Regulating Aged Care: Ritualism and the New Pyramid
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Regulating Aged Care represents an integration and synthesis of considerable breadth and depth about regulatory theory, practice and outcomes. It results from some three decades of systematic inquiry into regulatory design, practice and outcomes in care of the aged in the United States, England and Australia. Simply put, the authors comprehensively and critically examine the policy efficacy, over time, of regulatory structures of these three nation-states in assuring quality of care for the aged.

Based on this synthesis Braithwaite and his colleagues weave together a tapestry of evidence which overwhelmingly concludes that regulation in this domain is stuck in a cycle of systemic, ritualistic behaviours that do not support espoused policy outcomes of governments and major stakeholders about quality care for the aged. From this deeply troubling but not surprising conclusion about aged care regulation they offer a pathway forward which proposes to balance an enforcement-based, responsive regulation pyramid with a companion strengths-based pyramid (i.e. "the new pyramid" of the book’s subtitle).

The authors, all Australian-based, are among the world’s most respected and prolific contributors to regulation scholarship. John Braithwaite is a well-respected and widely-cited academic criminologist, regulation theorist and global-authority known for his scholarship in business regulation, corporate (i.e. “white collar”) crime, restorative justice, responsive regulation and regulatory capitalism (Braithwaite, 1989, 2002, 2008; Moran, 2002). Dr Braithwaite is an Australian Research Council Federation Fellow and a founder of the Regulatory Institutions Network (www.regnet.anu.edu.au) at Australian National University.

Toni Makkai is Dean and Chair of the College of Arts and Social Sciences at Australian National University. At the time of publication she was the Director of the Australian Institute of Criminology, Australia’s national research agency on crime and justice. Dr Makkai is internationally known for her scholarship on drugs, crime, regulation and compliance. Valerie Braithwaite is an interdisciplinary social scientist, trained in psychology, and has held research appointments in gerontology, tax system integrity, compliance and governance. Dr Braithwaite currently holds an academic appointment at Australia National University’s, Regulatory Institutions Network, where she studies psychological processes in regulation and governance.

Book overview
On the surface one might be tempted to think this book is of interest to only those involved in regulatory policy making for nursing homes and other long-term care/continuing care environments. This would be both an incorrect and unfortunate
misperception. It also does a disservice to a broader readership in health and social care policy leadership who could benefit from the book’s myriad insights and lessons.

The book is a well-written, accessible and thoughtfully presented exposé of regulation, using nursing home regulation as a domain of broader scholarship for regulatory theory. It carefully documents pathologies of well-intended health regulation efforts gone astray in a key domain of human service endeavour. The book is presented in two parts.

Part one comprises the first six chapters and is called “Nursing home inspection observed”. These chapters outline the methodology, data collection strategy, frame the history of nursing home regulation and then weave together a coherent, comparative and contrasting picture of nursing home regulation in the USA, England and Australia. The first part of the book develops a robust picture of the evolution and current state of nursing home regulation in the USA, with three chapters devoted to this task. The authors note that Australian data have been presented in some two-dozen previous publications and Regulating Aged Care “concentrates on data that have never been published before, especially from the United States, but also from the United Kingdom (UK) and the latest unpublished data from Australia” (Braithwaite et al., 2007, p. vii (Reader note: herein all references are from this source unless otherwise stated)).

The second part of the book is entitled “Rethinking regulation and governance”. It comprises four chapters, which represent a substantive theoretical contribution to regulation theory, policy and practice, especially useful for health and social care leaders. Chapter seven presents and then details ten types of ritualism emerging from the data that have been demonstrated to undermine regulatory effectiveness. Chapter eight briefly outlines three ages of health governance. It then focuses on the third and latest age, an age of regulatory capitalism, to highlight why commonly advanced constructs about market-based responses do not hold for nursing home markets.

The authors then develop chapter eight further based on a conclusion that, “...we part company with those who say that with deregulation and consumer choice, the worst providers will be driven out of the market; and so quality of care inspection can also be deregulated” (p. 261). They then go on to discuss the intricacies of incentives and rewards for achieving desired outcomes within market-based delivery structures, then frame this within the pros and cons of punishment and persuasion using a responsive regulation enforcement framework. The authors conclude that for nursing homes, the most vibrant markets are not nursing homes per se, but rather “the labour markets for the most senior people. These are the markets that drive quality” (p. 287).

Within chapter nine, called “Transcending ritualism”, five specific motivational postures of stakeholders are presented to illustrate how stakeholders feel about and wish to position themselves in relation to other stakeholders. These five motivational postures are based on recent scholarship by Valerie Braithwaite and are discussed as: commitment, capitulation, resistance, disengagement and game playing. Within the remainder of the chapter each of these motivational postures is elaborated on, with a focus on demonstrated approaches helpful for transcending the propensity of stakeholders’ preferred or default motivational style to contribute to ritualistic behaviour.

Chapter ten of Regulating Aged Care presents a promising, novel and important theoretical design contribution for substantive improvements to outcomes in health
and social care enterprises. This chapter focuses exclusively on "the new pyramid," which is a strengths-based approach for building new capacity within regulated enterprises. It identifies 28 strategies emerging from the study data that have been demonstrated to help improve compliance in certain contexts.

Drawing on complexity science, the authors then discuss aged care delivery environments within the conceptual lenses of complex adaptive systems. They advance the idea that multi-dimensional interventions, sensible to context, are most suitable for capacity-building in support of a companion strengths-based pyramid. They conclude the chapter and the book with a discussion of regenerative care and regenerative politics, noting that the predominant cohort of staff in aged care, health care aides and other support workers, are among the most marginalized in developed societies. In effect, the team submits that a developed society's most marginalized workers are serving a rapidly-growing cohort of developed society's most marginalized citizens. They then discuss with considerable depth, the fundamental risk, empowerment and justice concerns of this scenario as a longer-term staffing mix model in aged care policy.

Scholarly contribution to health service improvement
Braithwaite and his colleagues note Regulating Aged Care "... is a contribution to understanding both regulatory failure and market failure in health and social care, and how to fix them." (p. 11). Two varying explanations are offered for why nursing home regulation was chosen for study. The first explanation comes from an earlier work examining why restorative justice might work better that punitive justice principles. Braithwaite (2002) noted that with nursing home regulation "... we could measure compliance with the law with far greater reliability than can be obtained with traditional individual criminal offences or in other areas of business regulation" (p. 18).

In the current work the authors offer a somewhat different rationale, noting that nursing home regulation represents "... a least likely case for empowerment" (p. 3). That is, they suggest that when studying complex social phenomena it is the least likely case as one where the claims of a theory are the least likely to be supported. Therefore, they submit:

If regulatory strategies succeed by empowering clients as weak as nursing home residents, we can be more optimistic about such strategies with stronger stakeholders. Disempowered nursing home residents, closeted away in obscure corners of cities, seemed the least likely stakeholders in the deliberative forms of restorative and responsive regulation we favoured as we went into this project (p. 3).

The team approached the work through a regulatory systems approach with the nation-state as the unit of analysis. They draw on the conceptual lenses of well-known American sociologist Robert Merton. Specifically, they use Merton's (1968) typology of modes of individual adaptation as an organizing frame to discuss how aged care regulation as social phenomena has evolved. They establish a broad and rigorous evidentiary base to demonstrate that in the United States, England and Australia, expansive aged care regulatory policy and practice has had a systemic propensity towards ritualism and "runaway" ritualistic practice, as the concept was conceived by Merton.

This is a significant and disconcerting finding. It means, practically, that scarce resources are being directed to a regulatory "game" that has become more about game
playing than about using regulatory processes to assure desired quality of care outcomes in delivery systems. The team suggests this constitutes a regulatory policy failure, for the means of regulation become the ends rather than a means to serve originally-desired ends (i.e. socially-desired/prescribed quality of care outcomes). The book is rich in well-articulated examples from their tri-national data set. These examples illustrate the main means and causes by which actors at the delivery organization level and the regulatory monitor (i.e. inspector/surveyor) level play the game of regulatory ritualism. The multi-decade, longitudinal study frame further illustrates how actors have adapted to new forms of regulatory mechanisms over time, to optimize and often fraudulently maximize rewards of gain accruing from skillful regulatory gamesmanship.

The work is by multi-disciplinary social scientists whose early academic/sectoral experiences are not from within health service delivery, but rather criminal justice and business regulation. This is significant given that most contemporary health scholarship is undertaken by graduate-level scholars who are generally inducted into the health arena through a professional clinical discipline (e.g. nursing, medicine, social work, etc.) or another life or health science (e.g. health policy, health administration, etc.). This team brings a novel disciplinary experiential base rarely seen in contemporary health policy scholarship.

The researchers’ experiential backgrounds and interest about the study questions offer a “honest broker” type credibility to an area of health policy scholarship (i.e. regulation) that has historically been the domain of health profession regulators and others with deeply-entrenched parochial interests. Yes, the team is interested in health service delivery, but they are first more interested in what health service delivery can inform about regulatory theory. Throughout the book insights and conclusions emerge from the research team about the data set that come across with the tone of an academic anthropologist’s genuine observational curiosity, surprise and “meaning making” efforts.

This research team’s experiential background lends itself to discussing the work with directness, authenticity and concern which is refreshing. It lends credibility to the conclusions as well as the suggested pathways for rehabilitating well-meaning regulatory efforts that, over time, have gone terribly out of alignment with the original intent. For instance, in discussing a pathology emerging from the ritualism of myriad regulatory protocols, they find:

Protocols kill initiative under a pile of paper. With nursing home staff and inspectors alike, excessive demands for a task orientation distract attention from the outcomes that matter.

The result is the creation of health bureaucracies and regulatory bureaucracies that miss the big picture (p. 230).

This directness paints a picture of system evolution that has become the antithesis of what its creators espoused as a desired outcome to improve quality of care. The critically reflective perspective animating the text prompts many discomforting questions about the processes and products of regulation over time. The work constantly challenges leaders at the political, health system, other social systems and health service levels to reflect about if they are getting the results desired for the scarce societal resources invested in the regulation of service delivery. And, with equal directness, many leaders may be deeply comforted by what they learn from this work, particularly those in the USA:
Ritualism is such a deeply embedded, multilayered problem in the American nursing home industry that nothing short of a cultural revolution in the industry and its regulation may be needed to conquer it (p. 143) ... [W]e need to understand American regulation as a story of both accomplishment and counterproductivity (p. 144).

Ritualism is best summed up by the phrase “Just give us the rules and we’ll play the game.” (p. 228). Simply put, it’s the idea that it is possible to achieve paper compliance of standards without real compliance and that most inspectors can be fooled on most standards with creative paper compliance.

This ritualism has been most pervasive in the USA, but it has also manifested in the English and Australian experience. For instance, in the USA the team illustrates how regulatory ritualism has diverted the most skilled Registered Nurses from the bedside and into the backroom in efforts to optimize third-party payer Minimum Data Set (MDS) reimbursement coding. They also introduce data, which highlight US regulatory processes, which have evolved (or perhaps devolved) through micro-decisions (i.e. the cumulative effect of introducing a new rule [multiplied over time] as a reaction to politically-embarrassing pressure, without commensurate additional regulatory oversight resources), rather than evolution by regenerative, coherent design. The team illustrates how this has confounded regulation over time and rendered much of it meaningless for its prospective value in enhancing quality of care.

It would be misleading to suggest, however, that regulation has gone off-course only in the USA, or that the substantive narrative is one of only negative outcomes. The team notes within the comparison of the USA, England and Australia, similarities of experience to-date with aged care regulation which include:

- investment of substantial resources into inspecting nursing homes, and expanding resources, compared to other regulatory domains and earlier periods of history;
- regulation that has become more nationally centralized;
- the same basic range of issues cross-nationally;
- a broadening of standards beyond health care service issues which emphasize social care, fulfillment, activities, resident empowerment/rights;
- residents (clients) direct informant input as a source of regulatory data;
- more formalized and better resourced complaints procedures over time;
- more emphasis to a homelike environment in the regulatory standards;
- ritualized facility inspection tours and exit interviews with management;
- post-facility tour written inspection reports, now often disclosed publicly via a web-based posting;
- at least some unannounced inspections; and
- a distinct shift from direct state regulation to meta-regulation, based on regimes of self-regulated quality assurance at the service delivery-level.

The team notes that these dynamics are not surprising. They suggest, as do others (e.g. Braithwaite, 2008; Moran, 2002) that the current era is best characterized as one of regulatory capitalism. This is the idea that there is both more devolution of enterprises
and social and economic activity from public delivery models (e.g. public health service direct delivery) to private delivery models, with a commensurate proliferation in the regulation used to manage public interests pursued within private spaces (Braithwaite, 2006a). This regulatory capitalism regime is further juxtaposed against a backdrop of social and economic regulation in a broad range of societal arenas and rooted in a proliferating expansion of rights-based approaches (Moran, 2002; Sunstein, 1990). The team submits regulatory capitalism is “... found empirically to be freer markets, more rules, but also more capitalism, more regulation” (p. 219).

In England, notable cultural and structural differences in service delivery design include the prevalence of smaller homes and different levels of managerial professionalism and controls. The team introduces an interesting paradox (i.e. the English paradox) that increased levels of managerial professionalism and control, which characterize more the US context, do not necessarily mean clients get superior quality of care on several dimensions. In fact, they note that in English homes “… inferior managerial control of superior staff usually delivers better care than superior control of inferior staff” (p. 150).

There are other implications of this apparent English paradox for direct care staffing of services for the aged, which the authors discuss at length in chapter 10. They note a kind of folly in the prolific use of health care aides (i.e. particularly in the United States), who themselves tend to be socially-marginalized, as foundational agents of service for another profoundly marginalized cohort (i.e. the institutionally aged). In fact, the rapid growth in use of aides/support workers has compelled some to engage in more careful deliberation about the regulation of health workforce cohorts who have not historically been regulated using traditional health professions workforce regulatory models (Sais and Allsop, 2007).

The team does not call for eliminating the aged care workforce of health care aides/support workers. Rather, they call for a regenerative empowerment politics based on principles of restorative justice. This has a purposeful emancipating policy focus. Its intent is to help aides reclaim disenfranchised elements of their own personhood while extending an invitation to become active change agents for improved quality of care and continuous improvement in service of their often marginalized clients. This call will be one familiar to those acquainted with Brazilian adult educator Paulo Frere (1970), whose classic work Pedagogy of the Oppressed, also calls for enabling a conscientização, or critical consciousness of the marginalized in order enable transformation and help break pervasive cycles of marginalization.

Regulation in England is also described as a kind of “club governance.” There has been much more co-mingling of regulatory and entrepreneurial interests than in the USA and Australia. For those who have been socialized in administrative law and rule-of-law contexts that value procedural fairness and process transparency, a prima facia concern emerges. There is concern about the potential for individual administrative/bureaucratic abuse with the webs of relational power individual regulators are able to weave together in what the team calls “street-level bureaucrats.” The team goes on note, however, that “street-level bureaucrats” can be, and often are, very potent agents for continuous improvement and change, enabled through a creative array of tacit, informal practices and (to-date) a culturally-sustained professional role pride that has generally trumped the risk of abuse.
It is noted that all three regulatory regimes have become very intensive, national industries unto themselves. For the reader of other nations who may be looking to these nations for design leadership and lessons learned, there is value in the cross-national comparative analyses. It compares and contrasts the pros and cons of very large systems with those systems in smaller nations of varying administrative and policy contexts and traditions. Braithwaite and his colleagues note that the responsive regulatory approach using the enforcement pyramid, coupled with the strengths-based pyramid, hold promise. Specifically the idea that,

...formally weak regulators, such as poorly resourced and legally unsophisticated regulators in developing countries, can still mobilize a sophisticated responsive regulatory pyramid by escalating up through more and more networking of pressure on a recalcitrant firm, as opposed to escalating up through progressively more intensive state enforcement (p. 166).

To this end the team acknowledges newer approaches to more effective regulation are presenting as broader, strengths' balanced "networks of governance."

The authors note perhaps the single most significant enduring, and important regulatory change in nursing home practice to-date, has been achieved through this broader "networks of governance" approach. They hold this breakthrough change has been the systematic reduction of physical restraint of residents over the last three decades. In strategic locations throughout the book the team repeatedly comes back to the US National Citizens' Coalition for Nursing Home Reform (HCNNHR), who supported by progressive regulators, service providers and gerontologists, developed an evidence-based, compassionate rationale for "restraint free" homes.

This "networks of governance" approach also resonates with our more recent Canadian experience in hospice palliative care, strengths-based capacity-building. During a recent pan-Canadian national capacity investment project, significant new capacity was leveraged from within existing systems through an inter-sectoral Community of Practice (CoP) approach. This CoP was focused as an ad hoc, broad-based "network of governance" focused on specific improvements to access, quality and longer-term service delivery capacity in service of the seriously ill and dying (Aherne and Pereira, 2005, 2008).

Braithwaite (2006b) has noted the merits of "the new pyramid" approach for developing nations in considerable detail elsewhere, as the strengths-based pyramid approach helps mitigate the challenge that "...responsive regulation does require a big stick at the peak of an enforcement pyramid and big sticks are expensive, as well as demanding upon state capacities in other ways" (p. 884). He further notes that "...in an era of networked governance, weaker actors can enrol stronger ones to their projects if they are clever ... the globe is strewn with disaggregated bits of strong states that might be enrolled by weak ones (and by weak NGOs)" (2006b, p. 898).

A message emerges that good regulation done well is not without costs to be borne or resources to be deployed, but that it can be done to support capacity-based investment. The team, however, takes great care to explain that continuous improvement processes can be captured and embody their own kinds of ritualism and game playing. This includes, for instance, leaving known potential improvement areas unattended so there is something to improve later. They discuss continuous improvement and other organizational quality assurance as a form of self-regulation.

They conclude that continuous improvement and a strengths-based pyramid can never stand alone as a coherent regulatory strategy. Hence, the team emphasizes the
importance of balancing an enforcement pyramid approach with a strengths-based pyramid approach, or what they present as a dual pyramid strategy of regulation. They also note that most healthcare professionals are not taught, nor do most possess, essential continuous improvement skill sets, particularly skills required to undertake root-cause analysis. The absence of these skills further reinforces ritualism as there is a propensity to continually "game" the symptoms of a problem rather than to address the root cause(s).

The team draws on the more recent Australian experience to illustrate how a dual pyramid strategy might work elsewhere. The contemporary Australian nursing home accreditation models have not been without problems, including a wholesale government catalyzed regulatory enforcement reorganization in the late 1990s. They note, however, that Australia has moved to a much narrower list of broader outcomes-focused, aged care standards. More emphasis has been placed on local accountability and responsibility for determining the most appropriate means for standards achievement within a given service delivery context.

They observe that the newer Australian accreditation process is less oriented to control of weaknesses and more oriented to the development of strengths. In effect, the shift has been to pick strengths and build on them, and over time composites of strengths ought to sufficiently overlap to compensate for most delivery system weaknesses. Pride and shame are used strategically as key regulatory motivators. Shame is used through a process of "reintegrative shaming" in standards monitoring and pride through accreditation processes that emphasize strength-building and continuous improvement. Pride has been systematized by using the regulatory process to bring forward good things that have been done through a process of shared narrative which encourages "... enjoy[ing] yourselves telling the story of what you have accomplished." (p. 210). The team notes the concepts of pride and shame are key motivators for improvement, suggesting "... the micropolitics of pride and shame at street level (facility-level) are fundamental to building commitment to quality and integrity in particular organizations" (p. 303).

There is more purported emphasis in the contemporary Australian regulatory process on procedural fairness, which in turn is associated with improved compliance. There is also emphasis on systems-level strengthening through processes of informal learning (Marsick et al., 2009) as well as systemic triple-loop learning (Parker, 2002). The team notes the importance of mentoring and informal learning that occurs at the street-level among US and Australian regulators, as modes of transmitting tacit ways of knowing about effective tips and tactics for engaging regulatees. With some similarities but not to be confused with Chris Argyris' (1990) classic double-loop learning concepts in the North American tradition, triple loop learning is a systemic approach building from evidence-based practice (Healy and Braithwaite, 2006). Based on Parker's (2002) work, the first loop starts with innovators becoming more effective at improving an outcome. A second loop occurs when policy learning is implemented by clinicians and senior managers who, in response, change their management systems, culture and practices. A third loop occurs when a regulator learns from the monitoring and revises the regulatory goals for the whole field.

Perhaps one of the most successful instances demonstrating first and second loop learning and some aspects of the third loop comes from Lynn et al.'s (2001), continuous improvement study of end-of-life care. This large scale quality improvement study was
undertaken in partnership with Harvard University's, Institute for Health Care Improvement (IHI). It used the IHI's "breakthrough collaborative" approach to focus a large-scale, term-specific self-regulatory exercise in improving care at the end of life in four key areas with a critical mass of 47 US active treatment hospitals. It would be indeed interesting to see if such a large-scale, multi-site and focused "breakthrough collaborative" approach might work to animate a strengths-based approach in various national contexts, to advance improved care of the elderly.

Another somewhat disconcerting finding from the Braithwaite team is that in order to respond to the managerial sophistication and administrative demands of ever expanding regulation, they conclude that organizational size matters! Over the three decade frame of their study they conclude increased regulatory demands created barriers for smaller enterprises, beyond just driving poor performing or "bad" "mom and pop" operations out of the market.

Service delivery consolidation, in turn, has been a principal driver of increased institutionalized care of the aged, particularly in the United States. The parallels to "prison life" for many aged persons compels deeply-troubling leadership, ethical and moral questions about an emerging "control society" being inadvertently manufactured through regulatory policies invoked in the name of quality of care. Suffice it to say the team irrefutably establishes that regulatory ritualism drives institutionalization. Institutionalization, in turn, generally works counter to goals of enabling dignity and celebrating personhood. This conclusion is supported in the work by ample and heartbreaking examples emerging from the data.

These various and other contributions to the scholarship all lead to the question of how can we help persons working within delivery systems "get" compliance that is focused on desired quality of care outcomes? That is:

To motivate homes to draw on consultants, while being willing to enter into conversation about different solutions that the home chooses and how to adapt them to meet the standards … An important part of building a strengths-based approach is to signal how this can displace blaming people for single incidents as staff learn to develop their strengths in crafting systemic solutions to problems (p. 198).

Such dialogic and trust-based approaches, based on skill sets not readily found within existing delivery systems, is a hopeful pathway forward that is best approached cautiously and realistically. It will demand leadership at political-levels, system bureaucracy-levels, senior and front-line service delivery levels and different kinds of consumer/advocacy engagement in healthcare to mitigate further loss of due process and accountability from ritualism (Allsop and Jones, 2007). How hopeful can one be that the pervasive "short termism" that characterizes so many of our modern public and private enterprises can be turned around in an age of pervasive regulatory capitalism?

**Additional reflections**

After reading *Regulating Aged Care*, I am left with the distinct impression that unchecked ritualism in regulation is a game no one ever wins, because all the players are always in the defensive end of the pitch/field. Where the regulatory ritualism game is pervasive, staff are constantly "preparing for the exam" (i.e. inspection). Administrators are focused on producing defensive documentary records in support of "proof testing" for inspectors. Inspectors are busy gaming (particularly in the US)
the state and federal reporting processes as a default coping strategy for work volume, but no one actually “scores” because in a ritualistic regulatory regime no player is engaged in playing an outcome-oriented (i.e. improved quality of care), offensive game (i.e. they never score a goal).

Making matters worse, it seems different players (e.g. front-line/professional staff, administrators, inspectors/surveyors, other regulators, etc.) are often playing on parallel pitches/fields. This is perhaps why the dialogic approach advocated by the team is so important. It helps to refocus the various players on a goal-oriented, outcome-focused game and helps convergence of disparate players to work better together via their respective roles and responsibilities on the same pitch/field.

The team’s observation is that the same disciplinary approach which has helped humanity systematically organize, apply, evaluate and improve knowledge and transfer it to successive generations since the Age of Enlightenment, is also the same disciplinary approach which has fuelled ritualism and subsequent gamesmanship in regulation. On this point I am left with the impression that regulation itself is a form of soft technology. Like most technologies in and of themselves, regulation technologies tend to be value neutral. That is, they are approaches, methods, tools, tactics and applied processes.

It is the particular design, application and continuous oversight of regulatory technologies in authentic societal contexts and guided by stewardship principles which may best help achieve desired policy outcomes, in this context articulated as better quality of care for the aged. This observation could, and perhaps should, also serve as a cautionary note to readers in other nations who may have the luxury to “leap frog” over the pitfalls and hard earned lessons of these three developed nations. With thoughtfulness and resolve, they could mitigate reproducing the systemic regulation pathologies that can arise from a lack of critically-reflective application of the tools of a “disciplinary society.” Perhaps this too is another important reason to take the suggested dialogic approach so seriously.

We are a species who, when at its best, transmits values and knowledge about solving collective problems through respectful dialogue. Doing this more effectively in aging and social care regulation would require a purposeful shift from the more reductionist tendencies of the scientific method as it has been narrowly applied (arguably misapplied?) in contemporary regulation. Perhaps regulatory designers and program implementers have confused the navigation of complexity in service delivery (i.e. a more ecological approach suited to complex adaptive systems), with unduly complicating complex phenomena through increasingly ritualistic reductionism.

It may in fact be this inability for many to understand and respect complexity that causes intelligent people to personify inanimate delivery systems as “the system” or “the market,” as if these were sentient singular entities, rather than the manifestation of our collective behaviour and enterprise. As leaders, we are individually (i.e. micro-decisions) and collectively (i.e. impact of cumulative micro-decision and purposeful policy/legislative frameworks) responsible for the systems we create and allow to manifest unchecked.

Hence, an emerging imperative in reclaiming the moral and ethical space of individual decision-making in the communion of crafting collective enterprise (e.g. regulatory systems, institution-building, community-building, functional markets, etc.) will at some point be a predictable and unavoidable set of socio-political,
socio-economic and policy renewal endeavours (i.e. regenerative politics). This may in fact be one of the principal emerging leadership challenges for regulatory reform, for as the team notes, partnership achieves more than power assertion for "... we have entered an era of networked governance where hierarchical command and control does not work as well as it did in the decades of the wave of regulatory state growth following the [former US President Roosevelt's] New Deal" (p. 167).

It would be naive, however, to suggest that other forces motivated by proliferating micro-decisions about personal self-interest (e.g. greed, individual gain, personal prestige, etc.) cannot trump well-intended regulatory design, in any domain. The recent financial services meltdown and subsequent deep global recession of 2008 and beyond ought to be a self-evident testament to this statement. This is particularly so as the proverbial post-mortem continue to amass about how such massive regulatory failures could proliferate yet again into profound global economic crisis.

We ought not be surprised, however, as political elites and regulatory decision-makers knew, but perhaps did not understand the real potential for these kinds of regulatory failures (e.g. see especially Powers, 1997). I am left with the distinct impression that in the absence of thoughtful, critically-reflective moral discourse, stewardship-informed/improvement-oriented leadership, generational transmission of sustainable ethical principles of moral conduct, and meaningful enforcement, the most well-intended regulatory systems are fragile social constructions at best which can and often do quickly plummet into great disarray.

Given then, much of what has recently transpired particularly from United States-based financial markets of the last year, it would be interesting to know what additional insights could be brought to further inform health and social care regulation. One insight is that meta-regulation does not easily work without meaningful oversight AND earlier, meaningful enforcement (e.g. Enron, WorldCom, the 2008 US/global banking crisis, Bernie Madoff, etc). To this end, I agree with Braithwaite, Makkai and Braithwaite that a strong enforcement pyramid must co-exist with a strengths-based pyramid, but this still leaves troubling questions about processes of who regulates the regulators and who gets to decide what is in the best, overall public-interest in any given domain? And, what is a best overall public-interest in contemporary times of an unparalleled age of competing public and private agendas played out in an era of regulatory capitalism?

Current models, many the off-spring emerging from Roosevelt's New Deal era (Moran, 2002; Sunstein, 1990) appear stretched to a near breaking point. At time of publication the verdict is still out about the longer-term sustainability of our current regulatory approaches and the systems, which are the foci of their regulatory scope. One thing appears consistent across the various sectoral literatures on regulation, and that is that there is an inevitable risk that pathological behaviours will manifest in the absence of thoughtful, coherent and elegant system design as well as constant leader vigilance, critical reflection and purposeful regeneration. By elegant I mean not confusing the complexity inherent in our modern understanding of complex adaptive systems with unduly complicating systems’ regulatory oversight through “busy” work. The comparative analysis of the more recent US nursing home experience, when compared to that of Australian aged care systems, suggests the more that systems are unduly complicated by regulation and rule bound, the greater the risk of regulatory
oversight becoming overwhelmed thus propagating systemic ritualism and gamesmanship.

Finally, and perhaps most fundamental to the dignified and compassionate service of the aged, is a brief critically reflective discussion about the conceptual foundations of the team’s companion study subject – aged care. As noted, the team has introduced in this work the concept of what I have coined “the English paradox”. This paradox essentially states that overall during the study period, the English had the least developed systems of regulatory practice and least sophisticated management practices, and yet demonstrated the highest levels of quality of care of the three nation states on the criteria that tend to matter most as quality of life indicators for the aged. The team went so far as to definitively state:

We can stand back and say that as we ourselves move closer to retirement, we would rather end up in the English nursing homes we visited… than the Australian homes, and even more so most of the US homes we saw (p. 167).

We ought not be surprised by such a statement, given the tendency of English homes to be the least institutional and most community-linked. John McKnight (1995), the outspoken American civil rights activist and long-time academic community developer from Chicago’s, Northwestern University, delivered a scathing critique about prolific and unchecked institutionalization in The Careless Society. He later revised some of these ideas in a 2003 public policy lecture entitled Regenerating Community: The Recovery of a Space For Citizens, the latter which served as a capstone retrospective of his 40 year career. McKnight (1995) argued, in part, that service systems can never be reformed so they will “produce” care. He noted:

Care is a consenting commitment of citizens to one another. Care cannot be produced, provided, managed, organized, administered, or commodified. Care is the only thing a system cannot produce. Every institutional effort to replace the real thing is a counterfeit. Care is, indeed, the manifestation of a community. The community is the site for the relationship of citizens. And it is at this site that the primary work of a caring society must occur (p. x).

McKnight (2003) further offered:

It is one of the quiet tragedies of the 20th century that we have accepted the idea that institutions, rather than families, neighbors, and associations, are the primary sites of care. This mistaken understanding is the cause, rather than the solution, of many of our social problems. Who among us looks forward to old age under the “care” of a nursing home, now called a “care” facility… The critical reasons, then, for recognizing the place of associations in our local neighbourhoods and larger society is that they are our citizen tools for creating power, inventing solutions, and providing care. And these are the three capacities that our great systems cannot produce, however, well managed, technologically oriented, or professionally run (p. 10).

Respected Australian sociologist Allan Kellehear recently advanced similar ideas to McKnight based on some 20-years of applied research and demonstration projects in health-promoting, palliative care, noting “[t]he prevailing view that a service response (i.e. a solely clinical palliative care response) is an adequate main response to end-of-life care is in need of major re-examination and revision (Kellehear, 2005, p. 13).”

It is becoming imperative for health service leaders to move beyond the conceptual “fuzziness” too often co-mingled among the concept of quality, accountable services and the concept of care and caring. That is, to separate and critically reflect upon
concepts of service provision and concepts of care and caring. This is a pervasive challenge I have witnessed first hand in all Canadian provinces and territories and in all Canadian health delivery systems and service settings. I very seriously doubt Canadian health service policy and delivery leaders are alone in this regard, as the team’s own work demonstrates.

This is also not to suggest that care and caring does not, or cannot, take place in institutional and institutionalized service delivery settings. Care and caring does take place, but it is both a highly-variable and a deeply inter-personal encounter of shared commitment between two persons in an authentic lived experience of the moment, that may occur within the transactional encounter of service delivery. But too often services take place in institutional and other service delivery settings where care is not cultivated, and in many cases caring is systemically discouraged. This latter concept is a source of deep concern as newer scholarship emerges which illustrates the degree to which “otherisation” (i.e. seeing another person as one dimensional, such as a patient, a resident, a client, a frail elderly, a terminal patient, etc.) in institutional and other service delivery settings can proliferate systemic callousness, administrative cruelty and bureaucratic banality (Taylor, 2007, 2009).

The team’s identification of “the English paradox” then, illustrates that while services ought to be regulated more meaningfully, it is likely practically impossible to effectively regulate care or caring via traditional regulatory enforcement and punitive approaches and more hopelessly so in the face of rampant institutionalization. Perhaps the best hope (maybe the only hope at this point) is to facilitate the conditions, within the confines of various service relationships, to enable a fuller manifestation of caring relationships. Herein may lie the somewhat hidden pathway forward for the kind of hopeful change, based on the restorative justice principles and the empowerment politics, which the authors claim is so important for regenerative change.

Conclusion

It is rare today to have the privilege of reading a book that summarizes some 30 years of rigorous, systematic inquiry into important social phenomena. The research team has carefully compiled the “show me stuff” that political decision-makers and senior bureaucrats increasingly demand in option consideration and decision deliberation. They have further woven together a tightly-written, coherent and at times disconcerting narrative account of their journey in better understanding the dynamics of aged care regulation. In and of itself this is a commendable contribution to the literature.

But, in an emerging post-critical tradition, the team has also accepted academic leadership responsibility and offered hope, with substantive strategies for rethinking regulation and governance. Further, this scholarly leadership for transforming regulatory design applies not only to aged care, but promisingly to other domains of health and social care currently characterized by runaway ritualism, rapidly declining citizen trust/consumer confidence and decisional paralyses.

The growing stockpile of regulatory failures we see across all facets of modern life reflect perhaps not so much a failure of regulation per se, but rather may be reflective of the slow surrender of moral imperative and reasonable ethical conduct in daily practice to the conceding of ritualistic process. To the extent this may be a possible “truth” or reasonably valid interpretation of our socio-economic and socio-political
current state, then *Regulating Aged Care* is really a story about a profound failure of leadership at multiple levels of society. This is ultimately a failure to take stewardship responsibilities seriously, particularly in domains demanding a shared commitment to enabling personhood and compassion with the most frail and vulnerable of our societies.

But lest we despair, *Regulating Aged Care* also contains a roadmap for possible leadership redemption and regulatory renewal. So, is it possible to dig ourselves out of these deep holes of regulatory ritualism and enable regulation as a transformative force? A politics of hope taken seriously, with strategic investments (i.e., financial, human, leadership, political capital), would suggest it may be possible. But if possible, how likely given that the age of regulatory capitalism has itself spawned an expansive regulatory entrepreneurial sector devoted to its own sustenance? One of my early career mentors, an experienced Canadian senior policy advisor with extensive experience in professional regulation, would call this book a “fork in the road” type of work for leaders. In the spirit of Robert Frost’s (1921) classic poem, to what extent will leaders at various levels and fora have the courage to take this road less travelled? I do not know. But if they do it could make all the difference!

Michael Aherne

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Editorial

On a recent trip to New York I happened to pick up a book entitled, *A Whole New Mind* by Daniel Pink (2005). The thesis behind the mind is that right brained will rule the future. Just as this era of sustainability and rapid change has turned the traditional bureaucratic leadership paradigm upside down, so it has changed the way we need to think. It is no longer sufficient to rely on the linear logical planned step by step left brained approach to life – the age of accountants, lawyers and software engineers is coming to an end. According to Pink, the future belongs not to these types, but rather the right brained, inventive, design oriented, big picture, more emotional thinkers.

One of the reasons I enjoyed Pink’s thesis is that as a teacher of leadership I think he is right. I believe leadership to be not a quality emphasising left brained military analytical precision, but rather one where right brained, intuitive, relationship savvy, empathic qualities are of equal if not more importance. This is especially true in a health world of unprecedented complexity. In my opinion, the concepts of design, seeing the big picture, striving to make meaning in difficult situations, understanding the significance of relationships and the role of empathy have major implications for the world of health service leadership. We need to be able to see the whole story, blurring the boundaries, much more in tune with our emotions than our logic, so that we can start to design new solutions to the challenging problems we face.

The fact is that we are facing huge health challenges created by the demographic forces of increasing life span, exponential population growth and the rate of technological change. At the same time the world is going through a major economic downturn, which has served to exacerbate all these challenges. Health is no longer a local or national concern; it is a global concern. In every country, health costs are going through the roof. Even though the answer from political leadership all too often is to cut the budget by eliminating middle management positions, reorganizing and consolidating – typical left brained problem solving approaches – the problem of costs is real and continues to get worse. All too often it seems, our politicians act as though they should run the system, instead of making the case for change and then allowing the leadership in the system to act accordingly. In short, their ongoing tinkering with the system fails to produce sustained change, and often seems to compound the problems we face.

Here in my own Western Canadian province, it is reported that our health authority is running a 1.1 billion dollar deficit. It is reported that the NHS in the UK requires another 10 billion pounds in the next three years to survive as a national health service. The costs to reform the American health care system where many people do not have any health care coverage is estimated to be in the trillions of dollars. How many administrative reforms have been foisted on health care systems by well meaning politicians whose main concern is to bring costs down? At the same time, the costs keep going up.

We need to begin to ask ourselves – is this really a paper work problem? Can we bring about health service reform by continuing to shuffle paper, change the administrative systems, pay the managers to leave, lay off staff, recruit more? Or are
we facing a health problem? And if it is a health problem, then what can the leaders in the system do about it? Indeed what can we all do to participate in that discussion so that we can finally bring health to the forefront of our discussions. I read somewhere that health is simple, illness is complex. Some would argue that there is much going on in our modern western society – much that we have a vested interest in – that contributes to our sickness including modern food that promotes chronic disease, sedentary life styles, and pharmaceutical drugs that do not cure underlying conditions but merely manage them. These are huge issues and have major implications for our health – or lack thereof – yet our health service delivery systems operate almost independently of them.

On a large scale, to make the change possible requires a focused leadership and will and the imagination to do things differently. On a small scale, local practices often reflect a leadership initiative to do things better and differently. Whether driven by imagination, or necessity, we know that some good things are happening in the health care system – even though the big picture may be disheartening. The question for those who read and contribute to this journal is what can you do to make a difference? Leadership in Health Services needs your stories of leadership that have practical implications for health service – so that others can learn from your practices. If we cannot rely on the left brain actions of our political leaders to make a difference, then the actions of those actually working in the system become ever more important in their capacity to make a difference.

In this issue, Graham Dickson directly articulates this leadership paradox we particularly face. Although directly pertaining to Canada, his paper has much relevance to the entire global world of health leadership. As he analyzes the transformations that are ongoing in the Canadian health system and their theoretical and practical implications for leadership he notes the lag between the old “more administrative and managerial” models and the newer more innovative and transformative approaches to leadership. His paper speaks to the key leadership shifts that are required if leaders are to able to respond to the changes occurring in the health care environment and at the same time be effective and active leaders in shaping the new systems that are required. To this end he describes some of the positive dialogue currently occurring in Canada concerning newer more dynamic and contextually relevant leadership models that may be useful for guiding our health service development.

Other papers here also speak to leadership development and practices that have implications for the wider system. First, Peter Hickey and his co-authors describe a novel leadership competency development program where National Health Service medical professionals provide medical services in partnership with local people through the Maddox Jolie-Pitt Foundation in Cambodia, to both improve the health of people in a developing country and at the same time build their own leadership competencies. The paper is interesting on a number of levels. First, many of us know little of this foundation and what it does, and the paper does shed some information on this. Second, medical professionals get to interact and work with people entirely outside their own culture – where the stories and the contexts are very different from what they are used to, and then take the new skills and experiences back to the NHS. Leadership through learning, particularly when the learning occurs in such a culturally different context makes for a fascinating and ongoing study of leadership, and we can
look forward to more papers in the future that evaluate just exactly what competencies are developed and their contribution toward a better health care system.

In another vein, Janice Sharlow et al. describe a leadership development initiative from the Alberta Cancer Board in Western Canada. Framed conceptually on advanced leadership theories and practices, the paper describes a collaborative cohort approach to leadership development where leaders in all levels of management and administration, including individuals with medical and scientific leadership portfolios, come together in a carefully designed program to promote individual, group and organizational learning. The ultimate aim of the program is to impact organizational culture and promote organizational development and effectiveness against the backdrop of ongoing fiscal and demographic pressure. Given the political reality of the health service in this province, with the emphasis on major cost cutting, this type of program takes on particular importance.

Finally a group of Florida researchers is a pilot study speaking to gender differences in the extent to which male and female health care professionals participate in ongoing professional development activities and the impact this has on their careers. Although preliminary, their finding — that men participate more in ongoing professional development activities than women — suggests that the gap between these two groups in terms of health care career attainment may continue, with more men than women achieving leadership positions.

Also included here is an in-depth book review by Michael Aherne. Entitled *Regulating Aged Care: Ritualism and the New Pyramid*, published by Edward Elgar, and written by Australian writers, John Braithwaite, Toni Makkai, and Valerie Braithwaite, the book looks at 30 years of regulation and regulatory structures in terms of outcomes in aged care centers in three countries. Are we further ahead by having such regulation built into our health care structures? The authors would suggest not. Could this be more of the left brain thinking that Pink argues is becoming obsolete? Read Michael's extremely thorough review, then read the book, and then assess for yourselves how leaders can use regulation not to preserve the status quo through ritual, but as a transformative force to bring about real change in our health care services. If you read just one book this year, then this might just be the one to start you thinking about the leadership journey we can start to undertake.

Jennifer Bowerman

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