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Critical Success Factors for Speech
Language Pathology Private Practice in
New South Wales, Australia,
and New Zealand

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Science (Speech Science), The University of Auckland, 2016.*

Abstract

This research explores the critical success factors of private practice (PP) Speech Pathology/Speech-Language Therapy (Speech Language Pathology, (SLP)) in New South Wales (NSW), Australia, and in New Zealand (NZ). A cross-sectional mixed method survey provided quantitative and qualitative data allowing comparison between SLP private practitioners (SLPPPs) in terms of country, location (city, regional, rural), ethnicity, and age. The participants include 15 NZ SLPPPs, and 95 SLPPPs from NSW. The only significant difference between the participants from NSW and NZ was a lack of SLPPPs from rural locations in NZ. Participants' responses were combined for analysis. The 11 success criteria, consisting of 10 small business success criteria established by Gorgievski, Ascalon and Stephan (2011), and professional satisfaction, were ranked. 'Satisfied stakeholders', 'professional satisfaction' and 'utility' (usefulness) were the first three highest ranked criteria for SLPPPs. Factor analysis of the success criteria established four sub-groups: 'business', 'professional satisfaction', 'innovation', and 'contribution to society'. SLPPPs self-rated their performance on questions relating to the 11 success criteria; 70.9% of participants rated with a high level of total success. The sub-groups with the highest self-rated mean performance were: 'contribution to society', 'professional satisfaction', 'innovation', and 'business' (in order from highest to lowest). The performance of SLPPPs, rated using the total success rating score, was correlated or co-varied with SLPPPs' 'ability': personal characteristics: resilience, and cultural literacy; experience: business skills experience, experience as private practitioners (PPs) and on-the-job experience; and professional competence. Performance was also correlated or co-varied with 'opportunity': business structure; business strategy: cost value propositions; financial capital; human capital; marketing: challenging the assumption of referrers; management practices: leadership practices, documentation, business adaptability, support for innovation and business support; social capital; and professional practices: ensuring a range of clinical policies and practices in keeping with professional standards. These factors are the critical success factors (CSF) for SLPPPs. Thematic analysis of qualitative data reinforced the themes and issues relating to 'professionalism': clinical and business skills; the values of SLP, the relationship between PP and business, survival, support, time management, and practices around finance. This research provides support for the components of 'ability' and 'opportunity' in the performance of SLPPPs using Boxall and Purcell's (2011) model of performance where: performance = ability.motivation.opportunity.

Further research is necessary in order to explore the relationship between SLPPPs' 'motivation' and the performance of SLPPPs and the viability of SLP PP.

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Table of Abbreviations

Table 1. List of Abbreviations

Abbreviation	Definition
ABN	Australian Business Number
ACC	Accident Compensation Corporation (NZ)
ACST	The Australian College of Speech Therapists
CCP/ECP	Chronic Care Plan (supersedes the Enhanced Care Plan) (Australia)
CSF	Critical Success Factor
DHB	District Health Board (NZ)
EBP	Evidence based practice
EPC/CCP	Enhanced Care Plan (now replaced with Chronic Care Plan) (Australia)
GDP	Gross domestic product
GST	Goods and Services Tax
HBB	Home-based business
HCWA	Helping Children with Autism Scheme (Australia)
HPWS/HIWS	High performance work systems also called high involvement work systems
HWA	Health Workforce Australia
HWNZ	Health Workforce New Zealand
IPA	Independent Practitioner Organisation (NZ)
KPI	Key Performance Indicator
MDT	Multidisciplinary team
NDIS	National disability insurance scheme (Australia)
NGO	Non-Government Organisation (NZ)
NRAS	National Registration and Accreditation Scheme (Australia)
NSW	New South Wales
NZ	New Zealand
NZSTA	The New Zealand Speech-language Therapists' Association
OT	Occupational Therapist
PHO	Primary Health Organisation (NZ)

Table of Abbreviations

PP	Private practice
PPs	Private practitioners
PRISMA	Preferred Reporting Items for Systematic reviews and Meta-Analyses (Liberati et al., 2009)
PT	Physiotherapy
SES	Special Education Service (NZ)
SLP	Speech language pathology Includes: Speech-language therapy and/or speech pathology and used when referring to both
SLPs	Speech-language therapists (NZ) and/or speech pathologists (NSW) and used when referring to both
SLPPPs	Speech-language therapy private practitioners (NZ) and/or speech pathology private practitioners (NSW) and used when referring to both
SLT	Speech-language therapist (NZ)
SPA	Speech Pathology Association of Australia Limited
Speech path.	Speech pathologist (NSW)
SW	Social Work
USA	United States of America
WLB	Work-life balance

Table of Terminology

Table 2. Table of Terminology

Term	Definition
Allied Health Professionals	Health professionals who are not doctors or nurses
Bureaucracy	Large workforces led by salaried managers and predominantly managed through an industrial or craft model of business (Boxall & Purcell, 2011, p.239).
Business Birth/Enterprise Birth	A new enterprise starting operation (not due to restructuring or re-activations) (Ministry of Business Innovation and Employment, 2016)
Business Death/Enterprise Death	An enterprise ceasing operation (not due to restructuring) (Ministry of Business Innovation and Employment, 2016)
Business Failure	As for business death
Business Partnership	A business entity which is an association of people who carryout business and distribute profits and losses amongst themselves (Australian Taxation Office, 2015)
Business Start-up	As for business birth
Business Survival	Business that has not experienced an enterprise death
Company	Legal business entity run by its directors and owned by its shareholders (Australian Taxation Office, 2015)
Critical success factor	Factors that must go well to guarantee a business' success
Enterprise	Institutional unit [of business], usually a legal entity in New Zealand (Ministry of Business Innovation and Employment, 2016)

Table of Terminology

Entrepreneur (SLP)	An entrepreneur is a SLP who exhibits innovative practice for profit and growth, or, for the purpose of advancing the needs of clients or the profession.
Home Based Business	Business based at home (office or client contact at home)
Key Performance Indicator	An indicator able to be measured to monitor business performance
Microbusiness	Small businesses with 0–4 employees (Commonwealth of Australia, 2011, p.3).
Professional Craft Business	Businesses that rely on a profession
Small Business	A business with 0-19 employees (Commonwealth of Australia, 2011, p.3).
Speechies	Term of endearment for SLPs
Sole Trader	Business entity in which you trade on your own and control your own business (Australian Taxation Office, 2015)
Speech Language Pathology (SLP)	Term used when referring to both speech pathologists and speech-language therapists which describes the same profession in NZ and NSW
Speech-language Therapist	Term used by The New Zealand Speech-Language Therapists' Association to refer to SLP
Speech Pathologist	Term used by the Speech Pathology Association of Australia Limited to refer to SLP
Viability	Business survival, over time, in a chosen market (Boxall & Purcell, 2011, p43)

Unreferenced definitions are provided only as a guide to the way the term will be used in this research.

1 Introduction

1.1 Overview

Speech pathology/speech-language therapy (SLP) services in Australasia are usually provided in health, education, and disability sectors (Health Workforce Australia, 2014; Heine & Smith, 1990). Public services which require public funding are increasingly under pressure to provide for a growing demand in health services (Gorman, 2015), education services (Massey University, 2002) or disability services (Australian Law Reform Council, 2014; Ministry of Health New Zealand, 2001). Ensuring stable and sustainable SLP services in private practice (PP) is emerging as an important issue in Australasia. A viable SLP PP sector is important as private practitioners (PPs) are a major service provider for people with communication and swallowing difficulties. The PP sector is also a major employer of speech language pathologists (SLPs) and as such needs to be as robust as possible, to support the future viability of the profession.

Increasing economic rationalisation in public services and an increasing supply of new graduate SLPs (Brownfield, 2015) may be reasons for the growth of SLP PP. Increasing numbers of SLPs are working in PP in Australasia (Health Workforce Australia, 2014; Heine & Smith, 1990; The New Zealand Speech-language Therapists' Association, 2015), with more SLPs currently working in PP than for the public service in New South Wales, Australia (Health Workforce Australia, 2014).

SLP is a profession and hence all professionals including those in PP will have professional motives. Private practitioners (PPs) will also have business objectives and business success criteria in addition to professional motives. The way that government bureaucracies structure their business model (Boxall & Purcell, 2008), undertake workforce planning (Gorman, 2015) or provide funding for specific services (Gauld, 2008; Mousourakis, 2013; Skeat, Morgan, & Nickless, 2010) has had an impact on the type of workplace pressures experienced by SLPs (Boxall & Purcell, 2008; Severn, Searchfield, & Huggard, 2012), SLP service delivery (Massey University, 2002; Skeat et al., 2010), the ability to provide evidence based practice (Cheung, Trembath, Arciuli, & Togher, 2013), the ability to provide ethical practice (Atherton & McAllister, 2009; Flatley, Kenny, & Lincoln, 2014), and professional

satisfaction of SLPs (Harris, Prater, Dyches, & Heath, 2009; Hutchins, Howard, Prelock, & Belin, 2010; Kenny & Lincoln, 2012).

SLP PP can be viewed as a professional ‘craft’ model of business, where the business is based around a profession requiring “...*long periods of professional education and socialisation*” (Boxall & Purcell, 2011, p.234). A professional craft model of business offers more professional autonomy than a bureaucracy. A ‘public sector bureaucracy’ is described as a ‘classical bureaucracy’ in which “*salaried career managers lead large workforces which are predominantly managed through an industrial [or craft] model*” (Boxall & Purcell, 2011, p.239). Due to recent economic rationalisation, some public sector bureaucracies (Boxall & Purcell, 2011; Gorman, 2015; Milsted, 2013) have moved toward a ‘Flexible bureaucracy’ model where: “*.a salaried hierarchy remains but where it has become legitimate to out-source operations and specialist functions, downsize workforces and weaken long-term commitments to employees*” (Boxall & Purcell, 2011, p.240). In a professional craft business, PPs are usually self-directed without layers of non-SLP managers, which increases SLPs’ ability to make decisions that uphold the provision of evidence based practice (EBP). Providing EBP increases SLPs’ professional satisfaction (Cheung et al., 2013; Kenny & Lincoln, 2012). However, more autonomy means less regulation which raises concerns for professional governance/accreditation (Atherton & McAllister, 2009, p.6) and the robustness of the sector to support the profession (Health Workforce Australia, 2014).

SLP PP businesses in Australasia are usually classed as micro or small businesses. The Australian Bureau of Statistics (ABS) defines a small business as: “*...an actively trading business with 0–19 employees*” and ‘micro businesses’ as: “*businesses with 0–4 employees*” (Commonwealth of Australia, 2011, p.3). Actively trading businesses are defined as those that have an Australian Business Number (ABN) and are registered for Goods and Services Tax (GST) (Commonwealth of Australia, 2011, p.3). The same definition in terms of number of employees is used in New Zealand Government reports regarding small business (New Zealand Government, 2014, p.10). Concerns regarding the stability of SLP PP are well founded given the survival rate for small businesses in New South Wales (NSW) and New Zealand (NZ) (Griffith & Wilkinson, 2012; Ministry of Business Innovation and Employment, 2015; Wilkinson, 2005). The small business survival rate in NSW, from 2007-2011, is reported to be 54-69% depending on the size of the business: “*no employees: 54.1%*”, “*one to 19 employees: 68.7%*” (Griffith & Wilkinson, 2012, p.4). The survival rate for New Zealand small businesses in 2014 was reported as: “*no employees: 50%, one to five employees: 64%, six to 19 employees:*

69%” (Ministry of Business Innovation and Employment, 2015, p.2). However, in a longitudinal study covering 1973-1990, Wilkinson (2005, p.27) found, 74% of NSW small businesses failed over that period. Therefore, assuming SLPPPs are at least somewhat like other small businesses, a level of business risk is undertaken by SLPPPs. In order to mitigate that risk, it would be valuable for SLPPPs to have knowledge about what SLP professional and professional business factors enable viability of their business and success in their respective marketplaces. This information is currently lacking in the SLP and small business literature.

Establishing behaviours which support SLP PP business to survive and succeed will be increasingly important if the current growth of private practitioner numbers is sustained. However, the nature of success in business must first be defined. What are the success criteria for SLPPPs? Can SLPs rate themselves on those criteria? If SLPs rate themselves with a high level of success, what critical success factors, or make-or-break factors, do they employ to achieve that success? Can key performance indicators be established for those business practices?

This research hopes to establish:

- 1/ The success criteria of SLPPPs,
- 2/ A self-rating for success for SLPPPs, based on their judged success criteria,
- 3/ Business practices for SLPs with a self-rated high level of success in PP, and business practices for SLPs with a low level of self-rated success in PP,
- 4/ Key performance indicators for business practices associated with a high level of success in SLP PP, and,
- 5/ Differences between success criteria or critical success factors for the cohorts of NSW and NZ SLPPPs.

This chapter will introduce SLPs and SLP services in Australasia, present a brief history of SLP in Australasia, provide information on current models of business and workforce issues facing SLPPPs. A profile of what is known about PP businesses in Australasia is presented and the role of entrepreneurship in SLP is discussed. The business risk faced by SLPPPs is acknowledged with figures provided for small business failure in Australasia. The need for viable and successful SLP businesses is discussed within the Australasian economy, and in the professional context. The difficulty defining success in business is explored, highlighting the

need for success criteria for SLP PP. A model of individual and organisational performance is introduced and discussed in relation to potential use for SLPPPs. The role of strategic management in business viability and sustained advantage is presented showing the need to pinpoint critical success factors for SLPPPs. The chapter is concluded by providing the rationale for this research.

1.2 Who are Speech Language Pathologists (SLPs)?

SLP is an allied health profession. Allied health professionals are defined as: “[Health professionals] ...*who provide technical and scientific expertise to support the diagnosis, monitoring, management and treatment of health conditions*” (Ministry of Health, 2014, p11). The term SLPs has been used in this research to refer to both: speech pathologist, which is the term used by The Speech Pathology Association of Australia (SPA), and speech-language therapist, which is the term used for the same professional group, by The New Zealand Speech-language Therapists’ Association (NZSTA). SLPs: “...*diagnose, treat and provide management services to people of all ages with communication disorders, including speech, language, voice, fluency and literacy difficulties, or people who have problems with eating or swallowing*” (Health Workforce Australia, 2014, p6). The types of clients seen by SLPs are listed on the NZSTA website (The New Zealand Speech-language Therapists' Association, nd):

Children [with]: Speech difficulties or delays, Receptive language (language understanding) difficulties or delays, Expressive language (language use) difficulties or delays, Stuttering, Voice difficulties, Specific speech disorders (typically Developmental Verbal Dyspraxia or Childhood Apraxia of Speech, or speech difficulties associated with Hearing Impairment), Complex needs (e.g. children with Down Syndrome or Cerebral Palsy), Social communication difficulties (such as those associated with Autistic Spectrum Disorder), Feeding and/or swallowing difficulties, Reading and writing difficulties.

Adults [with]: Speech difficulties following stroke, Language difficulties following stroke, Speech and/or language difficulties following a Traumatic Brain Injury (TBI), Voice difficulties (including those associated with disorders such as Parkinson’s Disease), Stuttering, Swallowing difficulties, Language and social communication difficulties associated with disorders such as Dementia, Reading and writing

difficulties following stroke or TBI (The New Zealand Speech-language Therapists' Association, nd).

A similar client base is outlined by SPA (Speech Pathology Association of Australia, 2003, p11). Therefore, SLPs in Australia and New Zealand are allied health professionals who work in the health, education, or disability sectors, for private or public (government) organisations. The general scope of practice for SLPs includes the assessment, diagnosis, and, treatment, of communication and swallowing difficulties.

Business practices appropriate for SLPs are acknowledged and addressed within “*The Scope of Practice Guidelines*”:

[SLP] Conduct service management activities such as: Human resource management including: supervision of speech pathology students and colleagues, mentoring, recruitment, Business planning, Financial management, Physical resources and facilities management, Marketing and public relations, Quality improvement, Education of others (students, staff, carers and significant others and the community), Research (Speech Pathology Association of Australia, 2003, p.11).

These skills are relevant to PPs.

The qualifications required to operate as SLPs are, either, a professional bachelor of SLP; which is usually of a four-year duration, or, a two-year Masters qualification following a related undergraduate degree. SLP courses run by universities require recognition by SPA or NZSTA in order to be bona fide qualifying courses in Australasia (District Health Boards New Zealand, 2007; Health Workforce Australia, 2014). There is a clinical education component of all recognised SLP qualifications. SLPs working in Australasia, with qualifications from other countries, are required to meet qualification parity requirements provided by SPA or NZSTA; as stated on the professional bodies’ websites: www.speechtherapy.org.nz and www.speechpathologyaustralia.org.au. Standards for professional competency are outlined by SPA and NZSTA. The Australian standards are described in “*The Competency Based Occupational Standards (CBOS)*” (The Speech Pathology Association of Australia, 2011). It is expected that SLPs have met these standards on graduation from accredited courses.

1.3 A Definition of Speech Language Pathology Private Practitioners

SLPPPs are defined, for the purposes of this research, as SLPs working for, or owning, a for-profit business. This type of business can be termed a professional craft business, or business operating in a specific professional field. SLP private practices operate in the professional service industry because they are selling a service, not generally producing products.

1.4 Prevalence of Communication and Swallowing Disability

Almost six percent of the Australian population has a communication disability but actual incidence is likely to be underreported due to the way communication disability is conceptualised and reported (Crowley et al., 2013). Some researchers have focused on reporting the underlying medical condition and others on types of communication disorders (K. Wylie, McAllister, Davidson, & Marshall, 2013). Some indicators of prevalence of communication and swallowing disorders in Australia are provided by SPA, however few prevalence studies have been conducted in New Zealand:

...twenty percent of four year old children have difficulty understanding, or using language, fourteen percent of fifteen year olds have only basic literacy skills, twenty-eight percent of teachers take time off work each year because of voice problems, at least thirty percent of people post-stroke suffer loss of language (aphasia), eighty-five percent of those with Parkinson's disease have voice, speech and/ or swallowing difficulties, thirteen thousand Australians use electronic communication aids to get their message across, children with a language impairment are six times more likely to have a reading problem than children without, forty-six percent of young Australian offenders have a language impairment, there is a high correlation between communication difficulties and poor mental health, three in every one thousand newborns have hearing loss, which, without intervention can affect their speech, language and literacy, Indigenous children have three times more hearing problems than non-Indigenous children (The Speech Pathology Association of Australia, nd, p.1)

Effectively, the scope of SLP practice incorporates clients of the whole age span with a wide range of medical conditions and swallowing or communication impairments.

1.5 Professional Governance

Professional bodies provide professional governance for SLPs. Although membership of a professional body is not mandatory for private practitioners in New Zealand or Australia, SLPs must be eligible for membership to the relevant professional body in order to work as SLPs; as noted on the professional bodies' websites: www.speechtherapy.org.nz and www.speechpathologyaustralia.org.au. One of the purposes of NZSTA, listed in “*The Constitution of The New Zealand Speech-language Therapists' Association*”, is “[to]...promote, advance and support relevant evidence based speech-language therapy practice, and research, for the benefit of New Zealanders” (The New Zealand Speech-language Therapists' Association Incorporated, 2015, p.2)

Equally, “*The Charter of The Speech Pathology Association of Australia*” lists its mission as:

To prescribe, guide and govern the clinical and ethical standards of members in their practice of speech pathology • To facilitate and promote opportunities for members to pursue knowledge and develop professionally • To disseminate professional positions to key stakeholder groups including: the government, consumers, referrers and the public • To advocate for and respond to the needs of clients with communication and swallowing difficulties • To promote timely access to services • To represent the interests and views of members of the Association. (The Speech Pathology Association of Australia, 2010b, p.1)

The role of the professional body can be seen to benefit SLPPPs professionally and in business' endeavours. For example: professional bodies' promotion of the profession of SLP, and the profile of swallowing and communication disorders, in the wider community increases the profile of SLPPPs and raises the awareness of services offered by PP. National promotions such as: ‘*Speech Pathology Week*’/ ‘*Speech-language Therapy Week*’ market the profession and as a bi-product market SLP PP. Membership of a professional body for SLPPPs provides clinical and business advantages. Professional standards of practice including a Code of Ethics held by professional bodies provide the consumer an undertaking that members can be expected to practice within those standards. While SLP is not a government regulated profession in New Zealand or Australia, professional learning programs certified by professional bodies, such as the “*Certified Practice Speech Pathologist (CPSP)*” program, are used by stakeholders such as funding bodies and governments to regulate SLP service providers. This acknowledges that

CPSP certification provides some guarantee of professional standards and ongoing professional development/monitoring, to justify the validity of funding bodies' expenditure.

1.5.1 Supervision and mentoring

Supervision and mentoring foster professional support and provide monitoring of professional standards (The Speech Pathology Association of Australia, 2014d). Mentoring is defined by SPA (ibid.) as a relationship of “*equality*” between at least two SLPs functioning at the same level of expertise, which is beneficial for “*continued professional development*”. Discipline-specific supervision which is provided to SLPs by more experienced SLPs, and professional supervision, which can be provided to SLPs by another type of professional, are defined by SPA, as requiring an inherent power imbalance with “*clinical accountability*”. The requirement for discipline specific supervision, provided by SPA, for new graduate SLPs (with under two years' experience), is one hour per week. Discipline-specific supervision is recommended for all other SLPs, for one hour every two to four weeks (The Speech Pathology Association of Australia, 2014d). The aim of discipline specific supervision is to support the provision of ethical and evidence based standards of practice as outlined in “*The Code of Ethics*” (The Speech Pathology Association of Australia, 2010a) and “*The Principles of Practice*” (The Speech Pathology Association of Australia, 2001). While the profession supports the provision of supervision and mentoring for SLPs including PPs (ibid.), no specific literature is available regarding the actual levels of professional support used by SLPPPs in Australasia or the role of professional support in the success of SLPPPs or the SLP PP sector.

1.6 The History of Speech Language Pathology in New Zealand

The history of SLP in New Zealand, prior to 1990, is provided in the Workforce Development Report: “*Promoting Communication: The Speech-language Therapy Workforce in New Zealand*” (Heine & Smith, 1990). Training for SLPs was first provided, in 1942. Between 1942 and 1989, New Zealand's SLPs were trained at Christchurch Teacher's Training College, completing a one or two-year course for primary teaching. They were then endorsed as SLPs after “*one year of practice in the field*”. Demand for more health focused skills was reported in the 1950-1960s. This was addressed in the 1970s with a government initiated working party instigated by Ministers of Health and Education. A four-year Bachelor's degree in SLP began in 1989, and was jointly provided by Canterbury University and Christchurch College of Education, with support provided by the Christchurch School of Medicine. The

Bachelor of Speech-language Therapy was the only qualifying course in New Zealand until 2003, when Massey University began a Bachelor's course based in Albany, Auckland, and the University of Auckland, began a qualifying post graduate Master's course in the same year. Canterbury University also introduced a post graduate masters in 2014. Brownfield (2015) notes a 32.1% increase in SLP numbers from 2006 to 2013 with an annual intake of approximately 105 SLP students annually, in New Zealand, in 2015. Significant growth of the profession in New Zealand is evident over the last 10 years.

1.6.1 Sectors of employment

In New Zealand, SLPs have worked in health, education and disability sectors in public or PP to varying degrees. Heine and Smith (1990) compared sectors of employment for New Zealand SLPs, in workforce data from 1986 and 1989. They noted an increase in SLPs working in health (for hospital boards) 22 to 28% as opposed to education (for education boards) 78 to 72%, over the same period. The total number of SLPs employed across education and health increased from, 218 to 288 therapists, within that time period. In 1989, 11 SLPs were listed as completing part time PP (7.2% of all SLP) with no SLPs working in full time PP in 1989 (Heine & Smith, 1990, P. 17). In comparison, the number of PPs listed as members of NZSTA in October, 2015, was provided as: 133, which is 18.5% of the SLPs listed as members of NZSTA. It is not known whether these PPs work full, or, part-time (The New Zealand Speech-language Therapists' Association, 2015).

There is a lack of information about the NZ SLP workforce. No discipline specific workforce data has been reported by the public sector for SLPs working across all sectors in New Zealand, since 1990. A health workforce report completed in 2007 by the District Health Boards (DHBs) lists the number of SLPs working for DHBs as: '152' SLPs, with approximately '115 full time positions' (District Health Boards New Zealand, 2007, p.27). Alarming, the average length of retention of SLPs, is listed as: 3.5 years, with an average age of SLPs as: 34 years. The recent health workforce report: "*Health of the Health Workforce 2013 to 2014*", provides neither numbers of SLPs, and nor evaluation of the position of SLP within the workforce in New Zealand (Ministry of Health, 2014). The number of people listing their occupation as SLPs in the 2013 Census was 753 (Statistics New Zealand, 2013). However, this data is self-reported and it is unknown whether all would be eligible for membership of NZSTA. Formal registration of micro-businesses is not required in New Zealand, making it

difficult to track the actual numbers of SLPPPs. A lack of current comprehensive workforce data makes it difficult to predict the actual numbers of SLPs, and SLPPPs, in New Zealand.

1.6.2 Demand for speech language pathology services

An impression of demand for services is created by Heine and Smith (1990) reporting recruitment difficulties in health and education but not the disability sector (with few positions listed in the sector) in 1989. A *'brain drain'* was thought to exist with New Zealand trained SLPs emigrating in large numbers (Tillard, 2011). Although Tillard (2011) provided a figure of 15.8% of all New Zealanders emigrating, no actual numbers or percentages of New Zealand's SLP population working overseas, were provided. A shortage of SLP staff, is identified in DBH health workforce, with a need to address staffing and recruitment issues (District Health Boards New Zealand, 2007). A shortage of SLPs in NZ, was listed, as recently as two years ago, on Immigration New Zealand's *"Long-Term Skill Shortage List"* aimed at potential immigrants (New Zealand Government, 2015). The profession of SLP is no longer on this list, suggesting a perceived demand in SLP services was acknowledged, in New Zealand, until recently. The demand for SLP in New Zealand may have been addressed by attracting SLPs from other countries given New Zealand: *"...has the highest proportion of migrant doctors (42%) in the OECD countries (Ashton et al., 2013, p.10)"*. In addition, the Health Workforce New Zealand (HWNZ) was formed in 2009 due to: *"...criticism that the country had an unsustainable reliance on immigrant doctors and nurses to meet health care workforce needs"* (Gorman, 2015, p.401). The future need for healthcare services in New Zealand using *"population projections by age cohorts"* will *"significantly outstrip"* workforce supply using current staffing levels (Gorman, 2015, p.400). Accordingly, the attrition of staff from the allied health professions, need for extra training, and reliance on immigration to fill gaps in allied health positions, is documented in NZ (Ministry of Health, 2014, p.11). This implies a perception that the trend of a reduced SLP workforce in public health will continue in New Zealand.

1.7 Services Provided and Funding Models

A basic history of the funding models supplying SLP services and services provided are outlined.

1.7.1 Public health, disability and education in New Zealand

The public health, disability and education sectors have followed a trend outlined by Boxall and Purcell (2008) as bureaucracies increasingly establishing flexible business models to increase productivity and business performance. Economic rationalisation has forced changes in workforce focus in New Zealand due to healthcare costs growing almost three times that of GDP in New Zealand from 1950-2010 (Gorman, 2015). Changes have occurred in the health/education/disability services' business model, provision of funding, and, accordingly, SLP services, since 1942 (Barnett & Barnett, 2001; Heine & Smith, 1990; Massey University, 2002; Mousourakis, 2013). Initially services were provided in schools, then hospitals with few services provided to the disability sector (Heine & Smith, 1990). The bulk of government funding for SLP services in New Zealand has been provided by the Ministries of Education and Health. Initially SLP services were provided via departments of SLPs. More recently departments have evolved to teams in which line management is provided by other health professionals or managerial staff (Mueller & Neads, 2005) reflecting a multidivisional company type business model (Boxall & Purcell, 2008). Divisions of the business provide services for healthcare aggregates such as 'aged care'. Healthcare planning has increasingly focussed on 'service aggregates' such as early intervention rather than focusing on specific professional or 'craft' groups (Gorman, 2015). Changes in funding models and service delivery have reflected this focus in SLP service in New Zealand.

1.7.2 Legislation and business structure

Mousourakis (2013) provides an overview of the New Zealand health care system outlining the business model as determined by the NZ Public Health and Disability Act 2000 (Ministry of Health, 2000). Health boards in New Zealand were replaced by District Health Boards (DHBs) to reflect a "competitive internal market system (Mousourakis, 2013, p.112)" where the Ministry of Health provides public funds to support specific health services via funding agreements with DHBs. A DHB is a "publicly-owned health and disability organisation (Mousourakis, 2013, p.112)" that runs hospitals, provides community mental health services and public health. DHBs can contract services as part of their funding agreements to private providers such as Primary Health Organisations (not for profit primary health organisations), or private providers such as for disability services (Mousourakis, 2013).

1.7.3 Primary care funding

In response to this market centred approach to health care, independent practitioner associations (IPAs) were established prior to 2000 to mobilise GP groups to contract for government funded services with some degree of autonomy (Gauld, 2008). One IPA even developed services in which general practitioners provided an in-reach service following clients into hospitals (Gauld, 2008). Primary health organisation (PHOs) mandated and controlled by the government were intended to replace IPAs and introduce a multidisciplinary approach to primary care with community ownership/representation encouraged. This has been achieved to varying degrees according to Gauld (2008). No literature was found regarding SLPPPs involvement in PHOs. However, Mousourakis notes that SLPs form part of a basic health care team to older adults within their own home provided by DHBs or direct government funding, via “*The New Zealand Health of Older People Strategy*”(Ministry of Health New Zealand, 2002) released in 2001 (Mousourakis, 2013). The risk duplication of services within the DBH/PHO current funding framework for older New Zealanders is pointed out by Mousourakis (2013). No specific literature was available regarding the position of NZ SLPPPs within the scope of health/education/disability service provision in NZ.

1.7.4 Team structure

An example of the position of allied health professionals within the public health system is provided by Mueller and Neads (2005) who describe the flexible structure of the allied health workforce at Auckland District Health Board. In this model, line management is no longer provided to SLPs by SLPs. Line management exists in aggregate teams and is commonly provided by managers with a nursing qualifications (in the experience of the researcher having worked in that health system). In Muller and Neads’ model professional leadership/quality management and mentoring is provided for SLPs by a part time SLP position, which provides professional leadership to SLPs from different teams servicing aggregates such as aged care, rehabilitation, and paediatrics. In discussion of the New Zealand model of workforce development Gorman advocates further for:

...flexibility in deployment for all workers to allow us to fill the need for more general health care workers, such as rehabilitation practitioners, rather than specific roles, such as physiotherapy, occupational therapy, and speech language therapy (Gorman, 2015, p 402).

A transdisciplinary approach to health care can be seen as an ideal response to economic pressures by some bureaucracies. Professional craft models of business tend to favour a multidisciplinary team approach retaining craft professional grouping. Accordingly, there are no NZ SLPPPs who advertise as generic health care providers (yellow.co.nz, 2015).

1.7.5 Education and disability services

SLPs employed in education in NZ were initially based in schools and saw children with mild to moderate delays or disorders (Heine & Smith, 1990). Government reforms in the late 90s, established to promote a market orientated education/disability service, produced the Special Education Service (SES) (Massey University, 2002). SES (the provider) was set up as a business separate from the government (the funder), which could compete for services and secure government contracts for services. SLPs were initially asked to provide services under a contract to the Ministry of Education for children with moderate to severe communication needs (Else & Massey University, 1999). Services were provided as part of teams and were no longer clinic based. As SES was a business separate from the ministry of education, SLPs were able to provide private (fee paying services) to children who did not qualify for the contracted services, via an alternate arm of the Special Education Service. Government reforms in the 2000s saw the closure of this private arm of the SES and this model of business (Ministry of Health, 2000; C. Wylie, 2000). SES was disbanded in 2000. Further reforms changed the clients who were accessing the Ministry of Education's SLP services (Massey University, 2002). By 2008, SLP services were provided primarily for early intervention for children with severe communication needs before the age of five years (Ministry of Health New Zealand, 2001). Recent government initiatives have included provision of SLP services for children with severe communication needs for school aged children (Massey University, 2002). A revision of the NZ Disability Strategy is planned for November, 2016 (Office for Disability Issues, 2016).

The provision for children with moderate communication needs is addressed by ORRs (Ongoing Renewable Resourcing Scheme) funding. ORRs funding (previously ORs funding (Massey University, 2002)) was provided to schools to determine needs of other children with communication disability/delays; that funding was potentially available for SLP services (Massey University, 2002). Private SLPs could be contracted to particular schools to provide services for specific children identified by teaching staff using this funding. The same funding was also for teacher's aide hours in the classroom; meaning that teachers could elect to have

either SLP or teachers' aide services. Figures were not available for numbers of occasions of service provided by SLPPPs paid using ORRs funding. Children with mild or moderate communication needs not serviced could access private SLP services if families could afford those services. Given that significant numbers of the New Zealand population are deferring seeing primary health care providers such as doctors, dentists and collecting prescribed medicines due to cost (Jatrana & Crampton, 2009), it is likely that many families are deferring seeing private SLPs due to cost.

Some government initiatives have enabled private service providers to provide services to specific client populations. The Accident Compensation Corporation (ACC) which is owned by the government, provides personal injury cover with some funding to DHBs and PPs for specific services for disability services following an accident or injury (Accident Compensation Corporation, 2015). Specific client groups such as community based clients who have suffered a head injury, are provided packages of funding for specific interventions. Private SLP providers can be contracted by ACC to provide services for clients eligible for services. Clients who are eligible for services must have suffered a personal injury which includes either 'physical' or 'mental injury' (Accident Compensation Corporation, 2016). Many SLP clients, such as those with mild-moderate speech and language delay, not caused by a personal injury, would be excluded from accessing this funding.

Some clients may be eligible for services provided by non-government organisations (NGOs). NGOs were encouraged by the government as providers of health/education/disability services over the period (Mousourakis, 2013). Some NGOs have developed into Community Health Trusts who receive some government funding to provide health/disability services to specific groups (Barnett & Barnett, 2001). "*Community trusts are non-profit organisations, owned and controlled by communities, which provide, or ensure the provision of, primary care or other local health services under contracts with health funding agencies*" (Barnett & Barnett, 2001, p.229). Southern Health Trusts, as discussed by Barnett and Barnett (2001), are reported to provide some rehabilitation in Southern Regions of NZ. It is not stated whether these services include SLP services, and if so, whether these are contracted to private SLPs and which population of clients are included in the service provision.

In addition, some services are provided by Charitable Trusts. These not-for-profit organisations usually have a specific focus and specific business structure. *TalkLink Trust* is a charitable trust performing an assistive technology service that employ SLPs to assess people's

requirements for assistive communication technology, in NZ (TalkLink Trust, nd). *TalkLink* are able to access funding from ACC and procure contracts with the Ministry of Health for eligible clients. Other trusts such as *The Trusts Community Foundation* are mandated to provide funding to community groups for sport, arts, culture, health etc. with proceeds which derive from sources such as gaming (The Trusts Community Foundation, nd). Allied health services are listed as recipients of these funds. Recipients of funding from charitable trusts must meet certain criteria to receive funding. The majority of the funding for trusts is provided via public donations (The Public Trust, nd). No literature was found regarding the availability of services to support clients to find the appropriate funding body or to monitor any lack of funding/services for specific client groups.

1.7.6 Range of services

The range of funding models outlined represent a very flexible bureaucratic model of services. This flexibility has consequences for service provision and delivery. Gauld (2008) notes that one of the consequences of PHOs is: “*the creation of a labyrinth funding and organisation system with a variable capacity – at least in the short term- to deliver on the government’s reform objectives*” (Gauld, 2008, P 94). Accordingly, the flexibility of a business model, which services only particular aggregates of health care service, is not servicing the needs of all client groups. The provision of SLP services for children with mild-moderate communication delays or disorders may be one example. Parent blogsites regarding services for children with communication difficulties report long wait times for public paediatric SLP services in New Zealand (ENZ, nd). There is evidence in the SLP literature that intervention is appropriate for certain client groups such as those with articulation and phonological disorders (Royal College of Speech and Language Therapists, 2005) who may be considered as low priority in terms of service focus by government organisations.

1.7.7 Impact on speech-language therapists

Boxall and Purcell (2008) warn that increasing flexibility of services within a bureaucracy places demands on professionals to increase efficiency. Statistics programs were introduced in many major hospitals in New Zealand, in the mid-1990s, in order to measure the productivity of allied health professionals as experienced at North Shore and Dunedin Hospitals, by the researcher. However, Gorman states that incentivising workers to increase productivity has “*a poor track record*” because incentives have not been targeted to specific

funding strategies (Gorman, 2015). This type of multidivisional company-like government organisation can begin to compare workforce performance to investment decisions according to Boxall (2008).

Demand for increased productivity within public services in New Zealand is likely to have had an increase in SLP caseload size/workload with outlined need by District Health Boards (2007) for an increase in numbers of SLPs, particularly increasing numbers of experienced SLPs, and to ensure staff education and training. Increased caseload size and workload is associated with SLPs' job dissatisfaction (Hutchins et al., 2010) and increased job stress (Harris et al., 2009) for SLPs servicing schools in USA. The level of work intensification for SLPPPs in New Zealand, and, their level of professional satisfaction, is unknown.

1.8 History of Speech Language Pathology in New South Wales, Australia

A history of Speech Pathology Australia, provided by Alison McDougal (2004) is summarised alongside milestones outlined by SPA that are significant to the history of SLP and PP in NSW (The Speech Pathology Association of Australia, February, 2015). Elinor Wray trained as a speech therapist in London, graduating in 1929, and opened the first hospital clinic in Australia, at Sydney's Royal Alexandra's Hospital, in 1931. The first two-year diploma course, which developed into the current University of Sydney's bachelor's degree course in Speech Pathology, was started, in 1939. An association for speech therapists was established, in NSW, in 1944, and the Australian College of Speech Therapists (ACST) was incorporated, in 1949. In 1951, the Australian arm of the British Medical Association, granted full recognition to ACST as the examining and qualifying body for the Commonwealth. In the early 1970's, the role of the College changed with tertiary institutions undertaking training of SLPs and the association became: The Australian Association of Speech and Hearing (which was renamed Speech Pathology Australia in 1996).

Qualifying bachelor's degrees were established at Charles Sturt in Albury, in 1998, and at Newcastle University in 1994. A qualifying Masters' course was established at Macquarie University in Sydney, in 2001. Rapid growth of the profession has been observed with 10 of the 24 programs certified to train SLPs in Australia, nationally, emerging in the last 10 years (Health Workforce Australia, 2014). Mutual recognition of credentials was signed between Speech Pathology Australia and associations: RCSLT (Britain), CASLPA (Canada) and ASHA (USA) in 2004. This agreement was extended to include NZSTA (New Zealand)

and IASLT (Ireland) in 2008. SLP in Australia, and specifically, in NSW, has experienced rapid growth to date.

1.8.1 The history of private practice in New South Wales

In 1976, The Private Speech Pathologist's Association (NSW) was formed. Professional indemnity insurance was offered to association members in 1984 (The Speech Pathology Association of Australia, February, 2015). By 2003, the Private Practice Reference Group was formed, and, alongside PPs, established: a "*Guide to setting up a Private Practice*" (McDougall, 2004; The Speech Pathology Association of Australia, February, 2015; The Speech Pathology Association of Australia Limited, 2008). This guide, along with a range of other industry specific reference material for SLPPPs has recently been updated by SPA (The Speech Pathology Association of Australia, 2014a).

Despite a submission, made to the National Registration and Accreditation Scheme (NRAS) in 2008, SLP does not hold professional registration status in Australia (Health Workforce Australia, 2014). However, a professional self-regulation program started in 2000, allowing certified practicing status to members of SPA, who meet given clinical and professional standards. "*Practising membership of SPA is a requirement for Medicare provider status, private health fund provider registration, and eligibility to provide services under a range of Commonwealth-funded and third-party funding and insurance bodies*" (Health Workforce Australia, 2014, p 4). Linking government and business funding for SLP PP services in NSW, to a professional self-regulation program, run by the professional body, provides a form of accreditation that funding bodies can use to ensure the quality of the services they contract.

1.9 Sectors of Employment

Nationally, SLP employers are listed as the government or PP (Health Workforce Australia, 2014). Between 1996 and 2011, an increase in number of PPs is noted from 42% to 57%, and declines are noted for SLPs working for the Commonwealth government: 4.3% to 1.8%, State government: 51% to 41%, and Local government: 2.4% to 0.1% (Health Workforce Australia, 2014, p 12). PP has overtaken state and territory governments as the main employer of SLPs since 2006 (Health Workforce Australia, 2014). The number of SLPs, in NSW, in 2011, was 1629 (Health Workforce Australia, 2014). A breakdown by sector of employment for the SLP workforce in NSW is: PP; 63%, Commonwealth government; 3.1%, State

government; 33%, and no SLPs working for the local government (Health Workforce Australia, 2014). PP is the main source of employment for SLPs in NSW.

1.9.1 The public sector

The majority of SLPs employed in the public sector, are employed by NSW Health (Health Workforce Australia, 2014). SLPs employed by NSW Health usually work in, or from, hospitals or community health centres. SLPs who provide education-based paediatric services are usually based in or from community health services in NSW (in the experience of the researcher).

NSW Health service is operated as a bureaucracy, business model, funded by State and Commonwealth governments (NSW Health, 2012). *The Next Step: Funding Reform*, introduced by NSW Health in 2012, links patient outcomes with funding. In 2012, it was described as: “...a new approach to the funding, purchasing and performance of health services in NSW” (NSW Health, 2012, para 2). Activity and outcomes are monitored in order to increase productivity and allocate ‘taxpayer funding’. This is a targeted approach to economic rationalisation incentivising employees to reach health targets attached to funding as suggested by Gorman (2015).

In comparison to his recommendation for healthcare in NZ, professional groups are usually maintained in NSW. SLPs usually work in departments of SLPs or in a health service aggregates such as aged care within multidisciplinary teams with attachment to a SLP department. Regular workforce reports and strategic plans (NSW Ministry of Health, 2014) are undertaken to ensure adequate service provision and staffing priorities (Health Workforce Australia, 2014). Recent strategic planning providing a vision of: “*Right care, right place, right time*” (NSW Ministry of Health, 2014, p 1), and “*Right people, right skills, right place*” (NSW Ministry of Health, 2015, p 6) seems to marry the funding reform with professional skill groups and client outcomes. While this strategy may place value on professional groups it may increase work intensification.

A high-performance work systems (HPWS) or high involvement work systems approach to management, which is explained by Cox, Rickard and Tamkin (2012) as an approach for managing employee voice by engaging employees in the decision-making processes, is employed by NSW Health in recent strategies to manage economic rationalisation. The “*Health professionals’ workforce plan 2012-2022: Revised 2015*” (NSW Ministry of Health,

2015) lists strategies such as increasing the financial management skills and managerial skills of professional health managers while encouraging flexibility (movement of professionals) across the organisation. This approach allows maintenance of the ‘craft’ professional group for professionals in healthcare management and encourages responsible financial management and flexibility of professionals to work across services within that framework (NSW Ministry of Health, 2015). This model retains the line management expertise of experienced SLPs while developing their business skill set to meet fiscal targets driven by government funding accountability. It is unknown if this model of practice mitigates work intensification.

1.9.2 Range of services

Despite the maintenance of professional group in health management, publicly funded SLP jobs have not grown to meet the growing demand for SLP services with increased time spent on waiting lists in public services reported by SLPs (Kenny & Lincoln, 2012) and in the Australian media (Gleeson, 2015). Gleeson (2015) reports a wait time of nine months, for paediatric public services in the Newcastle (Hunter-New England catchment) area in NSW, Australia. Similar concerns are outlined by numerous stakeholders in the Senate report into SLP services in Australia (Commonwealth of Australia & Senate Community Affairs Secretariat, 2014). A growing demand for SLP services in Australia is related to population growth, increasing awareness of SLP services, an increasing evidence base for SLP services, and increased survival rate for clients with complex and chronic care needs (Kenny & Lincoln, 2012). Kenny and Lincoln (ibid) describe increasing work intensification for SLPs in Australia: “...surveys of practicing speech-language pathologists suggest that employer standards for a reasonable caseload do not reflect these qualitative changes to speech-language pathologists’ scope of practice” (Kenny & Lincoln, 2012, p 249). They completed workplace interviews regarding caseload management with SLPs in Australia and concluded that increased demand for services was not matched by adequate resourcing. Growing demand for services without equal public funding for SLPs in the public sector must be one factor increasing numbers of SLPs gaining employment in PP.

1.10 The nature of private practice in NSW

Growth in the SLP PP sector is documented with SPA providing a figure of 52.6 % of all SLPs work exclusively in PP: “...we are seeing a shift in where speech pathologists work towards an increasingly large private sector” (The Speech Pathology Association of Australia,

February, 2015, P.9). In order to examine SLP PP in Australia a national survey of PPs was completed by SPA in 2015 (The Speech Pathology Association of Australia Limited, 2015). SPA reported in the association's periodical magazine, "*Speak Out*", that nationally, most PPs are reported to: be sole practitioners (50%), work part time (58%) and work only in PP (69.7%) as opposed to working in public and private services (23.5%), or, not for profit organisations (6.7%) (The Speech Pathology Association of Australia, February, 2015). Most services are mobile and clinic based (59.6%) and work with children: infants: 59%, children 2-5 years (90%), children 6-12 years (90%), adolescents (66%); as opposed to adults: adults 16-65 (35%) and older age clients 65+ (24%) (The Speech Pathology Association of Australia Limited, 2015, P 7). These figures were not provided by State; business type and number of employees, are not provided. However, the number of SLPs working in PP in NSW listed as members of SPA in 2015 was 1497 (The Speech Pathology Association of Australia Limited, 2016). Given the number of PPs is '1629' (Health Workforce Australia, 2014, p 13), it is likely, a number of SLPPPs in NSW are not members of SPA.

1.10.1 Government funding for private speech pathology

There is acknowledgement of the importance of PP healthcare service providers in the Australian allied health literature (O'Toole & Schoo, 2010) and in government strategies (NSW Ministry of Health, 2014). PP is included as part of a wider health strategy to address public health needs via strategies such as: "...to establish health precincts with public and private services" (NSW Ministry of Health, 2014, p 6). This is in line with Commonwealth strategies to provide funding for services which can be provided by PPs such as: funding for specific services for veterans (DVA funding) (Department of Veteran's Affairs, 2016), National Disability Insurance Scheme (NDIS) (The Speech Pathology Association of Australia, 2014b) providing specific services for people with disabilities, Medicare Chronic Care Plan (CCP) (formerly known as Enhanced Care Plans) (Australian Government Department of Health and Ageing, 2014) a set rebate for five sessions of therapy, Helping Children with Autism (HCWA) a package of funding for children with Autism who are under six years of age, and Better Start programs a package of funding for children with Cerebral palsy, Down's Syndrome, vision or hearing loss (Australian Government Department of Social Services, 2016). Until the recent introduction of NDIS funding most funding has targeted specific health care aggregates such as children who are on the autism spectrum. The level of SLPPPs dependence on provision of services attracting these types of government funding is unknown.

Many private health care insurers, in NSW, offer rebates for SLP services, as part of comprehensive insurance policies (Australian Government Private Health Insurance Ombudsman, nd). In Australia, there are tax levies, for individuals who do not hold private health insurance, and a tax rebate, for individuals who do hold health insurance (Australian Taxation Office, 2016); incentivising a high number of people to hold health insurance. SLPs who are eligible to provide services rebated by health insurers and government funding, must hold a Medicare provider number and be practicing members of SPA (The Speech Pathology Association of Australia Limited, 2014); incentivising SLPs to maintain membership of the SPA.

While the availability of government funding for private SLP services is increasing, the same economic rationalisation observed in the public sector is also apparent in the private sector. The feedback towards government funding schemes from SLPs is mainly positive; with acknowledgement that the funding allows a range of clients to access services. However, some funding models, such as chronic care plans/enhanced care plans, are highlighted by SLPs as the amount of funding may not be in line with evidence based practice (Skeat, Morgan, & Nickless, 2009). Allied health PPs have suggested: increasing the funding to levels that provide for evidence based frequency of servicing (O'Toole & Schoo, 2010; Skeat et al., 2010), and, providing specific funding for actual cost of services such as travel costs (O'Toole & Schoo, 2010). Despite any shortfall in funding, the increase in available government funding in the PP sector in NSW must be one reason for increased growth in the sector.

1.11 Comparison of Speech Language Pathology in New South Wales and New Zealand

Despite the difference in origins of the profession in NZ and NSW; NZ as an education-based service and NSW, a health-based service, the agreement of mutual recognition of credentials means that the nature of SLP, must be relatively similar, currently. The availability of SLP training in NSW and NZ, is similar with four universities offering SLP courses in NSW and three offering SLP courses in NZ, (given the population of NZ is roughly 60% that of NSW). New Zealand's population, in April, 2016, is 4700,000 (Statistics New Zealand, 2016) and NSW's, 7600,000 (in September 2015) (Australian Bureau of Statistics, 2016) (both figures were rounded to the nearest hundred thousand by the researcher). The number of SLPPPs, in NSW, in 2011, was 1304, which was 63% of all SLPs. Although the exact number of New Zealand's SLPPPs is unknown, the number of practitioners listed as members of

NZSTA in 2015 was 133, which is 18.5% of the total number of listed SLPs (The New Zealand Speech-language Therapists' Association, 2015). A rough comparison can be drawn suggesting that NSW has more than three times the number of private SLPs than in NZ. A reduced number of PPs in NZ, may be due to differences in the way the different governments have structured funding incentives, or provided access to government funding.

The structure of funding and the structure of public services between countries, may be different but the pressure of economic rationalisation facing SLPs is similar. Increasing numbers of clients in both countries (Gorman, 2015; Kenny & Lincoln, 2012), has led to increased pressure upon public services to increase funding (District Health Boards New Zealand, 2007), or to choose between maximising the productivity of services or rationalising (decreasing) the services offered.

1.11.1 Underservicing people with communication and swallowing disability

It is likely that there is a level of underservicing of some client groups in both NSW and NZ (K. Wylie et al., 2013). In discussion of “*The World Report on Disability, 2011*”, Wylie et al. (2013) note an underservicing of the population of people with communication disabilities worldwide; including in majority and minority world countries. They note government policy and resultant funding in minority world countries such as Australia and New Zealand, results in people with communication disabilities having less access to services in rural and remote areas. In addition, those who are unable to pay for services: ‘...*minority groups, transient, migrant, and indigenous groups continue to have unmet need for services*’ (K. Wylie et al., 2013, p.4). One example provided by Wylie et al., as to the inaccessibility of services on cultural basis, is that in Australia, SLP services are usually not provided to people of Aboriginal and Torres Strait Islander descent by SLPs of the same descent, due to the lack of SLPs of the same descent (less than 1%). It is unknown if the number of Maori SLP in NZ is representative of actual numbers of Maori people in the population. Wylie et al. argue that in workplaces, SLP must consider service availability and accessibility for clients. Whether the causes for underservicing stem from a lack of workforce or barriers to services such as financial, language or cultural barriers they are still an ethical concern to SLPPPs. The issues are relevant to SLPPPs as part of the wider body of the profession seeking to service the needs of all people with swallowing and communication disability as the PP sector grows. It is not known the extent to which resolving this type of ethical concern impacts upon a PPs’ success.

1.11.2 Increase in new graduates in Australasia and implications for speech language pathology private practice

In order to meet the demand for more SLP services, more SLP students are now trained in Australia and New Zealand (Brownfield, 2015; Health Workforce Australia, 2014). Ten of the twenty-four programs certified to train SLPs in Australia have ‘*emerged in the last ten years*’ (Health Workforce Australia, 2014, p.19). In 1990, one university in New Zealand offered a qualifying course for SLPs (Heine & Smith, 1990); there are currently three universities offering qualifying courses in New Zealand. Increased student numbers, also increases the demand from universities offering SLP courses for student clinical placements for mandated clinical education, to SLP PP. It is reported that ‘14%’ of SLPPPs in Australia work in clinics that have student placements (The Speech Pathology Association of Australia Limited, 2015, p7). It is unknown how many SLPPPs in NZ work in clinics that offer student placements. It can be seen, with the increasing requirement to ensure evidence based practice (Metcalf et al., 2001; Roddam & Skeat, 2010) that SLPPPs have growing interdependence with universities based upon reciprocal needs. There is minimal literature regarding the formal or informal nature of this relationship in Australasia.

1.12 Speech Language Pathology Private Practice Business Profile

Undisputedly, the success of SLP businesses, is integral to the sustainability of the PP sector. However, the robustness and sustainability of the SLP PP sector is not well researched. In New Zealand, there is no current workforce data for the SLPs working in PP. However, it is likely that SLP PP in NZ and NSW, are owned and run by females; SLP in Australia are predominantly female; 97.5% (Health Workforce Australia, 2014). It is also likely that they are professional craft businesses outlined by Boxall (2008, p 205-209) in which:

Work practices reflect roots in ‘craft’ control and long periods of professional education and socialisation...employee ownership is the norm, in those parts of the public sector which depend on professional work (e.g. public health and education.) Craft or professional autonomy and high economic rewards are typical goals (Boxall & Purcell, 2008, p 205).

It is likely that the PP identified by Heine and Smith (1990) were in micro-businesses and were owner-operators of their businesses. No information is currently available on the structure, business type, or, size, of current SLP PP in New Zealand.

Some information regarding the national profile of SLPPPs, in Australia, was recently provided, by SPA (The Speech Pathology Association of Australia Limited, 2015). Sole providers constitute 50% of Australia's SLPPPs. Most PPs, 30%, have between one and five years' experience as a SLP. Although they report that 8% of PPs work in rural and remote areas in NSW, there is little data provided specifically for NSW (The Speech Pathology Association of Australia Limited, 2015). It is likely that SLP PP, in NSW and NZ, are small businesses, and, predominantly, sole traders. It is not known how many SLP PP are microbusinesses or small businesses, whether they are homebased, or how many businesses are sole traders, registered companies or partnerships (definitions are available for these terms in the Table of Terminology). Further information is required about the specific demographics of SLP PP in NSW and NZ.

1.13 Entrepreneurship in Speech Language Pathology Private Practice

A definition of entrepreneurship is variable in the literature (Anderson & Nelson, 2011; Cox et al., 2012). Carland, Hoy, Boulton and Carland (1984) associate entrepreneurship with assumed business risk and innovation. They seek to differentiate small business from an entrepreneurial venture by defining small business as an independently owned business that is not necessarily dominant in the field. In comparison, they define an entrepreneurial venture, as needing to meet one of four behaviours: 1/ 'introduction of new goods', 2/ 'introduction of new methods of production', 3/ 'opening new markets', 4/ 'industrial reorganisation' (Carland et al., 1984, p 357). Interestingly, Cox et al. (2012) simply define the entrepreneurship as innovation. SLPPPs regularly show innovation one example is the development of new resources in order to meet the needs of specific clients; by Carland et al.'s (1984) definition, could be defined as an entrepreneurial venture. However, SLPPPs showing innovation may only partially meet their criteria for entrepreneurs: "*An entrepreneur is an individual who establishes and manages a business for the principal purposes of profit and growth. The entrepreneur is characterised principally by innovative behaviour and will employ strategic management practices in the business*" (Carland et al., 1984, p 358). Although many SLPPPs may want to develop innovative practices, Walker and Brown (2004) suggest home-based businesses may not want growth, if their objective for starting a business, is to achieve home-work-life balance (WLB). Even if SLPPPs, would like to be profitable and grow their businesses, they are unlikely to relate to profit and business growth, as their principal objective, given the client-centred nature of SLP. It is possible, however, that SLPs may see an element

of social entrepreneurship in innovative practices. Social entrepreneurship is usually associated with not-for-profit innovative practices such as “*Talking Trouble*” (Talking Trouble Aotearoa NZ, 2016) an organisation in New Zealand that increases the awareness of the communication profile and communication needs of youth in the New Zealand justice system. For the purposes of this research, (SLP) entrepreneurs are defined as SLPPPs who exhibit innovative practice for profit and growth, or, for the purpose of advancing the needs of clients or the profession.

Entrepreneurship is well researched in the business literature, as entrepreneurs are associated with business growth and are valuable to the economy and job growth (Anderson & Nelson, 2011; Carland et al., 1984). The success of entrepreneurs is also well researched including individual profiles and business practices of successful entrepreneurs (Ayala & Manzano, 2014; Krishnan & Kamalanabhan, 2007). The profile of the entrepreneur in business is associated with: personal resilience, high personal efficacy, social competence, and the ability to take business risks (Ayala & Manzano, 2014; Baron & Markman, 2003; Krishnan & Kamalanabhan, 2007; G. D. Markman & Baron, 2003). These characteristics may be necessary for SLPPPs who desire business profit, growth or innovation in their practice.

1.14 Business Success

1.14.1 Small business failure rates

Failure rates of businesses have long been used to measure viability of businesses. Governments regularly collect data on the survival rates of small businesses given the high number of small businesses in an economy. Less than twenty employees, were employed by 97% of New Zealand’s businesses, in February, 2014 (Ministry of Business Innovation and Employment, 2015). Businesses with less than 20 employees, were reported by *The Ministry of Business, Innovation and Employment*, to account for 27% of the gross domestic product (GDP) in New Zealand, in 2014. Therefore, governments have an interest in monitoring small business survival rates. The survival rate for New Zealand small businesses, in 2014, was given as: “... 0 employees: 50%, 1-5 employees: 64%, 6-19 employees: 69%” (Ministry of Business Innovation and Employment, 2015, p 12). The small business survival rate in NSW, from 2007-2011, is provided as: “...no employees – 54.1%, 1-19 employees – 68.7%” (Griffith & Wilkinson, 2012, p 4). However, in a longitudinal study from 1973-1990 by Wilkinson, 32% of NSW small businesses, failed in the first year (Griffith & Wilkinson, 2012; Wilkinson, 2005). No specific data was found for survival rates of SLP PP in Australasia. High failure

rates given for small businesses in Australasia, are relevant to SLPPPs in Australasia, in order to show the business risk, they face.

1.15 Defining success

Due to the high representation of small businesses in Australasia, the risk of failure and the potential impact on the economy, the performance of small businesses is important to the governments of Australia, NSW, and NZ. Government agencies and websites offer general support to small business (Smallbiz, nd). Defining overarching requirements to ensure success for every business is not plausible as the requirements to achieve viability and success, are different for different industries (Gadenne, 1998). Importantly, the nature of success or the criteria for the success of a small business or a particular professional service industry must be defined (Gorgievski et al., 2011; Walker & Brown, 2004) in order to be measured. An examination of the literature is required in order to ascertain the success criteria of SLPPPs.

1.16 Quantifying success

1.16.1 Individual performance

Logically the viability and success of small business, is dependent on the performance of organisations and individuals. Individual performance is related to increased business productivity (Boxall & Purcell, 2008; Boxall & Purcell, 2011). Literature in the field of human resource management has sought to quantify the performance of businesses by examining the performance of individuals and organisations (Blumberg & Pringle, 1982; Boxall & Purcell, 2011; McCloy, Campbell, & Cudeck, 1994). Individual performance theory is explained by Boxall and Purcell as: “ $P = f(A.M.O)$ where: $P = Performance$, $A = Ability$ (the knowledge and skills to perform), $M = Motivation$ (staff are ‘adequately interested and incentivised’) and $O = Opportunity$ (‘work structure and its environment provides the necessary support and avenues for expression’)” (Boxall & Purcell, 2008, p 5). The model provided is derived from those of McCloy, Campbell and Clark (1994) and Blumberg and Pringle (1982). McCloy, Campbell and Clark (1994) define performance as: “...behaviours or actions that are relevant to the goals of the organisation in question. [It] ...is not the outcome, consequence, or result of behaviour or action; performance is the action itself.” (McCloy et al., 1994, p493). They further identify ‘ability’ as declarative knowledge: what is known and procedural knowledge and skill: how it is done (Boxall & Purcell, 2011, p190; McCloy et al., 1994, p494).

SLPPPs using this model may view their declarative knowledge as their knowledge, of SLP or business, academic theory. They may view their procedural knowledge, as their mastery of clinical education or on the job learning/SLP or business experience. McCloy et al. (1994) include motivation as: “*choice to expend effort*” [perform], “*what level to expend*” [level of effort] and “*the choice to persist in the expenditure*” (McCloy et al., 1994, p494), but they do not include ‘*opportunity*’ in their model. Blumberg and Pringle (1982) argue that ‘*opportunity*’ must be included as it acknowledges the impact of the environment on performance. They define ‘*opportunity to perform*’ as: “*Tools, equipment, materials, and supplies; working conditions; actions of co-workers; leader behaviour; mentorism; organisational policies, rules, and procedures; information; time; pay*” (Blumberg & Pringle, 1982, p562). McCloy et al. caution that, the relationship between the determinants are not additive, but multiplicative; each are always present in some small measure (McCloy et al., 1994), and have an impact upon each other. An example of this for SLPPPs, may be that more experienced SLPs could have the same level of performance as a less experienced SLPs, who have better working conditions, if both were equally motivated.

1.16.2 Organisational performance

Boxall and Purcell elaborate on the model of individual performance to provide a model of organisational performance in which: “*work and employment policies and practices*”, alongside, “*related management investments and policy choice*”, impacts upon: “*workforce: organisation, capabilities and attitudes*”; leading to: “*organisational performance outcomes*” (Boxall & Purcell, 2011, p7). This model accounts for the relationship between the business organisation and employees; where trust levels and organisational commitment are measured by the term ‘*attitudes*’. Not only the ability of staff but the teamwork is captured by ‘*capability*’ and ‘*organisation*’. The impact of managerial decisions, for example, the level of ‘*employee voice*’ or involvement in decision making processes, is seen to play a part in the performance of the organisation. At this level:

Human resource management is about building both human capital (what individuals can and will do that is valuable to an organisation) and social capital (relationships and networks among individuals and groups that create value for the organisation)”(Boxall & Purcell, 2011, p7).

The model of organisational performance is an important framework from which to view the performance of larger businesses such as public sector businesses. While it may be

beneficial to view employment issues facing SLPs employed in public organisations or large PP using this framework, most SLP PP are small businesses. Therefore, the performance of individual SLPPPs, is the performance of the business, and as such, could be examined using the model of individual performance where human capital fits into ‘*ability*’ and social capital fits into the model of individual performance as an ‘*opportunity*’.

1.17 Strategic Management

“To be successful, firms need an effective system of choices involving all the key dimensions of the business: marketing, production, human resource management and finance” (Boxall & Purcell, 2011, p49). An “*effective system of choices*” made by a business is termed the strategic management of a business. The viability and sustained advantage of a business are usually the goals of strategic management.

1.17.1 Viability

The viability of a business is the: “*fundamental strategic problem*” (Boxall & Purcell, 2008, p 38; Boxall & Purcell, 2011, p50) of a business and is relevant to SLPs in the face high failure rates of small businesses as previously described. In order to continue to function, businesses must be viable. Business viability is defined in terms of survival, over time, “*in a chosen market*”. Some researchers have chosen to define business survival as the success or failure of a business (Ayala & Manzano, 2014; Mirjam Van Praag, 2001; Watson, 2003). The “*table stakes*” of business viability are the: “*goals*”, “*resources*” and “*capable people*” of a business (Boxall & Purcell, 2011). These ‘*make-or-break*’ factors in the business according to Boxall and Purcell include:

Human resource management: recruitment, retention, and motivation of people with the relevant knowledge and skills, employed at an affordable cost, ...Production system: the technology/know-how and operational processes that reliably deliver the promised value to customers, ..Marketing: products or services that target a profitable set of customer needs, ...Funding: the necessary financial backing to pursue these business goals (Boxall & Purcell, 2011, p43)

They acknowledge that this model is a simplification of the complex factors required for business viability, and concede that different businesses in different industries at different times will interpret these critical factors differently (Boxall & Purcell, 2008; Boxall & Purcell, 2011).

It can be seen that these factors are related to the underlying strategy of a business. They are similar to the concept of critical success factors (CSF) or factors that must go well to guarantee a business' success (Boxall & Purcell, 2011; Jensen, 1987). However, it is likely that the CSF for SLP PP must also include those factors external to a business such as government support or professional networking. The viability of SLP PP, is an important issue for the SLP profession, as businesses that survive over a long period of time are more likely to provide long term and more stable services and employment for SLPs. An exploration of the viability of SLP PP would require data from SLP businesses that have existed over differing periods of time and include information about human resource management, provision of services, marketing and funding.

1.17.2 Strategic advantage/Sustained advantage

It is important to differentiate between business viability and business success. Although business viability is a necessary component of success, it may be only the vehicle to achieve SLPPPs' specific success criteria, such as a work-life balance or professional satisfaction as suggested by Walker and Brown (2004). In order to maintain business viability a strategic business advantage is necessary. "*Firms that survive are engaged in a struggle to build and defend competitive advantages*" (Boxall & Purcell, 2011, p46). The thought of maintaining a competitive advantage over others in the same field (other SLPs) may be foreign or even distasteful to some SLPs. However, competitive advantage in business may be seen as similar to competing interventions for particular SLP clients; some interventions are more suitable for particular groups of clients, and are, therefore, more successful. The use of particular competitive strategies in a business derive from the policies and marketing goals of that business' business strategy. Competitive strategies regarding market positioning, written or unwritten, target a certain type of customer/client with a specific type of service (or product). The difference in the above analogy, between business and SLP clinical practice, is that competitive advantage is also concerned with how a business positions itself in relation to competitors (other SLP services) for the same clients. This not necessarily as mercenary as it may sound, to some SLPs, as it is likely that SLPPPs with specialist skills and business experience, providing evidence based practice to certain client groups, are likely to target those clients as customers, and thereby, achieve competitive advantage via effective services. Market positioning is one type of business strategy; other business strategies may also be important for SLPPPs.

1.18 The Rationale for Researching Speech Language Pathology Private Practice

The purpose of this research is to investigate the critical success factors for SLPPPs in NSW and NZ. It is important for the field of SLP to better understand SLP PP as it is hypothesised that:

- 1/ A satisfied workforce increases productivity, increases retention and reduces attrition from the profession
- 2/ SLPPPs will become more significant service providers in the future.
- 3/ Supporting SLP PP business development will aid the provision of evidence based practice to clients with communication or swallowing difficulties
- 4/ Supporting SLPPPs will support future SLP students and new graduate SLPs
- 5/ Increasing awareness of SLPPPs' issues will facilitate increasing development of professional governance for PPs
- 6/ Better understanding of the private sector will allow professional bodies to provide targeted support
- 7/ Increasing awareness of SLPPPs' issues will facilitate increased professional supervision and professional mentoring within PP
- 8/ Supporting SLP PP aids the development of small business government assistance initiatives in SLP PP including small business innovation

2 Literature Review

2.1 Literature Review Method

2.1.1 Level of evidence

A systematic literature review was completed, in October, 2015, in order to develop an understanding of success for SLPPPs. A range of models are available as a framework from which to review healthcare research (Harbour & Miller, 2001; Hayhow, 2011; Liberati et al., 2009; Merlin, Weston, & Tooher, 2009). “*The PRISMA model*” (Preferred Reporting Items for Systematic reviews and Meta-Analyses) (Liberati et al., 2009) was chosen as a framework to systematise the review of literature with the addition of the provision of grading and synthesising the level of evidence using: “*The Oxford Centre for Evidence based Medicine – Levels of evidence*” (Phillips et al., 2009) as guided by Ferguson and Armstrong (2009).

2.1.2 PRISMA framework

The literature review was conducted in two parts (a) literature relevant to allied health, and, (b) literature relevant to small business. It was first necessary to develop a definition of success for SLPPPs. Therefore, a range of terminology was employed to develop a literature search including: the nature of success/success criteria applicable to SLPPPs, and, the CSF that would apply to SLPs working in PP businesses in Australasia. The second component of the literature review encompassed broader business terminology related to the known parameters of SLP PP such as usual business size: ‘microbusiness’, ‘home-based business’ (HBB) and ‘small business’. Definitions of these terms are provided in Table 1. The terms used in the literature search were: success, success criteria, professional satisfaction, job satisfaction, career satisfaction, workplace satisfaction, burnout, resilience, compassion satisfaction, retention, attrition, gender, critical success factors, speech pathology, speech language therapy, allied health, occupational therapy, dietitian, audiology, private practice, small business, business, micro business, business, homebased business, health, health care and combinations of these terms.

2.1.2.1 Inclusion and exclusion criteria

Inclusion and exclusion criteria were applied. The inclusion criteria were articles from 1985-2015, in English, relevant to SLP PP, relevant to small business, relevant to success criteria for SLP/Dietetics/Occupational Therapy/Audiology/allied health, relevant to critical success factors, or relevant business practices to SLPPPs. The exclusion criteria were: exclusively medium and large business, exclusively manufacturing or other unrelated business, business policy/government policy, articles not relevant to the Australasian context, advertisements/promotional material, public practice with no reference to PP, therapeutic interventions only, student or clinical education focused articles, advice only, descriptions of specific PP, non-English articles and duplicates.

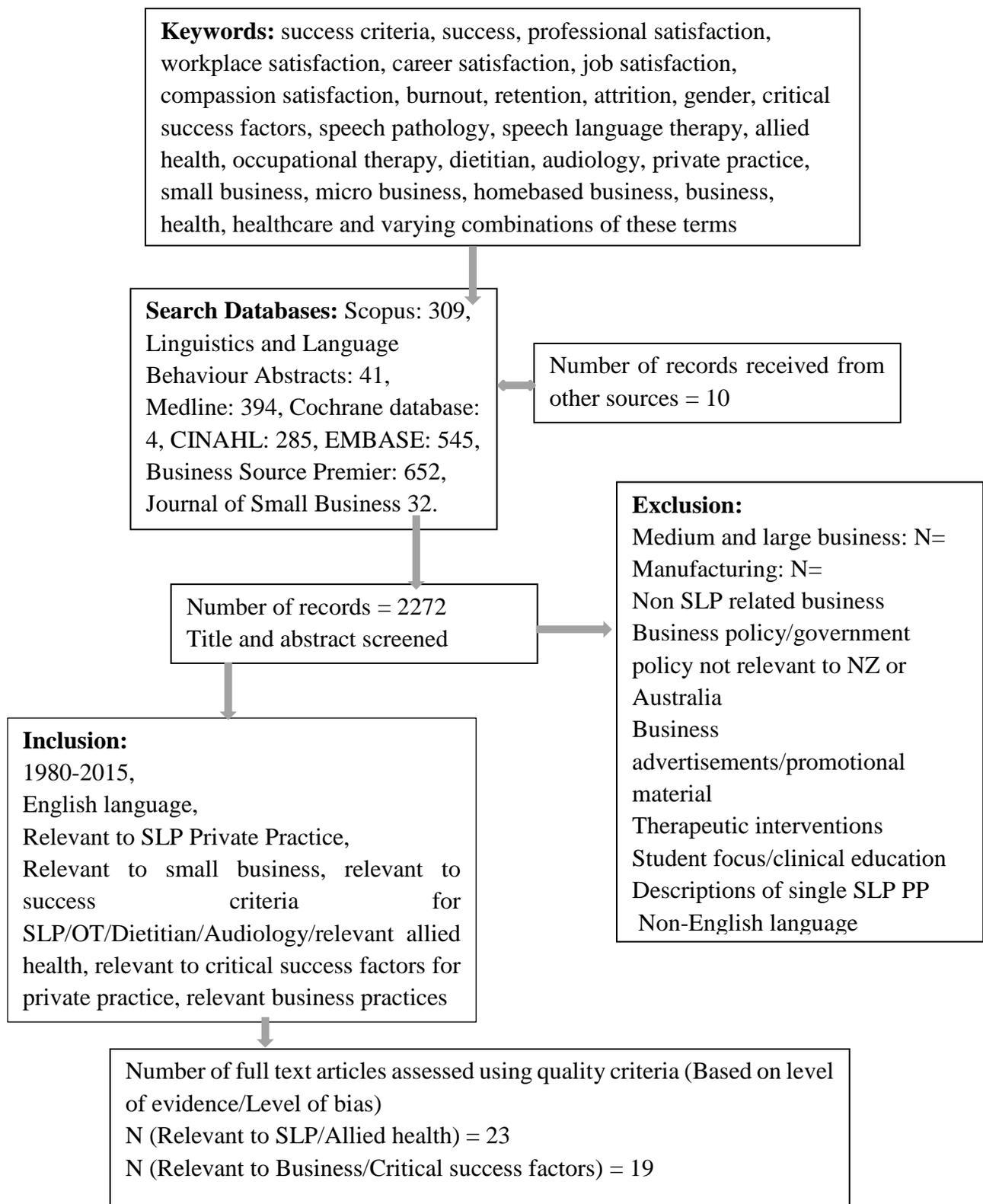


Figure 1. PRISMA Flowchart for literature review (Liberati et al., 2009)

2.1.2.2 Quality criteria

Table 3. Criteria Used to Appraise Quality of the Success in Speech Language Pathology Private Practice Literature (Nimmo & Huggard, 2013)

	Quality Criterion	Y/N
1	The research question/aims/objectives are clearly explained	–
2	An appropriate study design has been used	–
3	The study adequately describes the following:	
	I. Sample/participants	–
	II. Sample strategy	–
	III. Methods	–
	IV. Data collection methods	–
	V. Context of collection	–
4	Construct description and definition	–
5	Researcher reflexivity provided	–
6	Ethical concerns mentioned	–

The abstracts of articles sourced from search engines, relevant articles sourced from bibliographies of the initial articles, and articles provided by supervisors ($n=2272$) were reviewed for relevance. The articles were fully reviewed were separated into two groups of articles: those related to SLP/allied health PP, and those related to success criteria or critical success factors of small business; 31 articles in total. Full articles were appraised for research quality using criterion suggested by Nimmo and Huggard (2013, p 40).

The results of quality criterion were summarised for the research articles relevant to SLP or allied health, and, business, separately due to the cohesion of the business and health/education bodies of literature. Articles that provided expert opinion only, or a review of literature only, were excluded. The criteria were treated in the same manner as Nimmo and Huggard's summary of quality scores (2013) with each 'Y' counted as one point except for question 3, each point of which is counted as 0.2; all points per article are added together, then divided by 6, yielding a maximum score of 1.0 (highest quality rating).

2.1.3 Speech language pathology or allied health literature

The quality criteria outlined by Nimmo and Huggard (2013) were met by 13 articles as seen in Table 5. A summary of the literature relevant to SLP and allied health, is provided in Appendix C.

Table 4. Summary of Quality Score for SLP or Allied Health Related Articles (adapted from Nimmo and Huggard (2013, p 41))

Criterion	1	2	3	3	3	3	3	4	5	6	Total score
			(i)	(ii)	(iii)	(iv)	(v)				
Articles											
(Cheung et al., 2013)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	1
(Flower, Demir, McWilliams, & Johnson, 2015)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	.83
(Gillean, Shaha, Sampanes, & Mullins, 2006)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	.83
(Gu & Day, 2007)	Y	Y	Y	N	N	Y	Y	N	N	N	.43
(Harris et al., 2009)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	1
(Hutchins et al., 2010)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	.83
(Kalkhoff & Collins, 2012)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	1
(Keane, Lincoln, Rolfe, & Smith, 2013)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	1
(Kenny & Lincoln, 2012)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	1
(Lincoln, Adamson, & Cant, 2001)	Y	Y	Y	Y	Y	Y	Y	Y	N	N	.67
(Loan-Clarke, Arnold, Coombs, Bosley, & Martin, 2009)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	1
(McLaughlin, Lincoln, & Adamson, 2008)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	.83

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(McLaughlin, Adamson, Lincoln, Pallant, & Cooper, 2010)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	.83
(Milstead, 2013)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	1
(Ostergren, 2011)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	1
(O'Toole, Schoo, Stagnitti, & Cuss, 2008)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	1
(Severn et al., 2012)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	1
(Specht & Blanchet, 2009)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	1
(Stagnitti, Schoo, Dunbar, & Reid, 2006)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	1
(Tan, 2006)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	1
(Vinokur-Kaplan, Jayaratne, & Chess, 1994)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	.83

The quality criterion outlined by Nimmo and Huggard (2013) were met by 13 articles as seen in Table 4. A summary of the literature relevant to SLP and allied health, is provided in Appendix C.

2.1.4 Speech language pathology private practice business related literature

Although “*The Oxford Centre for Evidence based Medicine – Levels of Evidence*” (Phillips et al., 2009) is usually used for medical literature it has also been applied to the business literature reviewed in this research to ensure continuity of approach, as seen in Appendix D. A systematic approach was employed to review the business literature. Full articles were appraised, as was done for the SLP PP literature, on research quality using criteria suggested by Nimmo and Huggard (2013). The results are given in Table 5.

Table 5. Summary of Quality Score for Speech Language Pathology Private Practice Business Literature (adapted from Nimmo and Huggard (2013, p 41))

Criterion	1	2	3 (i)	3 (ii)	3 (iii)	3 (iv)	3 (v)	4	5	6	Total score
Article											
(Ayala & Manzano, 2014)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	0.83
(Baron & Markman, 2003)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	0.83
(Bradley & Roberts, 2004)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	0.83
(Chawla, Khanna, & Chen, 2010)	Y	Y	Y	Y	Y	Y	Y	Y	N	N	0.67
(Clark & Douglas, 2014)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	0.83
(Gadenne, 1998)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	1
(Gorgievski, Ascalon, & Stephan, 2011)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	1
(Jasra, Khan, Hunjra, Rehman, & Azam, 2011)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	0.83
(Kalleberg & Leicht, 1991)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	0.83
(Krishnan & Kamalanabhan, 2007)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	0.83
(Luisser & Halabi, 2010)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	0.83
(Rawashdeh, Al-Saraireh, & Obeidat, 2015)	Y	Y	Y	Y	Y	Y	Y	Y	N	N	0.67
(Still, Soutar, & Walker, 2005)	Y	Y	Y	Y	Y	Y	Y	Y	N	N	0.67

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(Walker & Brown, 2004)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	0.83
(Watson, 2003)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	0.83
(Yusuf, 1995)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	0.83
(Zheng, Molineux, Mirshekary, & Scarparo, 2015)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	1

Three articles received a rating of 1.0, meeting the complete set of criteria. For the 11 articles that received a rating of 0.83, all were written with reference to ethical requirements of their research, but did not acknowledge an ethics approval from an ethics committee, suggesting a reasonable level of quality.

2.2 Outline of the Literature

In order to examine the CSF for SLPPPs in NSW, and NZ, articles were reviewed from the allied health literature encompassing health, education and science, database searches, and from the body of business literature. The literature, which was initially examined in two parts, (a) literature relevant to allied health business/PP, and, (b) business literature relevant to SLP PP, is integrated in this examination. The following outline is provided for the literature review:

1. Success criteria for small businesses
2. Examination of individual performance of SLPPPs
 - a. Abilities required for successful SLP PP: The demographics of allied health in PP including: age, location, ethnic group, academic qualifications and experience, business qualifications and experience, are discussed with reference to the literature or lack of literature. The personal characteristics of: resilience, efficacy, and compassion satisfaction are explored in relation to the literature of retention/attrition and of entrepreneurship.
 - b. Factors that motivate SLPs to work in PP: the motivational factors leading to retention or attrition of SLPs in the workforce. The motivational factors are discussed using the framework: *'positive aspects of the profession'*,

'autonomy', 'workload', 'non-work commitments', 'effectiveness', 'recognition', 'support' and 'learning' McLaughlin et al. (2008).

- i. Success criteria for SLPPPs
 - c. The opportunities required for successful SLP PP: Strategic management: financial capital and funding opportunities, managerial capital and managerial learning, market orientation, marketing and social capital, professional capital and ongoing professional learning.
3. CSF and SLP PP: The concept of critical success factors leading to business success, is explored in the business literature. CSF are identified for small businesses in the professional service/professional craft industries. Differences in critical success factors are identified for female owned businesses, businesses in different locations and different types of businesses such as homebased business. Key performance indicators (KPI) for CSF are identified.

A conceptual framework is proposed in order to focus the literature discussed in relation to SLP PP in New South Wales and New Zealand, and to outline the specific need for research in this area.

2.3 Success Criteria

The business literature provides some diverse guidance from which to evaluate the success of small businesses with success measured by factors from *'profitability'* to *'lifestyle factors'* (Hirst, March 2013; Kalleberg & Leicht, 1991; LUISER & Halabi, 2010; Walker & Brown, 2004).

2.3.1 Profitability

Traditional views of success, equate success with profitability of a business (Gadenne, 1998; Hirst, March 2013; Kalleberg & Leicht, 1991). Gadenne (1998) used *'return on investment'* as a measure of success when surveying owner-managers of small businesses in the Sunshine Coast of Queensland, Australia. He examined the factors used to measure success via a survey of 369 owner-managers in different industries. Differences were shown between: *'service industries', 'retail industries' and 'manufacturing industries'*, business practices which showed greater return on investment (Gadenne, 1998). He asked questions about businesses:

“management practices, management styles, financing arrangements, innovation factors, personnel and motivation practices, marketing practices, planning, control factors, enterprise objectives, entrepreneur characteristics and demographic factors” (Gadenne, 1998, p 39). He was able to show that business practices impacting upon success were industry specific; although all industries surveyed showed a negative relationship with financial leverage, service industries returned better profits when they had better employee relations. He noted that innovative leadership significantly related to employee relations factor and gave specific aspects of employee relations as: *“a/ involving employees in decision making, b/ emphasising reward/discipline system for employees, c/ assessing performance of employees, d/ assessing employees’ satisfaction, e/encouraging employees’ constructive criticism and emphasising staff training “* (Gadenne, 1998, p 45). Owners’ objectives in service industry were also significantly related to return on investment in Gadenne’s research. However, it is possible that profitability may not be the main success criteria of all SLPPPs, as some SLPs may establish a PP while financially supported by a spouse or partner’s income and begin PP as a way of continuing in a career that provides personal or professional satisfaction.

2.3.2 Business growth

Business growth has also been used as a traditional measure of success (Ayala & Manzano, 2014) but may not be a success criterion for some small business owners, such as those business owners who do not require their business income as their primary source of income. Those business people may be motivated by other factors such as professional satisfaction, autonomy or lifestyle factors such as flexible working conditions (Walker & Brown, 2004), age (Kalleberg & Leicht, 1991) and social networks (Clark & Douglas, 2014). Clayton (1998) states: *“The main reason women give for working in small business includes the desire to work independently, job satisfaction, flexibility of lifestyle, financial security and the personal challenge of operating their own business.”* (Clayton, Nov 1998, P.37). Although the success criteria for SLPPPs’ in Australasia are not known, they may be similar to other small business owners’ or business women’s objectives.

2.3.3 Demographic variables

In addition, differences are possible in the success criteria of SLPs of different ages and in business locations. Still, Soutar and Walker (2005) surveyed generational differences in the start-up goals and later satisfaction of five hundred and seventeen women small business

owners of homebased and non-homebased businesses across Australia. Generational differences were reported in homebased and non-homebased businesses in terms of goals and professional satisfaction. The start-up goals were ranked: 1/ *“being my own boss”*, 2/ *“financial independence”*, 3/ *“meeting new challenges”*, and 4/ *“gaining control over my life”* (Still et al., 2005, p.75). In terms of satisfaction importance rated: *“Mature respondents were less concerned about “WLB [work-life balance], stress and economic returns. Non-homebased Boomers [baby boomers] and genXers [generation x] were more concerned about obtaining an economic return”* (Still et al., 2005, p78). Accordingly, a range of success criteria may be possible for SLPPPs depending on not only their objectives for going into PP but also on a range of demographic factors.

2.3.4 Success criteria in business

An examination of a comprehensive range of success criteria may be necessary. A comprehensive review of the business literature was completed by Gorgievski et al. (2011) examining the success criteria of small business owners and the values associated with those success criteria. Gorgievski et al. compiled ten criteria for success from the current literature:

- 1/ *Profitability: high yields, good profit,*
- 2/ *Growth: growth in the number of employees, sales, market share and/or distribution,*
- 3/ *Innovation: introduction of new products or production methods,*
- 4/ *Form survival/continuity: enables generational transfer or can be sold with a profit,*
- 5/ *Contribution back to society: socially conscious, sustainable production methods,*
- 6/ *Personal satisfaction: through attaining important things in life, such as autonomy, challenge, security, power, creativity etc,*
- 7/ *Satisfied stakeholders: satisfied and engaged employees, satisfied customers,*
- 8/ *Good balance between work and private life: positive mutual influence between work and private life, allows time for yourself, family, friends,*
- 9/ *Public recognition: good reputation, prize winner,*
- 10/ *Utility or usefulness: organization fulfils a need in society; it provides an important service or product.”* (Gorgievski et al., 2011, P.209)

They asked 184 Dutch business owners to rank their success criteria and analysed the data using principle component analysis. They compared those rankings with business owners' value orientations using multidimensional scaling. They found the rank order of criteria was: "1/ *personal satisfaction*, 2/*profitability*, 3/ *satisfied stakeholders*, 4/ *balance between work and private life*, 5/ *innovation*, 6/ *firm survival/continuity*, 7/ *utility/usefulness*, 8/ *contributing back to society*, 9/ *public recognition*, [and] 10/ *growth*" (Gorgievski et al., 2011, p.222).

The types of businesses run by their participants, were "*mainly micro-industries*", which they characterised as having one to 10 employees, and, were service industries. They found relationships exist between personal values and personal perceptions of success. Business, profitability, and innovativeness, were found to be guided by self-enhancing orientations. Satisfied stakeholders, and good work-life balance were guided by self-transcendent value orientations. Given the comprehensive literature review and thorough analysis of the data provided by Gorgievski et al. it is worth considering whether these success criteria are applicable to SLPPPs in Australasia. Certainly, given the business literature discussed, it will be necessary to find the perceptions of success criteria for a range of individual SLPPPs.

2.4 Examination of Individual Performance of Speech Language Pathology Private Practice

In order to ascertain the success criteria of SLPPPs, it will be necessary to make an examination of their abilities, motivations and the optimum opportunities for performance.

2.4.1 Attrition/retention

The success criteria, professional success and, or, business success, of SLPPPs, are not specifically addressed in the current SLP literature. Insights are available, however, via the concepts of 'retention' or 'attrition' of staff in the allied health literature. In this research, retention is defined as the ability to maintain an employee working in an organisation/business (Hutchins et al., 2010), and, attrition, the loss of an employee from a job or the profession (McLaughlin et al., 2008). The factors that cause an employee to be retained in an organisation must be motivating factors at a level sufficient to adequately reward that employee for their productivity. However, a relationship of trust, between employer and employee, which is mutually beneficial and motivates an employee to higher productivity and at the same time ensures appropriate employee reward, is a complex balance to maintain (Boxall & Purcell, 2011). Boxall and Purcell (2011) describe situations where a balance is not achieved; such as

when an employee is rewarded highly but lacks the ability to perform at the level expected by a business. An employee with the appropriate ability to perform at a high level of productivity, must be rewarded by factors which ensure the employee's motivation to perform at that high level of productivity. This is a state desired by organisations, as the ability of large organisations to attract and retain the best staff provides some human resource advantage (Boxall & Purcell, 2011). It is reasonable to assume that high retention of staff over a long period, may indicate job satisfaction and business viability. In effect, developing a knowledge of the motivational factors for an employee or group of employees, to be either retained in an organisation, consider leaving the job, or, consider leaving the profession, provides insight into an employee's possible success criteria and even critical success factors. Conversely, the sustained performance in any business/organisation is at least associated with developing the abilities and establishing the motivations of capable employees.

2.4.2 Ability

There is little known about the differences in the success criteria of SLPPPs, and professional or business success of SLP PP, in relation to the effects of differences in age, gender, ethnic group, SLP/business qualifications, and, SLP/business experience.

2.4.2.1 Ability and personal characteristics

Some relevant information is available in the literature regarding characteristics that are associated with retention/attrition, job stress and entrepreneurship in SLP, allied health professions or for small business people. Personality and value systems are reported to play a part in SLPs attitudes toward reduced retention and attrition from the profession in Australia (McLaughlin et al., 2008). Aspects of personality and values are known to exacerbate or mitigate workplace stress (Flower et al., 2015). Specific characteristics re-occur in the literature regarding entrepreneurs (Ayala & Manzano, 2014; Baron & Markman, 2003; Bradley & Roberts, 2004; Krishnan & Kamalanabhan, 2007; G. D. Markman & Baron, 2003). Three themes re-occur in the literature regarding personal characteristics associated with attrition and retention: compassion satisfaction, negative affect and personal resilience.

2.4.2.1.1 Compassion satisfaction

Reduced compassion satisfaction, burnout, and compassion fatigue are associated with occupational stress in Audiologists (Severn et al., 2012). Compassion satisfaction is the "*pleasure you derive from being able to do your work well*" (Stamm, 2010, p12). Conversely,

compassion fatigue incorporates primary and, or, secondary traumatic stress and “*exhaustion, anger, frustration and depression, typical of burnout*” (Stamm, 2010, p12). SLPs are at risk of compassion fatigue due to high client contact at a time of potential trauma for clients (McLaughlin et al., 2008), such as when a diagnosis is given to paediatric client’s caregivers, or, at the time of a significant trauma such as a stroke or head injury. Severn et al. (ibid) found a higher level of compassion satisfaction among audiologists working in PP, compared with audiologists working in the NZ public service (Severn et al., 2012). They relate this higher level of compassion satisfaction with PPs’ scope of practice outside the public health system where public health audiologists predominantly service paediatric clients, and, medically complex clients, whereas PPs service adult clients. Increasing age also reduced compassion satisfaction among NZ audiologists (Severn et al., 2012). Severn et al. discuss this trend as possibly influenced by higher business ownership for older audiologists. The level of compassion satisfaction or compassion fatigue for SLPPPs is unknown, but may be specific to SLPs scope of practice, ability to provide evidence based practice or age/business ownership.

2.4.2.1.2 Negative affect

Negative affect is described by Flower et al. (2015) as a “*pervasive dispositional trait*” in which a person holds a more negative world view and has a higher incidence of stress and anxiety (Flower et al., 2015, p 108). Flower et al. surveyed 134 professionals and found that negative affect was associated with “*lower job satisfaction*”, “*lower organisational commitment*”, and “*higher levels of depression*”. Accordingly, McLaughlin et al (2010) used the Positive and Negative Affect Schedule (PANAS) to establish the relationship between negative affect, and, attrition from SLP jobs and the SLP profession, in Australia. In a large scale cross sectional survey of 620 SLP (SPA members), using “*psychometrically-sound tools*”, they found the negative affect “*influenced the odds of leaving the profession*”; “*With each increase of one on the negative affect scale the odds of intending to leave the profession increased by 8%*” (McLaughlin et al., 2010, p232). Despite the inclusion of 23.2% of PPs, and, another 9.2% of participants working in the private sector in their sample, McLaughlin et al. did not provide a breakdown of the results by sector. They conclude that the relationship between negative affect and attrition from the profession requires further research.

2.4.2.1.3 Resilience

Rees et al. (2015) describe ‘*psychological resilience*’ as a factor that exacerbates or mitigates stress on employees. They propose a biopsychological model of workforce resilience influenced by results of current literature which draws a relationship of impact from traits:

neuroticism, mindfulness, self-efficacy and coping, to psychological adjustment, on the one hand, and resilience on the other; both relationships impacted by neuroticism. In the proposed model, resilience has its own impact upon adjustment (Rees et al., 2015). This model is provided to aid conceptualisation of the role that resilience has in the workforce and to promote further research into the functioning of resilience. However, it is also a description of the current conceptualisation of resilience in the literature.

McAllister and McKinnon (2009) present the argument that resilience is not only a group of specific personal attributes such as optimism, but also the ability to build supportive relationships and adapt to change. They outline the resilience of family, community and cultures adapting to change and dealing with adversity: “*As resilience is a personal and cultural strategy for surviving and even transcending adversity, the concept can be used to explore and understand health professionals who survive and thrive in their workplace*” (McAllister & McKinnon, 2009, p375). The role and level of resilience required by SLPPPs or in SLP PP businesses, to cope with possible trauma, secondary trauma or ongoing client contact, is not known.

2.4.3 Motivation

2.4.3.1 Psychological contracts

The maintenance of a psychological contract between an employee and employer/organisation has an impact on job satisfaction, employee affect and retention of staff in a business/organisation (Tan, 2006). The relationship between employee and employer encompasses not only an employee contract of some description, but also a psychological contract of assumed understanding or reciprocal expectations between employer and employee (Boxall & Purcell, 2011; Flower et al., 2015; Tan, 2006). The breach of a psychological contract is associated with “*lower job satisfaction and organisational commitment*” for an employee, whereas, its fulfilment is associated with higher job satisfaction and higher organisational commitment (Flower et al., 2015, p108).

Breached psychological contracts lead to reduced retention of staff (Tan, 2006). An example of this is provided by Boxall and Purcell (2011) who outline a current trend in public health and education organisations. The effect of “*downsizing and budget constraints*” in the face of increasing demand in public health and education sectors has led to work intensification (Boxall & Purcell, 2011, p154). Boxall and Purcell (ibid) explain that a ‘*target/audit culture*’

with a split of ‘*purchasers*’ (governments), from ‘*providers*’ (healthcare professionals), leads to increased workloads. An unrewarded increase in workload is a breach of the psychological contract, this leads to reduced trust in the employer/employee relationship as described by Flower et al. (2015, p107). It is the ‘*reduced trust*’ and ‘*antagonism*’ of public sector professionals that in turn increases problems of recruitment and retention in the public sector (Boxall & Purcell, 2011, p155). Tan cautions that reduced retention in a profession may also be due to personal life circumstances such as family commitments, or, the personality make up of an employee. Notwithstanding, reduced retention of SLP staff is reported in Australasia (District Health Boards New Zealand, 2007; Kenny & Lincoln, 2012; McLaughlin et al., 2010; Tillard, 2011) and could be associated with a breach of the psychological contract between employee and employer/organisation, causing some degree of job stress, professional dissatisfaction or reduced organisational commitment (Boxall & Purcell, 2011; Flower et al., 2015; Tan, 2006).

2.4.3.2 Psychological contracts of SLP

Psychological contracts which include a reciprocal relationship between SLPs and the employer/organisation, are observed in the public sector (Tan, 2006). Tan completed semi-structured interviews with 25 SLPs employed by New Zealand District Health Boards. He used grounded theory to build an interpretive conceptual model of the relationship between the psychological contracts of SLP employees and their employer/organisation (DHBs) via thematic analysis of his qualitative data. He found that reciprocal psychological contracts existed only between the employer and SLPs. SLPs’ relationships with colleagues, clients, and the profession were based on perceived obligation by SLPs only with no expectation of response from colleagues, clients or the profession.

Fulfilment and non-fulfilment of psychological contracts led to “*affect and behavioural responses*” for SLPs; examples are increased stress and modification of productivity. The SLPs felt the DHBs fulfilled their obligations to SLPs as employees’ responses in the area of: ‘*Needs-Supply fit (42.9%)* [such as a wage, flexibility, caseload size] ...*professional development (17.5%)*[ongoing training and development], *justice (15.9%)*[fairness or consistency dealing with employees], *humanity (12.7%)*[acting appropriately towards employees] and [work] *environment (9.5%)*’(Tan, 2006, p74). Fulfilment of psychological contracts increased SLPs’ perceived commitment to the DHB. Non-fulfilment was recorded in responses related to: “*Need-Supply fit (36.9%), environment (19.1%), professional*

development (14.3%) and humanity (14.3%)”(Tan, 2006, p74). These types of responses were associated with reduced organisational commitment and poor affect.

SLPs perceived psychological contract change over their length of time working in the DHB. Contract change that was *‘negotiated’* or included SLPs in the decision making process (high involvement work practices), led to more organisational commitment. Other managerial or leadership approaches to contract change were described as: “... *‘Implied’ – expectations or obligations determined by the socio-political situation of the workplace; or ‘Directed’ – direct orders from the superior or other representatives of the organisation/employer*” (Tan, 2006, p81). These leadership approaches lead to less organisation commitment by SLPs. Accordingly, increased retention rates or increased organisational productivity can be achieved by ensuring an awareness of the psychological contract expectations of SLPs, and, negotiating changes to contracts with SLPs.

However, Tan’s work did not include PPs. SLPs working in PP may hold different perceived expectations and feel different obligations as part of psychological contracts with their employers. It is possible that self-employed SLPs may perceive reciprocal psychological contracts with the profession or professional body in order to provide ethical and evidence based practice. Further research is required to develop an understanding of the way psychological contracts impact upon SLPPPs’ professional satisfaction, affect, and, ultimately, professional (personal and business) success.

2.4.3.3 Professional satisfaction

Professional satisfaction is used in this research to refer to enjoyment and fulfilment in professional work and, is used synonymously with career satisfaction, and job satisfaction. Professional satisfaction is reduced for SLPs when services, including evidence based services, are under resourced (Harris et al., 2009; Kenny & Lincoln, 2012). Work intensification is observed by SLPs with increasing referral rates not matched by increased staffing levels (Kenny & Lincoln, 2012). Kenny and Lincoln (2012) reviewed the current literature with regard to the retention of SLPs in Australia. They claim that work intensification and under resourcing, results in an inability to provide evidence based care for clients, and leads to reduced job satisfaction and job stress for Australian SLPs. Conversely, the ability to provide evidence based practice has been associated with job satisfaction by Australasian researchers (Cheung et al., 2013; Kenny & Lincoln, 2012; McLaughlin et al., 2008; McLaughlin et al., 2010).

Those factors have led to an examination of retention and attrition of SLPs, in the profession. McLaughlan et al. (2008) interviewed Australian SLPs, from all sectors of employment, about their views on attrition from the profession. They define attrition as SLPs leaving a job or the profession. Qualitative analysis of themes arising from answers given by a purposive sample of 18 SLPs, SPA members, responding to questions regarding attrition in SLP, exposed eight themes: '*positive aspects of the profession*', '*autonomy*', '*workload*', '*non-work commitments*', '*effectiveness*', '*recognition*', '*support*' and '*learning*' (McLaughlin et al., 2008, p161-163). These themes commonly occur in the literature regarding both, retention and attrition of SLPs, and are discussed in this research in relation to the factors that motivate SLPs to want to work. They also raise four issues that are of importance with regard to attrition, but that also apply to the ability and motivation of an employee, to work:

1/ the influence that individual characteristics such as value system and personality had on the perception of, and reaction to, these issues; 2/ the impact of these issues on job satisfaction; 3/ the contribution of these issues to stress levels; 4/ the influence of these issues on clinical effectiveness.(McLaughlin et al., 2008, p160)

The literature is explored with these issues providing parameters for discussion.

2.4.3.4 Motivation of speech language pathologists in private practice

The motivational factors aiding retention of SLPs and reducing attrition of SLPs from the field, can be explored with reference to the intrinsic and extrinsic motivators required to retain employees as described by Boxall et al. (2011). Intrinsic motivators are aspects inherent in the nature of a job which motivate an employee. Extrinsic factors are those external to the job such as a wage. An examination of the literature relevant to SLP with regard to retention or attrition rates is required in order to identify what motivates SLPs to maintain/build productivity within bureaucracies and for the professional craft service businesses of SLPPPs. It is likely that factors identified to increase or decrease the motivation of SLPPPs operate to build individual performance according to individual performance theory where performance, is equivalent to, ability, motivation, and, opportunity (Boxall & Purcell, 2008), in either and additive or multiplicative relationship (McCloy et al., 1994).

2.4.3.4.1 Workload

Increased caseloads or workloads are evidence of work intensification in SLPs' workplaces. Hutchins et al. (2010), responding to a national shortage of SLPs working in

schools in Vermont, USA, completed a job satisfaction survey with 75 full time SLPs working in schools. They found SLPs professional satisfaction, career advancement, caseload size, workload, parental involvement with clients, salary and collaborating with others, were related to retention of staff. The extrinsic motivators identified by their research are: reduction of caseload size, and reduction of workload. The intrinsic motivating factors identified by Hutchins et al. link best-practice and job satisfaction:

The ability to work with colleagues, time to contribute to current models of innovative practice in education... and opportunities to engage with families [of clients] are best practice activities that are likely to facilitate positive change for students with speech-language impairments and foster job satisfaction (Hutchins et al., 2010, p 147).

An association is made between increased case and workload, and reduced ability to provide best practice services to clients. This lends support to the depiction of reduced resourcing in public services leading to not only reduced retention, but also, reduced job satisfaction in the USA.

2.4.3.4.2 Retention in rural and remote Australia

Similarly the lack of allied health professionals in rural and remote areas has prompted examination of the retention of allied health staff in Australia (Keane et al., 2013; Keane, Smith, Lincoln, & Fisher, 2011; O'Toole et al., 2008; Stagnitti et al., 2006) and specifically in NSW (Keane et al., 2013; T. Smith, Fisher, Keane, & Lincoln, Jun 2011). Research regarding the retention of allied health professionals across public and private health sectors suggests that allied health PPs have higher job retention, in rural and remote settings, in comparison to allied health practitioners employed in public services (O'Toole et al., 2008; Stagnitti et al., 2006). Stagnitti et al. (2006) identified professional needs of allied health professionals as: "*feeling supported*", "*orientation to the position*", "*clear job description*", and feeling "*able to recommend the position to others*" (Stagnitti et al., 2006, p 228-229). Professional needs such as "*a clear job description*" reinforce findings by Flower et al. (2015, p 112) that informational justice or clear communication with employees, is an aspect of the psychological contract, associated with organisational commitment for allied health professionals. Stagnitti et al. report that their qualitative data associates "*recommending the position*" with: "*job satisfaction*", "*autonomy*", "*flexibility*" and "*variety of work*" (Stagnitti et al., 2006, p 226). However, the numbers of SLPPPs recruited, was small, in Stagnitti et al.'s (2006) research,

the research was conducted in Victoria not NSW, and, a breakdown of the allied health disciplines was not provided by O'Toole et al. (2010) or Stagnetti et al. (2006).

Allied health professionals in PP were included in research conducted in NSW, by Keane et al. (2013). They surveyed 833, public, and, 756, private, allied health professionals in the Hunter-New England catchment area of NSW and found increased retention of PPs, but, increased job satisfaction among public allied health professionals (Keane et al., 2013). A breakdown of 69 public and 33 SLPPPs, was provided. Age was a significant factor, contributing to retention, with older and younger allied health professionals, more likely to leave rural and remote employment (Keane et al., 2013, p5). No information was provided regarding ethnicity and all SLPs in the survey were female. Keane et al. found that "*high clinical demand*" which can be defined as work intensification, was a predictor of intention to leave in both public and private allied health professionals (Keane et al., 2013, p7). A breakdown of specific professional group was not provided for responses, reducing the certainty of the results for any specific group, including SLPPPs. Although allied health PPs are more likely to be retained in rural and remote locations, the actual comparison between likelihood of retaining SLPs in public or private rural and remote locations, is not provided.

2.4.3.4.3 Australasian SLP's workload

The demand for SLP services from the community is "*not met by existing speech-language pathology resources*" (Kenny & Lincoln, 2012). McLaughlin et al. (2008, p161) explain: "*high workload and high caseloads may cause stress responses in speech-language pathologists*" which can lead to "*fatigue*" and "*burnout*". This stress is predominantly caused by reduced ability to effectively service clients (Kenny & Lincoln, 2012; McLaughlin et al., 2008). Kenny et al. express concerns that some 'sub' groups of clients are not serviced due to referral policies or systems that rationalise available resources by prioritising certain client groups by "*diagnosis*", "*prognosis*" or "*age*". Workplaces are described, by some of the 16 SLPs participating in workplace interviews, with a "*war*" theme as "*battle grounds*" when they engage in "*fighting for funding*". Kenny et al. warn an "*indifference to clients*" needs can ensue with SLPs withdrawing from teamwork due to a "*perceived lack of workplace support*" and resulting professional isolation (Kenny & Lincoln, 2012, p256). A lack of workplace support was found to reduce workplace satisfaction and retention for allied health professionals by Stagnetti et al. (2006). Furthermore, professional isolation was one of the factors identified by Keane et al. (2013), associated with allied health professionals' intention to leave a job. Therefore, caseload size and workloads, which are able to be manipulated by business, and, as

such, are extrinsic motivators, also act as intrinsic motivators for SLPs, when caseload or workload prevent SLPs from providing adequate SLP service or evidence based practice.

2.4.3.4.4 Workload and stress

Work intensification is associated with work stress (Kenny & Lincoln, 2012; McLaughlin et al., 2008). A relationship exists between retention of SLPs, professional satisfaction and job stress (Harris et al., 2009; Kalkhoff & Collins, 2012). Harris et al. (2009) responded to the shortage in SLPs in schools in USA by surveying SLPs' level of job stress. "*Stress and burnout contribute significantly to the shortages of school-based speech-language pathologists*" (Harris et al., 2009, p 103). Harris et al. surveyed 97 school-based SLPs at the request of the Utah State Office of Education. They used standardised assessments to measure SLPs' stress levels and found that SLPs had more stress in three specific areas: "*caseload size, salary and the use of prescription drugs.*" (Harris et al., 2009, p 103). In addition, a high correlation was noted between the time and workload management scale and years of experience, suggesting that more stress is experienced with increasing years in the SLP profession. Harris explains the high use of prescription drugs as characteristic of levels of use in Utah, and dissatisfaction with salary as known to be lower than other states. This dissatisfaction between salaries in public and private settings was also observed by Vinokur-Kaplan et al. (1994) in a cross-sectional professional satisfaction survey of social workers in England and suggests that increased wages may be an extrinsic motivational factor that mitigates potential work intensification in PP.

Loan-Clarke et al. (2009) surveyed SLPs in the UK regarding their reasons for staying, leaving and returning to the *British National Health Service (NHS)*. They asked open ended questions of 516 SLPs in order to develop management strategies to increase retention and return of staff to the public health service. The SLPs defined as '*stayers*' gave reasons for staying as they: "*value job and pension security*", "*professional development opportunities*", "*the work itself*" and "*professional support*". '*Leavers*' were not retained due to "*workload/pressure/stress*", "*poor pay*" and reduced ability to provide adequate client care. '*Returners*' came back due to: "*flexible hours*", "*work location*", "*professional development*", and "*pension provision*" (Loan-Clarke et al., 2009, p 883). A '*pension*', which is not defined by Loan-Clarke et al., is likely to be some form of superannuation afforded by the public health service in UK. In Loan-Clarke et al.'s research, it is not only a wage providing the external financial motivational factor to retain staff, but also the financial security from some superannuation allocation for those who return or stay in public health employment. A

limitation of this study, as acknowledged by Loan-Clarke et al., is the lack of employment opportunities outside the public health service in the UK.

Although the American and British studies discussed are also not directly transferable to the Australasian context, it is probable that a wage or financial security may be an external motivating factor for SLPs in Australasia. In as much, the level to which SLPPPs are satisfied with their financial remuneration and whether that remuneration serves as a mitigating factor to work stress is important, but largely unknown. O'Toole et al (2010) interviewed allied health PPs in rural and remote Victoria finding that 'many' allied health PPs were not "*financially self-sustaining*" (O'Toole & Schoo, 2010, p7). The satisfaction of SLPPPs, with their financial remuneration, or, financial security, has not been reported in NSW or NZ. It is unknown whether profit or financial security serve as motivational factors or factors that mitigate work stress in SLP PP.

2.4.3.4.5 Work stress in private practice

Factors specifically related to the PP business environment, may also lead to work stress and lower job satisfaction in for SLPs. NZ Audiologists who work in PP, made up 73% of the Audiologists surveyed by Severn et al. (2012) report "*time demand*" was a major occupational stress factor, in comparison, for Audiologists who were employed in NZ public services. (Severn et al., 2012). Severn et al. completed the professional quality of life instrument (ProQOL) and the audiology occupational stress questionnaire (AOSQ) with eighty-two participating audiologists and found:

The level of service offered to patients was the highest reported (16% of variance) stressor noted by private audiologists. Patient contact time was the next most important stressor, accounting for 15% of the variance, followed by paperwork and administration (11%), staffing issues (10%), and patient unrealistic expectations (9%). (Severn et al., 2012, p 6)

Audiologists working in the public service were found to have higher stress levels and higher stress relating to '*accountability*' (discussed as possibly related to caseload type), and "*administration or equipment*". Owners of audiology clinics, who made up 50% of the PPs, in Severn et al.'s research, were noted to have higher stress levels associated with "*time*" and running a business (Severn et al., 2012, p7). It is reasonable to assume that similar stressors to those experienced by audiologists in PP may be experienced by SLPs employed in, or owning a PP in Australasia. Therefore, SLPs with a certain psychological make-up such as those with

high personal efficacy, and good time management skills, may be better able to cope with the stressors of PP and better suited to PP.

2.4.3.4.6 Recognition and Autonomy

A lack of understanding and awareness of SLPs' 'role and abilities' is identified as a stressor for SLPs with this lack of recognition shown in reduced remuneration and career structures (McLaughlin et al., 2008). However, SLPs define their level of autonomy in PP as a 'moderator' of stress (McLaughlin et al., 2008) and it is suggested caseload stress may be mitigated by PPs setting their own caseload (Cheung et al., 2013). Although there is limited research on work intensification in PP, SLPPPs do face less bureaucratic management than their public sector colleagues. Increasingly public sector bureaucracy faces change requiring increased flexibility of services requiring movement of personnel across organisations and reduced profession specific line management (Boxall & Purcell, 2011; Mueller & Neads, 2005). Reduced line management by professionals in the same field reduces specific professional knowledge of managers and can lead to funding and service decisions made by people who have little knowledge about the resources required to provide quality SLP services (McLaughlin et al., 2008). Less bureaucracy allows SLPs to make autonomous decisions that support their own professional socialisation, professional ethics and provision of evidence based practice.

The ability of SLPs to provide effective services to clients is associated with increased professional satisfaction. Several studies report that 'autonomy', and 'flexibility' are reasons given by allied health professionals: to recommend their positions (Stagnitti et al., 2006) or, to increase staff retention rates (O'Toole et al., 2008). O'Toole and Schoo completed an online survey of rural and remote allied health PPs, in Victoria, known to have higher retention rates. They asked allied health PPs about their willingness to engage in service partnerships with public sector services and their views on government incentives to attract and retain PPs to rural and remote areas. SLPs made up at least 32% of O'Toole and Schoo's 72 participants. The majority of PPs were supportive of public/private partnerships but their suggestions maintained their autonomy shown by funding suggestions such as: "...[government] *grants to assist with practice development*" and "*scholarships to support the training and development of private practitioners to fill service gaps [within the public health system]*" (O'Toole & Schoo, 2010, p4). The autonomy provided to PPs may also allow them to structure their businesses to engage their own professional interests in their scope of practice allowing

increased professional confidence and satisfaction. Further specific research is required to verify these projections.

2.4.3.4.7 Work life balance

Life circumstance can be seen to play a role in the retention of Australian SLPs. McLaughlin et al.'s (2008) qualitative thematic analysis of the interviews of 18 SLPs ascertained that family commitments were recognised as a reason to stay in the profession of SLP suggesting that profession offers flexibility to meet family commitments. Although their sample size was small, subsequent statistical analysis of quantitative data provided by McLaughlin et al. (2010) from a survey 620 SLPs provided similar conclusions. SLPs recruited from SPA were asked by McLaughlin et al. (2010) about their intent to leave their current positions. PPs accounted for approximately 23% of participants. McLaughlan et al. reported: "*age (SLP under 34 years of age)*", "*perceived level of job security*", and "*not feeling that work in as a speech pathologist met professional needs*", were factors associated with wanting to leave a job (McLaughlin et al., 2010, p 227). "*Spending more than half employed time on administration*", "*higher negative affect score*", "*not feeling that work in as a speech pathologist met professional needs*", and "*not having children under 18 years of age*", were factors they associated with SLP wanting to leave the profession (McLaughlin et al., 2010, p 227). These results support those of Kalkhoff et al. (2012) that the nature of work is an intrinsic motivator for SLPs. In addition, their findings can be seen to add weight to the importance of flexibility as an extrinsic motivating factor for SLPs creating a work-life-balance to suit SLPs' life circumstances. SLPs remain in employment and potentially seek out jobs which support their own life circumstances. The flexibility to fit in with family commitments may aid the retention of staff and increase the stability of SLP PP.

2.4.3.4.8 The nature of the work

The structure of business can support the professional interests of SLPs. The 'nature of the work', an intrinsic employee motivator, was found to be the factor most highly associated with job satisfaction by SLPs working in both educational and medical settings in a cross sectional job satisfaction survey of 98 SLPs working in USA (Kalkhoff & Collins, 2012). Both groups of SLPs also rated relationships with co-workers as the second most important factor, suggesting team structure/team work, which is an extrinsic motivator, is also important. This supports Australian researchers' findings that a lack of workplace support reduces job satisfaction and retention (McLaughlin et al., 2008; Stagnitti et al., 2006). Although both groups of SLPs in Kalkhoff and Collin's research, medical and educational, rated themselves

as having a high level of job satisfaction, a significantly higher level was recorded for SLPs working in medical settings. A robust argument was not presented to account for the difference in job satisfaction scores. However, it must be asked whether more emphasis was provided in the medical setting on the nature of the work, such as support for professional interests, or support for evidence based practice.

2.4.3.4.9 Contribution to society

SLPs are motivated by a feeling of contributing to society. McLaughlin et al. (2008) found the ‘stressors’ experienced by the SLPs they surveyed were noted to appear “...ameliorated by the feeling that, at the end of the day, the SLPs had achieved something worthwhile” (2008, p164). Their participants expressed intrinsic motivating factors of: “*being able to make a difference in people’s lives*”, and, “*achieving something worthwhile*” and were noted to be mitigating factors when SLPs faced work stress (McLaughlin et al., 2008, p164). It is not known how ‘utility’, defined as feeling useful, and/or ‘contribution to society’ relate to compassion satisfaction for SLPPPs. However, given Stamm’s definition of compassion satisfaction as the “*pleasure you derive from being able to do your work well*” (Stamm, 2010, p12), does suggest that those who feel they have contributed to society may have a higher level of compassion satisfaction and potentially increased ability to cope with stressors such as work intensification.

2.4.3.4.10 Ethical practice

‘It is fundamental to the professional responsibilities of speech pathologists that we observe the highest standards of integrity and ethical practice’ (The Speech Pathology Association of Australia, 2010a, p1). “*The Code of Ethics*” outlines the principles and values for speech pathologists in Australia including: “*1/beneficence and non-maleficence, 2/ truth, 3/ fairness (justice), 4/ autonomy, and 5/ professional integrity*” (The Speech Pathology Association of Australia, 2010a). NZSTA lists similar principles and rules of ethics on its website: “*1/ beneficence and non-maleficence, 2/ professional competence, 3/ promotion and development of the profession, 4/ professional integrity and 5/ fairness*” (The New Zealand Speech-language Therapists' Association, nd). Atherton and McAllister discuss the ethical issues emerging for SLPPPs including concerns regarding lack of accreditation of PPs (Atherton & McAllister, 2009). Flatley, Kenny and Lincoln (2014) completed semi-structured interviews with 10 SLPPPs, in Australia about the ethical issues they face. Despite the small number of participants, their thematic analysis of the qualitative data highlighted four common themes: “*balancing benefit and harm, fidelity of business practices, distributing funds, and*

personal and professional integrity” (Flatley et al., 2014, p296). Flatley et al. (2014) noted that some types of ethical issues such as those pertaining to the value of beneficence and non-malevolence are experienced by SLPs in both public and private work, due to the nature of SLP as a profession such as, high client contact time and providing an unwanted diagnosis.

Specific ethical issues were presented as arising from PPs’ *“business concerns”*. One such issue relating to the value of business fidelity is *“the need to make a profit in order to survive”*, and balance profitability with provision of quality care (Flatley et al., 2014, p 300). In comparison to the pressure placed upon public SLPs from caseload pressure, PPs were reported by Flatley et al. to face more financial pressure on time management supporting the findings of Severn et al. (2012). Flatley et al. found ethical issues occurred when SLPPPs followed particular business policies such as those related to charging fees for non-attendance of clients, or early discharge due to non-payment of fees. Business managers were noted to face ethical issues regarding beneficence: ensuring an adequate standard of care was received by clients, and ensuring professional integrity; ensuring SLP staff did not exceed their level of competence. Given Flatley et al.’s research, it is likely that PPs would be motivated by an ability ensure ethical practice. However, it is unknown whether ensuring ethical practice aids the professional success of PPs.

2.4.3.4.11 Evidence based practice

The requirement to provide evidence based practice (EBP) is outlined by Speech Pathology Australia (The Speech Pathology Association of Australia, 2001), and The New Zealand Speech-language Therapists’ Association (The New Zealand Speech-language Therapists’ Association Incorporated, 2015, p.2). It is known that the inability to provide effective services including EBP is a potential cause of stress and job dissatisfaction for SLPs facing work intensification (Kenny & Lincoln, 2012; McLaughlin et al., 2008). SLPPPs support the need for EBP (Cheung et al., 2013). Cheung et al. (2013) compared responses of Australian SLPPPs, to SLPs working in public, and not-for-profit organisations, to questions regarding the need for evidence based practice when working with children with Autism Spectrum Disorders. Cheung et al. found no significant difference between the PPs and other SLPs regarding their support for EBP. PPs, who made up almost half of the 105 participants, did differ from other SLPs in their response to prioritising waiting lists over EBP. SLPPPs were less likely to identify that their workplaces prioritised waiting lists over evidence based practice. Cheung et al. suggest that this may be due to SLPPPs having the ability to choose the size of their caseload (Cheung et al., 2013, p22). Given SLPPPs typically have more autonomy;

this is possible. However, there is no evidence presented to show that SLPPPs face less work intensification than their colleagues. Further research is required in order to document work intensification for PPs.

2.4.3.4.12 Support

Several researchers have found that a lack of support increases the likelihood of allied health professionals leaving a job, and, alternatively, that receiving support in a role can mitigate the impact of job stress (McLaughlin et al., 2008; Stagnitti et al., 2006). The types of support identified to mitigate job stress faced by SLPs in McLaughlin et al.'s (2008) research include: “...*enjoyment of collaborating with team members’, having management understand and value what they do, practical support such as assistance with administrative duties, and the opportunities to have face-to-face interaction with other SLP*” (McLaughlin et al., 2008, p 163). McLaughlin et al.'s participants report a lack of face-to-face contact with other SLPs as a cause of professional isolation. They postulate that SLPs who work in small departments, sole providers or PPs are at risk of feeling isolated. However, it is unknown whether PPs experience greater isolation than other SLPs.

Some SLPPPs may be more experienced than their colleagues and may be able to provide support for their public based colleagues. O’Toole et al. (2010) surveyed allied health PPs in Victoria, who suggested that collaboration between private and public rural services would benefit from supervision or mentoring provided by PPs to colleagues in the public service. Their participants were mainly between 36 and 50 years of age. It may be that their participants were more experienced than their colleagues working in the public service given that other researchers have found higher retention for PPs in rural and remote locations (Keane et al., 2013; Stagnitti et al., 2006). The level of collegial support experienced by SLPPPs, level of supervision, or use of PP/speech language pathology networks, are unknown in NZ and NSW. It is unknown whether levels of support and effectiveness of support for SLPPPs are different, in different locations.

2.4.3.4.13 Supervision

It can be seen that a successful supervisory relationship would mitigate work stress by supporting intrinsic motivating factors such as supporting ethical and evidence based practice, and provide support for extrinsic motivating factors such as ongoing professional development/educational needs. The core functions of supervision are given as:

1/ Ensuring the supervisee is supported and engages in critical reflection on their practice, 2/ Ensuring the supervisee's professional needs are discussed and addressed, 3/ Ensuring the supervisee's work is competent, accountable, and meets the requirements of their work role, and, 4/ Ensuring the supervisee is engaged with their employing organisation or field of practice (if self-employed) (The Speech Pathology Association of Australia, 2014d, p5).

Speech Pathology Australia provides a recommendation for type and frequency of supervision. The value of this type of professional support is shown by Ostergren et al. (2011) who surveyed first year new graduate SLPs in USA about their supervision relationship. They collected quantitative and qualitative data from a survey of 122 SLPs, of whom close to 16% were PPs. A “*relatively strong working alliance*” was reported with a predominantly ‘*collaborative*’ or ‘*consultative*’ supervisor role. A high level of satisfaction with the supervision relationship with no significant difference in the demographics of the supervisor-supervisee relationship found by Ostergren et al. suggesting that supervision may provide a valuable source of support for new graduate SLPs. Current levels of supervision and effectiveness of supervision relationships to provide support for SLPPPs across the range of experience, in Australasia, is required.

2.4.3.4.14 Professional socialisation and professional culture

A culture of organisational resilience in the workplace, as suggested by McAllister and McKinnon (2009), may be achieved by establishing a strong professional culture. They advocate building a resilient professional culture in order to mitigate work stress in the health professions. Australian researchers Kenny and Lincoln (2012) discuss building a professional SLP culture to mitigate workplace stress. They interviewed 16 practicing Australian SLPs in hospital or public community health settings, and used thematic analysis to describe their use of metaphors regarding caseload management. They describe participants’ reports of increased referral rates which are not met by increased staffing and outline the perceived pressure for SLPs to meet “*prescribed service limits*” at the expense of EBP. “... [*SLPs*] *have reported the perceived need to provide compromised clinical care as a major contributor to workload stress and reduced job satisfaction*” (Kenny & Lincoln, 2012, p249).

Kenny and Lincoln examine metaphor use in order to discuss manage caseload stress as a profession. The metaphors used by SLPs to talk about caseload management were able to be grouped into themes of sport, war, scales, journey or business. The most frequently used

metaphors were: sport, scales and war. Metaphors of sport were associated with “*energy*” and “*drive*”. Metaphors of scales were associated with: balancing economic demands with those of adequate client care, and, metaphors of war were used to express the “*destructive consequences*” of underfunded caseloads. Experienced SLPs provided more metaphors. The possibility of experienced SLPs using an awareness of metaphor use, to manage workplace culture, was raised by Kenny and Lincoln. They suggest an awareness of the professional discourse of SLPs is required in order to ensure positive professional socialisation of new graduate SLPs, to monitor those team members who may be at risk of burnout, and to maintain job satisfaction. Effectively, professional culture and professional socialisation are treated by Kenny and Lincoln as intrinsic motivators that are able to manage or mitigate job stress.

Professional socialisation is a part of building a professional identity which starts during training and is on-going (Milsteed, 2013). More than acquiring professional skills, it involves a process of acquiring professional values, attitudes, and ultimately an identity as a particular health professional. Milsteed uses social learning theory which she outlines as learning ‘*through observation and modelled behaviour*’ to describe how professional socialisation occurs. “*Typically, this socialisation into the mores of the profession is learned in the experience of practice where students observe and learn from role models*” (Milsteed, 2013, p65). Milsteed suggests that professional identity can be retained when health professionals move into managerial roles, and, “*resist adopting the ideology of management*”. Professional craft models of business are at risk of developing technical capabilities (SLP skills) in their profession rather than building managerial competence (Gerber, 2001; Milsteed, 2013) leading to increased business risk.

Professional socialisation could be seen to be at odds with business competence when SLPs have difficulty rationalising ethical concerns regarding the notion of for profit therapy (Flatley et al., 2014) and resist building business capabilities. Milsteed presents the case that health PPs need to develop ongoing managerial learning amid risk of small business failure given that: “*High level business competencies among small business owner-managers contribute to the profitability and growth of their businesses*” (Milsteed, 2013, p64). Therefore, ongoing learning and development for SLPPPs needs to include both clinical and business education.

2.4.3.4.15 Ongoing professional education

Ongoing professional education (clinical) is an important professional requirement for SLPs in Australia and New Zealand. Certified practicing status for SLPs requires evidence of ongoing professional education in both NSW and NZ. Practicing certification is of particular importance to PPs as it acts as a requirement of many government funding schemes such as: Better Start, Helping Children with Autism funding, Chronic Care funding and National Disability Insurance Scheme funding in Australia (Health Workforce Australia, 2014). Ensuring ongoing professional development is therefore both a professional and business requirement for SLPPPs. Ongoing education is identified by SLPs as a mediator of stress (Keane et al., 2011) while lack of professional development as a stressor linked to SLPs leaving their jobs (McLaughlin et al., 2008). Government support for access to professional education was an area highlighted by PPs, in research conducted by O'Toole and Schoo (2010), as an incentive to stay in rural and remote Victorian locations. The PPs surveyed by O'Toole and Schoo (2010) included 22 physiotherapists, 21 occupational therapists and 23 SLPs. Questions were asked regarding government incentives for: retention, professional development, and professional practice. It is unknown whether a lack of ongoing professional development is currently an area of professional dissatisfaction for SLPPPs.

2.4.3.4.16 Managerial learning and business training

Although many professionals including therapists may have effective technical skills ('craft' skills) these do not necessarily translate into effective business skills (Baron & Markman, 2003; Dorando-Unkle, 1995; Gerber, 2001; Milstead, 2013). It is known that *"...there is evidence that [managerial] competencies need to develop beyond those required for start-up if small business is to survive and for growth to occur"* (Baron & Markman, 2003; Milstead, 2013, p69). Despite the importance of managerial competence and ongoing managerial learning specific to PP, business skills are not a requirement of SLPPPs' certified practicing competency in Australia or New Zealand. Some of the allied health PPs interviewed by O'Toole et al. (2010) felt that business learning should not be provided in undergraduate training but be provided by professional associations, or by seeking alternative business training following graduation. It is unknown whether SLPPPs have a high level of business qualifications.

The management competence of new graduate SLPs in Australia, was examined by Lincoln et al. (2001). They examined the perceptions of 47 experienced SLPs, regarding their perceptions of the necessary managerial competencies of new graduates. Approximately 4% of

participants worked in PP alone, with another, approximately, 4%, working in both public and private services. They found SLPs felt the important skills were “...*management of future planning (time management, prioritising and planning goals for the work team) and organisational practices (being an advocate for the department) and legislative knowledge*” (Lincoln et al., 2001, p 25). However, these skills were not specific to PP and a break-down of responses provided by SLPPPs was not given.

Milsteed (2013) outlines the need for occupational therapy (OT) PPs to encompass managerial learning to ensure business success. Milsteed completed semi-structured interviews with 26 owner-operator OT PPs. Thematic analysis of the qualitative data provided a conceptual model of managerial learning based on the social learning theory which allowed for on-the-job managerial learning. The OTs interviewed gained managerial skills from: “*formal, informal learning and on the job experience*”. However, Milsteed found that, “*business learning was discontinuous even if it was required for business success*” (Milsteed, 2013, p vi). Participants were “*central to skills growth*” and the factors affecting business and management skills were: “*initial start-up goals, aspirations and engagement with external business environments*” (Milsteed, 2013, p vi). Given that OT PP, like SLP PP, are predominantly small businesses, it is likely that SLPPPs are central to business skills growth and their goals, aspirations and engagement with business environments are also important to their success. Further research is required to examine these aspects of PP for SLPs.

2.4.4 Opportunity and performance

Business opportunity is closely related to business strategy in that opportunity must be harnessed or even exploited via an appropriate business strategy in order to maximise resources and processes. It has already been noted that Bloomberg and Pringle define ‘*opportunity to perform*’ as: ‘*Tools, equipment, materials, and supplies; working conditions; actions of co-workers; leader behaviour; mentorism; organisational policies, rules, and procedures; information; time; pay* (Blumberg & Pringle, 1982, p562).’ The literature regarding these aspects of business opportunity, as well as the social capital and external business and funding relationships necessary for SLP PP organisational performance (Boxall & Purcell, 2011). Government funding for SLP services was examined in the introduction in sections 1.7 and 1.10.1. Other aspects of business ‘opportunity’ are examined.

2.4.4.1 Funding opportunities - Non-government organisations

Non-government services fund some SLP services in both NSW and New Zealand. Although Health Trusts in New Zealand such as Southern Health Trust (Barnett & Barnett, 2001) and TalkLink Trust (TalkLink Trust, nd) receive some government targeted funding by providing specific services. A large amount of health trusts' funding is through private donations and bequests (The Public Trust, nd). Similar organisations in NSW such as: Cerebral Palsy Alliance (Cerebral Palsy Alliance, nd) provide therapy services funded through donations and/or targeted government funding. Health insurance is available for SLP services in both New Zealand and NSW. The extent to which SLPPs access funding from non-government organisations or health insurers is unknown.

2.4.4.1.1 Start-up funding/resources

It is reasonable to assume that access to personal funding would aid the establishment of a business and provide increased business stability. The cost of standardised tests, test forms, toys, books and a photocopier are a few of the resource items cited by SPA (The Speech Pathology Association of Australia, 2014a) required when setting up a PP; the actual start-up cost provided by SPA is given as approximately \$20,000. Availability of start-up funding and a lack of financial leverage is acknowledged as a critical to the success or failure of small businesses (Gadenne, 1998; Jasra, Khan, Hunjra, Rehman, & Azam, 2011; Luisser & Halabi, 2010; Yusuf, 1995a). However, SLP PP is a service industry in which a large amount of financial outlay may not be necessary. It is unknown whether a perception of adequate start-up funding is seen as critical by SLPPs.

2.4.5 Business strategy

A successful business has a successful business model (Johnston, Christensen, & Kagermann, Dec 2008). Business models have a particular competitive strategy such as a 'customer value proposition' which targets customers with a specific type of offer or 'funding formula' for services or products. One customer value proposition is offering a low cost service targeting a large number of customers. Another is a high cost, high quality service, that targets few customers very well. In order to achieve the chosen 'customer value proposition' the business must have key resources and key processes. Dorando-Unkle (1995) provides an example of market orientation and a customer value proposition in healthcare PP using a single case study of a school-based OT PP. The development of awareness of the lack of existing OT services offered in a specific school was used to target an unmet service-need. Dorando-Unkle

advocates the use of formal business planning to outline not only strategic service plans but also to document key resources and processes required.

The development of innovative business ideas and practices for allied health PP is a strategic direction advocated by Anderson and Nelson (2011). They promote the development of OT entrepreneurs by outlining a range of specific OT services which could be extended or promoted using innovative business practice (Anderson & Nelson, 2011). Similarly, researchers from USA, Specht and Blanchet (2009) consider the advancement of the services of SLP PP by examining the experience of SLPs providing corporate SLP services in PP. They defined 'corporate services' as SLP PP services offered to clients in their workspaces or with a focus on enhancing the client's work performance such as accent modification services. They surveyed 54 SLPPPs, members of a corporate SLP association, regarding services and career satisfaction related to professional training, experience, client characteristics, services provided, and marketing practices. They found that participants were significantly more satisfied with their current corporate practice than with prior work setting suggesting that innovative business or clinical practice may enhance job satisfaction for SLPPPs. Conclusions drawn from this research, must consider the bias introduced by the SLPPPs' decision to provide corporate SLP services.

2.4.5.1 Strategic performance

Performance management has been associated with work intensification approaches that measure productivity in bureaucracies (Boxall & Purcell, 2011). These practices can be seen to derive from a Taylorist managerial approach (Peaucelle, 2000), which involves standardising work practises in order to increase mechanisation of work tasks. This model of management is known to be ineffective with professional groups who are required to make decisions professionally (Boxall & Purcell, 2011). High involvement work practices (HIWP) are defined by Cox et al. (2012) as an approach, that, has a broad focus on performance outcomes including: "*employee involvement or commitment*" (Cox et al., 2012, p10).

This type of performance management has been used to target specific health goals. Key health performance indicators relating to health outcomes are regularly measured with staff engaged in order to reduce ill health in the population such as handwashing behaviour of health professionals in hospitals. Key performance indicators (KPI) are defined in business as:

...a measure of business performance against an indicator that the business has set itself as a target... The KPIs set, if monitored properly, will help you determine where there are problems in a business and highlight areas that are successful' (Humphrey, 2010, P.269).

KPI are able to be measured and can be associated with increased financial performance of health services (Gillean et al., 2006). The measurement of productivity in SLPs is part of the strategic planning of a business (Kummer, 2014). Kummer (2014) provides a formula for productivity and business viability within the public sector. She acknowledges that business structure, such as the employment of support staff, can increase productivity by ensuring SLPs are able to deliver services that generate a business income, while administrative tasks are completed by support staff. KPI within SLP PP may aid both the delivery of quality health outcomes and strategic business planning practices. The use of key performance indicators by SLPPPs has not been documented in Australasia.

Sue Hirst (March 2013) encourages New Zealand businesses to measure key performance indicators in their businesses, related to short, and, long term business goals, in order to measure sustainable business growth. Hirst recommends establishing key performance indicators in each of the common divisions of business divisions: *'product and service development'*, *'sales and marketing'*, *'operations and finance'*, *'customer service'* and *'human resources'* (Hirst, March 2013, P. 44) which are measured against the financial-markers *'cashflow'* and *'profit'*. Well identified key performance indicators relating to CSF for SLP PP, could provide an indication of how a business is performing in relation to identified important success criteria; which may or may not be profit related. Weaker performance on KPI could be monitored in order to identify the need for strategic change.

2.4.6 Critical Success Factors

CSF are factors that must go well to guarantee a business' success and are an integral part of a business' strategy (Boxall & Purcell, 2011; Jensen, 1987). Critical success factors can be used to measure success (Gadenne, 1998). Jensen (1987) discusses results from a body of research from manufacturing industries where:

The firms that had a higher return on equity:

- *formally identified their critical success factors;*

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- *used these factors to monitor their progress in the implementation of strategic changes;*
- *benefited from formally integrated reporting and information systems (Jensen, 1987, P. 103)*

Therefore, a knowledge of the critical success factors for a particular industry would aid viability and possibly success.

A range of CSF for small businesses are outlined in the business literature. Jasra et al (2011) surveyed small and medium sized businesses in Pakistan and found: “...*financial resources, marketing strategy, technological resources, and government support and entrepreneurial skill*” (Jasra et al., 2011, p 277) were perceived to be CSF. Similar factors were found when Yusuf (1995a) surveyed South Pacific small business entrepreneurs, including: “*good management*”, “*satisfactory government support*”, “*marketing factors*”, “*overseas exposure*”, “*level of education and training*”, “*access to finances*”, “*level of initial investment*”, “*personal qualities and traits*”, “*prior experience in business*”, and “*political affiliation*”(Yusuf, 1995b, p 69-70). Lussier and Halabi (2010) used a success versus failure prediction model to compare the CSF for three countries Chile, Croatia and United States of America. They also found common CSF: ‘*adequate capital*’, ‘*good record keeping*’, ‘*financial control*’, ‘*specific plans*’, ‘*use of professional advice*’, ‘*higher levels of education*’, and ‘*effective marketing*’ (Luisser & Halabi, 2010, P. 368). Effectively, some CSF are similar for small businesses.

Several CSF were found to reoccur in the literature such as: financial expertise or capital (Gadenne, 1998; Jasra et al., 2011; Luisser & Halabi, 2010; Yusuf, 1995a), marketing including social networking (Chawla, Khanna, & Chen, 2010; Clark & Douglas, 2014; Jasra et al., 2011; Luisser & Halabi, 2010; Yusuf, 1995a), technology expertise and resources (Jasra et al., 2011), business planning (Jasra et al., 2011; Luisser & Halabi, 2010; Yusuf, 1995a), leadership strategies/styles (Cox et al., 2012; Gadenne, 1998; Porter, 2011), government or business support (Jasra et al., 2011; Yusuf, 1995a) or personal characteristics (Ayala & Manzano, 2014; Baron & Markman, 2003; Clark & Douglas, 2014; Krishnan & Kamalanabhan, 2007; G. D. Markman & Baron, 2003).

However, variations in CSF are noted for specific businesses. CSFs in business are known to be industry specific (Gadenne, 1998; Mirjam Van Praag, 2001), relate to gender

(Kalleberg & Leicht, 1991) and age specific objectives (Still et al., 2005) and to display differences in rural and remote areas in Australasia (Still & Simmons, 2006). On the basis of the current literature it may be projected that studying SLP PP across two varied markets (NSW, Australia, and NZ) across rural, regional or metropolitan locations would provide a similar set of variations for location. However, no literature is available regarding the CSF specific to SLP PP in Australasia.

2.4.6.1.1 Social competence and social capital as critical success factors for speech language pathologists in private practice

One type of potential CSF, social competence/capital, is worth specific investigation. Marketing practices including social networking are CSFs for many businesses (Chawla et al., 2010; Clark & Douglas, 2014; Jasra et al., 2011; Luisser & Halabi, 2010; Yusuf, 1995a). Inter-professional communication with other health professionals is integral to appropriate client management for SLPs, particularly with specific client groups such as those facing chronic care (Fouch, Kenealy, Mace, & Shaw, 2014). Therefore, at the very least, the relationships between multidisciplinary team members are of particular importance to SLPPPs as co-providers of high quality services and as referrers.

In addition, many SLP are sole traders; half of the SLPPPs in Australia are sole traders (The Speech Pathology Association of Australia Limited, 2015). It is likely that the skills of the owner operator act as the skills of the business (Milstead, 2013). In effect, some marketing practices and the entire social networking of SLP PP businesses, will depend on individual SLPs social networking skills and social competence. The aspects of ‘organisation’ Boxall and Purcell (2011) associate with organisational performance will be relevant for the individual performance for the SLP sole trader engaged in building social capital to facilitate the performance of the business. Managerial learning for OT PP owner operators is associated with “*engagement with external [business] environments*” (Milstead, 2013, p vi). Accordingly, networking within known business networks may be beneficial for SLPPPs.

PPs’ social skills may also be important for business success. Baron and Markman (2003) surveyed 240 entrepreneurs working in the high tech, or cosmetics industries, regarding their social competence with a social skills inventory measuring respondents level of social perception, expressiveness and social adaptability. Social capital, defined by Baron and Markman as: “*the sum of actual and potential resources individuals obtain from their relationships with others*” (Baron & Markman, 2003, p43) such as a “*favourable reputation*”

or “*an extensive social network*”, was found to gain access to people key to financial success. Social competence, defined by Baron and Markman as: the “*ability to interact effectively with others*”, and in particular, social perception, was found to be associated with financial success, for both groups of participants, once key people were accessed (Baron & Markman, 2003, p 43). Interestingly, variations were noted between industries; in the cosmetics industry an association between “*social adaptability*” and financial success was established, and, for those in the high tech industry, “*expressiveness*” was associated with financial success. It is unknown which social skills could be CSF for SLPPPs.

2.4.7 Summary

2.4.7.1.1 The success criteria of speech language pathologists in private practice suggested by the literature

In order to discuss the success of a business it is necessary to define success. Success for SLPPPs is defined by their own success criteria. It is likely that SLPPPs have similar success criteria to other small business people. Some of the criteria outlined by Gorgievski et al. (2011), are also identified in the SLP literature, such as: work life balance (McLaughlin et al., 2010), contribution to society (McLaughlin et al., 2008), utility (McLaughlin et al., 2008), personal satisfaction, profit (Harris et al., 2009; Loan-Clarke et al., 2009), flexibility (McLaughlin et al., 2010; Stagnitti et al., 2006), autonomy (O'Toole et al., 2008; Stagnitti et al., 2006), public recognition (McLaughlin et al., 2008), innovation (Specht & Blanchet, 2009), business survival (Milstead, 2013), growth (Milstead, 2013) and satisfied stakeholders (McLaughlin et al., 2008).

In addition to Gorgievski et al.'s (2011) success criteria, the criterion of professional satisfaction is relevant to SLPPPs, given that it is associated with several profession-specific motivating factors. Professional satisfaction is associated with the ‘*nature of the job*’ (Kalkhoff & Collins, 2012), providing ethical services (Atherton & McAllister, 2009; Flatley et al., 2014), and providing EBP (Cheung et al., 2013; Kenny & Lincoln, 2012; McLaughlin et al., 2008; McLaughlin et al., 2010). On the basis of the available literature it is reasonable to ask SLPPPs in Australasia for their perceptions of these criteria. Personal values may govern the importance of success criteria and marry with specific value-orientations such as ‘business’ or ‘person’ orientations as found by Gorgievski et al.'s participants. A measure of success for SLPPPs may be obtained by asking them to rate their own performance on questions that relate to their achievement in each of the specific success criteria. Knowledge about the criteria of survival

may identify those PPs who have concerns about business viability. Additionally, asking SLPPPs about the success criteria of business growth and innovation will identify potential entrepreneurial intention of SLPPPs.

Using the model of individual performance provided by Boxall et al. (2011) the requisite level of ability, motivation, and opportunity, can be examined with regard to a high or low level of performance on success criteria. CSFs can be identified relating to SLPPPs ability, their level of motivation, or the opportunities that allow them to perform at a high level.

2.4.7.2 Critical success factors for speech language pathologists in private practice

The CSF of a business are the factors that must go well to ensure a business' success (Boxall & Purcell, 2011; Jensen, 1987). These 'make-or-break' factors for SLPPPs will encompass both the professional identity of SLPs, which ensures evidence based practice (Roddam & Skeat, 2010) and ethical SLP practice (Atherton & McAllister, 2009; Flatley et al., 2014); and individual/organisational performance management including the strategic management of the business (Boxall & Purcell, 2011).

CSF will vary with industry type (Gadenne, 1998) so may be specific for SLP PP. Possible CSF raised by the literature are: adequate government funding for PP (Skeat et al., 2009), availability of professional support (McLaughlin et al., 2008), strong professional culture (Kenny & Lincoln, 2012), opportunities for professional development (O'Toole & Schoo, 2010) and managerial learning (Milstead, 2013), leadership style: specifically, employee involvement in decision making processes (Tan, 2006), clear communication (Flower et al., 2015) including provision of job descriptions (Stagnitti et al., 2006) and business plans (Dorando-Unkle, 1995), and involvement in business and clinical networks (Keane et al., 2013). Personal characteristics that mitigate job stress could also act as CSF such as high levels of: compassion satisfaction (Severn et al., 2012), resilience (McAllister & McKinnon, 2009), personal efficacy (G. Markman, Baron, & Balkin, 2005), social competence (Baron & Markman, 2003) and positivity (McCann et al., 2013).

The possible CSF listed in the business literature are outlined in Table 6. It is not known which of these factors are most important to SLPPPs or how these factors would co-vary with the self-rated achievement on questions relating to the identified success criteria.

2.5 Conceptual Framework

Individual performance and organisational performance for SLPPPs, is equated with SLPs': ability, motivation and opportunity for performance. Opportunity includes the resources and processes necessary for performance. Opportunity also includes social competence and social capital for SLPPPs, who are usually small business people. The professional identity of SLPPPs, which can be seen to be governed by professional associations, defines the level of professional competence, evidence based practice and ethical practice provided by individual SLPs. The strategic direction of a SLP business can be seen to harness these factors into a direction for business performance. The CSF of SLPPPs derive from individual/organisational performance, professional identity and the strategic management of a business. The conceptual model of this relationship is given in a model framework adapted from the '*Theory framework for applied disciplines: Boundaries, contributing, core, useful, novel, and irrelevant components*' (Swanson, 2007, p 328) and is provided in Figure 2.

Table 6. Possible critical success factors as suggested by the literature

Area of examination in the literature	Possible critical success factors
Human capability and capital	Resilience, Positivity, Personal efficacy, Social competence, Aspirations/objectives, Industry specific education, Clinical experience, Business Experience, Age, Personal support
Strategic capability and capital	Strategic planning, Market orientation, Customer value propositions, Business structure, Business culture, Business coaching
Financial capability and capital	Financial documentation practices, Use of external financial advice, Start-up capital, Access to cash flow, Availability of funding sources, Ongoing resourcing
Management capability and capital	Leadership style/practices, Planning and review practices, Key performance indicators, Documentation practices, Ongoing clinical and business education, Mentoring, Supervision
Professional capability and capital	Ability to provide evidence based practice (EBP), Support to provide EBP, Quality clinical outcomes, Documentation of clinical outcomes, Resourcing to provide EBP, Ethical clinical practice, Ethical business practice
Social capability and capital	Professional clinical affiliation, Professional clinical networks, Professional reputation, Relationships with allied health/education, Referral relationships, Business networks, Customer relationships, Marketing, Use of social media

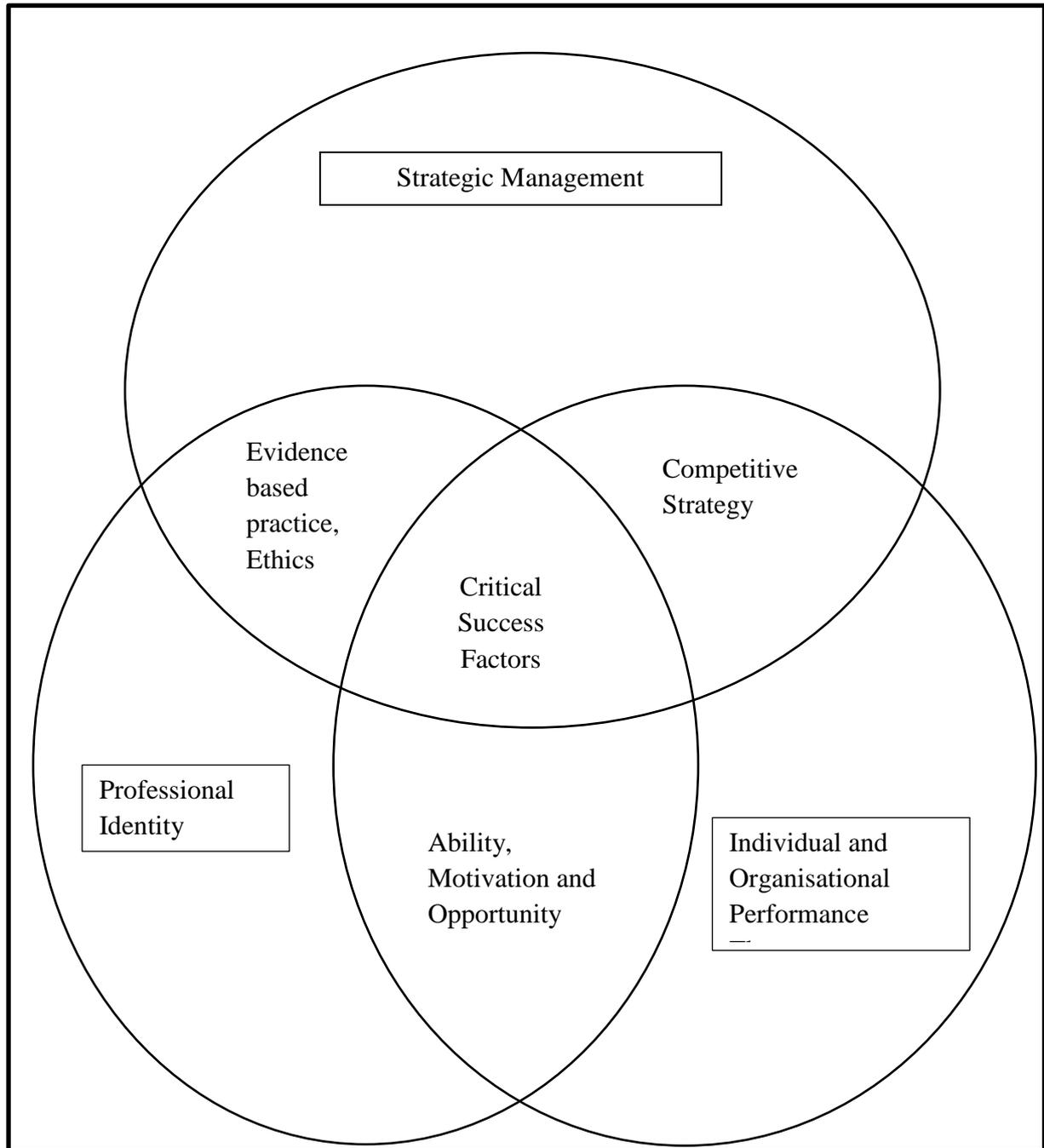


Figure 2. Theoretical framework for speech pathology private practice critical success factors (adapted from the Theory Framework for Applied Disciplines: Boundaries, Contributing, Core, Useful, Novel, and Irrelevant Components (Swanson, 2007, p 328)

3 Research Design

3.1 Research Objective

The objective of this research is to determine the critical success factors and indicative key performance indicators that allow SLPs to establish and monitor a high or low level of success in SLP PP, in NSW, Australia and NZ.

3.1.1 Justification for this research

This research is justified given:

- (a) a lack of current research and knowledge regarding SLP PP in Australasia,
- (b) the need for better documentation of the current SLP PP industry,
- (c) the need to support SLPPPs in a growth industry,
- (d) the need to support SLPPPs as an important supplier of employment for SLPs, and,
- (e) the provision of appropriate services to clients with communication and/or swallowing difficulties by SLPPPs in Australasia.

3.2 Research Questions

This exploratory research asks the questions:

- 1/ What are the success criteria of SLPs working in PP in Australasia?
- 2/ Can SLPs working in private practice self-rate their performance on questions relating to 11 success criteria in order to measure the success/viability of SLP PP?
- 3/ What are the critical success factors for SLP PP for speech language pathologists who self-rate with high levels of success on the 11 success criteria?
- 4/ Can critical success factors relevant to SLP PP be measured by key performance indicators in order to monitor ongoing success in SLP PP, in Australasia?
- 5/ What are the differences in success criteria, success ratings, or CSF between SLPPPs in New Zealand and NSW, Australia?

3.3 Research Structure

To summarise a simple metaphor, research methods can be likened to a craft person’s tool but research methodologies point at the beliefs, values and traditions he or she holds that underpin and overarch the craft and influence the way the tools are held and employed (Stokes, 2011, para 2).

Underlying philosophies are the framework from which research is structured, approached and can be interpreted. This relationship is shown in Figure 3, a model adapted from Saunders et al. (Collins, 2010, p 37; Milsteed, 2013, p.76; 2009) and Stokes (2011, Research Methods).

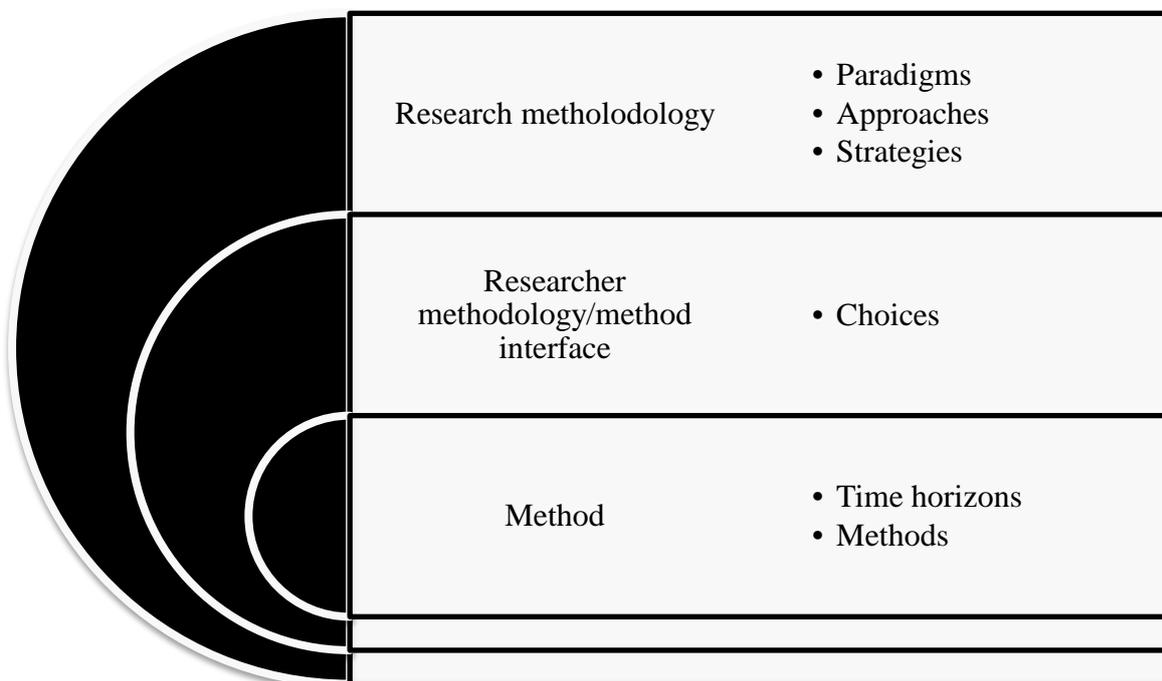


Figure 3. Relationship of research with research methodologies adapted from Saunders et al. (Collins, 2010, p.37; Milsteed, 2013, p.76; 2009) and Stokes (2011, Research Methods).

Research philosophies guide the research approach and strategy of this research. Epistemology and ontology are research philosophies that are concerned with the way researchers approach reality and knowledge (Collins, 2010; Milsteed, 2013; Stokes, 2011).

3.3.1 Ontology

Ontology encompasses the way researchers approach reality (Collins, 2010; Milsteed, 2013; Stokes, 2011). Different views about what constitutes reality are possible. People may experience and perceive the same phenomena differently. A person’s own view of reality

determines whether they believe reality is internal to a person's own mind or it has an existence external to the actor. Objectivism posits that reality exists external to oneself and subjectivism that the actor creates reality from perceptions and related actions (Collins, 2010; Milsted, 2013). The implication for research methodology is whether the research data exists objectively, external to the researcher, or whether it is subjective, with the researcher 'implicated and involved' in creating the knowledge.

3.3.2 Epistemology

Epistemology is the study of knowledge and justified beliefs (Collins, 2010). Stokes elaborates that it includes: "...theories about how and why knowledge is made..." (Stokes, 2011). It encompasses the conditions that are required to ensure knowledge and how beliefs are converted to knowledge. Stokes warns that researchers need to be aware of the 'assumptions' they make in creating knowledge. Understanding the conditions required to ensure knowledge implies that the context in which knowledge occurs is significant (Collins, 2010). Milsted (2013) points out that a subjective belief that context influences reality would be: "*best gained by studying the context in which those things occur*" (Milsted, 2013, p77). Ferguson and Armstrong (2009, p 50) discuss the need for ecological validity or "*sampling of behaviour in natural contexts*" in SLP research. A subjective understanding of SLPs' point of view and the way they think about, and shape their own PP reality is integral to the validity of research about SLP PP.

3.4 Research Paradigm and Approach

3.4.1 Positivist paradigm/deductive approach

The research paradigm of positivism stems from an objectivist ontological view that knowledge stems from human experience (Collins, 2010). It proposes that the natural world and people within are subject to scientific laws that are fixed, permanent and external to themselves (Collins, 2010; Stokes, 2011). It proposes an empirical position of realism and objectivity in a search for scientific truth. Aspects of an empirical positivist paradigm would provide valuable knowledge for SLPPPs. Knowledge of any industry specific, measurable universal or essential truths, would be valuable to the achievement/maintenance of business viability, and to SLPs understanding of the nature and general trends/behaviour in SLP PP.

A deductive approach to research flows from the positivist paradigm. Deductive research methods seek to associate existing theory to observed behaviour (Collins, 2010; Milstead, 2013; Stokes, 2011). Ferguson and Armstrong (2009, p 9) describe this as a '*top down approach*' to analysis in SLP research. Structured interviews or surveys with testable style questions enable a scientific approach to collecting quantitative data in an attempt to maintain objectivity and reduce bias. A deductive positivist approach from which to derive industry specific theories by testing appropriate business theory would also benefit the success and viability of SLP businesses.

3.4.2 Causality

Quantitative approaches rely on causality, or when a cause is responsible for an effect, as a conceptual foundation (Maggetti, Gilardi, & Radaelli, 2013). Maggetti et al. (2013) advocate a probabilistic causal approach to research that is '*indeterministic*' in that the method is viewed as "*inexact by design*" to cope with problems such as measurement errors (Maggetti et al., 2013, p161). This approach allows manipulation of statistics to address '*fallibilities*' and is outlined as: "*The event A must occur before its effect Z and must increase its 'unconditional probability' of occurring, while there must be no evidence that A is a spurious cause of Z*" (Maggetti et al., 2013, p 45). Quantitative probabilistic research relies on covariation. Covariation relies on the establishment (or not) of a relationship between: "*...one (or more) explanatory variables and a dependent variable, usually by excluding or controlling for other variables*" (Maggetti et al., 2013, p 54).

Cross-sectional quantitative data from a survey of SLPPPs is able to be analysed for within-group variation. The dependency of relationships between variables can be described as correlation. It is important to establish correlation between dependent and independent variables in order to establish a causal relationship. A reasonable causal relationship without spurious influence from other factors is required in order to establish causal inference.

3.4.3 Scientific method and deductive approach

An empirical positivist approach seeks to discover objective measurable phenomena using scientific method and deductive reasoning in analysis. Zikmund et al.(2013) outline a process for applying scientific method to research:

1/ Assessment of relevant existing knowledge of a phenomenon

2/ Formulation of concepts and propositions

3/ Statement of hypotheses

4/ Design of research to test the hypotheses

5/ Acquisition of meaningful empirical data

6/ Analysis and evaluation of data

7/ Proposal of an explanation of the phenomena and statement of new problems raised by the research (Zikmund et al., 2013, p 44)

This research seeks to follow scientific method during the positivist component of the research.

Although following a positivist approach and associated research methods may increase the reliability of the data it does not follow that causal inference will be generalised to the wider context due to the ‘specific nature’ of causal relationships imposed by the research conditions. It may be that the research question answered is too narrow to be applied to the naturalistic setting. Accordingly, the research paradigm of positivism is criticised for a lack of subjectivism (Collins, 2010; Milsted, 2013).

3.4.4 Interpretivist paradigm/inductive approach

The interpretivist research paradigm seeks to understand the world “...*as it is experienced and made meaningful by human beings*” (Collins, 2010, p 39). The ‘*interplay*’ between an actor and “*the objects that present themselves to our consciousness*” (Collins, 2010, p 39), characterises the subjective interpretivist paradigm. Effectively, from an interpretivist viewpoint actors participate in, and change, the nature of reality, as it evolves. Qualitative methods of research can be used to capture the complexity and realism of a research questions in social science research (Maggetti et al., 2013). Milsted (2013) notes an interpretivist viewpoint marries well with an inductive approach to research. Inductive approaches involve gathering data and then developing theory from that data. Ferguson and Armstrong (2009, p 9) describe this type of approach in SLP research as a “*bottom up approach*”. Due to the flexibility and changing nature inherent in the interpretivist approach the generalisability of interpretive research is not necessarily possible or paramount. Although this type of research may not derive general rules for SLP PP it may provide a dynamic, evolving picture, of the SLP PP industry.

This research proposes a survey providing predominantly quantitative data, with a subset of the survey seeking open ended comments from SLP regarding PP, thereby providing some qualitative data. The quantitative data will be treated with scientific methodology and the qualitative data collected will be analysed with thematic analysis and an inductive approach in order to provide subjective information; given that SLP PP is not separate from the influence of individual SLPs by its very nature as a professional service industry.

3.4.4.1 Qualitative and quantitative

Maggetti et al (2013) and Ferguson and Armstrong (2009) argue that qualitative and quantitative research methods are compatible in social science and SLP research, respectively. Both approaches are often combined in order to capture different aspects of the same research such as when qualitative data is used to refine survey questions which seek quantitative information.

3.5 Mixed Method Research Design

A mixed method research (MMR) design can be defined by incorporating both quantitative and qualitative research methods in order to add to the comprehensive nature of research (Bazeley, 2015). It would follow that MMR has at least two different research paradigms; positivist and interpretivist, and corresponding research approaches and methods. Mixed method research has received its equal share of credit and criticism (Tashakkori & Teddlie, 2010). Most criticism relates to the incompatibility of paradigms (Stokes, 2011). However, Collins (2010) outlines a range of options for mixed method research designs including collecting both quantitative and qualitative data and merging the results (Collins, 2010).

The benefit in using a MMR design is given by Bazeley (2015, p27) as “*greater flexibility*”, “*better supported arguments*” and “*increased relevance for a wider circle of stakeholders*”. The nature of SLP research is increasingly evidence-based (Ferguson & Armstrong, 2009), which can be viewed as supporting a quantitative, positivist paradigmatic standpoint. Evidence based business data specific to SLP PP would add to a body of knowledge for the wider discipline of SLP. However, SLP PP is also a professional service industry, in which: the industry, is, its people. The SLP PP industry is characterised small businesses with a complex and changing nature, similar to that of OT PP; as such, it is suited to an interpretivist paradigmatic standpoint (Milstead, 2013). The benefit of using both positivist and interpretive

paradigms to explore the CSF for SLP PP ensures both empirical objective quantitative data with a deductive approach to derive industry specific theory, and, the subjective context rich qualitative data providing personal insight into the experiences of SLPPPs allowing inductive theory to be established.

3.6 Research Strategy

Collins (2010) and Milsteed (2013), outline several types of research strategies: experiment, survey, case study, and action research. The survey is an appropriate strategy to provide largely quantitative and qualitative data. Closed questions and multi-choice questions using a Likert scale to provide quantitative data while open-ended questions provide qualitative data. The quantitative data will be treated using statistical analysis to build on existing theory using a deductive approach and the qualitative data will be treated with thematic analysis and inductive approach to building theory based on the data. The theories which result from both approaches can be viewed concurrently and integrated to form a more complete picture of SLP PP. This process is outlined in Figure 4.

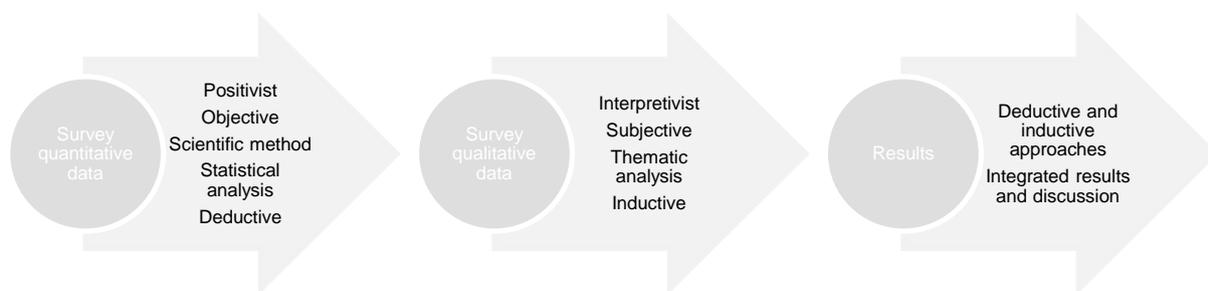


Figure 4. Mixed method research model

3.6.1 Research outline

This research is a cross sectional observational study of SLPPPs in NSW, Australia and New Zealand using an on-line survey. The questions in the survey are designed in order to:

- (a) Identify the demographics of SLPPPs

- (b) Establish the success criteria of SLPPPs
- (c) Self-rate the performance of SLPPPs on questions that are indicative of achievement on the identified success criteria.
- (d) Create a high and low total success rating score
- (e) Establish the CSF for SLPPPs by identifying the ‘abilities’ and ‘opportunities’ that correlate with a high total success rating.
- (f) Identify key performance indicators that can identify the CSF
- (g) Identify differences for the two cohorts of SLPPPs, NSW, Australia, and New Zealand
- (h) Elicit comments from SLPPPs about success in PP
- (i) Establish themes in the qualitative data that can be triangulated with the quantitative data and known literature

3.7 Statement of Hypotheses and Assumptions

It is assumed that the targeted questions directly relating to achievement on the 11 success criteria will provide a valid measure that SLPPPs can use to self-rate their performance and that CSF can be identified by establishing the correlation between the high or low total success rating, or the total success rating and identified ‘abilities’ and business ‘opportunities’.

It is hypothesized that:

1/ The 11 success criteria: business profitability, growth, innovation, survival/continuity, contribution to society, personal satisfaction, professional satisfaction, satisfied stakeholders, good balance between work and private life, public recognition, and the achievement of usefulness, will provide a reliable measure of success criteria for SLPPPs.

2/ Statements or questions with a 1-1 relationship to achievement on the 11 success criteria of the BSCIS will provide a reliable measure of success rating for SLPPPs.

3/ No significant differences will be shown in (a) success criteria, (b) self-rating of success, or, (c) CSF, between SLPPPs in NSW, Australia or New Zealand.

4/ Factors relating to ability or opportunity will correlate or co-vary with the total success rating providing a range of CSF for SLPPPs. Specific hypotheses will be listed in the results under each category of factor due to the large number of factors.

3.8 Method

3.8.1 Ethics approvals

An ethics application for this research was made to, and approved by, The University of Auckland Human Participants Ethics Committee, Auckland, New Zealand. The ethics application was approved with additional changes, 6/8/15, with reference number: 014107, for a period of three years. Consent for participation of its members was received from: The New Zealand Speech-language Therapists' Association, 2/8/15, (see Appendix L). In addition, an ethics application was also made to, and approved by, Newcastle University, University's Human Research Ethics Committee, Newcastle, Australia. Approval was received, 2/11/15, with approval number: H-2015-0321. Consent was received from the Speech Pathology Association of Australia, 6/11/15, seen in Appendix M. The participant information sheet for New Zealand participants is provided in Appendix H and for participants from New South Wales in Appendix I.

3.8.2 Survey design

3.8.2.1 Questionnaire Development

The online survey included forty-one items for Australian participants and 38 items for New Zealand participants. Two versions were constructed one for each country due to legislative, funding and terminology differences. The survey provided to New Zealand SLPs is provided in Appendix A, and to SLPs in NSW, Australia, in Appendix B. The questions which differed in NZ versus NSW, Australia, were those relating to demographics: ethnic group, gender, location of PP, and funding sources. These questions differed due to different national terminology or classification. Other questions only differed in terminology relating to SLP (speech pathology or speech-language therapy). An outline of the structure of the questionnaire is provided in Table 7.

Table 7. The Structure of the Questionnaire: Critical Success Factors for Speech Language Pathology Private Practice

	Question type	Australian version	New Zealand version	Scale
	Demographics	Items 1-6: age, gender, ethnicity (2-part), location	Items 1-4: age, gender, ethnicity, location	Categorical: specific multi-choice answers
Ability	Education	Item 12: business qualifications, Item 15: speech pathology qualifications,	Item 10: business qualifications, Item 13: speech-language therapy qualifications,	Categorical: specific multi-choice answers
	Experience	Items 13-14: business industry experience/ type, item 9: years in current role, item 16: years as a SLP, item 17: years' in PP	Items 11-12: business industry experience/ type, item 7: years in current role, item 14: years as a SLP, item 15: years' in PP	Categorical – multi-choice answers in years
Motivation	Perceived importance of business success criteria (11 items)	BSCIS 11 success criteria items, 10 from Gorgievski et al. (2011, P.209) and professional satisfaction		Statements rated with a 7-point Likert scale
Performance	Self-rated level of achievement for business success criteria (11 items)	11 questions relating to the 11 BSCIS items with Likert scale or semantically related scale for questions regarding growth and survival.		7-point Likert scale or Yes/No
Opportunity	Business structure	Items 18-25: Self-employment, business type, employer status, SLT supervisor, hours worked, business base, GST registration, caseload type and structure	Items 16-23: Self-employment, business type, employer status, SLT supervisor, hours worked, business base, GST registration, caseload type and structure	Categorical: specific multi-choice answers or yes/no answers,
	Funding	Item 26: funding types	Item 24: funding types	Categorical: specific multi-choice answers
	Business practices	Items 29-38	Items 27-36	7-point Likert scale, specific

Ability	<ul style="list-style-type: none"> Human capital 	Resilience, efficacy (time management), personal support, cultural literacy	multi-choice answers or Yes/No answers
	<ul style="list-style-type: none"> Professional competence 	Professional education, provide evidence based therapy, able to resolve ethical issues, clinical supervision	
Opportunity	<ul style="list-style-type: none"> Business strategy 	Cost value proposition, caseload type, service type, empowerment in strategic direction	
	<ul style="list-style-type: none"> Financial capital 	Start-up capital, adequate resources, pleasant environment, caseload manageable, technology use, financial practice documentation, financial processes in place	
	<ul style="list-style-type: none"> Human capital 	advancement opportunities, attracts new staff	
	<ul style="list-style-type: none"> Marketing capital 	Marketing plan with marketing strategy, website, challenge assumptions of referrers,	
	<ul style="list-style-type: none"> Management practices 	1/ Leadership practice: Shared decision making, involvement in reviews of business plans/strategic plans and quality improvement plans, involvement in productivity management, support by supervisors. 2/ Documentation: business plans, job descriptions, written contracts with referrers, effective information management systems. 3/ Business policies and procedures, quality performance reviews, key performance indicators 4/ Business adaptability: key areas identified for change are addressed 5/ Innovation supported 6/ Business support utilised	
	<ul style="list-style-type: none"> Professional practices 	Clinical policies and procedures, client outcome measures, client satisfaction monitoring, professional affiliations,	
	<ul style="list-style-type: none"> Social capital 	Effective teamwork, regular business-to-business networking with GPs/teachers/allied health or other referrers, business network affiliation, clinical mentoring	
	Perception of SLP private practice success	Open-ended request for SLP to provide any relevant information regarding SLPPPs	Qualitative data to be analysed with thematic analysis

3.8.3 Survey structure

The survey was structured to determine: the demographics of SLPPPs, the success criteria of SLPPPs, the performance of SLPPPs on questions that are indicative of achievement on the identified success criteria, the CSF for SLP PP by identifying the ‘abilities’ and ‘opportunities’ that correlate with a high total success rating and themes in the qualitative data provided by participants.

3.8.3.1 Demographic considerations

3.8.3.1.1 Ethnic group

Classification of ethnic groups differed between countries therefore the ethnicity of each sample is reported by country. The classifications of ethnicity in the 2013 New Zealand census data were: European, Maori, Pacific Peoples, Asian, Middle Eastern/Latin American/African, New Zealander, or Other (New Zealand Government, 2013). This classification was chosen in order get an indication of indigenous representation as well as broad representative groups.

The classifications of ethnic group for SLPs from New South Wales were taken from Census Classifications (Australian Bureau of Statistics, 2011). The classifications were: Oceanian, North West European, Southern and Eastern European, South Eastern Asian, North Eastern Asian, Southern and Central Asian, Americas, Sub-Sahara and African. The classification Oceanian peoples was further classified into the next division provided by the census classification system: Australian peoples, New Zealand peoples, Melanesian and Papuan, Micronesian and Polynesian (Australian Bureau of Statistics, 2011).

3.8.3.1.2 Geographical location

The New Zealand Statistical Classification of geographical areas in New Zealand, were taken from the website: <http://www.stats.govt.nz/Census/2013-census/info-about-2013-census-data/2013-census-definitions-forms/definitions/geographic.aspx#rural-centre>. These classifications were used in the survey of New Zealand SLPs, but were re-classified for purposes of analysis and comparison between countries. The following substitutions were made: main urban area of over 30,000 people (city), secondary urban area 10,000-29,999 people and minor urban area of 1000-999 people (regional), and rural centre/rural area (rural). The Australian Standard Geographical Classifications were provided on the website: <http://www.health.gov.au/internet/main/publishing.nsf/Content/Chronic+Disease+Allied+He>

alth+Individual+Services. These classifications, the Australian standard geographical classification (ASCG), were also simplified into the same three groupings (city, regional, rural): major city (RA1) (city), inner regional (RA2) and outer regional (RA3) (regional), remote (RA4) and very remote (RA5) (rural).

3.8.3.2 The Business Success Criteria Importance Scale

The Business Success Criteria Importance Scale (BSCIS) is a measure of motivating factors for employment adapted from Gorgiveski et al.'s (2011) listed success criteria. It includes Gorgiveski et al.'s 10 success criteria with the addition of professional satisfaction:

1. Profitability: high yields, good profit,
2. Growth: growth in the number of employees, sales, market share and/or distribution,
3. Innovation: introduction of new products or production methods,
4. Survival: enables generational transfer or can be sold with a profit,
5. Contribution back to society: socially conscious, sustainable production methods,
6. Personal satisfaction: through attaining important things in life, such as autonomy, challenge, security, power, creativity etc,
7. Satisfied stakeholders: satisfied and engaged employees, satisfied customers,
8. Good balance between work and private life: positive mutual influence between work and private life, allows time for yourself, family, friends,
9. Public recognition: good reputation, prize winner,
10. Utility or usefulness: organization fulfils a need in society; it provides an important service or product
11. Professional satisfaction: able to provide evidence based practice, ethical practice, enjoy the nature of the work.

These criteria were converted to statements such as: '*profitability (high yields, good profit margin) is an important criterion for success for me*' and rated with a seven point Likert scale: *1 = Strongly Disagree, 2 = Disagree, 3 = Somewhat Disagree, 4 = Neither agree nor disagree, 5 = Somewhat Agree, 6 = Agree, 7 = Strongly Agree*'.

3.8.3.3 Self-rated performance

The self-rated level of achievement for the success criteria were eleven questions directly related to the SLP's level of achievement on the eleven success criteria in the BSCIS. Nine of these questions were given as statements such as: *'I have a good balance between my work and private life'* and were rated with the same seven point Likert scale as the BSCIS. The question relating to the success criteria of business growth: *'Do you expect that the business you are in, as it exists now, will show growth?'* was given with five answer options: *'1/No, 2/ Not sure, 3/ Yes, one year from now, 4/ Yes, five years from now, 5/ Yes, ten years from now'*. The scale for the five question options was adapted to the seven point Likert scale using semantic similarity: *'1/No (1 = Strongly Disagree), 2/ Not sure (4 = Neither agree nor disagree), 3/ Yes, one year from now (5 = Somewhat Agree), 4/ Yes, five years from now (6 = Agree), 5/ Yes, ten years from now (7 = Strongly Agree)'*. The question relating to a rating for the success criteria of business survival: *'Is it likely that you will stay in your current job?'* with five possible multi-choice answers: *'1/ No, 2/ Yes, one year from now, 3/ Yes, five years from now, 4/ Yes, ten years from now, 5/ Yes, ongoing'* was also converted to a seven point Likert scale on the basis of semantics. The scale was equated: *'1/ No, (1 = Strongly Disagree), 2/ Yes, one year from now, (4 = Neither agree nor disagree), 3/ Yes, five years from now, (5 = Somewhat Agree), 4/ Yes, ten years from now, (6 = Agree), 5/ Yes, ongoing, (7 = Strongly Agree)'*. Although answer two records ongoing business for the next year, it also suggests possible business closure in one year, and, therefore, was associated with the rating of four on the Likert scale which denotes indecision. Self-ratings for these eleven achievement related questions could then be added and a mean established providing a rating for performance (P).

3.8.3.4 The opportunity and ability to perform

The factors which could provide the CSF for SLPPPs are presented as 'abilities' or 'opportunities' according to Boxall and Purcell's model of performance (Boxall & Purcell, 2008). This model is explained in depth in Chapter 1.16.1. Performance (P) is given by the equation: $P = A.M.O$ where Boxall and Purcell explain "A = Ability (*the knowledge and skills to perform*), M = Motivation (*staff are 'adequately interested and incentivised'*) and O = Opportunity (*'work structure and its environment provides the necessary support and avenues for expression'*)" (Boxall & Purcell, 2008, p 5). This model is proposed to be multiplicative meaning a measure of each of the factors must be present for SLPs to perform; for example, motivated SLPs with a lot of opportunity will not be able to perform in PP if they do not possess

the appropriate level of ability to ensure performance. If a high level of performance is identified for SLPPPs, then the abilities and opportunity required for that performance, alongside adequate motivation, could be identified as CSF. It is acknowledged that this research has not attempted to assess SLPs motivation to perform but will seek to determine the ability and opportunities that could be identified as CSF for PP.

The specific of factors associated with ‘ability’ to be probed by this research are informed by the literature. Business qualifications and business experience are associated with business success (Luisser & Halabi, 2010). Therefore, the survey includes questions regarding both business and SLP qualifications, and experience. Questions are included regarding the personal characteristics of professionals, associated with job satisfaction and success; specifically, personal resilience (Gu & Day, 2007; McAllister & McKinnon, 2009; McCann et al., 2013), personal efficacy including efficient time management skills (G. D. Markman & Baron, 2003; Severn et al., 2012), and level of personal support (Gu & Day, 2007). Cultural literacy (K. Wylie et al., 2013), and factors regarding professional competence: evidence based practice (Cheung et al., 2013; Ferguson & Armstrong, 2009; Roddam & Skeat, 2010), ethical practice (Atherton & McAllister, 2009; Flatley et al., 2014), professional education (McLaughlin et al., 2008; O’Toole & Schoo, 2010; Roddam & Skeat, 2010) and clinical supervision (The Speech Pathology Association of Australia, 2001; The Speech Pathology Association of Australia, 2010a; The Speech Pathology Association of Australia, 2014e), are included due to their association in the literature with provision of successful services.

A range of questions were established from the SLP and business literature regarding the ‘opportunity’ to perform (Gadenne, 1998; Jasra et al., 2011; Johnston et al., Dec 2008; Kummer, 2014; O’Toole & Schoo, 2010; Walker & Brown, 2004). Factors associated with business success in other industries, and possible CSF for SLPPPs, are included in the survey in the categories: business structure (Boxall & Purcell, 2011; Kalleberg & Leicht, 1991; Morris, Miyasaki, & Watters, 2006; Still et al., 2005), funding (Loan-Clarke et al., 2009; O’Toole & Schoo, 2010; Skeat et al., 2010), business strategy and strategic competence (Johnston et al., Dec 2008; Porter, 2011), financial capital and financial competence (Jasra et al., 2011; Kennedy & Tennent, 2006; Luisser & Halabi, 2010; Rainer & Papp, 2000), marketing capital and competence (Boxall & Purcell, 2011; Dorando-Unkle, 1995; Luisser & Halabi, 2010; Morley & Rennison, 2011), social capital and competence (Baron & Markman, 2003; Chawla et al., 2010; Clark & Douglas, 2014), human capital and competence (Boxall & Purcell, 2011; Keane et al., 2013; McLaughlin et al., 2010; Stagnitti et al., 2006), professional practices

(Kummer, 2014; The Speech Pathology Association of Australia, 2001; The Speech Pathology Association of Australia, 2014c), and management practices and managerial competence (Boxall & Purcell, 2011; Cox et al., 2012). The management category was further separated into: leadership practice (Cox et al., 2012; Gadenne, 1998; Kouzes, Posner, & Bunting, 2015), documentation (Dorando-Unkle, 1995; LUISSE & Halabi, 2010), business policies and procedures (Devaney, 2014), business adaptability (Boxall & Purcell, 2011), support for innovation (Anderson & Nelson, 2011; Specht & Blanchet, 2009) and business support (Luisser & Halabi, 2010) .

These questions were asked in either: a statement format requiring agreement in a 7-point Likert scale, multi-choice question format, specific open answer question or a question requiring a 'yes or 'no' answer.

3.8.3.5 Qualitative data

Qualitative data adds complexity and ecological validity to research in health private practice (Milstead, 2013). An open-ended question: '*Please make any further comments on issues regarding your experience of private practice or provide elaboration on any point*' was included in the survey in order to elicit qualitative data. This question will provide information which is pertinent to SLPPPs but is not prescribed by the closed questions in the survey; thereby increasing the validity of the survey.

3.8.4 Survey host

The survey was hosted by Qualtrics Research Suite (Qualtrics, 2015). Qualtrics provides a software platform which records responses, can perform analysis of data, and reports the data via the site <https://auckland.au1.qualtrics.com/>. The surveys for both countries were posted using this software. A link to both versions of the survey were provided in the Participant Information Sheets, Appendix I and J. Surveys were accessed by the participants' own web browser. The survey data output for was generated using Qualtrics software, Version 2.3 (Qualtrics, 2015).

3.8.5 Data Analysis of Quantitative Data

Data was exported in word, excel and SPSS formats for both surveys. Analysis of the quantitative data was completed with SPSS statistics (Statistical Package for Social Sciences), Version 23. IBM SPSS Statistics is a statistical software package for research that can provide

descriptive statistics and can perform ad-hoc analysis, hypothesis testing, and predictive analytics (IBM Corp, 2013). IBM SPSS Statistics was used to explore the data, and drive the statistical conclusions.

3.8.6 Data Analysis of Qualitative Data

The qualitative data was analysed using Leximancer (version 4) software (University of Queensland, 2011). The Leximancer system of software converts natural language into semantic patterns which are analysed for relational co-occurrence of ‘concepts’ and ‘themes’ (A. Smith & Humphreys, 2006). It searches for ‘thesaurus-based’ concepts, not just words, and evaluates for both semantic and relational information. Seed word concepts are learned by the software and approximately every three lines of text is analysed for frequencies of co-occurrence using statistical analysis (A. Smith & Humphreys, 2006). The frequencies of co-occurrence provide a two-dimensional concept map which is further developed into a three-dimensional concept map by adding statistical information for the relationships between words. This concept map shows clusters of concepts as ‘theme’ circles (Cretchley, Rooney, & Gallois, 2010) with similar concepts closer together and more prominent themes produced as larger circles. The colour of circles is important with warmer colours, such as red, indicating a warmer sentiment and cooler colours, such as blue, indicating less warm sentiment for a given textual data set (Beisenthal & Wilden, 2014). The concept circle is named as the most important concept and a directional line can be established from the most, to less, important concepts. The benefit of using Leximancer software for this sample is the subjectivity provided by its comprehensive statistical analysis in an ‘unsupervised manner’ (A. Smith & Humphreys, 2006). Its reproducibility and reliability are high with the bias of coding by the researcher removed from the analysis and a scientific basis for the statistical analysis (Cretchley et al., 2010; A. Smith & Humphreys, 2006). The face validity is provided by the basis of the algorithms as “grounded in Bayesian decision theory and word free association norms” as noted by Smith and Humphreys (2006, p.265). Leximancer analysis is used alongside an inductive approach to exploring the themes generated by SLPPPs about their success. As the primary researcher is also an Australasian SLPPPs, an inductive approach to exploring and developing the themes generated by Leximancer using grounded theory is appropriate. These themes and theory developed will be integrated with themes and theory generated by the quantitative data in the discussion section.

3.8.7 Survey timeline

The ethics approval for the New Zealand survey was received on 6/08/15. Consent was provided by the New Zealand Speech-language Therapists' Association, 2/08/15. The New Zealand survey was open for one month, from 2/9/15, to 1/10/15. The ethics approval for the Australian survey was received, 2/11/15. Consent for participation was received from The Speech Pathology Association of Australia, 6/11/15. The Australian survey was open, from 6/11/15, to 1/12/15. An extension was requested and approved with the final date for submission of the thesis, 31/05/16.

3.8.8 Recruitment of participants

This research used purposive sampling seeking a representative sample of SLPPPs in NSW and NZ. Participants were required to be eligible for membership to either: The New Zealand Speech-language Therapists' Association (NZSTA), or Speech Pathology Australia (SPA) as per criteria listed on the websites: www.nzsta.org.nz or www.speechpathologyaustralia.org.au. Participants in New Zealand were recruited by posting an advertisement on the NZSTA website, and New Zealand PPs' Facebook site, in September, 2015. A follow up email was sent to PPs who listed their email address in the Yellow Pages online phone directory, in the last week of September, 2015. A text message was sent to PPs who did not list their email and a telephone call made to those PPs who only listed a landline phone number. Entry into a "*Fishpond*" \$50 gift card prize draw was offered to participants as a gesture of appreciation for their participation in the NZ survey.

Participants, in NSW, Australia, were recruited via an email sent from Speech Pathology Australia, to members of the NSW PPs' Member Network. The representatives for the Hunter-New England and NSW branch of the PPs' Member Network were emailed and phoned to ensure the email was received. The initial email was not received so the Professional Standards Representative for SPA was contacted and the email was resent with a follow up email sent two weeks later. Entry into a "*Co-op Bookshop*" \$50 gift card prize draw was offered to participants as a gesture of appreciation for their participation in the NSW survey.

4 Results

4.1 Demographics

The demographic data for participants are summarised in Appendix E.

The initial participants in the survey included 19 NZ PPs and 105 NSW PPs. Four NZ participants and 10 NSW participants were excluded due to incomplete survey responses. The total number of participants from both NZ and New South Wales included in the analysis is 110. This is an approximately 11.3% response rate from NZ, based on a figure of 133 current PPs in NZ (The New Zealand Speech-language Therapists' Association, 2015), and a 6.3% response rate in NSW, which is based on a figure of 1497 PPs in NSW in 2016 (The Speech Pathology Association of Australia Limited, 2016). These figures are based on membership data and do not include SLPPPs who are not members of a professional association. These figures are estimates as it is not known how many practitioners opened the email about the survey.

4.1.1 Age of participants

The majority of participants, 17.3%, were in the '30-34 years' age group. Fewer participants were in the younger and older age groupings: 25-29 years; 13.6%, 30-34 years; 17.3%, 35-39 years, 13.6%, 40-44 years; 14.5%, 45-49 years; 15.5% encompassing the majority of participants.

The null hypothesis that 'the distribution of age is the same across countries', was retained using the independent samples Mann-Whitney U Test for non-parametric data, $U = 501.50$, $p = .06$, 95% *CI*. Some differences in the ages of NZ and NSW participants are seen in Figure 5. The contribution of the NZ participants to the whole sample did not change the overall pattern of ages.

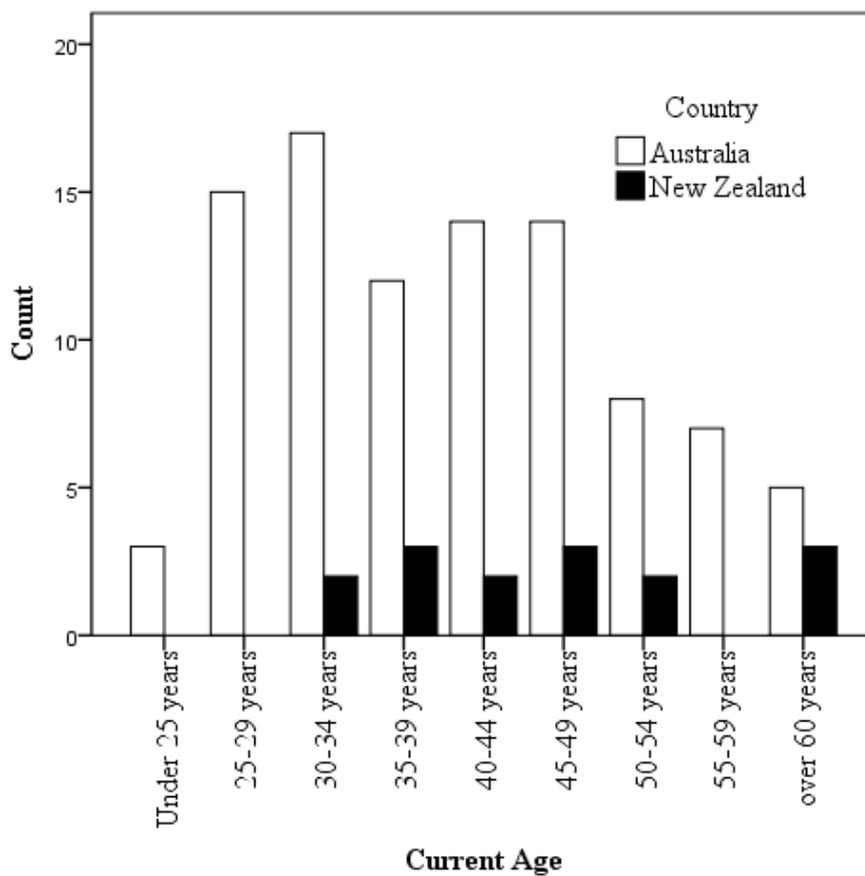


Figure 5. Age distribution of participants (participants from NSW categorised as Australia).

4.1.2 Gender

The participants did not vary in gender; 100% were female.

4.1.3 Ethnicity of New Zealand Participants

There were no SLPPPs in this sample who identified as who identified as Māori or Pacific peoples. The majority of participants identified as ‘New Zealander’ (53.3%), about a quarter identified themselves as ‘European’ (26.7%) and only 20% identified as ‘other’, as seen in Figure 6.

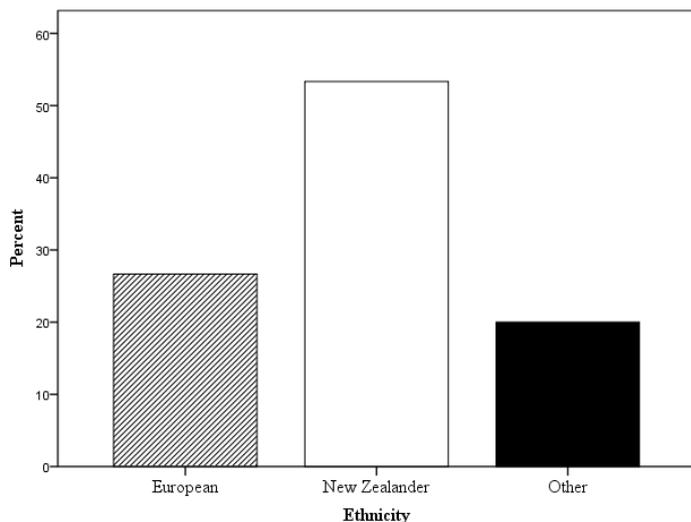


Figure 6. Ethnicity of New Zealand Participants Based on Broad NZ Census Classification

4.1.4 Ethnicity of NSW Participants

Although the standard classification system for ethnicity used in Australia (Australian Bureau of Statistics, 2011) provides a broad range of groupings it is not ideal as it does not provide an indication of indigenous representation. Feedback was provided by a participant that it did not suit participants as they could not provide two types of ethnic group. Therefore, these data are provided as only a broad indication of ethnic groups.

The majority of participants (72.6%) identified as ‘Oceanian’, and the next largest grouping was ‘North West European’ (16.8%). The other five ethnic groupings combined included 10.7% of the participants with the highest percentage, ‘Southern and Eastern European’, at 3.2%, as observed in Table 8. This three-way division is similar to that of the NZ sample. All participants who chose to further identify themselves under the Oceanian classification could further identify as Australian peoples, New Zealand peoples, Melanesian and Papuan, Micronesian or Polynesian but all of those who chose to respond further, approximately 76%, identified themselves as Australian peoples; the other 24% did not choose another option. There were no participants who identified as Indigenous Australians.

Table 8 Ethnicity of Participants in New South Wales

Ethnicity	Frequency	Percent
Oceanian Australian peoples New Zealand peoples Melanesian and Papuan Micronesian Polynesian;	69	72.6
North West European	16	16.8
Southern and Eastern European	3	3.2
South Eastern Asian	2	2.1
Southern and Central Asian	3	3.2
Americas	1	1.1
Sub-Sahara and African	1	1.1
Total	95	100.0

Note. Classifications taken from Census Classifications (Australian Bureau of Statistics, 2011).

Despite the differences within the ethnicity classification systems for the two groups, NZ and NSW, the broad pattern of ethnic groups is similar with participants largely identifying themselves as Australian or New Zealanders, with a smaller number identifying as European identification and much smaller portion in a range of other ethnic groups. The lack of indigenous representation is seen in both groups of participants.

4.1.5 Location

The location of participants was not evenly distributed with 60% of participants located in city areas. Another 36.4% of participants were located in regional areas, and only 3.6% of participants were located in rural locations. The null hypothesis that the NZ and NSW samples had the same distribution across locations was rejected. The independent samples Mann-Whitney U Test for non-parametric data showed that the distributions of SLP locations differed significantly between countries, $U = 435.50$, $p = .01$. It can be seen in Figure 7 that no NZ participants were located in rural areas.

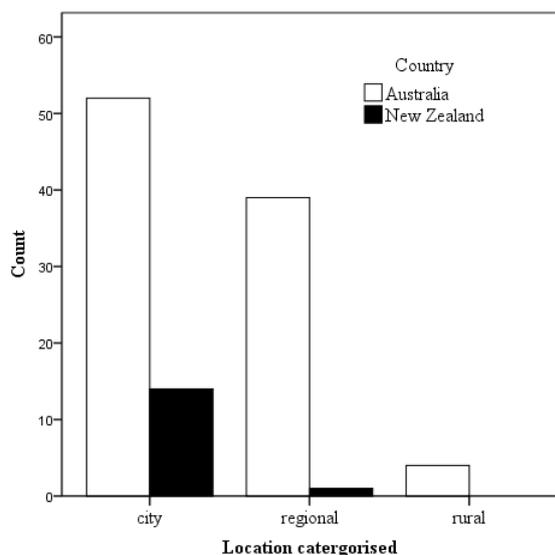


Figure 7. Distribution of Australian (NSW) and New Zealand speech language pathologists across three location types.

Although there was a difference in distribution of participants across types of location between countries, no significant difference was noted between the *total success rating* scores on the basis of country. The Mann-Whitney U test is an appropriate test to identify the differences in distribution between an ordinal dependent variable and nominal independent variable (Institute for Digital Research and Education, nd). The Mann-Whitney U test was used to test the distribution of the nominal variable *country* and across the ordinal variable *total success rating*, $U(N = 110) = 518, p = .09$. The Mann-Whitney U test was also used to test the distribution of the nominal variable of *country* and the ordinal variable *total success criteria*, $U(N = 110) = 693, p = .87$. No significant difference was noted in the distribution of success criteria or total success rating on the basis of country at a 0.05 level of significance.

4.2 Business Success Criteria Importance Scale (BSCIS)

The reliability of a test is a measure of its internal consistency or ability of all the parts of that test to measure the same concept (Tavakol & Dennick, 2011). Therefore, the ‘inter-relatedness’ of the 11 success criteria in the BSCIS were tested using Cronbach’s alpha to examine internal consistency with an acceptable level of alpha between 0.70 and 0.95 as described by Tavakol and Dennick (2011). Participants were asked to rate their level of agreement on a 7-point Likert scale with statements regarding the importance of the success criteria such as: “*Innovation (introduction of new methods or technologies) is an important*

criterion for success for me”. The 11 items showed an acceptable level of internal reliability (Cronbach’s $\alpha = 0.70$). The reliability scores for each criterion are listed in Appendix G. This internal reliability was achieved when all 11 items were included and the value of alpha reduced when any single BSCIS item was removed. Therefore, the total score for success criteria is a reliable indicator for the concept of *success criteria* for SLPPPs.

Descriptive statistics were used to rank the success criteria based on the mean score for each of the 11 success criteria. These rankings are compared to those of Gorgievski et al. (2011) and show a distinct pattern of difference for SLPPPs as seen in Table 9. Some criteria, such as public recognition, business growth, and work life balance, are ranked the same as Gorgievski et al.’s participants’ ranking. However, the top ranking three criteria for SLPPPs: satisfied stakeholders, professional satisfaction, and utility, appear to show a specific pattern for SLPPPs, perhaps due to the client-centred nature of SLP. Other factors such as profitability, business survival, and innovation, which were ranked more highly by Gorgievski et al.’s participants, were not perceived to be as important by the Australasian SLPPPs investigated here.

Table 9. Ranking of Success Criteria by Speech Language Pathology Private Practitioners Compared to Ranking by Gorgievski et al. (2011, P.209)

<i>Success Criterion</i>	Mean	Standard deviation	Rank	Rank by Gorgievski et al.
Satisfied Stakeholders	6.65	.72	1	3
Professional Satisfaction	6.45	.72	2	-
Utility or Usefulness	6.37	.72	3	7
A Good Balance between Work and Private life	6.35	.88	4	4
Personal Satisfaction	6.35	.88	5	1
Contributing back to Society	6.09	.87	6	8
Innovation	5.36	1.16	7	5
Profitability	5.31	1.12	8	2
Public recognition	5.13	1.60	9	9
Business Growth	4.77	1.64	10	10
Business Survival/Continuity	4.75	1.76	11	6

Factor analysis, a multivariate interdependence technique was completed with Principal Component Analysis in order to reduce the success criteria to a four-factor subgrouping. The

four sub-groups accounted for 64.93% of the total variance of the sample responses. This result was obtained using a rotated component matrix using the Varimax method with Kaiser Normalisation to determine factors. While it is acknowledged that approximately 35% of variance was not accounted for by this analysis and requires further investigation, four clear factors, or sub-groups of items emerged, as seen in Table 10. The sub-groups were labelled on the basis of semantic relationship between the 11 success criteria as: (a) *Business Orientated: survival, growth, profitability*, (b) *Professional Satisfaction Orientated: professional satisfaction, satisfied stakeholders, work-life-balance* (c) *Innovation Orientated: personal satisfaction, innovation, public recognition*, (d) *Contribution to Society Orientated: contribution to society, utility*. Each success criteria factor was an important factor in one sub-group, with a factor loading greater than 0.60. No success criteria were missing from the subgroups.

Table 10. Four Sub-Groups of Success Criteria (Factors) Determined Using Principal Component Analysis

Rotated Component Matrix^a for Success Criteria				
Success criteria	Component			
	1	2	3	4
Business survival/continuity	.83	.03	.01	.12
Business growth	.79	.07	.34	-.10
Profitability	.78	.05	.07	.02
A good balance between work and private life	.12	.81	-.23	.04
Professional satisfaction	.04	.79	.23	.10
Satisfied stakeholders	.00	.60	.21	.25
Innovation	.12	-.11	.72	.39
Personal satisfaction	.03	.41	.68	-.00
Public recognition	.19	.04	.67	-.01
Utility or usefulness	.06	.06	.10	.87
Contribution to society	-.03	.41	.05	.67

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.

a. Rotation converged in 6 iterations.

The mean ratings across participants for each sub-groups could be ranked: Professional satisfaction, $M = 6.48$ ($SD = .60$); Contribution to society, $M = 6.23$ ($SD = .66$), Innovation, $M = 5.61$, ($SD = .90$), and Business, $M = 4.95$ ($SD = 1.24$).

4.3 Success Ratings

The inter-item reliability of the 11 *success* rating questions directly related to the BSCIS, was tested with Cronbach's Alpha. An acceptable level of reliability was observed for all 11 success rating questions with Cronbach's $\alpha = .78$.

The highest mean score in the success rating related to *client satisfaction*, $M = 6.28$, ($SD = .77$), as seen in Table 12. The statement relating to the success criteria of *business survival* recorded the lowest mean score, $M = 4.17$, ($SD = 1.07$). The success criterion of *innovation*, is addressed with two questions, one clinical and one business-related. The mean of the statements regarding innovation, was used to compute a score for the sub-group *innovation* and for the *total success rating*. Only the mean innovation score is ranked in order to maintain 1-1 correspondence to the 11 success criteria, for comparison purposes.

Table 11. Mean Agreement with 11 Success Rating Statements or Questions

Statements or questions regarding success ratings	Rank	Mean	Standard deviation
My clients are satisfied with my work	1	6.28	.77
My work in private practice fulfils a need in the community	2	6.13	.98
My work contributes to society	3	6.00	.97
I have a high level of professional satisfaction	4	5.92	1.18
I have a high level of personal satisfaction	5	5.84	1.31
I establish innovative clinical practice	-	5.35	1.32
I establish innovative business practices	-	4.78	1.49
Innovation total	6	5.07	1.28
I am satisfied with financial reimbursement	7	5.02	1.43
I have a good balance between work and private life	8	4.73	1.73
The business, as it exists now, will show growth	9	4.40	1.65
I have a high level of public recognition for my work	10	4.20	1.62
What is the likelihood of staying in current job?	11	4.17	1.07

Chapter 4 Results

An overall mean success rating was calculated for SLPPPs. The mean for the *total success rating* was the averaged sum of all eleven questions relating directly to the success criteria. The score was then labelled as high or low on the basis of the semantics of the Likert scale used: 1 = Strongly Disagree, 2 = Disagree, 3 = Somewhat Disagree, 4 = Neither agree, nor disagree, 5 = Somewhat Agree, 6 = Agree, 7 = Strongly Agree. Scores above five related to agreement with the items and therefore any score of five or above was categorised as reflecting a *high level of success* and scores below five were categorised as a *low level of success*. About one third (29.1%) of participants rated themselves as having a low level of success and 70.9% of participants rated themselves as having a high level of success. The mean total success rating, $M = 5.20$, ($SD = .75$), is indicative of some agreement with a perception of success across the group. The sub-group of success rating achieving the highest level of success is: *Contribution to society*; $M = 6.06$, ($SD = .91$), followed by *Professional satisfaction*; $M = 5.64$, ($SD = .95$), *Innovation*; $M = 5.03$, ($SD = 1.099$), and finally, *Business success*; $M = 4.53$, ($SD = .81$). Each of the sub-groups were: (a) *Business Orientated: survival, growth, profitability*, (b) *Professional Satisfaction Orientated: professional satisfaction, satisfied stakeholders, work-life-balance* (c) *Innovation Orientated: personal satisfaction, innovation, public recognition*, (d) *Contribution to Society Orientated: contribution to society, utility*.

Bivariate correlations between the average ratings (ordinal data) of the success criteria in four sub-groupings and success rating scores grouped into the same sub-groups: *contribution to society*, *professional satisfaction*, *innovation*, and, *business success*, were tested using Kendall's Tau-b for non-parametric data. Kendall's Tau-b for the *business success criteria* sub-group (ordinal data) correlated with the average of means for success rating questions, *business success ratings*, $\tau (N = 110) = .20$, $p = .01$ (2-tailed), was observed to have a low p-value, allowing rejection of the null hypothesis. This indicates a correlation between the *business success criteria* and *business success ratings*. Significant bivariate correlations were achieved for all sub-group relationships between success criteria and success ratings: *professional satisfaction success criteria* and *professional satisfaction success rating*; $\tau (N = 110) = .19$, $p = .01$ (2-tailed); *innovation success criteria* and *innovation success rating*, $\tau (N = 110) = .42$, $p = .01$ (2-tailed); *contribution to society success criteria* sub-grouping and *contribution to society success rating*, $\tau (N = 110) = .27$, $p = .01$. A significant bivariate correlation was also achieved for the comparison between the *Total Success Criteria* score and *Total Success Rating* score, $\tau (N = 110) = .24$, $p = .01$ (2-tailed).

4.4 Ability

4.4.1 Qualifications and experience

The professional qualifications, business qualifications and professional/business experience of SLPPPs in Australasia, were explored using descriptive statistics.

Hypothesis 4 (a) It was hypothesised that participants' level of business qualification, business experience, level of SLP qualification, and SLP working experience would correlate with participants' *total success rating*.

4.4.1.1 Business qualifications

Only 44% of SLPs reported formal business qualifications with 25% of participants reporting a Bachelor's degree related to business and 13% reporting short course qualifications. Fewer participants had higher business qualifications with 8% reporting a Master's degree in business and 1% a PhD. A graduate certificate in business was reported by 4% of participants and a graduate diploma by 2%. A similar number of SLPs with and without formal business qualifications rated with a 'high' level of total success (ratings of 5 or more); $N = 38$ versus $N = 40$. The Kruskal Wallis test is an appropriate test for differences in distribution between an ordinal dependent variable and a nominal independent variable (Institute for Digital Research and Education, nd). The Kruskal Wallis test for independent samples was used to explore the relationship between the presence or absence of formal business qualifications (nominal data) and the *total success rating* (ordinal data); $X^2(1, N=110) = .01, p = .91$. The null hypothesis that the distribution of *total success rating* is the same across presence or absence of business qualifications was retained, based on a 0.05 level of significance. Thus overall self-rated success for the investigated criteria did not differ between SLPPPs with and without a business qualification.

4.4.1.2 Business experience

A large percentage of the 110 participants reported no previous business experience; 53.6%. The type of industry of experience was reported as: the health industry; 20.9%, the education industry; 13.6%, and other industries; 28.2%. It is possible that the business experience reported in the health and education sector is potentially in the public sector. If so, participants with small business experience would number fewer than 28.2% of the total 110 participants. The types of other industries listed by respondents was varied; the largest sector

of experience was “*retail*” with 5.4% of participants reporting retail experience. The main industry types of experience reported were service industries: disability sector, hospitality, tourism, law, managerial consulting, finance; although several participants reported experience in the agricultural sector and arts/publishing.

The null hypothesis that the distribution of the total success rating is the same across presence of business experience (some or none) was retained based on the Kruskal Wallis Independent samples test, $X^2(1, N = 110) = .47, p = .49$. Slightly more SLPPs with prior business skills had ratings indicating a *high* level of *total success rating*; 53.8% (some business skills experience) versus 46.2% (no business skills experience). The null hypothesis that the distribution of the *total success rating* is the same across the presence or absence of a business experience skill set was also retained, based on the results of the Kruskal Wallis Independent samples test, $X^2(1, N = 110) = .73, p = .39$.

4.4.1.3 Private practitioners’ speech language pathology qualifications

The majority of participants hold a Bachelor’s degree; 64.5%, followed by an Honour’s degree (including honour’s awarded within a bachelor’s degree and honours stream with completion of a research project); 12.7%, and Master’s level entry degree; 8.2%. A summary of participants SLPs’ qualifications can be seen in Appendix E.

4.4.1.4 Speech language pathology experience

Table 12 shows that the majority of participants have over 20 years’ experience in SLP and 1 to 5 years’ experience in PP. The *years worked in PP* were similar to *years in participants’ current role*, providing evidence of the stability of PPs’ employment in PP as seen in Table 12.

The group of SLPs with over twenty years’ experience, rated themselves as having a high level of total success. No correlation was noted between the *total success rating* and *years worked as SLPs*, Kendall’s Tau-b, $\tau(1, N = 110) = .11, p = .15$ (2-tailed). The high p-value indicates retention of the null hypothesis.

A correlation was noted between *total success rating* and *years worked in PP*, using Kendall’s Tau-b, $\tau(1, N = 110) = .16, p = .03$. The null hypothesis that there is not relationship between *total success rating* and *years worked in PP* was rejected. A correlation

was also noted between the *total success rating* and *years worked in current role*, $\tau(1, N = 110) = .17, p = .02$ (2-tailed).

The hypothesis that SLPPPs' experience is correlated with the total success rating is partially retained. *Years in current job* and *years as a PP* were correlated with *total success ratings*. There was, however, no correlation with years working in the SLP profession, indicating that the years in PP were what contributed to the perception of success rather than prior experience.

Table 12: Experience as a Speech Language Pathologist, in Private Practice and in Current Role

Experience	Years as a Speech Language Pathologist Percent	Years worked in private practice Percent	Years in your current role Percent
Over 20 years	37.3	14.5	14.5
16-20 years	13.6	8.2	8.2
11-15 years	18.2	10.9	7.3
6-10 years	18.2	25.5	23.6
1-5 years	10.0	33.7	35.5
< 1 year	2.7	7.3	10.9

4.4.2 Personal characteristics relevant to business practices

4 (b) It is hypothesised that participants' personal characteristics of resilience, efficacy (as evidenced by time management), cultural literacy and level of personal support, will correlate with participants' total success ratings. The results of participants' self-rated responses to questions and statements regarding personal characteristics are provided and compared.

4.4.2.1 Resilience

SLPPPs in this sample rated themselves as having a high level of personal resilience with a mean score of 6.23 ($SD = .89$); this relates to definite agreement with the statement: '*I have a high level of personal resilience*'. A correlation was noted between self-rated high

resilience and *total success rating*, using Kendall's Tau-b, $\tau(1, N = 110) = .35, p = .001$. Participants' level of agreement with a statement of high personal resilience cross tabulated with high or low total success ratings is seen in Figure 8.

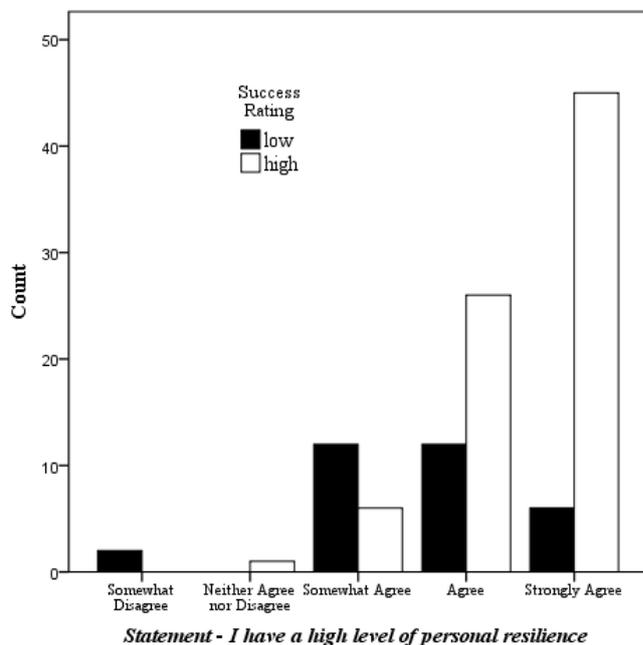


Figure 8. Level of agreement with the statement about high personal resilience, rated using a 7-point Likert scale, for participants with high or low total success ratings.

4.4.2.2 Efficacy

The mean rating score showing level of agreement with the statement ‘*I have effective time management skills*’ was high, $M = 5.72 (SD = 1.2)$. A correlation was observed between the means of *effective time management skills* and *total success rating*, using Kendall's Tau-b, $\tau(1, N = 110) = .17, p = .02$. A low p-value allows rejection of the null hypothesis that there is no relationship between *effective time management skills* and *total success rating*. Participants' agreement with a statement of effective time management skills is seen in Figure 9, for participants with high and low total success ratings.

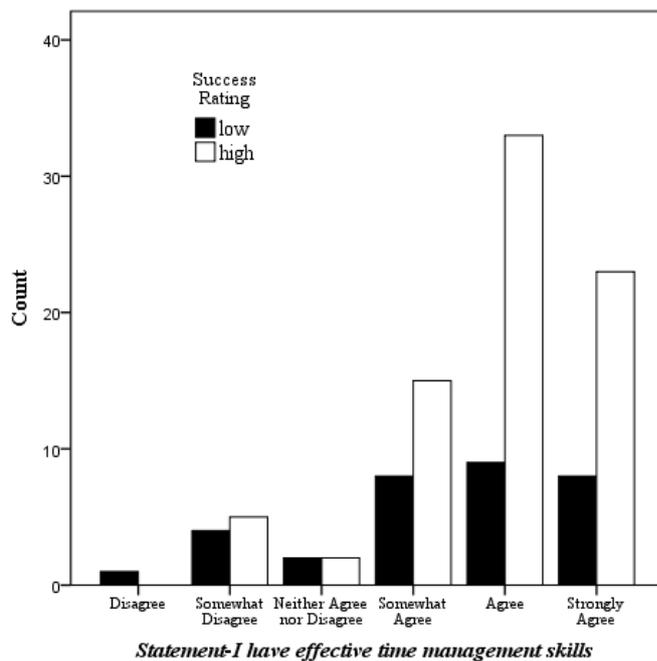


Figure 9. Ratings of agreement with the statement about effective time management on a 7-point Likert scale for people with high or low total success ratings.

4.4.2.3 Personal support

Most SLPPPs in this sample reported a high level of personal support with 40% of participants strongly agreeing to the statement: ‘*I have a high level of personal support*’ and a high mean score, $M = 5.8$, ($SD = 1.41$). In comparison, only 13.6% of SLPPPs felt they could not answer in agreement to this statement. However, no correlation was observed between *high personal support* and *total success rating* using Kendall’s Tau-b test, $\tau(1, N = 110) = .14, p = .06$.

4.4.2.4 Cultural literacy

It is reasonable to assume that high level of cultural literacy is of paramount importance to SLPs due to the expression of culture through communication. Consistent with this, the majority of SLPPPs reported they agree that they “*have a high level of cultural literacy*”, with a high mean score, $M = 5.60$ ($SD = 1.06$). The Kendall’s Tau-b test indicated a correlation between *a high level of cultural literacy* and *total success rating*, $\tau(1, N = 110) = .19, p = .01$ (2-tailed). The relationship between a high or low total success rating and agreement with a statement of high cultural literacy is seen in Figure 10.

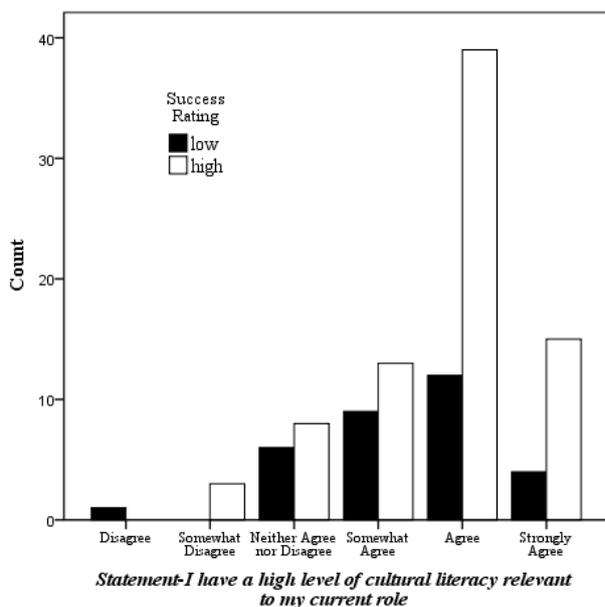


Figure 10. Participants' level of agreement with the statement about high cultural literacy on a 7-point Likert scale, for people with high or low total success ratings.

The personal characteristics that are correlated with total success rating are high resilience, a high level of cultural literacy and personal efficacy (time management). Personal support was not correlated with participants' total success rating.

4.4.3 Professional competence

The participants' professional competence was explored in order to document practices and establish any relationship between professional competence practices and success.

4 (c) It was hypothesised that a high level of perceived professional competence: participating in regular professional education, providing evidence based and ethical practice, and engaging in professional supervision, would correlate with participants' *total success rating*.

4.4.3.1 Professional education

A large number of participants undertake regular professional education with 37.3% stating they *agree* with the statement, and 52.7% of SLP stating they *strongly agree* with the statement. A high mean level of agreement was reported, $M = 6.35$. A significant correlation was found between *regular professional education* and *total success rating*, using Kendall's Tau-b, $\tau(1, N = 110) = .17, p = .03$.

4.4.3.2 Evidence based services

A high cumulative percentage of agreement, 86.3%, was reported regarding the statement: “*My therapy is evidence based*”, with 44.5% of SLPPPs stating they *agree* that their work is evidence based, and 41.8% stating they *strongly agree*, that their work is evidence based; $M = 6.25$ ($SD = .76$). A significant correlation was found between *evidence based practice* and *total success rating* using Kendall’s Tau-b test, $\tau(1, N = 110) = .32, p = .01$.

4.4.3.3 Ethical practice

SLPPPs also agreed they could resolve ethical issues arising in PP, $M = 5.65$ ($SD = 1.06$). However, only 20.9% of participants stated they *strongly agree* with the statement: ‘*I am easily able to resolve ethical issues that arise in my current role*’. This shows some degree of concern exists that not all ethical issues are able to be resolved in SLP PP for this group of participants. A significant correlation was found between *ethical services* and *total success rating*, using Kendall’s Tau-b test, $\tau(1, N = 110) = .23, p = .01$.

4.4.3.4 Clinical supervision (CS)

The nature of clinical supervision for SLP in this sample is mainly informal with 58.2% of SLPPPs engaging in *informal clinical supervision* and only 19.1% engaging in *formal supervision*. Interestingly, 22.7% of participants do not engage in clinical supervision at all. *Individual* supervision is more frequent than *group* supervision; 28.2% as opposed to 20.9%, respectively. Similar percentages of SLPPPs engage in *regular* as opposed to *irregular* supervision; 22.7% and 28.2%, respectively. Only 19.1% of supervision is supervised by another SLP. It is unlikely that this level of supervision would meet the recommendations for supervision outlined by SPA. The Kruskal Wallis test for independent samples used to examine the relationship between *existence of supervision* and *total success rating* was significant, using the, $X^2(1, N = 110) = 6.2, p = .01$, at 0.01 level of significance. The null hypothesis that the distribution of the *total success rating* is the same across existence or non-existence of supervision is rejected.

All of the factors of professional competence examined: regular professional education, provision of evidence based and ethical practice, and engagement in supervision, showed a significant correlation, indicating co-variation, with participants’ *total success rating*.

4.5 Opportunity

The potential critical factors related to opportunity are categorised into: business structure, funding, financial capital, human capital, marketing capital, professional practices, social capital and management practices. Management practices are further divided into: leadership practices, documentation, business adaptability, innovation and business support. Those aspects of opportunity in SLP PP are explored here using descriptive statistics. It is hypothesised that there will be factors that correlate or co-vary with total success rating in each of the categories.

4.5.1 Business structure

4 (d) It is hypothesised that business structure or funding are correlated with or co-vary with the total success rating.

Most participants are self-employed (86.4%). The majority of participants are sole traders with, 78.9% sole traders, 16.8% registered companies, and 4.2% operating as business partnerships. The only business type to register a low level of total success rating is the sole trader, as seen in Figure 11. Co-variation was found between *business type* and *total success rating* using the Kruskal Wallis test for independent samples, $X^2(2, N = 110) = 17.79, p = .01$, at a 0.01 level of significance. The staff mix within SLP businesses in this sample is mainly constituted of SLPs employing other SLPs, with 27.3% employing SLPs. Only 6.4% employ other allied health staff and 15.5% of SLP PP employ administration staff. The Kruskal Wallis test for independent samples was used to examine the relationship between *employing other SLPs* and *total success rating* and found a significant difference in ratings across employment categories; $X^2(1, N = 110) = 12.43, p = .001$, at a 0.01 level of significance. The null hypothesis that the distribution of the *total success rating* is the same across *employing other SLPs* is rejected.

No significant co-variation was found between *employing other allied health staff* or *employing administration staff* and *total success rating*, $X^2(1, N = 110) = .202, p = .653$, and, $X^2(1, N = 110) = 1.024, p = .312$, respectively.

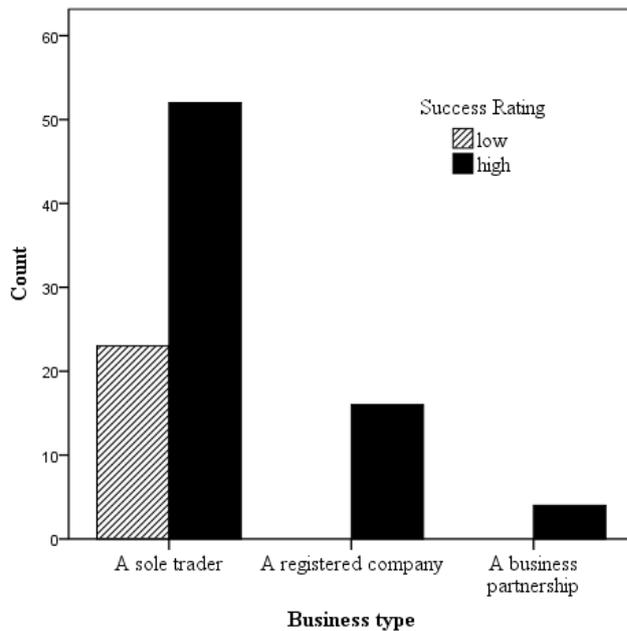


Figure 11. Distribution of registered business types for participants with high or low total success ratings

4.5.1.1 Speech language pathology private practitioners who are not self-employed

The majority of SLPPPs who are not self-employed, 73.3%, are employed by other SLPs. Another 20% are employed by an allied health PPs, and one of the SLPPPs from the total number of SLPPPs who are not self-employed reported an unspecified employer. Most PPs who are not self-employed in this sample, 80%, have SLPs as immediate supervisors. The *type of employer* and *total success rating* did not show significant co-variation, based on a Kruskal Wallis test for independent samples, $X^2(2, N = 110) = 3.27, p = .20$.

4.5.1.2 Hours of work

Most SLPPPs do not work a full-time 38-hour week, with only 33.6% of SLPPPs working full time. Most participants work 21-36 hours per week, 36.4%; or 6-20 hours per week, 26.4%. A small number of participants work fewer hours (five or less), 3.6%. A correlation was found between *hours of work* and *total success rating* using Kendall's Tau-b, $\tau(1, N = 110) = .15, p = .049$ (2-tailed). Those working more hours rated themselves with a higher total success rating .

4.5.1.3 Service base

The majority of participants, 50%, work from rented rooms with or without homebased or mobile services. Another 35.5% of SLPPPs, either work from home based businesses solely, or homebased businesses with a rented room or mobile service option. Fewer participants were owner occupiers of office space solely, 1.8%, or owner occupiers of office space and rent rooms, 0.9%. The *service base* and *total success rating* did not co-vary based on a Kruskal Wallis test for independent samples, $X^2(7, N = 110) = 12.16, p = .096$.

4.5.1.4 GST registration

Only 60% of the participants were registered for GST. No significant co-variation was found between *GST registration* and *total success rating*, based on a Kruskal Wallis test for independent samples, $X^2(1, N = 110) = 2.66, p = .103$.

4.5.2 Funding

A large proportion of funding was government-based with 93.7% of SLPPPs utilising some form of government funding (includes 16.4% of participants who have both government and private funding). Only 3.6% of participants used only private funding and 2.7% had no funding body. No significant co-variation was found between *funding source* and *total success rating*, using Kruskal Wallis test for independent samples, $X^2(3, N = 110) = 1.21, p = .75$.

The hypothesis that business structure or funding are correlated with or co-vary with the total success rating is partially rejected. Only three aspects of business structure showed covariance with the total success rating; *business type*, *employing other SLPs* and *hours of work*.

4.5.3 Business strategy

4 (e) It is hypothesised that business strategy: empowerment in the strategic direction of the business, cost value propositions, caseload age and type of service provision is correlated or co-varies with *total success rating*.

4.5.3.1 Strategic vision

Most SLPPPs felt empowered by the strategic direction of their PP with 60% of SLPPPs responding with some level of agreement to the statement: '*I am empowered by the strategic direction or vision of my private practice*', $M = 4.86 (SD = 1.49)$. Correlation was found

between *empowerment in strategic direction* and *total success rating* using Kendall's Tau-b, $\tau(1, N = 110) = .42, p = .01$ (2-tailed). The relationship between the participants' level of *empowerment in the strategic direction of PP* and the *total success rating* is best observed by cross tabulating high and low total success rating scores (see Figure 12).

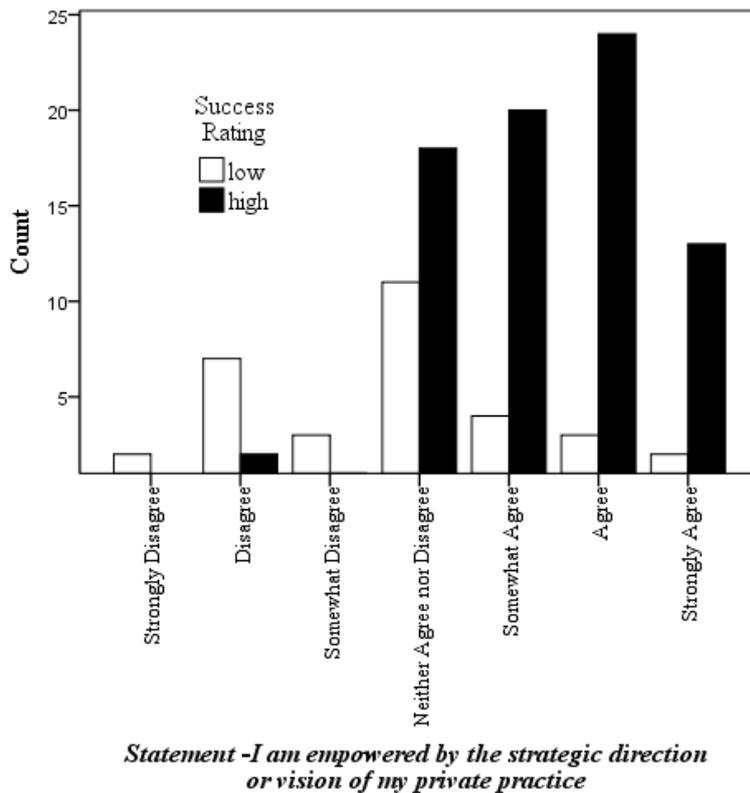


Figure 12. Participants' agreement with the statement of empowerment by the strategic direction or vision of the business on a 7-point Likert scale, for those with high or low total success ratings

4.5.3.2 Cost-value propositions

Most SLPPPs felt they provided *cost effective services*, $M = 5.99$ ($SD = .88$), and many SLPPPs felt they provide services that could not be replicated easily, $M = 5.04$ ($SD = 1.59$). Correlation was found between *provision of cost effective services* and *total success rating* using Kendall's Tau-b, $\tau(1, N = 110) = .344, p = .01$ (2-tailed). Correlation was found between the *provision of services which cannot easily be replicated* and *total success rating*, using Kendall's Tau-b, $\tau(1, N = 110) = .25, p = .01$ (2-tailed). The cross tabulation of *high* or *low*

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total success rating, and both cost-value propositions, showing a higher total success score for those who are able to agree with a cost-value statements is seen Figures 13 and 14.

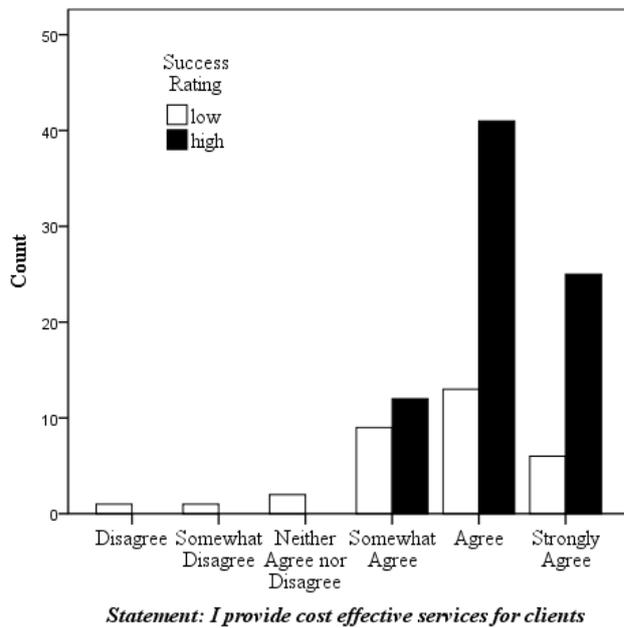


Figure 13 Participants' agreement with the statement: "I provide cost effective services for clients" rated on a 7-point Likert scale with high or low total success ratings

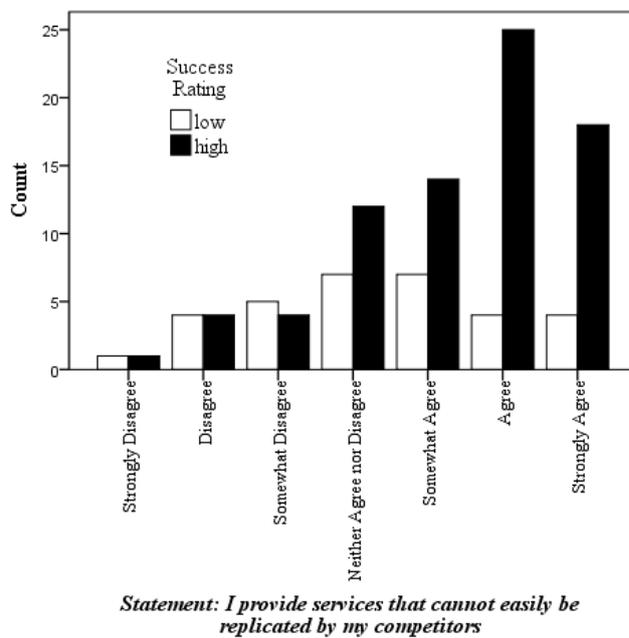


Figure 14. Participants' agreement with the statement: "I provide services that cannot be replicated by my competitors" rated on a 7-point Likert scale with high or low total success ratings

4.5.3.3 Caseload age and type

Most SLPPPs work with solely paediatric clients, 65.1%, and a smaller number, 29.2%, work with a mixed age caseload. Only 5.7% of SLPPPs work solely with an adult caseload. Co-variation was found between *caseload age* and *total success rating* using Kruskal Wallis test for independent samples, $X^2(2, N = 110) = 6.16, p = .046$, at a .05 level of significance.

Most SLPPPs provide independent services (80.9%), and provide services for an informal multidisciplinary team on a referral by referral basis (58.2%), consultative services (58.2%) and fewer participants provide formalised multidisciplinary services with other education or health professionals (20.9%). A small percentage of participants provide other services (2.7%), listed as: keyworker roles, medicolegal work and case management. Co-variation was found between responses to the statement *provide formalised multidisciplinary services with other education or health professionals* and *total success rating* using Kruskal Wallis test for independent samples, $X^2(2, N = 110) = 3.85, p = .05$, at the .05 level of significance, and between *provide an informal multidisciplinary team on a referral by referral basis* and *total success rating*, $X^2(2, N = 110) = 7.10, p = .01$, at the .01 level of significance. No significant co-variation was found between provision of *independent services* and *total success rating*, $X^2(1, N = 110) = .62, p = .43$, or between *provide consultative services* and *total success rating*, $X^2(1, N = 110) = 1.78, p = .18$.

The hypothesis that business strategy is correlated with *total success rating* is retained for: empowerment in the strategic direction of the business, both cost value propositions, caseload age and two specific types of service provision: *provide formalised multidisciplinary services with other education or health professionals* and *provide an informal multidisciplinary team on a referral by referral basis*.

4.5.4 Financial capital

4 (f) It is hypothesised that financial capital: financial practices such as clear financial reporting, adequate start-up capital, processes for ensuring adequate cash flow, adequate resourcing, a manageable caseload and use of technology, is either correlated with the total success rating.

4.5.4.1.1 Financial practices and processes

Clearly documented financial reporting is reported by 68.2% of participants. A significant level of co-variation was found between participants' report of *clearly documented financial reporting* and *total success rating* using the Kruskal Wallis test for independent samples, $X^2(1, N = 110) = 9.07, p = .01$, at a .01 level of significance.

Most SLPPPs have financial processes in place to ensure adequate cash flow with 45.5% of participants reporting cash flow processes. A significant co-variation was found between participants' report of *clearly documented financial reporting* and *total success rating* using the Kruskal Wallis test for independent samples, $X^2(1, N = 110) = 8.97, p = .01$, at a .01 level of significance.

4.5.4.1.2 Start-up capital

A number of participants, 13.6%, did not answer the question asking for agreement with *adequate cash flow to start the business*. However, 31.6% of participants who responded, felt they did not have adequate start-up capital to begin in PP, disagreeing with the statement: *'I had adequate start-up capital to begin in private practice'*, $M = 4.78 (SD = 1.62)$. A correlation was found between *adequate start-up capital* and *total success rating* using Kendall's Tau-b, $\tau(1, N = 95) = .18, p = .02$ (2-tailed).

4.5.4.1.3 Resourcing

Most SLPs, 89.1%, responded with some level of agreement to the statement: *'My work is adequately resourced'* ($M = 5.76, SD = 1.18$) and 90% of SLPs reported some level of agreement with the statement: *'The physical environment in which I work is pleasant'*, $M = 6.06, SD = .96$. Both *adequate resourcing* and a *pleasant environment* were found to be correlated with the *total success rating* and provided exactly the same Kendall's Tau-b result, $\tau(1, N = 110) = .32, p = .01$ (2-tailed).

4.5.4.1.4 Manageable caseload

A high mean agreement ($M = 5.46, SD = 1.35$) was achieved for the statement: *'My caseload is manageable'*. However, 14.7% of participants reported some level of disagreement with the statement suggesting high work intensity for those participants. The relationship between *caseload manageability* and *high or low total success rating* can be seen in Figure 15. *Manageability of caseload* and *total success rating* were found to be correlated, using Kendall's Tau-b, $\tau(1, N = 110) = 0.17, p = .02$ (2-tailed).

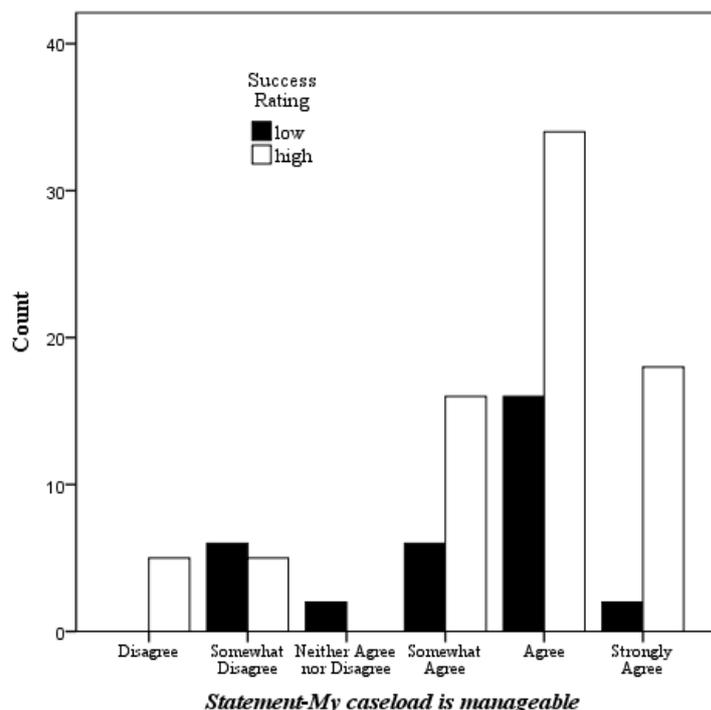


Figure 15. Participants' level of agreement with the statement about a manageable caseload on a 7-point Likert scale, for those with a high or low total success rating

4.5.4.1.5 Technology use

A high level of computer/technology use was reported with 89% of SLPPPs providing some level of agreement with the statement: *'I use a range of computer devices/technology in my practice'* ($M = 5.75, SD = 1.27$). Only 2.7% of respondents stated disagreement with the statement. *Use of a range of computer/technology devices* and *total success rating* were found to be correlated, using Kendall's Tau-b, $\tau(1, N = 110) = .32, p = .01$ (2-tailed). The relationship between agreement with use of a range of computer devices/technology and high or low total success rating is seen in Figure 16.

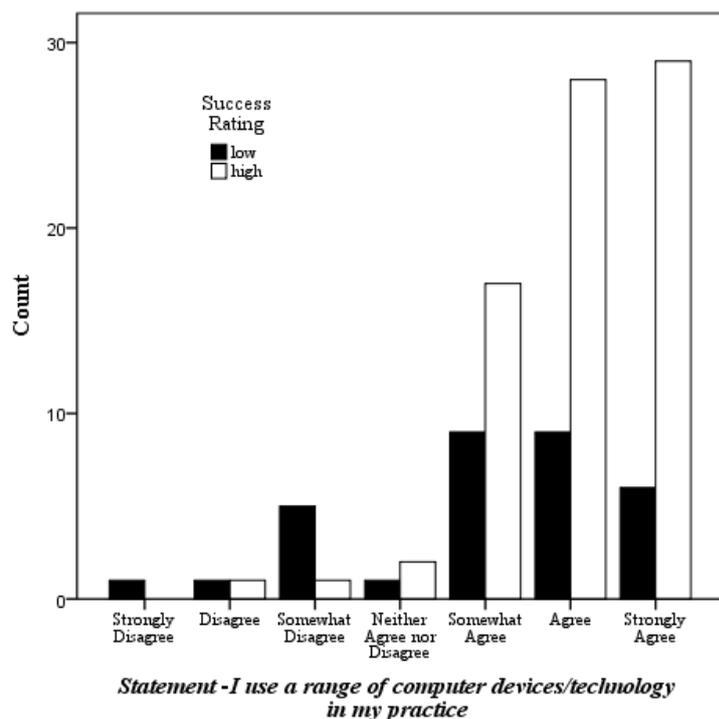


Figure 16. Participants’ agreement with the statement about the use of a range of technology on a 7-point Likert scale, for those with a high or low total success rating

The hypothesis that financial capital (which includes financial practices such as clear financial reporting, adequate start-up capital, processes for ensuring adequate cash flow, adequate resourcing, a manageable caseload and use of technology) is correlated with the total success rating, is retained.

4.5.5 Human capital

4 (g) It is hypothesised that human capital: *ability to attract new staff* and *presence of advancement opportunity*, correlates with the total success rating.

4.5.5.1.1 Advancement opportunities

Less than one third of participants agreed, at some level, with the statement: ‘*I have advancement opportunity in my current role*’. Only 6.4% of participants reported that they *strongly agree* with the statement, and only 14.5% state they *agree* with the statement ($M = 3.95, SD = 1.72$). These figures appear lower than expected given the large numbers of PPs in the NSW workforce. A correlation was found between *presence of advancement opportunity* and *total success rating* using Kendall’s Tau-b, $\tau(1, N = 110) = .27, p = .01$ (2-tailed).

4.5.5.1.2 Attractive to new staff

About one third (34.6%) of SLPPPs, responded with some level of agreement to the statement: *'It is easy to attract new speech language pathology staff in this PP'*. The mean rating of 4.30 ($SD = 1.65$) also indicates that the participants' perception of this issue is that it is difficult to attract new staff. A correlation was found between *ability to attract new staff* and *total success rating* using Kendall's Tau-b, $\tau(1, N = 110) = .25, p = .01$ (2-tailed).

The hypothesis that human capital: *ability to attract new staff* and *presence of advancement opportunity*, correlates with the total success rating, is retained.

4.5.6 Marketing capital

A marketing plan is an indication of planning for a specific market and the importance of marketing is outlined in the literature (Dorando-Unkle, 1995).

4 (h) It is hypothesised that marketing practices (including presence of a marketing plan, ongoing marketing, and use of a website), are correlated or co-vary with total success rating.

4.5.6.1.1 Marketing plan

Only 19.1% of participants reported that they have a marketing plan in place. However, no significant co-variation is noted between the presence or absence of a *marketing plan* and *total success rating*, using the Kruskal Wallis test for independent samples, $X^2(1, N = 110) = .69, p = .41$.

4.5.6.1.2 Ongoing marketing

Ongoing marketing depends involves continual highlighting of SLPs role and ensuring an awareness of SLP services among referrers. Only 17.3% of participants reported a level of agreement with the statement: *'I regularly challenge the assumptions of GPs/teachers/allied health professionals/clients/carers and other relevant referrers regarding the management of communication and swallowing'*. A large percentage of participants, 64.5%, report that they have some level of disagreement with the statement. It is likely that the wording of the question with some health professionals not relevant referral sources for some SLPPPs, did not elicit the intended information. However, a correlation was found between *challenging the assumptions of relevant referrers* and *total success rating* using Kendall's Tau-b, $\tau(1, N = 110) = .22, p = .01$ (2-tailed). Thus those with higher self-rated success were more likely to challenge assumptions.

4.5.6.1.3 Website

The majority of SLPPPs, 64.5%, report that they have a website. However, no significant co-variation is found between the presence or absence of a *website* and *total success rating*, using the Kruskal Wallis test for independent samples, $X^2(1, N = 110) = .69, p = .41$.

The hypothesis that marketing practices correlate with the ranked means of total success rating is partially rejected. The marketing practice of *challenging the assumptions of GPs/teachers/allied health professionals/clients/carers and other relevant referrers regarding the management of communication and swallowing* is correlated with the *total success rating*.

4.5.7 Management practices

4.5.7.1.1 Leadership practises

The leadership practices of SLPPPs were addressed with questions relating to high involvement work practices.

4 (i) It is hypothesised that leadership practices related to high involvement work practices will correlate with the total success rating.

A high level of involvement in decision making is recorded in this sample with a cumulative percentage of 93.6% of some level of agreement with the statement: '*I am involved in the decision making in my current role*'. This figure includes 70.9% of participants who *strongly agree* with the statement and a high mean level of agreement, $M = 6.47 (SD = 1.06)$. A correlation was found between *involvement in decision making* and *total success rating*, using Kendall's Tau-b, $\tau(1, N = 110) = .22, p = .01$ (2-tailed).

However, a lack of agreement at some level, 41.8%, is recorded regarding *involvement in regular reviews of a business plan/strategic plans and quality improvement plans to improve the productivity of PP*, and a low mean level of agreement, $M = 3.78 (SD = 1.799)$. A correlation was found between *involvement in regular reviews of business plans plan/strategic plans and quality improvement plans to improve the productivity of PP* and *total success rating*, using Kendall's Tau-b, $\tau(1, N = 110) = .25, p = .01$ (2-tailed).

Leadership support was also targeted in the survey. Participants provided a mean level of agreement of 4.7 ($SD = 1.79$) with the statement: '*I am adequately supported by supervisory staff or colleagues in my current role*'. A cumulative percentage of 57.3% of participants had some level of agreement with the statement. A correlation was found between *adequate*

supervisory or collegial support and *total success rating*, using Kendall's Tau-b, $\tau(1, N = 110) = 0.35, p = 0.01$ (2-tailed).

The hypothesis that management leadership practices including high involvement work practices (*shared decision making, involvement in regular reviews of productivity, and supervisory or collegial support*) are correlated with the *total success rating*, was retained.

4.5.7.1.2 Documentation

4(j) It is hypothesised that clear documentation including *written contacts with referrers, a comprehensive business plan, a clear job description* and a *comprehensive system for management of client information*, will be correlated with the total success rating.

Only 18.2% of participants indicated they had a comprehensive business plan in place. More participants indicated they had a clear job description, 36.4%, and written contracts with referrers, 30.9%. In comparison, 67.3% of participants, had a comprehensive information system for client information. Significant co-variation was observed between both, *a comprehensive business plan, and a comprehensive information system for client management*, and *total success rating*, using the Kruskal Wallis test for independent samples, $X^2(1, N = 110) = 6.62, p = .01$, and $X^2(1, N = 110) = 5.58, p = .01$, at a .01 level of significance, respectively. No significant co-variation was found for *a clear job description* or for *written contracts with referrers* and *total success rating*, $X^2(1, N = 110) = 1.58, p = .21$, and $X^2(1, N = 110) = 1.48, p = .22$. The hypothesis that management practices regarding documentation co-varied with total success rating was partially retained with a *comprehensive business plan* and a *comprehensive information system for client management* significantly co-varying with total success rating.

4.5.7.1.3 Business policies and procedures

4(k) It is hypothesised that the presence of a range of business policies and procedures will correlate or co-vary with the total success rating.

While almost half of the participants, 47.3%, had *a range of policies and procedures*, only 20.9% of participants had *identified key performance indicators for business performance* and fewer, 17.3% of participants, had *quality performance reviews such as occupational health and safety plans with reviews*. However, no significant co-variation was recorded for: *a range of policies and procedures, identified key performance indicators for business performance, or quality performance reviews such as occupational health and safety plans with reviews* and

total success rating, using the Kruskal Wallis test for independent samples, $X^2(1, N = 110) = 3.15, p = .08$, $X^2(1, N = 110) = 3.40, p = .07$; and $X^2(1, N = 110) = 2.17, p = .14$, respectively.

The hypothesis that the management practices of policies and procedures are correlated with the ranked mean of the total success rating, is rejected.

4.5.7.1.4 Business adaptability

4(l) It is hypothesised that business adaptability shown by level of agreement with “*issues identified as key areas for strategic change are addressed appropriately*” is correlated with *total success rating*.

The cumulative percentage of all ratings from somewhat agree to strongly agree with the statement “*issues identified as key areas for strategic change are addressed appropriately*”, is 50.9%. The mean level of agreement score is 4.65 ($SD = 1.42$). A correlation was found between *issues identified as key areas for strategic change are addressed appropriately* and *total success rating*, Kendall’s Tau-b, $\tau(1, N = 110) = .30, p = .01$ (2-tailed). The hypothesis that business adaptability shown by level of agreement with “*issues identified as key areas for strategic change are addressed appropriately*” is correlated with *total success rating*, is retained.

4.5.7.1.5 Innovation supported

4(m) It is hypothesised that *support for innovative practice* is correlated with *total success rating*.

A cumulative percentage of 75.5% was achieved for some level of agreement with the statement: ‘*The establishment of innovative: practice, client management or resources, is achievable and supported in my current speech pathology/SLP role*’, ($M = 5.15, SD = 1.37$). A correlation was found for *support for innovative practice* and *total success rating*, using Kendall’s Tau-b, $\tau(1, N = 110) = .29, p = .01$ (2-tailed). The hypothesis that *support for innovative practice* is correlated with *total success rating* is retained.

4.5.7.1.6 Business support

4(n) It is hypothesised that business support co-varies with the total success rating.

Most participants use some type of business support with 74.5% reporting use of business support. The type of support most frequently used by participants is book keeping,

with 39.1% use of book keeping support. A list of types of business support used by SLPPPs is seen in Table 13.

The relationship between *the use of business support* and *total success rating* was examined using the Kruskal Wallis test for independent samples and showed significant co-variation, $X^2(1, N = 110) = 8.64, p = .01$, at a .01 level of significance. The null hypothesis that the distribution of total success rating is the same across *the use of business support* is rejected. The use of business support co-varies with *total success rating*.

Table 13. Type of Business Support Used

Type of Support	Percent
Book keeping	39.1
Information Technology	36.4
Marketing	20.0
Legal	20.0
Financial planning	17.3
Business coaching	14.5
Human resources	7.3
Leadership coaching	0.9

4.5.8 Professional practices

4(o) It is hypothesised that the professional practices of *professional affiliation, monitoring client outcomes measures, monitoring client satisfaction* and *using a range of clinical policies and procedures* will correlate with the ranked mean of *total success rating*.

A high level of professional affiliation is recorded with 100% membership of professional bodies, SPA or NZSTA. Approximately half of the SLPPPs were members of special interest groups and informal member networks, and only approximately one third were members of formal networks as seen in Table 14. The Kruskal Wallis test for independent samples was used to explore the relationship between the presence or absence of professional affiliations and the *total success rating*. Only formal member networks: $X^2(1, N = 110) = 14.85, p = .00$ and informal member networks: $X^2(1, N = 110) = 4.52, p = .03$ were correlated with total success rating. Analysis for membership of professional body was not possible given that membership of a professional body is a constant for all SLPPPs participating in the survey.

Approximately one half of participants indicated they had a range of clinical policies and procedures in place (47.3%). Fewer SLPPPs use clinical quality management programs such as monitoring client outcome measures (35.5%), or use effective documented practices for monitoring client satisfaction (14.5%). A correlation was recorded between *a range of clinical policies and procedures in place* and *total success rating*, using Kendall's Tau-b, $\tau(1, N = 110) = .18, p = .03$ (2-tailed). No correlation was found between *monitoring client outcomes measures* or *monitoring client satisfaction*, and *total success rating*, $\tau(1, N = 110) = .14, p = .07$ (2-tailed), and $\tau(1, N = 110) = .13, p = .11$ (2-tailed).

The hypothesis that the professional practices of *professional affiliation*, *monitoring client outcomes measures*, *monitoring client satisfaction* or *using a range of clinical policies and procedures* correlate with the total success rating is partially rejected. Maintaining *a range of clinical policies and procedures specific to client management and NZSTA/SPA standards* and *membership of formal and informal networks*, were the only professional practices to correlate with the *total success rating*.

Table 14: Professional Memberships

Member of:	Percent
Formal clinical networks	29.1
Professional Body	100
Informal clinical networks	47.3
Speech language pathology specific special interest groups	52.7

Note. Percentages are taken from the total number of participants ($N = 110$)

4.5.9 Social capital

4(p) It is hypothesised that four aspects of social capital: teamwork, affiliation with a business network, regular business-to-business networking and mentoring, will be correlated with the *total success rating*.

The mean level of agreement to the statement: '*I engage in effective teamwork*', was high, $M = 5.88$ ($SD = 1.09$). A large majority of SLPPPs indicated use of effective teamwork with a cumulative percentage of 91.8%, rating at least some agreement; *somewhat agree to*

strongly agree. A correlation was found between *engagement in effective teamwork* and *total success rating*, using Kendall's Tau-b, $\tau(1, N = 110) = .397, p = .01$ (2-tailed).

Only 18.2% of participants indicated affiliation with a business network. There was no significant co-variation with total success rating based on the Kruskal Wallis test for independent samples, $X^2(1, N = 110) = .04, p = .84$, at a 0.05 level of significance. More than half, 53.6%, of participants indicated some level of agreement with the statement: '*I engage in regular business to business networking (with GPs/teachers/allied health or other referrers)*'. A correlation was found between *engagement in regular business to business networking* and *total success rating*, using Kendall's Tau-b, $\tau(1, N = 110) = .22, p = .01$ (2-tailed).

The most frequent form of mentoring is *informal mentoring*, with 65.5% of participants reporting their participation as seen in Table 16. Informal mentoring, group mentoring, individual mentoring and regular mentoring, show a significant co-variation with the total success rating using Kruskal Wallis test of independent samples, as seen in Table 15.

Table 15. Percent Participation in Mentoring and Kruskal Wallis Test Results

Clinical Mentoring	Percent	X²	p
Non-existent	14.5	(1, N = 110) 3.966	0.046*
Regular	17.3	(1, N = 110) 5.99	0.01**
Formal	19.1	(1, N = 110) 3.43	0.064
Group	19.1	(1, N = 110) 8.29	0.01**
Mentored by a Speech Language Pathologist	21.8	(1, N = 110) 0.52	0.47
Business related	26.4	(1, N = 110) 0.25	0.62
Irregular	33.6	(1, N = 110) 0.33	0.56
Individual	35.45	(1, N = 110) 6.08	0.01**
Clinical related	36.4	(1, N = 110) 0.61	0.44
Informal	65.5	(1, N = 110) 6.08	0.01**

Note. **significant at the 0.01 level of significance, *significant at the 0.05 level of significance

The hypothesis that social capital practices: *effective teamwork*, *regular business to business networking* and *mentoring* are correlated with *total success rating* is retained. The factor *affiliation with a business network* did not significantly co-vary with the *total success rating*.

4.6 Quantitative Results Summary

Table 16. Summary of Quantitative Data (MDT = Multidisciplinary team)

Question type	NSW participants: n = 95	NZ participants: n = 15	Results
Demographics	age, gender, ethnic group, location		Majority in 30-34 age group: (17.3%), age, gender and general pattern of ethnic group similar both groups. Location: majority in cities; variation in location across groups, no NZ SLP PP in rural areas
Question type	Australian and New Zealand data combined		Results
Perceived importance of business success criteria (11 items)	BSCIS: success criteria ranked means 1. Satisfied stakeholders 2. Professional satisfaction 3. Utility 4. Work life balance 5. Personal satisfaction 6. Contribution to society 7. Innovation 8. Profit 9. Public recognition 10. Growth 11. Survival		Reliability of data: Cronbach's alpha=.703 with inclusion of all 11 items Principal Components factor analysis with Varimax rotation generated a 4-factor solution accounting for 65% of the variance; The BSCIS thus has 4 subscales: Business, Professional Satisfaction, Innovation, Contribution to Society
Self-rated level of achievement for business success criteria (11 items)	11 questions relating to the 11 BSCIS items with Likert scale or semantically related scale for questions regarding growth and survival.		Reliability score: Cronbach's alpha = 0.78. Mean of all 11 items combined in a total self-rating score, and high or low ratings possible for total success rating score. Self-rated responses to questions in 4 subscales: Contribution to Society, Professional Satisfaction, Innovation, Business (in order of achievement), all correlated with criteria sub-group ratings.

Question type	Australian and New Zealand data combined	Results
Education	Business qualifications, Speech pathology qualifications,	Qualifications not correlated with total success rating
Experience	Business industry experience, SLP experience, on the job experience	Experience in job and private practice correlated with total success rating
Personal characteristics	Resilience, efficacy (time management), personal support, cultural literacy,	Resilience and cultural literacy and efficacy (time management) correlated with total success rating
Professional competence	Professional education, provide evidence based therapy, able to resolve ethical issues, clinical supervision	All factors significantly correlated with total success rating
Business structure	Self-employment, business type, employer status, SLT supervisor, hours worked, business base, GST registration	Hours worked, business type and employing other SLP co-vary with total success rating
Funding	Funding types	Mainly government funded; no co-variation with total success rating
Business strategy and strategic competence	Cost value proposition, caseload age, service type, empowerment in strategic direction,	Cost value propositions correlated with total success rating. Service type: formalised MDT and informal MDT, caseload age, co-varied with total success rating
Financial capital and competence	Start-up capital, adequate resources, pleasant environment, caseload manageable, technology use, financial practice documentation, financial processes in place	All aspects significantly correlated with total success rating.
Human competence and capital	Advancement opportunities, attracts new staff	Both factors correlated with total success rating
Marketing competence and capital	Marketing plan with marketing strategy, website, challenge assumptions of referrers,	Only challenging the assumptions of referrers correlates with total success rating
Management practices, Management competence and capital	1/ Leadership practice: Shared decision making, involvement in reviews of business plans/strategic plans and quality improvement plans, support by supervisors.	Shared decision making, involvement with reviews of plans, and support of supervisors are correlated with total success rating
	2/ Documentation: business plans, job descriptions, written contracts with referrers,	A comprehensive business plan and system for managing client

	effective information management systems.	information co-varied with total success rating
	3/ Business policies and procedures, quality performance reviews, key performance indicators, involvement in reviews of productivity management,	No factor correlated with total success rating
	4/ Business adaptability: key areas identified for change are addressed	Correlated with total success rating
	5/ Innovation supported	Correlated with total success rating
	6/ Business support utilised	Significantly co-varied with total success rating
Professional practices and competence	Clinical policies and procedures, client outcome measures, client satisfaction monitoring, professional affiliations	Correlation between total success rating and: clinical policies and procedures, informal and formal SLP member networks
Social capital and competence	Effective teamwork, regular business-to-business networking with GPs/teachers/allied health or other referrers, business network affiliation, clinical mentoring	All factors except business network affiliation are correlated with total success rating except business network affiliation.

4.7 Hypothesis 1

The hypothesis that 11 success criteria (the BSCIS): business profitability, growth, innovation, survival/continuity, contribution to society, personal satisfaction, professional satisfaction, satisfied stakeholders, good balance between work and private life, public recognition, and the achievement of usefulness, will provide a reliable measure of success criteria for SLPPPs, is accepted. This is based on the Cronbach's alpha value of $\alpha = .703$ for the 11 items, and the general agreement between the rankings of the criteria between SLPPPs in the current study and Gorgievski et al.'s (2011) success criteria.

4.8 Hypothesis 2

The hypothesis that statements or questions relating to achievement on the 11 success criteria of the BSCIS will provide a reliable measure of success rating for SLPPPs is accepted. This is based on the Cronbach's alpha value of $\alpha = .78$ for the 11 items, and the known reliability of the BSCIS.

4.9 Hypothesis 3

The hypothesis that no significant differences will be shown in (a) success criteria, (b) self-rating of success, or, (c) CSF, between SLPPPs in NSW, Australia or New Zealand, is accepted for parts (a) and (b), but rejected for part (c). The success criteria (a) and self-rating of success (b), do not show significant co-variation between groups. It was not possible to assess all the CSF for both groups as the numbers of NZ participants was low. Statistical analysis allowing comparison of the CSF for the two groups was not possible due to the low numbers of NZ participants. Therefore, the NZ participants were treated as part of the larger group of SLPPPs and hence any generalisation of the results to the NZ context alone, should be interpreted with caution.

4.10 Hypothesis 4(a-p)

The hypothesis the factors relating to ability or opportunity will correlate with the total success rating providing a range of CSF for SLPPPs (listed with outcomes in the text due to the large number), is retained. The CSF of SLPPPs were identified as 'abilities': on the job and PP experience; personal characteristics: resilience and personal efficacy (time management skills); and professional competence: providing evidence based practice, ethical practice, and undertaking professional education. The 'opportunities' identified as CSF were: business structure: business type and employing other SLP; business strategy: empowerment in the strategic direction of the PP, use of a cost-value propositions, and caseload age; financial capital: adequate start-up capital, adequate resourcing, manageable caseload, use of technology, clear financial documentation, financial processes and policies in place; human capital: advancement opportunities and ability to attract staff; marketing: challenging the assumption of referrers; management practices: leadership practices: supervisory support, shared decision making, involvement in reviews of business plans; documentation: a comprehensive business and an effective information management system plan in place; business adaptability: key areas identified for change are addressed; support for innovation and

business support; social capital: effective teamwork, regular business-to-business networking with referrers and involvement in mentoring; and professional practices: ensuring a range of clinical policies and practices in keeping with professional standards and professional affiliations with formal and informal member networks.

4.11 Qualitative Results

The response rate for the open question: “*Please make any further comments on issues regarding your experience of private practice or provide elaboration on any point*” was 41% of the complete number of participants. The NZ SLPPPs had a low participation rate with only 27% of NZ participants making a comment. In comparison, 43% of Australian participants added a comment. This may reflect the faster growth rate of the PP sector in NSW; 18.5% of NZ SLPs working in PP and 63% of SLPs are working in PP in NSW (as noted in section 1.11).

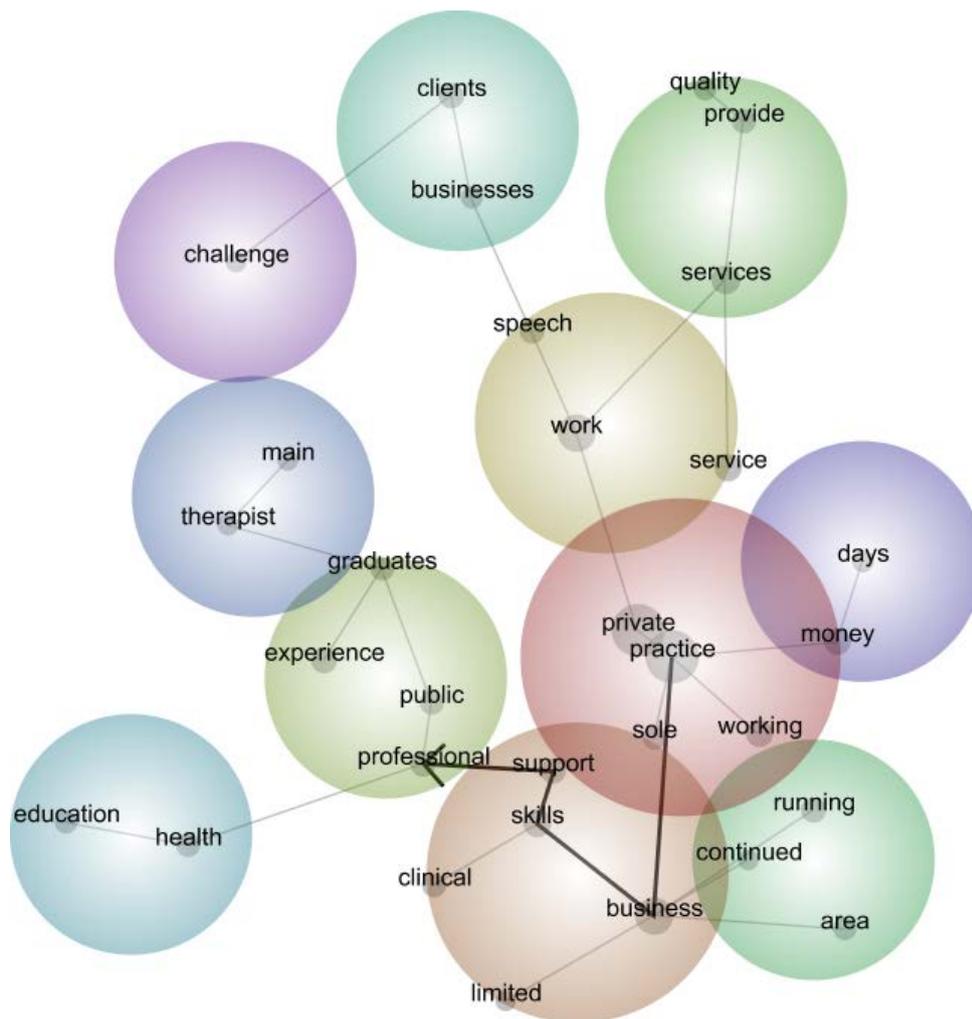


Figure 17. Concept map for “Professionalism” generated by Leximancer - 4 software using qualitative data provided by speech language pathology private practitioners from New South Wales, Australia, and New Zealand.

4.11.1 Themes

The themes are developed by the researcher, as a participant-observer, speech language pathologist, based in a PP in NSW, in Australia, since 2001. It is acknowledged that the literature presented in the literature review, Chapter 2 and the results of the quantitative data presented in Chapter 4 (4.1 – 4.6), influence and triangulate the themes presented. Yin (2012) advocates at least three data sources for appropriate triangulation of qualitative data which can

include: “*participant observation*”, “*open-ended conversations with key participants*”, “*documents*” such as “*reports*” (Yin, 2012, p.10).

The qualitative data is explored using the knowledge pathway of professionalism, to develop the themes using the concept map developed by Leximancer -4 software seen in Figure 16. As described in section 3.8.6 the concept map shows clusters of concepts as ‘theme’ circles (Cretchley et al., 2010) with similar concepts closer together and more prominent themes produced as larger circles. The theme circles as seen in figure 16 are: (a) private (main theme), practice (main theme), sole, working, money; (b) business (main theme), skills (main theme), limited, clinical, support; (c) work (main theme), speech and service (SLPs’ values concept); (d) experience, public, professional, graduates (all with similar weighting in terms of importance) (e) money (main theme), days (time/financial concept); (f) services (main theme), quality, provide; (g) education, health (equal weighting in terms of importance); (h) running, continued, area (equal weighting in terms of importance,) (location concept); (i) main, therapist (equal weighting in terms of importance); (j) client, business (equal weighting in terms of importance) (location concept) and (k) challenge .

Importantly, the warmer colours, such as shades of red, indicating warmer sentiment (Beisenthal & Wilden, 2014), are observed in themes (main theme provided): private practice (a), business skills (b), SLP values (c), public-professional, experience-new graduate (d). Cooler colours such as shades of blues and greens are observed in themes (main theme provided): health-education (g), main therapist (i), client-business (j), continued running area (location). A mix of blue (cool) and red (warm) coloured purple, are observed in themes: time/finance (e), and challenge (k).

The concept circle named as PP is the most important concept and a directional line is established from the most, to less, important concepts; in this case from PP (a) to business skills (b) and between (b) and (d) professional support. The position of the theme of *PP* is integral to this concept map with *PP(a)*; below *the values of SLP(c)*; above the *business (b)* theme; and surrounded by the cooler themes of: *time pressure*, and *financial pressure*, and *business survival*; relationships between: *education/health*, *professionalism/the public/graduates* and *experience*; and *challenge* next to: *clients, businesses*; and provision of *quality services*.

4.11.1.1 Professional values and professional socialisation

The combination of terms ‘*service*’, ‘*work*’ and ‘*speech*’ easily represent the values of the profession of ‘*speech*’ language pathology. The professional values and professional socialisation of SLPs are a part of the education and job satisfaction of health professionals including SLPs (Kenny & Lincoln, 2012; Milstead, 2013). The position of the circle, which can be named ‘*the values of SLPs*’, is the highest of the warm coloured circles and is paramount in the conceptual map. The placement of this circle, shows the importance of professional values and professional socialisation in SLPs’ conceptualisation of PP. One participant stated: “...it’s all about helping the community and offering a variety of services to those in need” (as seen in Appendix F, comment 31). This reinforces the quantitative results regarding the importance of the sub-group of ‘*contribution to society*’ as a high rating success criterion and the sub-group with the highest level of achievement for SLPPPs. The themes of this circle can be seen to guide the comments the SLPs provide about PP.

4.11.1.2 Ethical practice

Other cooler themes that stem from ‘*the values of SLPs*’ theme circle are the relationships between *businesses* and *clients*. This theme acknowledges the ethical issues reconciling business’, with clients’ needs, leading to concerns that this is a ‘*challenge*’ for participants. The ethical issues surrounding reconciling business issues in SLP PP with clients’ needs, such as charging fees for non-attendance, or juggling business and clinical tasks, have been highlighted in the literature (Flatley et al., 2014). The ethical dilemmas faced by Australian SLPPPs “...related to client management, business practices, access to external funding sources, and personal and professional integrity of other speech language pathologists” (Flatley et al., 2014, p.300). Like Flatley et al.’s (2014) participants, participants in this survey, were concerned about these types of issues: “*The biggest strain has been balancing all the business aspects with the practice aspects*” (as seen in Appendix F, comment 26). All of the ethical dilemmas described by Flatley et al.’s quote, were also addressed by comments in this survey.

4.11.1.3 Evidence based practice

Another cool theme leading from, and above, *the values of SLPs* in the concept map, is that the services provided are of adequate quality (“*service*”, “*provide*”, “*quality*”). This theme is reiterated in the SLP literature with a push for the provision of both ethical (Atherton

& McAllister, 2009; Flatley et al., 2014) and evidence based therapy (Cheung et al., 2013; Ferguson & Armstrong, 2009; Roddam & Skeat, 2010). There is a relationship between providing evidence based therapy and job satisfaction (Kenny & Lincoln, 2012; McLaughlin et al., 2008). A correlation between total success rating, and both, providing both evidence based therapy, and reconciling ethical issues in SLP PP, was found in the quantitative data. The value SLPPs place on providing quality service to clients is borne out in participants' comments such as: "*I'm proud to be able to provide high quality, evidence based services without having to deal with the daily dramas of large organisations*" (Appendix F, comment 6). However, many participants expressed concerns regarding the professional competence or provision of quality services in PP: "*...some do work using evidence based practice but many do not*" (Appendix F, comment 24). The ethical burden of ensuring EBP is expressed. The position of this theme circle in the conceptual map (Figure 16) is above *PP* as an indicator of omnipresence.

4.11.1.4 Professional satisfaction and private practice

The main issue and largest theme circle is *PP*. Many participants expressed their enjoyment of PP with comments such as: "*Best decision I ever made going into PP*" (Appendix F, comment 37), "*I enjoy my work*" (Appendix F, comment 12), and "*PP is hard work but very rewarding*" (Appendix F, comment 9). Evidence of this positive sentiment toward PP is given in the quantitative data with the sub-theme of *professional satisfaction* rated the most desirable success criterion, and with the second highest level of achievement; $M = 5.64$, ($SD = .95$). Many participants provided the benefits of working in PP such as not only enjoyable but beneficial for their clients: "*It's great to work in many settings (e.g. homes, preschools) and develop long-term working relationships*" (Appendix F, comment 39). This was borne out in the level of participants' mean agreement with "*My clients are satisfied with my work*" was the highest of all the individual achievement scores; $M = 6.28$, ($SD = .77$) in the quantitative data.

4.11.1.5 Autonomy and flexibility

The inclusion of '*sole*' in the *PP* theme circle is indicative of professional autonomy given the warm colour of the theme circle, it discussed as a positive concept. PP is providing an autonomy for participants in their work. Autonomy is discussed in the literature as a way SLPs can ensure providing quality services and evidence based practice bypassing managers who do not have an understanding of SLP service needs (McLaughlin et al., 2008). There is an

appreciation of this autonomy in the participants' comments: "...we can do a lot more direct service and shift our paperwork requirements to best suit that relationship" (Appendix F, comment 36). Autonomy is included in Gorgiveski et al.'s (2011, P.209) success criteria as part of the personal satisfaction criteria. *Personal satisfaction* was rated as the fifth highest success criteria and with the fifth highest achievement: $M = 5.84$, ($SD = 1.31$) reinforcing autonomy as desirable and achievable for these participants.

Testimony is also provided for the flexibility afforded by PP to create a work-life balance: "*I have operated as a sole trader in a rural area and work has fitted in well with my private life*" (Appendix F, comment 36), and "...it has allowed me a great deal of flexibility around personal commitments" (Appendix F, comment 40). 'Flexibility' is highlighted, in the literature, as a motivating factor for SLPs to be retained in the work force particularly when SLPs have small children (McLaughlin et al., 2010). However, participants provided a caveat: "*Private practice allows flexibility for both clients and clinicians. It requires very long hours which can make balancing work and personal life difficult*" (Appendix F, comment 29), and "*Managing work and family life is sometimes a challenge with four children*" (Appendix F, comment 19). Accordingly, there was poor agreement with participants' achievement of a *good work-life balance* which ranked eighth among the success ratings in the quantitative data. There is a sense in the comments that maintaining a work-life balance is a challenge: "...the challenge is keeping books closed when you are at capacity" (Appendix F, comment 17). However, participants can be seen to use the same skill set they apply to therapy, to manage this issue: "*I hope that once I have all procedures properly in place I will have a better work-life balance*" (Appendix F, comment 26). An emergence of managerial skills is acknowledged to address these pressures.

4.11.1.6 Time and money pressure

In the concept map, the theme circle of *time pressure* and *financial pressure* is a cool colour, denoting negative impact or concern, above *PP*. Notwithstanding the time pressure involved in maintaining a work-life balance, the issue of ensuring that an adequate number of clients are treated, to cover costs, is a re-occurring pressure that impacts upon appropriate clinical care. "*Those who don't seem to have to book more clients than they want to/can provide quality services to, in order to cover costs*" (Appendix F, comment 21). Effectively, time is seen to be linked to money.

Comments made by participants reinforce the pervasive position imposed by the *time/money* theme circle which is sitting above the PP theme circle: “*I find that it is far less financially secure than a position in [the public service]*” (Appendix F, comment 4). The need to maintain financial capital or to resource a practice adequately, is one concern noted by several participants: “*The cost of resources, especially formal tests, is extremely limiting for small businesses*” (Appendix F, comment 8). The need to ensure financial competence is also mentioned: “*I find the money side of running a business very difficult. ...I find it challenging working with third party funding bodies*” (Appendix F, comment 5). It is necessary for small businesses develop financial capital and financial competence (Jasra et al., 2011; Kennedy & Tennent, 2006; Luisser & Halabi, 2010; Rainer & Papp, 2000). The need to develop financial competence was noted: “*There needs to be basic knowledge about running a business (e.g. tax, setting up GST, accounting etc.)*” (Appendix F, comment 25). The need for cash flow was acknowledged: “*...the lack of cash flow[was] a barrier to continued active work on [my] own business*” (Appendix F, comment 15). Accordingly, clear financial documentation and having financial processes in place to ensure adequate cash flow correlated with total success rating in the quantitative data of this survey.

Start-up capital (Luisser & Halabi, 2010) and amount of leverage (Gadenne, 1998) of a small service business is integral to its success, however, 13.6% of participants chose not to answer the question regarding start-up capital in the survey. Despite this reticence many participants commented about limited start-up capital: “*...my start-up costs were minimal as I paid to borrow tests from [name of university] Uni. I could then wait until I could afford to buy*” (Appendix F, comment 22). The qualitative data supports these comments as there was low mean agreement to the statement “*I had adequate start-up capital*”; $M = 4.78$, ($SD = 1.62$). This suggests, it was either difficult for PPs to access start-up capital, or possible for most of the participants to start a PP with limited capital. Further research is required to clarify this issue.

There is a duality among the comments that suggests a SLPPPs objectives for entering PP and values are linked to the way they view finance in PP. One group of participants expressed that they do not require profitability as a success criterion: “*I have no plans to expand the business, or to try and make it a highly profitable business, as that is not my life's aim!*” (Appendix F, comment 4). Some participants expressed that a profit-related success criterion was contrary to their professional values: “*Need drive and be motivated to provide a high-quality service without being driven by the dollar*” (Appendix F, comment 13). Other

participants required profitability as a means of income: “*Many people in PP do it as a hobby, with their main income coming from another job, or their partners!*” (Appendix F, comment 20). It is possible that this duality has impacted upon the results of the qualitative data; the sub-group of *business*, which included the success criteria of: *profit*, *survival* and *business growth*, rated with the lowest mean score of the sub-groups; $M = 4.95$ ($SD = 1.24$) and *business success* the lowest mean level of achievement; $M = 4.53$, ($SD = .81$). Potentially participants who require profitability from PP, as their sole means of income, rated the *business* sub-group higher than other success criteria. Further research including case studies many benefit from separating participants who require PP as their sole source of income, from those who do not.

4.11.1.7 Private practice and business

The position of the concept of ‘*business*’ within the concept map, below ‘*PP*’, is important (Figure 14). *Business* is subordinate to, and possibly holds less value, than *PP*, with only a slight amount of overlap between the circles. This is reinforced by participants’ comments: “*I enjoy the clinical side of PP, I dislike the business side (invoicing, marketing, etc.)*” (Appendix F, comment 19). This type of disassociation with business is discussed in the literature (Milsted, 2013) with health professionals’ preference toward valuing technical skills (such as SLP skills) over business skills maintained by professional socialisation. This disconnect between PP and business is observed, in the concept map, with the lesser themes of *clinical* and *limited* within the theme of business far away from the main theme *business*. The relationship between a *clinical* and *business* identity is present but not close, whereas the theme ‘*limited*’ is directly in line with the concept of *business* and the cooler themes of ‘*business survival*’. The concepts of *skills* and *support*, although part of the same *business* theme circle, to are closer to *PP*, than, *business*. These relationships are depicted in participants’ comments: “*...but I regularly face several issues including a complete lack of business and marketing skills/training, having to start from scratch for the various admin and business set up, ...*” (Appendix F, comment 6). Several participants reported a lack of business skills. The results of the quantitative data show more than half of the participants have no previous business experience and only 44% have formal business qualifications. The growth of business skills on-the-job are evident in the participants’ comments with one participant (Appendix F, comment 15) realising a micro-business course may have been a more suitable training option showing an increasing understanding of the industry with experience.

4.11.1.8 Survival

This cooler theme of *survival*, and concern about survival, is not only slightly within *business* but also *PP*. Business exits from the sector were reported some with insightful reasoning provided:

With limited referral base and some mistakes in marketing resource allocation (e.g. attempting to start-up SLP in a more affluent area of [city provided] already over-serviced, investing in office materials and flyers for handover during face to face liaison with referrals, domain website name needed key words to obvious for traffic) found the isolation and lack of cash flow a barrier to continued active work on own business (Appendix F, comment 6).

The inclusion of ‘*area*’ with the same theme circle suggests that participants’ associate survival with the maintenance of an area (location or market) which is integral to their *business* and *PP*. “*Too much competition in a small condensed area has prompted me... to formally accept a speech language therapy position at a larger, more diverse company*” (Appendix F, comment 45). A reliance on a niche market by health professionals in which business skills are low and entry into field by new graduates impinges on an area dependent market is also described by Milstead et al.(2013). Milstead found that over time OT PPs built business skills and referral networks via on-the-job learning which aided their survival. Potentially concerns expressed by SLPPPs relate to a need to develop business skills including the social capital of referral networks.

A lack of business skill development is associated with business failure (Milsteed, 2013). The majority of participants, 53.6% had no previous business experience, and only 44% had any formal business qualifications. However, neither business experience, previous business skills or business qualifications had any significant correlation (at 95% CI) with the ranked mean of the total success rating. In fact, the participants reported stability in the sector, with little difference between reported ‘*years in their current role*’ and ‘*years in PP*’ as seen in Table 13 in Chapter 4. In addition, there was a significant difference between the ranked means of both ‘*years in current role*’, and ‘*years as a PP*’, and the total success rating. The majority of participants, 53.6%, had spent over five years in their current role and 30% had over 10 years. This suggests that like the OT PPs studied by Milstead, SLPPPs have sustainable businesses.

4.11.1.9 The readiness of new graduates for private practice

A cool theme, close to the theme of *business* in the concept map, is that of the relationship with the *public* stemming from *professionalism* and leading to *graduates* and *experience*. The combination of these themes suggests a concern with the maintenance of a professional reputation/service to the public regarding an increasing number of new graduates with a lack of experience, impacting upon the businesses of other PPs and clients. Participants report a lack of appropriate services provided by new graduates: “*New graduates start a practice often at considerable expense with limited experience*” (Appendix F, comment 24). Some participants are concerned by a lack of training: “*I am also concerned about the flooding of the market with poorly trained graduates who will be looking for work*” (Appendix F, comment 12). Most participants were concerned about a lack of evidence based practice or lack of commitment to clients: “*I worry about being undercut by someone who does not realise the true cost of running a practice, who will only stay in my rural area for a short time before moving on*” (Appendix F, comment 3). The potential damage to the face of the industry, the integrity of services and stability of businesses in a growth industry, is obvious to the participants who commented.

The actual numbers of new graduates captured in this sample was low. While the number of PP with under five years in their current role is high, 46.4%, there were only 10.9%, of participants who had less than one year in their current role. The number of PPs who had less than one years’ experience in SLP is lower again, 2.7%, and under five years’ experience in SLP, 10%. The perception of high numbers of new graduates is not supported by this sample. However, it may be that few new graduates took this survey; further research needs to be completed on the issue of new graduates in PP. The consistency of comments regarding new graduates suggests PPs have similar experiences regarding new graduates which may need to be addressed by training and support.

4.11.1.10 Support

The directional line from *PP* to *business*, *skills*, *support* and *professional* is integral to the concept map in Figure 16. It can be seen that PPs are moving toward a more professional persona in the public arena as they develop the business skills and engage the support they require. The majority of participants, 74.5%, reported receiving some form of business support from book keeping, to information technology as seen in Table 13 in Chapter 4. Business support is associated with success in the literature (Luisser & Halabi, 2010) and in participants’

comments. The role of professional associations was highlighted: “*It is great SPA are growing to support more regarding PP ... would be great to see more support in PP*” (Appendix F, comment 38). Most noted continued support was required.

The need for support for PPs within practices was also addressed. One participant expressed that “*owners do not know how, or are not interested in, supporting the women who work for them*” (Appendix F, comment 28). Work intensification was reported: “*They overbook them, they burden them with too much admin*” (Appendix F, comment 28), and specific types of support were noted to be lacking: “*professional development and support in the 'new grad' phase is unstructured and often lacking altogether*” (Appendix F, comment 28). Reduced collegial support was also reported: “*It is hard to connect with other SLPPPs. I feel that they are cautious to share their business experiences with others...*” (Appendix F, comment 41). There was a low mean level of agreement, $M = 4.7$ ($SD = 1.79$), with *adequate supervisory or collegial support* (4 = Neither agree nor disagree, 5 = Somewhat Agree, 6 = Agree). This suggests that most participants do not currently feel adequately supported.

Supervision/mentoring and business mentoring are effective forms of support noted in the literature (The Speech Pathology Association of Australia, 2014d). One participant provides exemplary testimony: “*I do find being a sole practitioner a lonely experience, however becoming a mentor and working very hard at creating professional networks has been a way of combating this and finding support*” (Appendix F, comment 2). Professional support, clinical supervision/mentoring and business mentoring, all rated with a significant co-variation with the total success rating. However, 22.7% of participants do not engage in clinical supervision and of those who do engage in supervision 28.2% have irregular supervision. Effectively, these forms of support are currently underutilised.

4.11.1.11 Professional isolation and inclusion

Following the direction of the professional focus, in the concept map, is the cool theme of the ‘*therapist*’ with ‘*main*’ suggesting some concern with the isolation of therapists. A lack of support is associated with professional isolation for SLPs (McLaughlin et al., 2008). The location of some PPs increases the possibility of isolation: “*I find living regionally means there are very few other speechies to work with*” (Appendix F, comment 5). Professional isolation can lead to mental health issues (McLaughlin et al., 2008) as were experienced by participants: “*depression and anxiety, loss of self-esteem*” (Appendix F, comment 16). Accordingly, lack of

acceptance and racism can lead to extreme isolation which needs to be addressed in order to ensure the well-being of our colleagues, the sector and profession.

I have experienced sometimes outright racial discrimination from new clients, from other allied health professionals and education staff. I find this issue has been glossed over by this survey as it's probably a bit too 'icky' to admit that discrimination exists in [country provided] when you're not white. It has impacted significantly in the marketing and advertising of my business and the fact my 'face' is the sales face for the business. Even when I have tried to collaborate with other practices in my area I've been given the cold shoulder and yet I know they are working with other private practices (Appendix F, comment 35).

As a participant observer, the bravery of this participant to speak out, highlights the researcher's need to maintain professional networks, not only to build social capital personally but among colleagues. Two aspects of social capital and competence, engaging in effective teamwork, and regular business to business networking, were correlated with the total success rating. Reduced levels of support, and the risk of professional isolation for SLPPPs, have emerged as important issues to address in terms of the well-being of SLPPPs. Accordingly, mechanisms to monitor the engagement of individual SLPPPs and level of social capital within the sector may be necessary to combat social isolation and provide ongoing support. This issue requires further discussion within the sector.

4.11.1.12 Relationships with health and education services

The cool theme of relationships with *health and education services*, are present but not close to the theme of PP, in the concept map. Presumably participants can distance themselves from this theme. The sense of comments, regarding the relationship between health/education SLPs and SLPPPs, is one of a lack of understanding about, and recognition for, the scope of practice or experience/expertise of PPs: *"I feel there is a huge disparity between the work of my colleagues in health/education, and what we can do in private practice"* (Appendix F, comment 20). A suggestion provided by the PPs in interviews completed by O'Toole et al. (2010), that PPs provide some supervision to their public health colleagues, may allow more of an understanding of the depth of experience of PPs; 37.3% of PPs in this sample had over twenty years' experience as SLPs. Given the health force report *"Speech Pathologists in Focus"* (Health Workforce Australia, 2014), has pointed out a difficulty hiring experienced SLPs, the private sector has a lot to offer other sectors of SLP employment.

4.11.2 Summary of qualitative data

The comments made by SLPPPs have provided personal insight that has been added to the quantitative data and themes from the literature reviewed. The value of the thematic analysis via Leximancer software is to provide a picture or conceptual map to aid the interpretation of not only the comments made by SLPPPs but also of the tone of the quantitative data. Feelings which are expressed in the comments of the qualitative data are not available in the quantitative data. The analysis of the data has provided similar themes to those in the current literature such as the importance of professional values, value of autonomy, need for support and professional isolation. However, this analysis has introduced themes of financial pressure facing SLPPPs, a lack of business/managerial skills addressed by on-the-job learning and a concern about survival including the experience of new graduates in SLP PP. The value of the qualitative data in this survey suggests that further case studies would provide a valuable exploration of the issues facing SLPPPs from the perspectives of those immersed in the industry.

5 Discussion

The new themes introduced by the qualitative data: financial pressures facing SLPPPs, a lack of business/managerial skills, on-the-job business upskilling, survival and new graduate SLPPPs, relate to the viability of SLP PP. This research set out to discover the critical success factors of SLPPPs by identifying and rating their success criteria, using a framework based on the work of Gorgievski et al. (2011), with the overall future objective of ensuring and supporting the viability of SLP PP.

This research has uncovered what appears to be a ‘disconnect’ between the main success criteria of SLPPPs: professional satisfaction and contributing to society, and the success criteria usually required for the viability of small businesses, business and innovation. SLPPPs’ preference for success criteria is guided by professional values and professional socialisation. A drive for professional competence was an important consideration, to establish a reputation for quality service and referral networks producing sustainable business in a niche market similar to the OT PPs studied by Milstead (2013). Like the OTs studied by Milstead, the SLPPPs report on-the-job learning to build business skills, a low level of business qualification and prior business experience amongst the participants contrasting with evidence for a stable and experienced SLP PP workforce provided by the participants.

Despite a high level of self-rated success, the responses in both the quantitative and qualitative data provided by SLPPPs showed concern for the survival of their businesses. Currently, SLPPPs are facing a changing business environment (Boxall & Purcell, 2011; Gorman, 2015; Milstead, 2013) and introduction of targeted funding available to private sector health service providers (Appendix F, comments: 36), (The Speech Pathology Association of Australia, 2014b). These issues are perceived to increase competition (Appendix F, comments: 3, 12), reduce business survival (Appendix F, comments: 6, 45) and increase the need for regulation (Appendix F, comments: 7, 27) and training (Appendix F, comments: 7, 12, 24, 38) for inexperienced and new graduate SLPPPs.

There may be a difference between the success criteria of SLPs who require PP as a main source of income (Appendix F, comment 20), and those who do not (Appendix, comment 11). Separation of these two groups may be beneficial for future research as those SLPs who rely solely on generating an income from their business, may provide specific insight into the challenges of business viability for SLPPPs.

This discussion takes account of the literature reviewed in Chapter 2, and builds upon the results given in Chapter 4, in order to address the purpose of this research which is to establish the critical success factors for SLPPPs in NZ and NSW. The demographics of the sample and validity of participants' representation of the SLP PP population of Australasia, is discussed. The discussion progresses to the five research questions related to participants' success criteria, the self-rating of performance on the 11 success criteria, and the use of the self-assessment of performance to establish a *high* or *low total success rating* to identify links between self-rated success and factors identified by the literature as critical to business success.. The themes of the qualitative data regarding professionalism, with reference to the relationship between *PP/business*, and, *PP/SLP values*, are integrated with the results of the quantitative data. The demographic similarities between the two groups, NZ and NSW, are established and due to the small sample size of the NZ SLPPPs, the samples are combined for discussion of the abilities and opportunities leading to high or low performance in PP. The conceptual framework established in the review of the literature is adapted with reference to findings of this research.

5.1 Demographics

The purposive sampling in this research required a reasonable representation of SLPPPs in two Australasian populations, NSW and NZ, to produce a valid analysis of the qualitative data. It has been argued that the same group of participants who can provide a statistically representative sample may not provide adequate information for qualitative analysis, if purposeful sampling is used alongside mixed method research (Sandelowski, 1995). The dilemma may be resolved, according to Sandelowski, if there are '*articulate informants whose selection for the qualitative portion of a combined study can be justified as purposeful*'. Although an assumption can be made that the participants in the current study, all qualified SLPs, are articulate, how representative they are of the population requires examination of the demographic data.

The demographic profile of the sample is similar to Australian national SLP PP profiles (Australian figures are used here as no recent demographics are known for NZ SLPPPs). The gender of the participants, 100% female, is similar to the national figure for Australia; '*97.5%*' female (Health Workforce Australia, 2014, p 12). The largest age grouping for SLPPPs nationally is in the '*25 to 29-year age group*' (Health Workforce Australia, 2014, p.8), but in the current study sample PPs were older, with most aged 30-34 years as seen in Appendix E.

Figures for age demographics of SLPs are not available for PPs, only for the overall profession. The number of PPs from a rural location in this sample (4.2%) was less than the national figure for PPs (8%). The figure for Australian PP based in cities in this sample, 54.7%, is less than the national figure for SLPs (not just PPs), based in cities (76.6%). The percentage of NZ SLPPPs based in cities (93.3%) with no NZ SLPPPs in the sample in rural locations, is different to the Australian profile, however no figures are available for comparison of location of the total population of SLPPPs in NZ. The distribution of ethnic groupings was similar for both samples with no indigenous representation for NSW, or NZ, despite the national figure of 0.21% of SLPs identifying as Aboriginal or Torres Strait Islander in Australia. Although the sample provides a reasonable representation, for statistical purposes demographic differences noted here will reduce the ability to generalise the findings to the wider population. This research also highlights the need for both NZ and Australia to develop more detailed information on the PP workforce.

The size of the sample in quantitative analysis, according to Speed (1994), is less important than its validity. The sample size of 110 participants, with a 11.3% response rate from the NZ sample, and a 6.3% response rate from the NSW sample, provided small actual numbers for the NZ component of the sample. Given the small percentage of NZ participants and the similarity between the demographics of participants in the two countries the two samples were combined for further analysis. This increased the overall sample size and slightly reduced the possibility of a type II error (improved statistical power).

The nature of SLP businesses also varied slightly from national statistics. The figure for sole trader status, is higher in this sample (78.9%) in comparison to the Australian national figure (50%) (The Speech Pathology Association of Australia Limited, 2015). Comparable NSW figures are unavailable. However, the distribution of (business) experience in PP was similar to the national figures in every age grouping with the maximum variation of 3.7% occurring in the majority experience group of 1-5 years (30% nationally versus 33.7% in this sample). It is unlikely that new graduates are under-represented, in the participants of this survey, given that they are higher than national figures for businesses. The percentage of NSW PPs working part time in this sample was slightly higher, at 62.1%, than the Australian national figure for PPs; 58% (The Speech Pathology Association of Australia, February, 2015) and the NZ figure in the sample; 53.3%. Although these differences need to be considered in any discussion of the results provided, they were not significantly correlated with the total success ratings and hence are unlikely to be important differences in the sample.

It is also likely that the means of recruitment, through an advertisement to NZSTA or an email to the NSW PP Members Network (a sub-group of SPA), provides a higher representation of PPs who are SPA/NZSTA members than in the population of SLPs in the workplace. However, it is likely that SPA membership is high among PPs in NSW, as eligibility to access government funding is linked to SPA membership. In an effort to address this bias in NZ, the advertisement for participation was also placed on the NZ speech-language Therapists' Facebook page, which has no access requirement for NZSTA membership. Despite this, 100% of participants, in this survey, were members of their professional body and hence it seems likely that a large proportion of PPs are members of a professional body in NZ and Australia.

An important assumption of this research is that individual PPs are synonymous with “*the business*”. Milsteed (2013, p.174) argues that individuals in small professional service firms can be seen as “*the business*” in that they are totally involved in business operationally and strategically. This is in part validated by the large percentage of sole traders in this sample, and the small number of employed SLPPPs. Additionally, the client-centred nature of SLP as a health service means the individual's performance is the performance of the business. The research questions relating to success criteria are directed to the SLPPPs and the CSF are directed to the PP.

Overall, we can conclude that the known demographics provided by the study sample is a reasonable representation from which to make assumptions about the population of SLPPPs in NSW and NZ, provided the reader is mindful of the differences that exist.

5.2 Research Question 1: What are the success criteria of speech language pathologists working in private practice in Australasia?

A pattern of success criteria was established for the Australasian SLPPPs in this survey. Although there were some similarities the rank order of the success criteria differed from that of Gorgievski et al. (2011) and the ranking is specific for this group. Unlike Gorgievski et al.'s survey, the *values* of participants were not examined in the current study and could not be compared to participants' success criteria. The success criteria of SLPPPs formed four sub-groups after factor analysis that could be identified semantically as: *professional satisfaction*, *contribution to society*, *innovation*, and *business*. These sub-groups of criteria are listed in the order of the SLPs' level of mean agreement with their importance, as success criteria. It is

likely that SLP professional values contributed to the different pattern of success criteria in comparison to Gorgievski et al.'s participants who were small service industry business owners. The inclusion of *professional satisfaction* as a success criterion for SLPPPs was validated as this group ranked it as the second most important success criterion. Inter-item reliability testing showed that the BSCIS is a robust measure of success criteria for SLPPPs and the inclusion of each of the eleven success criteria important for the reliability of the measure.

The first four highest ranking success criteria for this sample: *satisfied stakeholders*, *professional satisfaction*, *utility* and a *balanced home-work life*, complement the research finding that the traditional start-up objectives of small business owners (and motivators for the retention of SLPs) are not financial or business growth, but instead consist of other factors such as flexibility to maintain a lifestyle balance (McLaughlin et al., 2010; Walker & Brown, 2004) or “*mastery of the profession*” (Milstead, 2013, p.179). PP may provide a way for SLPs to maintain flexibility to balance family commitments and continue to maintain professional expertise/skills; only 33.6% of the SLPPPs work full-time. SLPPPs who fit this type of profile may not require profitability from a PP business income; the SLPPPs may be members of a family with other financial contributors

The primacy of the sub-grouping *professional satisfaction* in comparison to *business* ($M = 6.48$, $M = 4.95$ respectively) is evidence that the SLPPPs in this research, like the occupational therapy owner-operators in Milstead's research, see themselves primarily as health professionals and less as business people. This may be related to the professional values or professional socialisation required to maintain professional satisfaction (Kenny & Lincoln, 2012; Milstead, 2013). This is consistent with earlier work by (Milstead, 2013, p.177) who found that ‘*professional enculturation in caring professions...over-rides their desire for business success*’. The high failure rates for small businesses and need the need to develop business skills to survive (Luisser & Halabi, 2010; G. D. Markman & Baron, 2003; Milstead, 2013) may mean that the primacy of technical skills over business skills places small businesses in a precarious position of business risk. While success is defined by the participants subjectively in terms of professional goals, it does not guarantee business viability.

5.3 Research Question 2: Can speech language pathologists working in private practice self-rate their own performance on questions relating to 11 success criteria in order to measure the success/viability of speech language pathology private practices?

The subjective nature of self-assessment of business competence means that the findings are open to bias, however, studies show a “*strong relationship between perceived and actual business competencies*” (Milstead, 2013, p.191). The PPs in this sample were able to self-rate their own performance on questions relating to each of the success criteria of the BSCIS in order to provide a measure of their own performance. A *high* or *low* total success rating score was established for each participant. SLPPs in this sample mostly experience success, with 70.9% of participants’ ratings showing a high level of total success. The self-ratings were analysed within the sub-groups identified in the success criteria. Participants rated their performance highest in the sub-group, *success in contribution to society*; then *success in professional satisfaction*, *success in innovation*, and finally, *business success*. All of the success ratings sub-groups, had some degree of agreement with achievement.

The sub-group of *success in contribution to society*, made up of that success criterion and *utility* (usefulness), reflects the professional values of SLPs. Both “*The Constitution of, The New Zealand Speech-language Therapists’ Association*” (The New Zealand Speech-language Therapists' Association Incorporated, 2015) and “*The Charter of The Speech Pathology Association of Australia*” (The Speech Pathology Association of Australia, 2010b) outline altruistic motives for the profession. The professional values of SLPs (contribution to society) have the highest mean level of agreement with achievement, and are in the prime position on the qualitative data conceptual map (Figure 16). Not surprisingly, SLPPs are most successful in achieving professionally as SLPs. Similarly, achievement in a ‘mastery of practice’, unique among the success criteria of other small service businesses (Gorgievski et al., 2011; Walker & Brown, 2004), was also observed by Milstead (2013) for occupational therapists in PP.

The order of the first two success criteria sub-groups is reversed in the achievement scores, based on the SLPs self-ratings of success. This suggests that it is easier to achieve *success in contribution to society* than *professional satisfaction*. Caseload size with resultant work intensification is associated with job satisfaction (Harris et al., 2009; Hutchins et al., 2010). While it is known from the literature that PPs report less pressure from waiting lists to

provide evidence based therapy (Cheung et al., 2013), PPs in this sample did report work intensification pressures such as difficulty maintaining a work-life balance (Appendix F, comments 17, 19, 21 & 29), time pressure (Appendix F, comment 26), and financial pressure (Appendix F, comments 4, 5, 8 & 21). Although PPs in this sample rate themselves with a high mean level of *professional satisfaction*, reported work intensification may have reduced PPs' ratings for professional satisfaction.

There may be a heterogeneity in the sample causing differing success criteria across participants. For example, some SLPs who are motivated predominantly by professional satisfaction, may want to work only to retain professional skills and not want to make a profit as a second income earner in a household. Other SLPs may need to make a profit and show financial stability as an income earner. A correlation was found between success criteria subgroups and success ratings subgroups suggesting that PPs are successful for the criteria they set for themselves.

The self-rating of achievement against success criteria provides a measure of personal achievement but not necessarily success of the business. Participants were able to rate themselves on the success criteria, providing a measure of their own achievement, however, this was a measure of self-rated personal success, not the viability of PP. Effectively, PPs who derive great professional satisfaction from SLP PP but do not make a profit may rate themselves as having a high level of success but may not have a viable business without an external source of funding. SLPs' perceptions of the viability of PP businesses is concerning given the results of both qualitative and quantitative data. While the mean scores for achievement in sub-groups: *success in contribution to society* and *success in professional satisfaction*, rate around the *agree* (6) rating, there is only provisional agreement around the *somewhat agree* (5) rating, for *success in innovation* and *business*. This is also reflected in the qualitative data with the position of *business* under *private practice* on the conceptual map seen in Figure 16, Chapter 4. The sub-group *business success* comprises *survival*, *growth*, and *profitability*; which rank in the lowest five categories. The six lowest ranking success categories: *survival* (ranked 11), *public recognition* (ranked 10), *growth* (ranked 9), a *work-life balance* (ranked 8), *profitability* (7) and *innovation* (6), were rated with a mean score around five or under. This means that most SLPs in this sample cannot say they *agree* that their businesses will survive, that they get the recognition they deserve, that they want to grow their business, that they have established a work-life balance, or that they receive adequate financial remuneration. All of these issues were highlighted in the themes arising from the concept map seen in Figure 16.

Participants reported concern about their business survival or viability (Appendix F, comment 6), an over-population of PP in some areas (Appendix F, comment 45), and an influx of new graduates (Appendix F, comment 12). However, the similarity of ‘*years in current role*’ and ‘*years in PP*’ shows stability across the sector. The percentage of PPs who have over five years in their current role is 53.5%, and over five years in PP is 59%, showing a high level of experience in the sector. In addition, 37.3% of PPs have over 20 years’ experience, and 69.1%, over 10 years’ experience as SLPs showing that SLPPPs are highly experienced SLPs. Only 2.7% have under one year’s experience as SLPs and 10% between 1 to 5 years’ experience, showing that few PPs begin PP as new graduates. Despite growth in the sector in NSW (The Speech Pathology Association of Australia, February, 2015) and in NZ (The New Zealand Speech-language Therapists’ Association, 2015), there is a high level of professional depth in human capital, business stability and viability based on the current survey. The rating of achievement based on the success criteria of SLP can measure personal performance but the apparent perception of reduced business viability does not match the actual long term stability of SLP PP.

Assuming a “*strong relationship between perceived and actual business competencies*” (Milstead, 2013, p.191), perceptions of reduced business viability may indicate changes about to occur in the industry. The snapshot of business stability provided by current figures of longevity and the experience in the sector may be an indication of past stability. It may be that probing SLPPPs’ perceptions is a sensitive indicator of the expert opinion of SLPPPs. Changes are occurring in the industry (Kenny & Lincoln, 2012; McLaughlin et al., 2008) with an increasing number of clients and growing pressure on government funds for services. Government strategies to address this issue include devolution of services into the private arena (Gorman, 2015; Milstead, 2013). A lack of growth to meet demand for SLP services in the public sector (K. Wylie et al., 2013) and increasing numbers of new graduate SLPs (Brownfield, 2015; Health Workforce Australia, 2014, p.19) have aided growth in the PP sector. The regulated and supported job structure of public service departments of health professionals is changing (Gorman, 2015; Mueller & Neads, 2005). Some participants report reduced supervisory and collegial support (42% report some level of disagreement to the statement ‘*I am adequately supported by supervisory staff or colleagues in my current role*’) and a lack of advancement opportunity in PP (only 21% of participants report they agree or strongly agree that they have advancement opportunities in their current role). The perceptions of PPs that there is a lack of job structure to support new graduates in the private sector

(Appendix F, comments: 3, 12, 24), is supported by the data. Fears are expressed by participants that inexperienced SLPs who are unsupported in PP not only face business risk, but can pose clinical risks to clients (Appendix F, comments: 24,27,28). Although these fears are currently unsupported by evidence in this research, they warrant further research that could induce action to increase training, support and career structure within PP, in order to stabilise the sector.

5.4 Research Question 3: What are the critical success factors for private practice, used by speech language pathologists who self-rate with high levels of success on the 11 success criteria?

CSF are the practices that must occur in a business in order to ensure success. The covariation or correlation between the total success rating, and business practices identified in the literature, were examined in order to identify CSF for SLPPPs. Factors that rated with significant co-variation or correlated with the total success rating were included as CSF. However, covariation or correlation of a lone factor does not guarantee causation; spurious influences must be ruled out and the influence of other factors identified. The factors identified by this research can be seen to impact upon each other such as provision of professional education impacts upon the provision of evidence based practice. Performance theory (Boxall & Purcell, 2008, p 5) was used to quantify the relationship between the factors and performance using the relationship: '*Performance = Ability.Motivation.Opportunity*'. The possible factors were separated into '*ability*' or '*opportunity*'. Motivation was not addressed by this survey. It is acknowledged that SLPPPs must have adequate motivation to perform; the level of SLPPPs' motivation is not quantified by this research. No attempt is made to quantify the relationship only to use it as a multiplicative relationship to identify the CSF within '*ability*' or '*opportunity*' for SLPPPs. Examination of the factors includes identification of other factors which may support or detract from their possible influence.

5.4.1 Abilities

The '*abilities*' identified by this survey as CSF were: on the job and PP experience; personal characteristics: resilience and personal efficacy (time management skills); and professional competence: providing EBP, ethical practice, and undertaking professional education.

5.4.2 On-the-job learning

There was no co-variation between SLP/business qualifications, or correlation between business experience, and total success rating. However, experience in PP current role and in PP correlated with the total success rating. Milsteed et al. (2013) found that on-the-the job learning was an effective way of developing managerial competencies for occupational therapy owner-operator PPs. The growth of business skills on-the-job is also documented in PPs' comments (Appendix, comment 15) and growth in the value of business skills are heard in the comments of PPs: "*The reality of running a business has taught me to value my time and my expertise!*" (Appendix, comment 9). The value of on-the-job learning for SLPPPs has implications for supporting junior therapists not only in clinical skills but also developing business competencies. New graduate SLPs intending to pursue a career in PP may benefit from on-the-job experience as part of clinical education with a business focus. In addition, the small numbers of SLPPPs accessing mentoring when mentoring programs are available and access able via SPA's website www.speechpathologyaustralia.org.au, requires further research.

5.4.3 Personal characteristics

The personal resilience of nursing staff (McAllister & McKinnon, 2009) and allied health practitioners (McCann et al., 2013) is associated with an ability to cope with professional stress and trauma. The same resilience allows entrepreneurs to cope with business risk (Ayala & Manzano, 2014). Accordingly, a high level of resilience is required by professionals in small service industries which face high levels of business failure (Griffith & Wilkinson, 2012; Ministry of Business Innovation and Employment, 2015; Wilkinson, 2005). It is not surprising that SLPPPs self-rate high personal resilience, and that high resilience is correlated with the total success rating. It is possible to use knowledge about the importance of personal resilience to SLPPPs, to select staff who are resilient and provide training to increase the resilience of health professionals (McAllister & McKinnon, 2009) currently in PP.

Highlighted underservicing of minority groups and indigenous populations (K. Wylie et al., 2013), presents an ethical issue for SLPs to ensure accessibility and availability of appropriate services. The causes for underservicing may stem from a lack of workforce from similar ethnic groups or barriers to services such as financial, language or cultural barriers. Building cultural literacy is one way to personally address this issue. Participants' high level of agreement with the statement: "*I have a high level of cultural literacy relevant to my current*

role” is an indication of the commitment to addressing inequality in PP. A correlation was found between high cultural literacy and total success rating. However, the comment of one of the SLPPPs (Appendix F, comment 35), expresses a lack of support from colleagues on the basis of ethnic group, suggests broad strategies which build cultural literacy and competency across the sector are required.

Time management is recognised as a stress factor for PPs (Severn et al., 2012). Time pressure was also a theme of concern identified by participants (Appendix F, comment: 21, 26, 29) despite rating themselves with a generally high level of personal efficacy, shown by time management skills. Time management skills were also identified in the industry as management skills important for new graduate SLPs (Lincoln et al., 2001). Despite this acknowledgement only 15.5% of self-employed SLPPPs in this sample employ administration staff. Employing SLP support staff increases productivity (Kummer, 2014). The development of management competencies to develop strategies to reduce time pressure or to structure practises to maximise productivity may also maximise SLPPPs’ time management abilities.

5.4.4 Professional competence

The provision of evidence based practice (EBP) is supported by professional bodies, SPA (The Speech Pathology Association of Australia, 2001), and, NZSTA (The New Zealand Speech-language Therapists' Association Incorporated, 2015), and the SLP literature (Cheung et al., 2013; Ferguson & Armstrong, 2009; Roddam & Skeat, 2010). A relationship exists between providing EBP and job satisfaction (Kenny & Lincoln, 2012; McLaughlin et al., 2008). Participants expressed pride in providing EBP and concern regarding a lack of EBP (Appendix F, comments: 6, 24). The relationship between provision of EBP and the total success rating suggests that it also impacts upon success. Therefore, an understanding of, and commitment to, the provision of EBP, and a business structure that allows access to appropriate support and resources, aids the success of the SLPPPs. The provision of professional education is a part of the process of acquiring EBP in PP, but it also includes provision of non-clinical learning such as development of business competencies. Professional education is undertaken by most participants indicating health in the sector as ongoing professional development is a mediator of stress (Keane et al., 2011) and linked to retention of SLPs (McLaughlin et al., 2008). Effectively, a commitment to EBP, and professional education, is not only a personal but a business decision for SLPPPs.

Ethical practice is important both for clinical and business practice. Specific ethical concerns in PP, related to the code of ethics are known: “*balancing benefit and harm, fidelity of business practices, distributing funds, and personal and professional integrity*” (Flatley et al., 2014, p296). This research shows that while most participants can easily reconcile ethical issues that arise in PP, issues regarding business versus clinical priorities (Appendix F, comment 26), and ensuring all SLPs are providing a high standard of care (Appendix F, comment 24), continue to concern SLPPPs. Given the importance of ensuring ethical clinical and business practice the issue of accountability and accreditation of PP (Atherton & McAllister, 2009) is not only important for the sector but also for the profession. Professional associations provide professional governance supporting ethical practice. The high level of affiliation (100%) with professional association, although biased by the recruitment of participants mainly through SPA/NZSTA website or member networks, acknowledges this professional governance.

Regular professional supervision is a professional competency. Supervision is a way of ensuring clinical standards and also providing/receiving support (The Speech Pathology Association of Australia, 2014d). Ostergren et al. (2011) were able to show the benefit of supervision for SLPs in their first year of practice. SPA (2014d) recommend supervision for all SLPs. However, 22.7% of participants do not engage in clinical supervision at all. Engagement in supervision, rates with a significant covariation of ranked means with the total success rating, at a 99% *CI*. Given that supervision is one way of encouraging and supporting EBP and ethical practice, it is not surprising that the existence of supervision correlates with the total success rating. The benefit of supervision to business success requires further exploration. However, given that supervision supports EBP, ethical practice and provides support to SLPs, mandating supervision or linking supervision to funding may increase well-being and accountability of the sector.

5.4.5 Opportunities

The opportunities identified as CSF were: business structure: business type and employing other SLPs; business strategy: empowerment in the strategic direction of the PP, use of a cost-value propositions, and caseload age; financial capital: adequate start-up capital, adequate resourcing, manageable caseload, use of technology, clear financial documentation, financial processes and policies in place; human capital: advancement opportunities and ability to attract staff; marketing: challenging the assumption of referrers; management practices:

leadership practices: supervisory support, shared decision making, involvement in reviews of business plans; documentation: a comprehensive business and an effective information management system plan in place; business adaptability: key areas identified for change are addressed; support for innovation and business support; social capital: effective teamwork, regular business-to-business networking with referrers and involvement in mentoring; and professional practices: ensuring a range of clinical policies and practices in keeping with professional standards.

5.4.6 Business structure

Business structure is a CSF for SLP PP. Most PPs were sole traders and approximately half of the sole-traders rated with a high total success rating. PPs with a registered company or in a partnership all rated with a high total success rating. Business type, and employing other SLPs, significantly co-varied with the total success rating. Registering a company or partnership costs require more start-up-capital. Participants' agreement with having adequate start-up capital was correlated with the total success rating. These types of business structures are usually associated with businesses that are not Home-based businesses (HBB) and are larger. Therefore, operating as a registered company or partnership may lead to a more stable business structure potentially as larger businesses experience less failure (Griffith & Wilkinson, 2012; Ministry of Business Innovation and Employment, 2015; Wilkinson, 2005). More investment in business may also indicate more commitment (motivation) to ensure business survival and success.

5.4.7 Business strategy

Empowerment in a business vision or strategic direction of a business is a mark of commitment to an organisation that stems from the strategic direction of the business. Few participants who rated with a high total success rating disagreed with the statement of empowerment with the vision or strategic direction of the business (see Figure 12, Chapter 4). A psychological contract is the assumed understanding or '*reciprocal expectations*' between employer and employee (Boxall & Purcell, 2011, p219; Flower et al., 2015, p107; Tan, 2006). However, there is the potential for the psychological contract for SLPPs to be seen between the business and the PP (clinical)/PPs. In this scenario employees and owner-operators, would require a commitment to the PP. It can be seen that the strategic direction or vision links the

business with the PP (clinical) in order to address the separation between the business and PP as shown by the themes in the qualitative data (Figure 17 Chapter 4).

Although further research is required to clarify this possibility, examples of PPs defending their strategic direction were observed in the comments: *“I do not ... like the stereotype that 'some' people have that being in private practice is all about the money”* (Appendix F, comment 38); ‘some people’ may hold a perception of disconnect between the practice of SLP (clinical) and the money (business). The strategic vision of the PP follows: *“...that is not my drive (however I believe if you are passionate about what you do, the money follows also)”* (Appendix F, comment 38). Comparably, Tan (2006) found SLPs in the public service had a psychological contract only between themselves and their employer, and not colleagues, clients or the profession, with whom the SLPs perceived an obligation with no expectation of response. There is an expectation of payment for SLP work in the public system (Tan, 2006), which does not require a psychological contract with the business of the client as payer of the service as it does in PP. It is possible SLPPs have different types of psychological contracts than SLPs in the public service. However, there is the same expectation from the public service business, and from the PP business, of high quality service provision from SLPs. It may be helpful for SLPPs to be aware any psychological contracts with the business of the PP. Further research regarding the psychological contracts of SLPPs is necessary.

Strategic planning that includes appropriate market orientation is associated with the CSF of a small businesses (Yusuf, 1995a) . Employing competitive strategies such as cost value propositions requires a business to think about their target market (Johnston et al., Dec 2008). Market orientation is also required when targeting a caseload of a certain age. Cost value propositions were correlated with the total success rating. Some participants addressed poor market orientation in their comments about providing business in over-serviced areas (Appendix F, comments: 15, 45) supporting the need for careful consideration of the market prior to beginning services.

5.4.8 Human capital

The human capital factors correlated with the total success rating, are: availability of advancement opportunities and ability to attract new staff. Only approximately one third of participants agreed, at some level, with the presence of these factors in their PP. Yet their presence is an indication of business stability and growth; a SLP business must be growing, to require new staff and promote job structure within a business. However, business growth (rank

= 10) and survival (rank = 11), ranked the lowest of the success criteria and had the lowest rating success (9 and 11, respectively). Few SLP PP businesses are orientated toward the goals of business growth and survival which are two of the traditional makers of business success (Gorgievski et al., 2011; Milsteed, 2013; Walker & Brown, 2004). However, if the growth in the sector continues, and SLPPPs want a professional structure, more businesses will need to orientate towards the growth and survival of PPs.

5.4.9 Financial capital and competence

Financial capital competence are CSF in other small businesses (Jasra et al., 2011; Kennedy & Tennent, 2006; Luisser & Halabi, 2010; Rainer & Papp, 2000). Not surprisingly, all aspects of financial practices such as clear financial reporting, adequate start-up capital, processes for ensuring adequate cash flow, adequate resourcing, a manageable caseload and use of technology, were correlated with the total success rating. This research supports financial capital and competence as a CSF for SLPPPs. However, there were issues apparent in the profile of the financial capital and competence of PPs. Although the majority of participants reported they were adequately resourced, 14.7% of participants could not agree at any level, that they had a manageable caseload. Given that caseload size and work intensification are associated with increased stress (Harris et al., 2009), reduced retention (McLaughlin et al., 2010) and job dissatisfaction (Kenny & Lincoln, 2012; McLaughlin et al., 2008), caseload manageability is concern for the sector. Despite the lack of start-up capital required, potentially due to the gradual development of businesses described in the comments (Appendix F, comments: 6, 22), businesses investing more in business type have higher rates of high total success, as discussed. Concern regarding the lack of development of financial competencies were expressed by participants (Appendix F, comment 38). Given the importance of financial capital and competences to business success and viability it may be beneficial for SLPs starting-up in PP to have some training to build financial competence.

5.4.10 Marketing

The only marketing factor to be correlated with the total success rating was regularly challenging assumptions of referrers. The ability to regularly challenge the assumptions of referrers involves regularly talking or corresponding with the referrers. This involves building social capital similar to business-to-business networking which was also correlated with the total success rating. SLPs can challenge the assumptions of referrers when presenting evidence

based practice or research. Achieving this marketing CSF, encompasses PPs' professional competence and social capital, showing CSF that are abilities and opportunities do co-influence performance. This re-enforces the performance theory equation: '*Performance = ability.motivation.opportunity*' (Boxall & Purcell, 2008, p 5).

5.4.11 Management practices

High involvement work practice (HIWP) is a leadership style engaging employee voice (Boxall & Purcell, 2011; Cox et al., 2012; Kouzes et al., 2015) by involving staff in decision making. HIWP can be seen as antithesis of 'Taylorist' approach to management (Peaucelle, 2000), which involves increasing productivity by mechanising tasks. Professional service industries suit a HIWP management style (Boxall & Purcell, 2011). Accordingly, shared decision making, involvement in regular reviews of a business plan/strategic plans and quality improvement plans to improve the productivity of PP, and supervisory or collegial support, are correlated or co-varied with the *total success rating* in this research. Despite a high level of agreement with shared decision making, 93.6%, there was a lack of agreement with involvement in reviews of productivity of 42.7%, and with provision of adequate supervisory or collegial support of 41.8%. The high level of involvement in decision making shows that SLPPPs are using HIWPs, however, reduced involvement in reviews of productivity suggests that PPs are involved in clinical decision making but not necessarily business decisions. Involvement in business decision making would aid PPs to develop on-the-job business competencies.

The lack of supervisory or collegial support reported in both qualitative and quantitative data, is concerning, as support mitigates work stress (McLaughlin et al., 2008). Although supervision is associated with professional support (Ostergren, 2011), and recommended by SPA (The Speech Pathology Association of Australia, 2014d), close to a quarter of participants do not engage in clinical supervision at all, and close to a third have irregular supervision. The lack of support for PPs within practices, and sole practitioners (Appendix F, comments: 2, 28), is documented by participants. Ensuring support prior to setting up a practice or maintaining an evaluation or review of support as a key performance indicator, then addressing support needs, in existing practices, may be one way to ensure the use of this CSF for SLPPPs.

Clear documentation including comprehensive business planning, is recommended by experts in the field (Dorando-Unkle, 1995). Although clear job descriptions were associated with retention in rural and remote areas in Australia (O'Toole et al., 2008), job descriptions

were not associated with the total success rating for SLPPPs. However, both a comprehensive business plan and a comprehensive information system for client management, significantly co-varied with total success rating. Business planning is related to the strategic direction of the business; it is a link between the clinical and business components of SLP PP. A business plan which provides clear documentation of strategic planning such as: strategic vision/direction, market orientation, a cost value proposition, financial processes for funding services and cash flow, human resource strategies to build career advancement and attract new staff, identified referral networks with planned regular contact, identified support networks with planned regular contact, a HIWP leadership strategy, and planned reviews of plans with scope to address key areas identified for change; would have the scope to bring together the identified CSF and document them with key performance indicators.

Business adaptability is important in a changing marketplace. It is important to identify key areas that require attention in a business such as a lack of a support. However, once identified those key areas for change, need to be addressed. Approximately half of the participants indicated with that “*issues identified as key areas for strategic change are addressed appropriately.*” Involving staff in the processes of identification and change as part of regular review of the business plan, is another example of the inter-relationship of several CSF.

The use of government or business support is identified as a CSF in the literature (Jasra et al., 2011; Yusuf, 1995a). Most participants, 74.5%, use some type of business support; mainly reporting book keeping support. Despite the significant covariation, between the *use of support* and the *total success rating*, it is surprising that there were not more PPs using business support such as in human resources, business coaching or financial planning (which were used by under 20% of participants).

5.4.12 Social capital

A model of individual performance has been used to combine the CSF for PPs due to the small size of individual SLP PP businesses. The performance of organisations is given by “*organisational performance outcomes*” are equal to “*workforce: organisation, capabilities and attitudes*” (Boxall & Purcell, 2011, p7). The aspects of ‘organisation’ associated with organisational performance are also relevant for the individual performance for the SLP sole trader and small business engaged in building social capital to facilitate the performance of the business. Effective social capital and social competence are integral to small business

performance and are a CSF for many businesses (Chawla et al., 2010; Clark & Douglas, 2014; Jasra et al., 2011; Luisser & Halabi, 2010; Yusuf, 1995a). Inter-professional communication in healthcare is extremely important in decision making for SLP clients (Fouch et al., 2014) and managerial learning is associated with “*engagement with external business environments*” (Milstead, 2013).

Effective teamwork, regular business-to-business networking and mentoring were all correlated or co-varied with total success rating. Most participants reported effective teamwork with a cumulative percentage of 91.8%, rating at least some level of agreement. This means cross-business teamwork for sole traders and most small businesses. Therefore, it is not surprising that 53.6% of participants indicated regular business to business networking. Another source of regular contact with other professionals is to engage in mentoring. The most frequent form of mentoring is *informal mentoring*, with 65.5% of participants engaged. The *existence or non-existence of mentoring* significantly co-varied with the total success rating but no correlation was found for business network affiliations with total success rating. This was also confirmed by the comments of SLPs that networking with direct referral sources was a better business decision (Appendix F, comment 14). Effectively, the social capital of SLPPPs needs to be directed toward a SLP specific market.

5.4.13 Professional practices

The only professional practice correlated with the *total success rating*, was a *range of relevant policies and procedures specific to client management and SPA/NZSTA standards in place*. As previously stated professional standards of practice held by professional bodies provide the consumer an undertaking that members can be expected to practice within those standards. Professional learning programs certified by professional bodies such as CPSP certification provides some guarantee of professional standards and ongoing professional development/monitoring, to justify the validity of funding bodies’ expenditure. Membership of a professional body and adherence to standards of practice for a SLPPPs provides not only clinical but also business advantages.

5.5 Research Question 4: Can critical success factors relevant to speech language pathology private practice be indicated by specific key performance indicators in order to monitor ongoing success in Australasia?

The concept of KPI is well known in business (Hirst, March 2013) and healthcare (Gillean et al., 2006). Maintaining effective indicators of behaviour is an existing professional skill of SLPs. Although not all of the abilities and opportunities identified by this research can be identified by KPI, many KPI can be identified for SLP PP. Some 'abilities' identified as CSF by the research, not able to be used as KPI such as 'personal resilience', can be used as selection criteria for new staff or self-evaluation in existing practices within training programs or supervision to build those skills. The KPI able to be used from CSF within the 'opportunities' of a PP can be separated into planning activities, behaviours, processes and resources. The planning activities would include: business strategy, business structure, market orientation, and a business plan. The behaviours include: EBP, ethical practice, HIWP, documentation, reviews, business-to-business networking, teamwork, mentoring, supervision and professional education. The processes are: financial processes, information systems, and clinical policies and procedures relevant to SPA/NZSTA standards. The resources are: start-up funding, adequate resources including technology.

A business plan could be written including the identified CSF as: planning activities, behaviours, processes and resources. Each aspect of the business plan could be linked to KPI. For example: the planning activities could be checked with key indicators: Is there an appropriate business structure? Is there a cost-value proposition to customers? Is there a strategic vision that links the clinical and business goals? Is there a clear market orientation?, Is there a comprehensive business plan in place? The same types of check lists of KPI which correspond to the CSF could be identified for behaviours, processes and resources. Examples of KPI targeting behaviours related to CSF are monitoring client satisfaction via surveys or monitoring the completion of staff training or supervision. Examples of KPI targeting processes is monitoring lost revenue from client cancellations or lost time from staff illness or injuries. A KPI related to CSF in resources would be monitoring the use of technology relevant to advances in technology available. The use of KPI in SLP PP would aid the identification of planning activities, behaviours, processes and resources related to CSF.

5.6 Research Question 5: What are the differences in success criteria, success ratings, or critical success factors between SLP working in PP in New Zealand and NSW, Australia?

The only significant difference in demographics between NSW and NZ was in location with no PP working in rural NZ. No significant difference was noted in the distribution of success criteria or total success rating on the basis of country at a 0.05 level of significance. Despite the high response rate in NZ the actual numbers of the sample were too small to test the differences in CSF between NSW and NZ. Given the similarity of the total success rating between countries it can be assumed that differences in government policy, and funding options, do not change the total success rating for SLPPPs.

5.7 Conceptual Framework Revised

The conceptual framework shown in Figure 2, Chapter 1, is largely preserved by this research. A revised model of Figure 2 is provided by Figure 18.

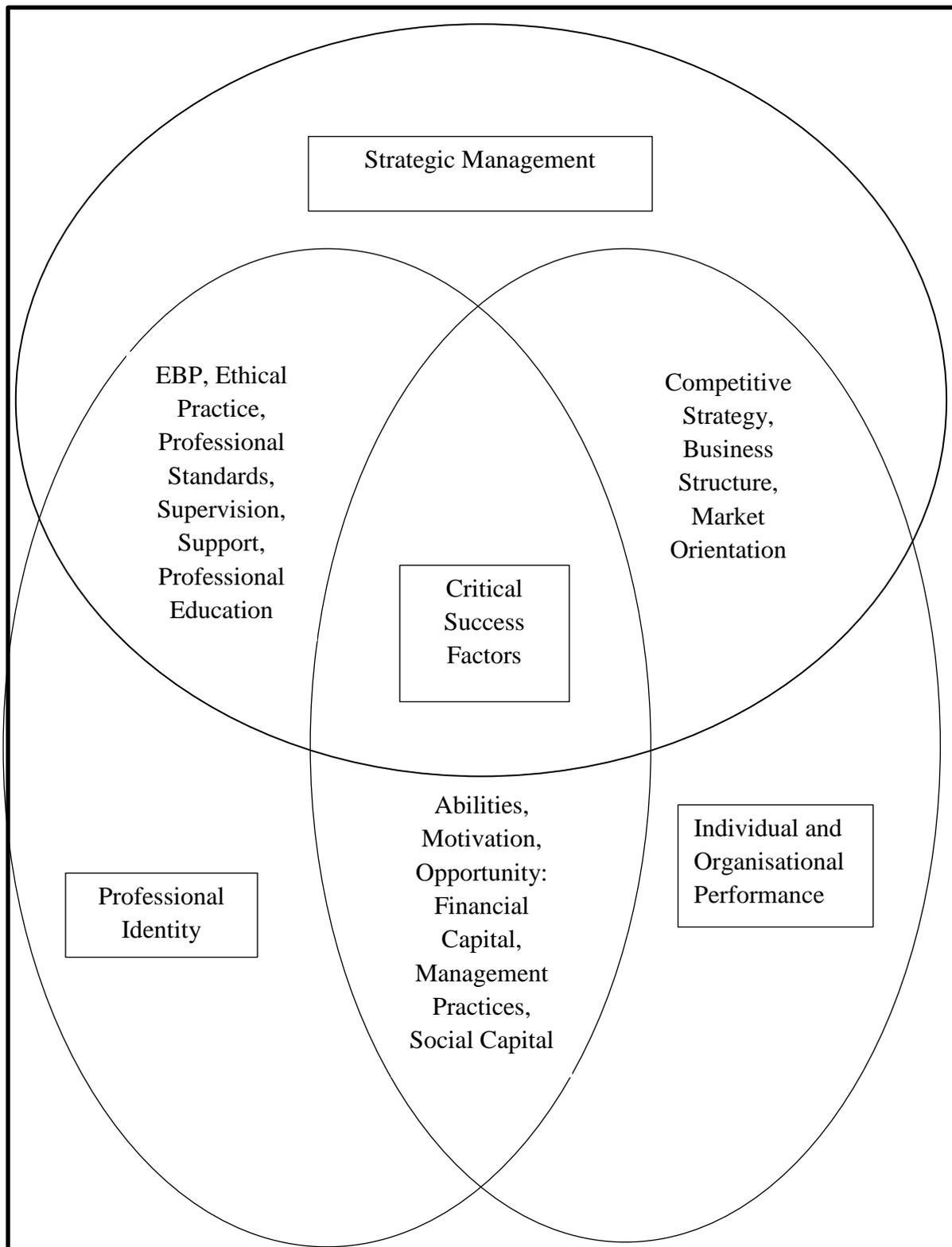


Figure 18. Theoretical framework for speech pathology private practice critical success factors Revised (adapted from the Theory Framework for Applied Disciplines: Boundaries, Contributing, Core, Useful, Novel, and Irrelevant Components (Swanson, 2007, p 328)

Chapter 5 Discussion

The shared areas contain the CSF. The area between professional identity and strategic management has the inclusion of professional standards, supervision, support, professional education, and professional standards (see Figure 18). These factors are directly related to the values of SLPs and support the CSF identified in the literature. Business structure and market orientation are added to the area between strategic management and individual/organisational performance. The human capital factors of career advancement opportunities and ability to attract new staff were not included in the model as they can be seen to rely upon and are included in business structure. In the individual performance/professional identity component opportunity is further elaborated: financial capital, management practices, and social capital; marketing was not included as the only critical factor was *regularly challenging the assumptions of referrers* which can also be seen as a part of social capital.

6 Conclusion

6.1 Discoveries

This research reinforces the demographic information about PPs provided by SPA (The Speech Pathology Association of Australia Limited, 2015) for SLPPPs in NSW and provides needed demographic information for NZ SLPPPs. SLPPPs in NSW and NZ work part-time, they predominantly identify as NZ or Australian with at least a third identifying as European. There is no indigenous representation of SLPPPs participants and only female representation (consistent with over-representation of females in SP in Australasia). The majority of PPs work in cities or regional areas with few rural SLPPPs in NSW and no rural SLPPPs in NZ. Most SLPPPs are sole practitioners and work in paediatrics. They are older than SLPs in the public service with most working in PP for between 1-5 years. The majority of SLPPPs have over 20 years' experience as SLPs. There is little difference between PPs' years in their current role and in PP showing this sector as a stable workforce. As a workforce SLPPPs in Australasia are experienced SLPs, but over half have no business experience, and three quarters have no business qualifications.

The BSCIS provides a reliable tool to measure the success criteria for SLPPPs in Australasia. The success criteria of SLPPPs are specific to the profession and ranked differently to those provided by Gorgievski et al. (2011). The top three success criteria for SLPPPs are: satisfied stakeholders, professional satisfaction and utility or usefulness. The success criteria of SLPPPs can be separated into four sub-groups listed in order of their importance to SLPPPs: professional satisfaction, contribution to society, innovation and business.

SLPPPs can self-rate their own performance on questions directly relating to the success criteria of the BSCIS providing a measure of their own success but not necessarily the viability of PP businesses. Three quarters of SLPPPs self-rated as having a high level of total success. Despite the perceptions of PPs of high achievement in their contribution to society and professional satisfaction, they perceived less achievement in innovation and business sub-groupings. Most PPs cannot say they *agree* that their businesses will survive, that they get the recognition they deserve, that they want to grow their business, that they have established a work-life balance, or that they receive adequate financial remuneration. The perceptions of

Chapter 6 Conclusion

business viability contrast with the stability of the sector given by years in PP and the current role of SLPPPs.

The CSF of SLPPPs were identified as ‘abilities’: on the job and PP experience; personal characteristics: resilience and personal efficacy (time management skills); and professional competence: providing evidence based practice, ethical practice, and undertaking professional education. The ‘opportunities’ identified as CSF were: business structure: business type and employing other SLPs; business strategy: empowerment in the strategic direction of the PP, use of a cost-value propositions, and caseload age; financial capital: adequate start-up capital, adequate resourcing, manageable caseload, use of technology, clear financial documentation, financial processes and policies in place; human capital: advancement opportunities and ability to attract staff; marketing: challenging the assumption of referrers; management practices: leadership practices: supervisory support, shared decision making, involvement in reviews of business plans; documentation: a comprehensive business and an effective information management system plan in place; business adaptability: key areas identified for change are addressed; support for innovation and business support; social capital: effective teamwork, regular business-to-business networking with referrers and involvement in mentoring; and professional practices: ensuring a range of clinical policies and practices in keeping with professional standards.

The relationship between these CSF was identified in a conceptual model (see Figure 18) in which the CFS are separated into relationships between: professional identity and strategic management, strategic management and individual/ organisational performance, and, professional identity and individual/ organisational performance. The model of individual performance (Boxall & Purcell, 2008, p 5), ‘*Performance = Ability .Motivation .Opportunity*’, was retained as a conceptual equation, assuming adequate motivation to perform by SLPPPs. This research did not seek to quantify the ratio of: ability, motivation or opportunity, but to identify the CSF that constitute the abilities and the opportunities required for high performance by SLPPPs. Further research is needed to better quantify different contributions to performance.

The issues arising from the thematic analysis of qualitative data provided by the SLPPPs in comments regarding PP were: the primacy of professional values/socialisation of SLPPPs; ethical concerns regarding the relationship between business and clinical aspects of PP and provision of EBP/high quality services; the professional satisfaction of SLPPPs

including the autonomy provided by PP; the relationship between clinical and business components of PP, growing business skills; time and financial pressure, concern regarding survival of clinical and business aspects of PP; concern about new graduates entering PP, concern about reduced levels of support and professional isolation, and relationships with health and education providers.

6.2 Implications

The demographic breakdown of this sample has implications for the sector. The over representation of females (which is an issue for SLP generally) and ethnic groups among SLPPPs, is concerning. The need to represent the whole community is highlighted by an under representation of services to minority groups, migrant, and indigenous groups (K. Wylie et al., 2013). If SLPPPs want to represent the whole community then building a representation of gender and ethnic groups that reflect the community, then supporting diversity in PP, needs to be a priority for the sector. Additionally, the lack of PPs in rural locations is also concerning given research that PPs are a stable, long term service option for clients in rural and remote locations.

The stability and experience of SLPPPs is an important asset for the profession. It is important that SLPPPs are acknowledged for the expertise and contribution made to the profession and business sector. In as much, the sector is potentially untapped with only 14% of SLPPPs that offer student placements in Australia (The Speech Pathology Association of Australia Limited, 2015) and little research regarding SLPPPs. The reciprocity of the relationship between SLPPPs' need for access to EBP and students' need for placements is the basis of a good business relationship. Further research is warranted on the relationship between SLPPPs and universities.

In effect, the need to develop business expertise is not limited to building an academic understanding of business principles but also about on-the-job experience in SLP PP. This will require ongoing education with a focus on building business expertise in the current workforce and training undergraduates with respect to the abilities and opportunities required for performance in PP. In order to achieve an increase in the perception of viability of PP, SLPPPs need to have a better understanding of business and place increased value on their business expertise.

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The separation of business from clinical PP can be seen as part of the value system or professional socialisation of SLPs. However, all SLPs who are paid are generating an income from the business of their profession; albeit from the client, the taxpayer or a charity. Increasing economic rationalisation resulting from an increasing demand for services is changing the business environment which impacts on both public and private sectors of SLP. There is currently little desire from SLPPPs for business growth. Lack of growth to meet client need in the public sector means that growth needs to occur in PP if SLPs seek to address the increasing demand for services from clients. An underlying value system/professional socialisation that separates clinical from business components of PP inhibits business growth by reducing the value of business expertise. However, valuing business expertise as a vehicle to provide SLPPPs services will help the profession. It is possible that new graduate SLPs, without job opportunities in the public sector, could start a PP without experience as SLPs. Larger PP business will provide better career opportunities for SLPs and better support for new graduate SLPs. It will be important to address the separation of clinical and business components of SLP PP via professional socialisation valuing ethical business in order to get to the core of the issue. Education regarding both business and clinical ethics needs to address access and equity to clinical services for clients without devaluing SLPPPs' ability to be paid for services and develop viable business.

An identified lack of support in SLP PP needs to be addressed by individual SLPPPs and the PP sector. The benefits of supervision and mentoring are known to SLPs however, the benefit of that support to business success may not be as well acknowledged. In addition, the mind-set in which SLP skills are valued more highly than business skills may cause SLPPPs not to seek business support. However, the value of using administration support to increase the productivity of SLP services (Kummer, 2014), or business coaching to build business strategies to develop clinical innovations or new services to clients, may enable SLPs to hold a more secure position in the market and provide services a wider range of clients.

A reliance on an area dependent niche market held by health professionals in which business skills are low may be possible for SLPs for whom PP is not their primary source of income. Most SLPPPs have built business skills and referral networks via on-the-job learning which has aided their survival. However, with a changing market place SLPs may be able to build business competencies and use a knowledge of the CSF for SLP PP and associated key performance indicators, to check the health of their business and build upon business and clinical issues identified.

6.3 Further Research

Any further research on PP in Australasia would benefit the sector not only to profile the industry, the growth and adaptation of the industry, or innovations in clinical or business provided by PPs, but also to document the changing skill base added to the profession by PPs. Further case studies which explore SLPPPs experiences of the way in which ethical clinical and ethical business objectives can co-occur would aid the sector.

6.4 Limitations

The limitations of this research are acknowledged. The survey was mainly offered to participants through contact with professional associations. All participants of this survey are all members of their professional associations suggesting a commitment to the values and principals of practice of those associations. This may have increased the level of achievement of the group of participants on the total success rating and guided the responses of participants toward the values of the professional bodies. SLPs who hold a view incongruous with the professional body may not want to express that view. In addition, the SLPs who are failing in business may not want to respond to the survey reducing the range of responses.

The small numbers of participants meant analysis of the CSF by country was not feasible and limited the generalisability of the data to specific aspects of the NZ sample as the smaller component of the participants.

PPs and PP were treated as a single entity by this research reducing the clarity of the results for each entity. Further research may benefit from seeking to study either individuals or the business itself.

SLPPPs were asked to self-rate on their own achievement reducing the objectivity of the quantitative data. However, a '*strong relationship*' is reported between '*perceived*' and '*actual business competencies*' (Milsteed, 2013, p.191) in the literature. Accordingly, the level of honesty of the comments provided by the SLPPPs in the qualitative data of this research provides some indication of the integrity of the participants.

The motivation of participants was not addressed by this research but may add valuable insight to the factors identified for individual performance. A knowledge of participants' level of motivation may also aid possible quantification of the components of the performance

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equation. No attempt has been made to quantify the ratio of components: ability, motivation or opportunity, in the model of individual performance (Boxall & Purcell, 2008).

Despite these limitations this research has added to information regarding the profile of SLPPPs in Australasia, has ranked the success criteria of SLPPPs, provided a snapshot of the perceived achievement of SLPPPs on the BSCIS, and identified CSF which relate to Boxall et al.'s model of performance.

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Appendix A: Online Survey New Zealand: Critical success factors for speech language pathology (SLP) private practice (PP) in New Zealand

Critical success factors for speech language pathology (SLP) private practice (PP) in NSW, Australia and New Zealand. The term speech language pathologist (SLP) is used in this research to refer to both speech-language therapists and speech pathologists. The aim of this research is to identify the factors that correlate with business success and stability for speech pathology/speech-language therapy private practices in the marketplace across two regions (New South Wales, Australia and New Zealand). The questions in this survey are designed to explore your experience as private practitioners in speech-language therapy businesses and your professional satisfaction within your current role. This survey is only intended for speech-language therapists (SLT) who are eligible to be members of NZSTA (as per criteria listed on the website: www.speechtherapy.org.nz) and who are currently working in private practice in New Zealand. Before completing this survey please read the Participant information sheet. By completing this survey, you will be providing your informed consent to participate. Your identity will not be linked with your responses in any communications or analyses of results. Your responses will be analysed, aggregated and reported for discussion. You are welcome to take a copy of your responses and/or, edit your responses as you complete the questionnaire. Thank you for participating in this research. By proceeding to the next questions you are consenting to participate in this research.

Likert scale used: 1 = Strongly Disagree, 2 = Disagree, 3 = Somewhat Disagree, 4 = Neither agree nor disagree, 5 = Somewhat Agree, 6 = Agree, 7 = Strongly Agree

Q1 What is your current age?

< 24 (1)

25-29 (2)

30-39 (3)

35-39 (4)

40-44 (5)

45-49 (6)

50-54 (7)

55-59 (8)

60+ (9)

Q2 What is your gender?

Male (1)

Appendix A

Female (2)

Q3 Please state your ethnicity? (Please tick one)

European (1)

Maori (2)

Pacific Peoples (3)

Asian (4)

Middle Eastern, Latin American, African (5)

New Zealander (6)

Other (7)

Q4 In which location do you operate? (Please tick one)

Main urban area (over 30,000 people) (1)

Minor urban area (1000-999 people) (2)

Secondary urban area (10,000-29,999 people) (3)

Rural centre (4)

Rural area (5)

Q5 Success is a concept that means different things to different individuals. Success in private practice may also differ for speech-language therapists. Please share what success means for you by rating the following statements:

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Profitability (high yields, good profit margin) is an important criterion for success for me (1)							
Business growth (growth in number of employees, sales, market share, and/or distribution) is an important criterion for success for me (2)							
Innovation (introduction of new methods or technologies) is an important criterion for success for me (3)							
Business survival/continuity (or business can be sold with a profit) is an important criterion for success for me (4)							
Contributing back to society is an important success criterion for me (5)							
Professional satisfaction is an important criterion for success for me (6)							
Personal satisfaction (through attaining important things in life, such as: autonomy, challenge, security, power, creativity, etc.) is an important criterion for success for me (7)							
Satisfied stakeholders (satisfied and engaged employees, satisfied clients, satisfied family							

Appendix A

<p>members) is an important criterion for success for me (8)</p> <p>A good balance between work and private life (positive mutual influence between work and private life, allows you time for yourself, family and friends) is an important criterion for success for me (9)</p> <p>Public recognition (good reputation, prize winner) is an important criterion for success for me (10)</p> <p>Utility or usefulness (practice fulfils a need in society, the business provides an important service) is an important criterion for success for me (11)</p>							
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Q6 Speech-language therapists' current level of achievement in private practice may be rated across a range of different criteria. Please rate the following statements:

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
My work in private practice fulfils a need in the community (1)							
I receive a high level of public recognition for my work in private practice (2)							
I have a good balance between my work and private life (3)							
I have a high level of professional satisfaction in my current private practice role (4)							
My clients are satisfied with my work (5)							
I have a high level of personal satisfaction in my current role (6)							
My work in my current role contributes to society (7)							
I establish innovative clinical practice in my current role (8)							
I establish innovative business practices in my current role (9)							
I am satisfied with my current financial reimbursement for my current role (10)							

Q7 How many years have you been in your current role?

- <1 year (1)
- 1-2 years (2)
- 3-5 years (3)
- 6-10 years (4)

Appendix A

11-15 years (5)

16-20 years (6)

over 20 years (7)

Q8 Is it likely that you will stay in your current job? (Please tick one)

No (1)

Yes, one year from now (2)

Yes, five years from now (3)

Yes, ten years from now (4)

Yes, ongoing (5)

Q9 Do you expect that the business you are in, as it exists now, will show growth? (Please tick one)

No (1)

Yes, one year from now (2)

Yes, five years from now (3)

Yes, ten years from now (4)

Not sure (5)

Q10 What business qualifications do you currently hold? (Please tick all those that apply)

None (1)

Short course (2)

Graduate certificate (3)

Graduate diploma (4)

Bachelor's degree (5)

Masters' degree (6)

PhD (7)

Other (Please state (8) _____)

Q11 I have non speech language therapy related business experience gained prior to beginning in private practice in: (Please tick all those that apply)

I have no other industry experience (1)

I have experience in the health industry (2)

I have experience in the education industry (3)

I have other industry experience (Please specify) (4) _____

Q12 My business experience includes experience in: (Please tick all those that apply)

Administration (1)

Accounting (2)

Law (3)

Marketing (4)

Management (5)

IT (6)

HR (7)

Appendix A

Tax management (8)

Other: Please specify (9) _____

None of the above (10)

Q13 What are your SLT qualifications? (Please tick those that apply)

Advanced diploma/certificate (1)

Bachelor's degree (2)

Honors degree (3)

Masters' qualification (entry level into speech pathology/therapy) (4)

Research Masters (post qualification) (5)

PhD (6)

Other (Please state) (7) _____

Q14 How many years have you worked as a SLT? (Please tick one)

< 1 year (1)

1-5 years (2)

6-10 years (3)

11-15 years (4)

16-20 years (5)

over 20 years (6)

Q15 How many years have you worked in private practice? (Please tick one)

< 1 year (1)

1-2 years (2)

3-5 years (3)

6-10 years (4)

11-15 years (5)

16-20 years (6)

over 20 years (7)

Q16 Are you self-employed?

Yes (1)

No (2)

Answer If Are you self-employed? Yes Is Selected

Q17 Are you..?

A sole trader (1)

A registered company (2)

A business partnership (3)

Answer If Are you self-employed? Yes Is Selected

Q18 I employ..? (Please add those that apply)

Other SLTs (Please provide a number) (1) _____

Other allied health staff (Please provide a number) (2) _____

Appendix A

Administration staff (Please provide a number) (3) _____

No other staff (4)

Answer If Are you self-employed? No Is Selected

Q19 Are you employed by..?(Please tick all those that apply)

A SLT private practice (1)

An allied health private practice (2)

A medical private practice (3)

An education private practice (4)

Another type of private enterprise (please state) (5)

Answer If Are you self-employed? No Is Selected

Q20 Is your immediate supervisor a SLT?

Yes (1)

No (2)

Q21 How many hours do you work per week in private practice?

< 6 hours (1)

6-20 hours (2)

21-36 hours (3)

> 37 hours (4)

Q22 Where are you based? (Please tick all those that apply)

In rented rooms (1)

At a clinic based at your home (2)

Other (Please state) (3) _____

Q23 Are you registered for GST?

Yes (1)

No (2)

Q24 Do you provide services for..?(Please tick all those that apply)

ACC (1)

Special education grants (2)

Health insurers (3)

Funding trusts (please state) (4) _____

Other funding body (please state) (5) _____

No funding body (6)

Q25 What is the constitution of your caseload? (Please tick all those that apply)

Only paediatric (1)

Only adult clients (2)

Only older aged clients (above 65 years) (3)

Mixed age caseload (4)

Specific caseload (e.g.: head injured clients) (5)

Appendix A

General caseload (6)

Q26 Do you provide...? (Please tick all those that apply)

Formalised multidisciplinary services with other education or health professionals (1)

An informal multidisciplinary team on a referral by referral basis (2)

Independent services (3)

Consultative services (4)

Other (please state) (5) _____

Q27 Business strategy can vary across businesses. Please rate the following statements

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
I provide cost effective services for clients (1)							
I provide services that cannot easily be replicated by my competitors (2)							

Answer If Are you self-employed? Yes Is Selected

Q28 The impact of start-up capital on speech-language therapy businesses is unknown.

Please rate this statement:

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
I had adequate start-up capital to begin this private practice (1)							

Q29 The nature of the workplace and staff characteristics will vary in speech-language therapy private practices. Please rate the following statements

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
The physical environment in which I work is pleasant (1)							
My caseload is manageable (2)							
My work is adequately resourced (3)							
I use a range of computer devices/technology in my practice (4)							
It is easy to attract new SLT staff in this private practice (5)							
I have a high level of personal support (such as from a partner/friends/family) (6)							
I have a high level of personal resilience (7)							
I have a high level of cultural literacy relevant to my current role (8)							

Appendix A

I have effective time management skills (9)							
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Q30 Which of the following do you have in place: (Tick all relevant options that apply)

- A comprehensive business plan (1)
- A clear job description (2)
- Quality performance reviews (such as: OH & S plans with regular reviews) (3)
- Identified key performance indicators to monitor business performance (4)
- Clearly documented financial reporting (5)
- Financial processes for ensuring adequate cash flow (6)
- A marketing plan outlining a marketing strategy for your private practice (7)
- A range of policies and procedures specific to business practice in your private practice (8)
- A range of relevant policies and procedures specific to client management and NZSTA standards in your private practice (9)
- Clinical quality management programs in place such as monitoring client outcome measures (10)
- Effective documented practices for monitoring client satisfaction (11)
- A website (12)
- Effective information management systems for management of client information (13)
- Written contracts with referrers (14)
- None of the above (15)

Q31 The management practices of speech-language therapy private practices are largely under researched. This section collects information on management practices. Please rank your level of agreement with the following statements:

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
I am involved in decision making in my current role (1)							
I am adequately supported by supervisory staff or colleagues in my current role (2)							
I engage in effective teamwork with all clients/carers/allied health professionals/referrers (3)							
I engage in regular business-to-business networking (with GPs/teachers/allied health or other referrers) (4)							
I regularly challenge the assumptions of GPs/teachers/allied health professionals/clients/carers and other relevant referrers regarding the management of communication and swallowing (5)							
I am involved in regular reviews of business plans/strategic plans and quality improvement							

Appendix A

<p>plans to improve the productivity of my private practice (6)</p> <p>I am empowered by the strategic direction or vision of my private practice (7)</p> <p>I am involved in regular reviews of business plans/strategic plans and quality improvement plans to improve the services offered to clients in the private practice (8)</p> <p>Issues identified as key areas for strategic change in the private practice are addressed appropriately (9)</p> <p>The establishment of innovative: practice, client management or resources, is achievable and supported in my current SLT role (10)</p> <p>I undertake regular professional education/ongoing education as part of my current private practice role (11)</p> <p>I have advancement opportunities in my current role (12)</p> <p>My therapy is evidence based (13)</p> <p>I am easily able to resolve ethical issues that arise in my current role (14)</p>							
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Q32 I have effective business support in the following areas: (Please tick areas in which you have support)

Accounting (1)

Book keeping (2)

Business coaching (3)

Information technology (4)

Marketing (5)

Human resources (6)

Financial planning (7)

Legal (8)

Other (Please specify) (9) _____

No business support (10)

Q33 Do you belong to a business network in your area?

Yes (1)

No (2)

Q34 Is your clinical supervision relationship: (Please tick those that apply)

Formal (1)

Informal (2)

Appendix A

- Individual (3)
- Group (4)
- Non-existent (5)
- Regular (6)
- Irregular (7)
- Supervised by a SLT (8)

Q35 Is your clinical mentoring relationship: (Please tick those that apply)

- Formal (1)
- Informal (2)
- Individual (3)
- Group (4)
- Non-existent (5)
- Regular (6)
- Irregular (7)
- Business related (8)
- Clinical related (9)
- Mentored by a SLT (10)

Q36 Are you a member of: (Please tick those that apply)

- NZSTA (1)
- Formal clinical networks (2)
- Informal clinical networks (3)
- SLT specific special interest groups (4)
- No memberships (5)

Q37 Please make any further comments on issues regarding your experience of private practice or provide elaboration on any point:

Q38 Invitation for participation in a business case study: Please indicate if you would be willing to participate in further research involving a case study of your business by providing your email address. Your email address will remain confidential and will not be attached to the results of this survey.

- email address (1) _____
- No thanks (2)

Thank you for completing this survey

Appendix B: Online Survey NSW, Australia:

Critical success factors for speech language pathology (SLP) private practice (PP) in NSW, Australia

Q1 Critical success factors for speech language pathology (SLP) private practice (PP) in NSW, Australia and New Zealand (Australian Version). The aim of this research is to identify the factors that correlate with business success and stability for speech pathology/speech-language therapy private practices in the marketplace across two regions (New South Wales (NSW), Australia and New Zealand (NZ)). The questions in the survey are designed to explore your experience as private practitioners in speech pathology/speech-language therapy businesses and your professional satisfaction within your current role. This survey is only intended for speech pathologists/speech-language therapists (SLP) who are eligible to be members of SPA or NZSTA (as per criteria listed on the websites: www.speechtherapy.org.nz or www.speechpathologyaustralia.org.au) and who are working in private practice in NSW, Australia and/or in NZ. Before completing this survey please read the Participant information statement. By completing this survey you will be providing your informed consent to participate. Your identity will not be linked with your responses in any communications or analyses of results. Your responses will be analysed, aggregated and reported for discussion. You are welcome to take a copy of your responses and/or, edit your responses as you complete the questionnaire. Please note you will not be able to withdraw your responses after your survey is completed unless you leave your email address. Thank you for participating in this research. By proceeding to the next questions you are consenting to participate in this research.

Likert scale used: 1 = Strongly Disagree, 2 = Disagree, 3 = Somewhat Disagree, 4 = Neither agree nor disagree, 5 = Somewhat Agree, 6 = Agree, 7 = Strongly Agree

Q2 What is your current age?

<25 years (1)

25-29 (2)

30-39 (3)

35-39 (4)

40-44 (5)

45-49 (6)

50-54 (7)

55-59 (8)

60+ (9)

Q3 What is your gender?

Male (1)

Female (2)

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Indeterminate/Intersex/Unspecified (3)

Q4 Please state your ethnicity? (Please tick one)

- Oceanian Australian peoples New Zealand peoples Melanesian and Papuan Micronesian Polynesian (1)
- North West European (2)
- Southern and Eastern European (3)
- South Eastern Asian (4)
- North Eastern Asian (5)
- Southern and Central Asian (6)
- Americas (7)
- Sub-Sahara and African (8)

Answer If Please state your ethnicity? (Please tick one) Oceanian
 Australian peoples
 New Zealand peoples
 Melanesian and Papuan
 Micronesian
 Polynesian
 Is Selected

Q5 Please clarify your ethnicity: (Please those that apply)

- Australian peoples (1)
- New Zealand peoples (2)
- Melanesian and Papuan (3)
- Micronesian (4)
- Polynesian (5)

Q6 In which type of location do you practice? (Please tick one)

- Major city (RA1) (1)
- Inner regional (RA2) (2)
- Outer regional (RA3) (3)
- Remote (RA4) (4)
- Very Remote (RA5) (5)

Q7 Success is a concept that means different things to different individuals. Success in private practice may also differ for speech pathologists. Please share what success means for you by rating the following statements:

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Profitability (high yields, good profit margin) is an important criterion for success for me (1)							
Business growth (growth in number of employees, sales, market share, and/or distribution) is an important criterion for success for me (2)							
Innovation (introduction of new methods or technologies) is an important criterion for success for me (3)							

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<p>Business survival/continuity (or business can be sold with a profit) is an important criterion for success for me (4)</p> <p>Contributing back to society is an important criterion for success for me (5)</p> <p>Professional satisfaction is an important criterion for success for me (6)</p> <p>Personal satisfaction (through attaining important things in life, such as: autonomy, challenge, security, power, creativity, etc.) is an important criterion for success for me (7)</p> <p>Satisfied stakeholders (satisfied and engaged employees, satisfied clients, satisfied family members) is an important criterion for success for me (8)</p> <p>A good balance between work and private life (positive mutual influence between work and private life, allows you time for yourself, family and friends) is an important criterion for success for me (9)</p> <p>Public recognition (good reputation, prize winner) is an important criterion for success for me (10)</p> <p>Utility or usefulness (practice fulfills a need in society, the business provides an important service) is an important criterion for success for me (11)</p>							
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Q8 Speech pathologists' current level of achievement in private practice may be rated across a range of success criteria. Please rate the following statements

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
My work in private practice fulfills a need in the community (1)							
I receive a high level of public recognition for my work in private practice (2)							
I have a good balance between my work and private life (3)							
I have a high level of satisfaction in my current private practice role (4)							
My clients are satisfied with my work (5)							
I have a high level of personal satisfaction in my current role (6)							

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My work in my current role contributes to society (7)							
I establish innovative clinical practice in my current role (8)							
I establish innovative business practices in my current role (9)							
I am satisfied with my current financial reimbursement for my current role (10)							

Q9 How many years have you been in your current role?

- < 1 year (1)
- 1-2 years (2)
- 3-5 years (3)
- 6-10 years (4)
- 11-15 years (5)
- 16-20 years (6)
- over 20 years (8)

Q10 Is it likely that you will stay in your current job? (Please tick one)

- No (1)
- Yes, one year from now (2)
- Yes, five years from now (3)
- Yes, ten years from now (4)
- Yes, ongoing (5)

Q11 Do you expect that the business you are in, as it exists now, will show growth? (Please tick one)

- No (1)
- Yes, one year from now (2)
- Yes, five years from now (3)
- Yes, ten years from now (4)
- Not sure (5)

Q12 What business qualifications do you currently hold? (Please tick all those that apply)

- None (1)
- Short course (2)
- Graduate certificate (3)
- Graduate diploma (4)
- Bachelor's degree (5)
- Master's degree (6)
- PhD (7)
- Other (8)

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Q13 Do you have non speech pathology/language therapy related business experience gained prior to beginning in private practice? (Please tick all those that apply)

I have no other industry experience (1)

I have worked in the health industry (2)

I have worked in the education industry (3)

I have other industry experience (Please state) (4) _____

Q14 My business experience includes experience in: (please tick all those that apply)

Administration (1)

Accounting (2)

Law (3)

Marketing (4)

Management (5)

IT (6)

HR (7)

Tax management (8)

Other: Please specify (9) _____

None of the above (10)

Q15 What are your speech pathology/SLT qualifications? (Please tick those that apply)

Advanced diploma/certificate (1)

Bachelor's degree (2)

Honor's degree (3)

Masters qualification (entry level into speech pathology/therapy) (4)

Research Masters (post qualification) (5)

PhD (6)

Other (Please state) (7) _____

Q16 How many years have you worked as a speech pathologist/SLT? (Please tick one)

< 1 year (1)

1-5 years (2)

6-10 years (3)

11-15 years (4)

16-20 years (5)

over 20 years (6)

Q17 How many years have you worked in private practice? (Please tick one)

< 1 year (1)

1-2 years (2)

3-5 years (3)

6-10 years (4)

11-15 years (5)

16-20 years (6)

over 20 years (7)

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Q18 Are you self-employed?

Yes (1)

No (2)

Answer If Are you self-employed? Yes Is Selected

Q19 Are you..?

A sole trader (1)

A registered company (2)

A business partnership (3)

Answer If Are you self-employed? Yes Is Selected

Q20 I employ..? (Please tick all those that apply)

Other speech pathologists/SLTs (please provide a number) (1) _____

Other allied health staff (Please provide a number) (2) _____

Administration staff (please provide a number) (3) _____

No other staff (4)

Answer If Are you self-employed? No Is Selected

Q21 Are you employed by..? (Please tick all those that apply)

A speech pathology/SLT private practice (1)

An allied health private practice (2)

A medical private practice (3)

An education private practice (4)

Another type of private enterprise (please state) (5)

Answer If Are you self-employed? No Is Selected

Q22 Is your immediate supervisor a speech pathologist/SLT?

Yes (1)

No (2)

Q23 How many hours do you work per week in private practice?

<6 hours (1)

6-20 hours (2)

21-36 hours (3)

> 37 hours (4)

Q24 Where are you based? (Please tick those that apply)

In rented rooms (1)

At a clinic based at your home (2)

Other (please state) (3) _____

Q25 Are you registered for GST?

Yes (1)

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No (2)

Q26 Do you provide services for..?(Please tick all those that apply)

DVA (Department of Veteran's Affairs) (1)

ECP (Enhanced Primary Care/ Chronic Disease Management (CDM) (2)

Better Start (3)

Helping Children with Autism (HCWA) (4)

National Disability Insurance Scheme (NDIS) (5)

Other funding body (please state) (6) _____

Q27 What is the constitution of your caseload? (Please tick all those that apply)

Only paediatric (1)

Only adult clients (2)

Only older aged clients (above 65 years) (3)

Mixed -age caseload (4)

Specific caseload (e.g.: head injured clients) (5)

General caseload (6)

Q28 At this private practice I/we provide...? (Please tick all those that apply)

Formalized multidisciplinary services with other education or health professionals (1)

An informal multidisciplinary team on a referral by referral basis (2)

Independent services (3)

Consultative services (4)

Other (please state) (5) _____

Q29 Business strategy can vary across businesses. Please rate the following statements:

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
I provide cost effective services for clients (1)							
I provide services that cannot easily be replicated by my competitors (2)							

Answer If Are you self-employed? Yes Is Selected

Q30 The impact of adequate start-up capital on speech pathology businesses is unknown.

Please rate this statement:

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
I had adequate start-up capital to begin this private practice (1)							

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Q31 The nature of the workplace and staff characteristics will vary in speech pathology private practices. Please rate the following statements

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
The physical environment in which I work is pleasant (1)							
My caseload is manageable (2)							
My work is adequately resourced (3)							
I use a range of computer devices/technology in my practice (4)							
It is easy to attract new speech pathology staff in this private practice (5)							
I have a high level of personal support (such as from a partner/friends/family) (6)							
I have a high level of personal resilience (7)							
I have a high level of cultural literacy relevant to my current role (8)							
I have effective time management skills (9)							

Q32 Which of the following do you have in place: (Tick all relevant options that apply)

A comprehensive business plan (1)

A clear job description (2)

Quality performance reviews (such as: OH & S plans with regular reviews) (3)

Identified key performance indicators to monitor business performance (4)

Clearly documented financial reporting (5)

Financial processes for ensuring adequate cash flow (6)

A marketing plan outlining a marketing strategy for your private practice (7)

A range of policies and procedures specific to business practice in your private practice (8)

A range of relevant policies and procedures specific to client management and NZSTA/SPA standards in your private practice (9)

Clinical quality management programs in place such as monitoring client outcome measures (10)

Effective documented practices for monitoring client satisfaction (11)

A website (12)

Effective information management systems for management of client information (13)

Written contracts with referrers (14)

None of the above (15)

Q33 The management practices of speech pathology businesses are largely under researched. This section collects information on current management practices. Please rank your level of agreement with the following statements:

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	(1)	(2)	(3)	(4)	(5)	(6)	(7)
I am involved in decision making in my current role (1)							
I am adequately supported by supervisory staff or colleagues in my current role (2)							
I engage in effective teamwork with all clients/carers/allied health professionals/referrers (3)							
I engage in regular business to business networking (with GPs/teachers/allied health or other referrers) (4)							
I regularly challenge the assumptions of GPs/teachers/allied health professionals/clients/carers and other relevant referrers regarding the management of communication and swallowing (5)							
I am involved in regular reviews of a business plan/strategic plans and quality improvement plans to improve the productivity of my private practice (6)							
I am empowered by the strategic direction or vision of my private practice (7)							
I am involved in regular reviews of a business plan/strategic plans and quality improvement plans to improve the services offered to clients in the private practice (8)							
Issues identified as key areas for strategic change in the private practice are addressed appropriately (9)							
The establishment of innovative: practice, client management or resources, is achievable and supported in my current speech pathology/SLT role (10)							
I undertake regular professional education/ongoing education as part of my current private practice role (11)							
I have advancement opportunities in my current role (12)							
My therapy is evidence based (13)							
I am easily able to resolve ethical issues that arise in my current role (14)							

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Q34 I have effective business support in the following areas: (Please tick areas in which you have support)

Accounting (1)

Book keeping (2)

Business coaching (3)

Information technology (4)

Marketing (5)

Human resources (6)

Financial planning (7)

Legal (8)

Other (Please specify) (9) _____

No business support (10)

Q35 Do you belong to a business network in your area?

Yes (1)

No (2)

Q36 Is your clinical supervision relationship: (Please tick those that apply)

Formal (1)

Informal (2)

Individual (3)

Group (4)

Non-existent (5)

Regular (6)

Irregular (7)

Supervised by a speech pathologist/SLT (8)

Q37 Is your clinical mentoring relationship: (Please tick those that apply)

Formal (1)

Informal (2)

Individual (3)

Group (4)

Non-existent (5)

Regular (6)

Irregular (7)

Business related (8)

Clinical related (9)

Mentored by a speech pathologist/SLT (10)

Q38 Are you a member of: (Please tick those that apply)

SPA or NZSTA (1)

Formal clinical networks (2)

Informal clinical networks (3)

Speech pathology/SLT specific special interest groups (4)

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No memberships (5)

Q39 Please make any further comments on issues regarding your experience of private practice or provide elaboration on any point:

Q40 Invitation for participation in a business case study Please indicate if you would be willing to participate in further research involving a case study of your business by providing your email address

email address (1) _____

No thanks (2)

Q42 Please leave your email address if you would like to go in the draw for a book prize (one \$50 book voucher for Co-op bookstore to be won in NSW)

email address (1) _____

Thank you for completing this survey

Appendix C: Summary of literature relevant to SLPPs' success

Reference	Research aims	Study design with level of evidence (LOE)	Methods and participants	Analysis	Key findings
(Anderson & Nelson, 2011)	To encourage Occupational Therapy entrepreneurs hip	Expert opinion, Provided to single group LOE = 5	Discussion regarding Occupational Therapists in PP	-	Types of entrepreneurship discussed. Advice given about ways of achieving entrepreneurship and examples of successful practitioners given.
(Cheung et al., 2013)	To examine the impact of workplace factors in the use of evidence based practice (EBP) among SLP who work with children with Autism Spectrum disorder (ASD).	Cross-sectional, quantitative and qualitative, observational study, single group of participants, targeted sampling, survey. LOE = 2b	Online survey: multiple choice, open ended question and statements with a 5 - Likert scale, 105 SLP across Australia who work with children with ASD. PP nearly 50% of sample.	Quantitative analysis using PASW stats. Descriptive statistics for demographics. Parametric test used with Likert scales. Mann-Whitney U test used as a comparative measure Qualitative data analysed using thematic analysis.	97% of SLP agree EBP is necessary; no significant difference between PP and other SLP. PP less likely to see waiting list as a barrier. Both groups felt insufficient funding to support EBP. Four themes: workplace culture and support, time, cost of EBP, and availability and accessibility of EBP resources.
(Dorando-Unkle, 1995)	To understand and apply business skills specifically business planning in Occupational Therapy	Expert opinion, Qualitative, single business case study design LOE = 5	Discussion of strategic direction: market analysis with reference to one briefly described business case study of a school based OT	A customer value proposition is discussed. Case not discussed with reference to the other areas of business planning.	Business planning described for Occupational Therapy (OT): business description, market potential, human resourcing, financial forecasts, and adequate documentation.

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			PP. Few demographics.		
(Flower et al., 2015)	To investigate the relationships between: the psychological contracts, organisational justice, and negative affect with employee outcomes such as job satisfaction, organisational commitment, depression and psychological distress.	Cross sectional, quantitative, observational study	Survey with a range of scales for 'obligation/fulfilment, breach, organisational justice, negative affect, organisational commitment, job satisfaction and depression of allied health professionals (no breakdown of profession provided) in healthcare organisation (type not given) in a metropolitan area in Australia	Missing data replaced by expectation-maximisation technique, descriptive statistics used with Chronbach's alpha variables calculated, regression analysis for variables	Higher negative affect was associated with lower organisational commitment, lower job satisfaction, and higher levels of depression. Psychological contract variable, breach, was associated with depression. Informational justice was associated with organisational commitment. Distributive justice was negatively associated with job satisfaction.
(Gilleen et al., 2006)	To explore the relationship between hospital's quality management and business success	Quantitative, cross sectional, observational study, single group of participants LOE = 2b	Clinical indicators compared to financial indicators for the same facility for 36 months (2002-2005). 18 acute care facilities run by a regional service provider, in USA.	Descriptive statistics analysed via SPSS software. Thorough statistical analysis completed.	Numerous indicators of clinical quality were significantly correlated with measures of business success; timely and appropriate interventions, alongside timely and complete documentation are correlated with improved business performance.

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(Gu & Day, 2007)	To determine resilience in teacher effectiveness	Cross sectional mixed method longitudinal study LOE = 5	Interviews with 300 teachers from England part of the VITAE, 3 interviews described	Thematic analysis of interviews, thematic analysis type not discussed	Multidimensional socially constructed concept, described examples of resilient teachers
(Harris et al., 2009)	To determine the stress levels of school based SLP at the request of the Utah State Office of Education	Cross-sectional, quantitative, observational study, single group of participants, targeted sampling. LOE = 2b	Email survey, the Speech Language Pathologist Stress Inventory, contains 48 items with a 5 point Likert scale 97 school based SLP in Utah, USA	Descriptive statistics used in analysis to examine correlations.	Participants' emotional-fatigue, instructional limitations, bio-behavioural manifestations, lack of professional supports, and total stress, lower than national sample. More stress in three areas: caseload size, salary, and use of prescription drugs. No significant differences for rural remote location, number of years of experience, number of students served.
(Hutchins et al., 2010)	To determine the factors related to retention of SLP in the school setting including: caseload size, workload satisfaction, job satisfaction, and time available to complete best practice.	Cross-sectional, quantitative, observational study, single group of participants, targeted sampling, survey. LOE = 2b	Paper-based survey, 21-item mainly closed question or 5 point Likert scale. 75 full time SLP working in schools in Vermont in USA	Descriptive statistics analysis. Bonferroni correction for familywise error. Pearson's product-moment correlations taken between survey variables.	Several dimensions of job satisfaction and best practice predicted retention including caseload and workload. Lowest rated dimension was satisfaction with caseload.
(Kalkhoff & Collins, 2012)	To determine if job satisfaction differs between speech-language pathologists working in	Cross-sectional, quantitative, observational study, two groups of participants	Job satisfaction survey, not sure if a paper survey, Response rate 19.6% or 98 SLP,	Statistical analysis: linear regression to determine predictive value for job satisfaction.	Both school and medical based generally satisfied with jobs, SLP in medical significantly higher overall job satisfaction. Nature of work highest ranking. Operating conditions

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	school and medical settings	, targeted sampling, survey. LOE = 2b	participants working in schools and medical settings in the USA		and promotion lowest. Linear regression for age, caseload, years in position not significant.
(Keane et al., 2013)	To explore sector differences in factors affecting retention of rural allied health by comparing private and public sectors	Cross-sectional, quantitative, observational study, single group of participants, targeted sampling, survey. LOE = 2b	Respondents from the 2008 Rural Allied Health Workforce (RAHW) survey compared. Allied health (AH) in NSW, Australia, working in public (n=833) & private (n=756) sectors. Only one SLP PP and 67 SLP from the public service.	Descriptive statistics used in analysis. Factor analysis was completed for each cohort. Factor reliability was assessed then binary logistic regression analysis completed on remaining factors predicting intention to leave.	Six factors: professional isolation, participation in the community, clinical demand, taking time away from work, resources, and 'specialist/generalist' work. Management was a factor only in the public group. Age strongest predictor of intention to leave; younger and older more likely to leave. Public respondents higher job satisfaction; more public (47%) respondents intended to leave their job (PP 35%).
(Kenny & Lincoln, 2012)	To explore SLP experiences of caseload management through metaphorical analysis	Qualitative, single group of participants, targeted sampling. LOE = 4	Workplace interviews with 16 practicing SLP in Australia employed in hospital and community settings	Metaphors for caseload management were analysed by thematic analysis	Metaphors used in relation to conflict due to a lack of workplace resources. Awareness workplace policies inconsistent with EBP guidelines and metaphors portrayed frustration. Experienced SLP used more metaphors. Shared metaphors discussed in relation to workplace culture and may impact on job satisfaction.
(Kummer, 2014)	Describes the concept of productivity and why it is important to measure and monitor for financial	Expert opinion LOE = (SIGN) 5	Discussion with examples provided regarding one workplace (metropolita	Productivity is described as a business metric with an equation given to measure productivity.	Barriers to achieving high productivity are discussed including use of support staff, scheduling for maximum billable time, and

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	success in SLP		n hospital in USA)	Levels of SLP productivity given from a national survey by ASHA	requirements of report writing.
(Lincoln et al., 2001)	To investigate perceptions about relative importance of managerial competencies for new graduate speech pathologists	Cross-sectional, quantitative, single group of participants, targeted, purposive sampling. LOE = 4	Survey, 5-point Likert scale. 47 experienced SLP in Australia (4.3% in PP alone, and 4.3% in both private and public services) SLP=9.1% of respondents, others were AH professionals.	Factor analysis completed on the whole sample including other allied health. Principal component analysis followed by orthogonal rotation as no specific hypotheses were stated. Eigen values used.	Most important skills: management of future planning (time management, prioritising and planning goals for the work team) and organisational practices (being an advocate for the department) and legislative knowledge.
(Loan-Clarke et al., 2009)	To identify what factors lead to SLP staying, leaving or returning to the public health service in UK.				Stayers: value job and pension security, professional development, the work itself, and professional support. Leavers left due to: workload/pressure/stress, poor pay, and reduced ability to provide clinical care. Returners came back due to: flexible hours, work location,
(McAllister & McKinnon, 2009)	Review of literature with discussion of resilience as it applies to nursing education	Literature review with expert opinion LOE = 2a	Literature review with no outline of the literature search. A wide range of research discussed. Literature regarding nursing and some allied health	Themes of the literature discussed	Advice given regarding health professional's education including workplace learning and learning and capacity building for healthcare students. New policy and practices needed such as inclusive decision making, support for reflection on practice,

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			professional groups		clinical facilitators, mentors, supervisors, and support for communication between teams.
(McCann et al., 2013)	To explain the processes and characteristics that enhance resilience in health professionals (nursing, social work, psychology, counselling and medicine)	Literature review LOE = 2a	Literature with search criteria given. No articles were found relating to SLP; no discussion of SLP, Literature from nursing, social work, psychology, counselling and medicine.	Themes of the literature discussed	Only gender (being female) and maintaining a work-life balance have been consistently related to resilience across 4 of the 5 disciplines. Four factors related to resilience in 4 of 5 disciplines: humour, self-reflection, beliefs/spirituality, and professional identity.
(McLaughlin et al., 2008)	To identify common themes in SLPs' perceptions of factors that increase and decrease job stress, job satisfaction, satisfaction with the profession, and opinions about why people leave speech-language pathology profession.	Cross-sectional, qualitative, observational study, single group of participants, targeted sampling. LOE = 4	Semi-structured telephone interviews, 22 questions, to 18 members of SPA from a range of locations, workplaces, in Australia (30% response rate) 27.8% from the private sector. 95% female, 18.6 years' mean experience and in current role 5.8 years (average).	Descriptive analysis of transcribed interviews. Themes identified and topic coded. Topics identified combined by researchers. Two researchers finalised a list of themes related to job satisfaction, stress, attrition, and retention.	8 major themes affecting job satisfaction identified: Positive aspects of the profession, workload, non-workload obligations, effectiveness, recognition, support, learning and autonomy.
(McLaughlin et al., 2010)	To determine what variables are related to SLP leaving their jobs	Cross-sectional, quantitative, observational study,	Survey: with shortened stress evaluation tool, AH Professional	Comprehensive statistical analysis completed.	SLP intending to leave were: more likely to be under 34 years, perceived low levels of job security and benefits of the

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		single group of participants , targeted sampling, survey. LOE = 3b	Likelihood of Resignation Scale and the Positive and Negative Affect Schedule. 620 SLP in Australia participated (21% response rate). 23.2% PP and 9.2% working in the private sector. Sample representative of SPA members but fewer PP.		profession, more likely to spend greater than half their time at work on administrative duties, have a higher negative affect score, did not have children under 18 years of age and perceive that speech pathology did not met professional needs. ASSET score above median increased likelihood of leaving. A negative affect score as measured by PANAS influenced intention to leave.
(Milstead, 2013)	To determine what factors contribute to the success of Occupational Therapy small business owners	Qualitative, cross-sectional study of a single group of participants , targeted sampling, case study with interviews LOE = 2c	Case interviews with purposive sampling with thematic analysis of data 26 OT PP small business owners (all female) in Perth, Australia.	Triangulating data to develop thematic analysis	Factors affecting business and management skills: initial start-up goals, aspirations and engagement with external business environments. Skills learnt from formal/ informal learning and on the job experience. Business learning was discontinuous even if required for business success. Participants central to skills growth. Model developed for monitoring business skills and business learning needs.
(Ostergren , 2011)	To explore the supervision experiences of SLP in their	Qualitative and quantitative data, case	Survey modified from: the Supervisors'	Parametric and non-parametric statistical	The majority of participants were satisfied with their supervision and had a

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	first year of professional service regarding: role of the supervisor, the working relationship with their supervisor, and their satisfaction with supervision.	control study, Non-experimental correlation design. LOE= 2b	Working Alliance Inventory (SWAI) and the General Perceived Self Efficacy Scale (GSE). 122 participants in first year of professional service in California, USA. 15.8% Participants in PP	analysis of quantitative data. Open ended questions were subjected to a content and theme analysis (software not provided).	relatively strong working relationship with their supervisor. Majority of supervisors used a collaborative or consultative supervisory role. Demographic variables of the supervisor, supervisee and setting did not play a dominant role in the findings.
(O'Toole et al., 2008)	To question the approach taken to retention of allied health professional in rural locations	Cross-sectional, quantitative, observational study, single group of participants, targeted sampling, survey. Sample purposive. LOE = 2b	Survey based on the SARRAH workforce survey with 78 questions relating to recruitment and retention. 138 respondents: 65 hospital employed, 42 PP (33 solely employed in PP) working in Southwest Victoria, Australia. No breakdown given for type of AH professionals involved.	Descriptive analysis of quantitative statistical data	Greater tendency for allied health in private practice to be retained. PP were older. PP more likely to have a well-defined position. Having a job description increased likelihood of staying. Implications for models of governance discussed.
(Rees et al., 2015)	To introduce a new theoretical model of individual workplace resilience	Literature review LOE = 3a	No literature search criteria are provided, the model presented is part of wider work on The International	A wide range of literature is reviewed to provide to support the model presented. The model is	The ICWR-1 model presented: neuroticism, mindfulness, self-efficacy, and coping have opposite relationships with resilience and neuroticism and

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			Collaboration Workforce Resilience (ICWR-1). Issues discussed with regard to health professionals.	not tested in this article	ultimately psychological adjustment. The central premise of the theory is that the construct of resilience will explain the relationships between the variables. Further testing is suggested.
(Severn et al., 2012)	To investigate occupational stress in Audiologists and to quantify their professional quality of life	Cross-sectional, quantitative, observational study, single group of participants, targeted sampling. LOE = 2b	Postal survey using AOSQ (Audiology Occupational Stress Questionnaire) and the ProQOL professional quality of life protocol. 82 respondents (Audiologists) from the New Zealand Audiological Society. 73% in PP.	Descriptive stats used with demographics. AOSQ and ProQOL analysed on SPSS. Parametric and non-parametric analysis used. Principal component analysis completed with several factors with eigenvalues greater than 1.	6 Stress factors found: 1/ time demand, 2/ audiological management, 3/ patient contact, 4/ clinical protocol, 5/patient accountability and 6/administration or equipment. A significant relationship was found between increasing age of the Audiologist and burnout. Pearson's correlations revealed time demand was the strongest predictor of low compassion satisfaction and burnout. Stress associated with patient contact was the strongest predictor of compassion satisfaction.
(Specht & Blanchet, 2009)	To examine a sample of Corporate Speech Pathologists' demographic characteristics, professional activities and career satisfaction related to professional training, experience, client	Cross-sectional, quantitative, observational study, single group of participants, targeted sampling, online survey LOE=2b	25 item online questionnaire closed & open ended questions and statements rated with a five point Likert scale 54 CORSPAN (Professional group promoting	Paired t-tests used to detect significant differences between participants job satisfaction in current corporate practice with previous	Participants significantly more satisfied with their current corporate practice than with prior work setting. Participants spend one third of work related time in client training, employ a variety of marketing tools, and are experienced in specific

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	characteristics, services provided, and marketing practices.		Corporate Speech Pathology) members based in USA participated (69% respondent rate)	job. (Pearson r) post-hoc correlation analysis to examine relationship between years in corporate PP and percentage of working hours in direct client training.	interventions. Provides data relevant to specific PP practice.
(Stagnitti et al., 2006)	To explore the issues relating to management and allied health professionals intention to stay in rural Australia	Cross-sectional, quantitative and qualitative, observational study, single group of participants, targeted sampling, survey. Sample purposive and analysis exploratory. LOE = 2b	Survey based on the SARRAH workforce survey with 78 questions relating to recruitment and retention. 138 AH respondents, 47.7% public, 30.7% PP working in Southwest Victoria, Australia. No breakdown given for what type of AH involved.	Data analysed using excel statistics package. Cross tabulations completed via SPSS.	No difference between PP and public AH recommending their position. Allied health who did not want to recommend their position were less likely to be supported in their role. Receiving an orientation was associated with intention to stay longer. Of those intending to stay the majority were managed by someone in the same allied health profession (46.7%). PP and managerial positions more likely to stay. PP were more likely to be older. Significant relationship between staying and being older.
(Tan, 2006)	To explore the psychological contracts of SLP	Cross sectional qualitative semi structured interviews	Semi structured interviews with 25 SLP in New Zealand working at DHBs	Thematic analysis via NVivo	SLP only form psychological contracts with employers or organisations. Obligation to clients, colleagues and profession.

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					Fulfilment and non-fulfilment lead to affect and behavioural responses. Negative responses lead to reduced organisational commitment and poor affect. Perceived psychological contract changes with time in an organisation.
(Vinokur-Kaplan et al., 1994)	To determine the factors relating to job satisfaction, and retention of Social Workers in public agencies, non-profit agencies and private practice	Cross-sectional, quantitative, observational study, single group of participants, targeted sampling, survey. LOE = 2b	Analysis of a sample from a study of Work and Family Life Among Professional Social Workers (SW) in USA conducted in 1991. Survey paper-based, 7 point Likert scale, one item questions or closed questions. Married SW from NASW professional body, USA. 746 participants with 56.7% males and 43.3% females. 155 participants in PP.	One way ANOVA used to analyse relationship between two items in survey. Multiple regression analysis used to assess specific contribution of demographic characteristics on workplace conditions and motivators as predictors of job satisfaction and intention to stay. Betaweights used to verify significance of variables.	Public agencies highest retention. Private practice earn higher salaries. PP involved in more casework and less administration. PP had higher job satisfaction. Not for profit and public Social Workers more likely to seek alternative employment. None of the group of variables predicted job satisfaction in PP. Only good pay predicted PP work satisfaction. Job challenge and promotional opportunity were significant for all PP, public and not for profit agencies.

Appendix D: Summary of literature relevant to SLP PP Business

Reference and research aims	Study design with level of evidence (LOE)	Methods and participants	Analysis	Key findings
<p>(Ayala & Manzano, 2014)</p> <p>To determine the relationship between resilience and success of Spanish tourism entrepreneurs, and any gender specific differences</p>	<p>Cross-sectional, quantitative, observational study, single group of participants, targeted sampling, telephone interview.</p>	<p>Spanish Connor-Davidson Resilience Scale (CD-RISC), survey, 5 phone interviewers. Data collected for 5 years after measuring resilience. Business growth = success Participant= owner/manager of a company operating for more than 42 months. Company 10-50 employees (N-534, 82% response rate - 39 business closure or failure)</p>	<p>Hierarchical linear regression analysis used to establish role of independent variables</p>	<p>The key factor in predicting success of the entrepreneur is resourcefulness. The three dimensions of resilience (hardiness, resourcefulness and optimism) help to predict entrepreneurial success. The ability to predict entrepreneurial success of those who have hardiness and optimism is different for men and women. The importance of resourcefulness is greater in men than women in predicting entrepreneurial success. Optimism is associated with growth for females. Hardiness is associated with subjective growth for men and objective growth for women.</p>
<p>(Baron & Markman, 2003)</p> <p>To determine the relationship between entrepreneurs' social competence</p>	<p>Quantitative, cross sectional, replicated single group survey</p>	<p>Survey, Measuring social competence: social perception, expressiveness, social adaptability (Social Skills Inventory). 30 items, five</p>	<p>Factor analysis to develop items for the four components to assess social competence. Parallel analysis with eigen values for retained</p>	<p>Accuracy perceiving others was associated with financial success for both industries. Expressiveness was also associated with financial success for high tech industry. Social adaptability almost rated as significant for cosmetics industry.</p>

<p>and financial success</p>		<p>point scale. Financial success = average income (over 4 or 2 years in the first then second survey). Entrepreneurs working in the cosmetics industry (n= 159, all female) and the high tech industry (n= 71, 91.5% male)</p>	<p>items. Descriptive statistics for the four factors. Multiple regression analysis for demographic variable and the four factors related to financial success.</p>	
<p>(Bradley & Roberts, 2004)</p> <p>To ascertain the impact of self-efficacy, depression and seniority on job satisfaction in the self-employed.</p>	<p>Cross sectional, quantitative , single group of participants Both waves sponsored by the Centre for Population Research of the National Institute of Child Health and Human Development.</p>	<p>The National Survey of Families and Households: (1987-1988) and (1992-1994). In person interviews and questionnaires. 7-point Likert scale, Modified scale Depression (CES-D) measuring affect. A self-efficacy index modified NSFH2. Based in USA. Respondents 1987-88 =13,008, Respondents 1992-94 =10,007, partners= 5624, former partners (789). Self-employed were 11.9%.</p>	<p>Descriptive statistics with means and standard deviations identified. Linear regression completed with covariation and levels of significance identified. Post-hoc analysis completed.</p>	<p>The zero-order association between self-employment and job satisfaction is positive and significant. A portion of the association between self-employment can be explained by higher levels of self-efficacy and lower levels of depression in the self-employed. For the newly self-employed, job satisfaction depends on the amount and quality of time invested in the business.</p>
<p>(Chawla et al., 2010)</p> <p>To determine the similarities</p>	<p>Cross-sectional, quantitative , observational study,</p>	<p>Personal interviews with two sections: 1/ demographic information and 2/</p>	<p>Crombach alpha analysis and factor analysis of proposed CSF.</p>	<p>CSF have more similarities than differences in China, USA and Mexico. There were differences in the factor structure of CSF and</p>

<p>and differences of CSF in different countries.</p>	<p>three groups of participants, targeted sampling, interview.</p>	<p>questions about owners perceptions of CSF to small business. Questions presented on a 5-point Likert type scale. 73 respondents from small business (less than 250 employees). Range of business types but mostly manufacturing (41.67%)</p>	<p>Composite value formed by calculating the mean of the items loading on each factor and performed reliability analysis on the items representing each factor; this gave the final factor make-up. 6 factors with eigen values greater than 1 which represented 50% of the variance in the data.</p>	<p>key differences is concerning the financial needs and location of the small firm in China. Lack of support found for a life-cycle effect on the importance of CSF in China. In China business owners are a key participant among a complex set of interrelated CSF including: marketing concerns, location, competitive forces, industry issues and trends, availability of capital as well as the motivation and ability of the owners themselves.</p>
<p>(Clark & Douglas, 2014)</p> <p>The importance of key business processes and resources for growth of home-based (HBB) is identified and reported by geographical location (local, regional, national, international.</p>	<p>Empirical research, exploratory study, web based survey, quantitative data</p>	<p>Survey, regarding: human capital, technology, marketing, financial resources, physical assets, risk management and growth strategies, social capital. 5-point Likert scale, Home based businesses in New Zealand (work at home or from home), members of Home Business New Zealand via HomebisBuzz online community, November,</p>	<p>Descriptive statistics and significance testing using Chi-square for categorical variables. Significance level of $p < 0.05$.</p>	<p>Results demonstrated importance of HBB personal aspirations, energy, commitment, priorities and social networks of the owner/managers, combined with core functional business activities and growth strategies. Valuing family, industry links and external advisors demonstrated the interconnectedness of personal and business factors. Only 5 variables showed significant difference with geographical sales scale, increasing scale and market scope. Aspirations for growth high in this group- 92.5%. GST registration – 56%. 75% of HBB had website (39% local, 87% international). Two most</p>

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		2009. 522 respondents (17% response rate).. HBBs 25.1% local, 18.6% regional, 33.1% national and 23.2% international.		important factors for growth: 1/ owners' aspirations/energy/commitment and time, 2/access to ideas and information from the internet. Top marketing activities: word of mouth promotion, face-to-face networking, direct feedback from customer and identifying target markets. Social capital =most important relationships with customers and suppliers but also high mean rankings for relationships with family, industry and external advisors. Female ownership of HBB high 56% compared with NZ female proprietors 38% (from LEED database 2008).
(Gadenne, 1998) To examine the factors used to measure success in different industries and establish a theoretical framework regarding the relationship between small business success and small business success factors.	Cross-sectional, quantitative , observational study, single group of participants, targeted sampling, survey.	Survey regarding: management practices, management styles, financing arrangements, innovation factors, personnel and motivation practices, marketing practices, planning, control factors, enterprise objectives, entrepreneur characteristics and demographic factors. Success =	Principal component analysis (varimax rotation) to reduce number of management practices. Selection of each factor based on criteria of Eigen values greater than 1 and factors loadings greater than 40%. Resulting factors regressed against success (return on investment= dependent	Financial leverage found to be negatively related to return on investment for all industries. Positively related factors: (retail industry-value for money), (service industry-employee relations & working capital negatively related), (manufacturing industry-'a competitive advantage). Service industry: employee relations factor: a/ involving employees in decision making, b/ emphasising reward/discipline system for employees, c/ assessing performance of employees, d/ assessing employees satisfaction, e/encouraging employees constructive criticism and emphasising staff training. Owners personal characteristics no significant results for all

		<p>return on investment. Participants = 369 owner-managers of small businesses in the Sunshine Coast of Queensland, Australia (24.7% response-rate). 145- retail industry, 150- service industry, and 74-firms in the manufacturing industry. Firms all micro businesses.</p>	<p>variable). Growth on investment was not significant in Univariate F tests for each industry.</p>	<p>three industries. Owners' objectives in service industry were significant; innovative leadership significantly related to employee relations factor while business growth was related to the working capital factor.</p>
<p>(Gorgievski et al., 2011)</p> <p>To establish a rank order for success criteria, to investigate relationship between small business owners understanding of success and their personal values</p>	<p>Cross-sectional, quantitative, observational study, single group of participants, targeted sampling, survey.</p>	<p>Online or on-paper survey, participants recruited face-to-face or over the phone. Asked to rank success criteria and rate personal value orientations with Portrait Values Questionnaire (PVQ) 184 Dutch Small Business owners responded with 150 usable responses</p>	<p>Analysed using multidimensional scaling (MDS techniques), PRINCIPAL component analysis alternating least squares to the range of success criteria, scree plot of eigenvalues for related success criteria, then MDS to examine relationship to values</p>	<p>Two dimensional rank order of success criteria: Person-oriented and Business-orientated, Ranking: 1/ personal satisfaction 2/ profitability 3/ satisfied stakeholders 4/ balance between work and private life 5/ innovation 6/ firm survival/continuity 7/ utility/usefulness 8/ contributing back to society 9/ public recognition 10/ growth Business, profitability, and innovativeness guided by self-enhancing orientations, whereas satisfied stakeholders, good work-life balance guided by self-transcendent value orientations</p>

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		(response rate of 30% with 38% female respondents)		
(Jasra et al., 2011) To examine the role of key factors in the success of small to medium enterprises in Pakistan	Cross-sectional, quantitative, observational study, single group of participants, targeted sampling, survey.	30 item questionnaires distributed to SME. Convenient sampling technique. 520 small and medium businesses in Pakistan from service to manufacturing	SPSS software used to analyse data. Reliability testing and regression techniques used to measure the relationship between business success and determinants.	There is a significant relationship between business success and its determinants. Financial resources are the most important factor. Other significant factors were: marketing strategy, technological resources, government support and entrepreneurial skill. Leadership skills, decision making skills, management skills and professional affiliation of the business is also important.
(Jensen, 1987) To provide expert opinion regarding strategic planning and strategic control process.	Expert opinion only	Method provided for designing a planning and control process: 1/ provide structure for design process 2/ determine general forces influencing strategy 3/ develop a strategic plan/review current plan, 4/identify a selected number of CSF, 5/ determine who is responsible for each critical area, 6/select the strategic performance		Elements influencing success: 1/ general environment, 2/ industry characteristics, 3/ competitive forces, 4/ company specific characteristics, 5/ personal values of key players, 6/ resource availability CSF are the limited number of areas important for strategic success. CSF must: 1/ reflect the success of the defined strategy, 2/ represent the foundation of this strategy, 3/ be able to motivate and align the managers as well as other employees and 4/ be very specific and measurable.

		indicators, 7/ develop and integrate appropriate reporting procedures, 8/ implement and initiate system use by senior personnel, 9/ establish evaluating process and procedures.		
(Johnston et al., Dec 2008) To outline the components of a business model	Expert opinion	Harvard Business Review Article		Three components to a business model: 1/ Customer value proposition 2/ Profit formula 3/ Key resources and processes
(Kalleberg & Leicht, 1991) To examine the relationship between survival and success of small businesses headed by men and women related to industry differences, organisational structures, and attributes of owners.	Cross-sectional, quantitative, observational study, single group of participants, targeted sampling, survey.	Business owner-managers were telephone interviewed. Success = gross earnings. Multilevel model of organisational performance; variables macro and micro levels of analysis: macro describing organisations and micro describing entrepreneurs' characteristics . Data collected over three years (1985-87)	Variable age censoring for data set. Logarithmic odds of going out of business used for data analysis. P149. Chi square values for business failure.	Businesses headed by women as successful as male owned businesses. 16% of male owned businesses went out of business compared with 15% of women owned business. Business failure did not significantly differ for industry. Prior self-employment differed for men and women. There were no overall difference in survival for different industries. Older companies were less likely to go out of business. Size of companies was not significant to business failure. Competition increased the death rate of businesses run by women. Generalists were less likely to go out of business than specialists but only for female owned businesses. Women who reported they had higher quality service

		from an initial group of 411 companies in computer sales, food & drink and health industries in South Central Indiana. 1986-n=286, 1987-n=310. Death rate of 8% of businesses.		were less likely to go out of business. Incorporation and high gross earnings increased survival rate amongst businesses owned by men. Innovation increased death rate of business for men. Confidence and being involved in other businesses increased survival rate for men. Businesses owned by men had higher earnings. There was no difference in earnings growth by gender. Businesses owned by men had higher earnings growth in health industries but not the other industries. Age of the company had no effect on earnings growth. Company size was positively related to earnings growth. Entrepreneurs' age was negatively related to growth of earnings for men. Only women who were involved in other businesses had less growth in income. Earnings growth was unrelated to experience, innovation and confidence for men or women.
(Krishnan & Kamalanabhan, 2007) To identify and assess entrepreneurial attitude orientation, competencies and skills among women entrepreneur	Empirical research with purposive sampling technique. Quantitative, survey	Survey, 5 point Likert scale, entrepreneurial attitude traits taken from EAO (Entrepreneurial Attitude Orientation Scale) Entrepreneurial competency scale used,	Multivariate analysis techniques, principal factor analysis (using SPSS software) and structural equation modelling (SEM) to identify the entrepreneurship success	Direct relationships shown for entrepreneurial attitude-related constructs and entrepreneurial competencies related factors leading to entrepreneurial success and life satisfaction among female micro entrepreneurs. 68% entrepreneurs level of life satisfaction high.

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<p>s in micro businesses</p>		<p>Success = profitability/ sales, return on investment, and employment generation. The SWLS (Satisfaction with Life Scale) used.400 women micro entrepreneurs from India in manufacturing , retail or service industries (200 in a rural area and 200 in an urban area), less than 20 employees and must be a stand-alone business.</p>	<p>related factors. Significance level for factor analysis 0.05 and goodness of fit testing completed</p>	
<p>(Luisser & Halabi, 2010) To test the Lussier-15 variable business success versus failure prediction model. The Lussier model is designed to determine which variables are more or less important to success and failure (1995).</p>	<p>Cross-sectional, quantitative , observational study, single group of participants, targeted sampling, survey. Results compared with similar research in two other countries.</p>	<p>Emailed survey. 15 variables Non-financial model. Success = profitable, failure = not profitable. CEOs compared firms' profits with industry average in a 7 point scale (1-3 failures & 4-7 successful). Control variables: size (number of</p>	<p>Logistic regression to test the model. chi squared tests run for the dependent variables, t-tests used to compare Success/Failure for firms. Multicollinearity –parameter estimated beta coefficients.</p>	<p>The model will reliably predict a group of businesses as failed or successful more accurately than random guessing in USA, Chile and Croatia. Factors: 1/ capital, record keeping and financial control, industry experience, management experience, planning, professional advice, education, staffing, product/service timing (selection of service/products that are too old or too new have a greater chance of failure), economic timing, age of owner, business partners, parents owned a business,</p>

		employees), age of the business and industry. Businesses in Chile 131 failed businesses and 103 successful businesses. Used small businesses under 500 employees.		marketing. A reduced model of only: staffing, professional advice, education and planning also had significant result with chi square test. Able to predict 63.4% s/f. Better at predicting failure 77% than success 44%. Addressing these issues leads to increased chances of business success in Chile. Only the variable 'planning' was significant due to multicollinearity Significant differences found for successful firms: started with greater capital, record keeping and financial control, more years of management experience, more specific plans, made greater use of outside professional advice, had more years of education, and had greater marketing skills.
(G. D. Markman & Baron, 2003)To build a model of distinct individual differences for entrepreneurs and success	Expert opinion derived from theoretical background based in Social sciences, person-organisatio n fit research.	Literature reviewed and model suggested	Thematic analysis and theoretical discussion leading to a model creation	Person-entrepreneurship fit model presented including: opportunity recognition, self-efficacy, social skills, human capital, personal perseverance which in turn influence ability to: evaluate opportunity, deploy to market, exploit opportunity, create new ventures. This in turn leads to entrepreneurial success.
(Rawashdeh, Al-Sarairh, & Obeidat, 2015) To investigate the relationship between organisational culture and employee job	Quantitative, cross sectional, Single group survey	Survey using 5 point Likert scale to assess job satisfaction and Organizational Culture Assessment used to measure	Descriptive statistics using SPSS software used to analyse data using mean, standard deviation, percentage, Pearson correlation coefficient, t-	Positive relationship between clan culture and job satisfaction and a negative relationship between market, adhocracy, hierarchy cultures and job satisfaction in Jordanian private aviation companies.

satisfaction in Jordanian private aviation companies		organisational culture; 288 employees of Jordanian aviation companies	test and regression.	
<p>(Still et al., 2005)</p> <p>To consider generational differences in the start-up goals and later satisfaction of women small business owners in two different locations: homebased and non-homebased.</p>	<p>Cross-sectional, quantitative , observational study, single group of participants, targeted sampling, survey.</p>	<p>Survey regarding start-up/operational aspects of small businesses. Goals & satisfaction for homebased/non-homebased women's businesses, generational differences in goals and satisfaction by location examined. Australian national survey of 517 women small business owners (70% response rate). 11% matures (born pre 1946), 62% baby boomers (born 1946-1964), 25% genXers (born 1965 to 1980) and 2% genYers (born post 1980)</p>	<p>Goals & satisfaction data + generational differences in goals and satisfaction by location examined by t-tests and one way ANOVAs. Discriminant analysis to examine differences of multi-variates.</p>	<p>Generational differences across the locations in respects to goals and satisfactions achieved. Most important goals for start-up all women ranked: 1/ being my own boss, 2/ financial independence, 3/ meeting new challenges, and 4/ gaining control over my life. In terms of satisfaction importance rated: 1/being my own boss, 2/ meeting new challenges, 3/ gaining variety in my activities and 4/ gaining control over my life. Start-up goals explained with 17% variance: Mature respondent less concerned about WLB, stress and economic returns. Non-homebased Boomers and genXers were more concerned about obtaining an economic return. Satisfaction differences with 11% variance between groups: home-based genXers and non-homebased matures satisfied with having control over their lives, WLB, and financial independence. Homebased Boomers and non-homebased genXers were more satisfied with stress reduction and leisure, while home-based matures and non-homebased boomers were less satisfied on these issues.</p>

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<p>(Walker & Brown, 2004)</p>	<p>Qualitative and quantitative, cross sectional, observational study</p>	<p>11 semi-structured interviews provided to variety of industry sectors, and questionnaire provided to only property and business services sector, with 6 point Likert scale with 14 statements about motivations and business start-ups, 290 respondents, 64% male.</p>	<p>Descriptive statistical analysis then exploratory factor analysis on the items: Factors: lifestyle, financial and social responsibility</p>	<p>Both financial and non-financial lifestyle criteria are used to judge business success. Non-financial most important. Personal satisfaction, achievement, pride in the job and lifestyle more important than profitability. Lifestyle factors more important for homebased businesses</p>
<p>(Watson, 2003)</p> <p>To determine whether female owned businesses have higher failure rates than male owned businesses and whether any difference still exists after controlling for industry</p>	<p>Cross-sectional, quantitative, observational study, single group of participants, targeted sampling, survey.</p>	<p>Data taken from 1994-1995, 1995-1996, 1996-97 and 1997-98 Business growth and performance surveys (Business longitudinal survey) by (ABS). Failure rates were measured by discontinuity. Australian businesses: Subset A: N=5030, Subset B: N=3046, Businesses employing more than 200 people were excluded.</p>	<p>Chi square tests completed for difference between male and female owned businesses. Logistic regression analysis used to control for industry.</p>	<p>Higher overall failure rate for female owned businesses. Difference between male and female owned businesses significant at the 10 % level. Businesses where women over represented higher failure rates. After controlling for industry differences between male and female discontinuity are not significant.</p>

		Range of business types		
<p>(Yusuf, 1995a)</p> <p>To identify the critical success factors perceived by South Pacific entrepreneurs necessary for small business success.</p>	<p>Cross-sectional, quantitative, observational study, single group of participants, targeted sampling, survey.</p>	<p>Survey. 5 point Likert scale used Respondents asked to identify and rank CSF for small business. 220 entrepreneurs (180 male, 40 female) from South Pacific. 65% indigenous, 35% non-indigenous. Range of business types studied.</p>	<p>T- tests and significance of factors assessed.</p>	<p>Identified CSF: 1/ good management, 2/ satisfactory government support, 3/ marketing factors, 4/overseas exposure, 5/ level of education and training, 6/access to finances and level of initial investment, 7/ personal qualities and traits, 8/ prior experience in business and 9/political affiliation. Highest ranked: good management, access to finance, initial investment, personal qualities, and satisfactory government support. Indigenous entrepreneurs differed from non-indigenous entrepreneurs in access to capital, initial investment, satisfactory government support, overseas exposure, and political exposure with non-indigenous entrepreneurs rating these factors lower. Policy implications are discussed.</p>
<p>(Zheng, Molineux, Mirshekary, & Scarparo, 2015)</p> <p>To explore relevant work-life balance (WLB) factors contributing to employee health, well-being and to understand</p>	<p>Cross-sectional, quantitative, observational study, single group of participants, targeted sampling, survey.</p>	<p>Large scale population survey via telephone interview. Rated the importance of WLB strategy and own health/wellbeing on a 5-point scale, Participants: Australian employees (N=700)</p>	<p>Regression analysis of WLB strategies and organisation WLB policies to evaluate interrelatedness and combined effect on employee well-being and health Cronbach's alpha for</p>	<p>WLB contributes to employee health and wellbeing. Employing their own WLB strategies showed better health conditions and well-being than those who did not. Availability and usage of organisational WLB strategies -employees reduced stress & no relationship with employee health or well-being. Control variables: age, working hours, education level and household</p>

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<p>interactive effects of WLB strategies and organisational WLB policies on improving employee health and wellbeing</p>		<p>based in Queensland aged over 18 years</p>	<p>independent variables on .83 giving reliability</p>	<p>incomes were shown to have moderate effects on employee health and wellbeing. Positive attitude, time and stress management skill essential to health and wellbeing can be identified in employee selection process.</p>
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Appendix E: Demographics of Speech Language Pathology Private Practitioners

Table 17. Percentage of Speech Language Pathology Private Practitioners' Age by Country

Age	New South Wales Australia	New Zealand	Total
Under 25 years	3.2%	0.0%	2.7%
25-29 years	15.8%	0.0%	13.6%
30-34 years	17.9%	13.3%	17.3%
35-39 years	12.6%	20.0%	13.6%
40-44 years	14.7%	13.3%	14.5%
45-49 years	14.7%	20.0%	15.5%
50-54 years	8.4%	13.3%	9.1%
55-59 years	7.4%	0.0%	6.4%
over 60 years	5.3%	20.0%	7.3%
Count	95	15	110

Table 18. Percentage of Speech Language Pathology Private Practitioners' Location by Country

Location	New South Wales Australia	New Zealand	Total
City	54.7%	93.3%	60.0%
Regional	41.1%	6.7%	36.4%
Rural	4.2%	0.0%	3.6%
Percentage	86.4%	13.6%	100.0%
Count	95	15	110

Table 19 Percentage of Speech Language Pathology Private Practitioners' Hours of Work by Country

Hours of work	New South Wales Australia	New Zealand	Total
5 or less hours	4.2%	0.0%	3.6%
6 - 20 hours	26.3%	26.7%	26.4%
21- 36 hours	37.9%	26.7%	36.4%
37 or greater hours	31.6%	46.7%	33.6%
Count	95	15	110

Table 20 Percentage of Speech Language Pathology Private Practitioners' Years Worked as a Speech Language Pathologist by Country

Years worked as a Speech Language Pathologist	New South Wales Australia	New Zealand	Total
< 1 year	3.2%	0.0%	2.7%
1-5 years	11.6%	0.0%	10.0%
6-10 years	17.9%	20.0%	18.2%
11-15 years	17.9%	20.0%	18.2%
16-20 years	12.6%	20.0%	13.6%
over 20 years	36.8%	40.0%	37.3%
Count	95	15	110

Table 5 Percentage of Speech Language Pathology Business Type by Country

Business Type	New South Wales Australia	New Zealand	Total
A sole trader	85.2%	42.9%	78.9%
A registered company	11.1%	50.0%	16.8%
A business partnership	3.7%	7.1%	4.2%
Count	81	14	95

Table 6 Percentage of Speech Language Pathology Qualifications by Country

Speech Language Pathology Qualifications	New South Wales Australia	New Zealand	Total
Dip Cert	4.2%	20.0%	6.4%
Bachelor	71.6%	20.0%	64.5%
Hons degree	10.5%	26.7%	12.7%
Masters entry level	6.3%	20.0%	8.2%
Research Masters	4.2%	0.0%	3.6%
PhD	2.1%	13.3%	3.6%
other	1.1%	0.0%	0.9%
Count	95	15	110

Appendix F: Comments by Participants

Participants were asked to: *“Please make any further comments on issues regarding your experience of private practice or provide elaboration on any point”*

Comments that only stated the SLP was part time or indicated no comment were removed. Identifying information such as: names of places, workplaces, names of universities, specific dates, qualifications, work histories, ethnic group, have been removed. Spelling errors have been corrected. References to speech pathology or speech-language therapy are substituted with SLP to protect the confidentiality of participants.

1. My networking and professional support is diverse across health and education sectors.
2. I have been very fortunate to have run a practice on two occasions. Both times to suit my lifestyle and personal needs. Once bringing up a family and the second to suit myself in a transition to retirement. However, previous roles working for other organisations have provided me with wonderful skills to manage my practice. I do find being a sole practitioner a lonely experience, however becoming a mentor and working very hard at creating professional networks has been a way of combating this and finding support.
3. I have large concerns about new graduates beginning their own Private Practices now that there are fewer public positions in [country provided]. Although I am a highly-experienced therapist, I struggle to manage the business and clinical parts of my practice at the same time. I worry about being undercut by someone who does not realise the true cost of running a practice, who will only stay in my rural area for a short time before moving on.
4. I went into private practice (self-employed) as it suited my plans for fostering children - it gives me more flexibility re: hours. I find that it is far less financially secure than a position in [the public service], but that is a compromise I have been willing to make for

the sake of my foster children. I have no plans to expand the business, or to try and make it a highly profitable business, as that is not my life's aim!

5. Private practice is really challenging. I find it very difficult to create an appropriate life/work balance which is what I was hoping for. I find living regionally means there are very few other speechies to work with. I find the money side of running a business very difficult. I find it challenging working with third party funding bodies [names of funding bodies removed].
6. I have really been thrilled to start my private practice. I'm proud to be able to provide high quality, evidence based services without having to deal with the daily dramas of large organisations.... but I regularly face several issues including a complete lack of business and marketing skills/training, having to start from scratch for the various admin and business set up, and as mentioned earlier - my move to private practice involved very little pre-planning, and I had hardly any money to begin it. I still have no regrets!
7. The rollout of the NDIA has led to an increase in the number of new graduates in private practice, posing a challenge for the sector in terms of maintaining professional standards, given that clinical supervision for inexperienced clinicians is not regulated.
8. The cost of resources, especially formal tests, is extremely limiting for small businesses.
9. Private practice is hard work but very rewarding. To be successful requires a mixture of: strong clinical skills, strong relationship skills, time management skills, strategic skills, and business skills. Your question about value for money dismayed me, as it plays into the old culture of 'nice ladies providing a service for the community' who do not value themselves greatly and in fact should not be charging much for their services. The reality of running a business has taught me to value my time and my expertise!

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10. This is the first private practise that I have worked in prior to a long career in public health. I think that there are much fewer opportunities for business practises such as CQI and business planning than in my previous roles, where it was very much expected.
11. Whilst my practise does make me money, I do not market it much at all and it is really my second income. If I did not have my public sector job, I would need to market myself more aggressively.
12. I enjoy my work. There is little to no incentive to grow the practice for two main reasons. Firstly, the work load to maintain staff is not financially viable. Secondly it is hard to recruit skilled staff. I appreciate the work SPA has done for private practices, but do not really feel private services are a priority, and are more reactive than assertive. This is particularly relevant with the effective privatisation of disability services. There seems to be very little awareness of the cultural shift this will have. I am also concerned about the flooding of the market with poorly trained graduates who will be looking for work, offered by new NGOs with very little experience and less budget in disability or speech pathology. This is a strong collaboration of forces to lower standards.
13. Reputation and word of mouth is everything! Have been in private practice in the same local area for [time period provided]. Need drive and be motivated to provide a high quality service without being driven by the dollar. Many many many hours of unpaid work....but great satisfaction
14. Since working for myself with limited start-up capital - mostly invested in SLP resource tools, have attempted liaison with local business network and other business promotion organisations such as World Wide Who's Who but the investments were ineffective in developing a direct referral network which is paramount for a start-up service industry.
15. With limited referral base and some mistakes in marketing resource allocation (e.g. attempting to start-up SLP in a more affluent area of [city provided] already over-serviced, investing in office materials and flyers for handover during face to face liaison

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with referrals, domain website name needed key words to obvious for traffic) found the isolation and lack of cash flow a barrier to continued active work on own business. The skills set required for marketing and developing my business has been largely out of my reach despite completing a Diploma of Management. A microbusiness diploma may have been a more realistic start. A service business cannot grow without referrals and cash flow.

16. The main things emotionally and mentally I need from a workplace is team interaction and multidisciplinary work - fulltime private sole practice is not the best fit fulltime for me. I have had to struggle with mental health issues at times - depression and anxiety, loss of self-esteem and some loss of skill sets with being underemployed within my own private practice.
17. Once establishing a name for yourself, the challenge is keeping books closed when you are at capacity, especially when asked to take on siblings from families with an already established relationship or see old clients again. Taking on too many clients and filling the day with appointments leads to excessive paperwork after hours and on weekends. It is a lesson I have learned and relearned too many times over the years - maybe I'll get it right one day.
18. Successful private practice is very rewarding but a balance between personal and work life when work is based at home is crucial for longevity.
19. I enjoy the clinical side of private practice, I dislike the business side (invoicing, marketing, etc.). Managing work and family life is sometimes a challenge with four children. I often have to work late into the evening completing reports and emailing parents of clients.
20. I feel there is a huge disparity between the work of my colleagues in health/education, and what we can do in private practice. Many people in private practice do it as a hobby, with their main income coming from another job, or their partners!

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21. Those who don't seem to have to book more clients than they want to/can provide quality services to, in order to cover costs.
22. Start-up costs - my start-up costs were minimal as I paid to borrow tests from [name of university] Uni. I could then wait until I could afford to buy
23. Starting up - I think you need experience before starting out in Private Practice so that the therapist can work out what type of client they like to see
24. The BIGGEST issue for private practice is inexperienced therapists. New graduates start a practice often at considerable expense with limited experience. They charge high fees and provide therapy with no clear long and short term goals and with minimal preparation prior to sessions. I have seen articulation tests administered and the conclusion has been 'receptive and expressive language is within normal limits' Of course some do work using evidence based practice but many do not. I can provide multiple examples of clients receiving 12 months of therapy with minimal change in their speech or language. I also think the profession is changing to be more fees focused than client focused which I think is sad. Bigger practices are undercutting smaller practices and sometimes unethical unsustainable business practices are employed.
25. I think running a private practice does not need to be difficult or complex or even large. There needs to be basic knowledge about running a business (e.g. tax, setting up GST, accounting etc.). I don't see the need for a big marketing plan or business plan in a small sole trading clinic that has been running effectively. There needs to be realistic expectations for new clinicians e.g. it took me 4 years before I could definitely say I will earn this much money per month. Initially the income was irregular. I have marketed my practice once (by sending out bimonthly newsletters free to preschools and medical centres containing information on normal development) and I give free talks to playgroups or preschools (you only need one referral for this to pay for itself).

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26. I have worked in two other private practices – [time provided]. I decided to start my own multi-disciplinary practice (3 treatment rooms) and opened in [date given]. Financially I needed a lot of capital (I did a suite fit-out and purchased all resources). The biggest strain has been balancing all the business aspects with the practice aspects, which has resulted in a very poor work-life balance (working 7 days a week for the past 2 months). I hope that once I have all procedures properly in place I will have a better work-life balance.
27. There needs to be a requirement by our SLP governing bodies to stop new graduates or graduates with no experience in setting up their own mobile speech pathology businesses.
28. When I first joined this industry at the age of [age given], I was appalled that most private practice owners do not know how, or are not interested in, supporting the women who work for them. They overbook them, they burden them with too much admin and professional development and support in the 'new grad' phase is unstructured and often lacking altogether. I opened my group clinic because I wanted my workplace to be one which developed speech pathologists professionally and personally as this ethos seemed so seriously lacking in the industry. I'm not sure how this problem can be solved but I think it needs to start at Uni. There needs to be a subject called "Private Practice - Blending clinical and business skills" and one of the modules needs to be about how we are all responsible for coaching each other and being professional and what the latter means in the context of health/education/small business. How's that for a great idea? I'll write the content if you pay me :)lots!
29. Private practice allows flexibility for both clients and clinicians. It requires very long hours which can make balancing work and personal life difficult.
30. Hiring and retaining SLPs with enough experience and good interpersonal skills is the greatest challenge.

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31. I previously worked for 2 years in a private practice that was a very different experience to my current role. I would have ticked many of the 'disagree' boxes and I found working in a private practice almost unbearable. I now work for a fee for service not for profit and it has completely changed my opinion of being a speech pathologist. Nobody is in it to make money, it is all about helping the community and offering a variety of services to those in need.
32. I have enjoyed most of my private practice years but find as a rural therapist that I am driving so many hours per day that the financial and physical costs are large. Population density is scant so my practice is quite small. I have decided to close my practice at the end of this year - I am lucky enough to be able to replace my income from new agricultural ventures.
33. Working in private practice part time and also having another part time job is common and also under researched.
34. would not recommend private practice to new speech pathologists- too much mentoring is needed and not always available when time is money!
35. I couldn't neatly identify my race in your racial category. I am [ethnic group provided] I work in a very conservative part of [city provided] and I have experienced sometimes outright racial discrimination from new clients, from other allied health professionals and education staff. I find this issue has been glossed over by this survey as it's probably a bit too 'icky' to admit that discrimination exists in [country provided] when you're not white. It has impacted significantly in the marketing and advertising of my business and the fact my 'face' is the sales face for the business. Even when I have tried to collaborate with other practices in my area I've been given the cold shoulder and yet I know they are working with other private practices. SLP is still a highly white female dominated profession and highly bitchy for not much monetary gain-jobs are given to mates in a tight public health network. I tell students wanting to do the profession the reality of it especially if they are ethnic looking. I'm in the process of changing careers as I've been

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very disillusioned my work 'choices' in the [city provided] area and the underlying perception of who and what is a speech therapist. This coupled with non-commercial skills has made running a practice very challenging especially with ZERO [personal] support [relationships removed] and the wider speech community. I've sought help from [name of service] small business advisory service but it's been futile and I've realised I need to pay good money for advice. Unfortunately, unlike women in other private practices I'm not married to an accountant, tax lawyer etc. who can give me advice for free and make the financial and business decisions on my behalf.

36. I have operated as a sole trader in a rural area and work has fitted in well with my private life. Until recently there were no other therapists in the area, so opportunity to work with colleagues has been limited. This will change in the coming years and with roll out of NDIS

37. Best decision I ever made going into private practice :)

38. From memory, as a student we had a 1-hour presentation regarding private practice. When we finished Uni (and with our experience) we are a qualified SLP, however we do not have appropriate skills to be a business owner. These skills are learnt through other avenues (i.e. business courses) and through networks. I do not however like the stereotype that 'some' people have that being in private practice is all about the money. I have never once started or continued in private practice for the money - that is not my drive (however I believe if you are passionate about what you do, the money follows also). It is great SPA are growing to support more regarding Private Practice- we are still a long way and would be great to see more support in PP. Thank you for helping support SLPPPs. Good luck and looking forward to seeing the results.

39. It is a great way to provide in-depth and long term services for clients and their families. It's great to work in many settings (e.g. homes, preschools) and develop long-term working relationships. The client types are varied (at times), and provide a great lifestyle for working parents, due to some flexibility with days/times available to work.

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However, it is a lot of work (especially outside work hours) due to packed caseloads and no clinic set up for mobile services. The costs families pay is high, but necessary for our expertise and quality services, however I feel some contractors aren't earning as much as they deserve as businesses like to keep the bulk for themselves, despite clinicians attracting clients and performing majority of the service. Also, small businesses aren't as well-resourced as larger businesses or public services, and access/provision of supervision and professional development is also lacking in small private businesses (due to funding, or lack of access/knowledge).

40. After working for a number of years in private practice it has allowed me a great deal of flexibility around personal commitments such as [family commitments provided]. It is difficult at times creating work life balance when management of other areas outside of SLP are required such as finances and marketing. It can be a difficult to charge adequately when morally it feels like our clients should be able to access our service under government funded entities but cannot. Now as the business grows it feels more empowering and fantastic to have very enthusiastic staff and we can create a supportive collegial environment. More recently setting up with other allied health professionals has also been a great benefit and is an excellent way to build a better more comprehensive practice.
41. It is hard to connect with other SLPs in private practice. I feel that they are cautious to share their business experiences with others (clinical yes, but business ideas no). We are worried about being 'caught' doing the wrong thing in terms of taxes and business management that we don't openly discuss things.
42. Much of what I know, I am gleaning from overseas sources which doesn't always apply to a [country provided] setting.
43. The demands and opportunities of private practice are very different from public sector (for example we can do a lot more direct service and shift our paperwork requirements to best suit that relationship); sometimes I feel stifled by what my public sector colleagues consider to be 'proper' speech therapy.

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44. I have been a private therapist for [time period provided] years. I am currently scaling down to full retirement working no more than ten cases a week. [type of work provided]. My husband is my accountant and financial advisor.

45. Too much competition in a small condensed area has prompted me after [time period provided] of being a sole proprietor to formally accept a speech language therapy position at a larger, more diverse company with a multidisciplinary team.

Appendix G: Reliability scores for success criteria

	Profitability SC	Business growth SC	Innovation SC	Utility or usefulness	Business survival/cont	Contributing back to	Professional satisfaction	Personal satisfaction	Satisfied stakeholder	A good balance	Public recognition
Profitability SC	1.000	.498	.103	.095	.423	.046	.032	.150	.020	.132	.249
Business growth SC	.498	1.000	.321	-.005	.586	-.011	.156	.220	.174	.036	.278
Innovation SC	.103	.321	1.000	.334	.157	.149	.134	.344	.218	-.106	.308
Utility or usefulness SC	.095	-.005	.334	1.000	.124	.386	.226	.172	.163	.128	.095
Business survival/continuity SC	.423	.586	.157	.124	1.000	.050	.122	.096	.070	.055	.125
Contributing back to society SC	.046	-.011	.149	.386	.050	1.000	.313	.185	.385	.257	.163
Professional satisfaction SC	.032	.156	.134	.226	.122	.313	1.000	.389	.385	.489	.188
Personal satisfaction SC	.150	.220	.344	.172	.096	.185	.389	1.000	.290	.152	.274
Satisfied stakeholders SC	.020	.174	.218	.163	.070	.385	.385	.290	1.000	.290	.038
A good balance between work and private life SC	.132	.036	-.106	.128	.055	.257	.489	.152	.290	1.000	-.005
Public recognition SC	.249	.278	.308	.095	.125	.163	.188	.274	.038	-.005	1.000

Appendix H: Participant Information Sheet for Participants in New Zealand

SCHOOL OF PSYCHOLOGY

Speech Language Therapy

Tamaki Innovation Campus
261 Morrin Road, Glen Innes
Auckland, New Zealand
The University of Auckland
Private Bag 92019

PARTICIPANT INFORMATION SHEET

**For Speech Pathologists/Speech-Language Therapists currently working in private
practice**

**Critical success factors for speech language pathology
private practice in NSW, Australia and New Zealand**

Researchers: Leanne Thomas, Master of Science (Speech) student researcher, Speech Pathologist. Supervised by Professor Suzanne Purdy, Director of Speech Sciences, School of Psychology, The University of Auckland, and Dr. Ashish Malik, Lecturer, Newcastle Business School, Faculty of Business and Law, University of Newcastle.

Introduction: Speech pathologists working in private practice in New South Wales, Australia and speech-language therapists working in private practice in New Zealand are invited to participate in an online survey regarding the nature of success in private practice. If speech pathologists/speech-language therapists would like to elaborate on their responses, they will be invited to add further information at the end of the survey or to provide an email address in order to indicate their willingness to participate in a case study at a later date. All participants in this research must be eligible to be a member of either the Speech Pathology Association of Australia or the New Zealand Speech–language Therapy Association.

Eligibility criteria can be found at www.nzsta.org.nz or www.speechpathologyaustralia.org.au .

Purpose of this research: The aim of this research is to identify the factors that correlate with business success and stability for speech pathology/speech-language therapy private practices in the marketplace across two locations.

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The questions in the survey are designed to explore your experience as a private practitioner in speech pathology/speech-language therapy business and your professional satisfaction within your current role.

Your responses will be collated, analysed and documented in a thesis to be submitted as part of a Master of Science (Speech Science).

Participant Rights

Participation in this survey is voluntary. You are welcome to review or edit your information up to September, 2015. You are also welcome to withdraw part or all of your information up to September, 2015. Written consent has been provided by the Speech Pathology Association of Australia and the New Zealand Speech–language Therapy Association for members to participate in this research. SPA and NZSTA have provided assurance that participation or non-participation in this research will not affect speech language pathologists’ relationship with their respective professional organisation. (Consent provided by SPA and NZSTA does not imply endorsement of this research).

Confidentiality

Your identity will remain confidential and you will be assigned a code to protect your anonymity within this research. The nature of your responses will be analysed in relationship with all of your responses using codes to identify each participant. Any email addresses provided to contact speech pathologists/speech-language therapists will be erased following the completion of the case studies.

All data collected including survey responses will be stored on the researchers’ or University of Auckland IT network, password protected, computers during the research process. On completion of the thesis, January, 2016, all data will be recorded onto CD-ROM/DVDs and erased from all of the researchers’ hard drives. The CD-ROM/DVDs and any written transcripts of survey questions will be stored in a locked filing cabinet at the University of Auckland Campus for a period of six years. All data will be shredded or destroyed following that six-year period. During the period of storage only those persons with authority to manage storage will access the data.

Research Procedures

Participants will be provided an invitation to access an electronic link via the NSW private practitioners’ network email groups or the New Zealand Private Practitioners’ Facebook or NZSTA sites. This information sheet will be provided as part of the email link and as advised in the introduction of the survey consent to participate will be given if the participant continues and completes the survey. The survey takes approximately one half hour to complete.

Participants will be invited to provide further elaboration on answers or relevant information at the end of the survey. However, if participants would like the opportunity to participate in

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a case study at a later date they are invited to provide their email address in order to be eligible for selection for a case study and researcher to make contact.

Participants will be offered the opportunity to view the transcribed responses and change or edit any responses prior to September, 2015. All participants will be offered a copy of a summary of the findings of the research via the NSW private practitioners' network email groups or the New Zealand Private practitioners' Facebook or NZSTA sites.

Statement of approval

Please feel free to talk to the contact person if you have any questions about this study. Contact details as follows:

Leanne Thomas (Master of speech science student researcher & Speech Pathologist)
Email: ltho026@aucklanduni.ac.nz
Phone: 61 2 49829876 or 0438233641
Communication Therapy,
P.O Box 418,
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Newcastle Business School
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10 Chittaway Drive, Ourimbah, NSW 2258
Australia

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 extn. 837711. Email: ro-ethics@auckland.ac.nz

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS
ETHICS COMMITTEE ON 6/8/15 FOR A PERIOD OF THREE YEARS. REFERENCE
NUMBER 014107

Appendix I: Participant Information Sheet for Participants in New South Wales

FACULTY OF BUSINESS AND LAW



APPENDIX- 4

INFORMATION STATEMENT FOR PARTICIPANTS

Dr Ashish Malik

BO 1.16 Business Office,

Central Coast Campus, Ourimbah, 2258

Newcastle Business School,

University of Newcastle, Australia.

Ph: 02-434 84133 (Extension: 84133).

Dear Case Study Participant,

Information Statement for the Research Project: Critical success factors for speech language pathology private practice in NSW, Australia and New Zealand

HREC reference number: H-2015-0321

Date of approval: 2/11/2015

Document version: 2

(Researcher: Ms. Leanne Thomas)

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You are invited to participate in the research project identified above which is being conducted by Dr Ashish Malik and Ms. Leanne Thomas from the Faculty of Business and Law at the University of Newcastle. The research is part of Ms. Leanne Thomas' Master of Science (Speech) research at Auckland University, supervised by Dr Ashish Malik from the Faculty of Business and Law at the University of Newcastle and Professor Suzanne Purdy, Director of Speech Sciences, School of Psychology, The University of Auckland.

Why is the research being done?

The purpose of this research is to identify the factors that correlate with business success and stability for speech pathology/speech-language therapy private practices in the marketplace across two locations.

The questions in the survey are designed to explore your experience as a private practitioner in speech pathology/speech-language therapy business and your professional satisfaction within your current role.

Who can participate in the research?

Speech pathologists who are currently working in private practice in NSW, Australia or in New Zealand and who are eligible to be a member of the Speech Pathology Association of Australia or The New Zealand Speech-language Therapists' Association (as per criteria listed on the websites: www.speechpathologyaustralia.org.au or www.speechtherapy.org.nz) including members of the NSW Private Practitioners' Members' Network, will be invited to participate in this research.

What choice do you have?

Participation in this survey is voluntary. You are welcome to withdraw part or all of your information up to December, 2015, if you have provided an email address. Participants who do not provide an email address will not be able to withdraw their information. Only those speech pathologists who read the information statement and provide their informed consent by participating in the survey will be included in the project.

What would you be asked to do?

NSW participants will be emailed a letter of recruitment by the NSW Private Practitioners' Members' Network representative. The letter provides an attached Participant Information Statement which includes a link to the online research survey. Participants will be asked to read and take a copy of this Participant Information Statement. Continuing to the link to the online survey will be admission of informed consent to participate in this research. Participants will be invited to provide further elaboration on answers or add relevant information at the end of the survey. However, if participants would like the opportunity to participate in a case study at a later date they are invited to provide their email address in

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order to be eligible for selection to take part in a case study. Members who participate in the research will be offered the opportunity to take part in a draw for one \$50 book voucher prize from Co-op Book Shop (one prize available for NSW participants). In order to be eligible for the book prize participants must complete the survey and leave their email address. Email addresses collected for the purpose of the book prize will be managed confidentially and will be destroyed on the 1st of December, 2015, following the draw.

How much time will it take?

The survey takes a maximum of thirty minutes to complete. All NSW participants will be offered a copy of a summary of the findings of the research via the NSW Private Practitioners' Network email group or via Speech Pathology Australia.

What are the risks and benefits of participating?

Written consent has been provided by the Speech Pathology Association of Australia (SPA) and the NSW Private Practitioners' Network. SPA and the NSW Private Practitioners' Network have provided assurance that participation or non-participation in this research will not affect speech pathologists' relationship with their respective professional organisations. Consent provided by SPA and the NSW private Practitioners' Network does not imply their endorsement of this research.

Your participation in this research project will provide information regarding the nature of private practice in speech language pathology in New South Wales and in New Zealand in order to strengthen the sector by providing information to aid the establishment of, and support for, effective business practice in speech language pathology in Australasia.

How will your privacy be protected?

Your identity will remain confidential and you will be assigned a code to protect your confidentiality within this research. Codes will be assigned in order to track your responses regarding your success to subsequent responses regarding your business practices. The nature of your responses will be analysed in relationship with all of your responses using codes to identify your pattern of response.

Any email addresses provided to contact speech pathologists/speech-language therapists for subsequent research (a case study), will be removed from the current research data on deactivation of the current online survey and saved onto a CD-ROM/DVDs to be stored in a locked filing cabinet at the School of Psychology, Auckland University until required for further research. Those emails will be removed from the researchers' University of Auckland IT network/University of Newcastle IT Network, password-protected computers and will be stored during the research process. A further ethics application will be made for the case studies. If that research does not proceed those email addresses will be destroyed following a six-year period.

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On December, 1st, 2015, email addresses provided to participate in the prize draw will be taken from the data results prior to analysis, physically written on pieces of paper for the draw, and will be wiped from researchers' computer hard drives. All email addresses will be placed in a hat and one drawn by a third party. The winner of the prize will be informed by email in order to arrange receipt of the prize. Written email addresses will be held confidentially in the researcher's locked filing cabinet until the winner's reply is received. All written email addresses will be shredded when the winner replies to the email.

All data collected including survey responses will be stored on the researchers' or University of Auckland IT network/University of Newcastle IT Network, password protected, computers during the research process. On completion of the thesis in January, 2016, all data will be recorded onto CD-ROM/DVDs and erased from all of the researchers' hard drives. The CD-ROM/DVDs and including any written transcripts of open ended questions will be stored in a locked filing cabinet at the School of Psychology, Auckland University. All data will be shredded or destroyed following that six year period. During the period of storage only those persons with authority to manage storage will access the data.

The online survey will be completed using Qualtrics software. Qualtrics is an application service provider who provide the Qualtrics Research Suite software used in this research. Qualtrics use firewall security and transport layer security (TLS) to encrypt all data. The site used by this research is hosted in the Asia-Pacific region by third party data centres that are SSAE-16 SOC 1 Type 2 attested. Data on hard drive is destroyed by U. S. DOD methods.

Further information regarding the security of the online survey is outlined by Qualtrics in **QUALTRICS: SECURITY WHITE PAPER LITE, DEFINING OUR SECURITY PROCESSES** (Qualtrics, 2014).

How will the information collected be used?

The findings and the analysis from this project will be disseminated in the form of:

1. A summary of the survey reports to the New South Wales Private Practitioners' Member Network, Speech Pathology Australia, and the New Zealand Speech-language Therapists Association.
2. Presentations at seminars and conferences
3. Published in papers in journals, books, posters, reports and other academic outputs

No directly identifiable information will be used in all the above dissemination avenues as required by law. Your confidentiality will be maintained at all times as required by law.

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What do you need to do to participate?

Please read this Information Statement, take a copy and be sure you understand its contents before you connect to the online link to the survey. By continuing and completing the survey you will be providing your consent to participate in this research. If there is anything you do not understand, or you have questions, please contact the researcher.

Link to the survey: https://auckland.au1.qualtrics.com/SE/?SID=SV_cDfpihwgyEuEiRn

Further information

If you would like further information, please contact the chief investigator

Dr Ashish Malik

Ph: (02) 434 84133

Ashish.Malik@newcastle.edu.au

Ms Leanne Thomas [Student/researcher]

Mob: 0438233641

Email: ltho026@aucklanduni.ac.nz

Thank you for considering this invitation.

Yours sincerely

Ashish Malik

Dr Ashish Malik

Lecturer-HRM

Newcastle Business School

University of Newcastle

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. (H-2015-0321) Date Approval given: 2/11/2015. Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au.

Appendix J: Organisation Participant Information Sheet New Zealand

SCHOOL OF PSYCHOLOGY

Speech Language Therapy

Tamaki Innovation Campus
261 Morrin Road, Glen Innes
Auckland, New Zealand
The University of Auckland
Private Bag 92019

ORGANISATION PARTICIPANT INFORMATION SHEET

Speech Pathology Australia's New South Wales Private Practitioners' network, New Zealand Speech-language Therapy Association private practitioners' network, New Zealand private practitioner' Facebook page

**Critical success factors for speech language pathology
private practice in NSW, Australia and New Zealand**

Researchers: Leanne Thomas, Master of Science (Speech) student researcher, Speech Pathologist. Supervised by Professor Suzanne Purdy, Director of Speech Sciences, School of Psychology, The University of Auckland, and Dr. Ashish Malik, Lecturer, Newcastle Business School, Faculty of Business and Law, University of Newcastle.

Introduction:

Members of your organisation (speech pathologists or speech-language therapists), who are currently working in private practice in New South Wales, Australia or in New Zealand are invited to participate in an online survey regarding the nature of success in private practice. If members of your organisation would like to elaborate on their responses, they will be invited to add further information at the end of the survey or to provide an email address in order to indicate their willingness to participate in a case study at a later date. All participants in this research must be eligible to be members of either the Speech Pathology Association of Australia or the New Zealand Speech-language Therapy Association. Eligibility criteria can be found at www.nzsta.org.nz or www.speechpathologyaustralia.org.au .

Purpose of this research:

The aim of this research is to identify the factors that correlate with business success and stability for speech pathology/speech-language therapy private practices in the marketplace across two locations.

The questions in the survey are designed to explore your members' experience as private practitioners in speech pathology/speech-language therapy business and their professional satisfaction within their current role.

Speech pathologists'/speech-language therapists' responses will be collated, analysed and documented in a thesis to be submitted as part of a Master of Science (Speech).

Participant Rights

Participation in this survey is voluntary. Your members are welcome to review or edit their information up to September, 2015. They are also welcome to withdraw part or all of their information up to September, 2015.

Confidentiality

Your members' identity will remain confidential and they will be assigned a code to protect their anonymity within this research. The nature of your member's responses will be analysed in relationship with all of their responses using codes to identify each participant. Any email addresses provided to contact speech pathologists/speech-language therapists will be erased following the completion of the case studies.

All data collected including survey responses and voice recording during case studies, will be stored on the researchers' or University of Auckland IT network, password protected, computers during the research process. On completion of the thesis, January, 2016, all data will be recorded onto CD-ROM/DVDs and erased from all of the researchers' hard drives. The CD-ROM/DVDs and any written transcripts of case studies will be stored in a locked filing cabinet at the University of Auckland Tamaki Campus for a period of six years. All data will be shredded or destroyed following that six-year period. During the period of storage only those persons with authority to manage storage will access the data.

Research Procedures

Your members will be provided an invitation to access an electronic link via NSW private practitioners' network email groups or the New Zealand Private practitioners' Facebook or NZSTA sites. A participant information sheet will be provided as part of the email link and as advised in the introduction of the survey consent to participate will be given if the participant continues and completes the survey. The survey takes approximately one half hour to complete.

Participants will be invited to provide further elaboration on answers or relevant information at the end of the survey. However, if participants would like the opportunity to participate in

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a case study they are invited to provide their email address to indicate willingness for a researcher to make contact at a later date.

All participants will be offered a copy of a summary of the findings of the research via the NSW private practitioners' network email groups, the New Zealand Private practitioners' Facebook or NZSTA sites.

Consent:

Your organisation will be asked to provide written consent to allow your members to take part in this research. By providing the consent the organisation will agree that they will provide an assurance that participation or non-participation in this research by members will have no effect on members' relationship with the organization. Consent will also be requested to allow an advertisement for the research with link to a participant information sheet and the research survey (in which completion of the survey implies participants' consent) to be emailed to members of the NSW Private practitioners network or posted on NZSTA website or NZ Private Practitioners' Facebook site. Consent will also be requested to email a reference for a summary of the research to the NSW Private Practitioners network. Your organisations' consent will not imply endorsement of this research.

Statement of approval

Please feel free to talk to the contact person if you have any questions about this study. Contact details as follows:

Leanne Thomas (Student researcher & Speech Pathologist)

Email: ltho026@aucklanduni.ac.nz

Phone: 61 2 49829876 or 0438233641

Communication Therapy,

P.O Box 418,

Salamander Bay, NSW 2317

Australia

Suzanne Purdy (Head of Speech Science)

Email: sc.purdy@auckland.ac.nz

Phone: 09 373-7599 extn. 82073

Speech Science, School of Psychology, Tamaki Innovation Campus, The University of Auckland

Private Bag 92019

Auckland 1142

Dr. Ashish Malik Lecturer

Email: Ashish.Malik@newcastle.edu.au

T: +61 2 434 84133

Newcastle Business School

Faculty of Business & Law

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10 Chittaway Drive, Ourimbah, NSW 2258
Australia

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 extn. 83711. Email: ro-ethics@auckland.ac.nz

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS
ETHICS COMMITTEE
ON 6/8/15 FOR A PERIOD OF THREE YEARS. REFERENCE NUMBER 014107

Appendix K: Organisation Participant Sheet: New South Wales

FACULTY OF BUSINESS AND LAW



APPENDIX- 3

INFORMATION STATEMENT FOR ORGANISATIONS

Speech Pathology Australia and New South Wales Private Practitioners' Network

2/11/15,

Dr Ashish Malik

BO 1.16 Business Office,

Central Coast Campus, Ourimbah, 2258

Newcastle Business School,

University of Newcastle, Australia.

Ph: 02-434 84133 (Extension: 84133).

To: Speech Pathology Australia and New South Wales Private Practitioners' Network

Information Statement for the Research Project: *Critical success factors for speech language pathology private practice in NSW, Australia and New Zealand*

Research number: H-2015-0321,

Date of approval: 2/11/15

Document version: 2

(Researcher: Ms. Leanne Thomas)

Speech Pathology Australia and New South Wales Private Practitioners' Network, are invited to participate in the research project identified above which is being conducted by student researcher Leanne Thomas, supervised by Dr. Ashish Malik, Lecturer, Human Resource Management (HRM) in the Faculty of Business and Law at the University of Newcastle, and, Professor Suzanne Purdy, Director of Speech Sciences, School of Psychology, The University of Auckland.

Why is the research being done?

The purpose of this research is to identify the factors that correlate with business success and stability for speech pathology/speech-language therapy private practices in the marketplace across two locations.

The questions in the survey are designed to explore the experience of private practitioners in speech pathology/speech-language therapy businesses and their perceived level of success and professional satisfaction.

Who can participate in the research?

Speech pathologists who are who are currently working in private practice in NSW, Australia and or in NZ and are eligible to be a member of the Speech Pathology Association of Australia or New Zealand Speech-language Therapists' Association (as per criteria listed on the websites: www.speechpathologyaustralia.org.au or www.speechtherapy.org.nz) including members of the NSW Private Practitioners' Member Network, will be invited to participate in this research.

What choice does your organisation have?

Participation in this survey is voluntary. Your members are welcome to withdraw part or all of their information up to December, 2015, if they have provided an email address. Participants who do not provide an email address will not be able to withdraw their

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information. Only those speech pathologists who read the information statement and provide their informed consent by participating in the survey will be included in the project.

What would your organisation be asked to do?

Your organisation will be asked to provide written consent to allow your members to take part in this research. By providing the consent the organisation will agree that they will provide an assurance that participation or non-participation in this research by members will have no effect on members' relationship with the organization. Consent is also be requested to allow a recruitment email for the research, with an attached participant information sheet including a link to the research survey (in which completion of the survey implies participants' consent), to be emailed to members of the NSW Private Practitioners' Network. If Speech Pathology Australia consents to members' participation, it is requested SPA forward: the organization participation statement, consent form and recruitment email, to the NSW Private practitioners' Member Network representatives. A summary of the research will be sent to Speech Pathology Australia, and to the New Zealand Speech-language Therapists' Association, in February, 2016. Speech Pathology Australia will be asked to forward a copy of the summary to the NSW Private Practitioners' Member Network. Your organizations' consent will not imply endorsement of this research.

Members of your organisation (speech pathologists), who are currently working in private practice in New South Wales are invited to participate in an online survey regarding the nature of success in private practice. If members of your organisation would like to elaborate on their responses they will be invited to add further information at the end of the survey or to provide an email address in order to indicate their willingness to participate in a case study at a later date. Members who participate in the research will be offered the opportunity to take part in a draw for one \$50 book voucher prize from Co-op Book Shop (one prize available for NSW participants). In order to be eligible for the book prize participants must complete the survey and leave their email address. Email addresses collected for the purpose of the book prize will be managed confidentially and will be destroyed on the 1st of December, 2015, following the draw.

How much time will it take?

The online survey will take a maximum of thirty minutes to complete.

What are the risks and benefits of participating?

Your participation in this research project will provide information regarding the nature of private practice in speech pathology/speech-language therapy in New South Wales and in New Zealand in order to strengthen the sector by providing information to aid the

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establishment of, and support for, effective business practice in speech pathology/speech-language therapy in Australasia.

How will your privacy be protected?

Your members' identity will remain confidential and they will be assigned a code to protect their confidentiality within this research. Codes will be assigned in order to track participants' responses regarding success to subsequent responses regarding business practice. The nature of your members' responses will be analysed in relationship with all of their responses using codes to identify each participants' pattern of response.

Any email addresses provided to contact speech pathologists/speech-language therapists for subsequent research (a case study), will be removed from the current research data on deactivation of the current online survey and saved onto a CD-ROM/DVDs to be stored in a locked filing cabinet at the School of Psychology, Auckland University until required for further research. Those emails will be removed from the researchers' University of Auckland IT network/University of Newcastle IT Network, password-protected computers and will be stored during the research process. A further ethics application will be made for the case studies. If that research does not proceed those email addresses will be destroyed following a six year period.

On December, 1st, 2015, email addresses provided to participate in the prize draw will be taken from the data results prior to analysis, physically written on pieces of paper for the draw, and will be wiped from researchers' computer hard drives. All email addresses will be placed in a hat and one drawn by a third party. The winner of the prize will be informed by email in order to arrange receipt of the prize. Written email addresses will be held confidentially in the researcher's locked filing cabinet until the winner's reply is received. All written email addresses will be shredded when the winner replies to the email.

All data collected including survey responses will be stored on the researchers' or University of Auckland IT network/University of Newcastle IT Network, password protected, computers during the research process. On completion of the thesis in February, 2016, all data will be recorded onto CD-ROM/DVDs and erased from all of the researchers' hard drives. The CD-ROM/DVDs and including any written transcripts of open ended questions will be stored in a locked filing cabinet at the School of Psychology, Auckland University. All data will be shredded or destroyed following a six year period. During the period of storage only those persons with authority to manage storage will access the data.

The online survey will be completed using Qualtrics software. Qualtrics is an application service provider who provide the Qualtrics Research Suite software used in this research. Qualtrics use firewall security and transport layer security (TLS) to encrypt all data. The site used by this research is hosted in the Asia-Pacific region by third party data centres that are SSAE-16 SOC 1 Type 2 attested. Data on hard drive is destroyed by U. S. DOD methods.

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Further information regarding the security of the online survey is outlined by Qualtrics in **QUALTRICS: SECURITY WHITE PAPER LITE, DEFINING OUR SECURITY PROCESSES** (Qualtrics, 2014).

How will the information collected be used?

The findings and the analysis from this project will be disseminated in the form of:

1. A summary of the survey in a report sent to the New Zealand Speech-language Therapists' Association and to Speech Pathology Australia (SPA). SPA will be asked to send the report to The NSW Private Practitioners' Member Network.
2. Presentations at seminars and conferences
3. Published papers in journals, books, posters, reports and other academic outputs

No organisational or individually identifiable information will be used in all the above dissemination avenues as required by law. Confidentiality of the participants and the case organisation will be maintained at all times as required by law.

What do you need to do to participate?

Please read this Information Statement and be sure you understand its contents before you consent to participate. If there is anything you do not understand, or you have questions, contact the researcher.

If you would like to participate, please complete the attached consent form and attach it with electronic signatures when replying to my email.

Please forward the attached Recruitment Email to the NSW Private Practitioners Network for dissemination.

Further information

If you would like further information please contact the chief investigator

Dr Ashish Malik

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Ph: (02) 434 84133

Ashish.Malik@newcastle.edu.au

Ms Leanne Thomas [Student/researcher]

Mob: 0438233641

Email: ltho026@aucklanduni.ac.nz

Thank you for considering this invitation.

Yours sincerely

Ashish Malik

Dr Ashish Malik

Lecturer-HRM

Newcastle Business School

University of Newcastle

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. (H-2015-0321) Date of Approval: 2/11/15 Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au.

Appendix L: Consent Form for The New Zealand Speech-language Therapists' Association

SCHOOL OF PSYCHOLOGY
Speech Language Therapy



Tamaki Innovation Campus
261 Morrin Road, Glen Innes
Auckland, New Zealand
The University of Auckland
Private Bag 92019

CONSENT FORM (New Zealand Speech-language Therapists' Association) THIS FORM WILL BE HELD FOR A PERIOD OF 6 YEARS

Project title: Critical success factors for speech language pathology private practice in NSW, Australia and New Zealand

Researchers: Leanne Thomas, Master of Science (Speech) student researcher, Speech Pathologist. Supervised by Professor Suzanne Purdy, Director of Speech Sciences, School of Psychology, The University of Auckland, Philippa Friary, Clinical Director, Speech Science, School of Psychology, The University of Auckland and Dr. Ashish Malik, Lecturer, Newcastle Business School, Faculty of Business and Law, University of Newcastle.

The term speech language pathology (SLP) is used in this research to refer to both speech-language therapists and speech pathologists

Appropriate representatives of NZSTA have read the Organisation Participant Information Sheet and have a clear understanding of the research. The organization has been given the opportunity to ask questions about the research and are satisfied with any answers given. While not endorsing the research NZSTA agrees:

- to let NZSTA members take part in this research
- to give an assurance that participation or non-participation in this research by members of NZSTA will have no effect on members' relationship with the organization
- to allow an advertisement for the research with link to participant information sheet and the research survey (in which completion of the survey implies participants' consent) to be posted on the NZSTA website and on the New Zealand Private Practitioners' Facebook site
- to post a reference to a summary of the research on completion on NZSTA's website.

NZSTA understands:

Appendix M: Consent Form Speech Pathology Australia

FACULTY OF BUSINESS AND LAW



APPENDIX- 1

Dr Ashish Malik
BO 1.16 Business Office,
Central Coast Campus, Ourimbah, 2258
Newcastle Business School,
University of Newcastle, Australia.
Ph: 02-434 84133 (Extension: 84133).

Organisation Consent Form for the Research Project: Critical success factors for speech language pathology private practice in NSW, Australia and New Zealand

Reference number: H-2015-0321

Date of approval: 2/11/2015

Document version: 2

(Researcher: Ms. Leanne Thomas)

The Speech Pathology Association of Australia agrees to participate in the above research project and gives its consent freely. The Speech Pathology Association of Australia understands that the project will be conducted as described in the Information Statement and has retained a copy of the information sheet. The Speech Pathology Association of Australia understands that it can withdraw from the project at any time and do not have to give any reason for withdrawing. Participation in the research project does not imply endorsement of the research. Further, participation or non-participation in this research by members of SPA will have no effect on members' relationship with the organization

The Speech Pathology Association of Australia (SPA) provides consent for/to: (please tick in the box space provided)

1. Participation by speech pathologists eligible to be members of SPA, as outlined in the Information Statement document provided, in an online survey.
2. Participation by the New South Wales, Speech Pathologists' Private Practitioners' Network in this research. ~~Please note that the representative for New South Wales, Speech Pathologists' Private Practitioners' Network will also be asked to provide consent to participate in this research.~~ *see note in email*
3. Allow a recruitment email for the research with an attached participant information sheet including a link to the research survey, to be emailed to members of the NSW Private Practitioners' Member Network, where completion of the survey by members implies their consent to participate.
4. Receive a survey summary report for dissemination to members.
5. Email a summary of the research to the NSW Private Practitioners network.

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Callaghan NSW 2308 Australia CRICOS Provider Number: 00109J www.newcastle.edu.au

