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John Braithwaite and Toni Makkai

Administration, Compliance and Governability Program
Working Paper No. 9
February 1993



ADMINISTRATION, COMPLIANCE
& GOVERNABILITY PROGRAM

RESEARCH SCHOOL OF SOCIAL SCIENCES

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SERIES EDITOR
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GPO Box 4
Canberra, ACT, Australia 2601

ISBN 0 7315 1514 5
ISSN 1036-1189

S/M
GG
5921592

© *Administration, Compliance & Governability Program,
Research School of Social Sciences, Australian National
University 1991*

National Library of Australia
Cataloguing-in-Publication data:

John Braithwaite. Trust and Compliance.

ISBN 0 7315 1514 5.

1. Corporations — Australia — State supervision. 2.
Nursing homes — Australia State supervision. I. Makkai,
Toni. II. Australian National University. Administration,
Compliance & Governability Program. III. Title. (Series:
Working paper (Australian National University,
Administration, Compliance and Governability Program);
no. 9).

346.94062



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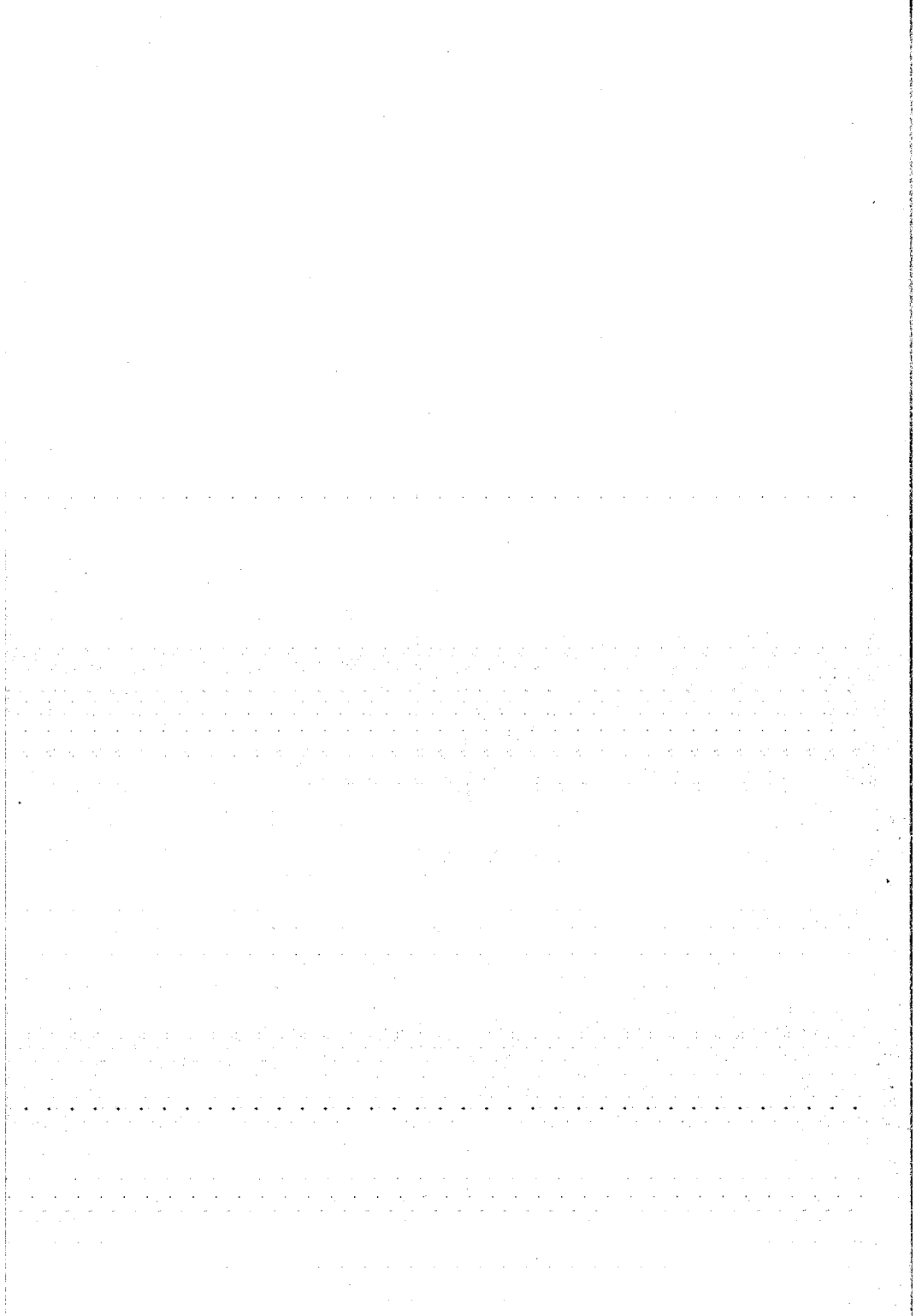
*Series Editor:
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Acknowledgements

This project has enjoyed the funding support of the Australian Department of Health, Housing and Community Services, The Australian Research Council, the American Bar Foundation and the Australian National University. The authors are indebted to the support of their colleagues on the Nursing Home Regulation in Action Project, Valerie Braithwaite, David Ermann, Diane Gibson and Anne Jenkins.

ABSTRACT

When regulatory inspectors trust industry, is this trust abused in a way that reduces regulatory compliance? Or does trust foster the internalisation of regulatory objectives by regulated managers? Does trust build goodwill that translates into improved voluntary compliance? Data on compliance by Australian nursing homes with quality-of-care standards supports the latter interpretation. Nursing homes experience improved compliance after regulatory encounters in which facility managers believe that they have been treated as trustworthy. This finding supports a regulatory strategy of dialogue and trust as a first choice followed by escalation to more punitive regulation when trust is abused.



TRUST AND COMPLIANCE

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INTRODUCTION

There are two views of trust in the literature on regulatory compliance. One has it that trust is *the* problem of regulatory non-compliance. The most eloquent expression of this line is to be found in the work of Susan Shapiro (1987, 1990) where she argues that white-collar crime is the violation of norms of trust. Relationships of trust, defined as the absence of beneficiary control in asymmetric relationships, 'institutionalize conflict between fidelity to principal interests and agent self-interest' (Shapiro, 1990: 348). This institutionalised conflict, according to Shapiro, is the heart of what is called the white-collar crime problem. While trust increases the potential of social systems for complexity (Luhmann, 1979), this complexity entails principals handing over distrust to institutionalised norms of trust (like honest disclosure) and their guardians (like auditors). At the same time as these norms and their guardianship make possible the fiduciary relationships on which capitalism depends, 'they increase the opportunities for the abuse of fiduciary relationships' (Shapiro, 1990: 350). Moreover, because there can be no satisfactory answer to the question of who guards the guardians, this abuse is endemic, ineliminable. Shapiro's sophisticated analysis has its echo in numerous populist accounts which assert that 'business cannot be trusted', that white-collar crime is endemic to capitalism because of the politics of business abuse of trust.

But there is also an opposite view in the literature of regulatory compliance. This is that trust *nurtures* compliance. The key idea is that if we treat actors as worthy of trust, they will repay this respect with voluntary compliance with fair rules¹. Underlying this idea is the psychological theory that compliance that is compelled rather than volunteered under conditions

¹ We assume throughout that Australian nursing home regulations are fair, that compliance with them is right and that the overwhelming majority of nursing home managers and proprietors believe them to be right. While the latter empirical assumption is supported by our data (Braithwaite *et al.*, 1992), and while we generally support these assumptions, we do not seek to defend them here.

of trust engenders cognitive dissonance (Bandura, 1986). When we are trusted to do the right thing and then choose to do it, we convince ourselves that we do it because we believe it to be right; we internalise the conception of right that we are trusted to have. On the other hand, when we comply in order to secure extrinsic rewards or avoid the punishments of distrustful regulators, we convince ourselves that we did it for those extrinsic reasons rather than for the intrinsic virtue of doing right (Ayes and Braithwaite, 1992: 49-51). When, therefore, our distrustful guardians cannot be present to put those rewards and punishments in our path, we do not bother with the extrinsically motivated behaviour.

In part, the opposition between the negative and positive accounts of trust and compliance arises from different conceptions of trust². But there are more fundamental differences. While Shapiro's negative analysis is grounded in an assumption of rational action (agents abuse trust when it is in their interest to do so), the alternative positive account is grounded in a conception of the actor as citizen (who respects norms of trust as an obligation of citizenship in circumstances where it may or may not be rationally self-interested to do so). The positive account does not deny self-interested action, but emphasises the competing significance of responsible citizenship even in the absence of guardianship. Shapiro's account does not deny the possibility of the ethically responsible fiduciary, but it gives emphasis to self-interested agency in the face of the impossibility of all guardians being guarded. More deeply still, we suggest that Shapiro's negative account of the trust-compliance interface is grounded in a liberal conception of individual action in an organisational world, while the positive account of trust and compliance is grounded in civic republican theory. The empirical work in this paper does not pit one conception against the other. There can be no definitive test of which is right since they do not involve incompatible claims. Rather, we have seen that they involve differences of emphasis (on self-interestedness versus citizenship) that lead to opposed attitudes to trust and compliance. While the empirical work we undertake in this paper can not adjudicate between the competing perspectives, these alternative conceptions establish its theoretical importance.

² Shapiro's conception of trust imputes the hierarchical fiduciary relationship from agent to principal that is enshrined in Western liberal legal systems. The positive conception of trust imputes a recursive relationship between two actors who share bonds of trust. This mutuality is more characteristic of Eastern legal systems, such as those grounded in Confucianism.

This study explores the crucial empirical claim of the positive conception of trust about regulatory compliance. This is that trust engenders trustworthiness. Conversely, the communication of distrust destroys virtuous citizenship. Trust in this formulation is conceived as having qualities opposed to other utilities in welfare economics. Trust is not a resource that is depleted through use; it is depleted through not being used (Gambetta, 1988: 234; Hirschman, 1984). Trust means allowing others discretion to act in ways considered appropriate without coercing the appropriate exercise of the discretion. Trust implies a relationship where the other can be taken at her word, where there is commitment to honest communication, to understanding the needs of the other, to agreed rules of fair play and to preference for cooperation.

Further discussion of the definition of trust has little point in the context of this paper because we follow a subjective conception of trust. Trust is what the actors in our study think it is. Our fieldwork suggests that these actors have a subjective conception of trust that is not restricted to the asymmetric relationships to which Shapiro restricts hers. For them, trust works up, down and sideways (between professional peers and friends, for example). But this divergence of conception is of little practical significance to the data that follow, which concern only relationships that happen to be rather asymmetrical, the relationship between regulator and regulatee. So we can proceed, relaxed about definitional dissensus, to test the proposition that trust, subjectively conceived, promotes compliance with regulatory laws.

THE NURSING HOME STUDY

The data employed to test whether or not subjective trust affects change in compliance comes from a study of the Australian nursing home industry. The impetus for this study came when the Australian Commonwealth government moved to take over from state governments the monitoring and enforcement of standards of quality of care in nursing homes throughout Australia. In conjunction with the introduction of this regulatory scheme, the Australian government commissioned an evaluation of this new initiative. The government agreed to inspect a stratified proportionate random sample (stratified by size, type of ownership and level of disability of residents) of 242 nursing homes over a twenty month period. These nursing homes surrounded the four largest metropolitan centres in Australia in which more

than two-thirds of all nursing homes in Australia are located. In order to increase sample size all additional homes inspected within the sampling regions during this period were included in the study ($n=168$)³.

As part of the new initiative, 31 standards that covered seven main objectives—health care, social independence, freedom of choice, privacy and dignity enjoyed by residents, the environment of the nursing home, the variety of experience available to residents, and safety (including risks from fire, violence, infection and the use of restraints)—were introduced in 1987⁴. The procedure for inspecting nursing homes is straightforward. A team of no fewer than two, one of whom must always be a trained nurse, visits the nursing home for an average of 6.5 hours. The team is required to inspect and rate each of the 31 standards as met, action required or urgent action required. Following this there is a compliance meeting between the nursing home and the inspection team where the team discusses its initial ratings with staff. Negotiation over the accuracy of the ratings sometimes requires the inspection team to revisit the home to gather further information. In this meeting the appropriate action plans to bring the nursing home into compliance are discussed and are included in the final report. Within ten days of the compliance meeting the final report is sent to the nursing home which has six weeks in which to object to its contents.

It is these 31 ratings which provide the objective dependent measure of organisational compliance. A separate study has shown that the standards are reliable, valid and comprehensive in their coverage of the medical, personal and social needs of the nursing homes' residents (Braithwaite, Braithwaite, Gibson, Landau and Makkai 1991). On this basis the standards are summed to form a total measure of compliance ranging from 0 (no compliance) to 31 (absolute compliance). Test-retest reliabilities based on independent inspectors rating 50 homes ranged from .93 to .96 (Braithwaite, Braithwaite, Gibson, Landau and Makkai, 1991). Following this initial inspection and the finalisation of action plans to remedy non-compliance, the

³ The random and supplementary sample were compared on a range of factors (see Braithwaite, Makkai, Braithwaite, Gibson and Ermann, 1990). There were no substantial differences between these two groups of homes in terms of geographical and organisational characteristics of the nursing home, the socio-demographic characteristics and attitudes of the directors of nursing and the nursing home's compliance ratings: On this basis the two groups have been combined. However, the models include a control variable indicating whether or not the nursing home was part of the random sample.

⁴ See Braithwaite, Braithwaite, Gibson, Landau and Makkai (1991) for a detailed discussion of the standards.

director of nursing in each home was interviewed. These interviews were extensive, encompassing over three hours and more than one sitting in some cases. The response rate for the random sample was 96 per cent. It is these data which provide the subjective trust measure.

A second inspection was undertaken of 341 of the initial 410 homes, mostly 18 to 20 months later⁵. The dependent variable is the total compliance score at this second inspection which, as discussed in the next section, will be explained, controlling for compliance at the first inspection. The addition of the first inspection ratings in Table 1 has the effect of controlling for a variety of factors that have been shown in previous work to affect corporate compliance amongst nursing homes (see Braithwaite and Makkai, 1991; Makkai and Braithwaite, 1991). These factors include the type of ownership, size and age of the nursing home, nursing resident profile, and number of inspectors on the team. As there is no theoretical rationale as to why these factors should also affect change in the level of compliance (compliance at time-2 controlling for compliance at time-1) we have assumed that the control for initial compliance captures all of their effects.

The model does control for four other factors. The first and most important is the geographical location of the nursing home. This factor is shown to be important in predicting first-wave compliance but, as our fieldwork suggests that interstate differences in regulatory styles may have varied across time, this has an impact on change in compliance. Three dummy variables are used to capture the four geographical regions—Queensland, Victoria, New South Wales and South Australia. South Australia has been chosen as the excluded category as nursing homes located in this state had significantly lower levels of compliance than nursing homes in the other three states. The second control variable is whether or not the nursing home had been selected as part of the original random sample. The third control is the time taken between the first and second inspections and the final variable controls for whether or not the director of nursing had

⁵ See Braithwaite, Makkai, Braithwaite and Gibson (1992) for a detailed discussion of the follow-up rates for the study. Although preliminary data analyses indicated that the time between the first and second inspections did not significantly affect compliance, the time between the two inspections has been included in the model as a control variable. Analyses were undertaken to determine if there were any significant differences between homes which had, and had not, been visited by an inspection team. Out of seven characteristics of the director of nursing, four characteristics of the nursing home and three characteristics of the proprietor only one characteristic of the director of nursing was found to differ significantly ($p < .01$) (Braithwaite, Makkai, Braithwaite and Gibson, 1992).

changed between the first and second inspections. Appendix Table A, page 14, provides descriptive statistics on the control variables.

This is a study of director of nursing perceptions of trust on the compliance of their nursing homes. Such a strategy of enquiry assumes that the director of nursing has the control necessary in the home to ensure compliance with the standards. We have argued elsewhere that this is generally the case (see Braithwaite and Makkai, 1991; Makkai and Braithwaite, 1991). Unlike US nursing homes where the director of nursing answers to senior management above and middle management below, in the Australian context directors of nursing are all-powerful matrons, a situation reinforced by the regulatory requirements. As the average Australian nursing home has about 40 employees, this also ensures that directors of nursing do have control over staff unlike those in larger American nursing homes. This claim is validated empirically by the 76 per cent of directors of nursing who said that they agree that they "have the final say on most of the decisions that matter". Twelve per cent neither agreed nor disagreed while 13 per cent disagreed. This finding from the quantitative component of the study is verified by fieldwork observing 56 inspections of Australian nursing homes.

Given, however, that there is a minority of directors of nursing who do indicate little control, and the critical importance of control in affecting corporate compliance, the analysis in this paper is restricted to those directors of nursing who indicate control over the running of the nursing home. The assumption is that, if directors of nursing are not in control, their perceptions will be of little consequence as to how their organisations respond to the standards. A scale comprising three items measuring director of nursing control over their nursing home (see Makkai and Braithwaite, 1991) was used to exclude directors of nursing more than one standard deviation below the mean on the scale. This resulted in a loss of 42 cases.

DOES TRUST PREDICT COMPLIANCE?

There is no reason to expect that trusting encounters between inspectors and directors of nursing will improve compliance on that inspection, since the actions that shape the level of compliance occur before the inspection begins. Rather, what we hypothesize is that trusting encounters during inspection 1 increase the prospects of an improvement in compliance

between inspection 1 and inspection 2. There is a further reason for controlling for time-1 compliance. If we find trust to be positively associated with time-2 compliance, this might be because inspectors can pick homes that are not worthy of trust. The two competing models are set out in Figure 1. Under Model 2, a positive association between trust and compliance is an artifact of good (trustworthy, compliant) homes being treated with trust because they are good homes. The good homes on which trust is selectively bestowed at time-1 are more likely to continue to be good homes at time-2. Hence, it is necessary to test for the effect of trust on compliance at time-2, controlling for how good the home was at time-1. Failure to do this would leave no basis for favouring model 1 over model 2 as the interpretation of the results.

Model 1



Model 2

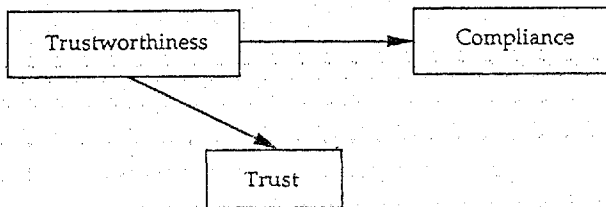


Figure 1: Competing models of trust and compliance

The measure of trust employed here uses two attitudinal statements to which directors of nursing were asked to respond following the first inspection. These statements were "The team treated me as someone who could only do the right thing when forced to" and "The team treated me as a person who could be trusted to do the right thing". Directors of nursing were asked the extent to which they strongly agreed, agreed, neither agreed nor

disagreed, disagreed or strongly disagreed with the statements. The two items are significantly negatively correlated ($r=-.43$; $p=.0001$). Responses to the negatively worded item were rescored and the two items were then summed⁶. As the scale had no natural metric it was rescored so that it ran from zero to 10. Figure 2 shows the distribution of responses across the item⁷. Clearly the majority of directors of nursing perceive the teams as having trust in them. This is also shown by the high mean for the scale ($M=7.59$).

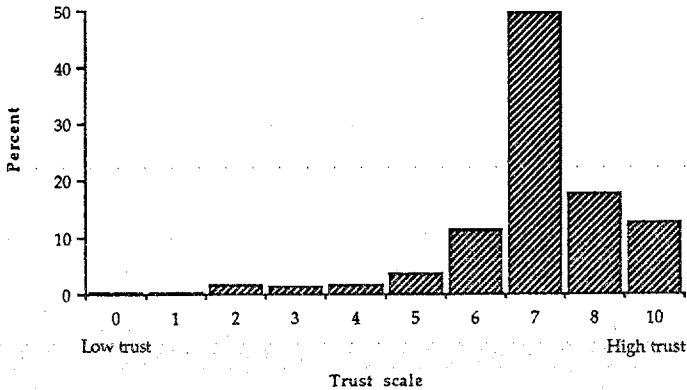


Figure 2: Distribution of response across trust scale (n=299)

The trust scale was then used to predict change in compliance. The analysis is shown in the first two columns of Table 1. Given that the dependent variable is continuous, ordinary least squares is the method used to estimate the effects. This method assumes that the relationship is both additive and linear (Hanuscheck and Jackson, 1977). The table provides both the standardized and unstandardized coefficients. The analysis shows that trust is significantly associated with the change in compliance between the first and second inspections. When regulators are seen as treating managers

⁶ Prior to summing the two items, missing values were recoded to the mean. This involved five cases on one variable and three on the other. In order that neither item dominated the scale, each item was divided by its standard deviation, effectively ensuring a variance of one but still retaining the mean.

⁷ For clarity the scores have been grouped into 10 categories.

with trust, compliance is more likely to improve after the trusting encounter. This improvement is above and beyond the effects of the different regulatory styles that operate in the different states, whether or not the nursing home's director has changed between the two inspections and the other variables implicitly controlled by the addition of time 1 compliance to the model.

Table 1: The effect of subjective trust on change in corporate compliance (n=299)

	Entering trust		Entering trustworthiness	
	b	(beta)	b	(beta)
Compliance at time 1	.29	(.27)**	.15	(.14)*
Queensland home	2.33	(.14)**	2.80	(.24)**
Victorian home	-.60	(-.06)	-.19	(-.02)
New South Wales home	2.89	(.32)**	2.97	(.33)**
Sample home	-.62	(-.07)	-.55	(-.06)
Change in director of nursing	-1.04	(-.11)*	-1.04	(-.11)*
Length of time between first and second inspection	-.07	(-.08)	-.06	(-.07)
Director of nursing's perception of team's trust in them	.39	(.14)**	.29	(.10)*
Team's assessment of the need for intervention in the nursing home (trustworthiness)	-	-	.34	(.20)**
Constant	16.10		17.58	
Adj R-square	.27		.29	

* significant at $p < .05$; ** $p < .01$.

TIGHTENING THE CONTROL FOR UNTRUSTWORTHINESS

In Table 1 how good the nursing home was during inspection 1 has been controlled. Yet it is possible that inspectors have the capacity to pick good homes that are about to go bad. Indeed, another study suggested that these inspectors do have a capacity to predict time-2 compliance over and beyond the predictive capacity afforded by time-1 compliance (Braithwaite, Braithwaite, Gibson and Makkai, 1992). Specifically, a perception by inspectors that this was a nursing home that needed intervention predicted time-2 compliance even after time-1 compliance had already been controlled. We construe perceived need for intervention as equivalent to perceived trustworthiness (as in Model 2, Figure 1). Need for intervention means that the view of the home is that it cannot be left to exercise its discretion freely on the matters of intervention and this is definitional of distrust.

The measure of need for intervention is based on whether or not the team assessed that: (a) they needed to get tough with the nursing home, (b) the home needed a lot of management advice, (c) the home needed a lot of educating as to what the standards meant, and (d) the home needed a lot of persuading that the standards were in the best interests of their residents. Teams assessed each of these strategies on a one-to-seven scale ranging from the strategy being seen as needed through to not needed. These four strategies are highly inter-correlated as is shown in Table 2. The correlations between the four measures range between .56 and .80. Given the high inter-correlations, the four strategies have been combined into a single measure of the team's assessment of the need for intervention in that nursing home. The Cronbach alpha is .89. The procedures were used to construct the trust scale were employed for developing the scale of need for intervention.

Table 2: Team's assessment scale (n=299)^a

	Percent not needing intervention	Inter-item correlation			Item-total correlation
		1	2	3	
1. Get tough	37				.67
2. Advice	13	.56**			.74
3. Education	21	.54**	.80**		.87
4. Persuasion	35	.64**	.62**	.79**	.77
(Cronbach's alpha)					(.89)

^a Was it a home a) where the team felt there was a need to get tough, to wave or use the big stick? b) that needed a lot of management advice on what options it could pursue to improve its compliance ratings? c) that needed a lot of educating as to what the standards meant? d) that needed a lot of persuading that the standards were in the best interests of their residents? Response categories ranged from 1 (needed the strategy) to 7 (did not need the strategy). ** p<.01; two-tailed.

Consistent with the prediction of Model 2 in Figure 2, when need for intervention (trustworthiness) is added into the regression, it has a significant effect on compliance. Moreover, this washes out some of the effect of trust on compliance as predicted by Model 1 in Figure 2. However, a significant positive effect of trust on compliance remains. Thus these data provide support for both models in Figure 2. There is a significant effect of regulatory trust on compliance. This effect comprises of a direct effect and an artifactual effect mediated by trustworthiness as a common cause of both trust and compliance.

POLICY ANALYSIS

The policy implications of a conclusion that trusting regulatory behaviour engenders compliance with the law are profound. The received wisdom of the American regulatory tradition is that business should be treated with distrust. In Japan, in contrast, the dominant ethos is that business executives should be treated as honourable citizens. These results can be read, therefore, as support for the Japanese ethos over the American. This would, however, be a simplistic reading. While aggregate quantitative analyses suggest that trust works and deterrence fails within Australian nursing home regulation (Braithwaite and Makkai, 1991; Makkai and Braithwaite, 1992b), data from the qualitative fieldwork observing 56 nursing home inspections suggests that these aggregate quantitative results mask a lot of cases where trust fails and where deterrence succeeds (Makkai and Braithwaite, 1992b). Regulatory institutions should not be designed to work well with the quantitatively revealed average case. Regulatory institutions must be designed with a capability for dealing with every kind of case—from the best to the worst. Bad single cases of abuse of trust can have truly catastrophic consequences—the nursing home that causes 20 deaths, the nuclear plant that destroys an ecosystem for centuries. Also, such cases can undermine perceptions of fairness and therefore of commitment to the rules among the trustworthy. What is needed is a regulatory strategy that combines a preference for trust with an ability to switch to a policy of distrust. Ayres and Braithwaite (1992: Chapter 2) have elaborated on what such a strategy involves. Briefly, it is a dynamic strategy that enables regulators to try trust first and then escalate up a pyramid of more and more interventionist regulation if abuse of trust occurs and persists.

In considerable measure, then, effective regulation involves a policy of keeping trust in the psychological foreground, while distrust looms as a structural fact in the background. The aphorism coined late in the cold war to characterise US strategic negotiation with Gorbachev captured well this sleight of hand: 'Trust but verify'. That is, it would have been a mistake to have dealt with Gorbachev as if he were untrustworthy and it would have been irresponsible to have failed to monitor abuse of trust and to have been unprepared to respond to such abuse. The regulatory state does best at securing compliance when it eschews threat, treating citizens as trustworthy.

Yet when the corporate citizen contemplates abuse of trust, it looks behind the demeanour of trust to see an image of state invincibility. This is perhaps not an inaccurate description of how Japanese corporations view their state (Braithwaite and Fisse, 1985).

At a more micro level, there are ways of institutionalising 'trust and verification'. This requires a shift from the frame of liberal theory to that of republican theory, a shift from a hierarchical fiduciary conception of trust to a communitarian conception. The hierarchical fiduciary conception is trapped in its own logic. Guardians like auditors are recruited to catch abuse of trust. But what if the guardians are untrustworthy? The only answer can be another layer of guardianship above them. In the hierarchical model, as in Figure 3, the only check on self-interested abuse by an n th order guardian is an $n+1$ th order guardian. But then if the $n+1$ th order guardian is corrupt, the whole edifice of assurance collapses. This is not just a nice philosophers' puzzle of infinite regress; we see its practical manifestation with police departments which, like fish, rot from the head down. Figure 3 shows a simple formal solution to the puzzle. Arrange guardians in a circle and there is no infinite regress. The logical structure is that everyone becomes a guardian of everyone else.

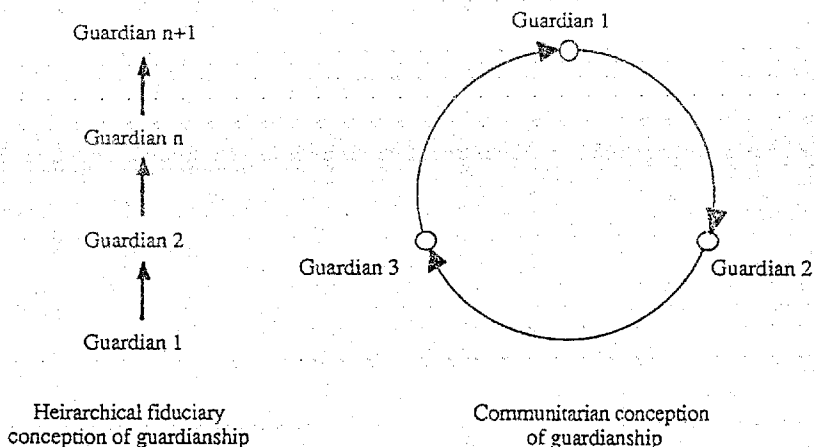


Figure 3: Formal models of heirarchical fiduciary and communitarian conception of trust

Arranging guardianship in a circle could be taken as definitional of communitarianism, of how the constitution of a republican democracy is different from that of a liberal representative democracy. The institutional embodiments of circular guardianship in business regulation are dialogic tripartite regulatory institutions where the actions of those in the circle are transparent and contestible from outside the circle (Ayres and Braithwaite, 1992). We see these with some, but not most, American and Australian nursing home regulation. State regulators sit down with representatives of nursing home management, staff and residents' council in an open problem-solving dialogue that leads to negotiated solutions to regulatory problems. Threat and the politics of distrust are rarely necessary in such negotiations. Management more often than not respond in a trustworthy way to the climate of trust because they can see that the very process of dialogue empowers the other participants with dangerous knowledge they could use against management. Management is not confronted with a residents' council that threatens litigation by an advocacy group lawyer. Even though that threat may be neither made nor thought by the residents' council, management can look behind the trusting demeanour of the council to see that such a capability is a structural fact of a residents' council empowered by the knowledge gained from participation in dialogic regulation and by the existence of competent advocacy groups at their disposal outside. By getting the structural conditions of communitarian regulation right, it is possible for regulatory encounters to be based on trust, with deterrence always threatening in the background but never threatened in the foreground. Of course, such an accomplishment would always be fragile, which is why regulatory institutions must be dynamic, responsive to their own histories of misplaced trust.

CONCLUSION

When nursing homes are untrustworthy, when they are at risk of slipping into patterns of poor-quality care for powerless residents who need protection, our data suggest that nursing home inspectors can identify this. They then act in a more distrustful (interventionist) way towards nursing home management. Even controlling for the effect of trustworthiness on compliance; however, we have found that the perception of trust is

associated with improved compliance. Obversely, when managers perceive that they are not trusted, compliance is more likely to deteriorate. Our policy analysis suggests that regulatory institutions should be designed, therefore, to nurture trust. They should not be designed for knaves as suggested by Hume and Hobbes. However, they should not assume that trust will be reciprocated. Regulatory institutions can both nurture trust and respond aggressively when it is abused. Guardianship of public values can be based on dialogue rather than distrust, dialogue that empowers with voice and knowledge those whose interests are at risk. There are two civic republican answers to the question of who guards the guardians? (a) communities of dialogue wherein each is recursively accountable to every other (dialogue that, without threatening distrust, naturally exposes abuse of trust to community disapproval); and (b) civic virtue nurtured by trust. Practical strategies are available for increasing the dialogic qualities of our regulatory institutions, for empowering residents' councils and advocacy groups in nursing home regulation, environmental groups in environmental regulation, worker representatives in occupational health and safety regulation, consumer groups in the regulation of banks, women's groups in affirmative action regulation. Protecting and nurturing the public trust will be best advanced through refining such practical strategies for expanding the boundaries of regulatory dialogue and enriching its quality.

*

Appendix Table A: Definitions, means and standard deviations for control variables (n=299)

Variables	Definition	Mean	(Std dev)
Queensland home	1=yes, 0=other	.17	(.38)
Victorian home	1=yes, 0=other	.27	(.44)
New South Wales home	1=yes, 0=other	.44	(.50)
Sample home	1=yes, 0=no	.59	(.49)
Change in director of nursing	1=yes, 0=no	.30	(.46)
Length of time between first and second inspection	months	21.80	(5.52)

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