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Governing for quality and safety: A new province for boards of Australian aged care and disability support providers?

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Abstract

The Australian Royal Commissions on aged care quality and safety, and on violence, abuse, neglect and exploitation of people with disability, have raised important questions about the degree to which boards of directors of aged care and disability support providers are assuring that the organisations they govern are providing quality and safe services. This article addresses the question of to what extent changes in legislation and regulatory standards in aged care and disability create new expectations of these boards and directors. Although directors have long been held to have a duty of care and diligence, and to have responsibility for determining and monitoring an organisation's services, these expectations have been elevated to a new level in relation to quality and safety.

KEYWORDS

aged care, board of directors, disability support, quality, safety

1 | INTRODUCTION

There are unacceptable rates of preventable death and harm in social care. The Chair of the Royal Commission into Aged Care Quality and Safety (2021: 7) wrote in its final report that "the extent of substandard care in the current aged care system is unacceptable, deeply

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concerning and has been known for many years". In its Interim Report, the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2021) documented by both statistics and case studies relevant evidence and identified emerging themes from its work including violation of human rights, limits on choice and control, unacceptable attitudes, and segregation and exclusion. Both reports suggest systemic neglect at both government and provider levels.

The Royal Commissions were established in a context of successive reports of inquiries and successive media reports of abuse or neglect of the elderly and of people with disability. In the case of aged care, this included the Oakden scandal (Carnell & Paterson, 2017; Independent Commissioner Against Corruption, 2018) and media exposés on residential aged care (4 Corners, 2018a, 2018b). In the case of disability supports, this included the reports of inquiries of Commonwealth and State Parliaments (Parliament of Victoria Family and Community Development Committee, 2016; The Senate Community Affairs References Committee, 2015) and adverse media reports (4 Corners, 2014, 2017).

Many factors are involved in assuring quality and safe social care, including government policy and funding, the specific and broader support systems, community attitudes, and provider practice. Provider practice can be further categorised into actual practice in service delivery, and supporting mechanisms such as the philosophical orientation and service model of the provider, the availability and selection of staff with appropriate values and skills, the training and development of staff, and the management and governance of the provider. In relation to the latter, both Royal Commissions believe that boards of providers and their directors are potentially part of the problem or part of the solution. The Royal Commission into Aged Care Quality and Safety (2021: 51) considered provider governance "extensively" and recommended "the need for boards and executives to act responsibly and appropriately; to lead their services with the interests of older people at heart; and to be more open and transparent about the quality performance of their services". Although the Disability Royal Commission is still conducting hearings and thus yet to publish its final report, the report on Public Hearing 13 on one provider's group home operations made several findings in relation to board-level governance. Royal Commission into Violence Abuse Neglect and Exploitation of People with Disability (2022: 131) focused on the issue of the lack of inclusion of people with disability as directors, asserting that this "contributed to the Board not being fully informed about the challenges … faced in ensuring the safety, support and wellbeing of residents in … disability residential accommodation". In passing, it should be noted that this analysis is arguably incomplete, ignoring evidence that inclusion of itself does not guarantee quality and safety (Charity Commission for England and Wales, 2020). Further, the Royal Commission found that directors of disability service providers "should inform themselves of conditions at residential disability accommodation and the experiences, needs and concerns of residents and other clients by meeting with them and their families and supporters" on a systematic basis (Royal Commission into Violence Abuse Neglect and Exploitation of People with Disability, 2022: 135).

While changes in the legislation and standards on organisational and board governance in the aged care and disability sectors in some cases pre-date these findings, in the case of aged care they are sometimes in direct response to the findings of the relevant Royal Commission. As will be demonstrated, the changes establish both organisational and board responsibilities for the achievement of quality and safeguarding as well as personal responsibilities of directors.

The findings of the aged care and disability Royal Commissions about board involvement in client issues are consistent with the findings of other commissions of inquiry, both in Australia and abroad (Francis, 2013; Royal Commission into Misconduct in the Banking Superannuation and Financial Services Industry, 2019; The Bristol Royal Infirmary Inquiry, 2001). Across the various Inquiries, there have been three overlapping arguments for board involvement in quality and safety. First, apart from members or shareholders in general meeting, the board is the

ultimate group responsible for an organisation and its responsibility extends to all aspects of the organisation including the services provided (Francis, 2013; Royal Commission into Aged Care Quality and Safety, 2021). Second, boards can provide a valuable "check and balance" on management and service delivery (The Bristol Royal Infirmary Inquiry, 2001). Third, implied but not necessarily made explicit by the Inquiries, board attention to quality and safety can create a cascading effect of attention at lower organisational levels (Lornudd et al., 2021).

The practical and policy challenge is how to ensure that organisations pursue and deliver quality and safe services. After all, corporations have "No soul to damn, no body to kick", to use the words of the Lord Chancellor of England from the eighteenth century (Coffee, 1981). The new legislation for aged care and disability supports in some ways lifts "the corporate veil", i.e., the notion that the corporation (where the provider is a corporation) has legal personhood and only the company has liability for the action of its agents – and not the company's individual directors. Considerable legislative, regulatory and academic attention has been given to how to make the people leading an organisation responsible for the failures of the corporate body (e.g., Coffee, 1981).

This article addresses the following research question: To what extent have legislation and regulatory standards created new expectations of boards of directors of Australian aged care and disability service providers about governing for quality and safety? To clarify the terms used in this article, the term "safety" is commonly used in aged care in Australia, e.g., in the name of the Aged Care Quality and Safety Commission. However, in Australian disability support, the term "safeguard" is more commonly used, e.g., in the name of the NDIS Quality and Safeguards Commission. For the purposes of this article, the two terms should be regarded as synonymous and are used interchangeably.

The article proceeds by examining the general legal and normative expectations of boards and directors. It then considers the existing theoretical and empirical literature on board responsibility for quality and safety. After explaining the research method, the relevant legislation is analysed. Finally, the implications of this new emphasis on board responsibility for quality and safeguarding are discussed.

2 | LEGAL AND NORMATIVE EXPECTATIONS OF BOARDS AND DIRECTORS

Providers can have a variety of legal forms, such as companies under the *Corporations Act 2001* (Cth), associations incorporated under the legislation of each State and Territory, Commonwealth legislation for Aboriginal and Torres Strait Islander bodies, and special legislation of the States (Lyons, 2001). Disability service providers can also be partnerships or sole traders. In the case of providers which are charities, the legal requirements are modified by the *Australian Charities and Not-for-profits Commission Act 2012* and associated Regulations and the ACNC Governance Standards. For simplicity, the Corporations Act—a common legal form among larger providers—will be examined.

In the English-speaking countries, both general law and corporate legislation tend to describe the role of boards and the duties of directors in general terms (Brody, 2007). In Australia, obligations and duties are imposed on directors and company officers from several sources, including the common law, equity, statute, the company's constitution, and contract (e.g., employment contracts in the case of managing directors). In equity, directors owe fiduciary duties to their company. Under both common law and equity, directors owe a duty to the company to exercise care and diligence in performing their functions.

In the case of companies, the common law duties are supplemented by statute, principally Part 2D.1 of the Corporations Act. The Act simply states that "The business of a company is to be managed by or under the direction of the directors" (s. 198A, a "replaceable rule"). The

duties of directors are described in broad terms, such as a duty of care and diligence (s. 180). It has been left to case law to describe what the director duty of care and diligence entails, and even here the statements tend to be generalised and limited, with responsibilities of: being familiar with the fundamentals of the business; keeping informed about activities; regularly attending meetings and otherwise generally monitoring the work of the organisation and its policies; and, being familiar with the financial status of the corporation: *ASIC v Adler & Others* ([2002] NSWSC 171 at para 372(8)).

State and Federal statutes - such as those for workplace health and safety, environmental protection and taxation cut through the corporate veil, making those who control companies liable for defaults by the organisation, subject to a defence for directors and officers that they took appropriate action to prevent and mitigate the risks of the specific mischief covered by the legislation. In most Australian States and Territories (Victoria being the exception), work health and safety legislation gives a moderate degree of guidance to directors and executives about how to exercise their due diligence obligations (Safe Work Australia, 2019, s. 27). This legislation applies to anyone in the workplace: people using services as well as the workers providing them. These obligations are nuanced (e.g., volunteer directors have the duty but not the associated liability), have their own case law and are worthy of an article in their own right; they will not be further discussed here.

Many providers of human services are not-for-profit organisations and it might be expected, on the basis of relevant theory (e.g., Hansmann, 1980) and on the research evidence to some extent (Anheier, 2014) that not-for-profit providers give higher priority to the welfare of the people they support than do for-profit providers. However, even in normative prescriptions of how boards of not-for-profit organisations should work, responsibilities for the quality and safety of services appear to be deprioritised. For example, in Ingram's (1996) classic statement of ten not-for-profit board responsibilities, issues such as selecting the CEO, supporting and evaluating the CEO, and being involved in organisational planning are all listed before the general statement of responsibility to monitor and strengthen programs and services. How to monitor the quality and safety of supports provided in human service organisations receives little attention even in later editions (Ingram, 2015). A rare exception to this trend is the article by Gibelman and Gelman (1999) which focuses on the role of boards in risk management but even these authors largely frame the issues as risks to the organisation rather than taking a person-centred approach. As will be seen, exhortations for boards to govern more and manage less (Carver, 2006; Trower, 2010) have sometimes resulted in perceptions that the quality and safety of services are largely operational issues best left to management and should not receive much attention from boards.

3 | EXISTING LITERATURE

Increased expectations of board involvement in quality and safety align (or, more accurately, partially align) with two existing theories about governance. The expectations can in part be understood as being based in agency theory (Eisenhardt, 1989; Fama & Jensen, 1983; Jensen & Meckling, 1976), with two variations of the "agency problem" of how a principal can ensure that their agent is acting in the principal's best interests assuming goal conflict and information asymmetry. There can be many permutations of arrangements, depending on the degree of information asymmetry and goal conflict (Waterman & Meier, 1998). Two aspects of the agency problem might arise. First, where government is the ultimate funder, there is the agency problem between the government as de-facto funder and actual standard setter, and the provider as the de-facto agent or supplier. The board can monitor quality and safety compliance, in some senses as an agent of government. Second, there is the agency problem between the organisation's members/shareholders and CEO, with the

board being the representative of the corporation's members or shareholders and the CEO being the agent.[1]

A key role for the board in agency theory is monitoring. However, Jensen and Meckling (1976: 354) acknowledged that they had "little which could be glorified by the title of a 'Theory of Monitoring' and yet this is a crucial building block of the analysis". More than 40 years later, while there have been contributions around the edges (e.g., Seo, 2017), a generalised theory of monitoring remains to be developed. Of course, failures in quality and safety are not mere "agency problems": for the people being supported they can sometimes have serious and even fatal consequences.

The trend of increased expectations of board involvement in quality and safety can also be understood as consistent with stakeholder theory (Evan & Freeman, 1993; Freeman, 1984) where boards must ensure that their organisation is responsible to the range of organisational stakeholders, including government and clients. Stakeholder theory also suggests boards should report regularly to stakeholders on matters relevant to the stakeholder groups. In this regard, Hill and Jones (1992) stress the importance of monitoring devices to reduce information imbalances among stakeholders. The calls in quality standards for service users to be included in governance-level quality and safety processes are consistent with stakeholder theory.

However, neither stakeholder nor agency theory guide *how* boards should discharge their responsibilities for the quality and safety of services. This void is filled by subordinate legislation, i.e., lower-level legislation made under the authority of an Act (to a limited extent), or standards. Although not the focus of this article, it is noteworthy that the new International Standard 37000 on organisational governance suggests a range of practical approaches to embed stakeholder perspectives (International Standards Organization, 2021).

Moving now to the research-based literature, at this stage, there appears to be no empirical evidence about boards and their impacts on quality and safety in aged care[2] or disability support. However, in another human services sector, namely the hospital and health care sector, there is a significant empirical literature on board impact, confirming that there can be small but positive associations between what boards do and quality and safety outcomes (Brown, 2020) (see reviews by: DeRegge & Eeckloo, 2020; Erwin et al., 2019; Millar et al., 2013). For example, the study of Jiang et al. (2009) demonstrated associations between the board oversight of quality on the one hand and process of care measures and risk-adjusted measures of mortality on the other, including in the former: the board receiving data on clinical quality, patient safety and patient satisfaction; the board receiving such data with national benchmark comparisons; having a specific item on quality on the board meeting agenda; CEO and executive performance evaluation including relevant measures; having strategic goals for quality improvement; board involvement in setting the organisation's quality agenda; and, having a single board committee focused exclusively on quality. In some ways, developments in aged care and disability support might be considered as catching-up with developments in the practice of governance in health care; in other ways, they are unique in that health care legislation does not provide individual legal liability for directors (e.g., the *National Health Reform Act 2011* (Cth) and the *Health Services Act 1988* (Vic) do not create individual responsibilities or liabilities for directors). A detailed consideration of what can be learnt from health care (beyond what is stated above) is outside the scope of a short article of this nature.

Also relevant is a small, but improving, research base on board impact on work health and safety (Ebbevi et al., 2021; Lornudd et al., 2020, 2021). That body of research has begun to identify how boards influence organisational performance in that arena. Some of the mechanisms are: board-level attention, which then instigates attention at lower organisational levels (Lornudd et al., 2021); director training in work health and safety, including assessment of director competency; director site inspections; and, the promotion of a safety culture (Ebbevi et al., 2021).

4 | METHOD

The authors reviewed the relevant federal legislation for aged care and disability supports before and after reforms (as at July 2022), including the Acts, Regulations and other formal instruments, which are variously titled Determinations, Guidelines, Principles and Rules. These are listed in Table 1. For completeness, there is also passing reference to some State-level legislation. Our analysis was by the historical comparative method (Hutchinson, 2018). As the name implies, this method involves comparing the provisions of the legislation at different points of time and identifying points of similarity or difference. This allows the identification of changes in key concepts and principles.

In the case of this article, there is also a comparison between the legislation relevant to quality and safety in aged care and that in disability support. The aim of such comparison is to discern themes: in this case, the analysis demonstrated that across time there have been markedly increased expectations of boards and, to some extent, convergence in expectations across sectors.

5 | DATA AND ANALYSIS

First, the old and new requirements for board involvement in quality and safety in aged care will be compared. Second, a similar comparison will be made for disability supports.

The *Aged Care Act 1997* (s. 2–1) seeks, among other things, to promote a high quality of care to clients and to protect their health and well-being. Responsibilities of approved providers include providing quality care and services and to comply with standards (s. 54–1). The Minister can establish standards under a legislative instrument known as "Quality of Care Principles" (s. 96–1 of the Act; *Quality of Care Principles 2014*). The old standards (those which applied before July 2019) were in two parts: "Accreditation Standards" for residential aged care, and "the Home Care Common Standards" for home and flexible care (Quality of Care Principles 2014, compilation date 1 May 2018, F2018C00294). The Accreditation Standards for residential aged

TABLE 1 Legislation analysed

All legislation is that of the Commonwealth Parliament.
Acts
Aged Care Act 1997
Disability Services Act 1986
National Disability Insurance Scheme Act 2013
National Disability Insurance Scheme Amendment (Quality and Safeguards Commission and Other Measures) Act 2017
National Disability Insurance Scheme Amendment (Improving Supports for At Risk Participants) Act 2021
Other instruments
Disability Services Act (National Standards for Disability Services) Determination 2014
National Disability Insurance Scheme (Code of Conduct) Rules 2018
National Disability Insurance Scheme (Quality Indicators for NDIS Practice Standards) Guidelines 2018
Quality of Care Principles 2014
Quality of Care Principles 2014, compilation date 1 May 2018, F2018C00294
Bills
Aged Care and Other Legislation Amendment (Royal Commission Response No. 2) Bill 2021

care did not mention "corporate governance" or "governing bodies" or any counterpart terms. The Home Care Common Standards included just one reference to corporate governance (but no explicit reference to governing bodies), with the expected outcome being that "The service provider has implemented corporate governance processes that are accountable to stakeholders" (Quality of Care Principles 2014, compilation date 1 May 2018, F2018C00294: 19). To the extent that the Aged Care Act created compliance obligations and liabilities in relation to these standards, these were on the organisations themselves, with no general quality and safety obligations applying to directors individually.

The new Aged Care Quality Standards apply across residential, home and flexible care. Of the eight Standards, one is dedicated to "organisational governance", and this is commonly regarded as a new Standard. The Standard is unambiguous in its expectation of boards regarding quality and safety: "The organisation's governing body is accountable for the delivery of safe and quality care and services" (Quality of Care Principles, compilation as at 1 September 2021, F2021C00887: 48). An associated requirement that must be met is that the provider can demonstrate that "the organisation's governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery" (Quality of Care Principles: 48). In summary, in aged care, expectations of board involvement in quality and safety have shifted from being not stated or barely stated to unequivocal demands that the board is responsible for the delivery of safe and quality care.

Directors of aged care providers are likely to be subject to a new code of conduct which will apply to a range of employees and other persons, including "governing persons" under the Aged Care Act: *Aged Care and Other Legislation Amendment (Royal Commission Response No. 2) Bill 2021 (Cth)*.[3] Under the proposed new section 74AD, a director can be subject to a civil penalty of up to $55,500 if they contravene the code. The then Commonwealth Government proposed that the aged care code will be part of a new integrated code across aged care, disability support and veteran care. The integrated code will be based on the existing National Disability Insurance Scheme (NDIS) code, which includes requirements for safe and competent support delivery (Australian Government, 2021). That code will be discussed shortly. Of course, whether the code applies to directors *when governing* will depend on the drafting of the subordinate legislation; however, it appears that this was the intention of the then Government and Parliament (House of Representatives, 2021: 10).

In disability, the old arrangements (i.e., prior to the phasing-in arrangements, with the commencing dates varying by State or Territory) were complex, with requirements sometimes under the Commonwealth Government's Disability Service Standards and sometimes under State and Territory arrangements (if any), depending on service types and which government had jurisdiction. In the interests of keeping within word limits, a more limited account of the disability standards and their context will be given. The old Commonwealth Standard 6 on service management required that: "The service or program has effective and accountable service management and leadership to maximise outcomes for individuals" *Disability Services Act (National Standards for Disability Services) Determination 2014*, Schedule 1. However, there was only one mention of boards, which was about board composition and process, with the relevant Indicator of Practice under Standard 6 stating that "Frontline staff, management and governing bodies are suitably qualified, skilled and supported".

Arrangements in the States and Territories varied. To give the example of New South Wales, that State's Disability Service Standards required that: "Providers of services to persons with disability are well managed and have strong and effective governance to deliver positive outcomes for the persons they support" (*Disability Inclusion Regulation 2014* [NSW], Schedule 1). One of the associated "practice requirements" was that "Each person receives quality services which are effectively and efficiently governed" (NSW Department of Family and Community Services, 2016: 68). While these opening statements were broad, the indicators associated with

the practice requirement were very much consistent with the limited view of board responsibilities of Ingram (1996, 2015) discussed earlier, for example:

The corporate governance body of an organisation: …

- is able to exercise objective and independent judgement on corporate affairs which is separate to decision making on operational matters …
- ensures the organisation has a quality management system and internal controls are in place to comply with relevant Standards … (NSW Department of Family and Community Services, 2016: 68).

Hence, for quality and safeguarding in particular, there were merely requirements that a quality management system and internal controls be in place. For the sake of completeness, elsewhere in this guidance document it stated that a board's agenda should include a standing item on complaints, and that the board should use stakeholder feedback to continuously improve.

Under the then Commonwealth and NSW legislation, there were no general compliance provisions applying to directors as individuals. There were no duties on individuals in relation to quality and safety, and no associated liabilities for breach.

Under the new NDIS quality and safeguarding arrangements, within the Core Module of the new Practice Standards, there is an entire part on "Provider governance and operational management", with a dedicated standard on "Governance and operational management", which provides that "Each participant's support is overseen by robust governance and operational management systems relevant and proportionate to the size and scale of the provider and the scope and complexity of the supports being delivered" NDIS (Quality Indicators for NDIS Practice Standards) Guidelines 2018, clause 11. The Standard has eight "quality indicators", of which five explicitly refer to the governing body, including requirements: to provide opportunities for people with disability to contribute to governance; to implement a defined structure and "to monitor and respond to quality and safeguarding matters associated with delivering supports to participants"; to identify required skills; to ensure that strategic and business planning occurs; and to manage the performance of managers, including responses to individual issues NDIS (Quality Indicators for NDIS Practice) Guidelines 2018, clause 11.

Although lacking the broad statements of the Aged Care Quality Standards about board responsibility for quality and safety, the Quality Indicators require that providers' boards have a structure to monitor and respond to quality and safeguarding issues. This is a significant elaboration on expectations for quality and safety under previous arrangements at both the Commonwealth and NSW levels.

Further, the NDIS Quality and Safeguards Commissioner was given the power to create rules for a code of conduct by amendments to the *National Disability Insurance Scheme Act 2013*. As this section was first enacted in 2017, the power was in relation to providers and "persons employed or otherwise engaged by NDIS providers" (NDIS Act, s. 73V, as created by the *National Disability Insurance Scheme Amendment [Quality and Safeguards Commission and Other Measures] Act 2017*), and non-executive directors, as a matter of law, might not have been covered as they are elected or appointed and not "engaged".[4] A recent amendment to the Act has remedied that deficiency by stating that the code can also apply to "key personnel", a phrase which explicitly includes non-executive directors: NDIS 2013, s. 73V, as amended by the *National Disability Insurance Scheme Amendment (Improving Supports for At Risk Participants) Act 2021*. Subject to the *National Disability Insurance Scheme (Code of Conduct) Rules 2018*, this also has the potential effect of making directors personally liable for civil penalties of up to $55,500 NDIS Act, s. 73V(3).

The preamble to the NDIS Code of Conduct Rules as currently promulgated gives the following rationale for their existence: "To ensure the safety and quality of supports … the NDIS Code of Conduct sets minimum expectations, shapes the behaviour and culture of NDIS providers and persons employed or otherwise engaged by NDIS providers, and empowers consumers in relation to their rights" (NDIS Code of Conduct Rules, Preamble). It then goes on to state that "in providing supports or services to people with disability" particular conduct must be demonstrated, such as to "promptly take steps to raise and act on concerns about matters that may impact the quality and safety of supports and services provided to people with disability" (clause 6). However, as the Code of Conduct Rules are currently written, it is unclear if the objective of the legislation to extend the code to directors has been realised as a matter of law for two reasons. First, the Rules (clause 5) still contain the old language of being limited to "persons employed or otherwise engaged". Second, the Code obligations (clause 6) apply "in providing supports or services to people with disability", and it might be arguable that these words are not broad enough to capture the work of directors, compared with an expression such as "in or *in connection with* providing supports or services". Nonetheless, the Rules can be amended by the Commissioner at any time, and it is foreseeable that the Commissioner might wish to do so in order to achieve the objectives of the amendment to section 73V.

To sum up, although there were the foundations of expectations for board responsibility for quality and safety in old standards and noting that some technical details are still to be addressed in the new systems, across both aged care and disability supports the expectations on directors have been made more explicit and have expanded. In both the aged care and disability support standards, consistent with the calls of commissions of inquiry, there are now clear expectations established for board and director involvement in promoting quality and safe care and supports. For the first time, under both the proposed legislation in aged care and in the legislation on disability supports, providers' directors potentially have personal obligations for quality and safety and potentially have personal liability. The analysis establishes that boards and directors must have concern for the governance of quality and safety.

6 | CONCLUSION

Commissions of inquiry have been critical of boards' lack of attention to service delivery, and especially to quality and safety. In many ways, the commissions have challenged common beliefs that boards should focus on strategy, financial sustainability, and supervision and support of the CEO, and that service delivery quality and safety was an operational matter. As has been shown, over time, subordinate legislation and standards have declared the responsibility of boards and directors for the quality and safety of services provided, ultimately creating the potential for individual legal liability of directors. However, it is curious that – at least at this time – the responsibility is found in subordinate legislation and standards and not in the primary legislation, even when this was recommended (Royal Commission into Aged Care Quality and Safety, 2021).

What then is involved in this province of board governance? How are directors to govern for quality and safety? What data do they need? What questions should they be asking and what decisions should they be making? Although detailed answers to the questions posed are beyond the scope of this article, there are suggestions in some of the more detailed provisions of the standards (such as the NDIS quality indicators) and suggestions in the research about boards and hospitals, and boards and WHS, recounted earlier. The research on hospital boards suggests that specialist board committees on quality be created if organisations have

not already done so, that quality be a dedicated item on the board meeting agenda, and that boards should receive relevant data, including data for benchmarking comparison (which is available for aged care, but is only patchy for disability supports). The research on boards and WHS, recounted in the literature review, also suggests what directors might do. Individual directors and providers should consider how they meet the regulatory requirements, and also consider how they might exceed the minimum requirements.

At a policy level, the question arises whether extending individual liability for quality and safety to non-executive directors—many who serve in a voluntary capacity—is an appropriate solution. Of course, enforcing such liability is just one of many levers for influence held by regulators. Of the solutions to making corporations responsible offered by Coffee (1981), in addition to lifting the corporate veil, vicarious liability already exists. Further, the regulators already have the power: to create adverse publicity; for corporate plea bargaining in the form of enforceable undertakings; and the power to inject their (quasi) agents into the corporation. One option that currently does not exist would be allowing private enforcement.

Turning now to limitations of our research, this article is limited in scope in that it only sought to identify quality and safety requirements for Australian aged care and disability supports and at a particular point in time (July 2022). It remains to be seen what changes in approach, if any, will be made by the new Australian Government. Further, although there is empirical evidence from the hospital sector of an association between boards and quality and safety outcomes, research is needed in the specific settings of both the aged care and disability sectors given that the desired outcomes of such support in the sectors (e.g., an improved quality of life, in all domains) are likely to differ substantially from those in the hospital and healthcare sector (e.g., where the desired outcome is likely to be improved health and often in the short run). There are likely to be differences within each sector, e.g., between the highly professionalised early intervention services for children with disability and the services delivered by those disability support workers with no qualifications. Further, the regulatory requirements on directors—as with the standards more generally—are not necessarily evidence-based, and there is a need to establish the empirical foundations for good practice. The quantitative studies completed in hospitals have been cross-sectional and, while demonstrating associations, do not demonstrate the direction of causality: longitudinal studies are needed. The recommendations made in the review articles on the hospital sector mentioned earlier point to areas where research is also needed in aged care and disability, e.g., to examine the relationship between board attributes, processes and dynamics. Finally, for nonprofit providers, there are a bundle of issues—not examined in this article—around whether organisations with membership (beyond the directors) and democratic control (Guo et al., 2014) achieve quality and safety to a greater degree than those which do not.

In summary, quality and safety can now be regarded as having a heightened place in board governance in aged care and disability support. The calls of commissions of inquiry have in part been answered. For some practicing directors, the need to focus on quality and safety, in addition to matters such as strategy and financial viability, might be uncomfortable as it involves unfamiliar territory about how to monitor, judge and influence performance. For other directors, it will be a welcome opportunity to focus on the needs and wishes of those people that their organisations serve.

AUTHOR CONTRIBUTIONS

Alan David Hough: Conceptualization; data curation; formal analysis; investigation; methodology; writing – original draft; writing – review and editing. **Myles McGregor-Lowndes:** Validation; writing – review and editing.

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ENDNOTES

[1] The first aspect of the agency problem identified is an extension of the 'principal-agent' notion of agency theory, 'a theory that can be applied to employer-employee, lawyer-client, buyer–supplier, and other agency relationships' (Eisenhardt, 1989: 60). The second aspect is consistent with the more traditional 'positivist agency theory' (Eisenhardt, 1989: 59).

[2] Hospital and health systems sometimes include aged care, but there appears to be no evidence about governing for quality and safety in dedicated aged care.

[3] This Bill was not passed by the end of the life of the 46th Parliament in 2022. However, it is anticipated that the new Parliament will pass that Bill or a Bill in substantially similar terms given the cross-party support for most aspects of the then Bill.

[4] The first author has seen two legal opinions to this effect.

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