

# Management challenges faced by managers of New Zealand long-term care facilities

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## Abstract

*This article reports on a postal survey of 78 long-term care managers in one region of New Zealand, of whom 45 (58%) responded. Most long-term care managers (73.2%) were middle-aged females holding nursing but not management qualifications. Most long-term care facilities (69%) tended to be stand-alone facilities providing a single type of care (rest home or continuing care hospital). The most prominent issues facing managers were considered to be inadequate funding to match the growing costs of providing long-term care and occupancy levels. Managers believed that political/regulatory, economic and social factors influenced these issues. Despite a turbulent health care environment and the challenges facing managers, long-term care managers reported they were coping well and valued networking.*

## Introduction

The speed and magnitude of change in New Zealand's health and disability support services, including long-term care, are making management increasingly challenging. The emphasis is on reducing the costs of providing care while increasing quality of care and productivity.

The long-term care industry forms a significant part of total health care activity of the nation. In 1997, the industry covered approximately 1064 facilities operating 33 187 beds (Duthie 1998), employed 25 000 people (O'Dowd 1998) and provided services for a growing number of older people (11.8% of the population is aged 65 years or over) (Statistics New Zealand 1994). Disability support services, which include age-related disability, accounted for 25.2% of total public health expenditure in 1995–96 (Ministry of Health 1998). Of the total public and private expenditure on disability support services to the year ending June 1997, 78.5% was spent on institutional

disability support services, which included long-term care provided through rest home and continuing care hospitals (Ministry of Health 1998).

Long-term care facilities are well established in New Zealand. Historically, they are licensed by the Ministry of Health with services purchased on a regional basis (there are four regions) by the Health Funding Authority. The long-term care industry comprises a mix of public, private and not-for-profit facilities, providing a range of care alternatives such as home care, short-term respite care and long-term residential care (including rest homes and continuing care hospitals). Definitions of these terms are provided in the glossary.

The level and type of services reflect the required level of care needed by an older person as assessed by an independent agency contracted by the Health Funding Authority. Depending upon the type of licence, long-term care facilities may provide a single type of service (for example, rest home) or a combination of services (for example, rest home plus continuing care hospital or rest home plus continuing care hospital plus Stage III rest home). Some facilities also provide other types of sheltered care (for example, retirement villages and independent units) in addition to the rest home and hospital-level services.

Long-term care facilities receive funding from public sources (the Health Funding Authority and Accident Compensation and Insurance Corporation) and from privately-paying clients. Needs-assessment and service coordination play a gatekeeper role for access to some disability services. Clients may pay charges for most services except needs-assessment and service coordination. In some cases this contribution is assessed according to a person's ability to pay, based on an income and assets test administered by Work and Income New Zealand (formerly the New Zealand Income Support Service), whereas a flat charge applies to others. A similar trend towards asset and means-testing has also been reported in Australia (Gibson 1998).

The size of the facilities (measured by the number of beds they operate) also varies. Regardless of ownership, type and size, long-term care facilities are affected by health sector changes and policy in the same way as other types of health services. Long-term care managers need to balance external environmental pressures with internal demands. Challenges facing managers of acute and continuing care health service organisations, reflecting the turbulent external environment, have attracted considerable interest and have been well described, particularly in the United States (Shortell & Kaluzny 1994; Duncan, Ginter & Swayne 1995). The skills and knowledge base required to effectively manage long-term care facilities have changed dramatically over the last five years, having been affected by political and regulatory changes, demographic shifts, technological changes, social changes, rising consumer expectations of higher quality standards and increasing stakeholder expectations. Managerial challenges related to balancing decreasing resources with growth in demand and expectations of quality need to be properly understood if long-term care managers are to continue playing a vital role in elderly care.

The few published studies conducted in New Zealand have been from either clinical gerontological perspectives, or have been reports by consultancies, predominantly on rest homes (Coopers & Lybrand 1996; Arthur Andersen 1998). The present study was conducted in order to explore the attitudes of active long-term care industry managers about the pressing problems facing management and the strategies they can develop to effectively manage their facilities.

## Methods

A survey, using a self-administered postal questionnaire, was conducted during May–June 1998. The questionnaire comprised structured and semi-structured questions and was pilot-tested. It sought information on the following topics:

- the manager (including job title, age, sex, education and years of experience)
- the facility (including type of licence, number of beds, other services offered, and size and category of the facility)
- the issues facing long-term care managers (ranked in order of importance)
- the impact of environmental factors on those managerial issues, and
- the effects of managerial challenges on managers' positions.

The specific questions relating to managerial issues were adapted from *Aspects of Rest Home Pricing*, a report commissioned by the then Central Regional Health Authority of New Zealand (Coopers & Lybrand 1996). The specific questions pertaining to environmental factors were adapted from Duncan, Ginter and Swayne (1995). An information sheet was included with the questionnaire which explained the purpose and objectives of the research and the voluntary nature of responding, and assured respondents of its confidentiality and anonymity.

The questionnaires were mailed to the total population of managers (identified as the person responsible for day-to-day management) of long-term care facilities in the Manawatu and Wanganui regions of the Health Funding Authority (Central) area. Of the 78 questionnaires mailed out, 45 completed questionnaires were returned, giving a response rate of 58%.

Because this sample represents 27% (78 of 289) of long-term care managers in the Central region, the findings may be cautiously generalised to the Central region of New Zealand. Open-ended questions were analysed using a content analysis approach. The structured questions were analysed using the SPSS program.

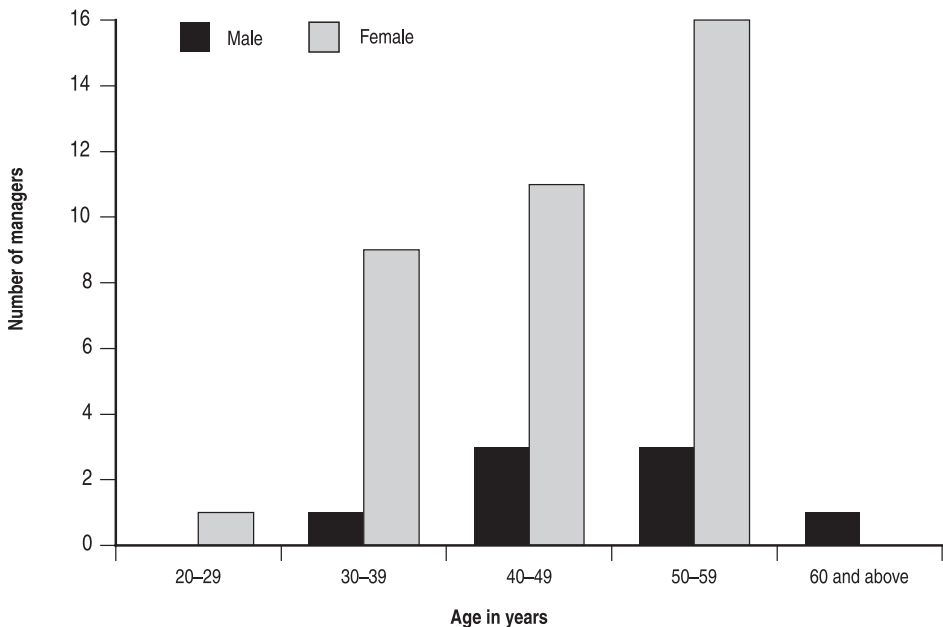
## Results and discussion

### Profile of long-term care managers

The preferred job titles (in about equal proportions) were:

- business/general manager
- principal nurse/nurse manager, and
- business manager/care manager.

Business or general manager titles were used by 9 of the 14 larger facilities but seldom by medium and small facilities, suggesting that larger facilities which have better economies of scale are more likely to employ general managers or business managers. More females (82%) than males (18%) filled management positions except for the better-paid business or general manager positions, in which males outnumbered females.



**Figure 1: Age and gender distribution of long-term care managers**

The finding that managers were predominantly female contrasts with findings of other studies that have been conducted in the health care industry in general. For example, a survey of members of the Australian College of Health Service Executives and members of the New Zealand Institute of Health Management found that 50.4% of health service managers were male and 49.6% female (Harris, Maddern & Research Associates 1998). Similarly, a United States study found that of the total American

College of Healthcare Executives affiliates who entered the field between 1971 and 1985, males and females contributed equally (American College of Healthcare Executives 1991). However, managerial positions at all levels in United States health service organisations are being increasingly filled by women (Pointer and Sanchez 1994).

Figure 1 shows that 55.4% of respondents were under the age of 50, with the largest number of these aged between 40 and 49 years. A recent study conducted among Australian and New Zealand health service managers also found that the majority (70%) was under the age of 50 years (Harris, Maddern & Research Associates 1998). However, the proportion of younger managers was lower in the present survey, the single largest age band falling within the 50–59 range (42.2%), suggesting that long-term care managers are older than general health service managers. Indeed, by far the majority (73.2%) of long-term care managers are middle-aged (between 40 and 59 years). By relating the different age bands with that of gender, no differences were observed.

Nursing qualifications only were held by 69% of respondents, including registered nurse, advanced diploma and Rest Home Care Management Certificate. Thirteen per cent held a combination of both nursing and management qualifications, 7% held business qualifications only (including postgraduate qualifications), 9% held unrelated qualifications and 2% had no formal qualifications. Given the nature of the roles and responsibilities expected of a manager, the finding that 69% of long-term care managers held only clinical qualifications (mainly nursing) and only 20% held management qualifications contrasts with some overseas studies which have found that long-term care managers in particular, and health services managers in general, held some sort of management qualification. For example, in the United States, most States' long-term care licensing procedures recognise the administrator's education, experience and overall competency as the primary determinant of the quality of services rendered within the facility (Abramovice 1988). Administrators of long-term care facilities in the United States preferably have a minimum executive management training either in health administration or some comparable field (Mitchel 1978; Abramovice 1988). Similarly, it has been reported that among Australian and New Zealand health service managers (including managers of long-term care), 71% hold postgraduate qualifications, 37.7% hold a health management qualification, 40% hold a business or commerce qualification and 52% hold both management and clinical (medicine, nursing or one of the allied health discipline) qualifications (Harris, Maddern & Research Associates 1998).

More than half of the respondents in the present survey had five years or less experience in managing long-term care facilities. Over half (51%) of respondents had no experience managing any kind of hospital/health care facility other than long-term care facilities. Of the 20% of respondents with wider health management experience, this experience was for three years or less. These findings suggest that the long-term care industry is not attracting experienced health managers.

### Profile of long-term care facilities

Of the facilities surveyed, 69% were licensed stand-alone facilities providing a single type of long-term care, of which 55% were rest homes, 7% continuing care hospitals, 4.4% psychogeriatric continuing care hospitals and 2% Stage III rest homes (see Figure 2).

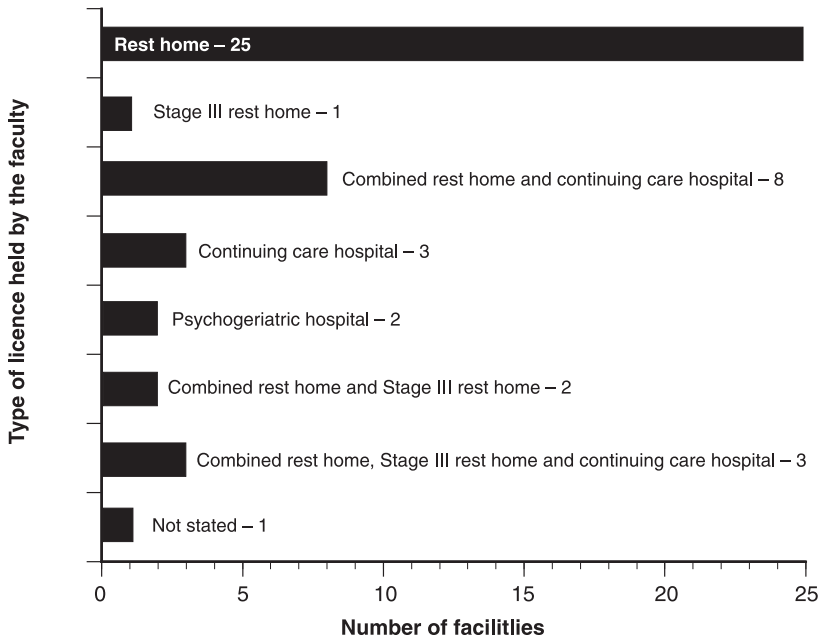


Figure 2: Type of licence held by the facility

Of the 31% of facilities that were licensed to provide more than one type of care, 18% were a combination of rest home and continuing care hospital (dual licence), 4.4% had rest home and Stage III rest home care, 7% were a combination of rest home plus Stage III rest home and continuing care hospital, and 2% did not specify. The number of beds operated per facility ranged from 10 to 131. A total of 1338 beds were operated by 39 facilities surveyed (six did not provide information on the number of beds they were operating), giving a mean of 34 beds per facility. These findings broadly reflect the actual licensing pattern and number of beds according to the Health Funding Authority's list of contracted long-term care facilities in Manawatu and Wanganui regions in 1997.

Government subsidies for long-term care are capped, but long-term care facilities can shield themselves through entrepreneurial business approaches and by exploring new revenue-generation strategies. The present study found that one-third of long-term care facilities surveyed had sheltered facilities in addition to rest home and continuing care hospital facilities, the single most frequent type (10 of 15) being independent units. This finding indicates that generally long-term care managers are recognising neither the

strategic advantage of expanding their market into other types of care facilities, nor the importance of providing seamless care. The Minister of Health recently emphasised the need for a greater flexibility of layout and design of long-term care facilities in order to provide a growing elderly population with seamless care through a continuum of care models, but this is only possible by having the full range of long-term care facilities (rest homes, continuing care hospitals, sheltered facilities, community support services and day care). The advantages of developing sheltered facilities in conjunction with more intensive long-term care facilities are also emphasised by the long-term care industry itself (O'Dowd 1998).

Other forms of service, such as respite, day care and home care, were provided by 80% of facilities. The majority provided more than one type of service, the largest number providing a combination of respite and day care services (42%) followed by a combination of respite, day care and home care services (9%). This pattern was also found in a previous survey of New Zealand long-term care organisations (Richmond et al. 1995).

The surveyed long-term care facilities were spread across three size categories, 40% being in the large category (>35 beds), 31% in the medium category (20–35 beds) and 29% in the small category (<20 beds). Previous surveys have reported similar patterns (Arthur Andersen 1996, 1998).

More than half of the long-term care facilities under study were in the private sector (58%) followed by public (15.6%), religious and welfare (15.6%) and trust (11%). Our finding that long-term care facilities are predominantly privately owned, with religious and welfare organisations owning the next largest proportion, are similar to those of other studies. The Arthur Andersen studies (1996, 1998) reported much higher levels of private ownership, with 72–73% of New Zealand's rest homes being privately owned. In Australia, privately-owned organisations provide 47% of nursing homes and 2% of hostel places, not-for-profit organisations provide 37% of nursing homes and 92% of hostel places, and State governments provide 16% of nursing home beds and 6% of hostel places (Department of Health, Housing and Community Services 1991). There was also reported a similar pattern of categorisation among long-term care providers in the United States (Abramovitch 1988). Nursing homes in the United States are owned predominantly by profit-orientated organisations, while not-for-profit nursing homes represented only 26% of nursing homes nationally in 1997 (Parkin 1997).

## **Managers' rating of managerial issues**

Pre-selected managerial issues rated as most important by respondents were:

- occupancy levels (86.6%)
- the increased cost of providing care not being matched by funding increases (also rated by 86.6%)

- the increased demand for higher quality standards not being matched by funding increases (73.3%)
- technical performance (68.9%)
- staffing problems (51%)
- ageing physical facilities (51%)
- the increasing difficulty in maintaining a balance between mission and business practices (46.7%)
- resident/patient care issues (44.4%), and
- increasing competition (40%).

No significant differences were found when the licence, size and categories of the long-term care facilities were cross-tabulated with the four most important managerial issues.

**Table 1: Managers' rating of selected managerial issues**

| Managerial issues                                                                                                                                                   | Important/<br>most<br>important | Neither<br>important<br>nor<br>unimportant | Less/<br>least<br>important | Not<br>stated | Total |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|--------------------------------------------|-----------------------------|---------------|-------|
| Occupancy levels<br>(declining or increasing)                                                                                                                       | 39*                             | 5                                          | 1                           | –             | 45    |
| Increased costs of providing care<br>not matched by funding increases<br>(increased costs may be due to<br>increased dependency levels and<br>Consumer Price Index) | 39                              | 6                                          | –                           | –             | 45    |
| Increased demand for higher quality<br>standards not matched by funding increases                                                                                   | 33                              | 11                                         | 1                           | –             | 45    |
| Staffing problems (for example, turnover,<br>short supply, commitment, apathy)                                                                                      | 23                              | 11                                         | 11                          | –             | 45    |
| Resident/patient care issues (for example,<br>fragmented funding, assessment and<br>coordination services)                                                          | 20                              | 17                                         | 8                           | –             | 45    |
| Increasing competition                                                                                                                                              | 18                              | 9                                          | 17                          | 1             | 45    |
| Technical performance (for example,<br>productivity, efficiency, quality)                                                                                           | 31                              | 8                                          | 3                           | 3             | 45    |
| Ageing (tired) physical facilities                                                                                                                                  | 23                              | 8                                          | 13                          | 1             | 45    |
| Increasing difficulty in maintaining the<br>balance between mission and business<br>practices                                                                       | 21                              | 8                                          | 16                          | –             | 45    |

\* Denotes that of 45 respondents, 39 rated this issue as the most important.



Inadequate funding is perceived as a major problem affecting the long-term care industry, in common with the health care industry in New Zealand. Failure to match the increased cost of providing care by funding increases is of constant concern to the industry. Residential Care New Zealand, an association of rest homes, commissioned a study of rest home costing in 1998. That study (Arthur Andersen 1998) estimated that the required price (including Return on Investment) per rest home bed-day care is in the range of \$86.63–\$88.94 (GST-exclusive; all amounts in New Zealand dollars). The Health Funding Authority's current average payment of approximately \$75 (GST-inclusive) per subsidised resident per bed-day care, is far below costs. Fees for rest homes ranged from \$466.41 to \$574.00 per week for subsidised residents and from \$399.98 to \$635.95 per week for private residents. However, the maximum amount that subsidised residents actually pay, regardless of income, is \$636 per week (*The Consumer* 1998). No study could be located that estimated the required price per bed-day for continuing care hospital or Stage III rest home or high-dependency psychogeriatric continuing hospital. However, the present survey, as well as earlier studies (Arthur Andersen 1996; Coopers & Lybrand 1996; Cornell 1998) have all highlighted concern with long-term care funding levels.

Information on whether occupancy levels were declining or increasing was not collected in this survey. Other studies have reported inconsistent findings. Arthur Andersen (1998) found that rest home occupancy rates increased in three regions of New Zealand (North, Midland and South) but declined in the Central region. Residential Care New Zealand's June/July 1998 survey revealed an increase in occupancy rates in all regions except the Midland region while the August/September 1998 survey found a decline in every region.

In the past two years, long-term care facilities have been increasingly required to meet a number of the Health Funding Authority's quality mandates through on-site audits. One estimate suggests that over the past three years the cost of complying with relevant regulations including quality mandates has increased by more than 100%, while in the same period there has been no real increase in government funding per subsidised resident per bed-day. These problems were reflected in the manager's responses in this study, as well as in problems associated with technical performance (such as productivity, efficiency and quality) which point to managers' ongoing challenges to improve the operational performance of the facilities they represent.

## **Managers' rating of the impact of six health care environmental factors on selected managerial issues**

Managers were asked to rate six health care environmental factors: political/regulatory, demographic, technological, social, economic and competitive. Respondents consistently rated political/regulatory, economic and social factors as the most important factors affecting the top four managerial issues identified in the previous section.

This finding is similar to those of other studies. For example, the most frequent problems (in order of importance) for health care managers in Australia and New Zealand were associated with change and uncertainty, financial resource allocation and control, and issues relating to human resource management (Harris, Maddern & Research Associates 1998). The 1998 Lampen Healthstaff Salary Survey carried out in New Zealand reported that the Government maintains a dramatic influence on the health sector, and economic and fiscal policies are the most significant factors driving current health reforms. How environmental factors were impacting on managerial issues, and the need for health services managers to position their organisations in line with the changing factors, were also identified in the United States (Shortell & Kaluzny 1994; Duncan, Ginter & Swayne 1995). Whilst recognising that managers of long-term care will have little control over these external factors, it is important that they understand these factors and trends and position the facilities they manage accordingly.

Sixty-four percent of respondents disagreed that they had difficulty in maintaining the balance between mission and business practices while 36% agreed that there was some difficulty. By relating facility category with the managers' perception on maintaining the balance between mission and business practices, it was found that more religious and welfare facilities (57%) than other categories reported difficulty. Some of the reasons given included:

- inadequate funding
- changing regulations putting more burden on costs
- perception that the board is more concerned about business than mission, and
- decreasing donations and volunteer involvement coupled with low public funding.

Not-for-profit organisations such as those religious and welfare facilities face a particular challenge in retaining their focus on mission while managing a financially viable facility under fierce resource constraints.

An overwhelming number of respondents (87%) agreed that the long-term care facilities have faced a turbulent, confusing and threatening environment over the past five years. This view is well supported by national (Residential Care New Zealand 1998) and international literature (Mitchel 1978; Abramovice 1988; Shortell & Kaluzny 1994; Duncan, Ginter & Swayne 1995). No significant differences of opinion were found by cross-tabulating managers' opinions on turbulent environment with their personal characteristics of title, age, gender and education.

## **Impact of managerial challenges on managers' views of their jobs**

The most common perceived effect of managerial challenges on managers' jobs as rated by the majority of respondents was that managers' positions were becoming more challenging (82%). Other perceived challenges were that more frequent upgrading of management skills is required (77.8%) and networking with other managers in the industry is required (77.8%). A corresponding development reflecting these findings

is that Residential Care New Zealand, which protects the interests of its members, is offering a range of services such as Aged Care Education programs, networking and regular briefing sessions for its members on the latest changes affecting the industry. A strong move toward networking with other managers in the long-term care industry appears contrary to the intended culture of competition of the 1993 health reforms.

With respect to how managers cope with the pressures of their jobs, 64% indicated that they were coping well, 27% were neither coping well nor not coping, and only 6.7% were not able to cope well, while 2% did not respond. These findings suggest that the long-term care managers were managing their facilities reasonably well even in a difficult, turbulent and uncertain environment. No significant differences of opinion were found by cross-tabulating managers' opinions on their ability to cope with personal characteristics of title, age, gender and education.

Eighty percent of respondents reported employing a combination of strategies in response to management challenges: 49% employed a combination of business or strategic planning and regular updates on the changes; and 31% used business or strategic plans, external consultant services and regular updates on the changes. Two-thirds of respondents agreed that further systematically designed education is desirable to help them cope with the challenges. The majority of managers (40%) indicated that financial viability of the facility is the most important factor needed to ensure job security for the next five years.

The findings of the present study are particularly important considering ongoing efforts towards deregulating the industry while developing national consistency of service contracts, quality audits and funding strategies. Along with other nations, New Zealand is observing the United Nations-initiated International Year of Older Persons in 1999. For too long, the long-term care industry has been the 'Cinderella' of the health services. As a new millennium dawns in which older persons comprise a growing proportion of the population, a well-managed long-term care industry is critically important to ensure excellence of care for the elderly in the final years of their lives.

## Conclusion

This study has found that inadequate funding to match the growing costs of providing long-term care services was the key issue considered to be facing the long-term care industry. Managerial challenges were reported by managers to have an impact on their jobs. However, despite the fact that the turbulent health care environment is impacting on day-to-day managerial issues, long-term care managers believed they were coping well and rising to the challenges through networking and taking support from the Long-Term Care Association, which regularly operates industry briefing sessions for its members.

## Glossary

The following terms are those used in New Zealand Government policy and other documents defining services for older New Zealanders.

*Continuing care hospitals:* Provide continuing hospital-type care with 24-hour supervision by registered nursing staff. Patients are frail, more dependent and need full-time care.

*Disability support services:* Services provided to a person with disability, including age-related disability, for their care, or support for their independence.

*Health Funding Authority (previously known as the Transitional Health Authority or Regional Health Authorities):* The government agency that purchases publicly-funded health and disability support services on behalf of the New Zealand population within the boundaries of guidelines set by the Ministry of Health.

*High-dependency psychogeriatric continuing hospitals:* Offer continuing hospital-type care with 24-hour nursing supervision for high-dependency patients with psychiatric and severe dementia-related disorders and whose needs cannot be met in a continuing care hospital or Stage III rest home.

*Home care:* Support services and personal care provided to elderly people in their homes.

*Institutional or sheltered care:* Included models (from less intensive to more intensive) are independent units, apartments, cottage-type units, studios, retirement villages, rest homes and continuing care hospitals.

*Long-term care for older people (also referred to as residential care for the elderly and aged care):* Disability support services for older people are generally required over a long time period. Long-term care services for older people are available in community and institutional settings.

*Older people:* People aged 65 years and over.

*Respite care:* A short period of care of an elderly person whose caregiver needs a break, or who is convalescing after surgery and acute medical conditions. Day care is respite care provided during the day only.

*Rest homes (previously referred to as Stage I and Stage II rest homes):* Provide a low level of care including 24-hour hotel and personal care for those whose age-related needs cannot be met in their homes.

*Stage III rest homes:* Provide a secure rest home for residents with dementia who need to be secure and under greater supervision. Staffing levels are higher and staff should have dementia-related training.

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