

23 July 2017

Attachment to:

Review of National Aged Care Quality Regulatory Processes – Public Submissions

We thank the Department of Health for the opportunity to supply an attachment, which contains a more in depth assessment of the aged care regulatory process. We have been acutely aware of its many failures and have been strong critics over the years in our submissions to inquiries, reviews and consultations. What has been revealed at Oakden in South Australia confirms our assessments.

Serious problems: In our view the policies adopted were misconceived when they were introduced, ignored available evidence they were aware of, and were driven by ideological beliefs that were unsuited to this sector.

The failure to confront the underlying problems has been due to an inability of those, who had invested their lives in this, to confront the flaws in the thinking that drove the ideology. That is now unravelling and this is reflected in the public's disenchantment with a political process that has been run like a competitive marketplace.

Finding a better way: Our analysis and efforts are not recriminatory but directed to understanding what has happened and opening debate that will lead to a way out of this system into one that is part of a cohesive community that is involved and in control of itself. This must take account of the nature of care and in doing so build a system that is underpinned by an understanding of human nature and the value of building social selves through responsible citizenship within society. We have been forced to recognise the benefits of this for other cultures (eg. Aboriginal services and in combating poverty and deprivation in the third world), yet deny it for ourselves.

The nature of government consultations and reviews: Aged Care Crisis are concerned that the consultation process around the *Review of National Aged Care Quality Regulatory Processes* has been largely inaccessible to the community, including family members and particularly to clients receiving aged care services. This is a trend that has been growing in government reviews.

Aged Care Crisis seeks assurance that there will be an opportunity for the public to provide feedback on any proposed legislative changes associated with any changes to the aged care quality regulatory processes and framework before they are presented to the parliament.

Parts to this Attachment:

Part 1: Staffing and Regulation - comparing Australia with the USA.

Part 2: Review - National Aged Care Quality Regulatory Processes and Framework

Part 3: A version of the online survey submission that is easily readable.

The department has a record of stripping all formatting including line breaks from their online submissions before publishing¹. For example, reliance on an inflexible online form, which allows plain text only (no basic formatting), coupled with the removal of paragraphs to indicate breaks (and to help assist accessibility with online readers), makes the contributions difficult to read so that the process is less transparent and public discussion is inhibited.

Further, the survey format is not conducive to the inclusion of research and evidence to back up responses, essential for the development of well-informed policy.

We believe that wide public discussion of these issues is essential before changes are made.

Prepared by:

*L Saltarelli and J M Wynne MBChB, FRCS, FRACS, Cert Ed (UQ)
Aged Care Crisis Inc.*

¹ Single Aged Care Quality Framework - Options for assessing performance against aged care quality standards: <http://bit.ly/2tvEnPN>

Part 1: Staffing and Regulation - comparing Australia with the USA

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Glossary and abbreviations

ACC	Aged Care Crisis
RN	Registered Nurse (<i>equivalent in the USA and Australia</i>)
AIN	Assistant In Nursing
CNA	Certified Nursing Assistant
CNA, NA	Certified Nursing Assistant, Nursing Assistant
LVNs/LPNs	Licensed vocational/practical nurses (USA) (<i>equivalent to Enrolled and certified nurses in Australia</i>)
PCW, PCA	Personal Care Worker, Personal Care Attendant, Personal Care Assistant (Level III or less)
hprpd OR hprd	hours per resident (per) day
CEPAR	Based at the University of New South Wales (UNSW) with nodes at the Australian National University (ANU) and The University of Sydney, CEPAR is producing world-class research on population ageing. The CEPAR is a unique collaboration bringing together academia, government and industry to address one of the major social challenges of the twenty first century.
CMS	The Centers for Medicare & Medicaid Services (CMS) , previously known as the Health Care Financing Administration (HCFA) , is a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. In addition to these programs, CMS has other responsibilities, including the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), quality standards in long-term care facilities (more commonly referred to as nursing homes) through its survey and certification process, clinical laboratory quality standards under the Clinical Laboratory Improvement Amendments, and oversight of HealthCare.gov.
OSCAR CASPER	The Online Survey, Certification and Reporting (OSCAR) system was an administrative database of the Centers for Medicare and Medicaid Services (CMS) for many years (in the USA). Effective July 2012, the OSCAR system was replaced by the Certification and Survey Provider Enhanced Reporting (CASPER) system and the Quality Improvement Evaluation System (QIES) .
Kaiser Foundation	The Henry J. Kaiser Family Foundation (KFF), or just Kaiser Family Foundation, is an American non-profit organisation, headquartered in Menlo Park, California. It focuses on major health care issues facing the nation, as well as U.S. role in global health policy.
Nursing Home Compare	Official USA government website that allows consumers to compare information about nursing homes. It contains quality of care and staffing information for all 15,000 plus Medicare and Medicaid participating nursing homes.
Pressure sores	Pressure sores - also called pressure ulcers, decubitus ulcers or bedsores, are injuries to skin and underlying tissue resulting from prolonged pressure on the skin. Pressure sores most often develop on skin that covers bony areas of the body, such as the heels, ankles, hips and tailbone. People most at risk of pressure sores are those with a medical condition that limits their ability to change positions or those who spend most of their time in a bed or chair.
SB	StewartBrown

1.1 Summary

Australia: In 1997 formal regulation in Australia was replaced by a system of 3-yearly accreditation. Staffing requirements were removed and the number of staff and the skills levels were left to the market to determine. How money was spent and how care was provided was in confidence. Staffing expectations have been based on benchmarks developed by marketplace financial advisers and not by academic research. (eg. 2.92 hours per resident day {hprd} of direct nursing care)

USA: In the USA, recommended minimum staffing levels in excess of 4 hours per resident day (hprd) are published by the federal regulator, the *Centre for Medicare and Medicaid Services* (CMS). These figures are based on extensive research and this research is ongoing. Actual staffing numbers and skills are published annually for each nursing home. Each nursing home is also inspected annually and 175 markers of care are evaluated and reported publicly.

Available data: In the USA, 93% of all 15,000 CMS registered nursing homes are found to have an average of 8.6 deficiencies. 20% of nursing homes had serious deficiencies causing harm or placing residents in jeopardy. Only 7% had **no deficiencies**. The results for every nursing home are published yearly and residents are urged to use this data.

By comparison in Australia, 97.8% of nursing homes passed all the accreditation standards and only 2.2% failed any standards.

Significant facts: In the USA staffing levels have steadily increased and deficiencies have decreased slowly. While half of all nursing homes do not reach minimum recommended levels the average levels particularly of trained nurses now reach the minimum levels.

Available figures show that Australian residents, on average, get half as much care from trained nurses and over an hour less care per day than in the USA. At the same time as resident acuity has increased in Australia, the number of nurses with the skills needed to care for them has declined. **During the same period, the success rate in meeting accreditation rates has increased from 64% to 97.8%**

Conclusion: The glaring disparity between regulatory successes in the two countries in the face of staffing data that are going in opposite directions raises disturbing questions. Staffing is the most critical determinant of care. Research studies indicate that good care cannot be provided with the sort of staffing provided in Australia.

The second part of our submission (Part B) is a slightly modified document we prepared for the minister for aged care in June 2017. It examines regulation in Australia in an attempt to explain what is happening.

1.2 Introduction

The recent exposure of the glaring failures in aged care at Oakden in South Australia going back over at least 10 years has focused attention back on to our regulatory system. There have been many ongoing failures to detect problems going back into the 1990s. These failures have been a focus of many of our submissions to inquiries and reviews.

In response to Oakden, Aged Care Crisis researched the issue and prepared a detailed analysis (dated 7 June 2017) of aged care regulation in Australia for the Minister.

The most recent and comprehensive Kaiser report analysing the extensive OSCAR and CASPER aged care data bases in the USA was published in July 2017. We have used this to contrast and compare the regulation of staffing and of nursing homes in the USA and Australia. There are important lessons in doing that.

Both the USA and Australia are characterised by regulatory systems that have been described as 'regulatory capitalism' – a centralised massive response to the problems that have developed in countries that adopted neoliberal beliefs. A system that believes markets work better with minimal regulation has been forced to increase regulation instead.

In both countries, regulation has, to a significant degree, been captured and controlled by a dominant neoliberal discourse. Both systems are at risk of ritualism and tokenism. There are significant differences in the way this regulation has been set up and operates in the two countries. They have adopted different approaches to dealing with system failure.

While accurate data is not collected in Australia, the available information suggests that Australia has a regulatory system that has allowed the nursing of the elderly to decline, leading to an aged care system that is in many ways inferior to that in the USA. It has been far more successful in hiding this from the public. The consequence has been that, despite even stronger commercial pressures and many documented failings, staffing skills and levels have improved in the USA and there has been some improvement in the services provided.

In Australia, staffing numbers have remained low and nursing skills have markedly deteriorated. Community unhappiness and anxiety has increased while at the same time there have been exaggerated and unbelievable claims to better and better performance - claims that are unsupported by clear evidence. There is a startling discordance in perception that can only be resolved by accurate data and genuine transparency.



The comparison using the Kaiser report provides a useful background to our analysis of regulation in Australia. In this document we first set the stage with our recent comparison and then follow that with our analysis of regulation in Australia

1.3 Staffing in the USA and Australia

The most critical determinant of both the quality of care and the quality of life is the number and the quality of staff and an adequate balance of each is required. The number of registered nurses has been shown to be most important in preventing harm to residents.

1.3.1 Staffing in the USA

While there are no federally legislated minimum staffing levels for the over 15,000 nursing homes registered to provide Medicare and Medicaid funded aged care in the USA, the CMS (Centre for Medicare and Medicaid Services) which regulates the sector sets out **recommended minimum staffing levels** that are required for safe care if residents are not to be harmed. These are based on careful research and expert opinion.

Because residents with greater acuity will require more skilled nursing, the CMS also published what it expects the **average expected minimum levels** to be. Several states do have legislated minimum staffing levels but the majority are inadequate. In states that have introduced higher minimum staffing standards, staffing levels and skills as well as care outcomes have improved.

The CMS collects data from all 15,000 nursing homes and this is publicly available on the large OSCAR and CASPER databases. The Kaiser Family Foundation, a nonprofit charity periodically reviews the database and reports its findings. These show that there has been some improvement in both the average numbers of skilled nursing staff and the total number of nurses.

The average has now reached the minimum recommended levels, but there are wide differences between states, within states, and between different types of owners.

The most recent Kaiser Report² dealing with the 7 years (2009 - 2015) was released in July 2017. The US figures in the graphs are taken from that.

1.3.2 Staffing in Australia

There are no minimum levels or skills specified in federal legislation in Australia and minimal data is collected and made public. Two financial entities, StewartBrown and Bentleys collect and analyse financial data from two self-selected groups of nursing homes who voluntarily supply it. That data has recently become available. Staffing is the largest cost and this data is collected and reported. The government's Quality Agency collects staffing data, but perhaps because its primary responsibility is to protect government from embarrassment that is not disclosed.

Australia has no recommended staffing levels or skills. Instead, StewartBrown has provided benchmark figures that fall a long way behind the scientifically assessed levels in the USA and Australia. Business managers use these benchmarking figures (and not the scientific assessed levels) to guide their staffing policies as well as to defend themselves against allegations of understaffing. These figures are based on financial considerations and the need to be competitive and not the needs of residents. Australian studies based on actual data in 1985 and on an academic analysis by academics in 2016 have generated figures that are close to the US recommendations.

The benchmarks in the following graphs are taken from StewartBrown's (SB) Dec 2015 report³ and the figures in the graphs from its June 2016 report⁴. The Bentleys figures are taken from a 2014 presentation to ACSA⁵.

² **Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2015.** Henry J Kaiser Foundation July 2017 <http://files.kff.org/attachment/REPORT-Nursing-Facilities-Staffing-Residents-and-Facility-Deficiencies-2009-2015>

³ **Aged Care Financial Performance Survey Summary of Survey Outcomes** StewartBrown December 2015 SB

⁴ **Aged Care Financial Performance Survey Residential Care Report** StewartBrown - June 2016 - SB

⁵ Peta Bourne presentation Aged Care Sustainability + benchmarks ACSA Finance Forum 30 October 2014 <http://bit.ly/2fAiKly>

Australia has half or less the numbers of registered and enrolled nurses compared to the USA:

- 22 to 26 min in Australia compared with 48 min for registered nurses in the USA; and
- 17 to 20 min in Australia compared with 48 min for enrolled nurses in the USA.

Combined, we see that Australian residents receive 0.7 to 0.73 hours (42 to 44 min). of trained nurse time each day compared with 1.6 hours (1 hour 36 min) in the USA.

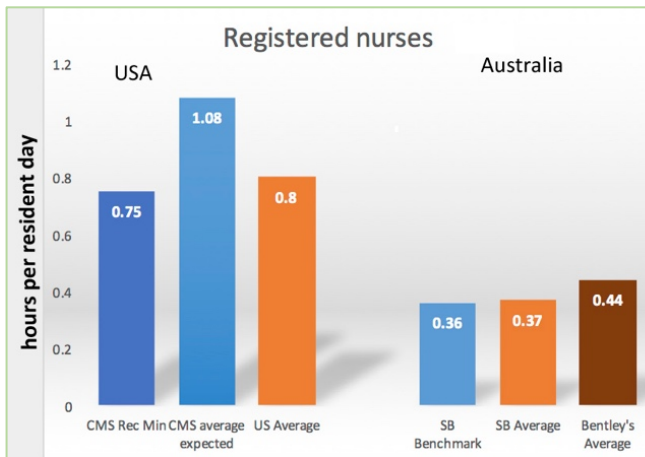


Chart 1: Comparison of Registered Nurses

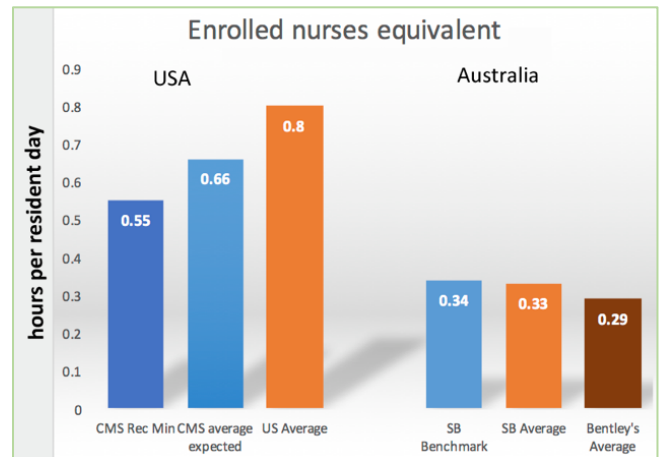


Chart 2: Comparison of Enrolled nurses equivalent

Australian aged care residents receive 52 to 54 min (55% less care) from trained staff each day.

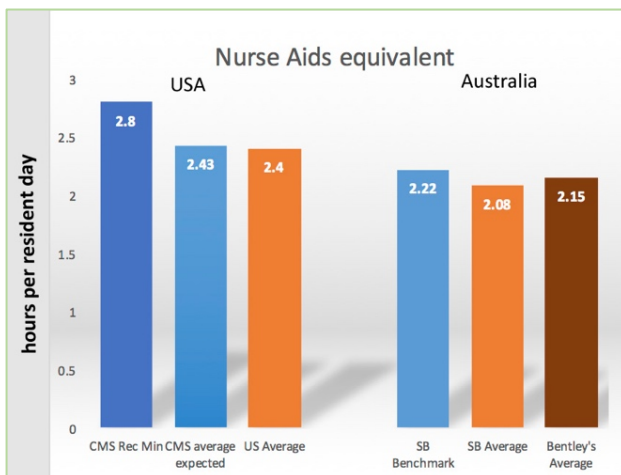


Chart 3: Comparison of Nurse Aids equivalent

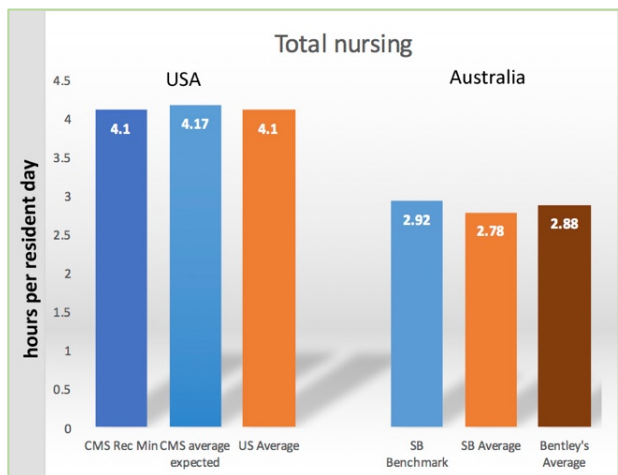


Chart 4: Comparison of Total nursing

With its low levels of trained nurses, Australia relies more heavily on nursing from personal care workers. But it still has fewer of them supplying 0.32 hrs (20 min less) to each resident compared with the USA.

In total, Australia on average 1.27 hrs (1 hr 16 min), or 30% less nursing time, is devoted to each resident per day than in the USA and that is provided by less trained staff.

1.4 Failures in care in the USA and Australia

If the US and Australian figures for staffing are accurate, then there should be many more failures in care in Australia and many more residents harmed. The data is not directly comparable in large part because of a failure to collect and publish data in Australia. Nevertheless, the difference in approach and the issues become glaringly apparent, when the figures are put next to one another.

USA: The assessments done in the USA differ from accreditation. Very few nursing homes seek accreditation although those that do perform better. In the USA, state authorities carry out yearly assessments and they are supervised by the CMS. They assess 175 individual care related items across eight major areas.

The steady increase in staffing has been associated with a slow decrease in the incidence of deficiencies but in 2015 on average there were still 8.60 deficiencies per US nursing home. State averages for deficiencies ranged from 3 to 21. Ninety three percent of nursing homes have some deficiencies. Only 7% of homes had no deficiencies. More serious deficiencies were instances of actual harm or jeopardy. One in 5 (20% of homes) had these serious deficiencies.

There were wide differences in performance between states and within states, which is what you might expect with the wide staffing differences. State staffing averages varied from 3.7 to 5.3 **hprd** (*hours of nursing care per resident per day*), all of them considerably more than Australia's 2.8 **hprd**.

An interesting example of an objective and comparable finding was pressure ulcers (bedsores) which occurred in 6.2% of residents in the USA. This can be contrasted with the 26 to 42 %, quoted by the Australian Department of Health in a consultation paper⁶ about plans to reduce the number of accreditation standards. Strangely they did not express any concern about these alarming figures. This is one of the most telling indicators of poor staffing.

Australia: Australia does not quantify specific failures in care but instead has scheduled cyclical accreditation/re-accreditation audits every 3 to 5 years that assesses 44 'quality standards'. In addition, homes are also visited yearly or if problems are reported, but the outcomes of these visits are not published.

The Quality Agency in its 2015/16 Annual Report⁷ boasts that *"more than 97 per cent of all residential aged care facilities that went through a full audit were assessed as meeting all expected outcomes of the 44 Accreditation Standards"*. Only 2.2% of nursing homes in Australia were found to have not passed all 44 standards – to have any problems in meeting standards.

The annual report indicates that of the 858, (of the total 2,678 nursing homes in Australia), that underwent an accreditation audit in 2015/16 only 70 (8%) were given a timetable for improvement. This suggests that at least 5.8% of facilities that passed all 44 standards were found at subsequent unreported visits to have deficiencies when they were not given time to prepare for the audit.

⁶ **Single Aged care quality framework** Draft Aged Care Quality Standards Consultation Paper
2017 Department of Health Consultation for proposed changes March 2017
<https://consultations.health.gov.au/aged-care-access-and-quality-acag/single-quality-framework-draft-standards/>

⁷ **Annual Report 2015/16 Australian Aged Care Quality Agency** https://www.agedcarecrisis.com/images/ar/ar_acsaa_2015-2016.pdf

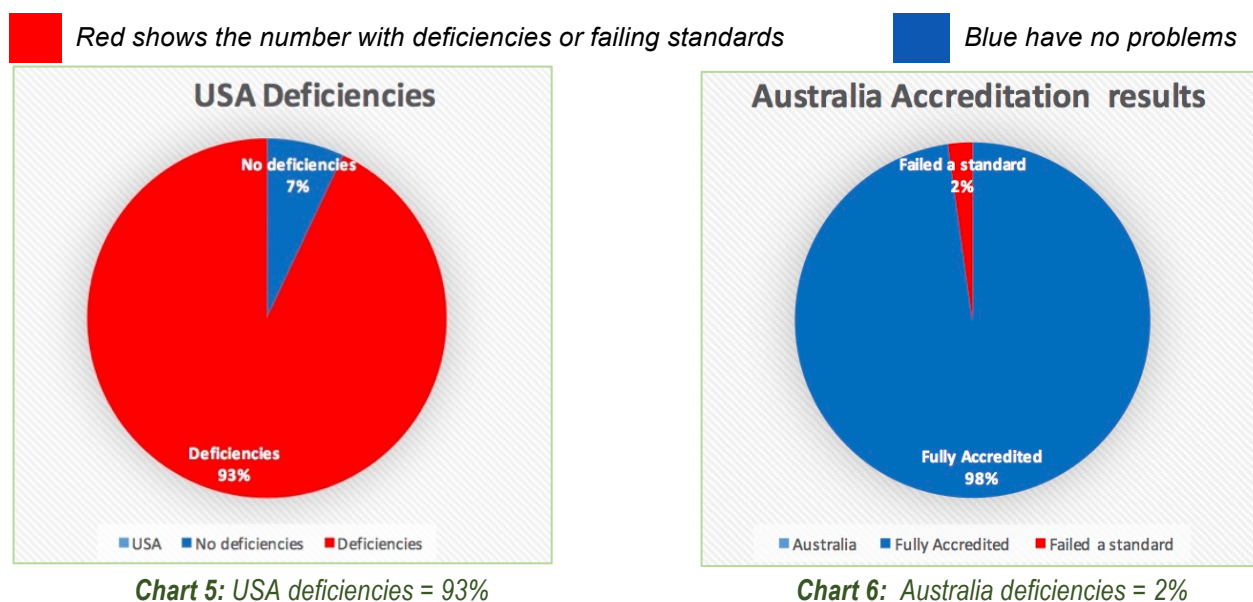
Of the 2,678 nursing homes in Australia 46 (1.7%) had been accredited for less than 3 years indicating that there were some problems. The Department of Health⁸ in its annual report indicates that it imposed 6 sanctions (0.22%) in a year during which each of the, 2,678 facilities would have been visited at least once.

Total data confusion: The difficulty in getting any accurate data in Australia is well illustrated by the federal health department's web site. A web page on the government's web site headed **Current Sanctions**⁹ and then "Display search results for Notices of Non-Compliance and Sanctions" was accessed on the 4 July 2017. It indicates that it is automatically updated. A total of 333 facilities were found and clicking on each gave details of the sanction or non-compliance.

When revisited on 18 July, two weeks later, only two facilities were found. The rest had been removed (? archived). The 2015/16 Annual Report indicates that only 6 sanctions were imposed that year. A year later on 4th July there were 333 (12% of all facilities) dodgy facilities and less than two weeks later there were only 2 (0.07%). Two facilities sanctioned for 6 months in May 2017 were not listed by 18 July 2017 – 2 months later. As the time period displayed is not given, nor the periods archived, it is impossible to do anything with these figures.

Dodgy reporting in the past: In 2008 the minister and the agency reported that only 46 (1.6% of homes) had been non-compliant with all standards.¹⁰ It turned out that this was because of the way the agency reported its figures. There were in fact 199 (7%). The (then) minister was forced to correct her error. When a sample of these failures were examined we found there were other discrepancies in the figures and in their interpretation. We suspect that the agency may still be reporting figures in the same deceptive way.

Even allowing for the unreliability of Australian data, the comparison with the USA is startling, as shown in the following two charts. Charts 5 and 6 (below) show the 2015/16 results.



Australia boasts of its 'world class system' and supports that by claiming a rigorous regulatory system. We challenge both assertions and can find no basis for them.

⁸ 2015–16 Report on the Operation of the Aged Care Act 1997 Department of Health: <http://bit.ly/2tiErOv>

⁹ Current Sanctions Department of Health: <http://bit.ly/2gNnqKu>

¹⁰ Aged Care Report Card Aged Care Crisis Dec 2008 <https://www.agedcarecrisis.com/news/research/108-aged-care-report-card>

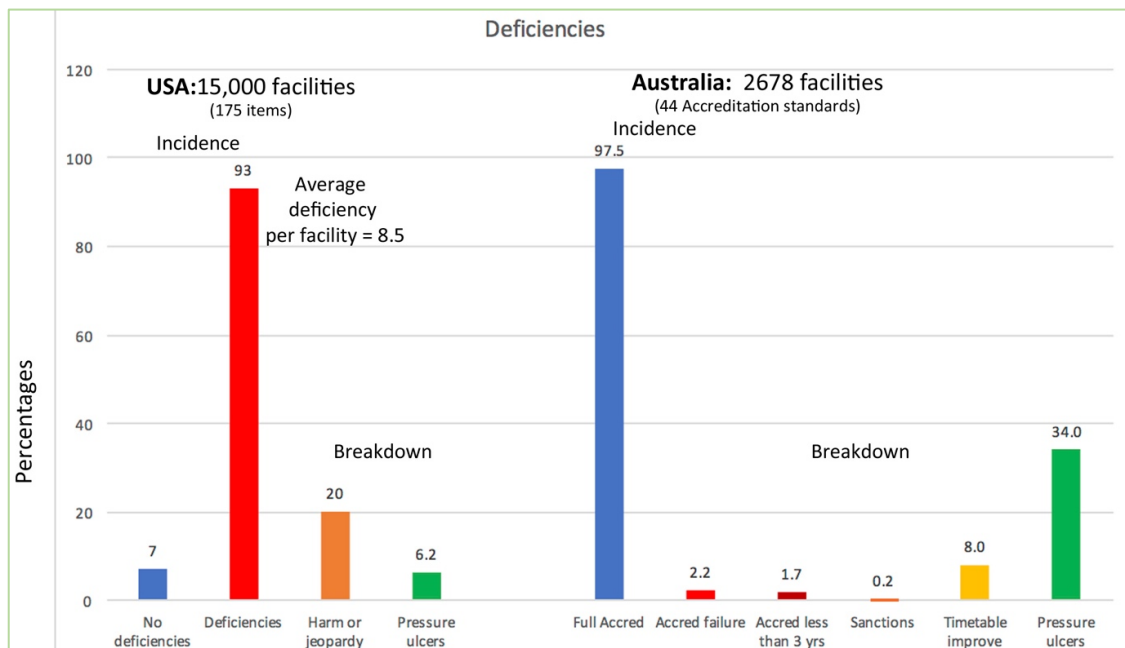


Chart 7 shows the difference in the regulatory approach between the USA and Australia:

The USA has more and better staff and the evidence indicates that it should have far fewer failures compared with Australia.

1.4.1 The different approaches used

USA: The clear difference between the USA and Australia is because, when the USA adopted a neoliberal marketplace, powerful forces including the Institute of Medicine (IOM), academics and active community advocacy groups ensured that both recommended staffing levels and oversight monitoring were based on the needs of residents, their care and a genuine desire to give resident's choice.

Both staffing and regulation have been captured by the neoliberal movement on many occasions. Needed reforms such as legislated minimum levels have been resisted or watered down. Despite this, the essential structure of the system is based on the needs of residents and the intent to give them choice. Attempts by President Reagan to use accreditation as a regulator in aged care were strongly resisted and blocked by the US congress.

In Australia: In contrast to the USA, regulation was structured to serve the market and the politicians that depended on it for support and funding. The response to intense community opposition in the late 1990s was to create a regulatory system whose primary objective was to protect neoliberal policies and serve as a marketing tool for politicians and providers in this marketplace. This was very successful but not we believe, for residents and their families.

The role of accreditation was to keep information away from the public and the press, and to create a positive image for the public. At the same time it needed to avoid the sort of failures that inevitably get to the media. This has become increasingly difficult to do. Angry families and dedicated nurses, prepared to sacrifice their jobs and future prospects have blown the whistle about serious failures in care.

It is interesting that as more scandals have been exposed, more nurses have complained and more anxiety has been generated by press exposures¹¹, the rate of successful accreditation

¹¹ Scandal after Scandal Inside Aged Care <https://www.insideagedcare.com/aged-care-analysis/19-years-of-care/scandal-after-scandal>

claimed by the Quality Agency has increased. The success rate has gone from unbelievable to incredulous. Residents cannot make choices when everyone gets full marks.



Figure: Annual Report 2015-2016 - Australian Aged Care Quality Agency, Page 7

Staffing benchmarks in Australia were developed by the marketplace and their financial advisors to serve their needs rather than that of the residents. These inadequate financially based staffing benchmarks have also been used by managers of non-profit organisations as justification for reducing staffing across all of their nursing homes¹². They have even been used (unsuccessfully) as a defense in a coroner's court when patients have died because of inadequate staffing¹³. At a time when increasing acuity demands more staffing, more and more providers are reducing staff¹⁴.

1.4.2 The Outcomes

These are reflected in the graphs.

USA: At the full yearly reviews in the USA, almost as many nursing homes (93%) had deficiencies as obtained a perfect score in Australia, where 97.6% of facilities passed all 44 standards at their regular 3-5 yearly accreditation/re-accreditation process.

In the USA 20% of deficiencies were severe enough to cause harm or create jeopardy. Only 7% had no deficiencies. In the real world you don't have perfection but this is clearly not good either!

These figures are in keeping with the fact that about half of all facilities fell below the safe minimum staffing levels and skills specified by the CMS. A panel of US experts and academics had advised even higher minimum levels for safe staffing¹⁵ but this was not adopted.

¹² Southern Cross Care defends nursing home cuts, families hit back The Chinchilla News 13 Jul 2017 <https://www.chinchillanews.com.au/news/southern-cross-care-defends-nursing-home-cuts-fami/3199884/>

¹³ Westcott, Inquest into the death of Barbara Westcott Coroners Court Tasmania 1 September 2016 http://www.magistratescourt.tas.gov.au/_data/assets/pdf_file/0007/354724/Westcott_Barbara.pdf

¹⁴ Bundaberg aged care job cuts present ethical dilemma, union says ABC News 20 Jul 2017 <http://www.abc.net.au/news/2017-07-20/concerns-over-cuts-to-aged-care-nurses-blue-care-bundaberg/8727734>

¹⁵ Harrington, C., Kovner, C., Mezey, M., Kayser-Jones, J., et al. (2000). Experts Recommend Minimum Nurse Staffing Standards for Nursing Facilities in the United States. *The Gerontologist*. 40 (1): 5-16.

Australia: In Australia very few are allowed to fail the regular accreditation audit. Sanctions are kept to a minimum. Facilities prepare for and put on a show for the 3 or 5 yearly accreditation process which is public and they advertise their success. The public are expected to believe that this reflects what happens in the 3 to 5 years between accreditation when no one is looking.

The majority of the visits in-between are not public. The facilities have sometimes not had time to prepare. An indication that problems are identified at these visits is revealed by the fact that 8%, almost 4 times as many facilities as the 2.2% who don't get 44/44 marks, are given a timetable to improve before getting their full accreditation.

The Quality Agency does not collect objective data of failures in care but some Australian academics have looked at this and found a 26 to 42% (average 34%) incidence of pressure ulcers, over 5 times that across the USA. That is what you might expect from the difference in staffing skills and numbers.

If we collected other comparable objective markers of poor care the comparisons might be similar. That this is probable is apparent from the message that nurses and family members who look and understand what is happening are sending¹⁶. Academics who have studied the sector and then spoken out about widespread failures in providing care have been attacked and pressure put on their universities¹⁷.

1.5 A balanced solution

The intense focus on data collection in the USA has resulted in task-focused care directed to documenting and performing better on the 175 items measured and on the processes of care. Assessments of care are “*decoupled*” from care itself causing “*documentation or assessment of care to trump the provision of care*”. The caring relationships and the culture on which care depends are lost. An excessive focus on data collection (the regulatory trap) takes care away from more important parameters¹⁸.

But this does not mean that no data needs to be collected. Accurate data anchors us to the real world and saves us from wandering into fantasy as seems to have happened in Australia. We are pressing for an integrated and balanced holistic system set within a social discourse of care where the different assessments and activities are integrated and balance one another. This cannot be achieved from the offices of multiple different regulatory organisations in Canberra.

¹⁶ Those who know Inside Aged Care <https://www.insideagedcare.com/aged-care-analysis/19-years-of-care/those-who-know>

¹⁷ Is this culturopathy? Inside Aged Care <https://www.insideagedcare.com/aged-care-analysis/widely-contrasting-views/is-this-culturopathy>

¹⁸ Banerjee A. The regulatory trap: Reflections on the vicious cycle of regulation in Canadian residential care - - Marketisation in Nordic eldercare: A research report on legislation, oversight, extent and consequences Stockholm Studies in Social Work 30 2013 Chapter 6 page 203 <http://bit.ly/2fEBPUv>

Part 2: Review of the National Aged Care Quality Regulatory Processes and Framework

Background

Following a meeting with The Hon Ken Wyatt, the Minister for Aged Care in May 2017, Aged Care Crisis wrote a review of the regulatory process and submitted the following analysis to the minister on the 7th June 2017. The background part of this document is slightly modified from the original.

Experience: We have closely followed the development and implementation of aged care policy for many years and have been concerned at the unwillingness of the market and politicians of both major parties to listen to critics and address their many concerns. In our view the problems revealed in the accreditation process are symptomatic of a wider structural problem in aged care that must be addressed.

Aged Care Crisis and its representatives recently attended public consultation workshops as part of the *Aged Care Legislated Review*¹ in Melbourne, Sydney and Brisbane. There was much criticism of the accreditation and the complaints systems, as well as the complexity and availability of information for both residential aged care and home care.

Put simply, the aged care system is not working for the elderly or for the community because of flawed policy by both parties. Acknowledging the problems and then working constructively together with the broad community to rebuild the system in a sustainable way can remedy this.

Trust: Aged Care is a sector where trust and trustworthiness are vitally important but these are qualities that are in short supply in the predatory marketplace. Aged Care Crisis is a strong critic of the current system and is well aware that this creates further distrust.

We would far rather work constructively with others in making the changes that are necessary.

Our analysis: In Part 2 we set out our analysis of the core problems in the regulation of aged care. We explain why it has so consistently failed and why this has so consistently been ignored and denied. The underlying problems in Australia become clearer when we look at the same problems occurring in regulation in other countries. We make suggestions for change.

We touch briefly on other matters to make the point that this is part of a larger problem in aged care and human services generally.

¹ Aged Care Legislated Review - submission Aged Care Crisis: <http://bit.ly/2qrkiEB>

Our concerns about the Review: We express our concern at the composition of the review panel, and at the narrowness of the community consultation in the Review of the National Aged Care Quality Regulator Processes and Framework². The process seems to be a repeat of the sort of responses we have seen to problems in the past. In our view, the way this has been done illustrates the problems in the regulatory system particularly well and explains why no progress is ever made.

We welcome the opportunity to contribute towards an aged care system, which the community feels is theirs and in which they can be confident living and working in aged care.

² Appointment of Panel to review National Aged Care Quality Regulatory Processes: <http://bit.ly/2q8BrSp> - 11 May 2017

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1 Summary

1.1 Regulation of aged care

1. We express our concern that social responsibility is no longer a requirement in the aged care marketplace. We look at the way the politics of responsibility has swung between those who are empathically motivated to care for the vulnerable and those who see their care as a source of profit.
2. We note that on the one hand, neoliberal free-market policy is all about less regulation, but on the other, the practical consequence of the problems created by this policy is that much more regulation has been required.
3. This regulation has been centrally controlled and that control has been vested in the marketplace and those who think in the same way.
4. The revolving door with industry has resulted in “regulatory capture” by the marketplace and the neoliberal discourse. These patterns of thinking are very different to the discourse of care and display little insight into the essential nature of care. As a consequence there is a startling lack of knowledge about care in senior management.
5. The USA and UK have similar policies to Australia and in these countries the same problems have developed. Regulation has been ineffective.
6. Regulating in this way has created major conflicts for those involved:
 - a. While the political and market discourse demands that regulation be reduced to a minimum, the problems in the system demand more regulation and not less.
 - b. There are strong pressures on regulation to protect the industry and the market from embarrassment. Exposure of the many failures not only challenges and embarrasses industry and government, but confronts those who are in charge of regulation. They too, are believers in the policy of less regulation.
 - c. The claimed rigour of the regulatory process is the rock on which the systems legitimacy depends. This is used to counter criticisms of the system when failures occur. It is also the rock on which our claims to a world class system and our ambitions in the global aged care marketplace rest.
 - d. There is a deep-conflict for those regulating. While they believe that they are regulating to improve standards and protect citizens, the pressure of their beliefs and the unspoken expectation that they will not embarrass government and marketplace are far more powerful. This leads to ritualisation and tokenism that undermines effective regulation. Coalface regulating staff who see what is happening and who try to act are overruled by their superiors. Regulators ultimately regulate in the interests of the system and its participants, ahead of those it is there to serve.
 - e. The extent to which the regulators are committed to meeting their responsibilities to government and the market is revealed in the way accreditation bodies have reported their data to hide and even counter evidence that would challenge governments claims and to support the illusion of 'world class' care.
7. When failures have increased, when regulation has come under pressure and when doubt has crept in to the minds of regulators, government has abandoned all pretence of regulatory independence and put senior industry figures in charge.

8. Formal regulation is far less effective than the social control exerted in discourse with community members in direct contact with care. They come to the problems from different points of view. In a civil society formal regulation is there to support but not replace the community. Both are necessary and should work together. Current managerial policies have negatively impacted the discourse on which social control depends so that there is little social control in aged care.

1.2 Accreditation

1. Accreditation was designed to assist motivated providers develop processes that improve care and not for any other purpose.
2. It was not intended to be a measure of standards of care, be a regulator or be used as a marketing tool. It has failed when required to perform any of these functions.
3. Accreditation has presided over and sanctioned a system where staffing levels and skills are so poor by international standards that it is impossible to provide good care and many failures are likely.
4. A focus on consumer experience when assessing standards, while ignoring the clinical outcomes of care, results in a distorted view of what is happening in the sector.
5. There are multiple inadequacies in the accreditation process.

1.3 The Complaints System

1. There has been intense and continuing unhappiness about the manner in which complaints have been handled.
2. The Walton review in 2009/10 was very critical but its recommendations compounded the problems by attempting resolution within a context where those who complained were powerless.
3. The government responded to the critical report and the expected consequences by putting appeals to decisions about complaints in the hands of a safe commissioner from the industry.
4. There is a list of concerns about its ineffectiveness.

1.4 The Department of Health

1. Whistleblowers spoke out in 2012 about the way the funding system was being rorted and the way in which the health department blocked their attempts to have action taken.
2. The health department responded by educating instead of sanctioning.
3. A 2014 review of the Department of Health⁴ revealed a toxic culture in which unpopular information was not welcomed.

⁴ Capability Review - Dept of Health (Oct 2014): https://www.apsc.gov.au/_data/assets/pdf_file/0005/64472/DoH-Capability-Review1.pdf

1.5 Part of a systemic problem

1. The aged care system is bureaucratised and controlled in a way that frustrates and inhibits the flexibility and the qualities that are needed for care.
2. The many failures in aged care are largely due to inadequate numbers as well as insufficient skilled staff, and the motivation of some staff. This is due to competition to be profitable rather than to care, an ineffective customer, a disengaged community and a regulator that protects the system rather than those it is charged to care for.
3. There are major problems and deficiencies in the collection and reporting of data.
4. Ineffective regulation has become burdensome to the industry.
5. The use of an unchecked free-market to provide care has resulted in a multitude of extra costs for both providers and consumers. It may be an efficient way of making money but it is an inefficient method for providing care.

1.6 Responsibility

1. The Government was criticised in 1997 and warned of the consequences of this sort of regulation again in 2007.
2. The responsibility for the problems lies firmly with policy makers who have adopted and imposed processes and patterns of thinking on the sector, which inhibit and prevent it from functioning effectively.
3. There are significant problems for politicians in addressing consequences, which will require a level of integrity and cooperation from politicians that the community is not used to.

1.7 The Review Panel

1. Reservations are expressed about the failure of consultation in the review process and about the appointees. We are concerned that this review has once again been set up to take the short-term expedient and paper over the problems in the system. This will be a disservice to all Australians.

1.8 Suggestions for change

1. The current aged care system has been created within a neoliberal free-market discourse and the discourse of care has been delegitimised and tokenised.
2. The values and motives required for effective care are vested in the community, which is the home of the discourse of care. It has been excluded.
3. To address the problems in care and in regulation it is essential that the discourse of care be fostered and become the driving discourse.
4. We propose an alternative approach to regulation, one which embraces the community and harnesses their strengths to manage and regulate the industry.
5. Proposals are made as to how that might be accomplished and how changes that are occurring in society can be harnessed to the effort.

2 Regulation of aged care

2.1 Centrally controlled regulation

2.1.1 History of aged care and regulation

The origins of current policy: Critics of free markets point to the issue of social responsibility and the views expressed by free market's most prominent modern advocate, economist Milton Friedman. He considered that social responsibility was socialist and should therefore not be a consideration in the marketplace.

The only responsibility in the market was to make a profit for the investors and any interference with that impeded market performance⁵. While claims are made to the contrary, this is the ethos on which discourse in our current marketplace is based. The problem with this is that unless restrained by a primary sense of social responsibility, the market readily comes to prey on society itself and particularly its more vulnerable members.

The history of responsibility: For over 2000 years social responsibility to others (particularly the vulnerable) and to the community has been a central tenet of health care and other humanitarian services. Those who exploited the vulnerable were stigmatised and subjected to pressure. The expectation that the provision of care be restricted to those who could be trusted was recognised in the passing of probity regulations.

One way of looking at the story of aged care over the last 50 years is as a battle between those who felt responsible for the vulnerable in society and those for whom they were an opportunity - a battle that in the last 20 years has put those looking for opportunities in charge of the system. The formal abolition of probity requirements in aged care in 1997 attracted hardly any attention at the time.

The abolition of the aged care probity regulations in Australia in 1997 was an affirmation that social responsibility was no longer a requirement. This was done shortly after state hospital probity requirements had seen off several very unsavoury multinational health care companies. This sent a very clear message to the marketplace that aged care was no longer different. It was now a competitive free for all. Any organisation with a track record for exploiting the vulnerability of trusting members of society can now buy Australian companies and appoint their own managers to follow their policies⁶, provided the immediate management don't have a criminal history – yet!⁷ The sector now depends almost entirely on the regulatory system to contain predatory tendencies.

The battle to rebuild social responsibility in aged care in the 1980s: Private ownership of hospitals and nursing homes had grown in the 1960s and 1970s. In 1981 there was growing concern in the community about the ownership and operation of private hospitals and private nursing homes. These included allegations about the standards of care received in nursing homes. The reports *'painted a bleak and depressing picture of life in a nursing home and some articles raised serious allegations of ill treatment or lack of care. In addition, allegations that private nursing home proprietors were making excessive profits at the expense of patients had become common.'*⁸

⁵ [The Social Responsibility of Business is to Increase its Profits](http://www.colorado.edu/studentgroups/libertarians/issues/friedman-soc-resp-business.html) by Milton Friedman The New York Times Magazine, September 13, 1970. <http://www.colorado.edu/studentgroups/libertarians/issues/friedman-soc-resp-business.html>

⁶ Letter from Department of Health and Ageing 20 Feb 2007 Corporate Medicine web site http://www.corpmedinfo.com/dca_obj2007.html

⁷ Officials 'asleep' on nursing care - SMH - 13 Feb 2013: <http://bit.ly/2pYhh2B>

⁸ Select Committee on Private Hospitals and Nursing Homes - Report (22 Feb 1985): <http://bit.ly/2rThtRd>

As in 2017, there were claims that *'private nursing home proprietors were making excessive profits at the expense of patients well being'*.

A champion of human rights and social responsibility, Senator Patricia Giles⁹, was chair of the Select Committee on Private Hospitals and Nursing Homes (1983–87). Trained as a nurse herself she understood the issues surrounding care.

Senator Giles was responsible for a 3-year review. It produced two reports¹⁰, which made significant recommendations on the ownership, administration and quality of care in nursing homes and private hospitals. These reports were critical of the failures in care in some private facilities. They felt that the only way to get the message to the Australian public was to publish the distressing photographs they were given and bring Australians *'face to face with the consequences of neglect of elderly and vulnerable individuals receiving insufficient nursing and insufficient care and suffering from poor management of nursing homes and poor nutrition'*.

The reports were critical of the fragmented regulatory system and made several recommendations for increasing regulatory oversight.

Major reforms requiring much more accountability were introduced in the late 1980s and early 1990s. A method of calculating required staffing based on the acuity of residents was developed by Dr Perrin and trialed by the Extended Care Society of Victoria. The community group Combined Pensioners and Superannuants Association (CPSA) were active in developing policy. Academic criminologist Prof John Braithwaite studied international regulation and developed a more effective regulatory system for Australia.

The market resists then triumphs: Corporate businessmen in aged care saw these regulations and the accountability as restricting their democratic rights in the marketplace. In the USA aged care had been reduced to a lucrative business like any other and Australian businessmen were envious. They claimed that these regulations impeded the successful operation of markets. These businesses took government to court in the mid-1980s in order to overturn these restrictive regulations and lost their case. They were subsequently very active in supporting and funding the party that shared their views. This support was well rewarded when the Howard government gained power in 1996.

In 1997, almost all accountability was abandoned. It was claimed that the new accreditation process would address any problems that the market did not fix itself. The *Aged Care Act (1997)* setting up the new aged care system was written to serve the industry that had supported the party rather than citizens. Doug Moran¹¹, a corporate owner, claimed to have written much of the legislation. Probity requirements were abolished.

Warning ignored: There were many critics. The focus of Senator Brenda Gibbs¹² political activities was on the interests and needs of people with physical and mental disabilities as well as on unemployed people, the aged, the chronically ill, the physically and mentally impaired, and similar issues. The interests of these groups were being abandoned as the new political focus shifted to supporting the markets that in the early 1980s had exploited the groups about whom she was concerned. She was warning of a return to those years.

⁹ Giles, Patricia Jessie (1928–) Australian Senate Biographies <http://biography.senate.gov.au/giles-patricia-jessie/>

¹⁰ Select Committee On Private Hospitals And Nursing Homes 22 February 1985 Hansard p 61 <http://bit.ly/2qCFGL8>

¹¹ Matters of Public Importance - Nursing Homes - House Hansard - 1 October 1997, Page 8926: <http://bit.ly/2qHgnq9>

¹² Gibbs, Brenda (1947–) Australian Senate Biographies <http://biography.senate.gov.au/gibbs-brenda/>

On the 24 June 1997, Gibbs gave a telling and prophetic speech in parliament¹³ in which she aptly referred to George Orwell's book '1984' as she described the way the words '*nursing care*' had disappeared from the discourse about aged care. She spoke of '*managers with no nursing experience. No longer do nursing homes have to employ a qualified director of nursing who will ensure that professional standards are met*'. She referred to '*dramatically decreased guarantees of the level of care that residents will receive*' in a system where there would '*no longer be the checks and balances*'.

Gibbs asked '*who is going to ensure that the taxpayers' money that the government allocates to these nursing homes is properly spent on nursing care?*'. Even at that early stage the '*minister is going around claiming that accreditation will take care of everything*'.

This is a claim that 20 years later is still repeatedly trotted out in the face of evidence that the system is failing. In the Bill there was '*a deliberate budget driven omission which fails to appreciate the health risk to residents in reducing or removing nurses*'.

She urged that '*aged care should never regress to the situation before 1984, as highlighted in the Giles report. This report highlighted a range of complaints against nursing homes. In fact, some of the photographs of neglected patients with bed sores you could put your fist into were horrifying*'.

Gibbs concluded her speech saying '*I believe this legislation will start a move which will work to the disadvantage of many of our most vulnerable senior citizens*'.

In retrospect, Gibbs could have been describing aged care in 2017. Sadly Labor, while in the political wilderness after 1996, abandoned the principle of social responsibility to the vulnerable and when it regained power did nothing to address the issues.

The last 20 years: Since 1997 there has been extensive rhetoric and impression management to create the perception that aged care has been improving. Luxury facilities have been built and impressive advertising brochures and websites developed. Most have accepted this claimed improvement uncritically. At the same time staffing has declined. There have been ongoing and recurrent scandals and reports of poor care and elder abuse.¹⁴ These have been brushed aside as rare exceptions. It is as if there are two different worlds.

We now know that levels of staffing and particularly skilled staff have steadily decreased at the same time as resident acuity has dramatically increased since 1997. It is not possible to provide 'world class' care with current staffing and skills. Nursing is the most important determinant of care and this suggests a steady regression back to the conditions that Giles identified in the early 1980s.

In a system, where no reliable data about failures or actual standards of care is collected, we do not know if there has been any actual improvement in care or how badly it has deteriorated. The growing unhappiness over the years has been attributed by industry to greater expectations by a more demanding population. That is likely to be wishful thinking.

We do not know how much has been swept under the carpet by a regulatory system that protects the industry and government policy from embarrassment. There has been much to indicate that the scandals and failures have been red flags to a deeply flawed system that has successfully kept failures under wraps as it protects government and market from embarrassment.

We examine that issue in this document. We conclude that this has happened and explain why.

¹³ [Aged Care Bill 1997](#) Hansard Senator Gibbs 24 June 1997 page 5042 <http://bit.ly/2rfThau>

¹⁴ [Scandal after scandal](#) Inside Aged Care <https://www.insideagedcare.com/aged-care-analysis/19-years-of-care/scandal-after-scandal>

2.1.2 The predatory market and regulation

The sort of regulation: Free-market/neoliberal policy is based on the idea that regulation inhibits the markets capacity and its ability to innovate. To deliver its benefits it must be free of these restraints. Regulation should therefore be reduced. Prominent members of the aged care market in their tweets suggest that Oakden illustrates the problem.

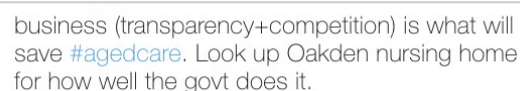


Figure 1: Twitter: <http://bit.ly/2rddWeK>

But despite this rhetoric, the predatory nature of the markets has forced increased regulation under a number of guises. Many analysts including Australian Criminologist John Braithwaite have considered this extensive regulation, rather than neoliberal theory, to be a defining feature of the era. They describe the last 40 years as the era of 'regulatory capitalism'¹⁵.

One of the features of this regulation is the extensive input and control that industry has had into the design and implementation of the regulatory processes. Any regulation has needed the approval of industry stakeholders. It has been designed within the thinking of the neoliberal discourse and many of those involved in formulating regulation would have been concerned about any consequences for them.

The other feature of this system of regulation is the frequency with which it has failed to protect vulnerable sectors of the marketplace and the participants whether these are the customers, vulnerable employees or weaknesses in the funding system. Aged care is only one example.

2.1.3 Structural issues

Regulatory capture: Control by the industry and the appointment of industry representatives to regulatory bodies is endemic in the USA where the term revolving door explains the phenomenon. We have not examined this closely in the UK.

In Australia too: At least since 1997, the market and political policies in Australia have been closely aligned. The market has exerted a disproportionate political influence when compared with other sectors.

Doug Moran may not have written the 1997 aged care regulations as he claimed, but there is no doubt that the market had a major input into and would have been heavily involved in the drafting of the regulations¹⁶. Community bodies and social service organisations that criticised either lost their funding, or were so concerned they might lose it, that criticism was muted.

Smaller and less representative community groups that embraced and supported providers and government reforms¹⁷ are well funded by government grants, projects, tenders and representation on various committees. They are prominent when making policy announcements so creating the impression that the bulk of seniors are supporting the changes.

¹⁵ [Neoliberalism Or Regulatory Capitalism](http://www.anu.edu.au/fellows/jbraithwaite/_documents/Articles/Neoliberalism_Regulatory_2005.pdf) John Braithwaite - Occasional Paper 5 Regnet Occasional Papers October 2005 http://www.anu.edu.au/fellows/jbraithwaite/_documents/Articles/Neoliberalism_Regulatory_2005.pdf

¹⁶ Matters of public importance - Nursing Homes - House Hansard - 1 Oct 1997: <http://bit.ly/2qHgnq9>

¹⁷ Community Affairs Legislation Committee - 02/05/2013: <http://bit.ly/2qV2Ubx>
COTA finds itself representing providers (CPSA) 27 June 2013: <http://bit.ly/2r1op9N>

Revolving doors: Since that time, government has appointed and been advised by a multitude of businessmen, accounting firms and economists. After the community aged care backlash in Australia in 1998, alternate views were marginalised and ‘credible’ discussion was contained within selected groups of like thinkers. Society as an effective democratic force was undermined. Knowledge and capacity within the community was lost.

Policy has been driven by those the government thought they could trust because of their shared views. Braithwaite, who studied regulation in the USA, UK and Australia applied the term ‘*revolving door*’ to Australia.

Distributive justice: What has eventuated in aged care and elsewhere has been a system of regulation that has been designed, controlled and largely operated by the belief system that underpins the market it regulates. This undermines the principle of distributive justice – the concept that regulatory effort should be shared between groups with different perspectives so that it remains independent. Different perspectives counter each other’s biases and failures.

Our assessment is that this is a major problem in aged care in Australia and is readily apparent in the regulatory processes.

2.1.4 Failures in aged care regulation globally

It is interesting that, even though they have different systems of regulation for aged care, in all three countries (USA, UK and Australia), centrally controlled models of regulation have repeatedly and consistently failed citizens in this sector. In these countries the neoliberal approach has changed the context of care from one of interaction and discourse to one of ‘payer and buyer’ or ‘salesman and customer’ and reliance on humanitarian motivation has been replaced by reliance on competition. These new paradigms are not directly applicable to aged care or to most human services.

Despite the collection of vast amounts of data in the USA, there have been recurrent and ongoing problems in aged care since the early 1980s at least. In the UK, the Care Quality Commission (CQC) has been repeatedly criticised and although it collects and reports on far more data than in Australia, it is no longer considered fit for purpose¹⁸.

Criticism of aged care in Australia has not been as strong as in these countries and this may be because government and industry don’t collect needed information. They control what is collected and how it is interpreted, and have made it far less transparent. Believers in this system have been in a stronger position to attack and discredit their critics and to paper over failures when they occur. There is now a growing ground swell from community members on websites, blogs, social media and petition sites. The extensive unhappiness about the aged care system can no longer be ignored.

There have been extensive failures in other vulnerable sectors (*eg banking, vocational training sector, employment programs and the Catholic Church*) and in other regulators (*eg ASIC, which also has a reputation for working with the market rather than regulating it*). All this suggests that we should look at structural factors in policy and in the entire centralised regulatory system. We should start by understanding what is happening.

¹⁸ [What’s Wrong with CQC?](http://bit.ly/2qMSjC3) John Burton The Centre for Welfare Reform Jan 2017: <http://bit.ly/2qMSjC3>

2.1.5 Regulatory Capture

Globally: Elsewhere¹⁹ one of us has examined the way the free-market neoliberal 'discourse' (patterns of thought) spread into health and aged care in the USA and the adverse consequences of this. Many were exploited and suffered. This discourse had captured the regulatory system, which was singularly ineffective and failed to detect what was happening. The spread of this discourse to Australia is described.

Australia: In a section "*The Politics of Capture*" on page 187 of his 2007 book, *Regulating Aged Care*²⁰, Braithwaite and his co-authors described the way in which regulation, and specifically accreditation, has been captured by the political and market discourse so that it has come to serve them rather than citizens. Braithwaite and co-workers found "*indefensible ratings of compliance during our fieldwork*". He quoted from comments by accreditation staff to show how accreditation had been dumbed down and their efforts to be effective frustrated by their superiors. He noted "*finding non-compliance would be changed by their supervisors without the reason being explained*" and "*cynicism was nurtured about the wisdom of forthrightly writing non-compliance*".

Braithwaite described the failures in regulation at that time. He may have underestimated the extent of this, or it may simply have become a bigger and bigger problem over that last 10 years. The response to the never ending exposure of failures in aged care and in its regulation has been for true believers to increase their control over the system in order to control the damage caused by publicity when the very opposite was required.

There is nothing new in this. Senator Jan McLucas described what was happening in 2001:

"... This type of approach is symbolic of this government. We have seen them destroy independent committees in Health and Aged Care. They do not like any advice that they cannot agree with, so they appoint their mates to the so-called independent committees.

The government's Aged Care Standards Advisory Committee, appointed by Mrs Bishop, is more like the quorum of a North Shore Liberal Party branch meeting than an advisory committee.

I recall that the members include Mr Lang, who is Mrs Bishop's campaign manager and president of her electorate council, Mr James Longley, a former state Liberal MP for the seat of Pittwater, and Mr James Harrowell, a long-time friend of the minister with no recognised experience in aged care. Mrs Bishop has also appointed Mr Rob Knowles, a former state Liberal minister, as complaints commissioner, so you have a friend of hers to talk to if you are not happy with the work of the standards agency.

The minister for health, Dr Woolridge, has made a number of similar appointments, including to the PBAC Mr Pat Clear, a man with 30 years experience as an industry lobbyist who now decides what medicines should be subsidised ..."

Source: Senator McLucas - Hansard - Environment And Heritage Legislation, 9 August 2001, Page 25978 <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansards%2F2001-08-09%2F0061%22>

¹⁹ Re-interpretation using Foucault - Health and Aged Care - Inside Aged Care - May 2017 <http://bit.ly/2qeluuX>

²⁰ *Regulating Aged Care* by J. Braithwaite; T. Makkai; V. Braithwaite e.Books.com: <http://bit.ly/2mUgU8>

Senator Chris Evans had raised the same issues in parliament²¹ and also expressed “serious concerns about the seemingly favourable treatment of Millie Phillips’s nursing homes, Yagoona and the Ritz. We have agency staff allegedly saying to staff at nursing homes, ‘There’s no chance of you being shut down because we know Mrs Phillips has political connections.’ Mrs Phillips, alleged to be a friend of the minister, was a controversial owner of nursing homes and retirement villages²²”.

The *Sydney Morning Herald*²³ reported concern at a decision by the “Aged Care Standards and Accreditation Agency to overturn a decision by its assessors that the Yagoona home’s accreditation should be revoked for failing to meet care standards”. They also reported that “The Australian Nursing Homes and Extended Care Association, which represents private homes, said there was a “deep-seated perception within the [sector] that the [agency] is not an independent statutory body free from political and bureaucratic interference”. It had become “part of the compliance processes of the Department of Health and Aged Care rather than a free and independent quality improvement body”.

The (then) Chairperson of the Accreditation Agency resigning because of this political interference. Senator Chris Evans indicated in 2001:

“... We have the industry—both the private, for-profit sector and the not-for-profit sector of the industry—calling for an inquiry into the agency’s handling of accreditation and expressing serious concern about what they see as political interference in the role of the agency.

And we have the former chairperson of the agency, Dr Penny Flett, a highly respected geriatrician and executive of a large aged care facility, resigning her position as chairman of the board and expressing her concern at the political interference that was taking place in the role of the agency and the operations of its board ...”

Source: Senate Hansard - Answers to Questions without Notice - Aged Care Standards and Accreditation Agency: Appointments - 26 Jun 2001, page 25079 <http://bit.ly/2rpzjtH>

It has become increasingly clear that the success of the regulatory process has been the bulwark that supports and protects the neoliberal discourse and makes it legitimate. It is used to market the government’s policies globally and to counter criticism locally. Without it the neoliberal agenda is exposed for the failure it has become in aged care. It has to be put into safe hands, hands that will protect policy and belief from embarrassing disclosures.

Different discourses: The significance of this capture is revealed when we look at the market focused discourse (patterns of thought) of managers and senior members of the industry drawn from the business sector and compare that with the discourse of care – those who actually know what is happening at the bedside. These industry representatives are the authorities appointed to the National Aged Care Alliance and multiple other bodies making policy and advising government.

²¹ Senate Hansard - Answers to questions without notice - Aged Care Standards and Accreditation Agency: Appointments <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansards%2F2001-06-26%2F0032%22>

²² Milstern Health Care: Corporate Medicine web site 2006-10 http://www.corpmedinfo.com/nh_milstern.html

²³ Bishop Feels The Heat Over Nursing Homes. Sydney Morning Herald - 22 June 2001

Example of ignorance:

Patrick Reid²⁴ who succeeded Nick Ryan as CEO of LASA and who was on the Ministerial Advisory Council on Ageing, on the Aged Care Sector Committee and Chairman, Aged Care Workforce Advisory Group, moved in 2016 to become Director - Aged Care, Community & Disability at StewartBrown, the large financial group collecting data, advising and lobbying for the industry.

In July 2016 on one of their reports, StewartBrown produced a graph of the average *Total Staff Hours* in facilities they surveyed and labelled it "Direct Care". Reid put this out on social media to counter widespread unhappiness about the direct care staffing in Australian nursing homes²⁵. It was sent to members of the senate who were running the Inquiry into the Aged Care Workforce.

Heather Witham, a senior executive with ACSA, used the same figures publicly to challenge criticism of the level of direct care by National Seniors²⁶.

These figures added almost an hour, 31% of extra direct care staffing (the staff who determine the standard of care and quality of life), to the care that each resident receives each day. But none of that was 'direct care'.

Incredibly, a CEO of LASA, who was advising government on workplace issues, as well as senior management at ACSA, did not know what direct care was. Heather Witham was previously a political adviser to Senator McLucas, a shadow minister for aged care. The CEO of ACSA in 2016 had recently been an adviser to the Minister for Aged Care.

This level of ignorance in senior management is staggering. It seems that for them, these were simply figures to be manipulated – staff were staff regardless of their training, skills or roles. These are the sort of people who manage the aged care system, influence policy and control regulation.

The discourse about failed care: The response on Twitter in May 2017 to the widespread revelations of failed care across the country, by members of LASA attending their conference, are representative of industry responses to any failure over the years. They are in denial and blame anyone except themselves. They were more interested in a talk to be given about "Innovative Fee Arrangements".

Is our industry judged by headlines? Enjoyed sharing insights @LASANational NSW conference today. Be prepared, get proactive & myth bust!

"Be prepared for the crisis - it will happen - no matter how good you are" #LASAevents

"we operate in a highly emotional sector which lends to explosive headlines" #LASAevents

Is our industry being judged by its headlines? Have your say and share your view at #LASAevents

RK Principal Victor Harcourt presenting on Innovative Fee Arrangements at the 2017 LASA VIC Conference today

Learning about Innovative Fee Arrangements from @HarcourtLaw Vic Conference

²⁴ Patrick Reid LinkedIn <https://au.linkedin.com/in/patrickwreid>

²⁵ Future of Australia's aged care sector workforce - Supplementary submission to Senate Workforce Inquiry 28 Nov 2016 Aged Care Crisis https://www.agedcarecrisis.com/images/pdf/sub302ss2_ACC.pdf

²⁶ Peaks raise aged care staffing levels and skill mix with Senate inquiry Australian Ageing Agenda 9 Nov 2016: <http://bit.ly/2rplo5G>

2.2 Conflicted regulation

2.2.1 A policy of less regulation that depends on more regulation

The conflict: We have a deeply conflicted regulatory system. It is an article of faith that regulation is bad and that we need less of it. In his book Braithwaite indicates that *the “The accreditation agency clung to the ideology that it was a child born of industry deregulation”*. It believes in less regulation and works to accomplish this (eg. attempts to accredit every 5 years instead of three, and the plan to reduce 44 standards to 8).

At the same time the extent and quality of the regulatory process is a core justification for the policies of government and the practices of the market – the rock on which its legitimacy is based. It is used for marketing the system and is the first line of defence when failures in care are publicly criticised.

The challenge: During the last 20 years the system has been plagued by recurrent scandals and ongoing failures in care. That accreditation is a flawed process and the complaints system ineffective have been recurrent complaints from community and staff, but neither can be acknowledged in the political and industry discourse if it is to remain legitimate.

The response: The defensive response has been to deny failures or else forcefully claim that failures are isolated examples in a 'world class' system as revealed by successful performance in a vigorous and effective accreditation system. That they are clear red flags to systemic problems in the system and that the regulatory system is deeply flawed are excluded from the discourse and from public rhetoric. Those who claim the system is failing are discredited.

2.2.2 Defending failures in care

The fallback position for ministers, industry advocates and businessmen when confronted by evidence of failures in the aged care system has been to assertively proclaim the rigor and effectiveness of our aged care regulation. Their responses and the claims they have made in the past are refuted by what has been revealed at Oakden and another series of similar examples on the Gold Coast, in Bundaberg, Newcastle and South Australia.

Our industry bodies including ACSA, the body representing not-for-profits, have responded to criticism by pointing to our robust regulation²⁷. ACSA has been particularly active in this and has attacked academics whose research has led them to identify serious deficiencies in the care being provided²⁸.

Individuals and their supporters who have been harmed by the system and who have received press coverage have been derided and threatened. But incredibly, the scandal that finally exposes the deficiencies in the regulatory system for all to see is defended in this way.

²⁷ How Aged Care is perceived - Inside Aged Care: <http://bit.ly/2kiybTr>

²⁸ Is this culturopathy? Inside Aged Care - Nov 2016 - <http://bit.ly/2qe7eT2>

Recent example: Oakden, the Quality Agency and Industry

As you are aware, there has been extensive press coverage and strong public criticism of the failures of the accreditation process as regulator over more than 10 years at Oakden and again recently at Bundaberg, Newcastle and Martindale Nursing Home in South Australia. The latter home has been sanctioned²⁹ only 3 months after passing all standards³⁰.

Once again, it was not the regulators, but a community visitor whose complaint about Oakden resulted in an independent outside report that exposed what had been happening at the regularly accredited Oakden.

Incredibly, the ink had barely dried on all this when ACSA, trotted out the neoliberal's article of faith by claiming that:

“Aged care is a highly regulated industry and subject to rigorous accreditation standards by the Australian Aged Care Quality Agency (AACQA). This includes both regular scheduled site visits and unscheduled “spot-checks” to ensure that providers are meeting high standards”³¹.

Then on ABC 7.30 Report on 29 May 2017, when under pressure about the many failures, Sean Rooney, the current CEO of LASA defended this with *“the accreditation system is quite robust”³².*

Truly, madly, deeply: It's like one of those old cracked vinyl records repeating their claims over and over again. The industry has been responding to criticism in this way for the last 17 years – a tried and trusted formula. They truly believe it – deeply and without doubt.

On multiple occasions the stellar performance of the providers in meeting standards has been used to counter any criticism. The legitimacy of the current aged care system, the credibility of the providers of care and the discourse on which our aged care system is based, have all depended on this defence.

A mea-culpa is needed: It is time to recognise the validity of the original issues raised and acknowledge the credibility of those who have suffered at the hands of this system but were discredited for raising their concerns. The credibility of those who attacked and discredited others in this way must now be challenged and the accuracy of the majority of the allegations accepted.

2.2.3 Selling Australia's 'world class' aged care system (Austrade)

Australia proclaims the vigour of its regulation as a measure of its quality in its promotion of our aged care services as part of its global marketing. Those speaking for government have promoted our system locally and globally by pointing to our rigorous regulatory system and our exemplary performance.

²⁹ Gawler Grande Views My Aged Care <https://www.myagedcare.gov.au/service-finder/aged-care-home-detail/sanction-detail?o=1-QQJKJS&svc=1-QQJVS8&fnd=y&s=1-AQ6XJQF&ty=ACH>

³⁰ Accreditation Reports Search AACQA http://www.aacqa.gov.au/publications/reports-b_start=0&c7=South+Australia&c5=Martindale+Nursing+Home

³¹ Statement regarding Oakden Older Persons Mental Health Service - ACSA media release - 21 Apr 2017 - <http://bit.ly/2rxJuNA>

³² Daughter says mum died in nursing home due to lack of staff, former nurses say care standards not improving. ABC News 29 May 2017 <http://www.abc.net.au/news/2017-05-29/preventable-nursing-home-deaths-skyrocket-care-standards-falling/8570096>

Australian Trade and Investment Commission (Austrade)

The Australian Government's Austrade website³³ proudly boasts of our aged care systems 'Industrial Strengths' claiming *"The aged care system in Australia is one of the most thoroughly regulated in the world and is used as a model by many other countries"*.

Our claim to be able to provide good care in Asia under our trade agreements rests on this rock. It was made of paper mache and is now a sodden mess. It is time to stop pretending and fix the system rather than paper over it again.

The real situation in Australia: Regulation, particularly accreditation is a process that has failed consistently and repeatedly since the late 1990s. It has been extensively criticised in senate inquiries, by nurses and by those families whose complaints have resulted in an accreditation whitewash. This has had little impact and the fundamental problems have been ignored.

It is now clear that all of the assurances we have been given were invalid. We need to question the performance of the entire aged care sector much more widely.

2.2.4 A deep internal conflict for regulators

There is a less easily recognised and much deeper ontological conflict (at the heart of being and identity)³⁴. This is best illustrated by the accreditation system but is generally applicable. The majority of those who manage the accreditation system are seen by the establishment and by much of society to be credible. They are appointed because they are believers in and support the discourse that underpins the free-market/neoliberal patterns of thought. They believe in what they are doing. Those who are critical are not seen as credible and are not appointed. Critics are marginalised and discredited.

Not only do those in charge of regulation share government beliefs, but also the Agency is dependent on government support for their existence. They cannot be seen to be challenging or undermining government policy.

The problem: The exposure of large numbers of failures in the aged care system exposes fundamental flaws in policy. This undermines both the credibility of this marketplace and of government policy. It challenges the discourse on which both operate and depend. It questions international claims we make as we struggle to address our balance of payments. It has political consequences. This is not something the agency's managers will want to do. They believe in the free market narrative and its failures challenge their beliefs.

The outcome: There is an intrinsic conflict that is not confronted. On the one hand, those involved assert and believe that they are regulating in the interests of the residents. On the other, they have an unstated prior more important responsibility to their belief as expressed in the discourse, to the system and to government. Everyone's gut response is to stand behind what you believe. This is not an uncommon situation. Philosophers have confronted it. Social scientists have studied the strategies we use that enable us to cope with situations like this.

The consequences in Australia: The upshot of both of these conflicts is that participants believe in what they publicly claim they are doing. In practice this is challenged and undermined by the strong pressure to defend their ideological positions and not damage government and the market.

³³ Australian Trade and Investment Commission - Austrade - Aged Care: (accessed 25 May 2017) <https://www.austrade.gov.au/aged-care/>

³⁴ Re-interpretation using Foucault - Health and Aged Care - Inside Aged Care - May 2017 <http://bit.ly/2qeluuX>

We can understand why regulation readily becomes ritualised (ie. process driven without addressing the issues) and tokenised (words and the presence of processes substitute for what should be there). These strategies allow the people involved to believe they are regulating effectively, but without doing so. The consequence is an oversight process that is easily gamed and this is glossed over.

Infrequent visits with 3 (or 5) yearly published assessments where providers have weeks to prepare and can game the system become tokens for the care that is actually provided over the remainder of the period. The claim that this is a measure of everyday care is ludicrous.

What we have is a regulatory system that supports the discourse (system of beliefs) on which policy is based and which protects government and the market ahead of the frail elderly and the standards of care that they should be receiving.

2.2.5 The extent of this problem in Australia

The extent of the problem is revealed in accreditation by the resistance to reporting staffing levels and documenting failures in care as well as the opacity and complexity of its reports to the public. Accreditation is the only source of information the public has in this marketplace and it is of very little value.

Very worrying is the high success rate in accreditation when contrasted with the situation described by nurses and families. That the nurses' concerns are well justified is confirmed by the recent release of staffing levels. These show that large numbers of Australian facilities are so poorly staffed that it is not possible for them to provide good care by international standards.

Protecting government in Australia: Good examples of the extent to which the Quality Agency is bound to the government's policies and supports them are revealed by the manner in which it has reported its data publicly.

Example 1

Government claims: Ministers and the department have justified the abolition of probity requirements by insisting that ownership had no impact on care. It was the actual providers and their managers that needed to be assessed – and in any event our vigorous accreditation would ensure that good care was provided.

International data since at least 1994 has shown that ownership type is one of the most important factors in both staffing levels and the incidence of failures in care. The more strongly profit focused the ownership type the poorer the staffing and the greater the number of failures. This was ignored.

Quality Agency support: The agency reports crude accreditation figures showing that for profit and not-for-profit owned facilities performed equally well. But even a cursory glance at the figures shows that when geographical distribution is factored in, the for-profit owned facilities must be failing much more frequently³⁵. Our analysis in 2008 revealed that when facilities in the same locations were compared for-profit owned facilities were failing between 2 to 4 times more often than non-profit.

Even after a UTS study (Baldwin et al) revealed that for-profit owned facilities were more than twice as likely to be sanctioned, the Agency responded by reporting that there was no difference in accreditation. When challenged on their analysis via phone, email and online³⁶, they refused to respond.

³⁵ Aged care report card Aged Care Crisis 2008 <http://www.agedcarecrisis.com/news/research/108-aged-care-report-card>

³⁶ Quality Agency rejects ownership factor on accreditation - AAA 15 Mar 2015 (Comments): <http://bit.ly/2r4XG0E>

Example 2

Government Claims: That we have a 'world class' system (supported by the success in meeting accreditation standards).

Agency support: The Quality Agency and its predecessor (Accreditation Agency) have consistently exaggerated the success of the sector by reporting their data as the number of failures not yet corrected on a single day each year. When failures were analysed over a 12 month period, we found that the actual number of failures over that year was roughly four times the figure given by the Agency. This was not a lie because of the small print - but the strategy used in reporting was deceptive and deliberately so³⁷.

2.2.6 Government response to problems in regulation

As indicated, 'credible' people from the sector have been put in control. But when faced by mounting evidence that the system is not working, even they begin to have their doubts and government itself then steps in to put regulation into safer hands³⁸ – one's that won't rock the boat for them.

In the USA: The major regulator in the USA even in health care is not accreditation. The main regulator for health and aged care is the 'Center for Medicare and Medicaid Services' (CMMS). The CMMS contracts most of the regulation to the states or to private organisations but it collates the data that is collected³⁹. It levies fines and penalties⁴⁰.

There were multiple undetected frauds and failures in care in various sectors in health care in the early and mid 1990s. These were followed by multiple frauds and scandals in aged care. The bulk of all this was exposed by outsiders and whistleblowers who went to the FBI under Qui Tam legislation. The regulators were singularly unsuccessful and there had been ongoing strong criticism.

Government and market were threatened. In the early 2000s President George Bush put Thomas Scully, the head of the Federation of Health Care Systems in charge of the Center for Medicare and Medicaid Services. The federation is the powerful body that represents the large corporate health care chains that were rorting the system. It lobbies for them – truly the fox in charge of the hen house. This was clearly not to protect the vulnerable but to harness the public relations skill of the industry to protect it and government. We are left wondering if it was the president of the USA or the industry that initiated this appointment. How much of a hold did industry have over government? The appointment did not stop failures or criticism of the regulator.

In Australia: As Braithwaite showed the accreditation process has been under pressure since the late 1990's with intense criticism on multiple occasions. It has doubted its role and capacity to regulate but was forced into doing so by the bureaucracy. Braithwaite quotes the chief executive of the agency as saying: *"We are not a regulator. The department is a regulator. We're an accreditor. We're about promoting quality of care."* The Auditor-General Audit Report No.42 2002-03 Performance Audit noted that even industry representatives *"have expressed concern over the Agency's dual roles as accreditor and educator"*.

³⁷ When 46 failed homes really means 199: <https://www.agedcarecrisis.com/news/research/108-aged-care-report-card>

³⁸ Re-interpretation using Foucault : Health and Aged Care Inside Aged Care May 2017 - <http://bit.ly/2qeluuX>

³⁹ Nursing Home Compare datasets: <https://data.medicare.gov/data/nursing-home-compare>

⁴⁰ Data.Medicare.gov: Penalties: <https://data.medicare.gov/Nursing-Home-Compare/Penalties/g6vv-u9sr>

The agency made a submission to the Productivity Commission in 2010. It indicated that its regulatory and accreditation roles were conflicted and incompatible. It asked to be relieved of its regulatory role – a request that the Commissioners did not accede to⁴¹.

We do not know what happened in regard to this unrest in the agency itself over the next 2 to 3 years, but in 2014 the pretense to an independent Accreditation Agency was abandoned. The Agency was transferred to a government department and the word 'Quality' added to its name.

Nick Ryan, the CEO of LASA, the industry body representing the for-profits (including the market listed and private equity owned facilities), was put in charge as CEO. The CEO now reports on the groups that, in his previous role, he was supporting and acting for. They may be sanctioned. The Quality Agency is a major component of the regulatory process and one that the public depends on. Putting it under the control of someone who comes directly from the organisation representing the industry is truly the fox guarding the henhouse.

(Ryan replaced Mark Brandon as CEO (2002 - 2013). Brandon's good relations with industry were confirmed when he became Chief Quality Officer for private equity owned Estia Health. His knowledge about the accreditation process must have been useful. Would any one dare find a facility mentored by their previous boss wanting.)

When the government put Dr. Barry Catchlove, a business executive from Australia's largest hospital corporation in charge of regulating the sector in the late 1990s, it was described as putting Dracula in charge of the blood bank. That there was no public criticism of Ryan's appointment, illustrates the extent to which conflicts of interest have become increasingly acceptable over the last 15 years.

We are left wondering about the failure to detect and act on recent problems on the Gold Coast, in Bundaberg, in Newcastle, in South Australia and at Oakden. Is this a measure of Ryan's commitment to less regulation or the extent to which the pressure to keep aged care out of the newspapers over the years has finally backfired under his stewardship?

2.3 Effective regulation - broad issues in vulnerable sectors

The absence of effective social control: The most effective form of regulation is undoubtedly the regulation that addresses dysfunctional thinking long before any harm is done. That regulation is the control that citizens exert over one another in everyday discourse. They point out problems when suggestions are made, challenge policies that are flawed, and stigmatise those whose conduct becomes questionable. But this control can only be exerted when the people concerned are in regular communication and the differences in knowledge and power do not allow the discourse to be constrained and its content limited.

In a functioning society more formal regulation is there to support this process. It is essential to deal with conduct that escapes the normal processes of social control and to objectify the limits of acceptable conduct by creating examples. They are complementary and both are essential.

Criminologist John Braithwaite's studies of aged care regulation in the USA and the UK during the 1990s identified many of their failures. He found that it was the dialog, the one on one discourse, expressed through relationships between regulators and managers during and after the site visits that was most effective in addressing issues. This went some way to compensate for the inadequacies of the systems in these countries. The most effective control is exerted by discourse because it addresses problems before they occur and addresses them immediately when they do.

⁴¹ Care and management of younger and older Australians Community Affairs References Committee (Hansard 14 Feb 2014): <http://bit.ly/1iyT2OH>

In Australia there is little real dialogue between providers and the communities they serve and there is a large disparity in knowledge and power when it does occur so it is relatively ineffective.

Developing silos: Society functions when it does not fragment into silos that no longer discuss contentious issues. When this happens each discounts the views of others. Instead of considering the arguments of its critics, the arguments are discredited by discrediting those with alternate points of view. This has been a major problem in Australia.

Reducing effective dialogue: A hierarchical management structure has spread across much of society. This has seen (particularly in aged care) one sector (or silo) of society dominate. Those most directly involved in care (the nurses and the families) are marginalised and discounted when they complain. Information about policy and processes comes down from the top without anything unwelcome or critical going back up. There is a one-way discourse that is not challenged.

The community, the repository of our social values and our humanity so important in this sector, has been marginalised and has little input. As a consequence, they are disengaged and do not understand the issues. Policies they have had no part in developing and are unable to evaluate are marketed to them like lollies.

In the absence of an effectively empowered customer and a concerned community, care has been driven by profitability, then organised into efficient processes and tasks. Empathy, and the important relationships on which care and quality of life depend are prominent on glossy web sites but are too often lost in the drive for efficiency. Attitudes and conduct, which an involved community would not tolerate, go unchecked.

3 Accreditation

Oakden glaringly exposed how flawed our accreditation system is and how unsuited accreditation is as a regulatory process. It has been heavily criticised for years and the government is now planning to bring in a new truncated accreditation process for all aged care services under the guise of the Single Aged Care Quality Framework⁴². We do not see this as an improvement. We set out our concerns and made some suggestions in our submission to the consultation process⁴³. The accreditation system has gone from bad to worse.

3.1 Background

Accreditation and its theoretical underpinning are designed to work with and assist motivated providers by helping them develop processes that improve care and certifying them when they show they have mastered the processes. We have no issue with this and believe it is useful when providers are genuinely motivated by an ethic of care. It was never designed to do anything else.

3.2 Australian accreditation within a global context

The problems in attempting to use accreditation in ways that it was not designed for are revealed in the USA where accreditation has been extensively developed. We can readily see the same problems in aged care in Australia.

It has been appropriated by the marketing process and given roles that it was never designed to fulfil. It has been used as a measure of standards of care, which it does not measure, and as a

⁴² Single Aged Care Quality Framework: <https://www.agedcarecrisis.com/news/384-single-aged-care-quality-framework-consultations>

⁴³ Single Aged Care Quality Framework - submission - Aged Care Crisis (21 Apr 2017): <http://bit.ly/2rOTlpV>

marketing tool for providers. This is deceptive because it is not a good measure of care, but simply a certification of the knowledge needed to provide good care.

Two glaring examples illustrate problems common to both countries. They are selected because they occurred in psychiatry and children were specifically targeted. This is significant because too often aged care residents suffer from cognitive impairment and anxious and stressed families who make the decisions for them readily accept the advice of trusted experts.

Example 1 - Marketing: A good illustration occurred in the 1980's when the large companies providing psychiatric care formed their own accreditation body operated by senior company executives. Accreditation became a very secondary activity and none failed. A 1992 House of Representatives Committee investigation, *'Profits of misery: How Inpatient Psychiatric Treatment Bilks the System and Betrays our trust'*, examined the way the corporate psychiatric industry had betrayed the trust of vulnerable citizens and exploited them (particularly children) in order to defraud their insurers.

It found that this psychiatric accreditation organisation was no more than a front for marketing by the industry. Any accreditation it did was tokenistic. It was aiding and abetting the fraud that was harming those who had come seeking help.

Example 2 - Measure of standards: The Joint Commission for the Accreditation of Health Care Organisations (JCAHO) is the principle accreditation body for hospitals in the USA. All of these psychiatric hospitals were also accredited by the JCAHO. What was happening at that time was glaringly obvious in readily available company documents yet the JCAHO failed to detect the administration of vast amounts of unnecessary and sometimes harmful treatment as well as this glaringly obvious fraud. On some occasions it even gave the names of those who had given them information to the provider, who was then able to victimise the complainant. Like Australia's Quality Agency, it has been heavily criticised because of the number of industry representatives on its board and has over the years been used as a marketing tool by the big hospital groups.

Accreditation of aged care in Australia is not only extensively used as the only measure of standards, but also as a marketing tool by industry and government. It is used to counter criticism and discredit those who identify problems. It has been critical to maintaining the legitimacy of both government and market in the sector. The need to protect the reputation of the aged care system has added an additional dimension. This has become increasingly important as Australia has entered into trade agreement and started selling aged care services across Asia. It is vital for the marketing of our aged care system in Asia.

3.2.1 Capturing accreditation

While the psychiatric accreditation in the 1980s and early 1990s is an extreme example, accreditation has increasingly been captured by the marketplace and has adopted its patterns of thought – the discourse that gives it legitimacy. When this happens, accreditation becomes ineffective as illustrated in the second example. Families, nurses and critics who experience and see things very differently and complain are not seen as credible within this discourse so are discredited and discounted. This was a problem in the USA and is, as indicated earlier, a major issue in Australia.

3.2.2 Accreditation as regulator

Accreditation was never intended to be a marketing tool or a regulator. Its theoretical underpinning is unsuited to this. It was never designed to, nor is it capable of coping effectively with the predatory nature of markets.

Accreditation has a very poor record as a regulator even in the USA where the world leader, the Joint Commission for the Accreditation of Health Care Organisation has had several failures in health care in the past. These have been glossed over as it has 'reformed' and 'moved on' to market itself globally. Marketing and credibility rather than performance has made it the model for other countries to follow.

Its control of information has enabled it to lead and control the discourse surrounding 'standards of care' to the extent that the word 'quality' has itself become tokenistic. It enables believers to make claims about things that are frequently deficient.

This is a particular problem in Australia. The word 'Quality Agency' is illustrative of the problem – as Oakden and other failures reveal. The Agency's recent public consultation about 'Quality' was a good example of how this word is used as a token in glossy brochures when government or businesses market idealised hype rather than practical policy or good care.

Others were wiser than Australia: In the 1980s President Ronald Reagan was talked out of his plans to use accreditation as the only regulator for aged care in the USA. Australia is the only country that has done so and it did so in the full knowledge of its failure to detect the problems in the psychiatric scandals. The prime offender in that scandal entered Australia in 1991, at the same time as the scandal in the USA were exposed. It was the subject of a series of probity reviews and extensive publicity before it was forced to leave Australia in 1995/6. Politicians of both parties were sent documents and were fully informed.

3.3 Accreditation and staffing

Staffing data: Australia was at the forefront of academic research in regulation (John Braithwaite⁴⁴) in the 1990s and also in determining staffing levels – way ahead of the USA.

As long ago as 1983/5, the Extended Care Society of Victoria produced a report⁴⁵ built around work done by Dr. Perrin in Bendigo where they had developed a 'patient-nurse dependency' system designed to calculate the nursing time needed. The study addressed the problem of understaffing that left no time for interaction and relationships. This undermined both the motivation of staff and the quality of life of residents. There was a need for a model for calculating the amount of care needed.

They worked on the basis that patients admitted to a nursing home were entitled to direct care by qualified nurses. This did not include time on non-direct activities which were calculated separately.

They carefully evaluated the acuity – the amount of care needed by residents – on a scale of 1 to 5 and the amount of nursing time needed for each level of acuity. Using their system, any facility could assess the acuity of its residents and calculate the staffing requirements.

⁴⁴ [Regulating Aged Care](http://bit.ly/2mUgU8) by J. Braithwaite; T. Makkai; V. Braithwaite e.Books.com: <http://bit.ly/2mUgU8>

⁴⁵ [Patient care analysis](http://trove.nla.gov.au/work/13159053) / presented by Extended Care Society of Victoria in conjunction with Bendigo Home and Hospital for the Aged <http://trove.nla.gov.au/work/13159053>

It was not until about 2000, 15 years later, that extensive studies in the USA during the late 1990s produced anything similar⁴⁶. In Australia it took another 16 years before researchers in South Australia carried out a study for the nurses⁴⁷. The latter two included assessments of the skill levels needed.

It is interesting that in the Extended Care Society Study in 1985, the direct trained nursing staff time recommended for levels 4 and 5 (the sort of residents in nursing homes today) was 3.4 and 4.6 hrs per day respectively, a mean of 4 hrs. This is very similar to the total hours recommended in the USA and by the recent Australian study.

Even in 2003 the industry were collecting data about staffing which showed the reduction in staffing that occurred after the 1997 changes. Talking about quality of life, an industry representative⁴⁸ told a parliamentary committee that *"Their (Bentleys) survey shows that the amount of time per resident per day has declined consistently over the last five years. So the amount of time that staff can spend talking to residents has been reduced"*.

We have recently learned that Australia today, averages roughly 2.8 hours per day and supplies much less than half as much trained nurse time as in the USA, which on average supplies less than its own recommendations.

Australian residents receive on average one hour less care than in the USA. In some instances there are no trained nurses on duty at all. As the 1983/5 study shows it is not possible to provide consistently safe care, let alone a good quality of life with this staffing.

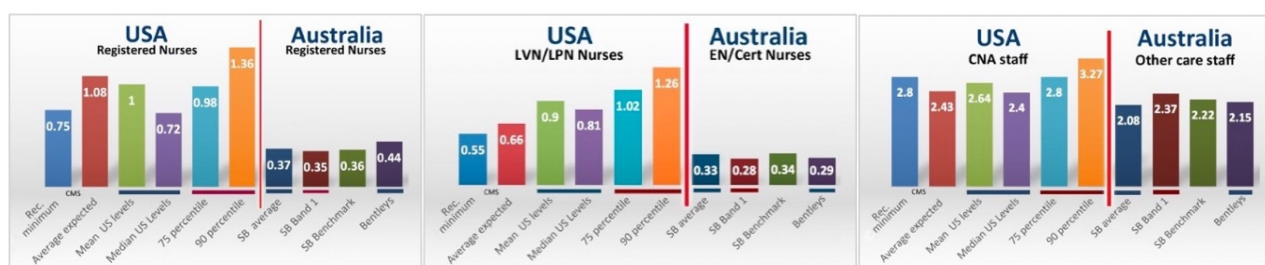


Figure 2: Future of Australia's aged care sector workforce - Supplementary submission
Australia and the USA - Comparison of staffing levels <http://bit.ly/2rEeSqM>

These changes in staffing have occurred under the watch of our regulators, who have consistently supported the claim by industry that requiring minimum staffing levels and skills is not effective or practical.

⁴⁶ [Future of Australia's aged care sector workforce](#) - Supplementary submission to Senate Workforce Inquiry 28 Nov 2016
Aged Care Crisis https://www.agedcarecrisis.com/images/pdf/sub302ss2_ACC.pdf

⁴⁷ National Aged Care Staffing and Skills Mix Project Report 2016 - ANMF & Flinders and Adelaide universities

⁴⁸ Review of Auditor-General's reports, fourth quarter 2002-03 - Joint Committee Of Public Accounts And Audit 18/08/2003
<http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;adv=yes;orderBy=customrank;page=0;query='mr bushrod';rec=1;resCount=Default>

Extreme example - DIY care: In 2012 there were astonishing revelations that no staff at all were rostered to look after residents in a Queensland nursing home for considerable lengths of time⁴⁹. They were left to look after themselves. Aged Care Crisis used the revelation to ask the Minister, if he wasn't prepared to set safe or minimum staffing ratios and skills in aged care, to at least mandate transparency about how homes were staffed. This would allow family members to make informed decisions about aged care placement for their loved ones.

Staffing information remained opaque and the facility was not sanctioned.

3.4 Accreditation and the 'consumer experience'

Components of care: Residential aged care has been seen as two components, clinical - which must be provided to all and lifestyle, which includes style of accommodation and creature comforts. Lifestyle is dependent on the level of wellness attainable by clinical support. It will vary with multiple factors including past career, academic attainment, mental capacity and financial resources.

We might see quality of life as the target of the market sector because that is where additional services beyond supporting wellness are provided. But the two are closely integrated and quality of life must be set into the context of clinical needs, which should not depend on the vagaries of the market. A rebellion against the 'medical model' of the past has failed to recognise that medical issues remain critical for wellbeing and so quality of life.

Confidential surveys and interviews with residents can be useful for monitoring quality of life but can be deceptive in regard to standards of clinical care. Even random selection selects from those who are well enough mentally and physically and who need less intense or even palliative care.

Most do not have the knowledge to judge the quality of nursing care and Australian facilities are seriously deficient in trained staff (eg, less than half the trained staff compared with the USA). This is where clinical care suffers most, where the major complaints are, and that is not being evaluated.

Consumer feedback: The Agency's recent introduction of a proforma 'consumer experience report'⁵⁰ imposes a strict formulaic style of feedback questions. The proforma used⁵¹ limits feedback to what the Agency wants, not what residents need. Surveys of this type have been undertaken by providers and others in the past and they fail to disclose what is clearly happening and causing so much unease.

Reflecting the discourse: As happened in the US examples (where children were abused and harmed) families and residents and families readily become part of the discourse around them and accept what is happening as good care without question. Consumer views are undoubtedly important, particularly in a sector like aged care, but they must be complimented by solid data about the clinical care if they are to be an accurate reflection of what is happening and counter this problem.



⁴⁹ No staff for 10.5 hours per day (19 Dec 2012): <https://www.agedcarecrisis.com/opinion/articles/213-no-staff-for-10-5-hours-per-day>

⁵⁰ Consumer Experience Reports: <https://www.aacqa.gov.au/publications/consumer-experience-reports>

⁵¹ Likert scale: <https://www.surveymonkey.com/mp/likert-scale/>

A market based approach: The focus on users experience is very important, but when used alone is a simplistic administrator/managerial/marketplace approach to problems and reflects the continued denial of the importance of clinical skills and palliative care in this setting. This approach is based on the illusion that ageing is normal and that people do not die from the same sort of organ failure that kills younger people and needs the same sort of support and care. Knowledgeable clinicians who have complained about this have been ignored.

Real support needed: Family members looking to place a loved one in care need local and personal advice from someone they can trust who has direct knowledge of the facility and can work with prospective residents by explaining both the clinical resources and performance they need as well as the opportunities for quality of life. They both need verifiable information including a transparent and standardised set of real-world measures of performance. Those measures should include information on pressure injuries, infection rates, staffing levels, restraint levels, complaints made to the service and what the provider did to remedy the problems in addition to feedback from existing consumers.

Support based on regular oversight: Other than the standard of the facilities themselves, any meaningful assessments require the presence of people who are regularly in attendance at the facilities. This is what Aged Care Crisis is proposing and what we describe later.

Subjective assessment: Subjective assessments are important but are only of real value when they are based on regular contact and interaction with residents and staff. They must be set against other objective data.

Potential bias: The 'consumer experience reports' are devised from a small sample of people interviewed - approximately 10%. As is apparent from recent failures, many family members and staff are reluctant to speak out about failures in care as they are fearful of retribution. This 10% would be readily identified and it would be easier to recognise who had had the insight to be critical. There is a massive power imbalance⁵².

Residents and families fear retribution and nurses fear for their jobs. Residents and families seek to protect hard working nurses who are overstretched because they and not management, will be blamed for failures.

One resident said it was impossible to complain to inspectors without managers finding out and being labelled a troublemaker. She said the accreditation team visits were tightly controlled.

While there was a sign up on the noticeboard telling residents they could speak anonymously to the Aged Care Standards and Accreditation Agency inspectors, the only way to contact them was through the nursing home office.

"You have to ask the office," she said. "People are definitely victimised."

As with all aspects of the regulatory framework, the industry has been heavily consulted to ensure the reports depend upon and validate the success of their businesses.

Moving from 44 to 8 standards: Instead of increasing access and oversight by regulators to address the increased risks, the proposed changes to the regulatory system reduces regulation. This makes it impossible to evaluate the ambience and cultural aspects of the services provided effectively. Many of the proposed new standards depend on subjective assessments.

⁵² Elderly in nursing homes tell of suffering in silence:
<http://www.couriermail.com.au/news/elderly-tell-of-suffering-in-silence/news-story/81175ec1f133931e7c79ed93a9c691e0>

While there are references to clinical care, quality of life and to outcomes, there are no plans to actually examine the way in which care is provided and to evaluate it in an ongoing manner. The assessments in the revised 8 standards will be largely subjective. The infrequency of assessments makes this unreliable.

Making it work: Consumer feed-back is an important component of assessment but it should be part of an independent process and in a context where consumers' contributions are welcomed and they cannot be victimised. Total transparency is impossible here.

3.5 Inadequacies of the accreditation process in Australia

1. There is a **paradigm conflict** between accreditation and regulation with consequences for the way the service is provided.
2. **The measurement of process rather than outcomes.** We simply do not know whether the processes work, whether they are followed and how often they fail.
3. **The measurement itself is farcical.** It lacks sensitivity and scale. A measure in which over 97% of those evaluated obtain full marks (97.8% or 100%) is meaningless. Having every result at one end of a Bell's curve is a test that does not discriminate.
4. **Lack of transparency:** Not only are the accreditation reports largely meaningless to the public and researchers, but until quite recently they spent only a very short period on the website before being replaced.
5. **There is no analyses of trends** for individual homes, company performance, ownership type performance, sector performance, or the multiple variables that apply. The department needs this information to advise government. It is essential for those undertaking research. The public needs it, so that it can debate rationally and effectively.
6. **Unannounced visits** which occur once a year show only what is happening on one day and not the other 364. Anecdotal stories suggest that few visits are unexpected. It is not possible to monitor and measure failures in care by occasional visits. An onsite regular presence is required. These findings are not made public.
7. **The vast number of reports that appear on the agency website** are from formal planned visits. These are prepared for and are easily gamed. They do not as claimed, represent what normally happens. They are not standards.
8. **Ritualisation and Tokenism:** Any bureaucratised process, but particularly one where there are paradigm conflicts is at risk of "ritualisation". The focus shifts to ticking the boxes and not on improving care. Processes become tokens for actual care.
9. **The foxes guarding the hen house.** The impact that having representatives of the sector on the board and in powerful positions in the agency – and the use of past, current or possibly prospective nursing home staff as assessors.
10. **Assessors can feel threatened:** No sensible assessor from one owner's nursing homes is going to produce negative findings on the homes of another large corporate provider whose executives are mates of their employer. Whistleblower's stories are a warning.
11. **Past assessors** have a number of lucrative employment opportunities because of their new skills. An assessor might be wary of compromising their future prospects. These problems arise because of the conflicting roles of the agency.

4 The Complaints system

We have concentrated on the accreditation system because the problems are currently so glaringly apparent. The complaints system⁵³ has suffered from many of the same problems over the years and has been revised many times without addressing the core problems.

Successive reviews and inquiries have ignored the logic of various submissions and cherry-picked items that have then been incorporated into policy and practice, adversely influencing the way in which the aged-care system operates. The systems fifth reincarnation is still deeply flawed.

The power imbalance: The system has been heavily criticised by families. It too has been captured by the market and its discourse. It thinks like the industry and too frequently discounts the experiences of those who complain. It does not consider them to be credible when compared with the providers. so that their complaints get nowhere. They are left disillusioned, angry and depressed.

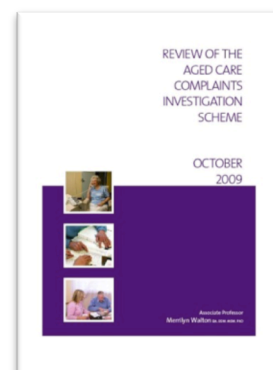
Families feel powerless and fear that their family member in the facility will be victimised if they complain. Many become dispirited and give up. For example, in 2005 the *Canberra Times* gave several examples and reported⁵⁴:

The ACT's aged care advocate has called for a national inquiry into retribution against nursing home residents, alleging up to 50 "payback" incidents in the territory in the past three years. Acting manager of the ACT Disability and Aged Care Advocacy Service, Michael Woodhead, told yesterday a Senate committee inquiry into aged care the problem of aged care residents being punished for complaining about their standard of care had existed in Canberra nursing homes for many years.

"What is needed is a national strategy for the elimination of retribution, and fear of retribution in aged care [and] in order to gain acceptance of the need for a national strategy to combat retribution, an investigation is required to identify the actual level of retribution in aged care," Mr Woodhead told the committee.

Mr Woodhead's assertions of widespread retribution have been backed up by other advocacy services around the country.

The Walton Review: An example of this is the way in which the review of the Aged Care Complaints Investigation Scheme, the Walton review in 2009-10⁵⁵, virtually destroyed the utility of the whole complaints system. It embraced our recommendation to place more focus on local resolution. But it ignored supporting information on the logic behind this and the **essential linked recommendation that the complainant should be supported and advised by a trained local facilitator with investigative powers.**



⁵³ Aged Care Complaints Commissioner (from 1 Jan 2016): <https://www.agedcarecomplaints.gov.au/about/>

⁵⁴ Call for probe into aged care paybacks *Canberra Times* 12 February 2005

⁵⁵ Review of the Aged Care Complaints Investigation Scheme - October 2009: <http://bit.ly/2qH2wQW>

Under the changes that were made, confused, upset and unsupported families were forced to resolve issues with powerful providers who did not accept that there were problems. As a consequence, vulnerable families were further disadvantaged. They learned not to complain and fewer did. This reduction was hailed as a success and not seen as the problem it was.⁵⁶

Problems identified: Professor Walton described the legalistic pattern of thought that developed in the department. It resulted in a legalistic evidence based natural justice approach that did nothing for residents and families. By the time staff from the department arrived in the scene documents had been tidied up and witnesses coached – or fired. Walton confirmed our own assessment.

Capture: Walton may have suspected that the system had been captured. She recommended that the complaints system be ‘independent’ of government. This recommendation was only implemented in a tokenistic way several years later. To be truly independent, staff appointments need to be independent as well. Currently, if they become too critical of the system they will be seen to lack credibility and brought to heel. This has happened elsewhere (eg. after the exposure of the abuse of asylum seeker children).

Government responded to the revelations of the Walton Review by making Professor John Kelly, a lawyer who represented and advised the industry and who had been a director of a for-profit company, (temporarily) Aged Care Commissioner. He subsequently became CEO of ACSA where his strong views and support of the industry were revealed in his response to criticism and in his attack on academics whose research exposed problems in the system⁵⁷.

Current concerns:

- There is much to suggest that, when problems are identified, aged-care homes are required to **do little more than agree to make some amendments** to policies and procedures.
- Residents and families who have plucked up the courage to complain are **not dealt with sympathetically**. On occasion the only feedback they have received has come when facility management has informed them that the accreditation visit that resulted gave them full marks. They have had no explanation.
- There is **no resolution or compensation** for those who suffer from dementia or are frail when they have suffered injury, health consequences or abuse.
- Healthy individuals in the community can seek **redress and compensation** through the courts. Frail residents and their families become tied down in the complaints process which does not give them redress or penalise those at fault, who go unpunished.
- The **widespread overuse of chemical restraint**⁵⁸ and excess use of psychotropic drugs is not being contained or addressed by the accreditation or the complaints system. A recent study (HALT⁵⁹) led by UNSW researchers labelled the inappropriate use of antipsychotic drugs in Australian nursing homes as 'widespread'.

⁵⁶ Evidence by Ms Smith (Dept Health) in 'Care and management of younger and older Australians living with dementia and behavioural and psychiatric symptoms of dementia (BPSD)' Senate Community Affairs References Committee - Wednesday, 17 July 2013 <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22committees%2Fcommsen%2Fae6cedd9-97a5-4214-a9da-24e4bad3a174%2F0005%22>

⁵⁷ Is this culturophathy? Inside Aged Care <https://www.insideagedcare.com/aged-care-analysis/widely-contrasting-views/is-this-culturophathy>

⁵⁸ Widespread antipsychotic use in nursing homes unnecessary, trial shows (26 Jul 2016): <http://newsroom.unsw.edu.au/news/health/widespread-antipsychotic-use-nursing-homes-unnecessary-trial-shows>

⁵⁹ Jessop, T., Harrison, F., Cations, M., Draper, B., Chenoweth, L., Hilmer, S., . . . Brodaty, H. (2017). Halting Antipsychotic Use in Long-Term care (HALT): A single-arm longitudinal study aiming to reduce inappropriate antipsychotic use in long-term care residents with behavioral and psychological symptoms of dementia. *International Psychogeriatrics*, 1-13. doi:10.1017/S1041610217000084 <http://bit.ly/2rOLH4j>

- **The very poor levels of staffing** in Australian facilities has not been impacted by the complaints system. The use of the courts by families, community groups and by employees using the Qui Tam laws in the USA has imposed a heavy penalty for poor care and understaffing.
- **A lack of transparency:** Data about the incidence and validity of complaints for each facility and provider are not published. Prospective residents and the community are kept in the dark. Their ability to choose wisely or to constrain the excesses of an aggressively competitive market are impeded.
- **Privacy** is an important consideration, but should not be used as an excuse or a barrier to transparency and accountability or as a way not to protect those who are unable to protect themselves.

5 The Department of Health

Ticking off fraud: Very similar problems were revealed by the ABC 7.30 report on 16 August 2012⁶⁰. These revealed the extent to which the bureaucracy had been captured and come to serve the market and protect politicians from embarrassment rather than the community. In Australia the department is the ultimate regulator and imposes sanctions. It monitors financial matters.

Nurses working for the health department spoke out and blew the whistle about the department's failure to address serious rotting of the system. They claimed that facilities were "treating the residents like a cash cow". It was their job to oversee the payments. The department was not acting on the information they supplied. They were *"told to look the other way, tick it all, let it go through."* and *"told many, many times it was not my money."*

The response: Instead of investigating after the television program, then stigmatising and penalising those responsible, the department elected to avoid publicity by 'educating' instead. Within 6 months the incidence had increased by another 4% and with nearly 20% of claims being incorrect. The department, talking to the *Senate Community Affairs Legislation Committee Estimates* on 13 February 2013⁶¹ referred to this as *"incorrect claiming"* rather than fraud. The department were still *"offering workshops for providers and their staff who make claims and working with the industry"*.

The nature of the department: Further insight into this was revealed in 2014. A Capability Review of the federal Department of Health and Ageing⁶² found that *"- it is beset by a culture of 'inappropriate behaviour' including bullying and harassment, a command-and-control approach by top bosses and an environment where mistakes are not tolerated"*.

It was *"hierarchical and siloed"* and *"public servants were afraid of the consequences of mistakes or to break bad news to its leadership"*.

There was a *"level of bullying and harassment they were told about and the reluctance of public servants at Health to make formal complaints"*.

⁶⁰ Funding feeds profits over aged care - ABC 7.30 Report, 16 Aug 2012 <http://www.abc.net.au/7.30/content/2012/s3569659.htm>

⁶¹ *Senate Community Affairs Legislation Committee Estimates* - Wed 13 Feb, 2013

⁶² The federal Health Department: 80-hour weeks, bullying, command and control The Canberra Times 8 Dec 2014 <http://www.canberratimes.com.au/national/public-service/the-federal-health-department-80hour-weeks-bullying-command-and-control-20141207-122cu8>

On reflection, we can understand that rorting by providers was bad news, would have embarrassed government and would have been unwelcome. This is similar to what Braithwaite and others described, in accreditation. Here, assessors who failed nursing homes were overruled.

A green light for rorting: It is hardly surprising that the system has been 'maximised' - but not called rorting, several times since then in Community packages (2013), the Dementia supplement (2014), Consumer Directed Care (2015), and then in 'complex health care' (2015)⁶³.

6 Other system problems

6.1 Part of a wider problem

The Gregory Report that preceded the 1997 legislation stated that with the proposed market system *"neither the current standards monitoring system, nor any alternatives considered, would be able to prevent the diversion of funding from nursing and personal care to profit"*. The response to this was to ensure that the entire regulatory process be in 'safe hands' – those who could be trusted to preserve and maintain the system.

Data was not collected and the interpretation of public information was in safe hands. The thinking behind this can only be imagined but logic was clearly not a part of it.

Both accreditation and complaints are a subset of a larger problem which at its heart allows the diversion of funds from care to profit. In doing that it has created a system that confronts and undermines the discourse of care and makes it difficult to realise.

The management and regulation of aged care is centralised, complex, fragmented, and poorly coordinated. It is bureaucratised, highly managed and process driven. This has resulted in a process and task focused system that is insensitive and impersonal. It inhibits empathy. It is unresponsive so that some fall through the cracks and others receive care because it is profitable rather than effective. Worse still, it is easily rorted by providers and it has been on multiple occasions.

The many failures in aged care are largely due to **inadequate numbers as well as insufficient skilled staff, and the motivation of some staff**. This is due to competition to be profitable rather than to care, an ineffective customer, a disengaged community and a regulator that protects the system rather than those it is charged to care for.

It is clear that many have been well motivated and succeeded in providing good care. That many have resisted the pressures and perverse incentives in this system, and provided good empathic care is not a defence of a system that makes this difficult to do. Good care is given in spite of and not because of the system. Without good data we know that too many are succumbing to commercial pressures but not how many.

We are not complaining about bad people but about a system built on bad policy and a deeply flawed discourse.

6.2 Data collection in Australia

Australia lags a long way behind the USA and the UK in the transparent collection and publication of data. In the USA the Nursing Home Compare⁶⁴ website allows the public to examine all of the

⁶³ Consequences of marketplace thinking: Slider 2: examples in Australia. Inside Aged Care <https://www.insideagedcare.com/aged-care-analysis/aged-care-marketplace/aged-care-in-the-dark/consequences-of-marketplace-thinking-slider-2-examples-in-australia>

data collected about nursing homes and home care. The entire data set⁶⁵ is available to the public and researchers.

The UK's Care Quality Commission⁶⁶ (CQC) provides extensive data going back for 10 years as for example for Donisthorpe Hall⁶⁷. Visits are more frequent and unlike Australia all are published. Its site is updated weekly⁶⁸ with comprehensive data, including the ability to download and analyse it.

While these countries have similar problems in regulation this is not due to a failure to collect and publish data. What they collect is far superior and far more useful than that available from our Quality Agency in Australia.

Data is essential for managing facilities, for government, local community and provider policy, for consumer and community information, for public discourse, for the market to work, and to anchor regulatory effort to what is happening in the facilities and the sector.

6.3 The story of data in Australia

The first audit: In its 2002-3 audit of the accreditation agency the Australian National Audit Office⁶⁹ (ANAO) was critical of the failure to collect useful data to assess whether accreditation had any impact on care, monitor its own performance and measure quality of life. It indicated that *“the Agency does not yet have a way to assess the outcome of its accreditation and monitoring work on the residential aged care industry”* and recommended that it *“plan an evaluation of the impact of accreditation on the quality of care in the residential care industry”* to *“provide the Agency with assurance that its management of the accreditation process is effective”*.

Then again it recommended that *“the Agency implement a suitable system to analyse the accreditation process and use the results to identify improvements to the process”* so that there were *“mechanisms to ensure that it has a robust, well-documented quality assurance system that supports high quality and consistent assessment outcomes and related decision-making”*

The senate debated the issues: These matters were raised in parliament during a hearing of the *Joint Committee Of Public Accounts And Audit* in August 2003⁷⁰ where the lack of consistency of audits was acknowledged and the failure to collect data to evaluate the accreditation process questioned. The industry and the agency indicated that they were addressing these issues.

The industry (Mr Mundy) indicated a willingness to use a *“resident-mix-adjusted basis - -(to) - look at the incidence of quality failures. For example, -- the incidence of ulcers from pressure sores and so on”*. Another industry representative (Mr Young) indicated that there were already:

“... in excess of 600 facilities out of nearly 3,000 nationally — who participate in some sort of voluntary benchmarking exercise for their clinical services. The sorts of things that Mr Mundy just mentioned — like the occurrence of infection rates, bed sore rates, medication errors and those sorts of things—are being recorded, in fact they form an integral part of those facilities' quality improvement systems for accreditation purposes”.

⁶⁴ Centre for Medicare - Nursing Home Compare: <http://www.medicare.gov/nursinghomecompare>

⁶⁵ Nursing Home Compare datasets <https://data.medicare.gov/data/nursing-home-compare>

⁶⁶ Care Quality Commission - UK - <http://www.cqc.org.uk/content/fundamental-standards>

⁶⁷ Donisthorpe Hall -- Care Quality Commission - UK - <http://www.cqc.org.uk/location/1-114958058/reports>

⁶⁸ CQC - Use our data - <http://www.cqc.org.uk/content/how-get-and-re-use-cqc-information-and-data>

⁶⁹ Managing Residential Aged Care Accreditation The Auditor-General Audit Report No.42 2002-03 Performance Audit Australian National Audit Office (ANAO) May 2003 https://www.anao.gov.au/sites/g/files/net2766/ff/anao_report_2002-2003_42.pdf

⁷⁰ Joint Committee of Public Accounts and Audit - Review of Auditor-General's reports, fourth quarter 2002-03 - 18 August 2003 <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22committees%2Fcommjnt%2F6844%2F0003%22>

He indicated that although not universal, the industry was “*certainly growing it over time*”.

There was also discussion of the need to assess accreditation against staffing levels. The committee asked “*what sort of impact does the availability or shortage of qualified nursing staff have on the accreditation process?*” Mr Mundy pointed out that things that were not regulated or assessed (ie staffing) were the first to be cut back (an example of Campbell’s Law at work).

The department indicated (Mr Mersiades) that those who were not tracking their performance were exiting the sector. He said “*Those who are left are signing up to a process of continuous improvement using the sorts of statistics that Mr Young was referring to in terms of tracking how they are performing against things like bedsores, falls and medication processes*” and “*we do need to be able to make a better fist of being able to demonstrate that the accreditation system is having a positive effect*”.

When the chairman of the *Joint Committee of Public Accounts and Audit* asked “*whether there is any variability between the sectors—that is, private, state or not-for-profit—that anybody could discern?*” Mr. Brandon (then CEO of the Agency) was quick to respond, “*No, we do not have any data*”.

As we know, international data in the USA had already clearly shown the differences and some of those present must have known this, but none volunteered this information. As illustrated earlier, when the agency did respond to this, it reported its data out in a way that concealed the differences.

Abandoning these good intentions: These lofty objectives were soon forgotten as competitive pressures began to bite. Few if any of these good intentions were ever implemented.

Senate Inquiry - 2005: Accreditation and complaints systems were heavily criticised in the June 2005 Senate Review of aged care⁷¹. It was claimed that “*Evidence indicates that there is little systematic data that demonstrates how accreditation has impacted on quality of care. One submission noted that the Agency has 'not produced any material which would provide the sector or the community with any level of assurance that the overall intention of accreditation in improving service quality has been achieved*”. (Page 34)

Another review of accreditation: In 2007 the agency chose an accreditation friendly review body to give it a pat on the back and supported them in not collecting, evaluating and reporting on failures in care⁷². In a report loaded with jargon and positive language, failures in care had become “indicators”.

The review confirmed that “*The purpose of the indicators should be confirmed to the sector - the basis for the indicator development was **the clear understanding that they were being developed not to measure performance, but as tools to assist aged care homes to monitor and improve the quality of their care and services***” (Page 99).

Because there was no reliable data on which to evaluate the performance of accreditation they did a survey of the staff in order to obtain positive feedback and claim that accreditation “*achieved an overall improvement in residents' quality of care and quality of life*”. Whether it was an effective regulator was not considered in this report. It made what the agency was doing and has been doing since look legitimate.

⁷¹ Criticism of senate review “Quality and equity in aged care” June 2005 Corporate Medicine web site <http://www.corpmedinfo.com/agereport2005b.html>

⁷² Criticism of “Evaluation of the impact of accreditation on the delivery of quality of care and quality of life” Corporate Medicine web site <http://www.corpmedinfo.com/agereport2007c.html>

6.4 The absence of data remains a huge problem

While there have been multiple studies of the financial performance of the sector, these have been quarantined from data about staffing and standards of care, even on the rare instances that they have been available.

Alzheimers Australia 2012: In a letter to Aged Care Funding Authority on 7 Sep 2012 Glen Rees the (then) CEO of Alzheimers Australia said *“I am disappointed that the Framework does not put more emphasis on the quality of services provided. I know that this will fall under the remit of the Aged Care Quality Agency (AACQA) which will be established in 2014 but in my view issues of cost and quality need to be considered together”*.

ACSA 2013: In a 2013 report, ACSA⁷³ noted the extensive variability in financial performance and the absence of data about care. The report indicated that *“There is no attempt in any of the reports reviewed to balance financial performance, financial viability or system sustainability with quality of care and outcomes for residents, or with community expectations or objectives. These financial estimates appear to make the assumption, but it is not explicitly stated, that all operating RAC (Residential Aged Care) service are of equal and acceptable quality”*. *“There appears to be a significant gap in our knowledge of the relationship between financial performance and of quality and between staffing levels and quality”*.

Alzheimers Australia: In 2015 Carol Bennett the new CEO of Alzheimers Australia indicated⁷⁴ that *“Every research study around the world has demonstrated that where you do put in place quality measures and they are comparable, you drive system performance and that is what we need to do here.”* In a radio interview⁷⁵ Bennet indicated that quality of care was one of the biggest gaping holes because we don’t have *“a single measure of quality”* and without accurate data about care you cannot have choices. She could not understand why this was so. Researcher Dr Richard Baldwin supported her comments.

Industry surveys: The financial sector has consistently reported on the most profitable performers as the best performers in aged care. But they are careful never to set the staffing levels against this good financial performance. Most profit comes from the income paid for care rather than for hotel services. StewartBrown reports both staffing levels and the wide difference in the money saved from the income derived from care without setting the two together. It requires little imagination to see that the good performers financially are likely to be poor performers in staffing and in providing care⁷⁶. Staffing comprises about 70% of the cost of care.

Aged Care Crisis have emphasised the lack of data and the lack of transparency on many occasions over the years. This lies at the root of the failures in the aged care system. If we had accurate data about the actual performance of providers and of the sector then the problems that we are describing could be addressed and regulatory failure could be confronted. We would have the data needed to develop a much better system and decide how much we were prepared to spend on it.

⁷³ The financial viability and sustainability of the aged care sector ACSA Report 2013 <https://opus.lib.uts.edu.au/bitstream/10453/36460/1/ACSAViabilityWhitePaper291113.pdf>

⁷⁴ Call to protect vulnerable in shift to aged care market Community Care Review 17 Nov 2015 <http://www.australianageingagenda.com.au/2015/11/17/call-to-protect-vulnerable-in-shift-to-aged-care-market/>

⁷⁵ Better data needed to compare aged care ABC Radio pm 24 Nov 2015 <http://www.abc.net.au/pm/content/2015/s4358621.htm>

⁷⁶ *Future of Australia's aged care sector workforce* - Supplementary submission to Senate Workforce Inquiry 28 Nov 2016 Aged Care Crisis pages 27 to 30 https://www.agedcarecrisis.com/images/pdf/sub302ss2_ACC.pdf

6.5 Regulation is 'burdensome'

The reduced regulation in order to appease the industry and reduce the perceived burden, will make regulation even less effective than the current system. It is interesting that in the highly regulated US system, with its extensive data collection, reporting and ways in which the data can be transparently downloaded and used⁷⁷, we don't hear the industry complaining about it being 'burdensome'⁷⁸.

We argue that regulation should not be an imposed burden. It should be part of the way the system operates on a day-to-day basis; something that is incorporated into a system that is regularly checking its performance and talking about it in an open and informed way.

6.6 Wasting money

Growth before care: Additional funding provided in 2014 has not gone to staffing. This and money saved by reducing costs has been squandered in a feeding frenzy on the share market and by those aspiring to list on the share market. As in other countries, private equity has led the process⁷⁹. Money that might have gone to care is squandered on inflated prices paid to buy overpriced facilities in order to increase market dominance. Residents bonds have gone into this putting them at risk.

No choice here: These pressures and the instability created take a heavy toll on staff and on the care of residents who unlike investors have no choice and simply become profit bodies traded with their facilities on the open market. The careful choice they made in choosing a nursing home was a hollow one, which many come to regret. Selling choice as a defining feature of this system is deceptive.

Pursuing a global empire: There is much to suggest that the primary purpose of current policy driving consolidation through corporatisation is to capitalise on international markets. This is in order to address our balance of payment problems.

Extensive data shows that these aggressively competitive corporations provide poorer care⁸⁰ and that this policy will compromise care. The morality of this must be questioned.

The overheads of competition: There are a large number of overheads to this competitive free market including endless consultants and advisers of all sorts promising to make providers more competitive and successful if their services are sought. It is clear that the threatened nonprofits have been most active in seeking this assistance and spending money on it.

Confused families faced by complexity and a predatory marketplace, have little choice but to turn to specialised financial advisers, lawyers and professional advisers to help them assess and choose from the available nursing homes on offer. Distrust has become integral to care provision and with good reason. This demand for help on all sides provides easy picking with some responding to a real need and others to opportunity. All of this ultimately comes directly out of the wallets of residents or from the money paid for their care.

There are a growing number of commercial operators looking at the opportunities all this offers. The opportunities for collusion and other lucrative practices are there.

⁷⁷ Data.Medicare.gov - Getting help with datasets: <https://data.medicare.gov/get-started>

⁷⁸ Medicare.gov - Nursing Home Compare datasets: <https://data.medicare.gov/data/nursing-home-compare>

⁷⁹ Private Equity Inside Aged Care <https://www.insideagedcare.com/aged-care-analysis/aged-care-marketplace/private-equity>

⁸⁰ Future of Australia's aged care sector workforce - Supplementary submission to Senate Workforce Inquiry - 28 Nov 2016 <http://bit.ly/2rEeSqM>

Efficiency: The competitive free market is undoubtedly the most efficient way of making money but the claim that it has been the most efficient way of providing good care does not stand up to any sort of analysis. It is time to accept the wisdom of the last 2000 plus years and accept that markets in human services are very different to those of the bazaar. They need to be structured differently. It takes time to care and develop the empathic relationships on which good care depends. A focus on financial efficiency rather than on care is destructive of care and so an inefficient use of money.

Choice and control: We also have serious reservations about the development of consumer directed care and the mantra of choice and control on which it is based. This is not because these are not valid aspirations but because in the present competitive predatory marketplace they expose the residents to financial and even personal risk. The situation is not dissimilar to that in which US psychiatric companies made vast profits by persuading people (including parents of children) into treatment they did not need.

We are aware of a US franchising company attracted by what is planned. They have a large number of packages ready to sell that they claim will improve the life of the elderly. There will be no way of controlling this. There are better ways of attaining the same worthwhile objectives.

7 Final comment on regulation

Braithwaite and co-authors indicated in his 2007 book:

“we fear from our observation of Australian business regulation over four decades that today business values are capturing regulatory values more than the reverse. When those regulatory values are about protecting the most vulnerable members of our society from abuse and neglect, the community should be concerned”.

His concerns were ignored and we are now confronted 10 years later by the consequences. We continue to ignore this and simply do more of the same at our peril. The Quality Agency should cease to be a regulator and regulation should be taken out of the hands of the market.

7.1 Who is responsible?

There is nothing unexpected in what has been revealed in Oakden, on the Gold Coast, in Bundaberg, in Newcastle and in South Australia. It is the logical consequence of policy based on ideology and its collision with the real world when implemented.

It is facile and disingenuous of politicians to shift the blame to those doing accreditation and then victimise the people involved. Those who understood what regulation should and could do tried, but were overruled. While it is wrong to use the word blame because ideology is a very human and recurrent failing, there is no doubt who is responsible, who should accept this and who should set an example in addressing the problems created?

Retired politician Carmen Lawrence has written about the failure of our political system⁸¹. As our analysis shows, we share her views. Aged care is a good example. A few phrases are indicative:

If we continue to airbrush our past and ignore human psychology in favour of glib sloganeering, how will we ever devise policies that succeed?

⁸¹ The denial, the infantilising babble, and the fantasies that permeate politics - The Guardian, 30 Jan 2017
<https://www.theguardian.com/commentisfree/2016/jan/30/the-denial-the-infantilising-babble-and-the-fantasies-that-permeate-politics>

----- asking serious questions about what the past can tell us about the likely effectiveness of proposed policies is rare. Even more uncommon is any deep exploration of what we know about human behaviour and how social structures are likely to influence it.

7.2 The political dilemma

We do understand the human propensity to reaffirm beliefs and blame inadequate implementation for failures in policy. The response too often is to change the implementation rather than the policy and this is readily apparent in the wording of the aged care roadmap. But this has gone on for far too long and the public deserves a realistic reappraisal that recognises where policies, however well intentioned, were flawed and have gone wrong.

We also understand the difficulties that individual politicians have in persuading colleagues that changes are needed to their discourse and the risks they face when they try to go it alone.

There are clearly political costs for political parties in a change of direction but in this instance both parties have followed the same policies and both are losing credibility in the community. It would be a tragedy if sensible debate became trapped in more party political point scoring. A sensible bipartisan approach is now essential in the interests of the community and the country.

An admission by all parties that policies are not working out as expected and that changes are needed would be less damaging in the long term and allow a cooperative solution.

8 Appointment of Panel to the Review

Appointment of Panel to review National Aged Care Quality Regulatory Processes⁸²

The Federal Minister for Aged Care, Ken Wyatt, announced the two person team who will conduct the independent review on national aged care quality regulatory processes.

Critical to the success of this review will be the discourse within which it is conducted. This will determine how they will interpret and understand the evidence they collect and the submissions that are made. The thinking that will inform the discourse is reflected in the careers of those appointed to conduct the review. Australian Kate Carnell has been appointed to review the regulatory process and New Zealand lawyer Professor Ron Paterson has been appointed to assist her⁸³.

Will they protect the current discourse (pattern of thought) about aged care or will they confront it and propose real changes?

8.1 Kate Carnell (AO)

Carnell's career

1. Carnell⁸⁴ started her business life owning a **pharmacy business** and has a long record as a business woman at the **business end of health care**. Her other roles have been in management as chair of the ACT Branch of the Australian Pharmacy Guild.
2. Carnell had a career as a **liberal party politician and state premier** of the ACT which was characterised by a multitude of blunders that raise issues about her character, judgement and her capability⁸⁵. After a final financial scandal she resigned in 2000 rather than face a motion of no confidence. It was described as a career ending in 'ignominy and disgrace'. In spite of this, the Liberal party continued to support her and she was appointed to several important roles by government.
3. She was appointed to fill a vacancy on **the board of the NRMA** in 2001 but was defeated at the next election. She was reappointed to another vacancy but resigned before the next election, which she was expected to lose.
4. While the public did not want her, politicians did. Soon after her political debacles she was appointed **chairperson of General Practice Education and Training Ltd** by the Health Minister Michael Wooldridge in 2001 and re-appointed by Wooldridge's successor Tony Abbott in 2004, so has served politicians well – a record for being a safe bet. She was rewarded for her efforts with an Officer of the **Order of Australia (AO)** in the Australia Day Honours list of 2006.
5. **Additional roles** have been CEO of the National Association of Forest Industries, the government funded Australian General Practice Network (AGPN), the industry sponsored Australian Food and Grocery Council (AFGC), Beyond Blue, and the Australian Chamber of Commerce and Industry. She has been a director of CRC Forestry and Australian Red Cross. In 2016 the government appointed her to be Small Business and Family Enterprise Ombudsman⁸⁶, putting this sensitive post into 'safe' hands.

⁸² <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2017-wyatt036.htm> (11 May 2017)

⁸³ Appointment of Panel to review National Aged Care Quality Regulatory Processes: <http://bit.ly/2q8BrSp>

⁸⁴ Kate Carnell - Wikipedia: https://en.wikipedia.org/wiki/Kate_Carnell; LinkedIn: <https://au.linkedin.com/in/kate-carnell-24ab4a15>

⁸⁵ The rare highs and many lows of Kate Carnell - Crikey, 9 Sep 2002 - <http://bit.ly/2qDzscr>

⁸⁶ Kate Carnell quits business lobby to become first small business ombudsman - SMH, 1 Feb 2016 <http://bit.ly/2qJD6Qv>

6. Her **list of skills** offered to the marketplace on LinkedIn includes Policy, Strategic communications, Health Policy, Healthcare, Management, Public Relations, Corporate Communications, Media Relations, Marketing strategy and much more.
7. Carnell was a **director of the Accreditation Agency**⁸⁷ during much of the period when Oakden's failures were overlooked and the agency reported its data out in a manner that most would consider deceptive⁸⁸.

Carnell's background suggests that she is deeply rooted in the marketplace and neoliberal policy discourse.

Conflict of interest: Rhonda Nay, a past Director of the Accreditation Agency for ten years (Jun 2002 - Jun 2012), is also concerned over the gaming of accreditation and points to the fragmentation of the system. Nay highlighted her concerns over the appointment of Kate Carnell to the review calling it a **'huge conflict of interest'**:

"... I am concerned that the current review is headed by Kate Carnell as I see a huge conflict of interest as she was a member of the agency ..."

Figure 3: LinkedIn (18 May 2017): <https://www.linkedin.com/pulse/maggots-abuse-aged-care-sector-rhonda-nay>

8.2 Professor Ron Paterson

Professor Ron Paterson is:

1. A Professor of Law at Auckland University⁸⁹ with legal degrees from Auckland and Oxford Universities. He is a Distinguished Visiting Fellow at the University of Melbourne; his expertise is in health law and ethics.
2. He is described as an *"international expert on complaints, healthcare quality and the regulation of health professions"* and as expert in *"patients rights, complaints, healthcare quality and the regulation of health professions"*.
3. He has written a book *"The Good Doctor - What Patients Want"*. He has conducted major Health reviews in Australia and New Zealand including one on the need for chaperones for the medical profession in Australia.
4. In New Zealand he was Deputy Director-General of Health 1999–2000, Health and Disability Commissioner 2000–2010, Chair of the Banking Ombudsman Scheme 2010–13, and Parliamentary Ombudsman 2013–16
5. It is interesting that he was appointed Parliamentary Ombudsman in 2013 then resigned in 2016⁹⁰ after 3 years instead of 5 to return to his role as a Professor of Law at Auckland University and resume his work in the health sector. At the time, the Ombudsman's service had a reputation for slowness with a backlog of 650 investigations that had been pending for more than a year. A new Chief Ombudsman had undertaken to reduce that. Paterson had just released a damning report into the Government's handling of an inquiry into leaks from the

⁸⁷ Kate Carnell - Director, Aged Care Standards and Accreditation Agency - 9 Dec 2008 - 8 Dec 2011 - (ACSAA Annual Report 2011 - 2012)

⁸⁸ Quality Agency rejects ownership factor on accreditation - AAA 15 Mar 2015 (Comments): <http://bit.ly/2r4XG0E>
Aged Care Report Card - 2008 - When 46 homes really means 199: <http://bit.ly/2rqai25>

⁸⁹ [Professor Ron Paterson](https://unidirectory.auckland.ac.nz/people/profile/r-paterson) University of Auckland NZ <https://unidirectory.auckland.ac.nz/people/profile/r-paterson>

⁹⁰ [Ombudsman Ron Paterson cuts short five-year term as office deals with investigations backlog](http://bit.ly/2rSN0CA) Stuff.co.nz 27 June 2016 <http://bit.ly/2rSN0CA>

Ministry of Foreign Affairs and Trade. We don't know if that was why there was a backlog or why he resigned.

8.3 Our concerns around the Review

This review is into regulation. We have a number of concerns:

1. That the review will only look at regulation and will not address the serious problems in the structure of the aged care sector that are creating the pressures that lead to increasing dysfunction and make it so difficult to regulate. They will be looking at it from the perspective of managers, administrators and markets rather than from the combination of clinical skills and caring relationships that are so very important in this sector.
2. While we do not think it is deliberate and that it simply reflects the way the neoliberal discourse conceptualizes regulation, we are concerned that this review will not protect the vulnerable residents who complain, but the government and the marketplace.

When seen from a different point of view, Carnell's appointment looks like the **fox guarding the hen house**. Her own past role as a director of the agency over the years when it was failing so badly puts a large question mark around her objectivity. She will be motivated to justify its practices and not advise the changes needed. Her support and reputation seems to have come from her service to government as someone they trusted rather than the trust of the community.

3. Several aged care companies are currently working with Chinese authorities and developing profitable joint ventures and government are strongly supporting this. We worry that the momentum created and the pressures in the government to support this will lead the government, through this review, to do everything it can to put a lid on this scandal and its publicity. It will find ways of justifying a continuation of current regulation and processes in order to appease an electorate that does not understand what has been happening. This would be a cynical betrayal of the trust citizens place in their government.

Carnell's assistant Professor Paterson appears to be well qualified, but we know less about the details of his work and how the community experienced that. His book and an article about compassion⁹¹ reveal that he has some understanding and might appreciate the problems that have become so widespread in our current aged care system, where too often compassion is absent.

He will hopefully recognise the difficulty of accreditation, regulation and even the complaints system in assessing whether compassion and empathy are defining characteristics of the services.

We hope that he will understand that it is just these characteristics that cannot be regulated for in the current system, nor can they play a role in consumer choice unless they are recognised and discussed. This is why Aged Care Crisis is pressing for direct community involvement, not only in identifying the problems in aged care, but also in directly addressing them. These problems are readily apparent to the knowledgeable regular visitor.

Professor Paterson's legal expertise will be useful if it gives the regulators the legal power to address issues. The threat of possible legal action has compromised the Care Quality Commission in the UK. In Australia the Quality Agency was embarrassed when they could not support their assessments on Carinity facilities in Queensland. They were overruled in the courts.

⁹¹ [Regulating for compassion?](http://bit.ly/2qPFCbm) Ron Paterson - Thomson Reuters, 2010 <http://bit.ly/2qPFCbm>

The extent to which the agency is legally constrained by the inadequacy of their assessments is unknown.

Lessons from the UK: The piecemeal investigations of what happened at Oakden remind one of the Mid-Staffs hospital scandal at Stafford hospital in the UK⁹². As in aged care in Australia decisions were made by management to reduce staffing without monitoring the consequences for care – a major reason for failed care. Here too a multitude of ignored warnings and failed oversight allowed serious problems to go unchecked.

When problems were finally detected there were another 5 piecemeal investigations of limited scope, perhaps in an attempt to limit the damage. It required a very active community movement⁹³ and one very critical review before the wide-ranging independent Francis Review⁹⁴ was finally commissioned. It identified systemic problems, which led to a major review of what was happening in the rest of the NHS and to many systemic changes and subsequent reviews⁹⁵ to see that changes were on track. This is not to suggest that aged care simply follow the same solutions.

The problems it identified were *“longstanding and apparently intractable”, “those with the most clear and close responsibility - - - failed to appreciate the enormity of what was happening”, “denial of concerns”, “clinicians - - - kept their heads down”, “inadequate processes for dealing with complaints”, “leadership was expected to focus on financial issues”, “the economies imposed - - - had a profound effect on the organisation’s ability to deliver a safe and effective service”, “Inadequate risk assessment of staff reduction”, “inadequate standard of nursing”, “prioritised its finances - - over its quality of care”, “mismatch between the resources allocated and the needs of the services”, “patients and relatives felt excluded from effective participation”, changes to administration “failed to produce an improved voice for patients and the public”, “failure of this form of patient and public involvement”, “the public of Stafford were left with no effective voice”, and “Local MPs received feedback and concerns - - - (but) - - -just passed on to others”.*

This report could have been describing aged care in Australia.

How like Aged Care in Australia: That there are so many ongoing confronting and recurrent failures in aged care, and that it is not only aged care and not only Australia, indicates that it is not only Oakden and not only accreditation but a whole of system problem that needs wider attention and some very basic rethinking.

What is required is a much broader review focusing on the care given and conducted by people who understand the nature of care including geriatricians and experienced nurses who have worked in the system. Those who have been part of managing this system don't qualify. As happened at Stafford, the managers of too many nursing homes focus on costs and profitability and don't understand the relationships between staffing and care.

⁹² Mid Staffs hospital scandal: the essential guide The Guardian 6 February 2013 <http://bit.ly/2rSNhFu>

⁹³ Cure the BHS <http://www.curethenhs.co.uk/>

⁹⁴ Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report) UK Government 6 Feb 2013 <http://bit.ly/2s6eOmS>

⁹⁵ Government's response UK Parliament <http://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN06690> - fullreport
About the Francis Inquiry The Health Foundation <http://www.health.org.uk/about-francis-inquiry>

9 Suggestions for change

While it is not a quick fix, our assessment is that the only really effective way of addressing these issues is for the government bureaucracy and the market to relinquish their tight grip on the aged care system.

9.1 Embracing Community

This is a system whose effectiveness depends on community norms, values and empathy as well as the pattern of empathic and empowering relationships that form between all those involved in the caring process. These have been fractured by current policy. There are many criticisms of the inadequacy of government regulation and arguments for community and families to become involved and be supported by government in doing this themselves⁹⁶

9.1.1 Balancing different discourses

The discourse of caring⁹⁷ is very different to the current discourse of government and market. The management and regulation of aged care under the latter discourse has been a dismal failure. Aged care should be returned to the discourse of care but clearly what can be accomplished might be limited by what is possible within the discourse of government, finances and market.

It is the intersection and discussion between these discourses in the public and political spheres which constrains the discourse of care from claiming more than society can give. This mode of operation ensures that available resources are used for maximum benefit and are not squandered in a market that is not constrained by an ethic of responsibility.

Control: There is now growing evidence that community services are most successful when they are planned, controlled and managed by the communities themselves. The role of aid organisations serving communities and of government is to support and mentor without intruding unless that is absolutely essential.

9.1.2 A way forward

We are pressing for a system that gradually, and not precipitously, moves the management of aged care into local areas. Here community should be supported and partnerships built with government and then with providers. The primary role of government would be to empower, support and mentor the communities, empowering them to take control of the services to the aged in their regions – to assume responsibility for the welfare of their members and work directly with providers in ensuring this.

In 2001 Kendig and Duckett⁹⁸ proposed that the financial management of aged care be undertaken locally. They outlined the many advantages of this including flexibility, responsiveness and much closer oversight. We agree that this would be desirable but the issues of data collection and regulatory oversight are much more pressing at this time.

⁹⁶ [Regulation without State Dominance : A Public Health Model of Social Care Regulation?](#)
Bob Rhodes The Centre for Welfare Reform 2012 <http://bit.ly/2qUkY4Q>

⁹⁷ [The Nature of Care](#) Inside Aged Care April 2017 <https://www.insideagedcare.com/aged-care-analysis/theory-and-research/nature-of-care>

⁹⁸ [Australian directions in aged care: the generation of policies for generations of older people](#). Hal Kendig and Stephen Duckett
Australian Health Policy Institute Commissioned Paper Series 2001/05 (NB We can supply a copy if needed)

Currently our major problems are market failure due to:

- (1) regulatory capture,
- (2) the lack of reliable data,
- (3) the absence of an empowered customer,
- (4) an involved and informed community to hold the providers to account and set the parameters of acceptable conduct and
- (5) a regulatory system that protects government and industry rather than vulnerable citizens.

The primary roles of regional community organisations and their government mentors might be:

- to work with facility and community staff, on a regular basis, collecting and validating the data needed for effective management of the facilities and the system - making it transparently available to managers, to community and prospective residents as well as to government and to the accreditation process.
- monitoring the care given in the facility by being involved with staff, residents and family on a regular basis – assessing the staffing, the patterns of relationships, the culture in the organization and investigating any failures in care.
- being the on-site regulatory arm of government, recording failures and successes and liaising with government mentors – meeting the principle of distributive justice.
- monitoring the welfare of residents and intervening tactfully when there were problems,
- ensuring that neither staff nor residents suffer when they speak out about problems they identify.
- supporting and advising residents and the families when they have complaints that need to be addressed – mediating and resolving issues,
- meeting regularly with management to discuss the services being provided to residents **on the community's behalf**, and
- supporting and assisting prospective residents and families when they are making choices, whether this be about which facility or which added service they might need - empowering customers,
- advocating for desired changes in the system

(NB. Campbell's law⁹⁹ would not operate because the collection of data would be only a part of a wider assessment so placing data indicating failures in care into a wider more holistic assessment.)

It is ironic that at the hearing of the Joint Committee Of Public Accounts And Audit in 2003 the industry (Mr Mundy) was itself calling for *“proper process that includes the genuine stakeholders in the sector not only us as providers but also consumer representatives and ideally an independent chair of such a process who can say, ‘This is all the evidence; this is what we think the next generation of quality systems in aged care should be.’”* This was another good intention that was lost in the competition to survive.

⁹⁹ [Campbell's law](https://en.wikipedia.org/wiki/Campbell%27s_law) Wikipedia https://en.wikipedia.org/wiki/Campbell%27s_law

9.1.3 Outcomes

Such a change would move the focus of aged care from the board room and corridors of power to the bedside and coffee rooms of communities so creating a new powerful discourse based on the real experience of aged care, rather than the theories of economists.

1. Information would flow in both directions in the overall management structure and differences in the discourses would need to be confronted and addressed.
2. The primary mode of regulation would become person on person but be supported by formal regulation. Community values, norms and empathy would once again become the driving motivation – those that failed to meet the community's expectations would be marginalized - probity and social responsibility would become important considerations.
3. There would be changes in the nature of the market which would become more stable and more suited to this sector.
4. The market would conform to traditional market theory by placing the customer at the centre of the processes and the community as overseer.
5. Control and choice could be key considerations without the risks.

9.2 Wider community considerations

Technology is finally meeting its promise of relieving us of the burden of work and it is clear that in addition to ageing the number of capable and often experienced unemployed will steadily increase. Without an active community within which the unemployed can realise their human potential and build identity we will face a huge existential problem with large numbers of disillusioned and frustrated citizens on the scrap heap. But this can also become an opportunity to be capitalised on, an opportunity to build civil society in ways that provide rewarding opportunities to contribute through service.

Instead of talking about bludgers and politicising unemployment rates we should be welcoming the opportunities offered and be planning sensibly for the future by building community and the opportunities there. Many of these communities may be virtual ones. These people could find new meaning in life in working with others in the community in humanitarian endeavours. Some already do so. Civil society has been eroded by an excess of centralised control and organisation. Too many feel left out and irrelevant. Repair work is needed.

There is already a large pool of active retirees living for many years who are seen as has-beens and have little in their lives. They could be contributing in ways that build society and give their lives meaning. Professor Fine has written about the *“potential value of an ageing population in the formation of social capital”* that is being squandered. We agree.

The responsibility of economists should be in designing an economic system that give those who are not needed to drive the economy, the security and freedom to engage and build new lives. The resources we need for community controlled human services are there but they have not been engaged or motivated. Too many still see this as a government responsibility.

9.3 Problems in implementation

Nothing could be more counterproductive than another glowing marketing endeavor clothed in headlined words like 'quality', selling ideas to the community – another reform. There are two lessons from experience.

1. Attempts by government to get citizens to do what they want seldom succeed because citizens don't own and identify what they are doing as their own. In the UK, attempts to provide consumer directed care through community based services are failing because the bureaucracy has refused to relinquish control.
2. Services provided to communities succeed and endure when they take control of those services themselves and own them. Aboriginal health is an example where this resulted in progress after years of failure.

Developing skills: There is currently a large gap in community knowledge and skill that cannot be addressed overnight. This is something that should be trialled and allowed to grow as community structures become established and skills are acquired. Government should support, encourage and mentor but do that as facilitator – even allowing community to learn from their mistakes. It must be driven by the communities themselves.

This might be done by progressively moving oversight services into selected communities, and then embracing the community partnership model to draw the community into working with government, progressively handing responsibility to them.

These ideas are not prescriptive but are simply an indication of the possibilities. There may be other community possibilities once the actual problems in the current system are recognised and accepted. It is unlikely that any real progress will occur until we do so.

Part 3: A version of the online survey submission that is easily readable

The department has a record of stripping all formatting including line breaks from their online submissions before publishing¹. For example, reliance on an inflexible online form, which allows plain text only (no basic formatting), coupled with the removal of paragraphs to indicate breaks (and to help assist accessibility with online readers), makes the contributions difficult to read so that the process is less transparent and public discussion is inhibited.

Further, the survey format is not conducive to the inclusion of research and evidence to back up responses, essential for the development of well-informed policy.

We believe that wide public discussion of these issues is essential before changes are made.

1.1 Responses to applicable questions

Question 2: Do you give consent for your submission to be published in whole or in part?

- Yes, we give our consent for our submission to be published in whole.

Questions about accreditation and monitoring compliance of residential aged care services

Question 11: Do you think that processes to accredit and monitor residential aged care services are effective?

	Yes, always	Yes, mostly	Yes, sometimes	No
Accreditation process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Monitoring process	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Question 12: Do you think processes to review and investigate non-compliance with the accreditation standards are effective?

- No

Question 13: Are you aware that sanctions can be imposed on residential aged care services when they fail to comply with the accreditation standards?

- Yes

¹ Single Aged Care Quality Framework - Options for assessing performance against aged care quality standards: <http://bit.ly/2tvEnPN>

Question 14: Do you think these sanctions are effective?

- No

Question 15: What features of the existing assessment and monitoring process should be retained?

The accreditation process is currently designed as a service to assist providers but also maintains a conflicting role as part of the regulatory framework.

Its activities should be reduced and restricted to working with and assisting providers to improve standards. It should not be responsible for data collection or regulation.

Government should retain a supervisory and support/mentoring role for data collection, oversight, complaints and front line regulation. These should be performed locally and in an ongoing manner but government should be prepared to step in to resolve serious issues if this becomes necessary. It should retain responsibility for imposing punitive penalties and sanctions when required.

Question 16: What features of the existing assessment and monitoring process should be changed?

If the existing system were to be retained then accreditation reports should be examined, commented and responded on by local resident/family and community organisations.

Aged care providers also receive a separate and more detailed report than that published online and are also able to provide a response, which is also not published. Both the comments from resident/family, community and provider responses including criticisms, should be published with the reports.

In our view, accreditation should be educative and supportive. It should not be involved in data collection or regulation but should be informed by both. Collected data should be available to them in order to evaluate their processes and improve their educatory efforts – continuous improvement.

The principal of distributive justice should be applied to data collection, oversight, regulatory action and complaints. This would be accomplished if all of these processes were managed by local structures that incorporated and involved local communities. Government would cooperate with, support, work through and mentor the local services.

The accuracy of data collected by providers would be verified locally and oversight would be ongoing. Both would become an integral part of the service so would not be burdensome. Regulatory issues and complaints would be addressed immediately, responsively and flexibly. They would be identified and addressed at an early stage before they became entrenched. While resolution of complaints would be prompt, the artificial separation of complaints from the regulatory process would be abolished.

Data collection and oversight, together with advocacy and the visitors scheme would be best integrated locally within the discourse of care in the community.

The local community structure would interact with providers locally in an ongoing manner and, as indicated earlier, it would be mentored by government. This would create a balance between the current neoliberal discourse and the more important discourse of care in the community. Issues would need to be debated and resolved. This would meet the principle of distributive justice.

Question 25: Please identify why a complaint has not been made about a residential aged care service in the last 10 years. *Please select all that apply.*

- Too much effort required
- Fear of retribution for making a complaint
- No confidence in the handling of a complaint

You are welcome to provide further details on your response:

Aged Care Crisis and its members have tracked the failures in the regulatory process in the USA and then in Australian aged care since the early 1990s and more recently, the UK. We have listened to residents, families and nurses, advised them in making complaints and advocated on their behalf.

We have made many submissions but our concerns and those we represent, have largely been ignored. Their validity has once again been confirmed by recent revelations about failure at Oakden as well as several other nursing homes and retirement villages (eg. Aveo).

Capture: In a 2007 book based on their research, Braithwaite et al concluded that all of the arms of the fragmented regulatory system including accreditation, complaints, advocacy and even the visitors scheme have been ‘captured’ or neutralised by believers in markets and the neoliberal approach to social services. There has been a revolving door between market and government.

They stated:

["The agency almost universally today manages to deal with problems of poor quality care while keeping them out of the media"] (pg 194).

We share this view and consider the regulatory system to be deeply conflicted in meeting its public duty to maintain standards. It has an unstated primary responsibility to support the government and the market system, and maintain the illusion that we have a world class system. To do so it must avoid adverse publicity and criticism which puts policy at risk.

Complaints: In spite of multiple reviews and extensive restructuring the centralized, impersonal and process driven complaints system has continued to fail our citizens. In their 2007 book Braithwaite et al said:

["Australian complaints mostly do not trigger visits to nursing homes and are universally steered to dispute resolution strategies, excluding enforcement and sanctions. A 2005 Senate inquiry concluded the complaints process was user-unfriendly and unresponsive, with the Aged Care Lobby Group, for example, arguing that family members have given up on complaining because ‘their complaints are trivialised’"] (pg 185).

The (then) Aged Care Commissioner, Rob Knowles (*Radio National 15 March 2006* (http://www.abc.net.au/pm/content/2006/s1592659.htm#_jmp0) indicated how the failing system should be reformed stating “when a complaint is made the first response is to have a full investigation of it”.

A Literature Review “Retribution in Residential Care” for the Commissioner of Complaints in May 2005 stated that:

“the Commissioner for Complaints noted that, during the period 1999 to June 2003, the word or words fear, intimidation, retribution, reprisal, harassment and victimisation’ were used in 4365 records created by the Complaints Resolution Scheme during interactions with complainants, with ‘fear’ contributing to the highest number of records”.

In her 2009 review of the complaints scheme, Walton ignored this warning and took a very different view. In focusing on local resolution above investigation, she required unsupported vulnerable families to resolve the issues directly with powerful and knowledgeable providers, essentially putting them at increased risk of retribution. Not surprisingly, this compounded the fears of residents and families. Fear of retribution and distrust has ensured that the number of complaints made has declined.

In our view, both prompt investigation and early resolution are required. The only effective way of doing this is to address the complaint by investigating it and addressing it locally where family can be involved and supported and residents protected.

This is what most would want and is the most effective way of securing early and effective resolution. The system needs to be situated within the community and be seen to be there for the residents rather than for providers. At the same time remediation and when required, appropriate regulatory action will be facilitated.

Question 26: Do you have anything else that you would like to contribute to the Review?

This review is intended to be a review of the “Aged Care Quality Regulatory Processes”, yet the format seriously limits the contributions that can be made to this.

This review is a response to the failures of the accreditation process and federal government to respond to the many years of abuse at Oakden in South Australia. Because of this, large numbers of vulnerable seniors were abused over many years. In spite of this, the questions about accreditation are very restrictive and the main focus of this questionnaire has been on the complaints system. Attention has been directed away from the health department, which is in overall control and advises government.

After one of us met with the minister about the failures at Oakden, we performed a detailed analysis of our regulatory system focussing primarily on accreditation, complaints and the Department of Health. We have since then compared the regulation of staffing and performance in Australia with that in the USA using the latest available figures. This informs our analysis and response to this review further.

We have combined those two analyses and attach them to this submission. If we are serious about addressing the serious flaws in our system and in its regulation, then we can no longer ignore criticism and research in the area, nor the lessons of the past.

There are two additional potential arms to the regulatory process and by utilising them we could broaden perspective and enhance the principle of distributive justice. These are Aged Care Advocacy organisations and Visitors Scheme. In their book Braithwaite et al were critical of the way the potential of these locally effective groups had been neutralised.

Advocacy: The 1989 Ronald's aged care report envisaged a far larger role for advocacy, one that was *"able to operate independently from industry organisations"*. At that time government was not bound to industry by shared beliefs or beholden to it for support. That did not last beyond the 1990s.

In writing about his research and the advocacy system in 2007, Braithwaite et al said:

"We were told if they criticize the government, it has a 'long memory'. Their funding contracts with the government have clauses that explicitly fetter their capacity to criticize government policy without notice or even to criticize named providers who they believe should be closed. Government by contrast attempts to ensure this is advocacy with a small 'a'"(page 186)

Visitor's scheme: Braithwaite et al indicated that under pressure from the industry, the protective role to be played by the visitor's scheme suggested by the 1989 Ronald's report (dubbed the *'community busybodies scheme'* by industry) was watered down. The government *"insist that community visitors leave matters of compliance with standards to standards monitoring and stay away from legal conflicts with nursing homes to assert rights"* (page 186).

Regulation an example of policy failure: In our view there is a wealth of evidence and argument indicating that this centralised but fragmented and ineffective regulation is only one part of the problem in aged care. In a well ordered functioning society citizens constrain one another. In such a system regulation should rest lightly and be seldom needed.

That we have come to depend on this flawed regulatory system as the only way to protect the vulnerable is an indictment of our society and the current policy for aged care.