to identify the policy problem and understand the context of the LLLB reforms. In this sense, it is useful to understand how Australia has arrived at the LLLB reforms where the policy approach shifted from residential aged care and provider-oriented to consumer-focused funding and service provision. As policy changes are generally influenced by historical context or experience (Allen et al., 2008; McClelland & Marston, 2021), the policy implementation

phase of the policy cycle in the Australian context is described as a policy initiative or a program (Bridgman & Davis, 2004). Therefore, Australia's national aged care policy development relevant to residential aged care has been charted in Chapter Two using a historical framework to understand the narrative of the policy development (Partner, 2013), including the residential aged care related elements of the LLLB reform package as part of the identifying policy problem process. The macro (organisational governance)-meso (operations)-micro (clients and families) levels of analysis as part of the policy evaluation phase of the policy cycle will be reported in Chapter Five, Six and Seven respectively.

4.3 Methodology

Reforms generally relate to institutional change which is a complex and lengthy process (Ranci & Pavolini, 2015). According to Vaismoradi et al. (2013), qualitative research methods provide the relevant tools for exploring complex phenomena with a commitment to the participants' viewpoint. More specifically, qualitative approaches seek to arrive at an understanding of a particular phenomenon from the perspective of those experiencing it which reflects a nuanced approach (Curry et al., 2009; Ratcliffe et al., 2010; Sandelowski, 2010). This is in line with the research aims of this thesis study to investigate the impact of LLLB reforms on residential aged care from the perspectives and lived experience of those providing and/or receiving residential care. Given the researcher's positioning stated earlier, privileging participants' voices also serves to mitigate researcher bias.

The qualitative descriptive research method was chosen because it follows traditional qualitative research as an empirical method with the advantage of gaining

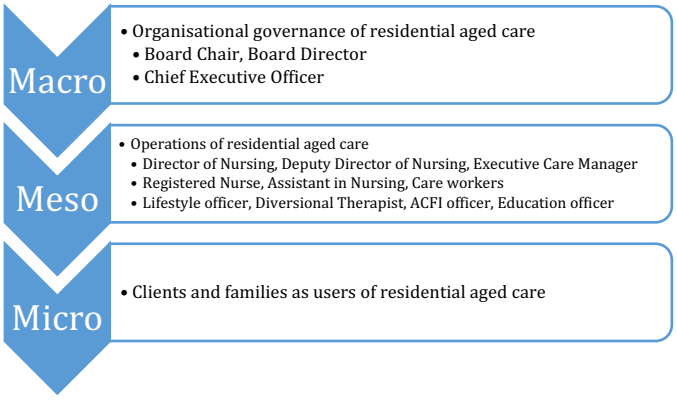
firsthand knowledge of those experiencing the impact of LLLB reforms even when time or resources are limited (Neergaard et al., 2009; Sandelowski, 2010). According to Bradshaw et al. (2017), qualitative descriptive research has a naturalistic philosophical underpinning in that the study of a phenomenon needs to be within its natural setting. Given the researcher positioning stated earlier, what constitutes reality for the researcher is not external to the phenomenon under investigation (Bishop & Shepherd, 2011; Denzin & Lincoln, 2011). As such, knowledge was constructed through the different, subjective interpretations of reality by study participants and the researcher (Carter & Little, 2007; Clough & Nutbrown, 2002). As the aims of this thesis study focused on the experiences of policy outputs, qualitative descriptive research is a relevant approach because it presents the points of view of the study participants as truthful reflection of their reality (Sandelowski, 2010).

The macro (organisational governance), meso (operations), micro (clients and families) levels of studies were conducted as three distinct sub-studies with data collection occurring in the order presented in the publications reported in Chapters Five, Six, and Seven respectively. The intention was to explore the perspectives of participants at each of these levels along the residential aged care provision system and to examine not only the experiences of participants at each of these levels, but also the relationships of experiences between these levels. Data collections were conducted one level at a time, in the order of organisational governance (macro)- operations (meso)- clients and families (micro) levels, with preliminary findings from each level contributing to the probing interview questions of the next sub-study.

4.4 Sampling strategy

The methodological assumption of qualitative descriptive research requires a purposive sample with participants that have the requisite knowledge and experience of the phenomenon being researched (Bradshaw et al., 2017). As such, the sample categories presented in Figure 4.1 indicate the relevant knowledge and experience required of the participants at the level of organisational governance (macro), the level of operations (meso) and the level of clients and families (micro). To explore the changes in residential aged care as a result of the LLLB reforms, categories for client experience include new admissions into residential aged care and those that had been in residence for two years or more. More detailed characteristics of the respective participant cohorts are reported in Chapters Five, Six and Seven presented in the form of published articles.

Figure 4.1 Overview of sample categories



In line with qualitative research practices, particularly with respect to the objective of acquiring a broad insight into a subject (Neergaard et al., 2009; Sandelowski, 1995), the sample size is relatively small given the holistic approach of this thesis study in investigating the reform impact at different levels. Residential aged care facilities in Australia are mostly operated by not-for-profit organisations (Department of Health, 2021). In the early stage of the LLLB reform implementation, 60% of residential aged care

beds were operated by not-for-profit organisations (Grant Thornton Australia, 2015). Therefore, a decision was made that not-for-profit residential aged care providers were the target cohorts for recruiting participants. As this thesis study aimed to adopt a holistic approach in exploring the reform impact on the various dimensions and aspects of residential aged care, it was advantageous to maintain consistency in organisational context related to governance, operations and client level perspectives. This was akin to the case study methods with the purpose of retaining a "holistic and real-world perspective" within a specific context (Yin, 2014, p. 4).

4.5 Recruitment of participants

An invitation to participate in this thesis study was sent to Aged and Community Services Australia (ACSA), the peak body for not-for-profit providers for distribution to their member organisations. The invitation was also sent to not-for-profit organisations through the professional networks of the researchers. Two organisations responded and consented to participate in this thesis study. One facility was in metropolitan Sydney with 120 residential aged care beds, and the other located in a regional area in NSW with 134 residential aged care beds. Both organisations were independent, single-site, not-for-profit providers who have been operating their respective residential aged care facilities for more than 55 years.

The participating organisations facilitated the recruitment of different categories of participants as part of the purposive and convenience sampling strategy to identify accessible participants (Bradshaw et al., 2017). At the board level, the CEO, or their representative invited board members to participate in the study by emailing the study information and promoting the study at the board meetings. At the operations level, the

study information and categories of participants were provided to staff members at internal meetings. To obtain a broad insight into the operational process of the participating organisations, staff with different operational roles or responsibilities were encouraged to participate. The researcher was onsite at the respective participating organisations to answer questions that staff had about the thesis study and about the background of the researcher. At the consumer level, a participant recruitment flyer and the study information were provided at resident meetings as well as putting the information on internal notice boards. Each of the participating organisations nominated a staff member as a point of contact for the researcher. The nominated staff member obtained permission from the interested individuals to pass on their details to the researcher who in turn distributed the relevant Participant Information Statements and consent forms. Potential participants were also able to contact the researcher directly with any enquiries. This process was followed to avoid real or perceived coercion particularly from having a staff member recruiting care recipients. The nominated staff member then assisted with scheduling interviews with study participants. Table 2 in Chapter Five, Table 1 in Chapter Six and Table 1 in Chapter Seven present information from the respective governance, operations and client level of participants.

4.6 Data collection

Semi-structured interviews with open-ended questions were used for data collection to promote alignment with the objectives of qualitative descriptive research methods for obtaining descriptions of the participants' lived experience (Kvale, 2007; Neergaard et al., 2009). More specifically, open-ended questions allowed flexibility in that participants were free to respond in their own words which in turn generated more

nuanced accounts of their experiences and how they interpreted their experiences (Doody & Noonan, 2013; Schultze & Avital, 2011).

A broad interview guide with open-ended questions was developed for each of the governance, operations and client and family categories of participants. Prompts were included in the respective interview guide for the purpose of steering the direction of the interview and helped focus on the reform-related elements. This was to avoid ambiguous or unfocused dialogues that could reduce the quality of the interview data (Malterud et al., 2016). An exploratory conversational style was adopted in the interviews to encourage positive interactions between the researcher and participants and to foster processes of co-creating knowledge between the researcher and the participants during interviews (Doody & Noonan, 2013; Fontana & Frey, 2003; Karnieli-Miller et al., 2009; Liamputtong, 2012).

Data were collected in 2018. Individual interviews were conducted in the order of organisational governance (macro), operations (meso), and resident-family (micro) level participant cohorts. All interviews were in-person, at the participants' workplace, or in resident participants' own rooms at the care facility. At the start of each interview, the researcher followed the Participant Information Statements and explained the nature of the thesis study, the consent form and the interview process, emphasising that the participant could stop the interview at any time to seek clarification or conclude the interview. Written consent forms were then signed by participants and collected by the researcher. Interviews were digitally recorded, with permission from the participants. The audio recordings were transcribed verbatim by the researcher for the purpose of data immersion in preparation for the data coding processes (Saldaña, 2013). This also provided opportunity for the researcher to listen closely to the participants and any

subtleties, ensuring the voices of the participants were privileged in the data analysis (Bradshaw et al., 2017; Fontana & Frey, 2003; Green & Thorogood, 2014). Participants were offered the opportunity to review the interview transcripts (Hagens et al., 2009). A copy of the transcript was sent to those participants who elected to review transcripts for comments, and no concerns or further comments were expressed from the participants. All transcripts were de-identified before the processes of data analysis.

4.7 Data analysis

Qualitative descriptive research commonly uses content analysis and thematic analysis, although often interchangeably because both approaches broadly aim to examine narrative materials from life experiences (Braun & Clarke, 2020; Vaismoradi et al., 2013). However, thematic analysis has been considered as a flexible foundational method, and is a useful research tool for rich and detailed account of data capturing experiences of the participants (Bradshaw et al., 2017; Braun & Clarke, 2013; Holloway, 2017). The elements of flexibility and the ability to gather rich data from the thematic analysis approach are well suited to the research aims of this thesis study. Therefore, thematic analysis was used in analysing the interview data.

As reported in the published articles presented in Chapters Five, Six and Seven, thematic data analysis followed the 6-phase process proposed by Braun and Clarke (2006). Table 4.2 presents the relevant phases and description of the analytic process (Braun & Clarke, 2006, p. 87). While consideration was given to both manual and computer assisted data analysis process (Davis & Meyer, 2009), it was decided that the research aims of this thesis study were more suited to a manual process of thematic

analysis where data immersion was achieved by working closely and repeatedly with the entire data set (Braun & Clarke, 2006).

Table 4.2 Process of thematic analysis

Proposed phase	Process description for this thesis study
1. familiarising yourself with your data	The interviewer: • transcribed interview data verbatim • read and re-read the transcripts • noted down initial ideas
2. generating initial codes	• Respective governance, operations and consumer level data was systematically coded • Data relevant to each code within the respective data set was collated.
3. searching for themes	• Potential themes were identified from the codes within the respective data set • Relevant data was collated to each theme • A coding book for each of the governance, operations and consumer level data was produced with coded extracts
4. reviewing themes	Themes within the respective data set were reviewed in the following order: • First to the coded extracts • Then to the entire data within the respective data set
5. defining and naming themes	• Conducted a process of refining the specifics of each theme and the overall narrative of the analysis • Definitions and names for each theme within the respective data set were produced
6. producing the report	• Selected compelling extract samples from governance, operations and consumer level data set • Analyses were related to the relevant research questions and literature • Reports produced in the published articles presented in Chapters Five, Six and Seven respectively

4.8 Considerations for research integrity and rigour

Transparency in reporting the research processes is critical for maintaining research integrity (Daly et al., 2007). The Consolidated Criteria for Reporting Qualitative research (COREQ) checklist was used for reporting the respective interview data processes of Chapters Five, Six and Seven. Qualitative descriptive studies have been criticised for their lack of rigour (Neergaard et al., 2009). This thesis study has adopted several strategies to increase rigour. Firstly, it used a broadly designed semi-structured interview guide with open-ended questions for each of the respective participant cohorts. This allowed the participants to express their experiences freely, ensuring a level of authenticity, that is, that the voices of the participants were emphasised, and their perceptions were accurately represented (Malterud et al., 2016; Neergaard et al., 2009). Secondly, analysis of each of the governance, operations and consumer level data followed the staged process described above. Coding was conducted with members of the supervision team to ensure transparency and to demonstrate the more rigorous approach to data analysis. These approaches increased both the rigour and credibility in the research processes of this thesis study (Neergaard et al., 2009). Thirdly, the opportunity for participants to review the interview transcripts further strengthened the representation of the participants' experiences (Hagens et al., 2009).

4.9 Ethical considerations

The participating organisations were completely supportive of participant recruitment and staff involvement. However, considerations were given to address potential risks or concerns about coercion that might arise for staff and resident participants given the nature of the research topic and the likelihood of their identification

as participants by management and others within the organisation. Conducting the sub-studies separately, and with individual face-to-face interviews helped address related risks particularly as each of the participant cohorts was interviewed separately and did not interact. For instance, resident participants were interviewed in their own rooms to avoid having to be led to a different location for the interview by care workers who may also be staff participants. As mentioned earlier, each of the interviews began with an explanation of the Participant Information Statements including the interview and deidentification processes to protect participants' identity and their interview data (Bradshaw et al., 2017). The consent forms were signed at each of the individual interviews and in the presence of the researcher. For resident participants, who were the most vulnerable group of the participants, consent processes involved both oral and written explanation of the research (Bomhoff & Friele, 2017). Participants were reminded of their right to ask questions at any time during the interview, or to stop the interview at any time. The researcher positioning reflects a level of awareness of each of the participant cohorts, which ensured that language used to ask the open-ended questions was clear and specific to the context and ability of the respective participant cohorts. This was important to ensure that participants understood the questions and that they felt comfortable and free to provide relevant answers (Bishop & Shepherd, 2011; Bradshaw et al., 2017; Karnieli-Miller et al., 2009). This thesis study did not include residents with dementia as participants due to the requirement of participants having the ability to conduct more in-depth conversations and difficulties with giving informed consent to interviews. This thesis study was approved by the University of Sydney Human Research Ethics Committee (2017-881).

Chapter 5

Reform impact at organisational governance level in residential aged care

5.1 Introduction to the macro level data analysis presented in a published article

This chapter presents the provider organisational governance perspective as the macro-level analysis. It draws on the individual in-depth semi-structured interviews of Board Chairs, Board Directors, and CEOs who were at the governing level of residential aged care provider organisations to explore the strategic responses to reform changes. It addresses the subset research question presented in the introductory chapter on what and how organisational strategies and processes in residential care facilities have changed in response to the reform changes. This macro-level study is presented in the form of a published article: **Monro, C., Mackenzie, L., Du Toit, S., O'Loughlin, K., & Low, L.-F. (2023). A preliminary exploration of the impact of aged care reforms on the governance of two Australian residential care facilities.** ***Gerontology & Geriatric Medicine, 9****,* **1-10.**

5.2 A preliminary exploration of the impact of aged care reforms on the governance of two Australian residential care facilities

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A Preliminary Exploration of the Impact of Aged Care Reforms on the Governance of Two Australian Residential Care Facilities

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Abstract

Objectives: Australia's ongoing aged care reforms have re-focused service provisions from a provider-driven policy approach to a consumer-directed care focus and redirected residential care subsidies. This study aimed (i) to identify the experiences and perceptions of people involved in the governance of residential care facilities about their management of changes due to new accreditation requirements and funding mechanisms, and (ii) to describe their strategic responses to aged care reform changes. **Methods:** A qualitative description design used interviews exploring perspectives of Board Chairs, Board Directors, and Chief Executive Officers of two NSW-based residential care organizations. Thematic analysis was conducted of interview transcripts. **Results:** Four key themes emerged from the data: (1) Business strategies and challenges under reform conditions including the need for business diversification and new approaches, (2) costs incurred by the reforms such as compliance with accreditation requirements, (3) workforce demands: for example maintaining staffing levels and training needs, and (4) expectations about maintaining quality of care. **Discussion:** Changes were necessary in business models for facilities to remain sustainable, meet staffing needs, and continue to provide services in a complex, changing fiscal environment. These included generating revenue streams other than government subsidies, better clarity about government support and establishing partnerships.

Keywords

Australia, health care reform, nursing homes, quality of care, management

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What Do We Already Know About This Topic?

Following recent aged care reforms in Australia there is very little known about the impact of these reforms on the governance of nursing homes and how boards and executives have had to adapt to remain financially viable and compliant with new regulations.

How Does Your Research Contribute to the Field?

This study has confirmed the governance challenges especially for single-site, non-profit providers to deliver high quality and efficient care that is consumer-focused by developing workforce capacity, diversifying income sources, and meeting accreditation requirements.

What Are Your Research's Implications Toward Theory, Practice, or Policy?

To adapt to the complex and changing residential care environment changes are necessary in the skills mix of board members responsible for governance, the capacity of the workforce, business models for facilities to remain sustainable, and support for residents and families.

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Introduction

Population aging is a global phenomenon. One in six people internationally will be aged 65 and over by 2050, with the number of people aged 80 and over tripling from 2019 to 2050 (United Nations Department of Economic and Social Affairs, 2019). In Australia, one in four people will be aged 65 or over, with the number of people aged 70 and over more than doubling by 2060 (Productivity Commission, 2013; Treasury, 2021). Australian government expenditure on aged care increased by more than 40% in the last decade, funding approximately 80% of total aged care spending while user contributions made up the balance (Treasury, 2021). Historically, Australia has had a residential aged care-oriented and provider-driven national policy focus and changes from residential to community care dates back to the McLeay Report in the 1980s (Royal Commission into Aged Care Quality and Safety, 2019). In 2012, the government announced the 10-year Living Longer Living Better (LLLB) aged care reforms as a response to population aging and to relieve fiscal pressure (Department of Health, 2012; Productivity Commission, 2013; Treasury, 2015). More recently the Royal Commission into Aged Care Quality and Safety (2021) has expanded age care reforms and governance requirements. These policy changes have impacted the governance of residential aged care facilities and consequently on the availability and quality of care for older people.

The LLLB reforms adopted a Consumer-Directed-Care (CDC) policy approach that shifted the focus from residential aged care provision to meeting the needs of older people for community supported care in the home. This reform approach also aimed to support older people's desire to remain living in the community for as long as possible (Kendig et al., 2017). While countries including the United States, United Kingdom, Germany, France, and Japan have long adopted the CDC model (Christensen & Pilling, 2019; Lewis & West, 2014; Phillipson et al., 2019; Prgomet et al., 2017), the commencement of LLLB reforms was a new CDC policy approach in Australia. Its intention was to provide control for older people over their care requirements and choice of service providers (Low et al., 2012; Phillipson et al., 2019). Similar to the UK, individual budgets were introduced to enable self-directed support, giving individuals the responsibility of deciding what services and support they needed (Prgomet et al., 2017). Under LLLB reforms, this CDC funding model only applied to homecare services while residential aged care remained under the previous funding model where providers claimed care subsidies from the government through the Aged Care Funding Instrument (ACFI) mechanism (Department of Health, 2017).

However, one of the reform initiatives was to redirect government subsidies from residential care (i.e., ACFI) over 5 years to other aged care reform initiatives such as homecare services and to train the aged care workforce to meet the demand for home and community supported care (Department of Health, 2012). This involved downgrading care subsidy categories and restricting eligibility of ACFI subsidy claims by residential care providers. Furthermore, government regulations also restricted providers in what they could charge the residents for their cost of care (Nusem et al., 2017). Whilst total expenditure on residential aged care consistently increased yearly throughout this period, residential care remained underfunded given the increased demands on services. As a result, providers who operate residential aged care facilities have had to find other sources of income to maintain the same level of quality care for their residents (Nusem et al., 2017).

At the start of LLLB reforms, the federal government provided 71% of total aged care funding to residential aged care providers, of which almost 80% paid for nursing and personal care through ACFI (Aged Care Financing Authority, 2013). Data in July 2021 reported that the total aged care funding allocated to residential aged was reduced to 63% (Aged Care Financing Authority, 2021). Given the ongoing and increasing demand for residential aged care places, residential care providers are faced with the challenge to ensure financial viability while maintaining quality of care for older Australians with increasing care needs. The number of older people entering Australian residential care has increased by 15% over the last 10 years, and older people living in permanent residential aged care are commonly aged 85 to 89, in need of more care and have a shorter length of stay (Australian Institute of Health and Welfare [AIHW], 2021). Most residential aged care facilities in Australia are operated by non-profit organizations (AIHW, 2021). Since the introduction of the CDC model in aged care policy, the number of residential care providers has been in steady decline. Government reports have shown that there were 1,054 residential aged care providers at the start of the LLLB reforms, and by 2019 the number had reduced to 873, suggesting a consolidation of providers (Aged Care Financing Authority, 2013, 2020). Industry reports have highlighted the vulnerable financial position, particularly of smaller, independent residential aged care providers as result of the reforms (StewartBrown, 2020, 2021).

Boards of Directors and Chief Executive Officers (CEOs) are at the governing level of provider organizations' decision-making processes (Considine et al., 2014). They have the governance responsibility of setting business strategies that ensure financial viability under the reform conditions while maintaining quality care delivery needed and expected by older Australians (Cooper, 2005). Corporate governance is defined as the systems that control an organization and how the organization is accountable. Clinical governance is "an integrated set of leadership behaviours, policies, procedures, responsibilities, relationships, planning, monitoring and improvement mechanisms that are implemented

Table 1. Interview Schedule.

Can you describe your background and experience in aged care?
• Work history and roles
• Understanding of the aged care reforms
How have the current aged care reforms affected your organization's governance and strategic directions?
• Changes made
• Costs
• Staffing
• Effect on services for residents
• Business models
• MyAgedCare portal
How have you accommodated the accreditation requirements?
• Staffing for accreditation preparation
• Costs of accreditation
• Audits and compliance
• Benchmarking
The government's perspective is to provide consumers in residential care with more choice and control. How does this translate into your organization?
• Attitudes to spending allocated funds
• Minimum services
• Extent of choice
What feedback have you received, from the staff, clients, and families about the aged care reform changes?
• Clarity about the future
• Staffing
Any other comments you would like to add?

to support safe, quality clinical care and good clinical outcomes for each aged care consumer" (Aged Care Quality and Safety Commission, 2019, p. 3). Despite this important role, studies concerning governance issues have been scarce and there is limited focus on examining the delivery of residential aged care under LLLB reforms from a governance level perspective (Considine et al., 2014; Johnston & Hume, 2015; Nusem et al., 2017). Hough and McGregor-Lowndes (2022) suggest that changes in legislation and regulatory standards in aged care have led to new expectations of boards and directors of service providers. Despite having always had a legal duty to demonstrate care and diligence, and monitoring an organization's services, the expectation on those responsible for governance (who are often voluntary) has been elevated to include higher expectations of ensuring quality and safety. The recent findings and recommendations made by the Royal Commission into Aged Care Quality and Safety (2021) have highlighted the critical nature of governance and emphasized the need for supporting and enabling providers to ensure governance accountability.

In 2022 a new funding process for residential care was introduced—the Australian National Aged Care Classification (AN-ACC) (Department of Health and Aged Care, 2022). This replaced ACFI and involves a detailed assessment of resident care needs performed by an independent assessor, resulting in the number of care minutes the resident is entitled to. Given the complex governance environment of residential care, and its effect on the decisions that can be made by clinicians and families on the long- term care of older people, this exploratory study aimed (i) to identify the experiences and perceptions of people involved in the governance of residential care facilities during ongoing aged care reforms about their management of changes due to new accreditation requirements and funding mechanisms, and (ii) to describe their strategic responses to aged care reform changes.

Methods

Study Design

This study draws on the perspectives of Board Chairs, Board Directors, and CEOs of residential aged care providers to explore the strategic and operational changes required of provider organizations in delivering care under aged care reform conditions. We explored the impact of the reforms on residential care delivery at governance levels for non-profit organizations (representing the majority of aged care facilities in Australia). Study information with invitations to participate were distributed through industry networks and peak bodies such as Aged and Community Services Australia. Retirement villages were excluded from this study as they provide accommodation for older people who do not require the higher level of care offered by residential aged care facilities, and they are not subsidized by the Australian Government (Department of Health and Aged Care, 2020).

The study design utilized qualitative descriptive research methods based on a naturalistic and inductive approach (Bradshaw et al., 2017; Neergaard et al., 2009). A qualitative design was chosen to explore the impact of the current reforms from the perspective of those who were experiencing it without seeking to measure outcomes quantitatively. Semi-structured interviews were used to allow flexibility and spontaneity with participants in describing their understanding and experiences of the reforms (Green & Thorogood, 2014; Neergaard et al., 2009). No repeat interviews were conducted. An intentionally broad interview guide was developed with open-ended questions for exploratory purposes (Liamputtong, 2012). See Table 1 for the interview schedule.

Data Collection

All interviews were conducted at the participants' workplace and were conversational and exploratory, allowing the opportunity to gain in-depth information from the participants (Doody & Noonan, 2013). Interviews ranged from 25 to 90 min and were digitally recorded with permission. Those who elected to review the coding were sent a copy for comments (Hagens et al., 2009). There were no further comments from the participants.

Table 2. Participant Information.

Participant code	Position (period)	Provider location	Business structure
G1	Board Chair (30+ years association with the organization, 2 years as Board Chair)	Central Coast, the State of New South Wales, independent organization at one site	Residential aged care facility, retirement village, with an introduction of homecare services being part of its new business strategy to adapt to the reforms
G2	Board Director (4 years)		
G3	Board Director (long association with the organization from CEO to Board Director)		
G4	CEO (12 months)		
G5	Board Chair (10 years)	Metropolitan Sydney, independent organization at one site	Residential aged care facility, retirement village, with a new Wellness Center providing services to the wider community as part of its business diversification strategy to adapt to the reforms
G6	CEO (8 years)		

Field notes addressing any contextual factors during the interviews were kept by the first author who conducted the interviews.

Data Analysis

All interviews were audio-taped and transcribed verbatim by the first author to allow data immersion, and to ensure that the perspectives of the participants were privileged in the data analysis process (Bradshaw et al., 2017; Saldaña, 2013). The first author kept a field diary following each interview. Using a process of reflective thematic analysis (Braun & Clarke, 2006, 2020), two authors repeatedly read the interview transcripts and coded the dataset independently. Consensus on the codes were reached following discussion and comparisons to ensure coding consistency. A coding book with descriptions was produced to guide the subsequent coding rounds, followed by categorizing themes and subthemes.

Ethical Considerations

This study was approved by the University of Sydney Human Research Ethics Committees (2017-881).

Results

Two non-profit organizations responded to the invitation. Two Board Chairs, two Board Directors, and two Chief Executive Officers consented to participate in the study (Table 2). No participants dropped out once recruited.

Both participating organizations were independent, non-profit, single-site residential aged care providers; one located in Metropolitan Sydney and the other in a regional area in the state of New South Wales. The regional area was introducing homecare services as part of its business strategy to adapt to the reforms' CDC focus, while the organization in metropolitan Sydney had established a homecare service within their retirement village and created a Wellness Center to increase revenue streams.

Four key themes emerged from the data: (1) Business strategies and challenges under reform conditions, (2) Areas of cost, (3) Staffing issues, and (4) Participants' perceived expectations. Table 3 summarizes the themes and sub-themes from the data.

Theme 1: Business Strategies and Challenges Under Reform Conditions

Business Diversification and Approaches. Participants identified changes that were required to their organization's governance and strategic direction. These involved generating revenue streams other than government subsidies including maximizing opportunities for homecare services, venturing into business outside of aged care services, and establishing partnerships to extend the scope of business.

Challenges for Residential Care Providers. Whilst attitudes toward the reforms was generally positive, participants described a lack of clarity over reform initiatives resulting in a level of uncertainty for providers. Some felt that their organizational mission and personal values were now being challenged. They considered their traditional approach to care to be a worthwhile contribution to society and were unwilling to compromise services in caring for older people. For instance, they preferred in-house services over outsourcing to a third party so that they could maintain standards, believing that "*the quality of service (is) down to us, not a third party*" (G5 Board Chair).

There were concerns over the potential increase in premature admission into residential care facilities as result of a shortage in homecare services, and that if the number of providers was reduced because of financial vulnerability, access to residential care in the future would be challenged. With the perceived threat to small independent providers, participants felt that the local

Table 3. Themes and Sub-themes.

Themes	Sub-themes	Sample quotes
Business strategies and challenges under reform conditions	Business diversification and approaches	"If we were just a residential aged care provider, we wouldn't survive. . . I'm talking new ventures as well, outside of aged care . . . one is the Wellness Centre that's predominately aimed at over 55-year-olds . . . and we also have a program called My Companion, which is a community-based program, assisting people to enjoy the community." (G5 Board Chair). "We are selling a retail product and therefore the business had to look and feel that way." (G6 CEO). "An aged care facility cannot be a hospital. It's got to present itself like a destination, a place to live where you can also enjoy the things you've enjoyed in life. You need to enjoy them here, have a coffee, have a meal, have a place to share with friends." (G3 Board Director).
	Challenges for residential care providers	"We don't know what's happening with ACFI. We don't know what's happening with the accreditation. We don't know what's happening with workforce . . . No one knows. I just want clarity going forward . . . It just makes it hard to plan for the future." (G4 CEO).
Costs incurred by the reforms	The impact of structural reform and initiatives on cost	"We used to get [from the government] "here's the money, and you spend it". Now, [the government says] "here's the potential money, what are the needs of your clients and how are you going to meet them?" It changes your entire focus of your business, to be customer focused." (G5 Board Chair). "It's the little things, like no CPI increase in government funding, or 50% indexation and so you know, wages go up by 3% and yet the funding goes up by 1.5%." (G5 Board Chair)
	Cost to provider mission and values	"If we wanted to make money, we would make it more efficient and get rid of a lot of staff and that's where the money would come from. But it's not what we are about." (G4 CEO).
	Cost of compliance	"You take good people off the floor, and you put them in admin positions to fill out bucket loads of paperwork that really aren't relevant and don't have direct impact on the quality of service the client gets . . . The reality is, the staff care for that person in the way they know what that person likes and wants and how they behave . . . they're not going to refer back to a complex 18-page assessment." (G6 CEO).
Workforce demands	Changing focus for staff	"The workload is going up. The staff can't keep up for various reasons. The young ones might not have enough knowledge or skills. The older ones might just not be able to keep up with the physical demand anymore." (G4 CEO). "People [who] have been [working] in aged care for twenty or thirty years . . . they're not going to make it unless they change their concept." (G3 Board Director).
	Staffing challenges	"Staffing levels and retaining staff are hard for us, because there are not many RNs [Registered Nurse] in the area . . . we find it difficult to get good quality RNs, or good quality CSEs [Care Service Employee] because we're just in a smaller demographic, smaller area." (G4 CEO). "At the moment you can come and you can work in aged care if you do a six-week course, Certificate III course in aged care . . . That's just wrong. We need professional standards and the staff have to be able to perform to those standards." (G3 Board Director).
Expectations about maintaining quality of care	Effective reform systems	"The reforms would be a great new way [to enable providers] to offer something special." (G6 CEO)
	Maintaining quality care	"There's a mismatch between what we get funded for, and what the families' expectations are, huge mismatch, and the government needs to understand that." (G6 CEO) "They [consumers and families] expect one to one care . . . I've had families that write to us or to the Commonwealth Investigation Complaint Scheme because we haven't put the doilies on a certain way. They expect us to build furniture and put together chairs, have families come and eat with them without charging. They expect a lot. They expect free physio. They expect bus trips every week." (G6 CEO)

community, particularly in regional areas, would be disadvantaged as a result.

Given the structural changes needed for business approaches and diversification, participants commented on the importance of board governance, and of seeking expertise to meet the requirements of a more market driven approach.

Theme 2: Costs Incurred by the Reforms

The Impact of Structural Reform and Initiatives on Cost. Participants acknowledged that the increasing cost of residential aged care due to an aging population would put the government under pressure. However, they highlighted the implications of changing funding focus from providers to consumers. In particular, the reduction in ACFI care subsidies had resulted in consistent operational loss for their organizations. More importantly, participants felt that the implications of a funding focus shift were not acknowledged, and providers were left without sufficient support in managing reform-induced challenges. In addition, implementing the reforms had been time consuming and labor intensive and had to be achieved with less resources.

Cost to Provider Mission and Values. Participants also perceived that adapting to reforms impacted the organization's mission and personal values in their approach to care provision by making them more focused on minimizing costs. One participant highlighted that reducing staff was the only way to minimize costs, which also resulted in outsourcing previous internal services such as catering and laundry (G4 CEO). Some emphasized a personal commitment to maintaining services and support for residents and cautioned against the market driven objectives implied in the reforms (G1 Board Chair, G2 Board Director, G3 Board Director). They felt pressured into refocusing their values from "*mission, vision*" to "*purpose, principles*" to reflect the more "*commercial*" nature of service provision (G6 CEO).

Cost of Compliance. Concerns were expressed over increasing costs of compliance since the reforms. These included technological development, staff education and training, monitoring, as well as administrative workload including rewriting policies and procedures to reflect the reforms' consumer-oriented policy approach (G6 CEO). While technology could be seen as a necessary cost, there were concerns around the complexity of technological development as part of compliance (G5 Board Chair). Increasing regulation such as the accreditation process was considered a high expense (G6 CEO). Others felt that monitoring compliance was less of a priority as the provision of quality care was already part of their organizational structure and practices. Other legislated financial restrictions such as the 28-day cooling off period for residents to make their payments were regarded as a threat to the viability of the organizations (G4 CEO, G6 CEO).

Theme 3: Workforce Demands

Changing Focus for Staff. Participants noted that a significant impact of the reforms was the need for staff to change focus from a relational approach to more performance-driven practices such as the time taken to complete a task and the number of residents they need to assist. One commented that the feedback from staff was that "*they just want to focus on care. They don't want to know or think that they're selling a product*" (G6 CEO). Another highlighted the close connection between staff and residents, stating that "*residents regard some of the staff members as friends*," and that residents would get stressed when those staff leave or are unavailable (G1 Board Chair). There was an increasing level of demand on staff given many residents had higher care needs or were in palliative care where families of residents also needed support (G2 Board Director).

Long-serving staff seemed particularly challenged by the current demands for delivering care. Some staff were resistant to change, resulting from previously entrenched understanding and practice, and a lack of knowledge about related implications (G2 Board Director, G5 Board Chair). Moreover, due to the aging of the existing staff, particularly those that were approaching "*the end of their nursing career*," there was a reluctance to undertake further training to meet the increasing care needs (G3 Board Director, G4 CEO).

Staffing Challenges. Participants emphasized the challenge of staff turnover resulting from business diversification measures such as the departure of key personnel including Director of Nursing and Deputy Director of Nursing as part of organizational restructure (G2 Board Director). Nevertheless, as new business approaches required "*the right people in the right positions*," the vacancies could be opportunities to recruit appropriate staff (G5 Board Chair). Although the provider in the regional area found it difficult to recruit skilled staff. The training quality for aged care staff was of concern to participants. Moreover, ethical and moral qualities of staff were considered fundamental to delivering quality care (G3 Board Director).

Theme 4: Expectations About Maintaining Quality of Care

Effective Reform Systems. Participants highlighted Australia's "*good culture*" in "*caring for our aged*," and that there was a progressive attitude to change in their experience (G1 Board Chair, G3 Board Director). However, they were disappointed by the ineffectiveness of reform initiatives such as the My Aged Care online information portal, and the perceived unrealistic government's expectation that all older people would be "*tech savvy*" and able to understand and operate new systems (G4 CEO). Clients and families found the portal difficult to understand and operate and required assistance from staff. More administrative staff had to be appointed and

the tool was described as "*dysfunctional*" and "*very difficult to navigate*" (G6 CEO).

Maintaining Quality Care. Participants generally felt that the government, clients and families expected the provider organizations to maintain a high level of care provision in residential facilities despite ACFI subsidies reduction (G5 Board Chair). In particular, the daily care fee subsidy was viewed as insufficient to cover the broader cost of caring for an older person such as the cost of amenities including electricity and building maintenance (G4 CEO, G6 CEO). Participants believed that families of residents were reluctant to pay for services that no longer qualified for ACFI care subsidies while expecting providers to maintain these services regardless (G3 Board Director, G5 Board Chair). Participants felt their needs as service providers delivering the care had not been met by the government in considering the implications of the reforms (G3 Board Director, G6 CEO).

Discussion

This study has explored the impact of aged care reforms on the governance and management of two residential care facilities in shifting the policy focus from provider-driven to a CDC approach. We explored a perspective that is currently under-represented in the research literature (Hough & McGregor-Lowndes, 2022). Changes in the funding of residential care services has resulted in a changing emphasis from service provision to financial sustainability for residential care providers. However, there is a disconnect between government policy and consumer expectations of high-quality service delivery under these reform conditions. The capacity of providers to meet the expected care demands is restricted given their financial vulnerability with rising costs. The narratives presented here provide policymakers, clinicians, and families with information about the issues that currently face the governance of residential care facilities.

The marketization of care implicit in the CDC model requires aged care service providers to take a more commercial approach to care by reframing their services as a marketable product, rather than one based on connection and compassion (Nusem et al., 2017). Both provider organizations in the study were challenged to shift from focusing on providing care to shrewd financial management. It presented a conflict between the organizations' desire for compassion-based care and their financial survival. Davidson (2015) suggested that corporatizing non-profit service providers would lead to an excessive focus on efficiency and profits rather than on the care needs of individuals. As non-profit organizations tend to pursue non-monetary goals and have a level of organizational commitment to social outcomes rather than economic outcomes, the experience of these participants highlights the impact on quality of care of an operational focus on financial viability.

Quality of care is a multidimensional concept involving nursing care as well as interpersonal care or person-centered care, which is related to meeting individual preferences and expectations (Rolland et al., 2011) in the context of an inter-professional team with the older person at the heart of the team (Bhattacharyya et al., 2022). Nursing care such as clinical practice is measurable, while person-centered care such as relationship building between care workers, residents, and families, is not. However, person-centered care contributes at a fundamental level to improving quality of care and accommodates any differences in individual preferences and expectations (Bhattacharyya et al., 2022). As most older people need to be listened to and treated with respect and empathy within residential care settings, a more personalized care planning process is needed that is tailored to individual needs to ensure quality care is provided. This will require a culture shift where residential care staff have time to talk with residents to understand their needs (Coulter & Oldham, 2016).

The strategic focus on measures to mitigate risks of insolvency for providers challenges the sustainability of care quality expected by consumers and required by regulatory guidelines (Nusem et al., 2017). There is a significant monetary cost to achieving both high quality nursing care and interpersonal care. The level of staffing and quality of the staff contribute to quality of care but add to the costs. Those that are in governing positions of residential care providers are faced with the difficult choice between the need to reduce costs and to deliver quality care that is central to their values. For non-profit providers, this conflicting scenario is of great concern (Royal Commission into Aged Care Quality and Safety, 2021). Furthermore, the lack of clarity for residential aged care during reform implementation has impacted the ability of providers to effectively devise appropriate staffing plans to meet the increasing care needs of the residents (Carnell & Paterson, 2017). The ramifications of reduction in subsidies were reflected in the Royal Commission's (2020, 2021) deliberations in acknowledging that the operations of services were unsupported and underfunded. More specifically, the review of LLLB reforms did not include the impact of ACFI subsidies reduction on service delivery (Department of Health, 2017).

Given the mismatch between government funding structure for residential aged care and the current shortage of aged care workers with the level of skills and knowledge needed to meet the increasing complexity of needs, providers feel constrained in their capacity to attract, (re)train, and retain care workers. This was of particular concern for providers outside of metropolitan areas where there is a general shortage of trained staff. These staffing issues are an ongoing concern and have been raised in reviews of Australia's aged care system (Aged Care Workforce Strategy Taskforce, 2018; Department of Health, 2017; Monro et al., 2021; Royal Commission into Aged Care Quality and Safety, 2021).

Finally, the COVID-19 pandemic (which occurred after the study data had been collected) brought many of these issues into sharp relief for the governance of residential care facilities. Expanded funding was needed to absorb the costs of personal protective equipment (PPE) and COVID testing for staff, residents and families and costs of providing staff cover for staff unable to work due to illness. Administration costs also increased. The workforce needed to be better trained and many care staff were only permitted to work in one aged care facility. There were also challenges for staff in maintaining quality of person-centered care for older residents who had visiting restrictions imposed on them during lockdowns.

Limitations

This study explored the governance issues for two non-profit residential aged care providers, that were both single site providers. The study did not involve not-for-profit providers with multiple sites or for-profit providers. Other organizations may have different perspectives and experiences of adapting to the reforms. The sample size was small and could not be generalized to all residential care providers, however a small sample allowed for a deep understanding of the experiences of key informants. The participants had shared experiences across a mix of participant roles (board members, board chairs, and chief executive officers). This was a small population from which to select participants across the two organizations and most eligible people participated. Repeated references made to similar issues suggests that data saturation was reached despite a relatively small group of six participants (Guest et al., 2006; Polit & Beck, 2004). Finally, the study collected data just prior to the COVID-19 outbreak which would have tested the governance of residential care providers further. Given the limited research focus on governance perspective of aged care delivery, this study provides a unique insight and contributes to building an in-depth understanding of the governance aspect of delivering residential aged care.

Conclusion

This study has provided an understanding of the governance responsibilities and related challenges of delivering care in Australian residential care facilities where there is a mismatch between government funding and consumer expectations of service delivery. The fundamental changes in policy from provider-focused to consumer-driven approaches has resulted in uncertainty and instability for residential aged care providers and challenged their financial viability. This is particularly difficult for small, single-site, non-profit providers. Demand for residential aged care continues to increase, and comprehensive policy considerations are needed to meet the costs of delivering high quality care services that reflect a consumer-directed approach, and to facilitate organizational governance accountability (Royal Commission into Aged Care Quality and Safety, 2021). More research into the effects of reforms on service providers' organizational governance is needed to understand how efficient and effective aged care service provisions can be ensured.

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Author Contributions

CM researched the literature; and CM, LM, KO, and LL designed the study and developed protocol and ethics clearance. CM recruited the participants and undertook the interviews. CM, LM, and SdT conducted the data analysis. CM wrote the first draft of the manuscript; and LM and SdT refined, edited, and submitted the manuscript. All authors approved the final version of the manuscript.

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Research Ethics

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Data Availability Statement

Data is available from authors on request.

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5.3 Chapter summary and the connection to the next chapter

The macro-level (i.e. organisational governance) study presented in this chapter has reported that to adapt to the changing policy focus of funding and provisions of aged care away from residential care and from providers, it was necessary for residential care provider organisations to find new ways of generating income. This involved redesigning their business models to include alternative services for the purpose of raising additional revenue to ensure financial viability and sustain operations. Other methods of generating income to sustain operations involved promoting residential aged care as a marketable product, with the organisational philosophy of care provision as a mission being changed to a more commercially focused framework which also required operational staff to shift from a relational approach in providing care to a more time and task efficiency-focused care delivery. The demand for maintaining operations with reduced resources required provider organisations to implement cost-saving measures including reducing staffing levels both in nursing professionals and care workers, and outsourcing previously in-house services such as catering and laundry. These findings have important implications for the flow on effect of these decisions into the provision of care and experience of staff, residents and families of residents. How these organisational strategic changes and reform adaptation measures impact on the operations of residential facilities delivering care to older Australians will be explored in the next chapter.

Chapter 6

Reform impact on the operations of residential aged care

6.1 Introduction to the meso level data analysis presented in a published article

This chapter reports on the meso-level analysis of residential aged care operations in the LLLB reform environment from the perspective of staff at various levels of operational responsibility in residential care facilities. It addresses the subset research question presented in the introductory chapter on what impact the organisational strategic adaptation to reform conditions had on the operations of residential care facilities in delivering services. This meso-level study is presented in the form of a published article: **Monro, C., Mackenzie, L., O'Loughlin, K., & Low, L.-F. (2021). Perspectives of operational staff working in residential care and aged care reforms.** ***Nursing & Health Sciences, 23(4),*** **948-956.**

6.2 Perspectives of operational staff working in residential aged care and aged care reforms

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Perspectives of operational staff working in residential care and aged care reforms

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Abstract

Australia is undergoing major aged care reforms, changing from the previous service provider-driven approach to consumer-directed care principles. In residential aged care, this has resulted in a significant reduction in government funding in order to support reform initiatives in home and community-based care. There has been limited research on the impact of structural aspects of the reforms such as the effect of changes in funding focus. Using a qualitative descriptive research methodology, this study explores the impact of the reforms on staff at various levels of operational responsibility in residential aged care. Issues identified by participants centered on the capacity to deliver care in three areas, the impact of funding reduction, challenges in meeting increasingly complex needs of residents and their families, and new requirements for care roles within current limitations. This paper provides an insight into how and why operational issues have informed the findings of the current Australian Royal Commission into Aged Care Quality and Safety. It identifies areas of support for the aged care workforce that are crucial in fulfilling consumer-focused care delivery.

KEYWORDS
aged care reforms, funding, quality of care, residential aged care, service delivery, workforce

Key points

- This qualitative description study provides insights into the challenges of delivering residential care amid Australia's ongoing aged care reforms.
- Operational staff are faced with competing tensions between economic and health outcomes caused by a mismatch between complex demands for care and the funding and training systems.
- This study highlights the complexities in policy implementation and the crucial structural support needed for staff at various levels of residential care operations to deliver the expected care.

1 | INTRODUCTION

Australia is undergoing major aged care reforms that refocused residential care provisions from a service provider-driven policy approach to one based on Consumer-Directed-Care (CDC) principles that empowers consumers in managing their care needs and outcomes (Department of Health, 2012). More specifically, the aim of the reforms was to increase home and community supported care to enable older people to stay at home for as long as possible. One of the ways to do this has been to redirect residential care subsidies to

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create more home care packages and help train the aged care workforce (Department of Health, 2012). Most residential aged care facilities in Australia are operated by non-profit organizations (Australian Institute of Health and Welfare, 2021b). These service providers are finding this reform environment where care subsidies have been reduced despite the increasing care needs of their residents particularly challenging. The recent findings of the Australian Royal Commission into Aged Care Quality and Safety have highlighted the concerns for older people in care, and emphasized the capacity and capability of the aged care workforce being critical to meeting older people's increasing complexity of needs (Royal Commission into Aged Care Quality and Safety, 2019, 2021).

Population aging is a challenge faced by countries around the world. In Australia, maintaining financial support and care provision for older people has become a national priority and central to addressing demographic pressures (Kendig et al., 2016; O'Loughlin et al., 2017). Other developed countries (e.g. USA, UK, Germany, France, Japan) have long adopted the CDC model although with mixed outcomes, particularly the level of self-management required to utilize the CDC initiatives that challenge older people's mental capacity (Christensen & Pilling, 2019; Prgomet et al., 2017). Australia historically had a provider-driven, primarily residential aged care service national policy focus until 2012 when the national government introduced a CDC approach to aged care policy through its Living Longer Living Better (LLLB) aged care reform package. This changed the focus to a consumer-directed, home and community care-driven model, with residential aged care becoming a component of services available to consumers (Department of Health, 2012). This change in policy direction was done to relieve fiscal pressure but also to reinforce the government's policy framework of aging in place; that is, supporting people as they age to remain living in the community for as long as possible as this also is the preferred option for older people themselves (Kendig et al., 2017).

Under the LLLB reforms, the government redirected the AU$1.6 billion residential care subsidies, saved over 5 years through restricting scope for subsidy claims for high "frailty" by providers, to support reform initiatives including the expansion of home care packages (Department of Health, 2012, p. 88). At the same time new quality standards were established that expected providers to deliver holistic and consumer-focused care (Aged Care Quality and Safety Commission, 2021). The subsidy restriction has challenged residential aged care providers to ensure financial viability while maintaining an expected quality of care for older Australians with increasing care needs (Prgomet et al., 2017). For instance, government aged care data indicate 58% of people using residential aged care are aged 85 and over, a 17% increase since 2010 (Australian Institute of Health and Welfare, 2021a). Almost 90% of people in residential aged care have a physical disability, and almost 75% have a psychosocial disability (Australian Bureau of Statistics, 2018). The LLLB reforms highlighted the labor-intensive nature of aged care work and the delivery of quality care being dependent on a well-qualified workforce. Key initiatives included enabling the aged care sector to attract, retain, and train aged care workers, although little information was provided on how the quality of the workforce training could be ensured (Department of Health, 2012).

In Australia, older people requiring residential aged care are assessed for their care needs by the relevant government agency (Department of Health, 2021a). The government then provides the care subsidies according to each person's assessed care needs. This is calculated through a mechanism, referred to as the Aged Care Funding Instrument (ACFI). Residential aged care providers then claim related care subsidies through the ACFI appraisal process (Department of Health, 2021b). Redirecting residential care subsidies (i.e. ACFI) to create more home care packages as a reform initiative was in effect downgrading the subsidy categories for complex care needs of those in residential aged care (Department of Health, 2017b). More importantly, the ACFI subsidy directly translates into staffing costs of residential care workers such as Registered Nurses (RNs) and Assistants in Nursing (AINs) (Aged Care Financing Authority, 2020; Eagar et al., 2019). Reductions in ACFI subsidies potentially lead to a reduction in staffing as providers attempt to maintain financial sustainability while providing the level of care needed, and expected by the residents and families (StewartBrown, 2018, 2020).

Studies concerned with the impact of LLLB reforms relating to residential aged care have provided insights into elements of the workforce (Davis et al., 2016; Gao et al., 2014; Henderson et al., 2018), technology in care facilities enabling regulatory compliance (Jiang et al., 2016; Wang et al., 2014), experiences of older Australians (Jeon et al., 2019; Wells et al., 2019), and issues of clinical care (Ostaszkiewicz et al., 2016; Tynan et al., 2018). However, there is less focus on the impact of the policy reforms such as the ACFI subsidy reduction on the operations of delivering care in residential facilities, particularly given its direct connection to staffing costs.

The demands on service providers as a result of the reforms were highlighted during the recently completed Royal Commission into Aged Care Quality and Safety, and generally reflected negatively on the service providers (Royal Commission into Aged Care Quality and Safety, 2021). Evidence suggests that providers are constrained in their ability to meet the needs of the consumers as their operational practices are set within the confines of government subsidy categories and the appraisal process. This paper explores the impact of LLLB aged care reforms on the operations of two residential aged care providers from the perspectives of nine staff in various operational positions.

2 | METHODS

This study was part of a larger research project investigating the impact of the fundamental policy change from a provider-driven to a consumer-focused approach on residential aged care service delivery at governance, operations, and client levels. Using qualitative descriptive research methods underpinned by a naturalistic approach and an inductive process (Bradshaw et al., 2017; Neergaard et al., 2009), this component explored the perspectives and experiences of operational

staff in their professional capacity within the provider organizations to gain a holistic snapshot of the impact of the reforms and related challenges in delivering care.

2.1 | Sample

Given that most residential aged care providers in Australia are non-profit, these organizations were targeted in promoting the study. Invitations to non-profit residential aged care providers to participate in the study were distributed by the first author through industry networks including Aged and Community Services Australia (ACSA). Two organizations responded and agreed to participate and facilitated recruitment of staff participants. A purposive sample of staff at the operations level was identified to gather rich information relevant to the study (Malterud et al., 2016; Sandelowski, 1995), and to capture the changes in staff experiences during the reform phase. Eligibility criteria followed the operational structure of the two participating organizations to include management, registered nurses, allied health professionals, and care team categories to ensure sample diversity.

2.2 | Data collection

In-depth, semi-structured interviews were used to obtain descriptions of the working world of the participants (Neergaard et al., 2009), and to allow for flexibility and spontaneity with participants (Green & Thorogood, 2014, pp. 95–97). A deliberately broad interview guide was formulated, with three open-ended questions but accompanied by prompts to set the focus on the impact of the reforms (Karnieli-Miller et al., 2009). Interviews were conversational and exploratory, thus maximizing the opportunity to gain in-depth information from participants (Doody & Noonan, 2013).

The first author interviewed the consenting participants at their workplace with further explanation of their rights. Interviews ranged from 30 to 90 min and were digitally recorded with permission. The audio recordings were transcribed verbatim and participants were provided with the opportunity to review the transcripts (Hagens et al., 2009). Those who elected to review the transcripts were sent a copy and invited to comment. No concerns or further comments were forthcoming from the participants.

2.3 | Data analysis

All interviews were transcribed by the first author. This provided further opportunity for data immersion (Braun & Clarke, 2006; Saldaña, 2013), and ensured that the participants' voices were privileged in the data analysis process (Bradshaw et al., 2017; Fontana & Frey, 2003).

A process of thematic analysis was applied to generating codes, searching, reviewing, and defining themes (Braun & Clarke, 2006). The first and second authors familiarized themselves with the interview transcripts and coded the full dataset independently. Codes were then compared and discussed to ensure their consistency. Upon reaching consensus regarding codes, a coding book was produced with descriptions to guide the next round of coding. Categories of codes were then identified and organized into themes and subthemes (Saldaña, 2013). All transcripts were reviewed again to extract direct quotes to illustrate the relevant themes. A research journal was also maintained to record themes and ideas that emerged from conducting interviews.

2.4 | Ethical considerations

The University of Sydney (2017–881) Human Research Ethics Committees approved the project. Support for data collection was provided by the CEOs of the participating organizations. Participants learned of the study through posters, study information sheets with explanations of the consent forms and interview process, as well as direct communication with the first author. Some of the participants were of a different cultural background than the first author, which consequently helped alleviate research bias. Deidentification was effected during interview transcription by using unique codes to replace the names of the participant to ensure anonymity.

3 | RESULTS

Staff who participated in the study represented categories of professions within the two participating organizations, namely Director of Nursing (DON), Executive Care Manager (ECM), RN, AIN, Care Worker (CW), Diversional Therapist (DT), Education Officer (EO), and ACFI Coordinator (AC), with years of service ranging from new recruits to those who had worked in the organizations for decades (Table 1). Participants' age and gender were not collected to protect anonymity of the participants. Both organizations were non-profit, single-site residential aged care providers with a retirement village. One was located in Metropolitan Sydney with existing home care provision, and the other in regional New South Wales that added a home care service stream to adapt to the reforms.

Three themes emerged from the data with related subthemes (Table 2): (i) Funding reductions and areas of impact; (ii) Changing care needs and related challenges; (iii) New skill requirements for care roles and current limitations.

3.1 | Funding reduction and capacity to deliver care

The reductions in ACFI subsidies from the national government were widely acknowledged by participants. They highlighted the effects of reduced resources on their capacity to provide the level of care that not only their residents needed, but was what many considered as

TABLE 1 Operations level participants

Participant code	Position	Length of service/basis for working in aged care	Provider location
P1	Director of Nursing (DON)	• In the position for 7 months • Wanted to work for smaller, independent provider	Central Coast, the State of New South Wales, independent organization at one site
P2	Registered Nurse (RN)	• Recent graduate and new to the organization • Felt affinity with older people	
P3	Assistant in Nursing (AIN)	• In the position for 3 years	
P4	Diversional Therapist (DT)	• In the organization for 8 years, progressing to current position • Wanted to advocate for older people	
P5	ACFI Coordinator (AC)	• In the position for 4 years • Had a long family history and connection with the organization	
P6	Executive Care Manager (ECM)	• New to residential aged care, and to the position • Career progression	Metropolitan Sydney, independent organization at one site
P7	Registered Nurse (RN)	• In the position for 2.5 years • Career progression	
P8	Care Worker (CW)	• In the organization for 34 years	
P9	Education Officer/Diversional Therapist (EO)	• In the organization for 21 years	

TABLE 2 Themes and subthemes

Themes	Subthemes
Funding reduction and capacity to deliver care	Staffing level challenges
	Increasing administrative burden
	Managing care delivery
Challenges in meeting increasing and complex needs of residents and families	Areas of needs
	Impact on staff
	Challenges of person-centered and individualized care
New requirements for care roles and current limitations	Areas of new skills needed
	Current state of education and skills training
	Managing generational differences

"proper" care (P7 RN), particularly when they did not have "the amount of staff needed to run a full high care cottage" (P5 AC). In addition to the limited staffing numbers, higher staff casualization and turnover were also of concern for participants (P2 RN, P5 AC, P7 RN).

> In the past, we had a lot of full-time staff, and it was one big family because we all knew each other – the same staff on the same day. There wasn't the turnover. Staff today are working in one, two, or three facilities around the areas … when you have casual staff that come in for one day, the residents don't know them and they don't know the residents, which triggers off behavior for our people living with dementia. It brings instability. (P9 EO)

Participants generally considered that care subsidies should not be confined to clinical or physical needs, but also include "emotional or psychosocial needs" as a core component in providing care (P1 DON). They were particularly frustrated with the constraints caused by the funding focus over time spent on clinical tasks and neglecting the overall well-being of the residents which they considered as a human rights issue.

> What we get from our ACFI funding gives us a base on our nursing hours. It tells us what nursing we need to provide residents. If the money is not going to be there, then we're not going to have the nursing hours to provide that care. (P1 DON)

> We are emotional beings, and we're social beings. If you put all that under clinical, it just won't get covered. It's their rights … I think you'll have a lot more depression … We see that verbal behavior in, you know where they lash out at people and that's because nobody's got time to listen to them … often times they're settled because somebody took the time to really listen. (P4 DT)

One area of the impact was the increasing rate of resident hospital admission. Participants considered this as preventable if enough qualified staff such as registered nurses were employed, whose training enabled the ability to recognize symptoms promptly and potentially prevent worsening escalation.

> The level of a Registered Nurse training meant that they can pick up the symptoms much quicker than a care staff member … they can … have interventions put in place before it progresses. The unregistered care worker would not identify so much the symptoms or might identify the symptoms but not have the knowledge base to act on that. Then what happens is the illness escalates further and progresses further where results in the resident ending up in hospital … Our care staff …[will] send them to hospital sooner. (P1 DON)

Participants stressed that the increasing documentation was a cumbersome and time-consuming exercise and impinged on their capacity to meet the needs of the residents. Many believed the purpose of documentation to be about satisfying compliance requirements of "dotting the 'i's and crossing the 't's" to qualify for subsidies (P3 AIN). Details were often recorded at the end of the shifts and could be fragmented or incomplete given the time lapse (P2 RN). Participants generally considered documentation to be secondary to their duty of care towards their residents.

> You are spending a lot more time in front of your computer, documenting and reporting … you are actually away from your residents more than you choose to be …. you have to maintain what you say you are doing and give evidence-based reporting on the computer. (P9 EO)

Participants emphasized the importance of quality of life for their residents and felt uneasy over cost-saving measures such as outsourcing services. They were concerned that the standards and procedures of the outsourced service providers may differ and may impact the overall quality of care (P9 EO). While organizations are willing to bear the cost of ensuring adequate level of qualified staff in the short-term, it was not considered a sustainable practice (P1 DON).

3.2 | Challenges in meeting increasing and complex needs of residents and families

Participants highlighted that the residents entered the facilities at a much later stage and usually due to them being no longer able to care for themselves or be cared for at home. They have less mobility and often are acutely unwell, with increasing needs for dementia and palliative care. More importantly, residents may differ in their requirements for the same categories of care needs (P9 EO). Further, families of the residents need emotional support from the staff during the time of transition (P4 DT, P6 ECM).

> We are overloaded all the time. In the past, you were doing ten residents. Five of them could shower themselves, then two afternoon showers and three in the morning. But now, it's like eight out of ten need assistance. They're getting old. Their mobility drops. You have to use manual handling more … equipment takes a lot of time as well. (P7 RN)

> You are seeing the families have tremendous amount of guilt when they come in. Because they've looked after them at home and then, all of a sudden, they just can't. So, they project this guilt onto the staff because they (staff) don't do it how they would do it at home. (P3 AIN)

Participants presented the discrepancy between the expected needs of the families concerning their loved one in care, and the providers' responsibility to all their residents particularly when resources were limited under the reforms. Complaints from families generally followed when they felt that their expectations were not met, with a lengthy resolution process that participants considered as impinging on their capacity to provide care to their residents.

> I had a family member come to me and asked what was happening with her loved one's product that they were purchasing. The product took seven days to come. But that product was her priority. For us, our priority was for three acutely unwell patients in the facility that were actually getting ready to go to heaven. (P1 DON)

One element of ensuring care delivery capacity was enlisting volunteers. Participants noted that the declining number of volunteers was due to the increasing complexity of the care needs, and to the working lives of people being much longer and therefore leaving them less able to commit to volunteering.

> We don't have as many volunteers as we did before … where people weren't working and they'd come in and donate their time … in aged care, because of the heavy workload and there're more and more people living with dementia, volunteers really don't know what to expect and how they're supposed to manage them. (P9 EO)

Participants found it difficult to apply a resident-oriented care approach when care subsidies were structured according to care tasks performed. They considered setting staff-resident ratios such as that of the childcare industry as a strategy to ensure provisions of the level of care that individual residents need.

> For someone (government agency) to say "okay, this is your assessed need; this is how much we pay you to meet that need." That's a blanket approach. It's not individualized. Every resident is completely different. (P1 DON)

> In aged care, the older they are, the less they can do. But we have no ratio at all. So, it's like, twenty people for one staff, how can they do the job? (P7 RN)

3.3 | New requirements for care roles and current limitations

Given the breadth of the needs of the residents and of their families, participants highlighted the increasing range of skills required to fulfill areas of their respective responsibilities. These skill areas extend to financial literacy, business skills, and pastoral care skills.

> It's having that insight and that knowledge to go, "OK, clinically this is where we need to meet," but you also need to have that business sense on how to manage resources. (P1 DON)

> My role is that I'm trying to get as much money as I can from each resident through their assessments so that we're not going backwards financially. We have to be honest and say "look, it's not just an accommodation. We get paid for how much we do for you"... it's trying to find somebody at that higher dollar level as well to sort of replace them to keep that funding up. (P5 AC)

> It's not just the clinical care, they've got to be social workers, pastoral care workers, psychologists ... it's not just a simple nursing role, absolutely not. Because they take a lot of emotional burden from families. (P1 DON)

Given the changing complexities in performing the work in aged care, participants indicated that the industry would lose some dedicated and experienced workers because "we are asking them to do things that traditionally they just didn't do" (P6 ECM). At the same time, participants stressed that the existing training system for aged care workers did not meet industry requirements for care, with organizations having to bear the costs of retraining new recruits to ensure the expected quality care is delivered.

> They are doing online courses to be a carer – twelve weeks to be a carer. You can't learn to be a carer in twelve weeks ... Their standards have not been high enough. So, then we've decided we actually need a clinical educator on-site to go and work one-on-one with these staff and retrain them on how to be a carer that we expect to meet our high standards. (P1 DON)

Generational differences between long-serving staff and newer recruits presented another dimension to the knowledge and skill required to fulfill care responsibilities. Those that were long-serving staff felt a closer connection with the residents and considered newer recruits rather task-oriented and detached from those in their care. Conversely, newer recruits disagreed with the entrenched practices of long-serving staff.

> I just think they're all career minded – the younger ones. Whereas the older ones, even though it was still a career, it was a more emotional attachment with their job. There isn't that emotional attachment with the younger ones to their job. (P4 DT)

> Most of the care staff have been working here for a long time ... Sometimes I don't really like the way they do things ... for example, for the RN, if we give them medication, we have to see the residents actually swallow the pills so we can sign the chart. But with the other care staff, they just give the pills and leave. (P2 RN)

Interestingly, some participants noted that residents who had been used to the previous practices were not necessarily happy with new practices (O2 RN).

4 | DISCUSSION

This study has explored the impact of the residential aged care subsidies reduction, part of the LLLB reforms to increase home care packages, on the operations of two residential care providers through the experiences of their staff in various operational positions. Participants indicated a keen desire to provide the best possible care to their residents with increasing needs, both in terms of clinical and overall well-being. However, their capacity to deliver such care had been significantly diminished by reduced resources resulting from ACFI subsidy reductions, and by the relevant education and training system lacking in standards appropriate to the industry requirements for delivering care. This echoes the Australian Royal Commission into Aged Care Quality and Safety final report, highlighting capacity and capability of the aged care workforce being critical to delivering care that meets the increasing complexity of needs (Royal Commission into Aged Care Quality and Safety, 2021).

The Organisation for Economic Co-operation and Development (OECD) long-term care quality framework emphasizes that staffing is pivotal in delivering safe and effective care to older people (OECD, 2013). In Australia, the ACFI care subsidy directly translates into staffing costs (Eagar et al., 2019). This study has found that the reduction in ACFI subsidies has resulted in reductions in staffing levels and in outsourcing previously on-site services that maximized residents' quality of life. Together with an administrative compliance burden, there was no capacity for the staff to provide additional support

crucial to the well-being of the residents. The Royal Commission report pointed to the failings of the aged care system particularly with respect to the task-driven nature of aged care and the neglect of holistic considerations for older people and their families (Royal Commission into Aged Care Quality and Safety, 2021). This highlights the consequences of an ongoing conflict between the aged care policy direction that promotes a more holistic, consumer-focused approach to care and the ACFI subsidy structure that drives medical and acute models of care (Fairbrother et al., 2015; White-Chu et al., 2009).

As the study findings indicate, the existence of the task-driven structure within residential aged care is largely due to the way care subsidies are distributed (McNamee et al., 2017). The rigid nature of government funding structures for residential care has restricted the level of flexibility needed for nurses and care workers to deliver care according to the needs of older people. It has resulted in staff being stifled by the documentation process required to claim funding for the categories of care tasks undertaken and to comply with regulatory review audits, adding to the workload of meeting increasing care needs (Carnell & Paterson, 2017; Eagar et al., 2019). More importantly, participants considered ensuring quality of life for their residents as being one of the critical elements of care provision, and that the task-oriented conditions did not permit the practice of resident-focused care. Studies have indicated that workers in aged care generally find professional satisfaction when they have opportunities to provide holistic care, and to address quality of life issues with residents (Davis et al., 2016). Participants in this study have consistently expressed the importance of holistic care. While not explicitly stated by the participants, it may be possible that restricted opportunities to providing holistic care would dampen their passion for caring for older people and lower their morale, further diminishing their capacity to deliver quality care.

One of the factors that participants found prohibitive was the need for a constant focus on saving time, and on documenting the information on care tasks required by the funding and regulatory compliance processes. Many considered documentation to be a compliance exercise, and that they would rather spend the time on caring for residents. This is consistent with other research that highlights the implications of a compliance-focused working culture and the conflict for the staff between their desire to exercise the duty of care and the compliance obligations (Davis et al., 2016; Stokoe et al., 2016). Moreover, some staff had worked in their respective organizations for some time and found this conflict distressing. Generational differences existed between participants and younger workers who have been trained differently and who participants considered were less inclined to take a holistic approach to individual residents. The longer-serving staff felt they had a strong emotional connection to their residents compared to the younger generation of workers. This reflects the changes in working environment and work ethics between the different generations of workers and may indicate different groups of workers are more aligned to the CDC approach.

Researchers such as Gao et al. (2014) have articulated that the demands on aged care workers are also psychological. The psychological health of the aged care workers and the related impact on their capacity to deliver care has been overlooked in government reviews (Aged Care Workforce Strategy Taskforce, 2018; Department of Health, 2017a). The Royal Commission findings highlighted the neglect of older Australians in care. However, to ensure that those providing care have the capacity to deliver, the extent of impact on their mental health under these challenging reform conditions warrants closer attention.

In line with the recent reviews of the aged care workforce as part of government measures of assessing the effectiveness of LLLB reforms (Aged Care Workforce Strategy Taskforce, 2018; Department of Health, 2017a; Henderson et al., 2016), the study participants highlighted the mismatch between the knowledge and skills needed to meet the increasingly complex demands in delivering care, and the existing level of aged care-related education and training. They identified the need for extended support within the provider organizations, particularly in transitioning newer recruits to performing their roles in the residential care setting, as well as coordinating the generations of workers in compliance practices. They stressed the urgency in lifting the quality of training for care workers given the reform conditions demanding their skill areas to include financial literacy, interpersonal skills, coordination and negotiation, as identified in the legislated review of LLLB reforms (Department of Health, 2017a).

4.1 | Limitations

This qualitative study had a relatively small sample size drawn from two non-profit providers and would not be representative of all residential aged care providers. However, it presents a description of the impact of the reform process at various levels of operational responsibilities in two residential aged care settings that highlights the complexities in policy implementation. Moreover, it achieved data saturation with repeated references to similar issues from participants (Guest et al., 2006; Polit & Beck, 2004), and allowed for in-depth understanding of the staff experiences (Green & Thorogood, 2014; Neergaard et al., 2009), and the mission and value-based approach to care by two non-profit providers.

4.2 | Conclusion

This study was conducted at a time when provider organizations were grappling with how best to maintain expected care levels under reform conditions. It has provided insights into how and why operational issues were central to the Royal Commission findings, and the competing tensions between economic and health outcomes. Given the Commission's emphasis on having "people committed to delivering the best care they can" being one of the keys to quality (Royal Commission into Aged Care Quality and Safety, 2019), this study has highlighted the crucial structural and organizational support needed for operational staff to truly fulfill a consumer-focused quality care delivery.

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CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

AUTHOR CONTRIBUTIONS

Study design: Cathy Monro, Lynette Mackenzie, Kate O'Loughlin, Lee-Fay Low.

Data collection: Cathy Monro.

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Manuscript writing: Cathy Monro, Lynette Mackenzie, Kate O'Loughlin, Lee-Fay Low.

AUTHORSHIP STATEMENT

All authors listed meet the authorship criteria and are in agreement with the manuscript.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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6.3 Chapter summary and the connection to the next chapter

The experiences of operational staff reported in this chapter demonstrated the impact of organisational adaptation to reform conditions on the capacity of aged care workers to deliver the level of quality care that not only met the needs of the residents but was also considered as appropriate by staff participants themselves. The ACFI funding reduction was recognised as causing the cost-cutting measures including reduced staff numbers and out-sourcing services such as catering that were considered important by staff participants to quality of life for their residents. The need for staff to focus more on efficiency in completing care tasks rather than building relationships and getting to know the residents conflicted with personal values in the purpose of providing care. These findings draw attention to the complex and conflicted position of those that deliver care being caught between enacting changing organisational policy and meeting the needs and expectations of individuals and families. How these operational constraints as a result of organisational strategic changes and reform adaptation measures are reflected in the user experiences of residential aged care delivery will be presented in the next chapter.

Chapter 7

Reform impact on clients and families as end-users of residential aged care

7.1 Introduction to the micro level data analysis presented in a published article

Having explored reform impact on organisational governance and operations of residential aged care, this chapter reports on the expectations and experiences of clients and families as recipients of residential aged care as a result of the organisational and operational adaption to the reform environment. This micro-level study is presented in the form of a published article*:* **Monro, C., Mackenzie, L., O'Loughlin, K., Low, L.-F., & du Toit, S. H. J. (2022). 'I could no longer cope at home': Experiences of clients and families in residential aged care within the context of Australia's aged care reforms.** ***Australasian Journal on Ageing, 00*****, 1-11.**

7.2 'I could no longer cope at home': Experiences of clients and families in residential aged care within the context of Australia's aged care reforms

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RESEARCH ARTICLE

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'I could no longer cope at home': Experiences of clients and families in residential aged care within the context of Australia's aged care reforms

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Abstract

Objectives: Since 2012, Australia has been undertaking major aged care reforms, moving from a previously service provider-focussed approach to a more consumer-oriented policy direction. There is limited research examining consumer perspectives of residential care in the reform environment particularly with respect to both clients and their families. This study explores the lived experiences of clients and families in residential aged care facilities amid the reform implementation process.

Methods: Using a qualitative descriptive research methodology, individual interviews were conducted with clients and family members ($n = 10$) about their expectations and experiences of residential care. Participants were drawn from two not-for-profit aged care providers.

Results: Two broad themes emerged: (i) entering residential aged care and related issues, with subthemes including reasons for entering, decision-making processes, choice of provider/facility and impact of entering care facilities; and (ii) expectations and experiences of care delivery, with subthemes including issues of staffing, service provision, communication and awareness of living in or through the reform environment. The discrepancy between the experiences of care delivered and expectations of initial and changing care needs being met was a major concern.

Conclusions: This study presents a snapshot of the expectations and experiences of both the client and the family cohorts in residential care under the reform conditions. Adequately addressing the relational and interpersonal elements of care delivery is critical in fulfilling the reforms' consumer-oriented objectives.

KEYWORDS

Australia, consumer experience, health care reform, nursing homes, quality of care

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1 | INTRODUCTION

Australia has been through a major aged care reform process since 2012. Essentially, these changes sought to redirect national aged care policy from a historically residential care dominated and service provider-driven approach, to one based on consumer-directed care (CDC) principles intended to empower older Australians to exercise choice and control over service design and delivery.[1,2] The reforms focussed on both relieving fiscal pressure on the government and increasing home and community care services to support the preference of older Australians to live in their homes for as long as possible. Prior to the reforms, residential care was the responsibility of the national government, whereas home and community-supported services were joint responsibility between national, state and local governments. Under the reforms, aged care funding and services, including residential care, are the responsibility of the national government.[3,4] The CDC principles have been embedded into funding home and community-supported care although not fully implemented in residential care settings. Funding for residential care delivery under the previous Aged Care Funding Instrument (ACFI) involved care subsidies through a care task-based appraisal process.[1,5] The recently implemented Australian National Aged Care Classification (AN-ACC) residential care funding model has replaced the ACFI to better reflect CDC principles in delivering consumer-oriented care.[6] The new Aged Care Quality Standards aimed at ensuring consumer-oriented quality care delivery by all organisations providing aged care services including residential care.[7] Initiatives such as the My Aged Care Website also reflected the consumer-focussed approach by providing a centralised platform as the 'principal entry point to the aged care system' for older people and their families to access all aged care-related information.[1]

Legislative reform centred on the Aged Care (Living Longer Living Better) Act 2013 (hereafter LLLB). While the potential financial risks of residential service providers were highlighted in the parliamentary debates, the impact of the associated funding model on older people in residential care was not fully addressed.[8,9] Over time, various reviews by the government examining the effectiveness of the reforms did not adequately address ongoing issues related to the ACFI funding model and its impact on older people in residential aged care.[10–12] The ACFI subsidies translated directly to staffing costs in delivering nursing and personal care, thus determining the level of care that residents receive, whereas the recently implemented AN-ACC residential care funding model is more concerned with consumer-focussed personal care needs.[2,6,13,14]

Policy Impact

This study found that clients and families were generally satisfied with their experiences of residential care; however, there was little knowledge or understanding of the consumer-oriented reform framework. Increased funding and support are needed to ensure providers and staff have the required knowledge and skills to meet all assessed care needs, including relational and interpersonal elements.

Practice Impact

Clients and families need access to information and support in the transition to residential aged care and a structure in place for ongoing communication and access to provider staff.

Recent studies on consumer experiences in residential aged care have focussed on transition to residential care,[15] food choices reflected in menu planning[16] and assessment of resident-focussed care delivery.[17] There is limited research examining consumer experiences of residential care in the reform environment particularly with respect to both clients and their families.[18–20] Older people often enter residential aged care at a stage of increased frailty and diminished capacity and rely on their families for support.[18,20,21] Therefore, the family perspective is central in examining residents' experiences generally and the impact, if any, of the reforms on care delivery. This study aimed at exploring the experiences of those either living in or having someone living in a residential care facility including reasons for entering residential care, their day-to-day activities and interactions with care staff and, given the timing of the study, their knowledge and understanding of the reform environment.

2 | METHODS

Using qualitative descriptive research methods with a naturalistic approach and an inductive process, this study was conducted to gain insights into a service user perspective by exploring the expectations and experiences of residential care clients and families.[22] This study is part of a broader project examining the different dimensions of care delivery from an organisational and consumer perspective in the context of operationalising Australia's aged care policy reforms and was carried out at the midway mark of the 10-year LLLB implementation period. Not-for-profit

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(NFP) organisations were the focus of this study as most residential care facilities in Australia are operated by NFPs.[23] Following approval by the University of Sydney Human Research Ethics Committee (number 2017-881), invitations to providers to participate in the study including a participant information statement were sent through industry peak bodies (e.g. Aged and Community Services Australia). Organisations that agreed to participate in the broader project facilitated the promotion of the study to residents and their families. A purposive sample of clients and families of both recent admissions and those who transitioned from the 'old' to the 'new' system was selected to explore their experiences in residential care generally and any perceived changes due to implementation of the reforms.

Individual in-depth, semistructured interviews allow for flexibility and spontaneity with the participants when capturing descriptions of their lived experience.[22] The interview guide was deliberately broad for exploratory purposes although accompanied by prompts to provide a focus on participants' experiences. Interviews were conversational to maximise the opportunity of gaining in-depth information from the participants.[22] Interviews ranged from 25 to 70 min and were audio-recorded with permission. The first author conducted the interviews at the facilities and transcribed the recorded interviews verbatim, providing opportunities for data immersion, and ensuring participants' voices were privileged in the data analysis process.[22] Participants were provided with the opportunity to review the transcripts.

A thematic analysis process was utilised to generate codes, and to search, review and define themes. Two authors coded the full data set independently, compared and discussed respective codes to reach consensus and compiled a coding book to guide the next round of coding. Categories of codes were then identified and organised into themes and subthemes, supported by direct quotations to illustrate relevance (see Tables 2–5). Saturation was reached through repeated reference to similar issues from participants to the point that no new data or coding emerged.

3 | RESULTS

Four clients and six family members consented to participate (see Table 1). Participants consisted of nine women and one man. A pseudonym was assigned to each of the participants. Two of the participating family members were also staff members at the facilities. While this may present as a potential source of bias, their dual role provided unique insights into the care from a family and organisational perspective.

Two broad themes emerged: Theme 1: entering residential aged care and related issues, with subthemes including reasons for entering, decision-making processes, choice of provider/facility and impact of entering care facilities (see Tables 2 and 3); Theme 2: expectations and experiences of care delivery, with subthemes including issues of staffing, service, communication and awareness of the reforms (see Tables 4 and 5).

3.1 | Theme 1: Entering residential aged care and related issues

Participants highlighted the reasons and processes of entering residential aged care. Tables 2 and 3 present data reflecting the respective client and family perspectives under relevant subthemes referenced in the sections below.

3.1.1 | Reasons for entering residential care facilities and emotional impact

Participants stated that inability to continue meeting care needs while living alone at home or with families had precipitated their admission into residential care facilities. From the client's perspective, it was the result of their diminished capacity for self-care and their unwillingness to burden family members with care responsibilities (Beth: Table 2(i)a, b). For the families, the increased care and safety needs of their loved ones were critical elements in the decision to enter residential care (Nancy: Table 3(i)a). In addition, residential facilities were considered as places where care responsibilities were transferred from clients and families to the service provider (Beth: Table 2(i)c; Frank: Table 3(i)b).

Although facilities presented a welcoming and homely environment, some client participants considered living in residential care as being 'institutionalised' and felt upset at having to leave their own home (Lyn: Table 2(i)a). Family participants also experienced feelings of guilt because of admitting loved ones into residential aged care (Frank: Table 3(i)b).

3.1.2 | Choosing facilities and related processes

Several participants mentioned their dependence on recommendations from others due to the reputation of the facilities, or a physical inspection of facilities that assisted them in choosing an appropriate provider or facility. Convenience of the location and the first impressions of

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TABLE 1 Client and family participants

Participant	Category	Length of stay	Provider location
Beth	Client (husband has dementia and is living in a double room with her)	New admission—3 weeks, moved from own home	Central Coast, New South Wales, single site, with a retirement village and residential care facility
Lisa	Client	Long association with the provider moving from its retirement village	
Frank	Family member (of client with dementia)	New admission—2 weeks, moved from own home	
Margaret	Family member (also works as Assistant-in-Nursing at the facility)	2.5 years—younger aged resident in his 40s transferred from another provider because family was unhappy with the service provided	
Karen	Family member (also Chaplain at the facility)	4 years, moved from own home	
Ruth	Client	New admission in previous few weeks	Metropolitan Sydney, single site, with a retirement village, residential care facility and homecare service
Lyn	Client (mother of family participant Nancy)	2 years (including 12 months in respite care)	
Mary	Family member (of client with dementia)	Less than 12 months—transferred from a for-profit provider as family not happy with services/practices	
Nancy	Family member of client participant Lyn	2 years (including 12 months in respite care)	
Sarah	Family member	5 years	

TABLE 2 Client perspective on entering residential aged care and related issues

Sub-theme	Summary of elements and relevant direct quotations
(i) Reason for admission and emotional impact	a. Diminished capacity for self-care 'I could no longer cope at home...I wasn't too good. I was out of breath, and he [son] said "mum, I cannot leave you at home."' (Beth) 'It's always a blow when you have to leave your own home and go into an institution'. (Lyn) b. Unwilling to burden family members 'Literally asking them [children] to give up their life [to care for me], I do not think children should have to do that'. (Beth) c. Transferring care responsibilities to service providers 'I no longer have to worry about shopping, cooking that takes up a lot of your life...We get looked after beautifully here'. (Beth)
(ii) Choosing facilities and related processes	a. Dependent on family for selection decision and the management of ongoing processes 'Since I have not been well, my son's sort of taken over, with my approval. He's very wise'. (Ruth)

the facility, including how staff responded, were among the critical elements in the participants' assessment of the provider and facility (Frank: Table 3(ii)b).

Clients were generally dependent on family support in managing administrative processes (Ruth: Table 2(ii)a), although some considered the ongoing administrative tasks to be a burden on the family (Nancy: Table 3(ii)a). Some participants commented on the relatively swift admission process including the perception that people being transferred from hospital were given priority (Nancy: Table 3(ii)c).

3.2 | Theme 2: Expectations and experiences of care delivery

Participants considered staffing issues, service delivery and communication to be among the vital elements of provision of care and were generally unaware of the reforms taking place under the CDC model. Tables 4 and 5 present the data reflecting the respective client and family perspectives under relevant subthemes referenced in the sections below.

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TABLE 3 Family perspective on entering residential aged care and related issues

Sub-theme	Summary of elements and relevant direct quotations
(i) Reason for admission and emotional impact	a. Unable to provide care 'I live in a house with a lot of steps. One of my sisters has large dogs...so living with any of us, and we all work, it just wasn't viable'. (Nancy) b. Care responsibilities transferred to residential service providers '[P]eople had said to put her [wife] in care because they [provider] can offer better care than I can at home... It was the hardest decision of my life actually, to put her into a home...I miss her terribly...I go to bed and I just cannot sleep...something that is constantly going through my head - the worry about her and how she's going'. (Frank)
(ii) Choosing facilities and related processes	a. Related and ongoing administrative tasks for families 'I had to go through Centrelink, or they contacted me with all the forms you have got to complete, just for the financial side of it. That's always ongoing, and time consuming'. (Nancy) b. Location convenience to families, first impression of the facility and staff 'She [staff] was very, very nice. It [facility] is so handy and it just seemed a nice place. There're all sorts of others but not necessarily close to home where I live'. (Frank) c. Perception of admission priority given to clients transferred from hospital 'I think it helped her to jump the queue because she was hospitalised at the time. She'd be a high-level care'. (Nancy)

3.2.1 | Staffing issues

While noting the diverse cultural background of staff members, participants found staff to be caring, respectful and approachable (Beth: Table 4(i)a; Karen, Sarah: Table 5(i)a). Value was placed on residents being treated like part of the family with staff going above and beyond in meeting individual needs (Karen: Table 5(i)e).

Familiarity and regular contact with staff were important issues for family participants because it represented a better understanding of residents' individual care needs; thus, high staff turnover was considered to negatively impact on the ability to be familiar with the needs of the residents and provide ongoing care (Karen: Table 5(i)d). In essence, family participants wanted their loved ones to be considered as a whole person regardless of any changes in their health (Nancy: Table 5(i)d).

Participants were generally understanding of the challenges that staff faced in caring for residents. While client participants were patient and accommodating (Beth: Table 4(i)c), family participants expected strategies such as staff–resident ratios to be in place to ensure individual care needs were met (Mary: Table 5(i)c). Staff training was also highlighted by the participants as needing further improvement (Mary: Table 5(i)b). Overseas-born staff were perceived as not being fully qualified (Lyn: Table 4(i)b).

A family participant who had experience of both a for-profit provider and not-for-profit provider felt the existence of long-serving staff in the not-for-profit organisation was an indication of the provider valuing and looking after their staff (Mary: Table 5(i)f). She also commented that the for-profit provider appeared to boost staffing levels at accreditation time because prior notice was given of the impending accreditation inspection (Mary: Table 5(i)f).

3.2.2 | Service issues

Participants identified a range of issues related to the provision of care services. Choice of food and its quality were critical (Lyn, Beth: Table 4(ii)a), with family participants stressing the importance of continuous monitoring and improvement of food quality (Mary: Table 5(ii)a). Other areas particularly highlighted by the participants were the need for mental stimulation and for addressing mental health issues among residents (Lyn: Table 4(ii)b; Margaret: Table 5(ii)b).

Family members often filled service gaps in the facility to ensure that the needs of their loved ones were met (Mary: Table 5(ii)d). For instance, families would take washing home because clothing items went missing (Frank: Table 5(ii)d). One participant needed her family to connect the telephone in her room due to delays in the facility organising the connection (Lyn). Consequently, all participants recognised having a supportive family was beneficial for residents.

Activity programs also formed part of the service issues raised by the participants. Some expected providers to commit to an appropriate level of activities (Nancy: Table 5(ii)c). Others emphasised that physical activities were beneficial to mental health and involving family members in the programs served as an educational strategy to increase understanding and awareness of well-being issues while also motivating residents to participate (Margaret: Table 5(ii)c). The nature of the activity program was regarded by

TABLE 4 Client expectations and experiences of care delivery

Sub-theme	Summary of elements and relevant direct quotations
(i) Staffing issues	a. Staff caring and respectful 'I've never heard them say "you have to do blah blah" to me. It's always "would you like to do this, or would you like to do that", which makes a big difference'. (Beth) b. Lack of qualifications of staff 'It's difficult with so many foreign speaking people [staff]. You do not know how well trained they are. Some of them are not trained at all'. (Lyn) c. Empathetic to challenges faced by the staff 'If you are well aware how many people there are in here...they cannot be just always hanging around the door waiting for me to want something, can they? But if I press that button...they are here within a matter of a couple of minutes'. (Beth)
(ii) Service issues	a. Quality of food provided 'The food is good. Although they got new caterers so the food is quite different at the moment...there's plenty to eat'. (Lyn) 'I would say you could not complain about the food at all, and it's nicely presented'. (Beth) 'We have breakfast at 8 am, morning tea at 10 am, midday meal at 12 noon, afternoon tea at 3 pm, and then tea at 5 pm...they'll send a tray to your room if you want. But it's still sent at that hour...you usually have a choice of two meals in your midday meal...So it's quite good that you have got that choice'. (Lyn) b. Lack of mental stimulation 'I bought a calendar so that the night staff could cross off what day it is, because most of the people here do not have a clue what day it is, or what time it is, or what month it is. They are small things, but...can make life more worth living. I think because this is my life until I die, doing nothing'. (Lyn) c. Nature of activity program considered 'juvenile' and level of activities unsatisfactory 'There's quite a few activities. I do not go to them a lot because... they are having something (that) kids would play, you know, treating us like kids. That's how I feel'. (Lisa) 'I have my breakfast at 8 (o'clock)...and doze off until lunch. Then get up, have lunch, then come back and doze off until tea. And that's my day because there's nothing else...I listen to radio and I watch television...This makes me feel very destitute because I just feel that I'm losing some of my capacities to remember things'. (Lyn)
(iii) Communication	a. Lack of communication and information 'There's no information. I find that really strange because we are not...children, or...mentally affected, incapacitated...The thing annoys me here is if a new person comes, they are just taken to the dining room and sat down, and staff go off...it would be nice when [staff] walk them past this door and say "this is so and so. She is coming to join us, or he is coming to join us."' (Lyn) b. Reluctant to complain 'I hate complaining...people do not want to talk [complain]'. (Lisa)
(iv) Awareness of LLLB reforms and initiatives	a. Relevant information needed 'I would really like more information about the things that the government is proposing, and the changes they would like to make, or the new things they would like to bring in'. (Lyn)

some as 'juvenile' and the level of activities and outings as unsatisfactory (Lisa, Lyn: Table 4(ii)c).

3.2.3 | Communication

Concerns over lack of communication and information from providers were highlighted by all participants. From the family's perspective, being informed of the care and well-being of their loved ones was important, and communication should extend beyond nursing care and administrative matters that required their approval and action (Nancy: Table 5(iii)a). Client participants were frustrated with the lack of communication and information because they wanted interaction particularly when new residents were admitted (Lyn: Table 4(iii)a). There was also a perception that the staff lacked organisational information (e.g. activity programs) indicating a lack of communication from management to staff (Nancy: Table 5(iii)e).

Client participants expressed a reluctance to voice complaints (Lisa: Table 4(iii)b), while family participants stated that they acted as advocates for their family member and for other residents in the facility (Mary: Table 5(iii)b). Several family participants mentioned interacting with individual care staff, attending resident-family meetings or participating in the organisation's internal surveys to express their concerns. Some highlighted the limitations of the complaint process within the organisation, such as the lack of information on procedures for addressing issues raised, and that anonymous complaints did not seem to

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TABLE 5 Family expectations and experiences of care delivery

Sub-theme	Summary of elements and relevant direct quotations
(i) Staffing issues	a. Staff caring and approachable 'My experience here has been that people are approachable, and that staff are caring'. (Karen) 'The staff now are mixed...I do not even know what their nationalities are, but they are all really nice'. (Sarah) b. Staff skill levels need to improve 'They need to upgrade their staff a little bit in training... they have got to have an awareness what they are dealing with in aged care, [and] the people that they are dealing with'. (Mary) c. Staff-resident ratio to ensure individual care needs are met 'There should be so many staff per high care resident...Mum always needs someone. She's completely dependent'. (Mary) d. Consistent staffing required for understanding of residents' care needs 'Staff stayed...and they would be the staff that you get used to...[then] they were sent away [different building] and new ones were brought in. Not that the level of care would not be there, but the level of understanding...so there's comfort in being familiar'. (Karen) '...if you first come in and you are more mobile, more proactive, more mentally alert, you are still a person. But once you start to deteriorate, they become forgotten people'. (Nancy) e. Family atmosphere in staff-resident interactions 'One of the staff brought in a pencil case and some colouring-ins for my mother-in-law. She bought that with her own money...another just found out what everyone was interested in...stamp collecting, or they were interested in cars; whatever it was, she would bring in information. She would print it out'. (Karen) f. Comparing experiences of for-profit provider and current not-for-profit provider relating to staffing issues '...it was like a revolving door at (previous for-profit provider). You'd get someone that was any good, and they'd be gone because they just could not cope. Whereas (current not-for-profit provider), she said most of the staff here had been here 20 odd years. So, they tend to look after their staff more here I would think'. (Mary) 'When [previous for-profit provider] had their accreditation, they were given two weeks' notice...And on the day, their staff were all dressed up to the nines, and doing all these wonderful things. The minute that's over, you do not see them [staff] for dust'. (Mary)
(ii) Service issues	a. Expecting continuous monitoring and improvement of food quality 'You've got to cater for people...the food quality definitely has to be monitored'. (Mary) b. Lack of recognition of residents' mental health issues 'Mental health assistance for the aged is just about non-existent...A lot of older people in particular do not like to talk about it...we need people that understand what it's like, and can communicate with them, and be able to talk them through some of these issues'. (Margaret) c. Expecting providers commit to an appropriate level of activities considered beneficial to mental health. 'When she first arrived, they [residents] were given a monthly or weekly program on a calendar...But they do not get that anymore. They [provider] had a social commitment but I think it just fizzled out'. (Nancy) 'Exercise is better for you mentally ... there's a risk of falling when they are not mobile. When they are not exercising at all...they can easily fall...if your family member comes to do it [exercise], they can help motivate that resident and we all get in and do exercises together'. (Margaret) d. Service gaps to ensure the needs are met 'I was there the other day, and she pressed the button. But the girls [staff] were looking after someone else. So, I had to help her'. (Mary) 'I packed clothes for her and put it all in the cupboard in her room...a few days later there were only about half of what was put there...I think what happened was one of the nurses decided that certain things needed to be washed but had not organised for them to be tagged...so I said "No washing thank you." From now on, I'll take the washing home and do it'. (Frank)

(Continues)

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TABLE 5 (Continued)

Sub-theme	Summary of elements and relevant direct quotations
(iii) Communication	a. Lack of communication from providers 'There's very little communication, except from the invoice every month. No one has ever said "your mum's been here for three months, six months whatever, let us have a six-monthly, quarterly catch up and we can go through how she's progressed or if she's declining, or issues that she may be having"... they are not proactive in that regard'. (Nancy) b. Needing to advocate for family member and other residents 'You've got people in there [facility] that do not have anyone to advocate for them. So, we were basically not just advocating for mum but advocating for [residents] of the whole facility'. (Mary) c. Perception of staff voicing their workplace issues to the residents 'There seemed to be a period of time where there was a lot of unhappiness with the old staff [long-serving], where those staff were doing a lot of complaining to the residents which seemed to me to be very unfair to the residents'. (Karen) d. Concerns over complaint process 'I actually do not know what happens to feedback forms...the feedback form is there, readily available to use as a way of communicating concerns. But if someone wants to do it in a way, say without signing... that can be dismissed. I guess whoever deals with that needs to communicate that "hey, whether you sign it or not, the concern is a legitimate concern and we will attend to it."' (Karen) e. Perception of lack of communication from management to staff '... she was really agitated, because she and the lady across, and also the lady next door all got dressed to go out. The bus was around the front door waiting...and then one of the staff came around and said it's been cancelled... So there's no communication from management down to different levels'. (Nancy)
(iv) Awareness of LLLB reforms and initiatives	a. Concerns over accessibility and effectiveness of centralising all relevant information through My Aged Care online portal 'My mum and dad do not own any computers... they [government] expect older people to educate themselves to be able to keep up with what's going, but they are not keeping up with what older people really need'. (Margaret) b. Experience of choice and control reflected in payment methods and family's ability to ensure staff addressing their concerns 'There were choices. Her payments were broken down into rental, or purchase of the bed...you did have different ways of purchase...' (Nancy) 'I think I have some control...if I wanted something done for [wife's name], I know that if I speak to the right person, it'll be done. I've got that sort of control'. (Frank) c. Comparison of practice between a for-profit and a not-for-profit provider reflecting consumer choice 'In [previous for-profit provider], they had one staff from 3 pm to 8 pm and they used to throw her [mother] in bed at 6 o'clock so they did not have to think about her...Here [not-for-profit provider], they do say to her "We'll put you to bed" and Mum says "No, not going to bed"...they were fine...I think the choice is here'. (Mary)

be taken seriously (Karen: Table 5(iii)d). Moreover, family participants felt that staff often placed an unfair emotional burden on the residents by voicing their own workplace issues (Karen: Table 5(iii)c).

3.2.4 | Awareness of LLLB reforms and initiatives

Participants had limited knowledge or understanding of the LLLB reforms although it was midway through the 10-year implementation plan at the time of the interviews. Some expressed the need to understand more about the reforms, although they were uncertain how to obtain information even when accessing the My Aged Care online portal (Lyn: Table 4(iv)a; Margaret: Table 5(iv)a).

There was a lack of awareness with respect to the consumer-oriented focus of the reforms such as the choice and control framework. When asked about their understanding of the reform framework, several participants stressed the lack of relevant information, and that their experience of choice was confined to what was available to them from the providers; for example, choices in food, or where to have their meals, but with no choice for preferred mealtimes (Lyn: Table 4(ii)a). For family members, their experience of the choice and control concept was reflected in their ability to ensure staff addressed any concerns raised (Frank: Table 5(iv)b), and in the choice of payment methods available to them (Nancy: Table 5(iv)b). One participant commented on their experiences of both for-profit and not-for-profit providers indicating they found more of a focus on consumer choice with the not-for-profit provider (Mary: Table 5(iv)c).

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4 | DISCUSSION

While the study participants generally expressed a qualified satisfaction with their experiences in residential aged care, the findings do illustrate an apparent desire from clients and their families for a more relationship-based and holistic well-being-focussed model of care to ensure a sense of choice and control in meeting their individual preferences and expectations.[19,20,24] From the client and family perspective, as individual care needs and expectations change, it is critical for the care staff to have a corresponding level of understanding and related skills to appropriately meet the changing needs. This may require a staff–resident–family relationship building component in care delivery that encompasses staffing level stability, more individual or personalised programs ensuring a meaningful existence, and communication strategies informing families of residents' progress and well-being.

Additionally, client and family expectations include the provision of quality physical, nursing and interpersonal care services because they understand that the often highly emotional decision to enter residential care essentially transfers their respective self-care and carer responsibilities to the service provider.[20,25] As this study found, older people are reliant on the service providers to fulfil their care responsibilities irrespective of the impact of policy reforms and the ongoing funding issues on quality care delivery. Moreover, from the client and family perspective, interpersonal care, and the need to focus on overall well-being regardless of the person's general health, are central to delivering quality care. These elements were reflected in the definition of 'high quality care' provided by the Royal Commission into Aged Care Quality and Safety.[26] More specifically, it considered that a foundational imperative in delivering high-quality care to sustain a purposeful and dignified life for older people is a compassionate and skilled workforce.[26] One of the recommendations of the Royal Commission was to stipulate a mandatory period of time that care staff need to spend with residents.[26] However, implicit in this is a perpetuation of a task-oriented, performance-driven approach in that the focus is on the amount of time spent rather than addressing the various facets of quality care delivery that require levels of skills and knowledge encompassing nursing, pastoral care, and interpersonal elements.[25,27]

A point to note is that despite the reforms being implemented at the time of the interviews, client and family participants had limited knowledge and understanding of the reforms and related objectives. An explanation for this could be that the majority of the participants' involvement with residential care occurred after the rollout of the reforms, and their understanding was confined to the existing options made known to them by the care facility. More specifically, their expectations and experiences of residential care delivery during this reform period generally reflected their focus on the capacity of the care staff to recognise and accommodate the changing needs and preferences of clients and family members themselves. Consequent to the general lack of awareness of the consumer-focussed reforms, related initiatives such as the My Aged Care online information portal have not achieved their intended objectives. This is in line with research that questions the effectiveness of a centralised, technology-based approach to information dissemination.[28]

The lack of consumer awareness of the nature and implications of the reforms indicates a disconnect between the reform objectives and practical outcomes. Increased and clearer communication is needed to ensure that consumers are well-informed and can actively participate in the process which may contribute to achieving optimal outcomes. More importantly, as family members play a significant part in the lives of older people and largely act in a support and often decision-making role (e.g. provider selection, care needs assessment), their understanding, support and facilitation was crucial in achieving desired policy outcomes.

While for-profit organisations were not included in this study, the observational comparison made by a participant of the care service approaches between for-profit and not-for-profit organisations may reflect the impact of an organisation's level of emphasis on economic outcomes over care delivery. The consumer experience may indicate a perception of not-for-profit organisations being focussed on care rather than on generating profit, hence a consumer preference for using not-for-profit service providers. However, the current funding models may require not-for-profit providers to address the issue of financial viability and focus on generating revenue at the expense of maintaining quality care delivery.[29,30]

A limitation of the study is the small sample size drawn from two not-for-profit providers; however, there were difficulties with recruitment of residents in the care facilities for a range of reasons including episodes of ill health and relocation to a different facility. A further limitation was that the participants entered the two care facilities after the implementation of the reforms; that is, none of the participants transitioned from the 'old' to the 'new' system, thus eliminating that experience from the analysis.

5 | CONCLUSIONS

This study explored the experiences of clients and families with respect to residential aged care delivery within the reform environment. The sample size drawn from two not-for-profit providers may not be representative of the

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service user experience of other residential aged care facilities; however, it presents a snapshot of the expectations and experiences of both the client and the family cohorts in residential care, thus providing insight into an end-user perspective during the implementation process. For clients and families, high-quality care requires some sense of consumer choice and control in meeting all assessed care needs including adequately addressing the relational and interpersonal elements of care delivery.

Australia continues to undertake aged care reforms including in residential care particularly in the light of the findings and recommendations by the Royal Commission into Aged Care Quality and Safety.[26] Further research will be needed to gain an understanding of the different dimensions of care provision in the context of responses to the Royal Commission and to inform strategies to ensure the reform objectives are met and to minimise the risk of unintended consequences for consumers.

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CONFLICTS OF INTEREST

No conflicts of interest declared.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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7.3 Chapter summary and introduction to the final chapter

The end-user perspective presented in this chapter illustrated the focus of recipients of residential aged care and how their expectations of care needs were met regardless of the ongoing reforms. Because the resident participants interviewed in this micro-level study were largely dependent on their families for care and decision-making support, they expected that their self-care and carer responsibilities be transferred to the residential care service providers. Of particular importance was the level of personal approach expected to be applied to care of the individuals. Findings of this micro-level study also revealed assumptions that residents were not interested or wanting to be informed about the reforms and potential changes that would affect them. Further, this indicates critical shortfalls in the translation of consumer-focused and choice-oriented policy objectives to end-users.

As mentioned in this chapter, two of the family members interviewed were also staff members of the residential care facility. However, they were not among the staff participants in the meso-level study, and only involved in this micro-level study as family members.

This chapter concludes the macro (organisational governance)-meso (operations)-micro (client and family) levels of analysis. The next chapter draws together the related findings to illustrate the interconnectedness between each of these levels and the relevant flow on effects. It also discusses key issues in the context of ongoing changes to residential aged car including the funding structure, quality standards and regulatory processes as result of the Royal Commission into Aged Care Quality and Safety.

Chapter 8

Discussion and conclusion

This thesis study adopted a holistic approach to explore the impact of the LLLB reforms on residential aged care services at the levels of organisational governance, operations, and clients and families using residential care. The key findings (see Table 8.1) illustrate the cascading effects of policy directional changes at governance and operations levels of provider organisations, with the outcomes of activities of these structural levels reflected in how care recipients experienced the provision for their care needs. In essence, at the organisational governance level, the focus was on the capacity to sustain care services; at the operations level, the focus was on the capacity to deliver care that meets the needs of the residents and families; and at the consumer level, the focus was on whether the expected level of care was delivered. As discussed in the following sections, many of the issues highlighted by the respective participant cohorts were interconnected.

Table 8.1 Elements of emphasis from governance, operations, clients and families of residential aged care in the reform context

	Governance level	Operations level	Client-family level
Reform adaptation measures or experiences in the reform environment	• Redesigning business model including adding home care business stream and services outside of the aged care scope to generate more revenue • Cost-saving measures including staffing reduction and out-sourcing previous in-house services such as catering and laundry • Reframing organisational philosophy to more commercial-focused framework • Promoting residential aged care as a marketable product or a lifestyle choice • Requiring staff to change from a relational care approach to more efficiency-focused care delivery	• Inadequate staff number to deliver care • Reduced resources for staff as result of ACFI reduction • High turnover and casualisation of staff caused instability • Increasing compliance tasks and complaint resolution impinged on staff's capacity to meet care needs of residents and families of residents • Staff being uneasy about out-sourcing services • Staff required to have a wide range of skills including financial literacy, business skills and pastoral care skills • Conflicts between long-serving staff and newer recruits in care philosophy and practices • Lack of volunteers	• Residents dependent on their families for decision making and managing ongoing required financial and administrative processes • Appreciative of staff being caring and respectful • Being aware of and empathetic to workload challenges faced by staff • Families filling services gaps to ensure their family member's needs were met • Families needing to advocate for their family member and other residents in the facility • Lack of qualified staff • Lack of mental stimulation • Lack of clarity on complaint process • Lack of communication from providers • Lack of awareness of aged care reforms • Perceived not-for-profit providers focusing more on care than profit
Ongoing pressures and challenges for provider organisations and their staff	• Training quality incompatible to industry requirements • Staff shortage particularly in regional areas	• Cost-saving measures impinging on quality of life for residents • Increasing frailty of residents and differing individual and complex needs	

	• Increasing demand on residential care places amid provider sustainability issues • Increasing complex governance responsibilities requiring boards to have corresponding knowledge and skills • Compliance costs	• Families of residents needing emotional support from staff during transition to residential aged care • Funding structure being inflexible for resident-focused holistic approach in providing care	
End-user expectations of residential care provision			• Self-care and carer responsibilities being transferred to residential care providers on admission • Staff-resident ratio being essential to ensure consistent staffing with deeper understanding of the needs of individuals and to provide a family atmosphere in staff-resident interactions • Staff skill levels to be improved • Residents' mental health issues to be recognised and addressed • Provider organisations to commit to an appropriate level of activities considered beneficial to mental health • Continuous monitoring and improvement of food quality

During the time of this thesis study, there have been ongoing changes to residential aged care including the funding structure, quality standards and regulatory processes as result of the Royal Commission into Aged Care Quality and Safety (Department of Health and Aged Care, 2022e, 2022f; Royal Commission into Aged Care Quality and Safety, 2019, 2021). In addition, the COVID-19 pandemic further impacted on residential care at all levels of governance, operations and care recipients (Department of Health, 2022; Krzyzaniak et al., 2021; Usher et al., 2021). To present the findings of this thesis study in a meaningful way given these changing circumstances, the discussion element of this chapter is organised into two parts. The first part reviews the findings of this thesis study along with comparative analyses between the three-level participant cohorts where applicable. This also serves to add extra dimensions to the specific levels of governance, operations and care recipient data discussed in Chapters Five, Six and Seven respectively. The second part of the discussion element focuses on the key issues identified by this thesis study in the current context. These include sustainability in delivering residential care, issues of residential aged care workforce, and measures of quality care. This is followed by a discussion on the strengths and limitations of this thesis study in the context of rapid change in the aged care sector. This chapter concludes with recommendations for policy consideration and future research needed to contribute to the empowerment of older Australians to direct their care needs.

8.1 Key themes from the findings of this thesis study

The key findings indicated different areas of focus for the respective participant cohorts in experiencing residential aged care during the reform implementation. Participants with organisational governance responsibilities were concerned with their organisation's financial and workforce capacity to sustain care service delivery that met

funding and regulatory requirements as well as the needs of their care recipients. Those at the operations level within residential care facilities focused on their capacity to deliver the range of quality care they considered essential and that was also expected by their residents and the families of their residents. For residents and families as recipients of residential aged care, their emphasis was on whether their expectations of the needs of individuals were met and how they could and should be met.

8.1.1 Organisational strategies and challenges in sustaining residential care

As presented in Chapter Five, to adapt to the changing policy focus of funding and provisions of aged care away from residential care service providers, the participating organisations needed to find new ways of generating income in addition to government funding (i.e. ACFI subsidy). These included redesigning their business model to add alternative services such as a Wellness Centre, to attract the general public so that additional revenue could be raised to sustain operations of residential care. Cost-saving measures included reducing staffing levels in both nursing professionals and care workers, and outsourcing previously in-house services such as catering and laundry. These were also implemented to ensure financial viability of the participating organisations while adjusting to reform changes. In addition, demands on compliance requiring technological development and human resources for administrative tasks, including assisting residents and families with the aged care system processes such as the My Aged Care online platform, placed further financial strain on the provider organisations. The consumer-level data analysis reported in Chapter Seven also indicated that providers assisting the families of their residents was a part of consumers transferring self-care and carer responsibilities to the service providers. From the

consumer perspective, the administrative assistance formed part of their care needs that had to be met.

The strategy to frame the organisational philosophy of care provision as a mission to be more commercial-oriented resulted in residential aged care being promoted as a marketable product, with residential care facilities being a lifestyle choice for residents and their families to enjoy as a community (Cochrane et al., 2021; Fine & Davidson, 2018; Hodgkin et al., 2020). As discussed in Chapter Five, this required staff to shift from a relational approach in providing care to a more task and efficiency-focused care delivery which presented a conflict between the staff-preferred care delivery based on compassion and the need for financial viability by focusing on economic efficiency (Cochrane et al., 2021). Other factors constraining the capacity of provider organisations to sustain operations was reflected in the existing aged care skills training system not satisfying industry requirements for meeting increasingly complex care needs (Davis et al., 2016; Nichols et al., 2015). Furthermore, staff shortages particularly in regional areas were an issue (Hodgkin et al., 2017), as was the case for the participating organisation of this thesis study located in a regional area of NSW.

Of note is that since this thesis study was conducted, the Wellness Centre established by the participating organisation located in the metropolitan area, to generate additional revenue to sustain residential care services, failed to succeed and has been closed. Further, both participating provider organisations, who were long-established, independent, not-for-profit and operated as a single site, have been taken over by larger providers who operate multiple sites across different states and territories in Australia. Provider viability and related implications will be discussed in more details later in this chapter.

8.1.2 Operational perspective on capacity to deliver quality care

The experiences of operational staff explored in Chapter Six demonstrated the impact of organisational adaptation to the reform conditions on the capacity of aged care workers to deliver the level of quality care, that not only met the needs of care recipients but was also considered as appropriate by the staff participants themselves. More specifically, the ACFI funding reduction was perceived as causing the cost-cutting measures mentioned earlier. The need for staff to focus more on efficiency in completing care tasks rather than building relationships and getting to know the residents as part of the care delivery created a degree of unhappiness among staff participants because the efficiency-focused approach conflicted with their personal values in the purpose of care. Furthermore, in line with other research (Jeon et al., 2019; Seah et al., 2021), the ACFI funding model was regarded by staff participants as being incompatible to meeting increasingly complex needs and inflexible for practising resident-focused holistic approaches in providing care. The newly implemented AN-ACC residential care funding structure has replaced the ACFI to better reflect a more consumer-focused care delivery with measures such as mandating 200 care minutes per resident per day (Department of Health and Aged Care, 2022c). The emphasis is on the amount of time spent on residents by nurses and care staff as measures of care quality (Department of Health and Aged Care, 2022b). However, the consumer perspective reported in Chapter Seven indicated that the measure of quality care by residential care recipients was in elements of relational care and whether there was a focus on overall wellbeing of the residents. While family participants wanted staff to spend time with residents, they also require flexibility with care routines (Milte et al., 2022). How the mandated care minutes would reflect relational and flexible care delivery hence translating to quality care expected by recipients are yet

to be tested, although early evaluations suggest that this may not meet the care needs particularly of residents with dementia (Wesson et al., 2023).

As found in other studies, workers are motivated to work in aged care because of the satisfaction in exercising a duty of care to those in need (Hodgkin et al., 2017; Venturato et al., 2006). Increasing administrative tasks related to compliance were considered as secondary to their duty of care and not necessarily effective in ensuring high quality by staff participants (Bell et al., 2013; Carnell & Paterson, 2017; Ostaszkiewicz et al., 2016). As one of the outputs of this thesis study indicated (Monro et al., 2021) and supported by the work of Stokoe et al. (2016), the preference of aged care workers for relational and resident-focused care is more aligned to the consumer-oriented reform objectives, and limiting the opportunities to exercise such an approach may lower staff motivation and diminish their capacity to deliver quality care.

Ongoing staff shortages, particularly for participants of the regional provider, who were interviewed in Chapter Six was considered as one of the reasons for the lack of opportunities for staff to build relationships with the residents in their care. This was further exacerbated by high staff turnovers (Bonner et al., 2021; Gao et al., 2014; Hodgkin et al., 2017). The recent Aged Care Workforce Action Plan 2022-2025 mentioned the transient characteristics of the workforce with staff working multiple jobs across different providers or different facilities (Department of Health, 2022). This phenomenon was observed by some of the staff participants interviewed in Chapter Six as a result of cost-cutting measures and induced workplace tensions particularly between long-serving staff with their traditional compassionate and relational care approach and the task-oriented and efficiency-driven objectives of newer recruits (Monro et al., 2021; Seah et al., 2021). To the family participants interviewed in Chapter Seven, high staff turnover created

instability in the care facility and triggered behavioural issues in some of the residents, which further tested the capacity of staff to deliver care.

Establishing a staff-resident ratio evidently support increased staffing levels (Department of Health and Aged Care, 2022g; Sutton et al., 2022). To the staff participants who were interviewed in Chapter Six, setting a staff-resident ratio was a strategy to distribute workload so that they could spend more time with their residents. The family participants interviewed in Chapter Seven were empathetic to the challenges faced by care staff and perceived that having a staff-resident ratio would lead to increased staffing level, which would better enable the needs of individuals to be met. However, while setting a staff-resident ratio may increase staffing levels as a structural measure of quality (Mukamel et al., 2012), higher staffing levels may not always lead to higher quality of care that meets consumer expectations (Bowblis & Applebaum, 2017; Commission on Dignity in Care for Older People, 2012). Factors such as levels of skills and knowledge relevant to the needs of the residents in care also impact on staff's capacity to deliver care (Bonner et al., 2021; Cooke & Bartram, 2015; Davis et al., 2016; Monro et al., 2021). This was a common theme between the staff and client participant cohorts reported in Chapter Six and Seven respectively. More specifically, families of residents concerned about care needs not being met would lodge complaints, thus triggering a frequently time-consuming resolution processes which further encroached on the staff's capacity to provide care.

8.1.3 Consumer perspective on residential aged care

As illustrated by the residents and families interviewed in Chapter Seven, when transitioning from home to residential aged care facilities, they expected that their respective self-care and carer responsibilities were transferred to the residential care providers (Gilbert, 2020). Further, they wanted the service provision to reflect that each

resident was considered as a human being above all, with different levels of mental and physical capability. More specifically, the required level of understanding of the needs of the individuals, including social and emotional needs, had to be demonstrated through the level of personal approach applied to care of the individuals. Their experience of care delivery that lacked a personal approach indicated to them a lack of understanding of the individuals in care. In other words, it was the understanding and care of the whole person regardless of their general health that was valued by residents and their families, and should be central to organising care delivery (Cochrane et al., 2021; Milte et al., 2022). However, the governance and operations level findings reported in Chapters Five and Six indicated that provider organisations did not have the resources or the capacity to meet this level of expectations, despite their expressed preference for delivering holistic and relational care. Reports of ongoing precarious financial capability of provider organisations highlight the barriers for service providers to deliver the level of care that consumers expect and feel confident receiving (Cochrane et al., 2021; Woods & Corderoy, 2021).

As reported in Chapter Seven, families of residents often filled service gaps such as laundry service to ensure that the needs of their family member were met. They also acted as advocates for their family member and other residents particularly when expected care needs failed to be met. To some extent, this form of negative resident care outcome was what many staff participants interviewed in Chapter Six wanted to avoid, because they were unhappy about outsourcing services such as laundry and catering that they considered as contributing to quality of life for residents. A further issue was the perception by family participants interviewed in Chapter Six, that not-for-profit providers focused more on care rather than generating income, and that the existence of long-serving staff in not-for-profit organisations was considered as an indication that staff

were being looked after by the organisations. While this study did not include for-profit providers in its scope, the findings of this study may indicate a connection between the mission and value of not-for-profit providers in the approach to care provision and their reluctance to divert attention to focusing on generating revenue.

8.2 Key issues in the current changing environment

This thesis study collected data at the levels of governance, operations and consumers of residential aged care, and it is evident that there is an interconnectedness between these three levels. The current environment including the effects of COVID-19 pandemic and the ongoing reforms in residential aged care have significantly affected and will continue to affect the service delivery and recipients of residential care. This section focuses on the key issues identified in this thesis study in the current changing environment. These include financial sustainability of residential care service delivery, workforce issues with relation to the requirements of people in organisational governance as well as workers in residential aged care, and measures of quality care.

8.2.1 Financial sustainability of residential aged care delivery

As mentioned earlier, since this thesis study's completion, both of the participating provider organisations were taken over by larger providers who operate multiple sites across NSW and other states in Australia. This was despite both participating organisations redesigning their business models to add service streams to generate more revenue which was still unable to secure financial viability but diverted their organisational focus from their fundamental purpose of providing care in the process. Participants who were interviewed in Chapter Five had expressed concerns for financial viability of their organisations and the risk of local community being disadvantaged if

their local provider was overtaken by out-of-area providers that did not have relevant local knowledge. Residential care provider organisations require financial capacity to remain viable and be able to sustain operations particularly given the increasing demand for residential aged care (Austin et al., 2022). Several studies reported that nationally, over 65% of all residential aged care facilities were running at an operational loss (Cochrane et al., 2021; Woods & Corderoy, 2021). The number of residential aged care providers has reduced from 1,054 at the start of the LLLB reforms to 805 at the end of 2022 (Aged Care Financing Authority, 2013; Department of Health and Aged Care, 2023c).

Arrangements such as increasing consumer contribution through more comprehensive means testing in residential aged care were designed to reduce government spending while providers did not receive an increase in funding despite the rising costs and higher care needs of residents (Aged Care Financing Authority, 2013; Grove, 2018). Furthermore, the Royal Commission into Aged Care Quality and Safety (2021) found that the government has consistently kept indexation of funding levels low. For instance, it was estimated that during 2018-19 financial year, the Commonwealth government spent $9.8billion less on aged care than it should have (Duckett & Stobart, 2021). At the start of the LLLB reform process, 71% of total aged care funding provided by the government went to residential aged care (Aged Care Financing Authority, 2013). Data in July 2021 reported that 63% of the government's total aged care funding was allocated to residential aged care, indicating a reduced funding focus on residential aged care (Aged Care Financing Authority, 2021; Grove, 2018). In addition, from the government perspective, the key sustainability metric for provider viability was the growth in capital value from which investment would generate a return, and the surplus would support provider operations (Aged Care Financing Authority, 2013). As such, the viability of providers was expected to depend on generating a surplus. Recent

government reports on the financial performance of the aged care sector found that only 33.9% of residential aged care providers were profitable, and only 25% of the profitable providers were not-for-profit organisations (Department of Health and Aged Care, 2023c). As this thesis study has indicated, consumers of residential aged care who were interviewed preferred using not-for-profit providers. The declining number of residential aged care providers presents a risk of not meeting the increasing consumer demand for residential care (Austin et al., 2022), and the small percentage of viable not-for-profit organisations may limit consumer choice for not-for-profit residential aged care providers.

Furthermore, as highlighted by the participants interviewed in Chapter Five, the financial pressure on them as not-for-profit providers of residential aged care has compelled them to compromise their relational approach to delivering care by having to consider care as a marketable product to generate revenue. Although economic efficiency may be achieved for not-for-profit providers by reducing costs while combining a critical mass of services across multiple centres (Tran et al., 2019), the Royal Commission into Aged Care Quality and Safety (2021, p. 75) has emphasised that focusing on financial risks and performance has affected the focus on care quality and safety. It also advocated for socially impactful and mission-based aged care organisations to be actively supported by the government. This is important as the growth in market-share by for-profit providers has meant that mission-based, social purpose and government aged care services have lost out to the expansion of the for-profit sector (Royal Commission into Aged Care Quality and Safety, 2021).

The recent COVID-19 pandemic has amplified what were already precarious financial circumstances of residential aged care providers. Industry reports indicated that

for the last five years (2017-2022), the residential aged care sector has sustained operating losses totalling an estimated $3.7 billion, with $1.4 billion occurring in the last 12 months (StewartBrown, 2022, p. 3). While there has been funding support from the government for additional personal protective equipment and workforce support during COVID-19 outbreaks, the mechanism for accessing this funding is through claims for reimbursement of related costs which meant that the providers first needed to have additional level of cash flow to cover COVID-19 related costs (Department of Health and Aged Care, 2021b, 2023b; StewartBrown, 2022).

The ongoing structural changes such as the minimum staffing requirements in residential aged care may place further financial strain on providers because the need to employ more Registered Nurses at a higher cost than employing care workers that have less qualifications (Department of Health and Aged Care, 2023a; Norman, 2023; Sutton et al., 2022). While the AN-ACC funding guide stipulates the provision of additional funding to "help providers manage their workforce" to meet these requirements (Department of Health and Aged Care, 2022b, p. 9), the sustainability of these requirements on residential care providers is of concern given their already precarious financial position. Furthermore, the effectiveness of achieving the intended objectives has yet to be tested. More importantly, there are ongoing risks of residential aged care facility closures because of the burden of these requirements on provider organisations, further impacting on consumers requiring residential aged care (Cockburn, 2023).

8.2.2 Residential aged care workforce issues

Discussions from government reviews and other research on issues relating to aged care workforce have largely focused on staffing levels, workforce shortage in rural and remote areas, employment intentions of aged care workers, and COVID-19 impact on

labour market from migrant intake (Bonner et al., 2021; Cooke & Bartram, 2015; Department of Employment and Workplace Relations, 2022; Department of Health, 2022; Gao et al., 2015). However, the findings of this thesis study have highlighted that the common desire between service providers, their staff, residents and families was for a compassionate and relational approach to providing care. A compassionate and skilled workforce has been identified by the Royal Commission into Aged Care Quality and Safety to be a foundational imperative in delivering the level of quality care that would ensure a purposeful and dignified life for older Australians (Royal Commission into Aged Care Quality and Safety, 2021). The pre-existing workforce shortage, staffing level reduction as a cost-cutting measure under the LLLB reforms, and the further impact of COVID-19 on residential aged care workforce severely challenge the development and encouragement of such a compassionate and skilled workforce (Chroinin et al., 2023; Department of Employment and Workplace Relations, 2022; Krzyzaniak et al., 2021; Swerissen, 2022).

Given the common desire for a compassionate and relational approach to providing care, it is important to emphasise that care and care giving involve intense and personal expressions of social support (Fine & Davidson, 2018). The concept of care is in the interdependent and relational way that care occurs between the care giver and the care recipient (Barnes, 2012). There is an element of emotional labour on both side of giving and receiving care because trust is established through relationship building as part of the relational approach to care (Gilbert, 2020). Further, there are reciprocal or mutual benefits in compassion and kindness-based care delivery in that care workers find it intrinsically rewarding in providing care to residents where they have a sense of attachment and emotional investment (Venturato et al., 2006). There is a level of professional pride and satisfaction for care workers to exercise a relational approach in providing care rather than seeing care provision as a marketable product or a commodity

(Hodgkin et al., 2020). The current objectives of the Commonwealth government include ensuring the aged care workforce has a fulfilling career with better employee retention (Department of Employment and Workplace Relations, 2022). As such, compromising staff preferences for relational care delivery to focusing on time and task efficiency presents a prohibiting factor in workforce development, which may make aged care work less meaningful and attractive (Gao et al., 2015; Hodgkin et al., 2020; Hodgkin et al., 2017). As mentioned earlier, families of residents regarded staff familiarity with residents as achieved through relationship building and therefore demonstrated the level of understanding of the needs of residents. Gilbert (2020) highlights that relationship building leads to establishing trust between residents and staff and could contribute to better health outcomes for residents, because residents who do not trust staff may be less likely to cooperate with care tasks and may experience social isolation and depression.

As indicated by participants interviewed in Chapters Six and Seven, relationship building and interpersonal skills were developed over time, and the current transient nature of the aged care workforce, that is, staff working across multiple sites, meant that staff might not have the opportunity to know residents on a deeper level to build that interpersonal trust (Gilbert, 2020). The recent COVID-19 pandemic has seen further erosion of interpersonal development opportunities exacerbated by compounding staff shortages with increasing short-term staff covering across different organisations and facilities to deliver care during periods of COVID-19 outbreaks in residential aged care (Department of Health and Aged Care, 2021b; Jepsen & Barker, 2022). The newly implemented AN-ACC funding model mandated 200 care minutes per resident per day as part of the minimum staffing requirements. It specified "social and emotional support" as part of direct care activities assigned to personal care workers (PCWs) and assistants in nursing (AINs) (Department of Health and Aged Care, 2023a, p. 17). Examples given under

the social and emotional support category included PCWs or AINs spending social time to have a conversation with a resident, and personally assisting a resident to participate in a group activity (Department of Health and Aged Care, 2023a, pp. 17, 21). However, PCWs and AINs are also required to perform tasks delegated by Registered Nurses (RNs) and Enrolled Nurses (ENs) (Department of Health and Aged Care, 2023a, p. 15). As reported in the scoping review in Chapter Three, the previous ACFI funding structure had fostered a task-oriented practices in delivering care, which the staff participants interviewed in Chapter Six had also identified. The structure of the new AN-ACC indicates a perpetual task-oriented approach to delivering care and the opportunities for exercising the preferred relational care approach remains limited (Davis et al., 2016; Jeon et al., 2019; Monro et al., 2021). Without the opportunities to exercise relationship-based care, attracting and retaining aged care workers remains an ongoing challenge which in turn, presents a barrier to achieving the objective set in the National Care and Support Workforce Strategy to deliver consumer-centric services with better equipped and responsive workforce (Department of Employment and Workplace Relations, 2022).

One of the issues raised by participants interviewed in Chapter Five was that board directors required external expertise to assist them in understanding and fulfilling governance responsibilities in the aged care reform environment. In other words, governance responsibilities require board directors to have corresponding level of knowledge and skills for aged care delivery (Hough & McGregor-Lowndes, 2022; Royal Commission into Aged Care Quality and Safety, 2021). Like the participating organisations in this thesis study, board directors of not-for-profit providers are largely voluntary roles but now require more time commitment and relevant skills and knowledge to fulfil governance responsibilities applicable to all board directors regardless of voluntary or

remunerated basis (Aged Care Quality and Safety Commission, 2023b; Australian Institute of Company Directors, 2019, 2023). Provider governance has been highlighted by the Royal Commission into Aged Care Quality and Safety (2021) as being critical to delivering quality care. While new governance requirements are being introduced and implemented (Aged Care Quality and Safety Commission, 2023d), there appears to be a lack of information and initiatives on how providers are being supported in meeting these requirements particularly the not-for-profit organisations with voluntary board directors as part of the governing body. This is despite the Royal Commission into Aged Care Quality and Safety (2021) advocating for providers to be given support to ensure governance responsibilities are adequately fulfilled.

Also of note is the issue of mental health. While participants interviewed in Chapter Six identified the lack of awareness and skills in addressing mental health needs of the residents (Stewart et al., 2018), mental health of the staff in residential care is also a critical issue in the process of care delivery because the nature of care work being both physically and psychologically demanding (Gao et al., 2015; Monro et al., 2021). The recent COVID-19 pandemic has brought the issue of mental health of staff and residents to the fore (Brydon et al., 2022), with the Royal Commission into Aged Care Quality and Safety (2021, p. 1) citing a workforce being "traumatised" as result of managing COVID-19 outbreaks. More needs to be done to ensure the health of the aged care workforce is adequately supported so that they have the capacity to deliver the level of care needed by residents.

8.2.3 Measures of quality care in residential aged care

As emphasised by the staff, resident and family participants discussed in Chapters Six and Seven, the interpersonal or relational elements in care delivery are integral to

quality care. These elements are built on compassion and kindness and cannot be commodified or legislated (Donabedian, 1988; Gilbert, 2020; Lewis & West, 2013). As such, providing care is not merely a mechanical undertaking but also a human service that entails a sense of duty and responsibility which ultimately contributes to quality care for residents (Chen et al., 2021; Cochrane et al., 2021). While measurements for clinical care may be clear and precise, and regulatory mechanisms such as the accreditation processes may be among the limited options for government to assess care quality, it is difficult to measure the relational elements in care delivery because of the subjective perception of quality (Baldwin et al., 2015; Barsanti et al., 2017; Donabedian, 1988; Jeon et al., 2019). However, the care needs are not confined to the clearly measurable clinical or physical needs. They include "social, mental, emotional, cultural and spiritual" needs (Aged Care Workforce Industry Council, 2020, p. 6). As this thesis study has also indicated, staff satisfaction arose from being able to deliver relationship-based care to residents, and consumers found satisfaction in experiencing the care focus on their wellbeing as a whole person, beside their physical needs (Chen et al., 2021; Milte et al., 2022; Roos et al., 2016). The new minimum staffing requirements, care minutes mandate, the Star Ratings system, and the National Aged Care Mandatory Quality Indicator Program all aimed at lifting care quality in residential aged care and engaging consumers in evaluating the care they are provided with (Aged Care Quality and Safety Commission, 2023a, 2023c; Department of Health and Aged Care, 2022d, 2023a). However, whether these new initiatives would deliver the interpersonal elements of care, as expected and measured by care recipients and desired by staff, remain uncertain.

The newly implemented AN-ACC residential aged care funding mechanism seems to continue with the previously task-oriented ACFI funding structure in that the mandated objective is for residential care providers to meet the care minute target (Department of

Health and Aged Care, 2022b), and the Star Ratings system measuring the staffing element of quality delivery is whether providers have met their minimum care minute target (Aged Care Quality and Safety Commission, 2023c). There is an element of consumer experience in both the Star Ratings system and the newly expanded National Aged Care Mandatory Quality Indicator Program. However, the focus seems to be on whether there is evidence of efforts being made to help consumers have better experience of care rather than whether the desired trust and care relationships have been established. For instance, the National Aged Care Mandatory Quality Indicator Program includes a consumer survey that asks care recipients whether they "receive services and supports for daily living that are important for their health and wellbeing", and whether they are "supported to maintain social relationships and connections with the community" (Department of Health and Aged Care, 2022d, p. 7Appendix C). There are no questions on whether residents feel that their desired care relationship with staff have been established, or whether residents feel socially connected. More specifically, staff relationship with their residents is the most important element in the residents' perception of quality (Barsanti et al., 2017). The algorithm used in the Star Ratings system to ascertain the experience of residents also focuses on whether various tasks or actions have been performed. Residents are asked questions such as "do you get the care you need", "do staff know what they are doing", "do staff follow up when you raise things with them", and "are you encouraged to do as much as possible for yourself" (Aged Care Quality and Safety Commission, 2023c, p. 11). There are no questions to clarify whether residents feel that their social or cultural or spiritual care needs have been met (Aged Care Workforce Industry Council, 2020). To accurately measure the quality in consumer-centric care delivery, more focus is needed on whether the outcomes for residents are as they desire and expect (Zuidgeest et al., 2012).

8.3 Strengths and limitations of this thesis study

Taken as a comprehensive and systems-oriented view to the analysis of reform changes, this thesis study has provided a holistic snapshot of the impact of the LLLB reforms at different levels of residential aged care delivery, including clients and families as end-users of residential aged care. Its findings highlighted the interconnectedness and often interdependent nature of the relationship between the different levels of operationalising reform changes and particularly how they affect the health and wellbeing outcomes for older Australians. Reforms generally relate to institutional changes which is a complex and lengthy process (Ranci & Pavolini, 2015). This thesis study contributes to a deeper understanding of various factors influencing the success of desired policy outcomes. There is a lack of research focus on the area of governance within aged care provider organisations which illustrates a gap in knowledge that is critical to the organisational effectiveness of delivering the expected quality of care (Hough & McGregor-Lowndes, 2022; Royal Commission into Aged Care Quality and Safety, 2021).

The research design of this thesis study included aged care provider governance and the findings highlighted the fact that the governance functions of an organisation where the strategic and operational directions rest in the hands of the board of directors and the CEO to ensure the implementation of government policy changes and their operationalisation. Therefore, this thesis study contributes to raising awareness of aged care organisational governance, its critical responsibilities and how they affect care delivery in residential aged care settings. It highlights the urgency in addressing this knowledge gap given the emphasis of aged care governance being essential for delivering quality care in the recommendations by the Royal Commission into Aged Care Quality and Safety (2021) (Hough & McGregor-Lowndes, 2022).

There is limited empirical data on the impact of marketisation in Australian residential aged care (Cochrane et al., 2021). Therefore, this thesis study contributes to building the body of empirical research to investigate the connection between economic efficiency and quality in residential age care. More importantly, the Productivity Commission findings on which the LLLB reforms were based had highlighted the need to measure consumer outcomes against consumer needs and priorities (Productivity Commission, 2011), and the optimal scenario for consumer choice is reflected in the level of understanding of consumer expectations (Cochrane et al., 2021). The findings of this thesis study provide insights into consumer expectations of care delivery and the barriers to meeting related expectations. Given the seemingly ongoing lack of focus on funding and regulatory measures to ensure quality care delivery that meets consumer needs and expectations as discussed earlier, this thesis study raises awareness of the critical areas of consumer-desired care delivery.

The data collection was conducted in 2018, five years into implementing LLLB reform measures and at the time most of the planned, residential care related measures such as the ACFI funding reduction, and the viability supplement for providers in regional, rural and remote areas had concluded. Given the scope of this thesis study, the purposive sample size from two consenting participating provider organisations was relatively small. However, this thesis study aimed to use a more comprehensive approach and provide a snapshot of the various dimensions in the processes and organisations of delivering residential aged care in the reform environment. Both participating organisations in this thesis study were single-site, not-for-profit and independent providers that were long-established in their local communities. Other residential care providers including for-profit providers may have different experiences under the reform conditions. While residents with dementia is an important component for understanding

care needs and how best to meet the needs (Du Toit et al., 2019; Laver et al., 2018; L. Phillipson et al., 2019), this thesis study did not include residents with dementia as participants due to the requirement of participants having the ability to conduct more in-depth conversations and difficulties with giving informed consent to interviews.

When discussing the fundamental reform changes from a residential aged care dominated and provider driven policy focus to a consumer-oriented policy direction, this thesis study did not explore the level of attention paid to home and community supported care by Commonwealth government over time. However, the LLLB reforms represented the first time that the Commonwealth government consolidated funding and administration of the home support services for older Australians provided under the Home and Community Care (HACC) Program provisions previously shared with most states and territories (Courtney et al., 1997; Gillard & Butler, 2012). While ongoing changes continue to be made, such as the new AN-ACC, the revision of Aged Care Quality Standards to include the Star Ratings system and the expansion of the National Aged Care Mandatory Quality Indicator Program (Department of Health and Aged Care, 2022b, 2022h), experiences of providers and consumers during the reform implementation process reported by this thesis study provide insights into the complex dimensions of reform impact. The learnings from these experiences may assist enhancing success of future reforms and mitigate risks of unintended consequences.

8.4 Conclusion

This thesis study aimed at a comprehensive and systems-oriented exploration of the impact of LLLB aged care reforms on residential aged care because of the fundamental national aged care policy shift from a historically residential aged care and provider

driven emphasis to a more consumer-oriented funding and care provision policy approach. Chapter Two charted the development of national aged care policy in Australia and illustrated the fundamental business culture in residential aged care as a result of historic national policy approach that fostered funding dependency and regulatory compliant operational practices for residential care providers (Fine & Davidson, 2018; Gibson, 1998; Ostaszkiewicz et al., 2016). The policy directional change in the LLLB reforms has meant that funding focus and reform initiatives have been geared towards enabling older Australians to cater to their preference of staying in their own homes for as long as possible. This has been achieved by increasing home and community supported care services, whereas residential aged care providers face the challenges of maintaining service delivery at the level of care provision and quality expected by older Australians and their families with reduced funding whilst meeting various compliance requirements. This thesis study has revealed that adapting to the LLLB reform objectives of consumer-oriented funding and practices has been a process of residential care providers having to facilitate culture change in their business operations of delivering consumer-expected care, and the experiences of residents and families reflected the limitations of providers to meet the care needs in the reform environment. As such, there is an interconnectedness between different components in delivering and receiving residential aged care and how they reflect policy outcomes. Therefore, there is a need for a more mutually nuanced level of understanding between policy makers, residential aged care providers, their workforce, and users of residential care.

This thesis study has demonstrated that there is a general appreciation from provider organisations and care recipients for the fiscal pressure on government as result of an increasingly ageing population. However, policy makers need to be more aware of operational implications of policy changes on organisations providing care and on older

Australians receiving care. For instance, the need for residential care providers to focus on mitigating risks of insolvency as the result of a changing funding focus may come at a cost to providing quality services to older Australians in their care. It is important to consider the implications of structural changes and to anticipate potential consequences of transitional and longer-term policy outcomes for intended benefits for older Australians as their needs and expectations continue to change (McClelland & Marston, 2021). The recent closure of several residential aged care facilities due to challenges of meeting the mandatory staffing requirements given the acute aged care workforce shortages, where the aged care minister stated their unawareness of such possibilities, further highlight the critical importance in anticipating potential outcomes to policy changes with mitigating strategies (Cockburn, 2023).

The lack of knowledge found by this thesis study of LLLB reforms taking place among staff, and care recipients who were particularly unaware of the reforms' consumer-oriented objectives could be addressed by providers educating their workforce and care recipients of the changes and reasons behind the changes. This may enable more understanding and cooperation from staff, and families of their residents when care recipients require service providers to meet their particular needs regardless of changes in funding and regulations. Clearer and timely communications of future reform intent to relevant people and organisations are vital in garnering understanding and support for the policy implementation, and yield mutual benefits for all stakeholders of aged care (Chenoweth et al., 2015; Davis et al., 2016; McClelland & Marston, 2021).

This thesis study predates the implementation of the new AN-ACC funding system, of which early evaluations suggest the needs of residents may not be met (Wesson et al., 2023). More focus is needed on the flexibility and capability of the AN-ACC in fostering a

consumer-oriented care delivery. Regulatory requirements should be accompanied with supporting mechanisms such as long-term funding to sustain regulatory compliance for the purpose of ensuring quality care (McClelland & Marston, 2021; Royal Commission into Aged Care Quality and Safety, 2021). Time and task-based care may be a limited measure of quality care and the compassionate relational approach of care delivery is much more difficult to measure (Lewis & West, 2013). However, this thesis study has highlighted that the overall desire of not-for-profit organisations, their staff and care recipients was for the compassionate and relational type of care provision that could be measured in the level of their professional, personal and consumer satisfactions.

While promoting more consumer-focused aged care policies was well intentioned, the LLLB reforms have only made minor changes around the regulatory edges of the aged care system particularly with strengthening standards and their enforcement in residential aged care (Gilbert, 2020). Structural reform is a long-lasting process, incorporating multilevel and multidimensional considerations in the policy making process is vital for operationalising reform changes and ensuring successful enactment of the intended objectives (Pavolini & Theobald, 2016; Ranci & Pavolini, 2015). This thesis study demonstrated that enabling necessary capability to deliver the expected quality residential aged care requires concerted collaboration between the government, provider organisations, aged care workforce, and clients and families (Jorgensen & Haddock, 2018). A system-wide approach is needed in facilitating the consumer-focused reforms through deeper mutual understanding and collegiality of the government, residential aged care providers and recipients as key stakeholders in Australia's residential aged care (Brooker & Latham, 2016; Chenoweth et al., 2015; Cochrane et al., 2021). More importantly, unless interpersonal approaches to care are encouraged and supported in the funding and regulatory mechanisms and the areas of need outside of the care tasks are addressed,

questions remain as to whether the new reform measures would achieve the desired outcomes of ensuring quality-consumer-centric care for older Australians (Bonner et al., 2021; Roos et al., 2016). Overall, the misalignment between the LLLB reform objectives and the expectations or experiences of people working or living in residential aged care facilities demonstrated in this thesis study highlights the inadequacy of LLLB reforms in meeting the stated objectives. Future reforms in residential aged care need to acknowledge that those working and living in residential aged care facilities should not be expected to simply accept reform changes, and that reforms should be more responsive to the needs of those at the receiving end of the reform implementation outcomes.

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