Governments are increasingly using a collaborative approach to develop policies in a wide range of fields, yet little is known about the reasons behind such an approach, nor about its impact on the policies developed. Regulation is a policy tool that is increasingly developed using a partnership or collaborative approach. It is possible that governments therefore develop regulatory systems to regain the trust of the electorate, by showing that contentious decisions are taken independently (Jordana and Levi-Faur 2004). Thus, regulation effectively reduces the power of government. However, it is also possible that government still remains in control, behind the scenes, e.g. by limiting the power of regulators and limiting their resources (Thatcher 2005).

In 2005, the Irish government announced its intention to improve the quality of nursing home and regulation, following the broadcast of a documentary showing hidden footage of “systematic” abuse of residents of a private facility, which had been given a clean bill of health by the then regulator. In 2006, a new, independent regulator was established, which set up a 34-member Working Group to develop a set of minimum care standards. The Working Group was made up of many relevant stakeholders from the residential care sector. The development process also involved an extensive public consultation process. Regulations underpinning the Standards were subsequently drawn up by officials within the government’s Department of Health and Children. The first inspections under the new regime began in September 2009.

This paper sets out to develop our understanding about how collaborative approaches to regulation work in practice and also to ascertain what this case reveals about care policies for older people in Ireland. A review of relevant documentation suggests that the (mandatory) regulations developed to underpin the Standards were only loosely based on the Standards document itself. As such, many of the Standards are now simply “guidelines”, which providers are not obliged to meet. While many benefitted from the collaborative approach, the extent to which nursing home residents will remains open to question. Such findings appear to add strength to the idea that governments retain ultimate control of partnership processes and that partnership may not be the most suitable tool for ensuring that the interests of older people living in residential care form a part of the policy-making process.
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Introduction

Partnership approaches to policy-making have become common in many countries and many sectors, at local, national and supra-national level, to the point where consultation and partnership with non-government actors have become the norm in developing government policies and laws. It is seen as a more beneficial approach than more traditional approaches to policy development as it increases the level of expertise available, ensures policies are realistic and gives ordinary citizens and relevant stakeholders more of a say in the policy making process (OECD 2001).

Policy-making through partnership is becoming particularly prevalent in the healthcare sector, largely due to the development of a patient, or person-centred approach to service provision, whereby the patient would share control over decisions affecting their care. Much of the emphasis on partnership and collaboration came about as a result of calls for increased accountability in the healthcare system, arising from mistakes made by healthcare professionals (Green 2007). Giving patients more control over their care would allow them to question poor or questionable practice. Similarly, involving patients in healthcare policy planning would ensure that service provision would become more responsive to the needs of patients throughout the system.

However, ensuring that partnerships are truly equal can be a challenge; it has long been asserted that there is often a naive assumption that the different agendas and vested interests of various actors will dissipate into a consensus and mutually beneficial solution throughout the partnership process (Hunter 1953, Lukes 2005, Mills 1956). This naive assumption can thus lead to a struggle within the process to gain ownership over the process, and whoever is most capable of doing so can have their own hopes realised over those of other actors. Many authors have suggested that this has led to a rise of power of the for-profit sector within the policy-making process (Skelcher 2005). Others, however, have suggested that governments remain firmly in control, as they retain the decision-making role (Thatcher 2005).

Such findings perhaps highlight the ambivalent position which partnerships hold within the policy-making arena. The extent to which ordinary citizens truly hold an equal position within partnerships has long been a subject for debate. This in turn brings into question the purpose and the rationale for the popularity of such partnerships, in spite of the inherent challenges they present. This paper sets out to develop our understanding of the benefits and challenges of policy-making through partnership by exploring the development of new minimum care standards and regulations governing Irish residential care settings for older people. A review of literature on partnership within the policy-making process, the development of regulations and the challenges involved in developing person-centred care for older people is first presented.

Policy Making in Partnership

Policy-making through partnership is becoming increasingly common at local, national and supra-national levels. Partnerships are used to formulate and implement policies in many areas, including employment, social and economic development.

Before assessing the relative strengths and weaknesses of a partnership approach, it is first of all necessary to articulate what is meant by “partnership” in policy-formulation. Partnership has been defined as a coalition of organisations and individuals who agree to work together for a set of compatible aims (Civic Trust 1999). However, this definition does not indicate where the ownership
of power rests. Arnstein (1969) suggested that partnership should be seen the context of citizen participation and citizen power:

> Citizen participation is the redistribution of power that enables the have-not citizens, presently excluded from the political and economic processes, to be deliberately included in the future. It is the strategy by which the have-nots join in determining how information is shared, goals and policies are set, tax resources are allocated, programs are operated, and benefits like contracts and patronage are parceled out. In short, it is the means by which they can induce significant social reform which enables them to share in the benefits of the affluent society.

(Arnstein 1969: 216)

Without a redistribution of power, participation simply becomes an “empty ritual”. For Arstein, partnership is a form of citizen power, though to a lesser extent than delegated power or citizen control. Within a partnership, citizens have greater decision-making clout; they can negotiate and engage in trade-offs within traditional power-holders and also agree to share planning and decision-making responsibilities through such structures as joint policy boards, planning committees and mechanisms for resolving impasses (see Figure 1). Arstein suggests that successful partnerships often from the ground up, rather than from a top-down perspective.

**Figure 1: Eight rungs on the ladder of citizen participation**

<table>
<thead>
<tr>
<th>8</th>
<th>Citizen Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Delegated Power</td>
</tr>
<tr>
<td>6</td>
<td>Partnership</td>
</tr>
<tr>
<td>5</td>
<td>Placation</td>
</tr>
<tr>
<td>4</td>
<td>Consultation</td>
</tr>
<tr>
<td>3</td>
<td>Informing</td>
</tr>
<tr>
<td>2</td>
<td>Therapy</td>
</tr>
<tr>
<td>1</td>
<td>Manipulation</td>
</tr>
</tbody>
</table>

(Arnstein 1969)

Arstein’s ladder implies that a collaborative group should only been seen as a partnership if it successfully manages to share decision-making between the various partners. However, partnership is also understood in other ways, for example, Public-Private Partnerships (PPP), which typically refer to an approach whereby the resources of government are combined with those of private agents (businesses or non-profit bodies) in order to achieve societal goals (Skelcher 2005). Linder and Rosenau suggest that PPPs can give rise to significant ideological choices, including in particular the
relationship between private actors and the state and how they work together in pursuit of societal goals. Skelcher (2005) suggests that, as private actors interests can be simply a business strategy, driven by considerations of competitive advantage, both sides may have different understandings of what represents the common interest. Therefore, the question of the common interest is understood and represented can become distorted:

Values of active citizenship stand in contradistinction to the relocation of services from democratically controlled bureaus into the nether world of quasi-governmental hybrids.

(Skelcher 2005: 364)

Similarly, networks can also form the basis for partnerships. A network, which has become a loaded term within the governance literature (cf Dowding 2001), broadly refers to a group of individuals or organisations linked by a set of social relationships (Scott 2000). Networks are particularly popular in the UK, whereby partnerships between a wide range of participants, from the statutory, private and voluntary sectors are established in order to address the long-term problems confronting modern societies (Hudson 2004). Networks are usually task-focused, rather than structure-fixated, and membership usually reflects the task to be completed. Often, members of networks aim to represent a set of stake-holders, though the emphasis on friendships, personal contact and informality in network style relationships means that ‘insider’ and ‘outsider’ groups can develop (Hudson 2004). Sørensen (2002) suggests that networks reconstitutes the notion of political representation. From being an expression of the political will of the people, through the electoral and other processes of representative democracy, it becomes a terrain contested between a multitude of actors.

Overall, it can be seen that the partnership approach to policy-making, in all its forms, has at its heart the recognition by governments of the importance of lay involvement in the policy-making process (OECD 2001). However, the extent to which the voice of ordinary citizens is heard, and listened to, is unclear, as their views are often not taken into account in subsequent policy decisions (Irvin and Stansbury 2004, Lezaun and Soneryd 2007, Newman, Barnes, Sullivan and Knops 2004). Similarly, PPPs and networks also have limitations in ensuring that the voice of citizens is heard, as both have the potential to become caught up in the vested interests of those around the table, particularly private sector interests (Skelcher 2005). However, as noted earlier, governments retain decision-making powers and so can retain “ownership” over the partnership process (Thatcher 2005). Thus, the extent to which non-governmental actors have real power and can influence decisions remains unclear.

**Partnership in Developing Regulations**

Regulation can be understood as “sustained and focused control exercised by a public agency over activities which are valued by a community” (Selnick 1985). Regulation is commonly seen as remedy for market failure, though “social regulation” is often used to achieve wider social goals. May (2002) describes social regulation as a system aimed at restricting behaviours that directly threaten public health, safety, welfare or well-being. This suggests that regulation is at heart a policy tool which governments use to protect the best interests of citizens and users of both statutory and non-statutory services. This may help to explain why civil society non-governmental organisations are increasingly being consulted in the development of minimum standards and statutory regulations, often as representatives of the public, for whom regulations are designed to protect (Hutter 2006).

While empirical research evaluating the benefits and shortcomings of this ‘partnership’ approach is limited, findings have been largely positive. Both Stern and Holder (1999) and Ayres and Braithwaite
(1992) suggest that the participation of relevant stakeholders in the development of regulations is one of the criteria necessary for developing successful regulations. Freeman and Langbein (2000), who reviewed empirical research on negotiated rulemaking, concluded that it the costs of traditional rule making and negotiated rulemaking differed little, and there was also greater legitimacy and ‘buy-in’ from participants for the latter processes. Selmi (2005) also suggests that this approach, while not a cure-all for the shortcomings of regulation, can help parties with very different interests reach creative solutions to regulatory problems.

However, several critics have questioned whether partnership or collaborative approaches for developing regulations truly benefit the wider public. Jordana and Levi-Faur (2004) suggest that governments increasingly develop regulatory systems as a means of regaining the trust of the electorate; the act of handing over responsibility for emotive and important policy issues to an external regulator, who will keep bad behaviour in check, can help to restore public trust in the government. However, as regulatory systems are difficult to develop, a regulatory system can be captured by any organised interest, including politicians or service providers, who wish to appear trustworthy to the electorate and to consumers (Jordana and Levi-Faur 2004). Viewed from this perspective, it is possible to assume that partnership approaches to the development of regulation are merely rhetorical attempts by the government to gain the trust of the electorate. Indeed, there has been little systematic research assessing the effectiveness of regulations developed using a partnership approach against more traditional forms (Coglianese 2001). Seidenfeld (2000) suggests that claims of collaboration usually fall short of the mark; instead, instead of forming a consensus, participants usually attempt to create strategic advantages vis-a-vis other stakeholders. He argues that regulation developed through collaboration require significant empowerment of public interest groups in the development and enforcement of regulations. Cuellar (2005) found empirical evidence which suggested that regulatory agencies who attempt to involve the public, as well as regulated agencies, in the development of regulations, may not necessarily take the views of the former into account. According to Cuellar, politicians and other stakeholders involved in the development of regulations dislike hearing the voice of the public, as it would make it more difficult for powerful interest groups to influence the regulations in their favour.

Regulating Residential Care for Older People

Statutory regulation is perhaps the most common approach used to improve the quality of care provided in nursing homes. Regulation was introduced in several countries, including the United States (in 1987), Australia (1987), Canada (1990), Hong Kong (1994) and the UK (2001) as a result of an influx of private providers into the industry (Bartlett and Phillips 1996, Bartlett and Phillips 1995, Baum 1999, Braithwaite 2001, Harrington 2001). In many of these countries, governments were motivated to work towards improving the quality of care within the nursing home industry after incidences of abuse or mistreatment were reported in the media (Bartlett and Phillips 1995, Kerrison and Pollock 2001, Nedza 2005).

In many countries, a wide range of stakeholders participated in either the development of regulations, or in the minimum standards underpinning the regulations (Australian Government Department of Health and Ageing 1998, Department of Health 1999, Institute of Medicine 1986). None of these processes have been studied nor have the details on how they operated been documented. In addition, older residents themselves had little opportunity to input their views into the process, in spite of the significant emphasis since the 1980’s on the benefits of a person-centred approach to residential care for older people (Netten 1989, Wilkin and Hughes 1987). Person-centred care refers to the practice whereby older care recipients become involved in planning their own care and exercising choice and control over the services they receive (Eales et al., 2001). This
suggests that excluding older people from the development of regulations may result in a vision for care that does not adhere to the needs (and choices) of older people. Indeed, Kerrison and Pollock (2001) argue that the lack of consumer involvement in regulatory processes within the nursing home sector in the UK may weaken public opinion about the motivations of the regulator.

**Situation the Current Paper**

As outlined above, a partnership approach to both policy-making and the development of regulations has many benefits, but there is little consensus about what constitutes ‘partnership’ or what is the best approach to developing a partnership approach. There are a number of challenges in ensuring that the wider community can truly share planning and decision-making responsibilities. Using an inadequate format (such as a public consultation process) may simply result in the voices of the wider community not being listened to in the resulting policy. In addition, the knowledge base of the wider community may not be adequately developed in order to allow them to properly articulate their wishes. However, perhaps the biggest barrier is when there is a lack of political will from the policy-makers, who may not have the vision or competence to ensure that an equal partnership can develop. This is a particular difficulty when it comes to the development of regulations. Although collaborative approaches to the development of regulation may arguably help to ensure that regulations developed will protect the best interests of consumers, research has shown that this is not always the case. Instead, regulations can at times suit the interests of private interest groups (i.e. service providers).

While the participation of consumers in developing standards has regulations is now commonly used, it is possible that this approach fails to take into account the barriers to the empowerment of older people living in residential care. Older residents are disempowered and disenfranchised not only as a result of communication problems (estimates suggest that between 60% and 80% of residents have some form of cognitive impairment (Cahill, Diaz-Ponce, Coen and Walsh, Magaziner, German, Zimmerman, Hebel, Burton, Gruber-Baldini, May and Kittner 2000)), and physical disability (up to 90% of residents (Falcone and O'Neill 2007)), but also because of widespread assumptions that older residents are not capable of participating in decision-making processes and social policies which prohibit the involvement of older people (Bytheway 1995, Kane and Kane 2001, Townsend 1981).

In spite of all of the challenges facing the principle of policy-making and the development of regulation using a partnership approach, there are very few studies that document how the process works in practice. This paper therefore sets out to address this gap in the literature by studying one example of negotiated regulation, the case of the development of the National Quality Standards for Residential Care Settings for Older People in Ireland (HIQA 2009), and the regulations that underpin them (Government of Ireland 2009). Specifically, the study aimed to examine the extent to which the views of older people living in residential care were taken into account in the development of both the Standards and the regulations, vis-a-vis those of other stakeholders.

**Background**

In July 2009, the Irish government introduced new legislation (Government of Ireland 2009) which provided a new independent inspectorate, the Health and Information Quality Authority (HIQA) with the power to inspect and regulate residential care settings for older people. Prior to this, the system for inspecting and regulating residential care settings for older people in Ireland was weak (Mangan 2003). Public sector facilities were not subject to any inspection, and the inspection of private and voluntary-owned facilities focuses more on the physical environment rather than on the quality of life of residents. While the government had been making plans to reform the regulation prior to this
(Department of Health and Children 2001), the execution of the new system was arguably sped up after a documentary broadcast on a national television station in May 2005, which showed the systemic abuse of residents in a privately-run residential care home for older people caused public outcry.

In January 2006, a small working group, made up of representatives from the Department of Health and Children, the Health Services Executive and other public bodies, was convened to develop a set of minimum quality Standards. The English minimum quality standards (Department of Health 2003) were used as a template for their development. These draft standards were then handed over to a newly-established independent organisation, the Health and Information Quality Authority (HIQA) tasked with inter alia the inspection of the residential care sector. This document was then further developed by a 37-member working group made up of service providers, representatives of advocacy groups for older people, carers and nursing home staff, and government representatives. Upon the completion of a draft set of Standards, a large public consultation process was carried out, in which prospective and current nursing home residents, their relatives and carers, service providers and health and social care professionals, were asked to give their views on this draft set of Standards prior to their finalisation. The final version of the Standards (hereinafter the Standards) “set out what a quality, safe service for an older person living in a residential care setting should be” and strive to ensure that “the holistic needs of the resident take preference” within care homes (HIQA 2009).

Methodology

Study Design: Case Study Approach
The study took the form of a qualitative, revelatory case study (Yin 2003). Yin suggests that a case is ‘revelatory’ when an investigator has an opportunity to observe and analyse a phenomenon previously inaccessible to scientific investigation. It should be distinguished from the rare or unique case, as revelatory cases occur frequently but are simply difficult to study. A qualitative approach was used as this approach locates the researcher in the world they are researching, whereby researchers study things in their natural settings, attempting to make sense of or explain phenomena in terms of the meanings different people bring to them (Denzin and Lincoln 2005). Cassell and Symon (1994) suggest that qualitative methods are more appropriate than quantitative methods to answer research questions that focus on ‘processes’, the aim of the present study, rather than causal phenomena.

The fieldwork was conducted in three discrete (but partly overlapping) phases of data collection:

1. Documentary analysis (a qualitative content analysis supplemented with some quantitative content analysis) of the four drafts of the Standards plus other supporting documentation in order to identify underlying themes in each document;
2. In-depth interviews with all 37 members of the Working Group, including HIQA staff who facilitated group meetings, which aimed to explore both how the Group operated and how decisions were made and also to ascertain their attitudes towards the Standards; and
3. In-depth interviews with other relevant stakeholders of the nursing home sector, who did not participate in the Working Group, in order to understand why they did not participate in the Working Group and also to ascertain their attitudes towards the Standards.

Data were collected between February, 2009 and February 2010. Interviews lasted forty-five minutes on average. All were audio-recorded. All bar three interviews were conducted in the
respondent’s place of work; two were conducted in Trinity College and one respondent was interviewed over the phone (using a device to allow the interview to be audio-recorded.

The majority of interviews were transcribed verbatim on the day of or in the days immediately following the interview in order to allow each interview to inform the rest of the interviews.

Data Analysis
Yin (2003) suggests that case study analysis should be based on the extent to which the data support a particular theoretical propositions. As noted earlier, the study aimed to examine the extent to which the views of older people living in residential care were taken into account in the development of both the Standards and the regulations, vis-a-vis those of other stakeholders. Analysis was conducted in three phases, using tools outlined by Miles and Huberman (1994). The first stage of analysis involved examining the membership of the Working Group to ascertain how older people living in residential care were represented. The second stage involved examining the dynamics of the group in order to ascertain the interests of all stakeholders on the group. The third stage, which consisted in particular of an analysis of the documentary data, examined how the various interests were reflected within both the Standards and the regulations documents. The software program NVivo 8 (QSR International, Doncaster Australia) was used to aid analysis.

Findings

Developing the partnership

As noted previously, a draft of the National Quality Standards for Residential Care Settings for Older People in Ireland was developed by a small group of civil and public servants within the government Department of Health and Children in 2006. In early 2007, these draft standards were then formally referred to the (interim) Health Information and Quality Authority to “further develop, consult on and finalise as the mandatory, meaningful standards against which all residential care settings, both public and private will be inspected by the Authority” (HIQA 2007: 4). According to HIQA, “it is crucial that standards are developed with the involvement, engagement and consultation with users of the service, providers, and other key stakeholders” (HIQA 2007: 4). Ergo, a Working Group representing the key stakeholders in the residential care sector was established in order to ensure “a shared vision across all stakeholders as to what should be contained in the National Quality Standards” (HIQA 2009: 6).

The selection of members by HIQA was broadly developed in accordance with the basic strategy for selecting stakeholders, firstly, ‘brainstorming’, followed by asking those present at the first meeting to identify other relevant stakeholders not already present (Achterkamp and Vos 2007, Varvasovszky and Brugha 2000). As a result, by the end of its work, the group had a total of 37 members. As can be seen in Table 1 below, members represented a wide variety of stakeholders of the residential care sector. A significant number were representing various staff groups working in residential care, while policy-makers and representatives of private sector homes were also heavily-represented. It is important to point out that all of those representing their professions (staff representative groups) were employed by the HSE and many of these worked solely in the HSE. As a result, there were a total of 22 individuals employed by the public sector, compared to just six representing the private sector. However, perhaps more importantly, only three people at the table were there to represent older residents.
The rationale for such a large, inclusive group was to enable HIQA to get “buy-in” from all sides and to ensure that all relevant stakeholders would have a chance to input their own opinions and object to radical/impractical suggestions. This was in contrast to the earlier draft developed by the Department of Health and Children, which had resisted calls for wider consultation. Although all members recognised the purpose of having such an inclusive group, many were critical of the group’s size and makeup. Some suggested that it may have been more appropriate to have a smaller core group made up of essential stakeholders, coupled with consultation with other stakeholders on specific issues (such as with staff representative bodies, who were seen by many members of the

Table 1: Membership of the Working Group on the National Quality Standards for Residential Care Settings for Older People

<table>
<thead>
<tr>
<th>Stakeholder Groups</th>
<th>N</th>
<th>Organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIQA Staff</td>
<td>4</td>
<td>Health Information and Quality Authority</td>
</tr>
<tr>
<td>Regulatory Body for Nurses</td>
<td>1</td>
<td>An Bord Altranais</td>
</tr>
<tr>
<td>Residents Representative Groups</td>
<td>3</td>
<td>Age Action Ireland</td>
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<tr>
<td></td>
<td></td>
<td>Alzheimer Society of Ireland</td>
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<tr>
<td></td>
<td></td>
<td>Hospice Friendly Hospitals Programme</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Irish Senior Citizen’s Parliament</td>
</tr>
<tr>
<td>Relatives Representative Groups</td>
<td>1</td>
<td>Caring for Carers Ireland</td>
</tr>
<tr>
<td>Staff Representative Groups</td>
<td>8</td>
<td>Association of Occupational Therapists of Ireland</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Irish Association of Social Workers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Irish Association of Speech and Language Therapists</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Irish College of General Practitioners</td>
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<tr>
<td></td>
<td></td>
<td>Irish Society of Chartered Physiotherapans</td>
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<tr>
<td></td>
<td></td>
<td>Irish Society of Physicians in Geriatric Medicine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychiatry of Old Age Services (X2)</td>
</tr>
<tr>
<td>Private Nursing Home Providers</td>
<td>6</td>
<td>Federation of Irish Nursing Homes (X2)</td>
</tr>
<tr>
<td>Advocacy/Representative Groups</td>
<td></td>
<td>Nursing Homes Nursing Projects (X2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Irish Nursing Homes Organisation (X2)</td>
</tr>
<tr>
<td>Public Nursing Home Providers</td>
<td>2</td>
<td>HSE Directors of Nursing/Administrator (X2)</td>
</tr>
<tr>
<td>HSE Policy Staff</td>
<td>7</td>
<td>Elder Abuse National Implementation Group</td>
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<tr>
<td></td>
<td></td>
<td>Assistant National Director for Older People</td>
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<tr>
<td></td>
<td></td>
<td>Senior Environmental Health Officer</td>
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<td></td>
<td></td>
<td>Assistant National Director of Estates</td>
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<td></td>
<td></td>
<td>National Planning Specialist for Older People</td>
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<tr>
<td></td>
<td></td>
<td>Director of Nursing Research and Development</td>
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<td></td>
<td></td>
<td>Health Service Executive, Senior Administrator</td>
</tr>
<tr>
<td>Government</td>
<td>2</td>
<td>Department of Health and Children (x 2)</td>
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<tr>
<td>Government Advisory body Representatives</td>
<td>2</td>
<td>Dementia Services Information and Development Centre, St James Hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Council on Ageing and Older People</td>
</tr>
<tr>
<td>Additional</td>
<td>1</td>
<td>Hospice Friendly Hospitals Programme</td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td></td>
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</table>
group as not playing a central role in the development of the Standards). It was also suggested that there was significant over-representation from the private sector, largely because private sector members did not adhere to the rules of membership:

There was a couple of occasions where people arrived in and you’re going “hey, where did they come from? They’re not supposed to be here” and they were influencing decisions, so where it was supposed to be an equal balance of public sector and private sector, there was times when it wasn’t like that and it would cause huge consternation over a particular standard. I know after one meeting where something just got torn apart by the private sector, I actually raised the question to say “we took a vote in there but there was people in there that shouldn’t have been in the room” and what they had said was that “we came because such and such is going to be missing three meetings so we are going to be taking over and we want to get a sense of what’s happening” and all of a sudden they became permanent members of the group and the balance of the group shifted.

(Member of the Working Group, public sector)

It later appeared that this process of self-selection was allowed to develop largely because official rules around membership were not set down at any point. For their part, private sector representatives suggested that they had invited new members onto the group in order to redress the imbalance of power. This suggestion suggests that there perhaps remained a lack of trust between members, in spite of the efforts made by HIQA to create a sense of openness, collaboration and partnership.

There were no trade unions present on the group, in spite of the importance of the social partnership process in Ireland. This perhaps highlights the difficulties of trying to ensure inclusivity when there are no rules or parameters for inclusion, particularly in a sector with many stakeholders and interest groups. However, as Barnes et al. (2003) have previously noted, those with extreme or radical views are often excluded from the partnership process. It is also clear that many members were also cognisant of the benefits of being a member of the group, including the ability to get important information before others. Others also suggested that being on the group gave them an advantage in terms of having gained useful knowledge and information about what was discussed at group meetings, and also in developing new contacts in other members of the group. It is possible that the advantageous position such individuals held may have in turn prevented them from giving a similar advantage to other potential members of the group.

These findings suggest that, in spite of the best efforts of HIQA, developing an open, transparent process, where there was trust between members and in the process, was a difficult task. This lack of trust is commonly found in instances of collaborative policy-making, where different stakeholders have competing vested interests (Hudson 2004, Sørensen 2002). The competing vested interests of the Working Group, and how these differences manifested themselves within the Working Group are discussed below.

**Dynamics of the group**

A significant number of respondents suggested that the size and diverse membership of the group detracted from the process, as it made the meetings somewhat impersonal and impractical, as it was not always possible to see and hear all other members of the group. In spite of this, the vast majority felt that it had been a successful process, given that the Standards were of a high quality and were
likely to improve the care of older people when implemented. Most praised the work of the HIQA staff involved in the process, suggesting that this was the crucial factor in bringing about this success. It was felt that the actions of HIQA staff helped to foster meetings which were respectful and inclusive in nature, and helped to ensure consensus over most issues, which in turn helped everyone to participate fully and continue to work hard to ensure that the Standards would be effective.

Many also felt that the process had been useful as it had enabled them to hear other people’s points of view and together decide on wording for a particular standard that was realistic, but would also help to improve care for older people living in residential care. It appeared that there was general consensus on the vast majority of standards, particularly around quality of life (“who wouldn’t agree with it?”). However, conflict had developed in relation to standards that would result in a significant financial cost being incurred. This appeared to arise largely due to concerns by private sector providers that they would have to spend significant amounts of money meeting new standards which exceeded the existing requirements:

> Their fear is that they are not going to get a return on their capital investment, which is a genuine fear. They are very concerned about the HIQA standards, how they are going to leave the, and the physical environment standards, how they are going to leave them. Whether it will be cost-effective, or whether they will have to close their nursing homes.

(Member of the Working Group, private sector)

By contrast, many public providers wanted to ensure that the standards were sufficiently high in order to be able to lobby the government for new facilities to replace their existing, out-dated homes, some of which had been built in the 1840’s and were unsuitable for the needs of their residents.

All respondents were passionate about particular aspects of residential care for older people and made significant efforts to influence the content of the Standards. Citing empirical evidence of best practice, emotive persuasion, relying on allies and emailing HIQA staff between meetings were some of the tactics employed to be heard and influence the process. However, it appeared that some may have been more successful than others in influencing the process. Many highlighted changes which they suggested they had negotiated in the Standards, although subsequent analysis of the drafts appeared to show no change. However, representatives from the private sector had a strategic, planned-out strategy to try to influence the process:

> It would have become far too expensive for us to build a new nursing home on the regs that these lads were suggesting. They were looking for room sizes of 18, 19, 20 square metres, which didn’t bare any resemblance to international best practice. Like, we had all the figures from Scotland, Wales, all over the world, in front of us and the HSE Estates were there... “we want this, and that and everything else” and everybody knows that it costs the HSE twice what it costs the private nursing homes to build... there was a case to be made that existing homes, be grandfathered, I suppose, for want of a better word. And to allow us to do that, we went into battle quite hard.

*Ciara:* And how would you have managed if you were going into meetings and knowing that this was going to happen, how did you prepare?

> It almost turned into a kind of filibustering. We were almost talking down the clock. It got to that stage, where you just kept talking and arguing and arguing, so as at the next meeting, maybe the guy who was arguing against you wouldn’t be there and you
would be able to knock it on the head. You know what I mean by filibustering? We just kept talking and talking, in the hope that we would wear everybody out!

Ciara: And did it work?

Andy: It did I suppose, yeah. We wore a lot of people out.... we reached consensus on that issue pretty quickly.

(Member of the Working Group, private sector)

This finding further highlights the importance of the membership of the group, as those with more to lose were ultimately pitted against those who were not directly involved in delivering and funding residential care and therefore may not have had the same vested interests in influencing the Standards.

However, findings from the interviews suggested that ownership of the group (and of the Standards) was not as clear-cut as had been initially thought. In one of the meetings, staff from HIQA informed members that the group was an advisory group, and HIQA could choose to reject this advice, as it was the body responsible for standards development by law. Reactions to this hinged upon members own vested interests. The majority of respondents, particularly those who worked in the public sector, accepted that consensus was not possible in all cases, and were happy to see HIQA making decisions in the best interests of residents, again most likely as a result of the lack of responsibility all of the public sector representatives had for sourcing funding for meeting the Standards. The only criticism came from the private sector representatives, who argued that HIQA was working to its own agenda without taking on board the comments from members of the Working Group:

I suppose one of the frustrations I suppose to be honest is that when things reached the end matters, there was an issue where there wasn’t unanimity about an agreement that was parked, and it was parked and then HIQA made the call. And that happened very, very rarely to be fair, but I know there was some instances when it went back to HIQA and I suppose they had to make a call at some stage, but... It was democracy, but it was democracy on occasions on someone else’s terms.

(Member of the Working Group, private sector)

According to HIQA, it was necessary to make decisions in the best interests of residents, particularly given their under-representation within the group. While there were a number of individuals from advocacy groups for older people participating in the process, their personal and professional knowledge on the news of older people living in residential care was limited, as the primary focus of these organisations was on supporting older people in the community:

And of course from our point of view, concerned about all older people, we are talking about 4.8% of the older population. And now we think they are very important but they may, and I can’t remember the study, there was a UK based study that said there was a 20% mismatch between placement of need right across the board, so there are sicker people in the community than in residential care and there are people who aren’t as sick in residential care than some in the community. I suppose that would be eh... I suppose not being responsible for managing residential care, ours might be a somewhat abstract view of what might be going on, and so I was very keen to listen to the providers of residential care about the detail and there was a lot of detail, like about drug management, safety issues and so on and that was very interesting and informative.

(Member of the Working Group, advocacy group for older people)
Many other members also suggested that the representatives from the advocacy groups contributed little to the process, and seemed to understand little about what older people might want from residential care. This is highly suggestive of a partnership process that did not include what was arguably the most important partner, older residents themselves. Including older residents in decision-making processes is widely considered to be problematic (Abbott, Fisk and Forward 2000, Barnes 2005, Mitchell and Koch 1997).

*Cui Bono? Who influenced the process?*

An analysis of the various drafts of the Standards document suggests that private providers’ strategy of filibustering and arguing helped them to reduce the amount of money they would have to spend on meeting new, higher standards. Firstly, the private providers “won” the battle to “grandfather” to allow the existing rules to apply to pre-existing homes. As can be seen in Table 2 below, the second draft (i.e. after the Working Group’s input) clearly demarcated between standards for pre-existing homes and new-builds. In addition, the Department’s draft stated that no more than 20% of accommodation for residents would be provided in double bedrooms, with the remaining 80% provided in single rooms. However, in the Working Group’s revised version, this had been reduced to just 60% of all single rooms for any home built after the introduction of the Standards, with no requirements on the proportion of single rooms for pre-existing homes. Requirements on the floor space available in bedrooms, bathrooms and other areas were also reduced in the second draft (i.e. after the Working Group’s input).

Table 2: *Examples of Changes to specific criteria between Drafts of the Standards*

<table>
<thead>
<tr>
<th>Original Draft (drawn up by the Department of Health and Children)</th>
<th>HIQA’s first Draft (with inputs from the Working Group)</th>
<th>HIQA’s Second Draft (following public consultation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little demarcation between standards for pre-existing homes and new-builds</td>
<td>Formal demarcation between standards for pre-existing homes and new-builds</td>
<td>Formal demarcation between standards for pre-existing homes and new-builds</td>
</tr>
<tr>
<td>Minimum of 80% of residents in single rooms</td>
<td>A minimum of 60% of residents in single rooms for newly-built homes; for pre-existing homes, no more than 4 residents per room except in high-dependency units (up to 6 residents) within 5 years.</td>
<td>A minimum of 80% of residents in single rooms for newly-built homes; no more than 2 per room except in high-dependency units (up to 6 residents) within 6 years.</td>
</tr>
<tr>
<td>1 assisted bath for every 7 residents</td>
<td>1 assisted bath to every 11 residents (pre-existing homes); 1:8 (new-builds)</td>
<td>1 assisted bath to every 11 residents (pre-existing homes); 1:8 (new-builds)</td>
</tr>
<tr>
<td>13m² usable floor space in single bedrooms</td>
<td>9m² (pre-existing); 12.5m² (new-builds)</td>
<td>9.3m² (pre-existing); 12.5m² (new-builds)</td>
</tr>
</tbody>
</table>

Table 2 also shows that most of these standards were retained following the public consultation process carried out by HIQA after the first draft had been published, after which HIQA decided to reinstate the initial requirement to have a minimum of 80% of residents in single rooms in new-builds. While this would not have impacted directly on private providers present at the meetings, it is possible that the requirements to have no more than two residents per room may have, given that the existing regulations did not have any requirements with regard to single rooms ratios (Government of Ireland 1993). It is also important to point out that HIQA made the decision to make the proportion of single rooms higher in spite of evidence from the public consultation process that
current residents of care homes prefer sharing rooms (Health Care Informed 2007). According to interviews with HIQA staff, this decision was made on the basis that, once built, it would be difficult to change the physical structure of care homes. As a result, they wanted to make sure that the physical environment of care homes would meet the needs of residents long into the future.

However, it appears that HIQA may have itself been ‘trumped’ by the Department of Health and Children, as the legislation underpinning the Standards (the 2009 Care and Welfare Regulations) contained significant differences with regard to the physical environment standards inter alia. While the regulations do allow HIQA to determine the maximum number of residents to be accommodated in shared rooms, something which is likely to cost the government a significant amount of money, there is no reference to differences between pre-existing and new homes in relation to the physical environment. Nor do the regulations specify room sizes or ratios; the regulations require a “sufficient” number of toilets, baths and showers, and state that “the size and layout of rooms occupied or used by residents are suitable for their needs” (Government of Ireland 2009).

These regulations may give HIQA the discretion to define “sufficient”, thought it appears that the wording chosen by the Department has given leeway to private providers to oppose requests from HIQA to engage in costly refurbishments. However, it is important to note that the government probably did not write the Standards to suit the needs of the private providers but rather to suit itself. Although staff from the Department of Health and Children sat on HIQA’s Working Group and were thus aware of what was proposed, it is possible that the demise of the Celtic Tiger may have changed the position of the government to invest significant amounts of money into its own residential care settings. Following the publication of the final version of the Standards by HIQA in March 2008, the Department of Health and Children commissioned a costs assessment of the Standards, which suggested that there would be significant costs involved in public sector compliance with the Standards (approximately €1.2bn) (PA Consulting 2009). Thus, while it has been suggested that governments remain can be captured by various interests (Jordana and Levi-Faur 2004), this case perhaps highlights the ambivalent position of governments within a partnership process. However, it is the ability of the government to create these rules which did not take on board the agreements made by the Working Group with so little criticism that is perhaps the most interesting finding in this case. It appears that the government’s awareness that taking part in a partnership process is more important for some than the decisions reached; this knowledge suggests that governments may be willing to engage in partnership because it is aware it allows it to meet its own interests, the restoration of the trust of the electorate with the retention of the status quo.

Discussion

This case highlights some interesting points about the purpose and functions of partnerships. Much of the focus of the partnership process is on the extent to which all stakeholders are involved and have ownership over the process (Arnstein 1969, Rhodes 2007, Sørensen 2002). It is often assumed that a partnership process without shared ownership and decision-making rights is simply an empty ritual (Arnstein 1969). However, this view assumes that citizens share one common interest, which diverges from the interests of the powerful, who control the political and economic system. This study suggested that members of the Working Group each had their own interests, which did not necessarily mirror those of older people living in residential care. Thus, there can be a wide variety of stakeholders within a partnership process, who often have different and competing interests, rather than one common interest (Skelcher 2005). This suggests that a partnership can become a power-broking process between the strongest vested interests (Sørensen 2002).
This finding suggests that the membership of partnership groups is important. Without adequate representation of the voice of the powerless, their interests may be ignored by more powerful groups. The fact that there is currently no advocacy group in Ireland with the resources and skills to represent the interests of older people living in residential care is perhaps not particularly surprising, as this group is often under-represented within decision-making processes, even where significant effort has been made by policy-makers to do so (Barnes 2005, Gibson, Turrell and Jenkins 1993). Indeed, as noted earlier, the voices of ordinary citizens are not always taken into account in policy decisions (Newman, Barnes, Sullivan and Knops 2004).

It was the absence of the voice of older people which forced HIQA to compromise its approach to the partnership process. Instead of focusing on achieving consensus, it began to veto suggestions made within the group and take responsibility for making decisions in the best interests of residents, rather than any of the other stakeholders represented on the group. The fact that this change in the terms of reference of the group was accepted by members can be explained by their recognition of the need to improve standards for older people. However, it can also be explained by suggesting that, for many, the act of participating, of being heard, of being given an opportunity to meet others and develop useful new contacts was more important than influencing the decisions reached. This was particularly the case for those who were not directly involved in the provision of residential care. This possibility strikes a chord with Lukes’ (2005) understanding of power; the selection of the members of the Working Group implied that each individual had something more to contribute than those not asked to participate. Therefore, being a part of the process was enough, apart from the private providers, who stood to lose significant amounts of money unless they were in a position to influence the process. Thus, the determined (and successful) strategy to ensure existing homes (i.e. members own nursing homes) would not be significantly affected is not surprising.

The subsequent actions of the government in failing to take on board many of the recommendations of the Working Group in drawing up the regulations underpinning the Standards gives support to the argument that governments do retain control over partnership processes and may suggest that partnerships are simply another tool to suit governments. The rhetoric of partnerships can help to restore trust in governments while limiting the impact of unwelcome, costly changes in the services it provides (Jordana and Levi-Faur 2004). In short, the government benefited from the process by regaining the trust of the electorate in setting up what is widely deemed to be a robust inspection system for residential care for older people; HIQA benefitted from developing Standards through consultation; and members of the Working Group benefitted from having been part of the process. The extent to which the process benefitted older people living in residential care, whose views were largely not taken into account and who are unlikely to see existing unsuitable accommodation being replaced, remains to be seen. Although the impact of the new regulatory system on the quality of residential care for older people is outside the remit of this paper, it is perhaps possible to conclude that partnership may not be the most suitable tool for ensuring that the interests of older people living in residential care form a part of the policy-making process.
References


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