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Profits, pressure and corporate lawbreaking

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Abstract. While neglect, exploitation, denial of human rights and abuse of nursing home residents can be found in both non-profit and for-profit nursing homes, substantially higher non-compliance with the law is found among for-profits. A significant source of non-compliance is pressure on senior management from proprietors to reach financial goals that can only be attained by cutting corners on quality of care. This source of non-compliance is stronger among for-profits than non-profits in a sample of 410 Australian nursing homes. These data therefore supply more systematic support for what has been a commonplace observation in the corporate crime literature: that pressure for lawbreaking comes from the top down and from profits.

Introduction

There are not many themes in the empirical literature on corporate crime that are repeatedly reported. A recurrent one, however, is that pressure for the worst types of corporate crimes comes from the top. Organizations, like fish, rot from the head down. This was a recurrent theme in Braithwaite's interviews with 131 pharmaceutical industry executives:

> [The Chief executive] sets the tone and the rest of management fall in line. The ethical standards of anyone other than him don't matter so much. Well, unless you have one of those companies where an old guy at the helm has a right hand man making all the real decisions [US executive].[1]

Baumart[2] found that executives ranked the behavior of their superiors in the company as the principal determinant of unethical decisions. In a fifteen-year follow-up of Baumart's work, Brenner and Molander[3] found that superiors still ranked as the primary influence on unethical decision-making. Half of the 1977 sample of executives believed that superiors often do not want to know how results are obtained, so long as the desired outcome is achieved. Clinard's middle managers also repeatedly argued that it was "top management, and in particular the chief executive officer (CEO) who sets the ethical tone."[4] Similarly, Cressey and Moore's interviews with auditors supported the conclusion that the pressure for lawbreaking that counts comes from the top.[5] While it is often,

even typically, middle managers who carry out corporate crimes, these crimes are frequently the result of pressure from the top to "get this done, but don't tell me how you do it." Obversely, one of the characteristics found in firms that have exemplary records of compliance with laws of a certain type, is top management commitment to and backing for internal compliance systems.[6]

A second recurrent theme has been that it is greed or the profit motive that is responsible for corporate crime.[7] While this seems almost a banal observation, it has actually been contested in various ways by scholars who have pointed to the ubiquitous organizational crime of state run bureaucracies in both the East and the West.[8] Gross, for example, concluded: "Some organizations seek profit, others seek survival, still others seek to fulfil government-imposed quotas, others seek to serve a body of professionals who run them, some seek to win wars, and some seek to serve a clientele. Whatever the goals might be, it is the emphasis on them that creates the trouble."[9]

In this paper, we explore these two hypotheses about corporate lawbreaking – that pressure from the top and pressure to make profits causes lawbreaking – using quantitative data of a sort that has not been applied to these hypotheses in the past. We embark on this research as scholars who basically agree with Coleman's lament that "reliable statistical analysis" has not been possible on the basis of corporate offending rates available from U.S. government agencies: "The best work done so far in this field is the case studies that carefully analyze the conditions in particular organizations or industries, and I would suggest that lacking the development of a significant new data base, this approach offers the brightest hope of future progress . . ."[10] The data presented in this paper are indeed based on a "significant new data base", albeit one that will seem obscure to scholars in the Northern hemisphere. So we suggest that the analyses do not justify our being included among Coleman's researchers who have been "seduced into carrying on empirical research based on unreliable data."[11] Rather, we have discovered a kind of data on corporate lawbreaking much more reliable than traditional measures of either corporate or street crime. We use these data to test whether widely reported conclusions from qualitative research are quantitatively sustainable.

Australian nursing home compliance

In 1987, our research team seized an unusual opportunity to get in on the ground floor with the establishment of a completely new regulatory program for the Australian federal government to regulate quality of care in nursing homes. Previously this had been primarily a state government responsibility. The federal program involved a radical shift to 31 outcome-oriented standards away from the enforcement of inputs. Our research team has had a significant

effect on the design of the emerging new regulatory process during the past six years. Part of the agreement reached by the two peak (profit and non-profit) industry associations in relation to the new program was to urge their members to cooperate with the research described in this paper. Part of our agreement with the federal government was that they would inspect a random sample of 242 nursing homes, stratified by size (number of beds), ownership (for-profit, non-profit), and the mean level of disability of the residents, on an agreed schedule. Interviews were conducted with directors of nursing, inspectors, staff and proprietors not only for these nursing homes, but also at all other nursing homes inspected in the four study regions (in New South Wales, Victoria, Queensland and South Australia) during the period of the study. Addition of this non-randomly selected supplementary sample increased the number of nursing homes included in the first wave of the study to 410.

The federal government and the industry also agreed to cooperate with follow-up inspections being completed within 18–20 months of the first inspection wherever possible for the random sample and also to do as many of the supplementary sample as they could manage within 18–24 months of the first inspection.

The commitments on the random sample, but not the supplementary sample, were delivered with impressive diligence. For the first wave random sample, only nine nursing homes refused to cooperate in the study, a 96 per cent response rate. The industry associations were extremely helpful in urging the cooperation of homes that were reluctant. We even received a message of cooperation from a proprietor who was in hiding in the United States at the time of the study, being pursued by the Australian Federal Police in relation to nursing home fraud allegations! Similarly, completed inspectors' questionnaires were received for 406 of the 410 first wave inspections.

A number of factors such as closures and ownership changes caused a considerable attrition of cases between the first and second waves, however. By far the most important cause of attrition was the inspectors not managing to get to most of the supplementary sample on time.[12] Repeatedly, analyses have not found results to be significantly different for randomly selected versus supplementary homes. Hence, we have adopted the practice of combining the random and supplementary samples. Nevertheless, a control dummy for random versus non-random selection is included in the regressions reported here as a check on selection bias affecting results.

What is most innovative about the new Australian nursing home regulation is the way its compliance ratings are based on a systematic dialogue among a number of participants – an inspection team (usually only two, but three and more in the more difficult cases), nursing home staff and management and the residents. By a systematic dialogue, we mean one that sees debate about the positives and negatives under each standard, addressed one after the other un-

til all standards are completed. Australian nursing home regulation is far more resident-centred, relying more on interviews with residents, than nursing home regulation in the other countries where we have conducted research – the United States, Canada, England and Japan.

An unexpected and exciting finding of the research program has been that this participatory-dialogic approach to regulatory inspection generates unprecedented reliability in ratings of compliance with the law. Test-retest reliabilities on total compliance scores when inspectors employed by our research team visited nursing homes at the same time as the government inspection teams ranged from 0.93 to 0.96, depending on the point in the process where agreement was calculated.[13] When chief executives of the organization were asked what ratings they should have received on a three-point rating scale on each of the standards, 84 per cent of the time they gave themselves the same rating as the team gave them. In short, the dialogic regulatory process generated an unusual degree of consensus on what was the true status of the facility's compliance with the law.

For most of the nursing homes in this study, most of the standards have the status of criminal law, the federal standards having been wholly incorporated into state law in New South Wales and many of them have been incorporated into Victorian state law. However, the operational effectiveness of these standards comes from the National Health Act, from the fact that the federal government can and does impose sanctions on non-compliant nursing homes by cutting off universal federal government per-patient benefits that are payable to all Australian nursing homes.

Compliance with the National Health Act is measured in the present study by adding compliance scores for each of the 31 standards (met scores 1, met in part scores 0.5, not met 0) to generate a total compliance score of 31, a procedure shown by earlier multivariate analyses to be sound.[14] In addition, the self-reported ratings given by directors of nursing to their own home were used as an alternative measure of compliance.

Measuring profit-orientation and pressure from the top

Profit orientation is measured simply by classifying nursing homes as non-profit (33 per cent of cases) versus for-profit (66 per cent). For-profit homes are then classified according to whether the director of nursing (the chief executive) is also the owner or a joint owner (often a couple are joint owners with the wife being the director of nursing). For almost a quarter of for-profit homes, the director of nursing is an owner or joint owner. For another slightly larger group of homes, the owner is a private individual other than the director of nursing and for the largest group of for-profit homes (almost half), the owner is a corpo-

ration. Three-quarters of the non-profit homes are run by churches with the remainder being run by charitable institutions such as lodges. Government-run nursing homes, which are small in number, were not subject to this regulatory program at the time of the study except in unusual circumstances.

The measure of pressure from the top is less reliable than the measurement of either compliance or for-profit status. We have only a three item scale (alpha = 0.61) based on an interview with the director of nursing after the first wave inspection. The items are "My proprietor sets me goals that can only be achieved by breaching the standards"; "My proprietor sometimes puts me under a financial squeeze that makes it impossible to meet the standards"; and a reverse scored item, "My proprietor has the attitude that the government's standards and regulations must be met no matter what the costs". These items are rated on a five point scale: strongly disagree, disagree, neither agree nor disagree, agree or strongly agree. In order to ensure that a particular item did not dominate the scale, individual items were divided by their standard deviation prior to summing their scores. In order to facilitate interpretation, the scores were rescaled to run from 0 to 10. The mean of the scale was 3.29 and the standard deviation 1.87.

Controls

When examining the relationship between financial pressures and nursing home compliance, it is important to take into account the influence of a number of antecedent factors which, the literature suggests, also affect nursing home compliance. Characteristics of the home such as its size and age may influence the quality of care provided. In general, larger homes provide poorer quality care.[15] As Fottler, Smith and James suggest, larger homes with high occupancy rates require a proportionately larger amount of nursing service. One of the major dilemmas that nursing home administrators face, however, is that profits can be increased by decreasing the intensity of patient care service and thereby decreasing the quality of service provided.[16] Clearly, then, it is necessary to control for both the size of the home and the amount of nursing care required by residents. Homes in older buildings are also be more likely to provide inadequate care to residents. In older buildings, maintenance requirements are greater and there is a greater likelihood of encountering design problems which require costly alterations in order to meet standards such as those relating to fire and physical safety.[17]

Apart from the characteristics of the home itself, factors associated with the inspection teams also have an impact on the compliance ratings given to a home. Inspection teams vary in size. While there is no hard and fast rule, the policy of the government has been to send larger inspection teams to larger

homes in order to adequately cover the ground. The smaller the team, the greater the likelihood that instances of non-compliance will go unnoticed. The effect of team size is controlled in the analyses. Each state of Australia has its own teams which carry out the inspection of homes in that state only. Inspectors rarely work with teams based in other states. Although the standards for nursing home compliance are the same across the country, previous work suggests that significant variation on compliance ratings occurs across the states.[18] The pattern of compliance ratings suggested that state teams varied in the degree of toughness or permissiveness shown with regard to some standards. To control for geographical location, three dummy variables representing Queensland, New South Wales and Victoria, were entered into the regression equations.

As indicated previously, nursing homes participating in this study were drawn from a random and supplementary sample. A dummy variable for the sample from which the home is drawn is included in analyses. Table 1 describes the scoring used for each of the control variables along with means and standard deviations.

Table 1. Definitions, means, and standard deviations for background variables.

Variable	Coding	Mean	SD
Non-profit home[a]	1 = yes, 0 = no	0.34	0.47
Number of beds in the home[a,c]	Number	49	36
Age of home[a]	Years	36.4	30.6
Mean disability of residents[b]	Mean hrs care	19	2.11
Number on inspection team[a]	Low 2 – high 9	2.49	0.60
Queensland home[a]	1 = yes, 0 = other	0.18	0.39
Victorian home[a]	1 = yes, 0 = other	0.23	0.42
New South Wales home[a]	1 = yes, 0 = other	0.41	0.49
Sample home	1 = yes, 0 = no	0.59	0.49

[a] These variables were taken from the interviews with directors of nursing.

[b] This variable was taken from the Commonwealth Department of Health, Housing and Community Services data base, which contains demographic information about nursing home residents. Each resident entering a home is allocated to one of five service need categories (resident's classification index, or RCI), according to the average number of hours of nursing and personal care (NPC) required per week. Residents allocated to level one require an average of 27 NPC hours; those at level two require 23.5 NPC hours; those at level three require 20 NPC hours; those at level four require 13 NPC hours; and those at level five require 10 NPC hours. To calculate the mean weekly hours of nursing care per resident provided by each home, the average number of NPC hours, according to the RCI, were calculated across all residents in the home.

[c] The number of beds in the home was a highly skewed variable, with most homes having around 50 beds but some having as many as 200 or, in one case, 510. Residual analysis confirmed the need for a log transformation of this variable. The interpretation of the effect of this transformed variable in regression is that larger homes tend to have more incidences of non-compliance, but that as home size increases, larger differences in bed numbers lead to smaller increases in predicted non-compliance.

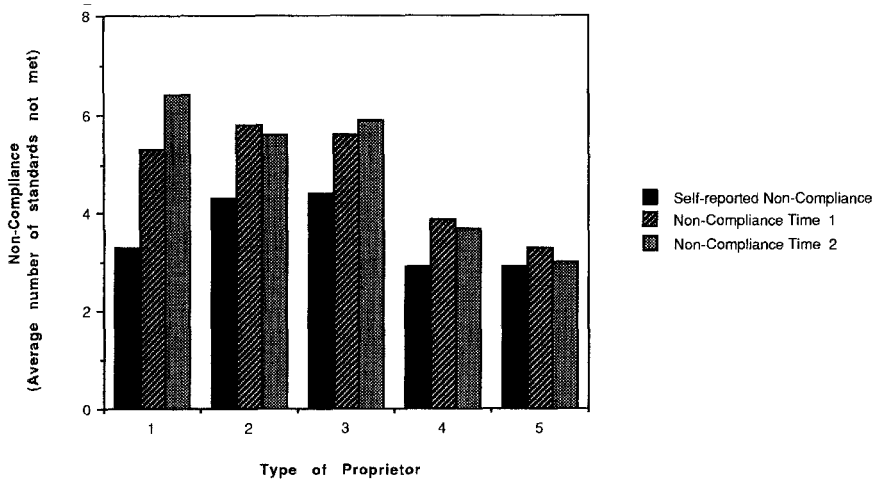

Fig. 1. Incidence of non-compliance according to type of proprietor.
Type of proprietor:
1 DON is owner or joint owner
2 Private individual
3 Private company
4 Church group
5 Other charitable

Results

Three measures of compliance are available: self-rated compliance at time 1 as assessed by the director of nursing, governmentally rated compliance at time 1 and governmentally rated compliance at time 2. The data in Fig. 1 show that for-profit homes on all three measures break the law more often than non-profit homes. While on the wave 1 data, non-compliance is only 47 per cent higher among the for-profits, at wave 2, it is 60 per cent higher.

There are many possible interpretations of why for-profit homes should have lower compliance than non-profits. One is simply based on the level of government funding support. Historically, though not today, non-profit homes attracted greater financial support from the government than for-profits and even today non-profits get more favorable tax treatment. Conversely, one of the arguments as to why residents get poorer care in for-profit nursing homes is that money is diverted from resident care to profits. A previous study found that directors of nursing in non-profit homes have a stronger commitment to nursing professionalism than for-profit directors of nursing.[19]

The question of particular interest in this paper is whether pressure for non-compliance from the top is greater in for-profit than in non-profit homes. Figure 2 shows that it is. The effect is not large, but top-down pressure for non-

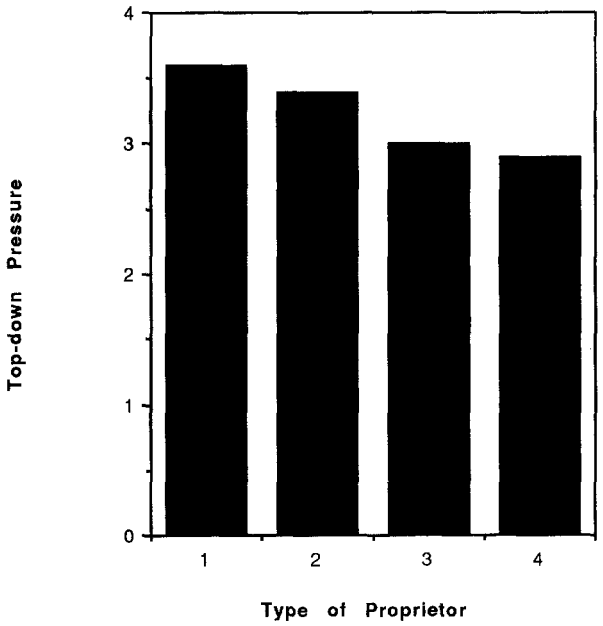

Fig. 2. Perceived top-down pressure on Director of Nursing according to type of proprietor.
Type of proprietor:
1 Private individual (cases where DON is proprietor are excluded)
2 Private company
3 Church group
4 Other charitable

compliance is significantly ($t = 3.36$, $df = 408$, $p < 0.001$) greater in for-profit homes than in non-profits.

At the bivariate level there is also a significant association between top-down pressure and non-compliance ($r = 0.32$, $p < 0.001$). Table 2 summarizes how these associations hold up after entering the controls discussed above, fitting an ordinary least squares regression model to the data.

Table 2 shows that top-down pressure for non-compliance has a significant effect in reducing compliance after entering the appropriate controls, including the control for the ownership of the nursing home. The significant effect of perceived pressure at time 1 on compliance at time 2 is the more compelling result than the significant effect of time 1 pressure on time 1 compliance. This is because the latter result might conceivably be discounted as time 1 non-compliance causing the perception of pressure than the reverse. Any such interpretation is untenable with the time lagged data. Being a for-profit nursing home significantly reduces compliance net of the effect of top-down pressure for compliance at both points in time. However, the effect of for-profit status in

reducing compliance is not significant when the self-reported measure of compliance is used.

Conclusion

U.S. data on nursing home compliance, while it is inferior to the Australian data in terms of reliability of the measurement of compliance,[20] generally support the conclusion that for-profit homes have lower compliance and/or lower quality of care than non-profits.[21] Overall, our own impressionistic observations from visiting over 50 U.S. nursing homes, reading the literature and interviewing the key players in the industry is the same as Valdeck's:

> [O]n the average, voluntary facilities are somewhat better than proprietary ones. The best voluntary facilities are the best there are. The worst nursing homes are almost exclusively proprietary. But in the middle ranges, there is substantial overlap.[22]

Table 2. Regression results for the effect of top down pressure experienced by the Director of Nursing on three measures of compliance.

Variable Controls	Compliance time 1				Compliance time 2	
	Government rated		Self-rated		Government rated	
	b	beta	b	beta	b	beta
Number of beds in the home	− 2.85	(− 0.14)**	− 0.01	(− 0.10)*	− 2.66	(− 0.14)*
Age of the home	− 0.57	(− 0.15)***	− 0.03	(− 0.20)***	− 0.03	(− 0.18)**
Mean disability of residents	0.23	(0.09)	0.24	(0.12)*	0.26	(0.12)
Number of inspectors	− 0.95	(− 0.11)*	− 0.49	(− 0.07)		[a]
Queensland home	5.18	(0.41)***	3.98	(0.38)***	4.33	(0.42)***
Victoria home	4.79	(0.39)***	4.09	(0.40)***	1.29	(0.13)
New South Wales home	4.49	(0.45)***	4.01	(0.48)***	5.52	(0.67)***
Sample home	− 0.94	(− 0.09)	− 0.75	(− 0.09)	− 0.58	(− 0.07)
Non-profit home	1.15	(0.11)*	0.71	(0.08)	1.21	(0.15)*
Top down pressure	− 0.62	(− 0.24)***	− 0.57	(− 0.26)***	− 0.36	(− 0.15)*
Constant		28.41		26.98		24.08
R^2 (adjusted)		0.346		0.349		0.304

[a] Information not available.

* $p < 0.05$, (two tailed). ** $p < 0.01$, (two tailed). *** $p < 0.001$, (two tailed).

The Australian data support a similar conclusion. However, we would say that some of the church homes have very poor compliance indeed with residents' rights standards; these are church homes with an ideology of paternalistic caring that brings them into conflict with the regulators and advocacy groups.[23] Certainly, there are good for-profit and non-profit nursing homes, even though the latter are better on average. While pressure for profits does motivate law breaking, non-profits have their own pressures, including financial ones:

> Profit for us is not different from an increase in the 'general fund' for not-for-profits. [Administrator of a New York for-profit nursing home]

During our fieldwork, we did indeed encounter the odd case of a church using nursing home revenues to cross-subsidize other church activities. This does lead us back to Gross's critique of profit or greed as the pre-eminent explanation of organizational crime. Since before the Inquisition, it has been clear that churches have objectives so important to them that terrible crimes can be committed when attainment of those objectives is frustrated. Compliance differences between for-profit and non-profit institutions are not so great as to justify systematically lower regulatory scrutiny of non-profit providers. Indeed, given a choice between regulated private provision and unregulated voluntary or state provision of care to vulnerable people, prudent advocates might opt for the former. Yet there is an irony here, as political pressure for regulation only becomes effective when traditionally public or voluntary provision is shifted to the for-profit sector (as with aged care in Britain during the 1980s). This happens after decades of misplaced trust in public and voluntary providers to care ethically for vulnerable people who are difficult to manage.

At the same time, these unique quantitative data confirm what qualitative corporate crime researchers have consistently reported: that pressure for profits matters and that when the pressure for profits is greatest, the boss is more likely to say: "This is the bottom line I want. I don't care (and I don't want to know) what you have to do to get there". But just as business tycoons sometimes say this, so too do bishops. The policy implication of this would seem to be the importance of individual criminal liability of proprietors for serious regulatory offences, be they businessmen or bishops.

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Notes and references

1. John Braithwaite, *Corporate Crime in the Pharmaceutical Industry* (London: Routledge and Kegan Paul, 1984), 351.
2. R.C. Baumart, "How Ethical are Businessmen?" in Gilbert Geis (ed.) *White-Collar Criminal* (New York: Atherton, 1968).
3. S.N. Brenner and E.A. Molander, "Is the Ethics of Business Changing?" *Harvard Business Review,* 1977 (55), 59–70.
4. Marshall Clinard, *Corporate Ethics and Crime: The Role of Middle Management* (Beverly Hills: Sage 1983).
5. Donald R. Cressey and Charles A. Moore, *Corporation Codes of Ethical Conduct* (Santa Barbara: Department of Sociology, University of Santa Barbara, 1980).
6. John Braithwaite, *To Punish or Persuade: Enforcement of Coal Mine Safety* (Albany: State University of New York Press, 1985).
7. See, for example, Harold C. Barnett, " Corporate Capitalism, Corporate Crime", *Crime and Delinquency,* 1981 (27), 4–23.
8. See, for example, P.N. Grabosky, *Wayward Governance: Illegality and its Control in the Public Sector* (Canberra: Australian Institute of Criminology, 1989); Ronald C. Kramer, "The Space Shuttle Challenger Explosion: A Case Study of State-Corporate Crime," in Kip Schlegel and David Weisburd (eds.), *White-Collar Crime Reconsidered* (Boston: Northeaster University Press, 1992); John Braithwaite, "White-Collar Crime, Competition and Capitalism: Comment on Coleman", *American Journal of Sociology,* 1988 (94), 627–631; and see the rejoinder, James William Coleman, "Competition and the Structure of Industrial Society: Reply to Braithwaite," *American Journal of Sociology* 1988 (94), 632–636.
9. Edward Gross, "Organizations as Criminal Actors," in P.R. Wilson and J. Braithwaite (eds.) *Two Faces of Deviance: Crimes of the Powerless and Powerful* (Brisbane: University of Queensland Press, 1978), 209.
10. James William Coleman, "The Theory of White-Collar Crime: From Sutherland to the 1990s," in Kip Schlegel and David Weisburd (eds.) *White-Collar Crime Reconsidered* (Boston: Northeastern University Press, 1992), 71.
11. Ibid., p. 71.
12. For complete details on the sampling and other methodological issues, see John Braithwaite, Toni Makkai, Valerie Braithwaite and Diane Gibson, *Raising the Standard: Resident Centred Nursing Home Regulation in Australia.* (Canberra: Australian Government Publishing Service, 1993).
13. John Braithwaite, Valerie Braithwaite, Diane Gibson, Miriam Landau and Toni Makkai, *The Reliability and Validity of Nursing Home Standards* (Canberra: Australian Government Publishing Service, 1992).
14. Valerie Braithwaite, John Braithwaite, Diane Gibson and Toni Makkai, "Assessing the Quality of Australian Nursing Home Care", *Australian Journal of Public Health,* 1992 (16), 89–97.
15. For example, S.R. Greenwald and M.W. Linn, "Intercorrelation of data on nursing homes," *The Gerontologist,* 1971 (11), 337–346.
16. Myron D. Fottler, Howard L. Smith and William L. James, "Profits and patient care quality in nursing homes: Are they compatible?" *The Gerontologist,* 1981 (21), 532–538.

17. See Vernon L. Green and Deborah J. Monahan, "Structural and operational factors affecting quality of patient care in nursing homes," *Public Policy,* 1981 (29: 4), 399–415.
18. See John Braithwaite, Toni Makkai, Valerie Braithwaite, Diane Gibson and David Ermann, *The Contribution of the Standards Monitoring Process to the Quality of Nursing Home Life: A Preliminary Report.* (Canberra: Department of Health, Housing and Community Services, 1990).
19. Toni Makkai and Valerie Braithwaite, "Professionalism, Organizations and Compliance," *Law and Social Inquiry,* 1993.
20. See John Braithwaite, Valerie Braithwaite, Diane Gibson, Miriam Landau and Toni Makkai, *The Reliability and Validity of Nursing Home Standards.* (Canberra: Australian Government Publishing Service, 1992).
21. The New York State Moreland Act Commission on Nursing Homes and Residential Facilities. Report 1: *Regulating Nursing Home Care: The Paper Tigers.* (Albany: New York, 1975), 37; V.L. Green and D.J. Monahan, "Structural and Operational Factors Affecting Quality of Patient Care in Nursing Homes," *Public Policy,* 1981 (29) 399–415; F. Elwell, "The Effects of Ownership on Institutional Services," *The Gerontologist,* 1984 (24), 77–83; Yong S. Lee, "Nursing Homes and Quality of Health Care: The First Year Result of an Outcome-Oriented Survey," *Journal of Health and Human Resources Administration, 1984 (7), 32–60; Sonne Lemke and Rudolf H. Moos, "Quality of Residential Settings for Elderly Adults," Journal of Gerontology,* 1986 (41), 268–276; Catherine Hawes and Charles D. Phillips, "The changing structure of the nursing home industry and the impact of ownership on quality cost and access," in Bradford H. Gray (ed.), *For-Profit Enterprise in Health Care* (Washington D.C.: National Academy Press, 1986); Pamela Paul-Shaheen and Andrew J. Hogan, *Identifying Cost Effective Nursing Homes: A Benefit/Cost Tradeoff Analysis* (Lansing: Bureau of Health Facilities, Michigan Department of Public Health, 1988). Sonne Lemke and Rudolf H. Moos, "Ownership and Quality of Care in Residential Facilities for the Elderly," *The Gerontologist,* 1989 (29), 209–215; Riportella-Muller and Slesinger found that in general Wisconsin non-profits had fewer code violations and complaints than for-profits, but that large non-profits had more violations than large for-profits (Roberta Riportella-Muller and Doris P. Slesinger, "The Relationship of Ownership and Size to Quality of Care in Wisconsin Nursing Homes," *The Gerontologist,* 1982 (22), 429–434). Some studies have not found poorer quality care in for-profit nursing homes: R.H. Holmberg and N. Anderson, "Implications of Ownership for Nursing Home Care," *Medical Care,* 1968 (6), 300–307; S. Levey, H.S. Ruchlin, B.A. Stotsky, D.R. Kinloch and W. Oppenheim "An Appraisal of Nursing Home Care," *Journal of Gerontology,* 1973 (28), 222–228; and S. Winn, "Analysis of selected characteristics of a matched sample of non-profit and proprietary nursing homes in the state of Washington," *Medical Care,* 1974 (12), 221–228. A study of Detroit homes by Gottesman suggested that the quality of care in church-related nonprofit homes was largely due to the socially and in many cases, economically advantaged group which used such facilities (Leonard E. Gottesman, "Nursing home performance as related to resident traits, ownership, size and source of payment," *American Journal of Public Health,* 1974 (64), 269–276. An important study by Koetting found that while non-profits provided substantially superior care than for-profits, this was because non-profits spent more on their residents. For-profits were more efficient in providing care with the discretionary dollars available to them, so that for any given quality level, for-profits were less expensive (M. Koetting, *Nursing Home Organization and Efficiency: Profit Versus Nonprofit.* (Lexington, Mass: Lexington Books, 1980).
22. Bruce Vladeck, *Unloving Care: The Nursing Home Tragedy* (New York: Basic Books, 1980), 123.
23. One of Australia's most outstanding directors of nursing, who has worked in both the for-profit and non-profit sectors made this point in a somewhat different way: "Some of the church homes are too much into the caring role. They're not enough into independence. They encourage the sick role, dependency."