

26 July 2018

Senate Standing Committees on Economics
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Committee,

Re: Inquiry into the Financial and Tax Practices of For-profit Aged Care Providers

Aged Care Crisis (ACC) has examined the transcript of the hearing of your committee in Sydney on 17 July 2018 and were disturbed by the unsupported statements and assertions made, and at the lack of evidence supplied in regard to the availability of data particularly about staffing and care.

ACC has been monitoring several of these issues since the 1990s and is well informed. It is not being given an opportunity to confront these assertions in person. We are therefore writing to make a number of points and challenge unsupported statements.

Fact checks

1. Claims to a “good aged-care system in this country”

Similar assertions made by several participants are unsupported with any data and yet were uncritically accepted.

We have:

- the hundreds of accounts from families and nurses,
- the recurrent scandals over the years since 1997,
- the inadequate and unsafe staffing levels by international standards,
- the steady decline in staffing skills at the same time as the number of people needing increasing skills increased rapidly.
- Dr Richard Kidd chair of AMA Council of General Practice, a doctor who has worked in the sector for years claiming “*It's definitely worse now than it was 20 years ago*”¹, and
- the president of the AMA, another GP who provides nursing home care saying that the “*workforce did not have the “capability, capacity and connectedness to adequately meet the needs of older people”*. Doctors are crying out against “*replacing registered and enrolled nurses with medically unqualified “personal care attendants*”².

¹ Quality of care in residential aged-care facilities, Standing Committee On Health, Aged Care And Sport; Hearing; 11 May 2018, Canberra: <http://bit.ly/2LDHgpN>

² Stressed doctors quit aged-care sector in droves, The Australian, 25 July 2018 <http://bit.ly/2NIP1IA>

This speaks for an ‘**exceptionally poor system**’, one in which all of the pressures in the system are driving it down to third world levels and where the regulator has claimed that care was improving when it cannot possibly be. The committee did not raise these issues with the participants and did not press them on this when they made these claims.

The forces driving this process are described across our submission to your Committee. The staffing evidence is on pages 29 to 32 in our original submission³. The evidence for poor care and a regulatory system that is so deeply flawed that it showed improvement to near perfection at the same time as care steadily deteriorated was addressed in depth In Part 1 and Appendix 1 of our March 2018 submission to the ‘*Inquiry into the Quality of Care*’ by the Standing Committee on Health, Aged Care and Sport (pages 16-37 and 69-93)⁴.

The reasons for this regulatory failure were explored further in our submission dated August 2017 to the senate inquiry ‘*Effectiveness of the Aged Care Quality Assessment and accreditation framework*’ (pages 42 to 81)⁵.

2. Claims to “large amounts of data”

- a. **No we don’t collect it.** We agree that it is possible to collect large amounts of data but until it is collected it cannot be rich, it cannot be described as information or knowledge. The data that is needed is not collected in Australia. What has happened could not have occurred and current policy would have become untenable had even basic clinical data been collected. What is collected is of little value for policy or the public. That collected by the Quality Agency is deceptive and offers false assurance.
- b. **Comparisons and sensitivity.** In the USA 175 items of data about care are collected annually from over 15,000 facilities. They are available for research in public databases and are presented to the public within weeks in a readily accessible form. This makes the data system sensitive and helpful but costly and burdensome. In Australia 44 items of not very helpful data which few had any difficulty with is being reduced to only 8. This reduces the very limited sensitivity of the system to a ridiculous level.
- c. **System vs regulation.** The dysfunction and aggressively predatory US system requires intense regulation and a large amount of data to track what is happening and keep it under some sort of control. Australia has introduced the same sort of system but we don’t collect the data so cannot measure what we are doing and it is not under control. Perhaps we should change the system instead?

Example in Australia: Pressure injuries and ulcers are one of the most critical markers of poor care and inadequate staffing. Neither we nor the full resources of the Minister and his department were able to come up with any studies of the incidence of pressure ulcers later than incidences of 26 and 42% from studies done in 2003 and 2005. The incidence from every facility in the USA is collected quarterly, is publicly available, and the average is 6%. We don’t know the incidence in even one of ours.

The Australian figure shows that there was an 8-fold increase in the incidence of pressure ulcers within 8 years of the 1997 changes to the *Aged Care Act*. They were previously better than the USA. This is what you might expect with the massive disruption of staffing and care that occurred during that period.

³ ACC Submission: Inquiry Financial and tax practices of for-profit aged care providers, <http://bit.ly/2LoVZG3>

⁴ ACC Submission: Inquiry into the Quality of Care in Residential Aged Care Facilities, <http://bit.ly/2l69uZv>

⁵ ACC Submission: Effectiveness of the Aged Care Quality Assessment and accreditation framework <http://bit.ly/2A4Uu6x>

- d. **A broken promise⁶:** In 2003, industry and the Health Department promised parliament that they would collect this sort of data and indicated they were already doing so. In a system driven by self-interest and based on belief and not logic or data we can understand why they buried that quickly when they looked at what the data showed. In 2007 the industry-dominated Quality Agency confirmed that they need not do this.

3. Discussion of financial data and accountability

- a. **Accountability:** When money is being paid for care then however much financial data is provided there can be no financial accountability if data about that care is not available to set against the money spent.
- b. **Censorship:** The only reason for confidentiality and opacity of de-identified financial data in such a vulnerable sector is fear of what it might reveal. That the industry indicates it is finally willing to disclose, suggests that it is government that has something to hide. In the past it has been both.
- c. **Lack of money:** We agree that more funding will be required but until we know what we are paying for and have some control over that, it would be a mistake. When there was more money it was absorbed by frenzied marketplace activities and little if any went to staff and care. That is likely to happen again.
- d. **Rationing:** If we are to meet the needs of the next generation and not sacrifice them, then it is very probable that rationing will be required. The current system is poorly structured for this and any attempt to do so will only increase the distrust. Rationing will require real honesty on the part of politicians as well as oversight by communities so that they can be assured that their sacrifice is for the benefit of their grandchildren and not those on the rich list.

4. Transparency

An opaque system: Aged care has been one of the most opaque and secretive sections of government activity, and any transparency has only come after years of pressure. The lack of enthusiasm and which group has most to fear from transparency is apparent from the small number of for-profits that have participated in the *National Aged Care Quality Indicator Programme⁷*.

Example - Quality Indicators: In total, 299 facilities submitted data for Pilot Cycle One and 292 facilities submitted data for Pilot Cycle Two. **Only 17.5% were for-profit.**

Organisational type	Pilot Cycle One	Pilot Cycle Two
Religious	94	87
Charitable	73	67
Community Based	55	62
Private Incorporated Body	53	50
State Government	24	26
Other	0	0
Total	299	292

Source: KPMG

⁶ ACC Submission, Inquiry into the Quality of Care in Residential Aged Care Facilities: pages 41-42 <http://bit.ly/2l69uZv>

⁷ National Aged Care Quality Indicator Programme (NQIP) – Residential Care Pilot Outcomes (March 2016): <http://bit.ly/2Og2Xen>

Agency reports: At one time failures in meeting accreditation were pulled from the Agency's website as soon as a provider had corrected the problems. Only those who had not been corrected on 31 December were counted and then reported publicly as the incidence of failures. In 2008 the true incidence of failures was under-reported by 75%.

FOI – Like pulling hen's teeth: FOI requests can be made as difficult as possible - as much if not more than other sectors.

Example: ACC frequently receives requests from families for assistance with help in locating a range of suitable aged care services. ACC volunteers assist families by providing a list of facilities with street addresses in their localities. To do so, they need a master list from which local information is readily extracted.

In 2013, ACC did an FOI request for the names, addresses and contact details of all nursing homes so that it could advise those who approached them where to look. This was refused on the basis that "Address information of Aged Care Services is classified as Protected Information under the Aged Care Act 1997". The information was finally released when a politician appealed the issue on our behalf⁸.

International Staffing And Australia

When staffing levels finally became available to us in 2016 we were able to compare them with the extensive data collected in the USA. There the massive databases are publicly available for analysis⁹. They are regularly analysed and the results published in an accessible form. The public are encouraged to use it. This information was supplied to the Senate 2016 Aged Care Workforce in our 2nd supplementary submission on 28 November 2016 to the 45th parliament¹⁰.

The committee invited more submissions when the review was reconvened under the 45th parliament but **the committee then elected not to consider them for its report**. They could hardly have given the report that they did if they had done so. We were bewildered by this and attach this submission for your committee's information. The next section draws on this supplementary submission. The US data presented is from studies up to 2014. More recently ACC submissions use similar data up to 2016.

Required staffing

5. The USA¹¹

- a. **Extensive studies** of care and outcomes were done by the Institute of Medicine (IOM) and the Centers for Medicare and Medicaid over an eight-year period in order to determine safe levels of care. While many recommended 4.5 hprd (**hours of direct nursing care per residents day**), the figure of 4.1 was adopted as the minimum recommended level below which unacceptable failures would occur.

⁸ Freedom from information: A case study: <https://www.agedcarecrisis.com/opinion/articles/115-freedom-from-information-a-case-study>

⁹ Data.Medicare.gov - Nursing Home Compare datasets: <https://data.medicare.gov/data/nursing-home-compare>

¹⁰ ACC 2nd Supplementary Aged Care Workforce submission 28 Nov 2016, attached: **pages 11 to 33**

¹¹ ACC 2nd Supplementary Aged Care Workforce submission 28 Nov 2016, attached: **pages 11 to 15**

- b. **The minimum recommended levels** for Registered Nurses were 0.75 hours per resident day (hprd), EN equivalent 0.22 hprd and Care Assistants 2.8 hprd. Because this does not allow for greater acuity, higher average levels were expected particularly for RN's. Some studies suggest Nurse Assistant numbers should also increase with greater acuity to 3.2 hprd.
- c. **The test of time:** These levels have been confirmed and honed by the extensive data collected from over 15,000 nursing homes quarterly¹² for a period of 20 years. The close relationship between staffing and care cannot credibly be challenged. The arguments by providers in Australia are unsupported by data and experience.
- d. **Improved staffing:** While only 12% of families use the public data when selecting a nursing home for a relative this has a flow on effect in the community. Staffing skills and levels have increased slowly over the years and the average has now reached minimum levels. In Australia skilled staffing levels have fallen by 35% over the same period.

6. Australia

a. Comparable studies:

Guidelines for calculating the number of staff based on acuity were developed by clinicians and were reported by Hardy et al in 1985 but not adopted¹³. The average of their two top grades, which would most closely reflect current acuity, was 4 hprd. The only other study done in Australia was by the South Australian Nursing schools in 2016 and this recommended a minimum of 4.3 hprd. These are both close to the US figures so must be accepted as valid. The industry has rejected these figures.

b. Scientific studies are ignored in favour of commercial benchmarking:

In Australia providers are guided by a 2.9 hprd benchmark¹⁴ developed by StewartBrown an accounting business that like KPMG and others whom we described in our supplementary submission has a tarnished history of being less than frank. The basis for their benchmark is unknown. Providers who have previously provided better staffing have reduced staffing to meet these benchmarks.

A coroner who deliberated on one of the inevitable consequences of this was very critical of these benchmarks¹⁵.

Measuring staffing levels

7. No facility staffing data reported in Australia

There are no data reported for individual nursing homes in Australia and facilities do not willingly disclose this even when asked. This should be a critical consideration for prospective residents and their families.

¹² Staffing data - Centers for Medicare & Medicaid Services: <http://go.cms.gov/2frxXuQ>

¹³ Hardy V et al, 1985, Patient Care Analysis by Extended Care Society of Victoria <http://trove.nla.gov.au/work/13159053>

¹⁴ ACC 2nd Supplementary Aged Care Workforce submission 28 Nov 2016, attached: **pages 20-21**

¹⁵ Inquest into the death of BW Coroners Court Tasmania 1 Sep 2016 <http://bit.ly/2unfrdR>

8. Quality Agency

We are aware that the quality agency has been collecting staffing data for some years but has not reported it publicly. The Agency should be requested to supply data to the committee but the committee should commission its own statistician to evaluate the data because of:

- a. **Flawed data handling:** The agency and the department do not understand the nature of variables rendering their assessments and conclusions deeply flawed. They have over the years made no allowance, for example when comparing provider types, for the fact that there are wide differences in performance that are unrelated to provider type between metropolitan where both operate and rural sectors where there are no for-profit operators. Any comparisons must take account of these two variables to be valid¹⁶.

The agency were certainly aware of this in 2008 when we raised these issues with them but they continued to do it. While this could be simply ineptitude, it might also be due to a strong imperative not to expose policy and so embarrass government and providers. There were certainly people with sufficient expertise on its board at the time.

9. Financial service organisations

StewartBrown and Bentleys collect voluntary staffing data. In a sector that has been strongly criticised for poor staffing there are pressures to inflate figures as much as possible and they need confirmation.

- a. **StewartBrown** data comprising about 8-900 facilities is largely restricted to the nonprofits (about 90% in most studies) so really represents only one sector, the one that should be mission and not profit driven. There are no other details. It does not report on the large profit driven entities so is not representative of 40% of the industry.
- b. **Bentleys** has a much smaller self-reporting sample and its composition and findings are not revealed to the public. The fee for access to its reports is exorbitant. What is available is similar to StewartBrown.
- c. **International comparison:** Available data shows that US residents on average get at least twice as much care from trained nurses and a third (1 hour) more total nursing care than residents in Australia. Australian levels would be considered dangerously low in the USA¹⁷.

Example to show significance: On page 55 of our submission to the committee we recorded how Mr Toohey, a past CEO of Tricare indignantly recorded that a US expert who examined our system in 2010 had concluded that he would not put an *“elderly relative, or indeed even a family pet, into a residential aged care facility”* in Australia. We now understand exactly why the US expert reached that conclusion and how out of touch Toohey was.

¹⁶ Aged Care Report Card, Aged Care Crisis, 2007 to 2008 <https://www.agedcarecrisis.com/news/research/108-aged-care-report-card>

¹⁷ ACC 2nd Supplementary Aged Care Workforce submission 28 Nov 2016, attached: pages 21 to 22

10. Staffing and profitability¹⁸

- a. **USA:** The striking differences between different types of owner and the way this correlated with the pressures for profit was first clearly exposed in research done for Consumer Affairs in the USA in 1994. Since that time multiple studies in the USA have confirmed the close relationship between staffing levels, failures in care and the profit focus/corporate structure of the type of owner/provider.

The best staffers and performers in care were the smaller nonchain nonprofits increasing progressively through nonprofit chain, for-profit nonchain, for-profit chain, and the most aggressive large “top 10” chains, which were the worst. More recent studies have shown that the latest arrivals, private equity, are even worse in all respects and that the situation continues to deteriorate the longer they own the facilities.

- b. **Canada:** Average staffing levels of all types of non-profit providers including government are either well above or just below the 4 hprd level. The for-profits are at roughly the same level as Australia 2.71 hprd.

c. **Australia:**

- i. **Meeting industry demands:** Government policy in 1996 was for a corporatised aged care marketplace. Staffing requirements prevented companies from controlling their costs and they would not invest unless they could. Government obliged by removing all staffing requirements in 1998. But many investors considered that the unions were too powerful and could prevent them from keeping costs down. In 2005 companies indicated that this was preventing them from investing. The government helped them by introducing work-choices, which markedly reduced the union’s power¹⁹.
- ii. **Competition:** As should have been anticipated and as nurses and families have told us, money is made and competition is about keeping costs (mainly staffing) down. The 35% fall in expensive skilled staff in the face of a need for more skilled staff to manage sicker seniors is a consequence.
- iii. **Collecting staffing data:** In the face of rising pressure and public complaint, Australia avoided collecting and analysing data about staffing for years. When the Quality Agency did finally start collecting staffing data it kept this confidential. That StewartBrown was collecting staffing data for the industry was not widely known until 2016 when they inflated the data in one of their charts and used this to suggest that Australians were getting an hour more direct care than they actually were (see later).
- iv. **Failure to compare staffing and profitability:** StewartBrown collects and analyses both staffing data and the profits made from the money paid for providing care. It has the data but avoids comparing staffing levels with the profits made from care. Instead it urges providers to keep their costs down if they want to remain viable. The committee should ask for this data and have it independently analysed.
- v. **Ignoring staffing:** In the face of strong international evidence that the drive for profit is the most important factor impacting on staffing and so quality of care, Australia has continued to ignore staffing data and create the illusion that there is little difference between types of provider.

¹⁸ ACC 2nd Supplementary Aged Care Workforce submission 28 Nov 2016, attached: pages 23 to 27

¹⁹ ACC submission to Senate Inquiry into tax practices by for-profit aged care providers: pages 61 to 62 <http://bit.ly/2LoVZG3>

- vi. **A changing pattern in non-profits:** While we do not have data, press reports show that nonprofits, particularly in Queensland, have, over the last 2 years been reducing staffing rapidly. There have been more failures in care as a result.

Reasons for this might be:

- Australia differs from the USA in that, without good data about staffing and care, there is no niche market of discerning customers to support well-staffed non-profit facilities. Good staffing impedes profitability and threatens viability. Nonprofits are forced to adopt glossy but unrealistic marketing to secure customers and abandon their mission. They seek advice from the marketplace and appoint similar managers.
- Government favours and prefers to deal with commercially successful and profitable larger nonprofits placing this ahead of performance in providing care.

This has seen the emergence of “Big Charity” groups that develop the characteristics and the market practices that the government favours. They thrive by behaving like for-profits.

- The increased adoption of depersonalising ‘New management’.

- vii. **Government run nursing homes.** There appear to have been an increasing number of failures and staffing problems in government run facilities.

This might be due to:

- the threat of privatisation, the changes made in preparation for, and the disillusionment that this entails (eg. Oakden)
- the impact of ‘New Management’

11. Mandatory staff/resident ratios

- a. **Safe levels.** There are levels below which safe care cannot be provided and in the USA where data is available, many for-profit facilities fall into this bracket and have serious problems. This cannot be prevented without requiring acceptably safe staff levels.
- b. **Mandated staff levels** are required in several states and to be effective the safe level of each type of nurse must be specified. Industry, who want to control their expenses by keeping staff levels low have strongly opposed this. It is acknowledged that because of this levels in most states are too low to be effective, but that in states where they are higher they are effective²⁰.
- c. **Increasing levels.** Some states now recognise this and are changing. California has taken the first step by increasing its total level from 3.2 to 3.5 hprd and the Nurse Assistant levels to 2.4 hprd²¹. These are both well above our StewartBrown benchmark and average levels.
- d. **Australia.** Ratios must be a sensible response to what has happened in Australia unless we can devise a different more effective system where staffing is not under pressure and where the community has effective oversight. To do anything else is to put the commercial interests of providers ahead of the needs of the elderly in our communities.

For Mr Rooney, as a representative of a sector that has fought tooth and nail to avoid them, the claim that “*there are staff-to-resident ratios*” is a bit rich. If they are there, why don’t they disclose them? If realistic they would be good for business.

²⁰ Staffing Levels in New York Nursing Homes: Important Information for Making Choices Eliot Spitzer Attorney General Office of the Attorney General Medicaid Fraud Control Unit January 2006 <http://www.ag.ny.gov/sites/default/files/press-releases/archived/final.pdf>

²¹ New staffing law, old struggles bedevil California nursing homes LA Times 13 Jul 2018 <https://lat.ms/2v4lwlt>

12. Standards of care and ownership type²²

- a. **International data** shows that the most important determinant of care and staffing is ownership type. Australian politicians and providers have denied this in the face of evidence and refused to collect accurate data. Richard Baldwin reviewed the data in his doctoral thesis and in his publications.
- b. **Sanctions.** In 2014 Baldwin et al showed that in Australia for-profits were more than twice as likely to be sanctioned for poor care as nonprofits²³. Government run facilities were least likely.
- c. **Accreditation data.** The agency have since 2003 claimed that there was no real difference between nonprofits and for profits. The industry (Mr Young and Mr Mundy) indicated to parliament that they had not seen anything that suggested there was any difference in performance between for-profit and nonprofit owners. The then agency CEO (Mr Brandon) indicated that *“we do not have any data”*²⁴.

Over the years the agency also reported the much poorer performance in rural and remote areas when compared with centrally located facilities. As there are hardly any for-profit owned providers in rural and remote areas, it is clear that nonprofits must be performing several times better than for-profit in central locations. When like was compared with like, the agency’s own figures clearly disproved their claim²⁵.

- d. **Aged Care Crisis study.** In the year 2007/8 ACC regularly checked the agency’s website and downloaded all available reports it could of failed standards. Despite this we only secured 108 instances of failures because the others were removed too quickly. Imagine our surprise when the minister proudly reported to parliament that only 44 (1.6%) facilities had failed when we had 108. The minister was forced to retract and acknowledge that there were 199 (7%).
Unable to get the remainder we analysed the 108 and found that the incidence was indeed not very different between non-profit and for-profit. When rural and remote were excluded the incidence of failure in for profits was 2 to 4 times greater than that of the different types of non-profit including government operated (chart reproduced page 27 of our 2nd supplementary workforce submission to the 45th parliament). There was correspondence with the agency at the time. But in 2010 the agency was still reporting its data this way²⁶.
- e. **For-profit homes failures:** Since the inception of the Accommodation Payment Guarantee Scheme in 2006²⁷ (and up until March 2017), the Scheme has been triggered 10 times for 11 aged care homes and provided \$43 million in refunds of bonds, the cost of which was born by the taxpayer. **All these homes are from the for-profit sector.**
- f. **Continual false claims by the agency in 2014.** After Baldwin showed that for-profits were sanctioned more than twice as often, the (then) Accreditation Agency presented a paper at the LASA conference in Queensland²⁸.

²² ACC 2nd Supplementary Aged Care Workforce submission 28 Nov 2016, attached: pages 3 to 27

²³ Quality failures in residential aged care in Australia: The relationship between structural factors and regulation imposed sanctions *Australian Journal on Ageing*, 22 May 2014 <http://onlinelibrary.wiley.com/doi/10.1111/ajag.12165/abstract>
For-profit providers more likely to be sanctioned: study, *Australian Ageing Agenda*, 8 Oct 2014 <http://bit.ly/1et9uyF>

²⁴ Joint Committee Of Public Accounts And Audit, Review of Auditor-General’s reports, fourth quarter 2002-03, 18/08/2003 <http://bit.ly/2A1xAgm>

²⁵ Aged Care Report Card, Aged Care Crisis, 2007 to 2008 <https://www.agedcarecrisis.com/news/research/108-aged-care-report-card>

²⁶ 10 years of accreditation experience Industry performance page 5 The Standard Special Edition 2010

²⁷ See Appendix 1: Accommodation Payment Guarantee Scheme (pg 13)

²⁸ Quality Agency rejects ownership factor on accreditation *Australian Ageing Agenda*, 25 Mar 2015 <http://bit.ly/2fvux4v>

This emphasised that *“ownership type has ‘no discernible’ impact on passing accreditation”*. It acknowledged that remote services had difficulty but then asserted again *“But certainly we are seeing no discernible difference between the for-profit and not-for-profit sector”*.

It was clear that crude figures were being used and the presenter was asked how the figures were analysed and if variables had been considered. This matter was pursued with the presenter and the agency but no response was received.

We acknowledged in our workforce submission that, due to the pressures in the system away from care, the incidence of nonprofit and government failures were increasing. We realise it is coming closer to for-profits but we don't know how close.

- g. Consolidation.** As Mr Rooney indicates, Australia has pursued a policy of marketplace consolidation in the face of international evidence that the large commercial chains that drive this process provide poorer care – and in the absence of any strategy to monitor performance while doing so. Available evidence suggests that, at least until recently, the same pattern has happened in Australia. Baldwin's research questioned the basis of this policy²⁹. That policy continues. This is what we see with cults and ideologies.

13. Architect of system called “independent”

Mr Rooney claimed that the review into aged care that was conducted last year by David Tune was independent.

Tune was Chairman of the sector committee that wrote the Aged Care Roadmap after the 2011 productivity report and LLLB reforms. He is very much an architect of the system, was not receptive to criticism of the system. He was wedded to current policy so not really independent.

14. Deceptive information

Mr Corderoy speaking for StewartBrown claimed that: *“we're not an advocate for any stakeholder in the sector”* and *“We can provide a balanced perspective to the Senate to support your inquiry and your findings”*.

We draw your attention to our supplementary submission in which we examined KPMG's conduct as representative of the conduct of the sector to illustrate the pervasiveness of the discourse and the sort of conduct it leads to. All of these companies including providers, work with public relations businesses whose mode of operation is to select and massage the information and data, then often distort the truth in order to create positive images that will seduce the public. This readily rubs off onto businessmen who may be unaware of the consequences of what they are doing.

StewartBrown collects data for use by the industry and advises them. That data is used to lobby by the industry and StewartBrown assists by lobbying on their behalf. This is also confirmed in their 2017 “Registration Kit” and forms part of the “Background & Purpose”:

“The results of the survey may also be used for other purposes. It is likely that summary data will be used by industry bodies to lobby Government and in the formulation of policy. If data is provided to outside parties, at no time are the results of individual participating organisations identified. The only data supplied is in a summary format.”

StewartBrown - 2017 Registration Kit <http://bit.ly/2AhDiPx>

²⁹ Residential Aged Care Policy in Australia - Are We Learning from Evidence? Australian Journal of Public Administration 5 Feb 2015
<http://onlinelibrary.wiley.com/doi/10.1111/1467-8500.12131/abstract>

Worrying Example:

'Direct Care' is the direct hands on care that residents receive from nurses and sometimes by other professional carers. It is defined and explained on the MyAgedCare web site³⁰. StewartBrown has calculated and charted *direct care* directly in its reports to industry over the years.

In June 2016, the year of the Senate Aged Care Workforce Inquiry, an additional chart was added to the report. It included hotel and other staff that did not provide *direct care* and added an extra hour of care. This was labelled 'Direct Care'. It suggested the levels of direct care approached international levels.

Three days before the hearing of the senate workforce at which industry were appearing, this chart was tweeted publicly and to members of the Senate in support of claims to good staffing by a director of StewartBrown (also a previous CEO of LASA).

The same figures were used by a senior member of ACSA in responding to an article about the inadequate numbers of direct care staff in order to refute the claims made. When the figures were challenged, Mr Corderoy himself responded defending them so clearly considered this legitimate.

The details of what happened including all the relevant charts are set out on pages 7 to 10 of our attached supplementary workforce submission to the 45th parliament dated 28 November 2016³¹.

We think that the claims to not advocating for any group deserve the same level of credibility as apply to the claims about direct care.

Comment. We do not want to single StewartBrown out. They are simply representative of the patterns of thinking that we have seen in the banks at the Royal Commission, in the multiple sectors where exploitative and dishonest behaviour has recently been exposed and in the behaviour and exaggerated claims made by providers and their representative bodies across the aged care industry and to your committee.

We urge the committee to never forget the wisdom from the past in assessing the arguments made by industry and their representatives and those whose livelihood depends on their support.

The interest of [businessmen] is always in some respects different from, and even opposite to, that of the public ... The proposal of any new law or regulation of commerce which comes from this order ... ought never to be adopted, till after having been long and carefully examined ... with the most suspicious attention. It comes from an order of men ... who have generally an interest to deceive and even oppress the public.

(Adam Smith in The Wealth of Nations -1776)

We do agree with Mr Corderoy that things are "at a critical stage in the aged-care sector" but the problem is primarily in the structure of the system, in the policies and in the lack of data on which any decisions about finance can be made. These must be addressed first. What he and the industry are pressing for puts the cart before the horse.

³⁰ MyAgedCare website - Aged Care Workforce: <http://bit.ly/2LJZin7> (See Appendix 2)

³¹ Aged Care Crisis - submission: Future of Australia's aged care sector workforce <http://bit.ly/2BHoOrc>

15. “Choice” as the guiding principle in aged care (the Aged Care Roadmap)

- a. **A false image.** As is clear from the *Aged Care Roadmap* ‘choice’ and sometimes with ‘control’ added is the rationale and justification used by the neoliberal believers who designed the Aged Care Roadmap. That is the carrot being sold to the public. It uses these words to cloak the vulnerability and ready confusion of the elderly, as well as the aggressively competitive market and the confusion of options that the elderly will be cajoled to buy by the multiple franchisees attracted by the potential profitability of the sector.
- b. **Care and relationships.** But care has always been about caring relationships. Much has been written about these relationships (once called professional relationships) over many years. At the heart of them has been interdependence, trust and trustworthiness – a relationship that is under greater and greater pressure in many professions today.
- c. **Professor Michael Fine** has rediscovered this, researched and written extensively about it calling it the relationship of care and a culture of care³². He explores its many facets in great depth. He looks at the interdependence and the relationship of trust on which care ultimately depends in many different ways. And of course guided choice and control are important within these relationships because without them there could be no trust.

As Fine indicates *“the richness of academic discussion on the topic of aged care stands in contrast to its limited use in policy”*. But in his arguments he explains just how difficult if not impossible it is to form these relationships within the current competitive market system.

- d. **Relationships and competition.** Caring relationships take time to form and maintain. They are neither competitive nor efficient. The neoliberal model of markets is unable to accommodate to the needs of the sector and this is one of the reasons why it was doomed to fail and has failed so badly.

Any system that truly cares depends on caring relationships and these must take precedence over competition and efficiency. This is not to suggest that there should be no competition or that we should be inefficient but that both should be constrained by the relationships that are the mode of operation of real care. The current market cannot do that because it depends on competition and efficiency for its claimed benefits.

Rooney misunderstands the human condition when he claims that *‘If you have choice, you also need market based competition’*. His claim is rooted in managerialist discourse. What he believes in makes it very difficult if not impossible to give expression to our humanity and that is needed for care. We have social selves and do not depend on self-interest driven competition for everything we do in life.

- e. **It’s the role of community.** Caring relationships reside in families, in the community and in the professions. They cannot be legislated or imposed – any more than a central government can regulate such a diverse and complex requirement.

If we are to make the changes needed then aged care must be controlled and managed by the community and the market must serve them. Ultimately we will have to move in this direction and the sooner we do so the less harm will be done.

³² For an overview see: The Nature of Care (Inside Aged Care)
<https://www.insideagedcare.com/aged-care-analysis/theory-and-research/nature-of-care>

1 Appendix 1 (for information)

1.1 Accommodation Payment Guarantee Scheme

The Accommodation Payment Guarantee Scheme (Guarantee Scheme) was established under the *Aged Care (Accommodation Payment Security) Act 2006*³³. If a provider becomes insolvent and defaults on its obligation to refund a Refundable Accommodation Deposit (RAD), the Guarantee Scheme enables the Government to pay care recipients an amount equal to each RAD balance. The Guarantee Scheme is triggered if the provider has been placed into bankruptcy or liquidation and there is at least one outstanding RAD.

The Secretary of the Department of Health must then make and publish a default event declaration in order to enable payments to be made under the scheme. On receipt of their payment, the rights of each resident to recover the amount from their provider are transferred to the Commonwealth so it can pursue recovery of the funds.

The total value of bonds held by nursing homes, now at over \$21 billion, is growing each year.

Since the inception of the Guarantee Scheme in 2006 (and up until March 2017), the Scheme has been triggered 10 times for 11 aged care homes and provided \$43 million in refunds of bonds, the costs of which were born by taxpayers. **All these homes are from the for-profit sector.**

1.2 Levy costs born by taxpayers

The Government has not yet chosen to levy the industry to recoup its outlays and instead, taxpayers have made up the approximately \$43 million dollars shortfall in picking up the tab in the loss of accommodation payments for those collapsed providers. These payments do not include the administrative and legal costs accrued by Government and departmental efforts in pursuing the funds.

Change is coming: In the 2018-2019 Budget, aged care providers were informed that the government would be introducing a levy to fund the Accommodation Payment Security Scheme ("Scheme"). This levy has been foreshadowed for a long time and the government has had the power to set and impose a levy on providers since 2006. It is not clear why it has been deferred and we wonder if this will happen again.

The Aged Care Financing Authority concluded in their 2017 report *The Protection Of Residential Aged Care Lump Sum Accommodation Payments*³⁴ that “ACFA agrees in principle with previous reviews, including by the Productivity Commission and the National Commission of Audit, which concluded that the Scheme’s beneficiaries should contribute to the costs of the guarantee. This would bring the existing Scheme into line with other similar systems, such as building completion warranty, medical indemnity and student tuition fee protection. It would also limit the Commonwealth’s liability. This should be the case whether the existing Scheme is retained, or another model is implemented. However, in practice, a levy or other cost sharing mechanism should only be implemented if the benefits of doing so outweigh the costs.”

³³ *Aged Care (Accommodation Payment Security) Act 2006* <https://www.legislation.gov.au/Series/C2006A00026>

³⁴ Australian Government Aged Care Financing Authority - *The Protection Of Residential Aged Care Lump Sum Accommodation Payments* (May 2017) <http://bit.ly/2JOpYJ>

2 Appendix 2

2.1 References

Figure 1: MyAgedCare website* (as at 13 Mar 2018): <http://bit.ly/2LJZin7>



The screenshot shows the top of a webpage with the Australian Government logo and the MyAgedCare logo. The main heading is "Aged care workforce". The text discusses the contribution of aged care workers and provides statistics for 2012. A list of direct-care workers is provided, with some items highlighted in yellow. The text also mentions future workforce projections and accreditation standards. A final paragraph highlights non-direct care roles, also with a yellow highlight.

Aged care workforce

Aged care workers make a valuable contribution to the daily lives of many thousands of older people across Australia. Creating an appropriately skilled and well-qualified workforce is fundamental to delivering high-quality aged care services that meet the needs of older Australians. In 2012, there were over 352,100 (estimated) employees in the aged care sector working in residential and community settings, and in a variety of direct-care and non-direct care occupations.

Of these, 240,445 were **direct-care** workers including:

- **nurses**
- **personal care or community care workers**
- **allied health professionals such as physiotherapists and occupational therapists.**

Australia's aged care workforce is expected to grow to around 827,100 in 2050. There will be opportunities for people to become involved in this expanding industry. There are a range of aged care qualifications, career development opportunities and skills training available.

Direct-care workers may provide care in a person's home or in an aged care home. All aged care homes are required under the [Accreditation Standards](#) to employ appropriately skilled and qualified staff to care for residents. For example, all residents with high-level care must have any nursing services carried out by a registered nurse or other appropriate professional.

Workers in non-direct care roles might be managers who work in administration or ancillary workers who provide catering, cleaning, laundry, maintenance and gardening.

***Notes:**

- Colours used to emphasise point re 'direct care'
- This web page has since been removed from the MyAgedCare website sometime after March this year. A search failed to locate its replacement.

28 November 2016

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

Re: Future of Australia's aged care sector workforce - Supplementary submission

Dear Senators,

We thank the Committee for the opportunity to submit a supplementary submission as outlined in earlier correspondence.

Aged Care Crisis were recently alerted to the availability of data regarding the provision of 'Direct Care', which we believe gives a false impression of nursing care that frail residents in Australian nursing homes are receiving.

We have tracked staffing issues and staffing ratios in the USA since the late 1990s and have been particularly interested in the wide disparities in staffing and care revealed by the type of ownership of nursing homes. ACC have consistently highlighted the absence of this sort of data in Australia.

We find that data on staffing has been collected and published not by government, but by private entities including StewartBrown (SB)¹ and Bentleys², enabling us to compare our system with that in the USA and tap into the vast amount of research done there. This has enabled us to closely examine and compare nursing staff levels and costs in order to compare them with the USA where extensive data is publicly available for analysis and research. To do so, we need to use consistent terminology and collect information in the same way.

For example, the term 'Direct Care' (in the USA) refers to *person-to-person care* - and unless stated otherwise, indicates *nursing care*³. We have not had access to Bentley's confidential reports so are unable to determine the terminology used in their reports.

We have been assured that the committee will accept a late supplementary submission and have addressed the issues raised by this information. It is an opportunity to use the extensive research that has been done internationally to throw additional light on our problems.

¹ Chartered accountants and aged and community care advisors based in Sydney

² Bentleys are an international network of business advisors and professionals that provide accounting, audit and assurance, business advisory, corporate recovery and financial planning services, as well as superannuation advice, trusts and estates planning and taxation consulting.

³ Bowblis J R. Staffing Ratios and Quality: An Analysis of Minimum Direct Care Staffing Requirements for Nursing Homes Health Serv Res. 2011 Oct; 46(5): 1495–1516. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3207189>

Table of Contents

1 In summary	3
Glossary and abbreviations	6
2 Muddled waters	7
2.1 Use of the term 'direct care'	8
2.2 Analysis of staff data	9
3 Comparing Australian staffing levels with the USA.....	11
3.1.1 A comparable system.....	11
3.2 Data collection in the USA.....	12
3.2.1 Problems in care persist in the USA.....	13
3.3 Some lessons for Australia	14
3.4 Financial pressures impact on staffing in Australia	15
3.4.1 Data collection and transparency: missing in Australia	17
3.5 Comparing Australian and USA staffing.....	17
3.5.1 Total nursing hours.....	17
3.5.2 Individual skill levels.....	19
3.5.3 Australia and the USA: Comparison of staffing levels.....	21
3.6 Staffing of nursing homes and ownership type	23
3.7 Analysis of structure and staffing in the USA	23
3.8 Studies of private equity in the USA	25
3.9 Analysis of structure and staffing in the Australia	26
3.10 Comparing profitability and staffing in Australia.....	27
A. The marketplace perspective	27
B. The community perspective	29
4 Conclusions	31
5 Recommendations	34
Appendix A: A community controlled aged care marketplace	35
Appendix B: Personality, social responsibility and staffing	37

1 In summary

The following points bring the issues, our concerns and views together in point form. Some of the matters have also received attention in our previous submission:

1. The confusion caused by the misuse of the term '*direct care*' is addressed and clarified in this supplementary submission.
2. The remainder of the submission looks at what comprises adequate numbers and skills for nursing care. USA studies based on extensive outcome measures have clearly delineated and established the number and skills of nursing staff that are necessary if failures in care are to be avoided. The relationship between staffing and nursing care is indisputable. Australia does not collect objective data and falls a long way behind other countries. It has woefully inadequate numbers and skills ratios (which is illustrated in our analysis). But while numbers and skills are essential, they do not guarantee good care. Much more is needed.
3. The USA has developed one of the most expensive and intense systems of data collection and oversight. It collects staffing levels and measures outcomes so that comparisons and necessary staffing levels can be determined. Canada too, collects large amounts of data.

This pressure and total transparency, which allows real choice, has resulted in increased overall staffing levels as well as an increase in skills to meet increasing resident acuity. Evidence confirms that despite some problems adequate minimum staffing ratios improve staffing and care if done properly. The distribution of skills is as important. Using only total ratios can distort services and this can offset some of the advantages.

Other pressures in the system have resulted in wide differences in performance. Far too many nursing homes provide inadequate staffing and inferior care. We address the reasons for this. There is much to learn from the USA experience.

4. The extensive data collection and oversight in these countries is superior to anything we have and has been beneficial particularly for staffing, but it does have some significant adverse outcomes in practice.
 - a) Much of the data is self-reported and in a competitive market where it forms the basis for choice it suffers from bias. The system can be and has been gamed. Australia's plans for Quality Indicators⁴ (currently voluntary) are at high risk of a similar problem⁵.
 - b) The focus on particular measurable outcomes directs attention and effort away from equally or more important parameters of care.
 - c) Aged care is an intimate personnel experience and its success depends on the quality of relationship between staff and between staff and residents. None of this is assessed and it is consequently ignored.
 - d) Aged care readily becomes process and outcome driven and so task rather than person focused. This undermines our humanity and insulates us from the suffering of those we are there to help.
 - e) Staff are most affected by this. An excessive focus on measuring and regulating care can take the care out of care or as one critic indicated this destroys the way people work together - 'the glue of life'.
 - f) While Australia's accreditation process does not collect objective data, it is strongly process driven and has the same impact. It is easily gamed and looks past and ignores the things that matter. Industry groups claim that it is a "*very robust system - - to ensure quality of care*"⁶ but it was not designed to regulate and the concepts on which its operations are based are unsuited

⁴ Aged Care Quality Indicator Program - Guidance: <http://bit.ly/2gLydV3>

⁵ Perverse effects of quality indicators raised, Australian Ageing Agenda, 20 Feb 2015: <http://bit.ly/2gLEAr5>

⁶ ACSA Position Statement - Staffing Ratios, November 2015: <http://bit.ly/2gGZBDv>

to this role. It assists the motivated, but it does not ensure anything. No other country relies on accreditation as the sole regulator.

5. Early USA data showed that increasing acuity requires an increase in skills rather than numbers. Some recent studies suggest it also requires an increase in nurse assistants, who do the heavy lifting. Oversight pressure in the USA and the use of minimum levels has maintained and supported larger numbers of trained nurses in response to rising acuity. Their absence in Australia combined with commercial pressures has seen a steady decrease in skilled staff and increase in unskilled staff in the face of rising acuity – the opposite of what is needed.
6. Data in the USA and Canada examining ownership clearly show the clear relationship between the pressure for profit and both lower staffing levels and failures in care. Australian data supports this. Australia's aged care system abandoned probity requirements in favour of an approved provider system in 1997. This change was justified on the unfounded assertion that ownership does not impact care.
7. The aged care system in Australia was switched to a competitive market system in 1997 without due attention to the conditions needed for markets to work in a vulnerable sector of society. The necessary conditions are an effective customer and an alert and involved civil society to set permissible parameters. These conditions were ignored. People with increasingly impaired cognition and their anxious families cannot qualify as effective customers and are not in a position to choose wisely.
8. As a consequence, provider thinking, incentives and disincentives are all directed towards keeping costs down by reducing staff and spending less on care. They don't have their attention on the things that matter for society. The real competition is what you can succeed in getting away with. Good providers provide good care in spite of the system but pay a heavy price for doing so. They risk going out of business and are unable to grow so become fewer and fewer. It's not just about money. It's where it goes and the incentives are to keep staffing as low as possible.
9. In the 1990s, Australia was at the forefront in developing an effective oversight and regulatory system led by criminologist John Braithwaite. He not only collected needed objective data, but also introduced a flexible investigative and interview style of oversight and regulation⁷ that explored and assessed the subjective experiences of staff and residents so assessing and addressing the critically important "glue of life" on which care depends. While identifying problems and being critical of them he worked constructively with the providers to address them. Braithwaite was aware of the problems with the system in the USA and wrote comparing Australia's system of oversight positively with what the USA were doing. This was abandoned in favour of accreditation in 1997. These were important advances and Aged Care Crisis would like to see a new regulatory system based on them.
10. The aged care system today is vastly different to that in which Braithwaite developed his ideas and his program. There are powerful commercial pressures and a cohort of strong dominant and credible believers who have identified with the current system and will be resistant. The regulatory processes are fragmented, inflexible, and process driven so impersonal and unhelpful to residents. They are poorly integrated. Braithwaite's sort of regulation will have benefit but this benefit will be limited by its need to struggle against the conviction and certainty in a sector whose standing and legitimacy is now based on market success rather than the standard of care provided.
11. Dr. de Bellis using the insights of the philosopher Foucault studied the way in which powerful structures in the marketplace took over and controlled the discourse of aged care in the 1990s⁸. This moved the focus from care to market and culminated in the system we have today. If we are

⁷ Braithwaite J and Braithwaite V The Politics Of Legalism : Rules Versus Standards In Nursing-Home Regulation: Social & Legal Studies, Vol. 4 (1995), 307-341 https://www.anu.edu.au/fellows/jbraithwaite/_documents/Articles/politicsoflegalism_95.pdf

⁸ De Bellis A Thesis: Behind Open Doors - A Construct of Nursing Practice in an Australian Residential Aged Care Facility <http://bit.ly/2guYZQK>

to move the focus back to care we need to counter this by creating an effective customer and an interested and powerful community (civil society) – one which will, in working with the industry, set the values, norms and limits of acceptable conduct in the sector and place care back at the centre of the aged care discourse.

12. Aged Care Crisis urges the re-establishment of a regulatory system based on Braithwaite's principles^{9 10}. It should work closely with and through a community that works with the industry and supports constructive engagement. It should aim to build community knowledge and involvement. It should support community by giving community structures important functions so that they play a role both in assisting with data collection, with complaints and with regulation. By delegating important parts of the investigation and oversight as well as having them engage with management in addressing the issues we would build relationships. But these relationships should be underpinned by community power. For this reason we believe that the community should be empowered by a right of veto over providers. We can re-establish the customer (supported and empowered by community) as well as build an interested and knowledgeable civil society that has the respect of the industry.
13. This approach also addresses vulnerabilities in the Braithwaite system by having a regular on site presence with members of the community working with and assisting facility staff in data collection and management - as a joint venture. This interaction encourages the sort of regular dialog in which group dynamics becomes a regulatory process by confronting and challenging inappropriate thinking.
14. In doing this we empower the customer and community so restoring the necessary conditions for the market to work. It creates an empowered community that can focus the discourse in the sector back on care. Staffing and all the attributes that motivated staff bring to care then become core considerations that cannot be explained away or glossed over.
15. Aged care has traditionally been a community activity. There are sound reasons for involving community, not least the role that they can play in building relationships with staff and residents and so contributing to the "glue of life" that makes residents lives worthwhile. A UK study by psychologists looks at the sort of facility that provides a successful community service and the benefits of close community ties¹¹.
16. This is not something that can be done all at once. It needs to come in stages, some more quickly than others. It needs to be part of a long-term process and objective. It can be positioned within and be part of a move towards participatory democracy when that term is used in a broad context. It might become a pilot project.

In Conclusion: The power structure, the strong pressures and the incentives in our aged care system are all directed towards the minimum levels of staffing and care that providers can get away with. Unless some means is found to change the way that the system operates, any recommendations that the workforce committee makes are likely to be no more successful than previous inquiries in addressing staffing issues.

We believe our suggestions would go a long way to addressing these pressures and the worrying issues surrounding staffing. They should be applicable to other staff and in other settings. Some of these comments refer to matters that we addressed in our previous submission.

⁹ Braithwaite J. Regulation and Quality in Aged Care: a Cross-National Perspective Australian Journal on Ageing 17 (4) Nov 1998 page 172 http://www.anu.edu.au/fellows/jbraithwaite/documents/Articles/Regulation_Quality_1998.pdf

¹⁰ Braithwaite J Accountability and Governance under the New Regulatory State; Accountability in Australian Government Symposium in the Australian Journal of Public Administration 58(1):90-97, March 1999: <http://bit.ly/2guMogo>

¹¹ Karl Nunokoosing and Mark Haydon-Laurelut The Relational Basis of Empowerment Published in "The Need for Roots" series. The Centre for Welfare Reform: <http://www.centreforwelfarereform.org/library/type/pdfs/the-relational-basis-of-empowerment.html>

Glossary and abbreviations

ACC	Aged Care Crisis
RN	Registered Nurse (equivalent in the USA and Australia)
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	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 (CHIP), 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.
SB	StewartBrown

2 Muddied waters

Since the aged care workforce inquiry has been announced, the waters have been muddied.

StewartBrown (SB) has recently started using the same term '*direct care*' for two quite separate sets of data, one of which includes '*non-direct care*'. They have included: hotel services, maintenance, administration, and quality and education under chartered staffing data labelled '*direct care*'.

We are not aware of this ever being done before.

The inflated figures for staffing data that include '*non-direct care*' have been published using the words '*direct care*' on social media¹². These were copied to senators only 48 hours before the workforce inquiry interviewed industry representatives. The industry has used these figures to respond to discussion on social media and in response to an article where National Seniors was critical of deficiencies in '*direct care*'¹³.

The issue here is that a reputable organisation has used the same words for two very different sets of data without clearly labelling on the graph and in any text, exactly what the difference was. If we did that at an academic meeting or in a research paper without clearly specifying the difference on the graphs and explaining this fully in the text, we might be accused of fraud and investigated by our universities.

This is especially pertinent as the information contained in the reports are clearly used by industry bodies to lobby Government and in the formulation of policy. SB's registration form¹⁴ states "*The results of the survey may also be used for other purposes. It is likely that summary data will be used by industry bodies to lobby Government and in the formulation of policy.*"

Critics and family members of loved ones in aged care are primarily concerned about deficiencies in nursing care staffing. The response has been to use data that includes much more without disclosing this. The Committee must draw its own conclusions as to whether this was self-serving or socially responsible.

One of those responding to criticism using these inflated figures was interviewed by the Inquiry. We do not know if this data was presented to the inquiry but to put any confusion about the data to bed we will clarify this issue before looking at data in the USA.

¹² Social media post re RACF Average direct care hours per resident per day: <http://bit.ly/2fmloAd>

¹³ Comment on "Peaks raise aged care staffing levels and skill mix with Senate inquiry" - Australian Ageing Agenda, 9 Nov 2016
<http://bit.ly/2fnKDwT>

¹⁴ Aged Care Financial Performance Survey - Registration Kit 2016, pg2: *Background & Purpose of Survey* <http://bit.ly/2gomLhx>

2.1 Use of the term 'direct care'

By adding nearly an hour of extra time that others^{15 16 17} in Australia and specifically the MyAgedCare website¹⁸ call *non-direct care this*, we believe, seeks to undermine the accuracy of criticisms about staffing.

The term '*direct care*' in Australia usually includes allied health services but what is included under that term varies, as for example between MyAgedCare (*Footnote: 18*) and Access Economics (*Footnote: 15*). It would be more consistent and helpful to separate allied health and examine it separately, as they are very different services.

Figure 1: MyAgedCare website - <http://www.myagedcare.gov.au/about-us/aged-care-workforce>



The screenshot shows the MyAgedCare website page. At the top, there are logos for the Australian Government and MyAgedCare. The main heading is 'Aged care workforce'. The text describes the contribution of aged care workers and provides statistics for 2012. A list of direct-care workers is provided, including nurses, personal care or community care workers, and allied health professionals. The page also mentions future workforce projections and accreditation standards.

Aged care workforce

Aged care workers make a valuable contribution to the daily lives of many thousands of older people across Australia. Creating an appropriately skilled and well-qualified workforce is fundamental to delivering high-quality aged care services that meet the needs of older Australians. In 2012, there were over 352,100 (estimated) employees in the aged care sector working in residential and community settings, and in a variety of direct-care and non-direct care occupations.

Of these, 240,445 were **direct-care workers** including:

- **nurses**
- **personal care or community care workers**
- **allied health professionals such as physiotherapists and occupational therapists.**

Australia's aged care workforce is expected to grow to around 827,100 in 2050. There will be opportunities for people to become involved in this expanding industry. There are a range of aged care qualifications, career development opportunities and skills training available.

Direct-care workers may provide care in a person's home or in an aged care home. All aged care homes are required under the [Accreditation Standards](#) to employ appropriately skilled and qualified staff to care for residents. For example, all residents with high-level care must have any nursing services carried out by a registered nurse or other appropriate professional.

Workers in non-direct care roles might be managers who work in administration or ancillary workers who provide catering, cleaning, laundry, maintenance and gardening.

¹⁵ Nurses in residential aged care - Access Economics for ANMF, November 2009 - <http://bit.ly/2gxLmki>

¹⁶ The Aged Care Workforce in Australia White Paper (draft) July 2013 ACSA - <http://bit.ly/2fleu9a>

¹⁷ A snapshot of residential aged care Australian Nursing & Midwifery Federation August 2016 Page 2 - <http://bit.ly/2fNMgl5>

¹⁸ Aged care workforce - Myagedcare web site Nov 2016: <http://www.myagedcare.gov.au/about-us/aged-care-workforce>

2.2 Analysis of staff data

SB breaks down its data into 5 bands based on the income generated from care. It consequently reflects resident acuity. The highest payment in band 1 indicates the greatest resident acuity and band 5 the lowest. Each band represents groups who have very similar amounts of money to spend on care so making them comparable.

Figure 2: Data supplied by a Director of SB

Total care staff hours and Total staff hours June 2016 hours per resident per day						
	SURVEY ALL FACILITIES Average (817 Facilities)	BAND 1 Average (320 Facilities)	BAND 2 Average (228 Facilities)	BAND 3 Average (149 Facilities)	BAND 4 Average (68 Facilities)	BAND 5 Average (52 Facilities)
Staff Hours Analysis						
Hours worked per resident per day						
Care management	0.10	0.09	0.09	0.11	0.10	0.12
Registered nurses	0.36	0.41	0.37	0.34	0.29	0.15
Enrolled and certified nurses	0.32	0.35	0.32	0.32	0.20	0.17
Other care staff	2.02	2.19	2.00	1.82	1.92	1.50
Therapy	0.11	0.12	0.10	0.11	0.11	0.11
Total Care Hours	2.90	3.16	2.88	2.68	2.62	2.05
Hotel services	0.66	0.68	0.66	0.64	0.69	0.59
Maintenance	0.07	0.07	0.07	0.08	0.09	0.07
Administration	0.16	0.15	0.15	0.17	0.17	0.13
Quality and Education	0.02	0.02	0.02	0.02	0.02	0.02
Total Staff Hours	3.81	4.08	3.79	3.58	3.59	2.86

Figure 3: Note 'actual' nursing hours (Registered nurses, Enrolled and certified nurses, Other care staff)

	SURVEY ALL FACILITIES Average (817 Facilities)	BAND 1 Average (320 Facilities)	BAND 2 Average (228 Facilities)	BAND 3 Average (149 Facilities)	BAND 4 Average (68 Facilities)	BAND 5 Average (52 Facilities)
Total Nursing Hours	2.70	2.95	2.69	2.48	2.41	1.82

Note: Both versions of *direct care* figures charted are derived from the data in the 2016 report¹⁹. The figures fall from band 1 to band 5 reflecting the difference in resident acuity. The figures used for the 2016 charts are arrowed. **Total Staff Hours** adds 0.91 hours (55 min) of *non-direct care* to **Total Care Hours** and over 1 hour to actual "direct care nursing hours".

¹⁹ Aged Care Financial Performance Survey Residential Care Report - June 2016, SB

Figure 4: Total Care staff hours (SB²⁰, Chart 7)

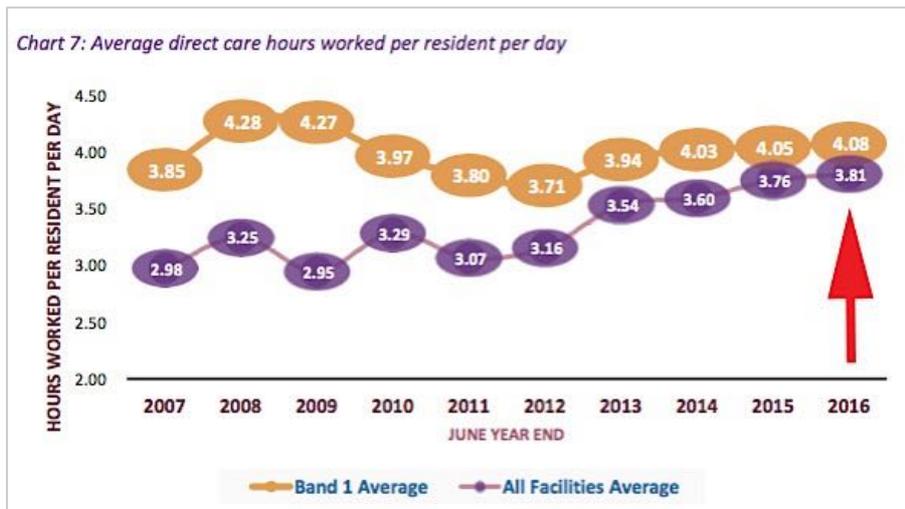


Chart 7: (left) from the June 2016 report shows the *Total staff hours* that were posted on social media as direct care and used to refute claims of poor staffing.

The arrow points to the 2016 average and band 1 figures which are identical to the total hours in the staff report above (also arrowed). These include 0.91 hours non-direct care items.

Figure 5: Total Care staff hours (SB²¹, Chart 28)

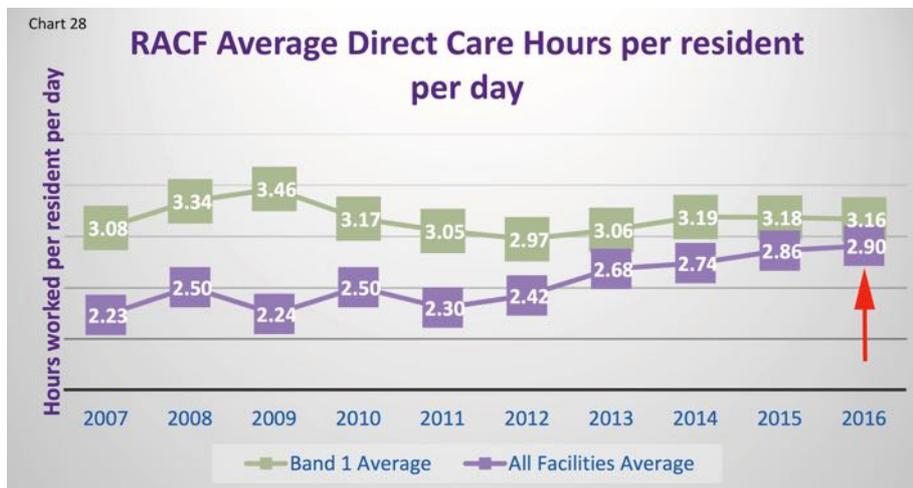


Chart 28: (left) approximates what others in Australia call *direct care* - although few would include “care management”. The arrowed band 1 and average are also arrowed on the table above under *Total Care Hours*.

Others in Australia vary in what they include under therapy depending on which allied health professionals²²²³ are providing it.

Recommendation:

- **The term 'direct care' is misused in Australia. It should be used to describe direct hands on time spent on clients as contrasted with time spent by the staff referred to under administration or management.**

Staff in nursing homes carry out very different types of services that need to be costed and evaluated separately. Even the second graph, *Chart 28* above is also imprecise because it includes some management and therapist hours. It would be appropriate to always follow it with the service that is being provided. Eg. “*direct nursing care*” and so on for physiotherapists, doctors etc.

²⁰ Aged Care Financial Performance Survey Residential Care Report - June 2016 - SB, pg 15

²¹ Aged Care Financial Performance Survey Residential Care Report - June 2016 - SB, pg 38

²² Nurses in residential aged care - Access Economics for ANMF, November 2009 - <http://bit.ly/2gxLmki>

²³ Aged care workforce - Myagedcare web site Nov 2016: <http://www.myagedcare.gov.au/about-us/aged-care-workforce>

3 Comparing Australian staffing levels with the USA

The staffing structure in Australia is similar to that in the USA and there are three broad grades in each country:

Role:	USA	Australia
1. Clinical assessment, complex tasks and supervision of others	Registered Nurses (RNs)	Registered Nurses (RNs)
2. Tasks requiring certification (eg medications)	Licensed vocational/practical nurses (LVNs/LPNs;)	Enrolled and certified nurses
3. The hard work of lifting, toileting and caring.	Certified Nursing Assistants (CNAs)	Personal Care Assistants -- PCA's (Level III or less)

For the purpose of this analysis, we will assume that CNAs and PCAs do roughly the same type of work, although Australian PCAs are probably better trained.

3.1.1 A comparable system

While there may be some difference in skills, the tasks performed by each group are similar and they will take the same amount of time. The USA figures will therefore be reasonably applicable in Australia. The levels of acuity are measured differently, but the spectrum across the sectors are likely to be similar.

The reasons for comparing Australia with the USA is not because the care provided is so good, but because so much money and effort has been devoted to collecting data, reporting it out publicly to inform consumers and in regulating the system. The studies using this data are illuminating. In fact, many are critical of the data and of the care. It is to learn from all the work that they have done and examine the reasons why they, like the UK, have still far too often failed to provide the care needed for elderly citizens ^{24 25 26 27}.

Staffing and care occur in the context of the sort of system that we have, so we need to look at what the two countries do differently first.

²⁴ Fernandez E Low Staffing and Poor Quality of Care at Nation's For-Profit Nursing Homes University of California San Francisco 29 Nov 2011 <https://www.ucsf.edu/news/2011/11/11037/low-staffing-and-poor-quality-care-nations-profit-nursing-homes>

²⁵ Harrington C, Schnelle J F, McGregor M, Simmons S F. The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes Harrington C et al Health Serv Insights. 2016; 9: 13–19 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4833431/>

²⁶ Unmasked: How California's largest nursing home chains perform Three part series - The Sacramento Bee Nov 2014 -- more articles here <http://media.sacbee.com/static/sinclair/Nursing1c/index.html> ; <http://www.sacbee.com/news/investigations/nursing-homes/>

²⁷ Harrington C Understanding the relationship of nursing home ownership and quality in the United States - Marketisation in Nordic eldercare: A research report on legislation, oversight, extent and consequences Stockholm Studies in Social Work 30 2013 Chapter 8 page 229 <http://www.normacare.net/wp-content/uploads/2013/09/Marketisation-in-nordic-eldercare-webbversion-med-omslag1.pdf>

3.2 Data collection in the USA

The IOM studies: The Institution of Medicine did an extensive 3-year study and 345-page report in 2001²⁸. By then, “*information to evaluate quality of care in nursing homes was extensive*” but “*in many nursing homes quality of care continued to be problematic*”. The report indicated that improving quality depended on “*a work force that is sufficient in size, with the necessary skills, competence, and commitment*”. **It recommended in 1996 and reiterated in 2001 that 24-hour registered nursing care was required.**

The USA CMS study: The Centers for Medicare and Medicaid Services (CMS) carried out a 9-year government initiated study and reported its extensive findings in December 2001^{29 30}. Based on the evidence it recommended minimum staffing levels that have not changed much since. Many others including academics like Professor Charlene Harrington who was a member of the Institute of Medicine Committee that issued the 2001 report, have continued to study the sector and build on these efforts.

Limited political commitment: Despite intense pressure from academia and the community, strong opposition from the industry, particularly the powerful and wealthy corporate chains, has prevented minimum standards being legislated in many states and the minimum requirements by those states that do regulate vary widely and are too low³¹. Harrington et al³² reviewed the reasons why progress was so slow in 2016. They analysed the political and industrial forces that have restricted the use of all this data to improve services. They are remarkably similar to the situation in Australia.

The current USA data set: In the USA there is a vast amount of detailed information about the acuity of residents, data about nursing staff and large amounts of data about standards and failures in care. It is collected into the massive OSCAR and CASPER databases³³. Regular independent reports are prepared by the CMS^{34 35 36 37} and by other large organisations such as the Kaiser Foundation^{38 39 40}. It is a resource for academics doing research in the area.

²⁸ Wunderlich G S et al Improving the Quality of Long-Term Care. Committee on Improving Quality in Long-Term Care, Division of Health Care Services Institute of Medicine 2001 <https://www.nap.edu/catalog/9611/improving-the-quality-of-long-term-care>

²⁹ Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Report to Congress: Phase II Final Volume I Centers for Medicare and Medicaid Services December 24, 2001 <http://theconsumervoice.org/uploads/files/issues/CMS-Staffing-Study-Phase-II.pdf>

³⁰ Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Overview of the Phase II Report: Background, Study Approach, Findings, and Conclusions Centers for Medicare and Medicaid Services (CMS). December 2001 <http://world.std.com/~goldberg/nursingstaff2.pdf>

³¹ Staffing Levels in New York Nursing Homes: Important Information for Making Choices Eliot Spitzer Attorney General Office of the Attorney General Medicaid Fraud Control Unit January 2006 <http://www.ag.ny.gov/sites/default/files/press-releases/archived/final.pdf>

³² Harrington C, Schnelle J F, McGregor M, Simmons S F. The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes Harrington C et al Health Serv Insights. 2016; 9: 13–19 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4833431/>

³³ CASPER & OSCAR - Cowles Research Group <http://www.longtermcareinfo.com/data/casper-and-oscar.php>

³⁴ Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Report to Congress: Phase II Final Volume I Centers for Medicare and Medicaid Services December 24, 2001 <http://theconsumervoice.org/uploads/files/issues/CMS-Staffing-Study-Phase-II.pdf>

³⁵ Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Overview of the Phase II Report: Background, Study Approach, Findings, and Conclusions Centers for Medicare and Medicaid Services (CMS). December 2001 <http://bit.ly/2gAFczK>

³⁶ Nursing home data compendium 2015 edition Centre for Medicare & Medicaid Services <http://go.cms.gov/2f5STGH>

³⁷ Nursing Home Compare Five-Star Quality Rating System: Year Three Report Center for Medicare & Medicaid Services 7 June 2013 <http://go.cms.gov/2gKgyxs>

³⁸ Harrington C and Carrillo H. Nursing Facilities, Staffng, Residents and Facility Deficiencies, 2009 Through 2014 The Kaiser Commission on Medicaid and the Uninsured <http://bit.ly/2gACZEI>

³⁹ Harrington C and Carrillo H Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2014 Technical Notes <http://kaiserf.am/2ggkgha>

⁴⁰ Harrington C, Carrillo H. Nursing Facilities, Staffng, August 2015 Residents and Facility Deficiencies, 2009 Through 2014 Kaiser Supplemental tables Commission on Medicaid and the uninsured <http://bit.ly/2ggYPY>

In 2014 there were “approximately 175 individual” process and outcome requirements assessed⁴¹. The vast volume of material invites analysis and conclusions can be drawn from it. Canada too collects large amounts of data. Ontario measures 450 standards⁴².

Complexity and cost: It is a large costly bureaucratised exercise and is becoming increasingly costly as concerns about the accuracy of this self-reported data mount^{43 44 45 46}. Government is seeking ways to verify the data. They plan to use payroll tax data to verify the brief assessments of staffing levels made by state assessors. They are easily gamed. Some question whether this massive data collection and regulation is the best option^{47 48}. Unlike Australia, no one seems to be complaining about this being too onerous.

We need to use the USA data and what is said about it to understand the problems in aged care and the difficulties in regulating, rather than copy what the USA is doing. There must be a better way.

3.2.1 Problems in care persist in the USA

Standards: Standards of care continue to be a problem in 2016 and strong commercial competitive pressures in the marketplace have kept staffing and standards of care too low in many nursing homes. Regulatory vigour, sanctions and the publication of vast amounts of data that allow those who can get their heads around it to choose wisely, have improved the overall situation as far as measurable objective measures are concerned⁴⁹ but it is not uniform and unhappiness continues.

In 2014 up to 20.5% of nursing homes were cited for “potential or actual harm or jeopardy to residents”(Footnote: 49). A recent government study found that 33% of Medicare post-acute patients experienced adverse events resulting in harm or death in the first 35 days after admission to a nursing home (Footnote: 49). Newspapers periodically do in-depth investigations and report their troubling findings as a series of articles (eg 1998⁵⁰, 2002⁵¹, 2014⁵²). Academics working in the area remain critical (Footnote: 45). Important factors that impact on the resident's lives are not examined under this system.

-
- ⁴¹ Harrington C and Carillo H. Nursing Facilities, Staffng, Residents and Facility Deficiencies, 2009 Through 2014 The Kaiser Commission on Medicaid and the Uninsured <http://bit.ly/2gACZEr>
- ⁴² 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>
- ⁴³ Staffing Levels in New York Nursing Homes: Important Information for Making Choices Eliot Spitzer Attorney General Office of the Attorney General Medicaid Fraud Control Unit January 2006 <http://on.ny.gov/2gf9fJ3>
- ⁴⁴ Howe C L Staffing Ratios in Nursing Homes Howe C L Arizona Geriatrics society Vol. 15 no.2 pages 23-25 <http://bit.ly/2ggmA7N> (Reviews complexity of regulation and their nonspecificity. “points strongly to the need to consider interaction effects”)
- ⁴⁵ Harrington C Understanding the relationship of nursing home ownership and quality in the United States - Marketisation in Nordic eldercare: A research report on legislation, oversight, extent and consequences Stockholm Studies in Social Work 30 2013 Chapter 8 page 229 <http://bit.ly/2fEBPUv>
- ⁴⁶ Harrington C. USA Quality differences in For-profit and Not-for-profit Nursing Homes Presentation to Normacare conference - Marketisation in Nordic eldercare 2013 <http://bit.ly/2gjlxku>
- ⁴⁷ Howe C L Staffing Ratios in Nursing Homes Howe C L Arizona Geriatrics society Vol. 15 no.2 pages 23-25 <http://bit.ly/2ggmA7N>
- ⁴⁸ 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>
- ⁴⁹ Harrington C, Schnelle J F, McGregor M, Simmons S F. The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes Harrington C et al Health Serv Insights. 2016; 9: 13–19 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4833431/>
- ⁵⁰ “Money or Mercy” multiple reports of a 6 month study Tampa Tribune 15 November 1998
- ⁵¹ Negligence in Nursing Homes: An investigative series of the St. Louis Post-Dispatch !7 articles October 2002 <http://bit.ly/2fopNhc>
- ⁵² Unmasked: How California's largest nursing home chains perform Three part series The Sacramento Bee Nov 2014 -- more articles here <http://bit.ly/2gf980I> <http://bit.ly/2foogHH>

Choice helps some but not others: The positive images on brochures and web sites coupled with salesman skills are persuasive (*Footnotes: 45, 46*) and the extensive well organised data available on the Nursing Home Compare site is still too complex for many to understand and use^{53 54 55}. Warnings about potential bias in the data on some Nursing Home Compare website pages are not reassuring. CEPAR research in Australia⁵⁶ has also warned that choice can be difficult for some who will need assistance.

Complex corporate structures: The pressures in the system have led many for-profit companies to develop complex corporate structures^{57 58 59}. These permit profits and costs to be legally shifted between companies as one company overcharges another for services provided. Poor providers' profits are protected from government fines, lawsuits and bankruptcy, as the money is not held in the responsible company. This has complicated the situation and caused major problems. This is something we should be wary of.

3.3 Some lessons for Australia

Relying on incomplete data: Meeting numbers, skills, outcome measures, and ticking boxes may create the necessary conditions but they do not guarantee an effective and caring environment. It takes much more and this is more difficult to evaluate.

A focus only on staffing parameters or some other measurable objective parameter in isolation can be at the expense of other aspects of care and can distort the way services are provided. Attaining a good working environment and good care requires more than pressure to meet measurable processes and outcomes.

A focus on financial data without linking it to objective measures and to subjective assessments of the way the service is provided has the potential to mask failures. It can distort the aged care system. There is much to suggest that this has happened in Australia.

Missing information: Oversight in the USA, like ours in Australia, fails to evaluate corporate and facility culture, the interplay of personalities and relationships, motivation and the way in which staff, residents and families interact. The potential adverse consequences resulting from the interplay of multiple measured and not measured factors cannot be assessed under the system in either country.

It is very difficult to develop and maintain these important additional facility attributes when there are staff deficiencies. This is particularly so when the owner or manager's primary objectives are not care, or when the image the facility presents to the public misrepresents the true situation. This results in alienation among staff whose interests lie with the residents and what actually happens to them. Motivation suffers.

⁵³ Stevenson D G, Bramson J S, Grabowski D C. Nursing Home Ownership Trends and Their Impact on Quality of Care: A Study Using Detailed Ownership Data from Texas Stevenson D G et al J Aging Soc Policy. 2013; 25(1): 30–47. <http://bit.ly/2fomPco>

⁵⁴ Nursing Home Compare USA government <https://www.medicare.gov/nursinghomecompare/search.html>

⁵⁵ About Nursing Home Compare data USA government Nursing Home Compare <http://bit.ly/2g2Howx>

⁵⁶ CEPAR Research Aged care in Australia: Part II – Industry and practice: CEPAR research brief 2014/02 <http://bit.ly/2g1q0KW> (some people may find choice difficult and will require guidance and information).

⁵⁷ Unmasked: How California's largest nursing home chains perform Three part series The Sacramento Bee Nov 2014 -- more articles here <http://bit.ly/2gf980l> <http://bit.ly/2foogHH>

⁵⁸ Stevenson D G, Bramson J S, Grabowski D C. Nursing Home Ownership Trends and Their Impact on Quality of Care: A Study Using Detailed Ownership Data from Texas Stevenson D G et al J Aging Soc Policy. 2013; 25(1): 30–47. <http://bit.ly/2fomPco> (Corporate structures -- Use of these structures did not change failures in care --- ? impact on accountability --- "difficulty consumers may have in navigating the information available on Nursing Home Compare")

⁵⁹ Harrington C, Ross L, and Kang T Hidden Owners, Hidden Profits, and Poor Nursing Home Care: A Case Study International Journal of Health Services · 2015, Vol. 45(4) 779–800 <http://bit.ly/2f5Zj8M>

More flexible and responsive regulation needed: A multifaceted and flexible approach to regulation and oversight is required if we are to make a balanced assessment. This is difficult in the current centralised models of arms-length and infrequent oversight and regulation.

Self-reporting results in bias and results can be distorted^{60 61}, particularly when competition is strong.

In Australia Braithwaite and Braithwaite were critical of the USA regulatory approach and during the 1990s were developing a more investigative and intersubjective approach to regulatory oversight, which tapped into the experiences of residents and staff to collect the missing information. They compared this with the USA and found it to be superior⁶². This work was abandoned in 1997 when Australia replaced oversight with accreditation. Braithwaite was very critical⁶³.

Banerjee is very critical about the excesses of data collection in Canada⁶⁴. He referred to “the regulatory trap” and a “vicious cycle”. He considers that an excess of data collection and process take attention away from important parameters “*such as the allocation of resources, the role of the state and the place of for-profit corporations*”. Assessment of care is “decoupled” from care itself causing “documentation or assessment of care to trump the provision of care”. An excess of process and regulation destroys the way people work together and the formation of caring relationships - ‘the glue of life’. He considers that we should be “regulating where it matters”.

The approach suggested by Braithwaite would throw far more light on the experience of staffing and residents making both important. It would concentrate on the experience of care as well as support, skill and numbers. Staffing would become a prime focus.

The approach suggested by Braithwaite^{65 66} when coupled with a community presence in the facilities would throw far more light on the experience of staffing and residents making both important. It would concentrate on the experience of care as well as support, skill and numbers. Staffing would become a prime focus.

3.4 Financial pressures impact on staffing in Australia

Staff salaries are the single largest cost of care and profit pressures impact on staffing numbers and structure. USA data shows that minimum staffing levels do address this problem by improving staffing and care.

⁶⁰ Harrington C, Schnelle J F, McGregor M, Simmons S F. The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes Harrington C et al Health Serv Insights. 2016; 9: 13–19 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4833431/>

⁶¹ Staffing Levels in New York Nursing Homes: Important Information for Making Choices Eliot Spitzer Attorney General Office of the Attorney General Medicaid Fraud Control Unit January 2006 <http://www.ag.ny.gov/sites/default/files/press-releases/archived/final.pdf>

⁶² Braithwaite J and Braithwaite V The Politics Of Legalism : Rules Versus Standards In Nursing-Home Regulation: Social & Legal Studies (SAGE, London, Thousand Oaks, CA and New Delhi), Vol. 4 (1995), 307-341

⁶³ Braithwaite J The challenge of regulating care for older people in Australia BMJ 2001;323:443-6 -- 25 Aug 2001: <http://bit.ly/2gy2ZxK>

⁶⁴ 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>

⁶⁵ Braithwaite J. Regulation and Quality in Aged Care: a Cross-National Perspective Australian Journal on Ageing 17 (4) Nov 1998 page 172 http://www.anu.edu.au/fellows/jbraithwaite/_documents/Articles/Regulation_Quality_1998.pdf

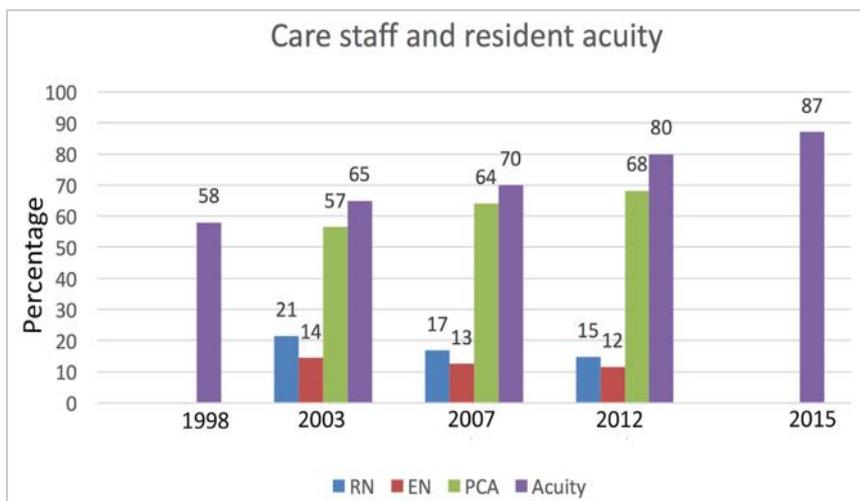
⁶⁶ Braithwaite J Accountability and Governance under the New Regulatory State; Accountability in Australian Government Symposium in the Australian Journal of Public Administration 58(1):90-97, March 1999 http://johnbraithwaite.com/wp-content/uploads/2016/03/Accountability_Governance_1999.pdf

State minimum staff ratios in the USA have improved staffing levels but financial pressures have sometimes resulted in less skilled staff being employed in order to meet the minimum numbers without increasing overall costs. This has been shown to compromise some aspects of care^{67 68}. It is clear that minimum levels of each type of nurse are required and simply specifying total numbers is suboptimal.

Without minimum staffing levels in Australia, the competitive market pressures are having an even greater impact on staff numbers and distribution. There has been a much larger shift in the distribution of nursing staff in Australia than in the USA where skill levels have been steady or increased.

The importance of an adequate number of registered nurses is well established. The increase in resident acuity, at the same time as the skills needed to provide the extra more sophisticated care these frailer residents need decreases, is a pointer to what we would probably find if we collected data about standards of care.

Figure 6: A snapshot of residential aged care - ANMF (Aug 2016)⁶⁹



As nursing acuity (measured as the percentage of high care residents) has increased, the percentages of registered and enrolled nurses has fallen.

They have been replaced by much less skilled personal care assistants.

Note: that allied health professionals have not been included in the chart

On page 12 of SB's December 2015 review⁷⁰, the report indicates "The number of hours worked by other care staff compared to registered nurses has been increasing due to the change in staff mix to accommodate the pressure on costs". Bentley's also documents a fall in registered nurses and an increase in less trained staff between 2004 and 2014⁷¹. In the early 1990s states like Victoria expected almost a third of high care facility staff to be registered nurses.

The rise in acuity has been accompanied by steadily decreasing trained staff, the very opposite of what is needed.

⁶⁷ Bowlblis J R. Staffing Ratios and Quality: An Analysis of Minimum Direct Care Staffing Requirements for Nursing Homes Health Serv Res. 2011 Oct; 46(5): 1495–1516. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3207189>

⁶⁸ Kim H, Kovner C, Harrington C, Greene W, and Mezey M. A Panel Data Analysis of the Relationships of Nursing Home Staffing Levels and Standards to Regulatory Deficiencies J Gerontol B Psychol Sci Soc Sci. 2009 Mar; 64B(2): 269–278 <http://bit.ly/2fqloMV>

⁶⁹ A snapshot of residential aged care Australian Nursing & Midwifery Federation August 2016 Page 2 : <http://bit.ly/2fNMgl5>

⁷⁰ Aged Care Financial Performance Survey Summary of Survey Outcomes, December 2015 Review, SB

⁷¹ Peta Bourne presentation Aged Care Sustainability + benchmarks ACSA Finance Forum 30 October 2014 <http://bit.ly/2fAiKly>

3.4.1 Data collection and transparency: missing in Australia

Transparency: All of the original data collected in the USA is publicly available and any academic or citizen can access, download⁷² and research the data. The data collected for each facility is available on the USA government's Nursing Home Compare website^{73 74}. Every resident and family member is able to access the data, which is presented in a clear and informative manner. They can use it to make informed choices.

The only data reliably collected in Australia is financial and much of it is stored in industry and government silos. Other than the accreditation process, which does not collect objective data, no attempt is made to collect good data about care or use what we have to assess the effectiveness of staffing or the care provided. There is little transparency.

It is important that we stop pretending that we are providing good care and instead collect accurate data about staffing, outcomes and what it is like working and living in our nursing homes. This should be transparent if we are to be able to choose wisely. The issue should be how best to do this so that we get the information needed while at the same time encouraging and supporting the staff in what they do.

Reliability: When there were failures of care in New York, its attorney general, Eliot Spitzer, not only prosecuted offenders but published a list of all the state facilities setting their performance against federal and several state regulatory requirements urging the community to choose carefully. The problem in the USA is that this is self-reported data and Spitzer warned prospective residents not to rely on it too heavily as he had *"serious reservations about the reliability of staffing data at the nursing home level"*. Under current systems in both countries it is difficult to ensure that the figures reflect what is happening when the assessors are not there.

Choice: One of the lessons from the USA is that they have been providing information and urging choice for over 20 years. The impact this has had in improving staffing and services has fallen short of expectations. Many struggle with the way the star system is developed and with the additional data whose significance is difficult to understand, For many the simple images created by marketing brochures and web sites, and the one on one salesmanship of managers, remain the primary method for selecting a nursing home.

In Australia we are being sold the idea of choice without the information, the knowledge and capacity to assess it, or the power needed to be effective and fully in control.

3.5 Comparing Australian and USA staffing

Adequate staffing remains the foundation of good care and we should compare our figures to see where we stand.

3.5.1 Total nursing hours

The CMS (Centre for Medicare and Medicaid Services) recommends minimum total nursing ratio of 4.1 hprpd (**hours per resident per day**). Data shows that below this level, some residents are at risk of being harmed. They also found that 2.9 hours seemed to be a critical point for nurse aids - equivalent to Personal Care Assistants (PCAs) in Australia. Below this there are likely to be many more problems.

⁷² Nursing Home Compare - USA government: Datasets <https://data.medicare.gov/data/nursing-home-compare>

⁷³ Nursing Home Compare - USA government - Search: <https://www.medicare.gov/nursinghomecompare/search.html>

⁷⁴ About Nursing Home Compare data USA government Nursing Home Compare <http://bit.ly/2g2Howx>

The Orlando Sentinel when criticizing the Florida government's tardiness in introducing promised minimum staffing levels in 2006 put it this way⁷⁵:

"... Yet lawmakers still have not kept their promise that, in exchange for lawsuit limits, residents would receive 2.9 hours per day of nursing aide care.

Why is 2.9 hours per day so important? An eight-year federal study found that below 2.9 hours (of nursing aide care), most residents "needlessly suffer harm." This means residents aren't fed when they are supposed to be; they aren't turned in their beds often enough to prevent bedsores; or they aren't assisted to the bathroom ..."

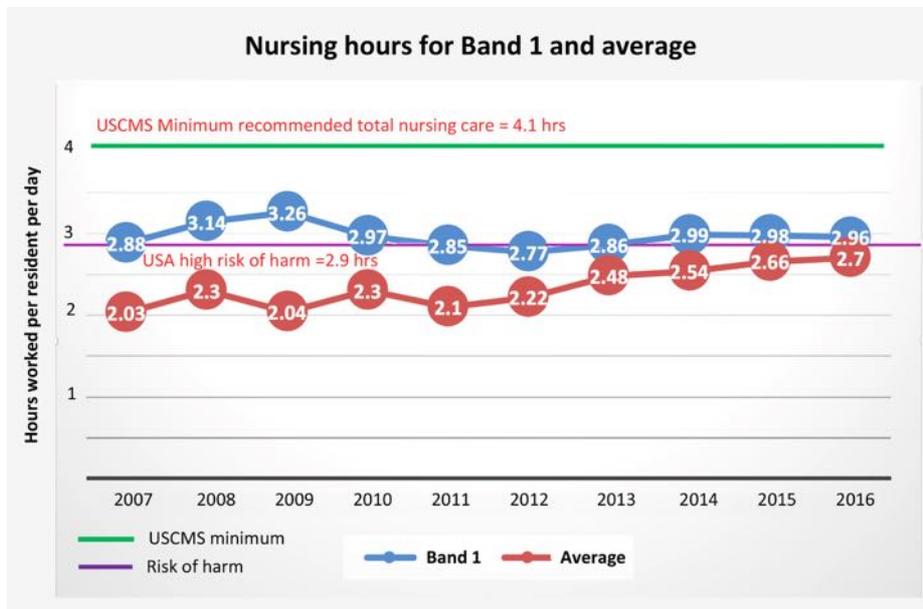
This is exactly what so many Australian families and despondent nurses have been complaining about, at least since 2000 when the competitive pressures introduced in 1997 began to bite.

Australian figures: We have detailed access to figures from SB's reports for only two or three years. These include care management and therapy, which are not provided by nurses. These makes up approximately 0.2 hours (12 min) of the "direct care" provided.

To make the figures comparable to those in the USA in plotting the chart below (**Figure 7**), we have subtracted 0.2 hours from SB's own chart showing **direct care** over the years.

On the graph below, we have marked the USA CMS 4.1 hrrpd recommended minimum total level for all staff and also the 2.9 danger level. Remember that did not include qualified nurses so the number of personal care workers (equivalent to nurse aids) is actually much lower than the total level charted. The 2.9 hours did not include any qualified nurses:

Figure 7: Comparison of "direct care" between USA and Australia



Note that the band 1 average levels, comprising the residents with the greatest acuity, receive one hour less care than the USA CMS minimum recommended level for all facilities. In fact, it sits directly on the 2.9-hour danger level.

The average figure is a long way below this 2.9 level and provides roughly between 1.5 and 2 hours less care per day to the average resident than the recommended minimum in the USA.

⁷⁵ Still waiting for nursing-home staff increase, Orlando Sentinel, 10 Feb 2006 <http://bit.ly/2g68enA>

3.5.2 Individual skill levels

The distribution of different staffing levels is also very important for good care.

As Spitzer indicated when advising New Yorkers in 2006⁷⁶:

"... Over the past 25 years, numerous research studies have documented the important relationship between nurse staffing levels, particularly RN staffing, and the outcomes of care. The benefits of higher staffing levels, especially RN staffing, can include lower mortality rates; improved physical functioning; less antibiotic use; fewer pressure ulcers, catheterized residents, and urinary tract infections; lower hospitalization rates; and less weight loss and dehydration ..."

USA studies indicate that of the three levels of care, registered nurses have the most impact on care outcomes followed by the total number and the number of nurse assistants⁷⁷.

Registered Nurses

Based on her studies in Victoria, Professor Nay⁷⁸ has indicated that once a sufficient number of staff are present, then the number of skilled registered nurses becomes most important for the standard of care provided.

In the USA in 2009 Kim et al (*Footnote: 77*) reported that in their study in California, nursing homes with higher RN staffing levels received significantly fewer total and Quality of Care deficiencies. The number of nursing assistants also had a significant impact but the less highly trained licensed practical nurses (LPN) had little impact on failures in care or quality of life. They commented that replacing RN's with less well trained nurses impacted negatively on care.

An adequate number of RN's is the most important requirement and the greater the acuity the more are required. The average expected figures set out by the USA CMS show a higher level of RN's (well above the minimum) and slightly fewer CNA's. High acuity facilities are expected to have more RN's and so bring up the average.

Certified Nursing Aids

Professor Schnelle (Director, Center for Quality Ageing at Vanderbilt University) using data from a time and motion study, produced this graph (**Figure 8**) at a meeting in Toronto⁷⁹ showing the percentage of care that would be omitted with different levels of CNA staffing hours based on acuity graded workload percentiles. This is equivalent to Australia's PCA's. As can be seen in the slide from his presentation below, the percentage of tasks that are omitted increases rapidly when levels of CNA's fall below 2.8 hours, the minimum recommended by the USACMS. It is greatest in the 95th heaviest workload percentile where more staff are required.

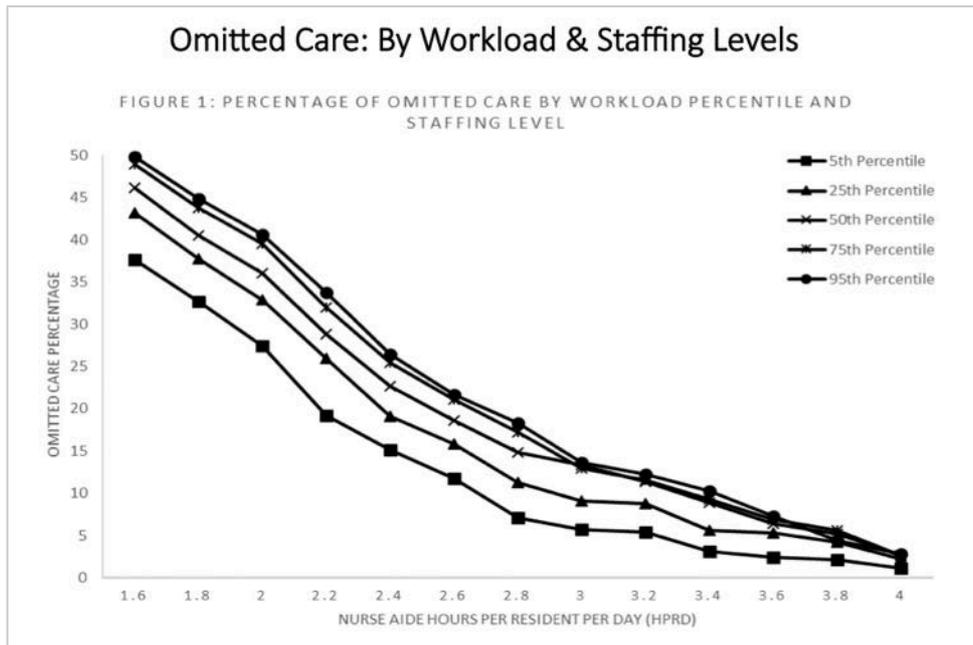
⁷⁶ Staffing Levels in New York Nursing Homes: Important Information for Making Choices Eliot Spitzer Attorney General Office of the Attorney General Medicaid Fraud Control Unit January 2006 <http://on.ny.gov/2gf9fJ3>

⁷⁷ Kim H, Kovner C, Harrington C, Greene W, and Mezey M. A Panel Data Analysis of the Relationships of Nursing Home Staffing Levels and Standards to Regulatory Deficiencies J Gerontol B Psychol Sci Soc Sci. 2009 Mar; 64B(2): 269–278 <http://bit.ly/2fqloMV>

⁷⁸ Innovative workforce responses to a changing aged care environment, Department of Health, August 2015 <http://bit.ly/2f9wrfX>

⁷⁹ Schnelle JF Determining Nurse Aide Staffing Requirements to Provide Care Based on Resident Workload: A Discrete Event Simulation Model. Presentation in Canada 2016, Presentation: <http://bit.ly/2gnTbpZ>

Figure 8: Determining Nurse Aide Requirements to Provide Care Based on Resident Workload: A Discrete Event Simulation Model (November 2016), Slide 12



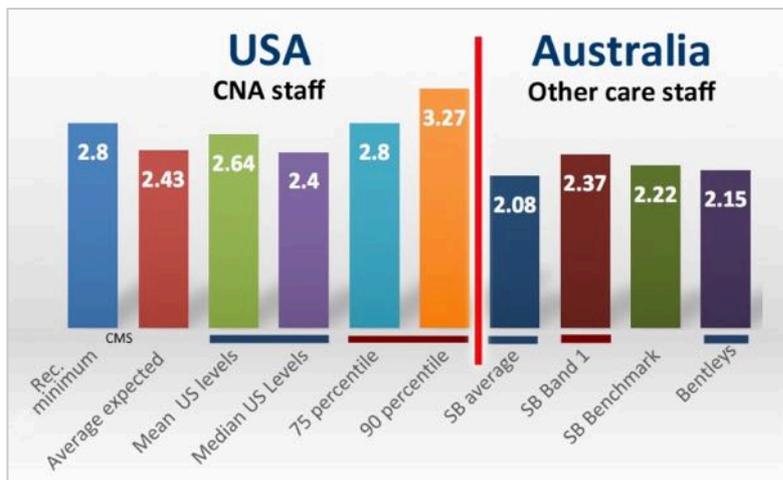
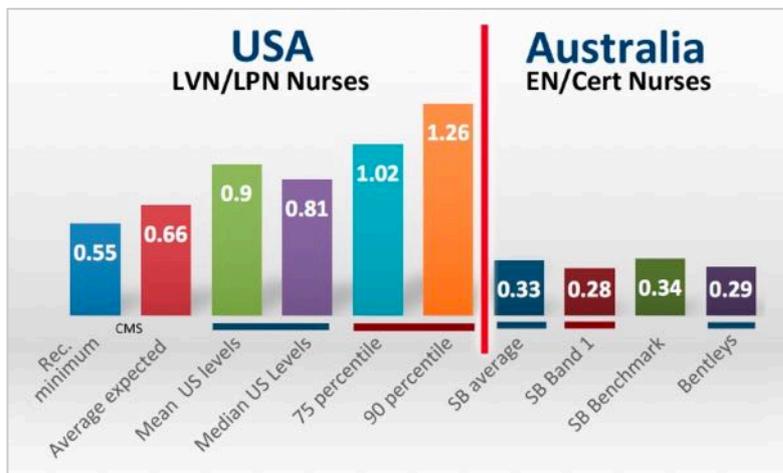
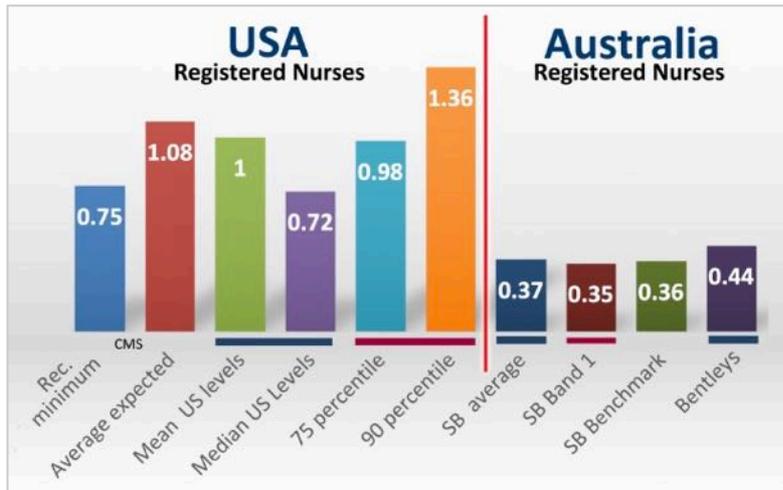
In his 2016 paper on the subject, Schnelle⁸⁰ found that that Nurse Aid levels were not being increased to meet increased resident acuity. This would require “2.8 hours/resident/day for NHs with a low workload (5th percentile) to 3.6 hours/resident/day for NHs with a high workload (95th percentile). In contrast, NHs reported staffing levels that ranged from an average of 2.3 to 2.5 hours/resident/day across all 5 workload percentiles”. He found that “the average nurse aide staffing levels reported by NHs falls below the level of staffing predicted as necessary to provide consistent ADL care to all residents in need”. This would probably apply equally to PCAs in Australia.

Professor Carol Howe⁸¹ in her review of staffing ratios in 2009 also commented on studies that “showed that 2.8 to 3.2 NA hprd, depending on the acuity level of the NH population, were necessary to consistently provide all of these daily care processes”.

⁸⁰ Schnelle JF, Schroyer LD, Saraf AA, Simmons SF, Determining Nurse Aide Staffing Requirements to Provide Care Based on Resident Workload: A Discrete Event Simulation Model J Am Med Dir Assoc. 2016 Nov 1;17(11):970-977 <http://bit.ly/2gnYOEB>

⁸¹ Howe C L - Staffing Ratios in Nursing Homes Howe C L Arizona Geriatrics Society, Vol. 15 no.2, pages 23-25 <http://bit.ly/2ggmA7N>

3.5.3 Australia and the USA: Comparison of staffing levels



Notes about the following charts:

Note 1: The USA figures are taken from over 15,000 Medicare and Medicaid facilities and all facilities are included and all are required to submit data. They include for-profit, not-for-profit and government owned facilities. The data is self-reported and collected by states so is subject to a commercial interest bias and to variable state systems. They are quoted from Harrington et al's 2016 paper⁸² and were taken from the Kaiser report⁸³ of which Harrington was co-author. This was based on the large USA KASPAR and OSCAR databases⁸⁴. We assume these are equivalent to our accredited facilities. Both receive government and private funding.

Note 2: The USA mean (ie average) figure is skewed by a number of very well staffed facilities as revealed in the 90-percentile figure. The median is a better reflection of the situation as it indicates that 50% of facilities fell below that level.

Note 3: The SB figures taken from their June 2016 report⁸⁵ largely represent not-for-profit providers so we are comparing Australian not-for-profits against a USA group that includes for-profits that in the USA, staffed more poorly. The approximately 800 SB participants are self-selected and figures are self-reported so are subject to both selection bias and commercial interest bias. They are also used for lobbying and formulation of policy⁸⁶.

Note 4: SB's Band 1 is Australia's highest acuity best funded and staffed group. It is not strictly comparable to the 75 and 90 percentiles in the USA, but it does show the difference between the best-staffed facilities in the two countries.

Note 5: SB's Dec 2015⁸⁷ Benchmark is derived from the most profitable quartile in band 1. This is the target it is setting for those who want to perform well financially.

⁸² Harrington C, Schnelle J F, McGregor M, Simmons S F. The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes Harrington C et al Health Serv Insights. 2016; 9: 13–19 <http://bit.ly/2fHPvhB>

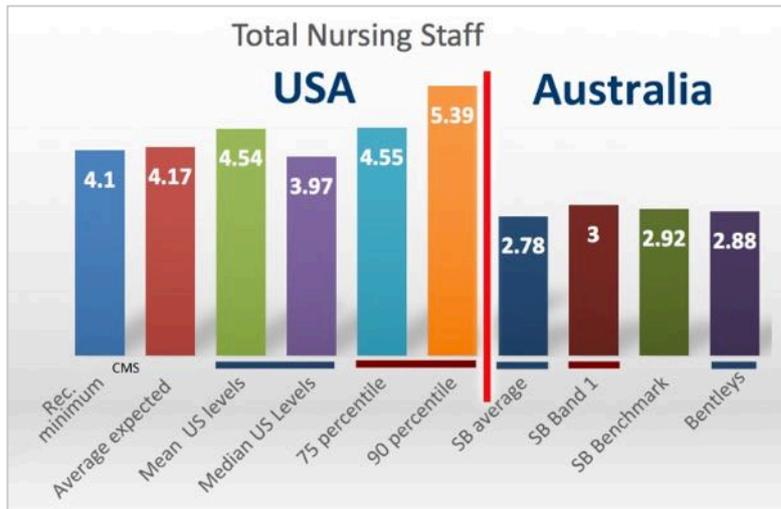
⁸³ Harrington C and Carillo H. Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2014 - The Kaiser Commission on Medicaid and the Uninsured <http://bit.ly/2gACZEr>

⁸⁴ CASPER & OSCAR - Cowles Research Group: <http://www.longtermcareinfo.com/data/casper-and-oscar.php>

⁸⁵ Aged Care Financial Performance Survey Residential Care Report - June 2016 - SB

⁸⁶ Aged Care Financial Performance Survey - Registration Kit 2016, pg2: Background & Purpose of Survey <http://bit.ly/2gomLhx>

⁸⁷ Aged Care Financial Performance Survey Summary of Survey Outcomes December 2015 SB



Note 6: The smaller Bentleys report from a smaller number of facilities is also self-selected and may contain more for-profits. The figures are derived from a presentation to ACSA in 2014⁸⁸.

Note 7: We do not know if the market listed and private equity groups that in the USA staff more poorly put themselves forward and provided their data to Bentleys.

Note 8: The CMS expected acuity adjusted average expects more RN's and fewer CNA's. Schnelle's study found that you also needed more CNAs as acuity increased so the average expected CNAs and average expected total in the USA may be too low.

i Comment:

The USA has a third more total staff and double the number of registered nurses compared with Australia.

We are comparing different systems and there will be factors that will impact on their comparability. Nevertheless, the figures for staffing in Australia are so strikingly different that, in the absence of our own data, we must assume that these reflect a very different and poorer standard of care in Australia.

Particularly significant is the low ratio of registered and enrolled nurses. Both the total and the number of support nursing staff are well below the USA.

⁸⁸ Peta Bourne presentation Aged Care Sustainability + benchmarks ACSA Finance Forum 30 October 2014 <http://bit.ly/2fAiKly>

3.6 Staffing of nursing homes and ownership type

One of the most heavily studied parameters in the USA has been the ownership structure of the facilities. This has been shown to have a major impact both on staffing levels and on the objectively collected data of performance, particularly failures in care.

Little effort has been directed to assessing the important parameters of corporate culture, facility culture, staff motivation and morale or the patterns of relationship between staff and residents/families – the quality of life. Because corporate objectives in profit-focused entities are often so different from those of staff, this is more likely to become an issue. It is something we need to measure to understand the impact.

Since 1997 in Australia when the probity requirements were replaced by the approved provider process, politicians and bureaucrats have strongly asserted that it was the managers of the provider and not the owners who were important for care. All the regulatory effort has focused on the local facilities and on managers. This belief flies in the face of evidence.

The second pillar of their arguments has been the alleged strengths and effectiveness of the “rigorous” Accreditation process. While the industry and the Quality Agency continue to support these claims, politicians have gone silent. None of these claims stands up to any sort of evidence based or logical arguments.

3.7 Analysis of structure and staffing in the USA

There have been multiple studies in the USA since 1994 that have documented the lower levels of staffing and the increased number of deficiencies in care in nursing homes by the large for-profit chains including those owned by private equity^{89 90 91 92 93 94 95}. This has also been found in Canada⁹⁶.

Further studies have shown that the performance of private equity owned nursing homes on both of these measures is worse than the market listed chains and continue to deteriorate the longer the facilities are owned by private equity.

The Nursing Home Compare web site uses a five star rating system to inform potential clients. It is based on staffing and on overall performance including health inspections and quality measures. Its report (*Footnote: 95*) gives a comparison of for-profit and not for profit facilities. The not-for-profits outperform for-profits in overall performance in total staffing and in registered nurses (*see Figure 9*).

⁸⁹ Harrington C, Schnelle J F, McGregor M, Simmons S F. The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes Harrington C et al Health Serv Insights. 2016; 9: 13–19 <http://bit.ly/2fHPvhB>

⁹⁰ Non-Profit vs. For-Profit Nursing Homes: Is there a Difference in Care? Center for Medicare Advocacy accessed Nov 2016 <http://bit.ly/1SJcMLJ>

⁹¹ “Money or Mercy” multiple reports of a 6 month study Tampa Tribune 15 November 1998

⁹² Fernandez E Low Staffing and Poor Quality of Care at Nation's For-Profit Nursing Homes University of California San Francisco 29 Nov 2011 <https://www.ucsf.edu/news/2011/11/11037/low-staffing-and-poor-quality-care-nations-profit-nursing-homes>

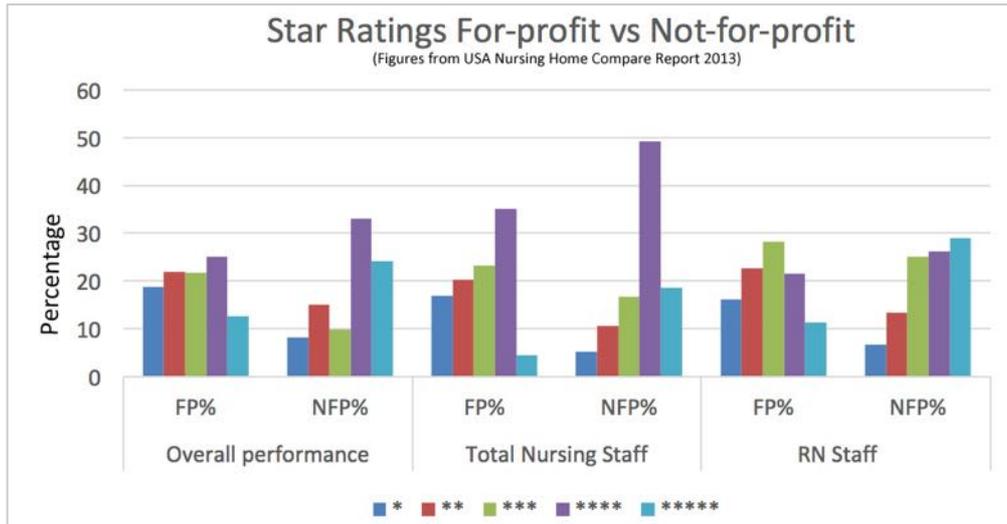
⁹³ Harrington H, Olney B, Carrillo H, and Kang T Nurse Staffing and Deficiencies in the Largest For-Profit Nursing Home Chains and Chains Owned by Private Equity Companies Health Research and Education Trust 2011 DOI: 10.1111/j.1475-6773.2011.01 311. <https://www.ncbi.nlm.nih.gov/pubmed/22091627>

⁹⁴ Nursing home data compendium 2015 edition Centre for Medicare & Medicaid Services <http://go.cms.gov/2f5STGH>

⁹⁵ Nursing Home Compare Five-Star Quality Rating System: Year Three Report Center for Medicare & Medicaid Services 7 June 2013 <http://go.cms.gov/2gKgyxs>

⁹⁶ McGregor M J, Cohen M, McGrail K, Broemeling A M, . Adler R N, Schulzer M, Ronald L, Cvitkovich Y, and Beck M Staffing levels in not-for-profit and for-profit long-term care facilities: Does type of ownership matter? CMAJ. 2005 Mar 1; 172(5): 645–649. <http://bit.ly/2f9UP0P>

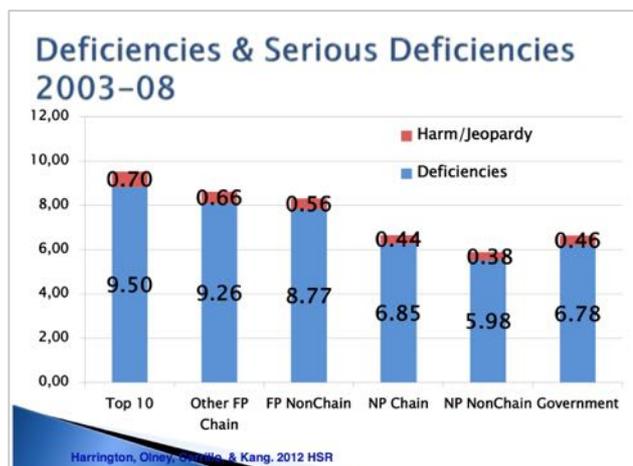
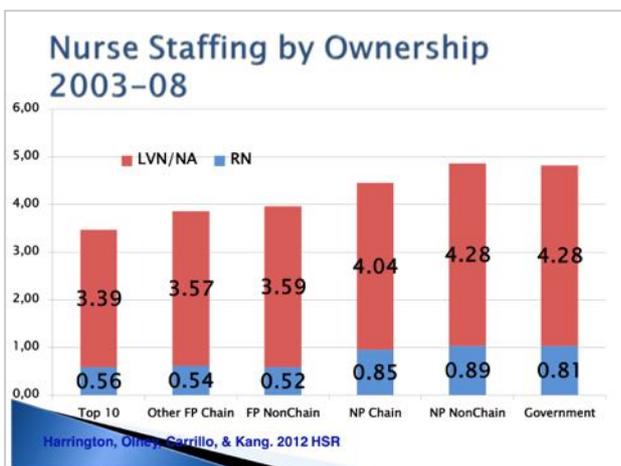
Figure 9: Analysis of performance when comparing for-profit vs not-for-profit



The charts show the percentage of each group that were awarded star ratings. Note that in every comparison, the for-profits have larger numbers in the poor one and two star columns. The not-for-profits outperform the for-profits in every four and five star column, the best performers.

The CMS Nursing Home Data Compendium 2015 Edition⁹⁷ documented the findings between 2010 and 2014. The supplementary tables show that Not-for-profits had consistently lower failure rates overall including for: Actual Harm or Immediate Jeopardy, substandard quality of care, citations for use of restraints and Pressure ulcers.

An article⁹⁸ to a Normacare organised seminar “Marketisation in Nordic eldercare” in Stockholm in 2013, and charts⁹⁹ from a presentation to that seminar by Professor Charlene Harrington UCSF School of Nursing, bring it all together. She has been involved in many of the major analyses of the USA data and written about it extensively.



⁹⁷ Nursing home data compendium 2015 edition Centre for Medicare & Medicaid Services <http://go.cms.gov/2f5STGH>

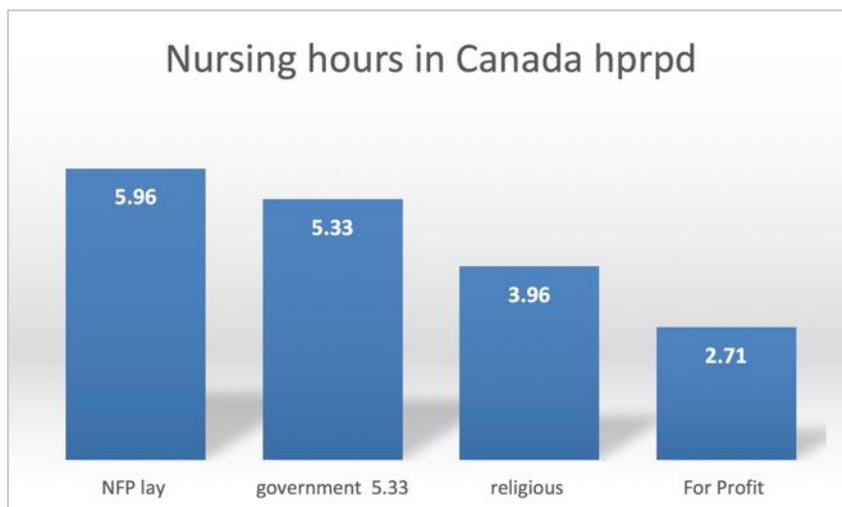
⁹⁸ Harrington C - Understanding the relationship of nursing home ownership and quality in the United States - Marketisation in Nordic eldercare: A research report on legislation, oversight, extent and consequences Stockholm Studies in Social Work 30 2013 Chapter 8 page 229 <http://bit.ly/2FEBPUv> (Poor care persists and visits easily gamed FPs and NFPs differences. FPs able to market in spite of poor quality and more lawyers to fight regulators and politicians, (weak, decentralized regulatory system)

⁹⁹ Harrington C. USA Quality differences in For-profit and Not-for-profit Nursing Homes Presentation to Normacare conference - Marketisation in Nordic eldercare 2013 <http://bit.ly/2gjlxku>

The charts from Harrington's presentation compare the most aggressive top 10 market for-profit chains with other for-profit chains, and with non-chain (private) for-profits and then the more profit focused non-profit chains, non-chain non-profits and government facilities.

The graphs show how the increasing pressures for profitability impact staffing and care in the far more regulated USA system. Private equity is not separated out.

Canadian figures also show the for-profit owned facilities staffing poorly.



Canada: Figures show a different pattern but staffing in for-profits facilities are also by far the lowest at 2.71 hprpd

(Figures from Banerjee A. An Overview of Long-Term Care in Canada and Selected Provinces and Territories¹⁰⁰)

3.8 Studies of private equity in the USA

The Australian Senate Standing Committee on Economics Inquiry investigating Private Equity investment in 2006/7 rejected arguments^{101 102} that Private Equity posed a threat to our health and aged care systems in its final report¹⁰³. On 20 August 2007, exactly one month later the *New York Times* wrote the first major analysis¹⁰⁴ of the impact of private equity in aged care. USA studies have since shown that private equity owned facilities perform more poorly^{105 106} than all other for-profit facilities in regard to both staffing and care and one found that both continued to deteriorate^{107 108} the longer the facilities were owned by private equity.

¹⁰⁰ Banerjee A. An Overview of Long-Term Care in Canada and Selected Provinces and Territories Women and Health Care Reform October 2007 <http://bit.ly/2fRhone>

¹⁰¹ Wynne J M. Submission 3 The Senate Standing Committee on Economics Inquiry 2007 <http://bit.ly/2gjCCO4>

¹⁰² dela Rama M. Submission 5 The Senate Standing Committee on Economics Inquiry 2007 <http://bit.ly/2gowlOR>

¹⁰³ Private equity investment in Australia The Senate Standing Committee on Economics Inquiry 2007 <http://bit.ly/2gDfRW6>

¹⁰⁴ More Profit and Less Nursing at Many Homes The New York Times, 23 Sep 2007 <http://nyti.ms/2gow6DA>

¹⁰⁵ Fernandez E Low Staffing and Poor Quality of Care at Nation's For-Profit Nursing Homes University of California San Francisco 29 Nov 2011 <http://bit.ly/2fTWG9q>

¹⁰⁶ Harrington H, Olney B, Carrillo H, and Kang T Nurse Staffing and Deficiencies in the Largest For-Profit Nursing Home Chains and Chains Owned by Private Equity Companies Health Research and Education Trust 2011 DOI: 10.1111/j.1475-6773.2011.01311. <https://www.ncbi.nlm.nih.gov/pubmed/22091627> (Private equity)

¹⁰⁷ Nursing Facilities Owned by Private Equity Firms: Fewer Nurses, More Deficiencies Center for Medicare Advocacy Accessed November 2016 <http://www.medicareadvocacy.org/nursing-facilities-owned-by-private-equity-firms-fewer-nurses-more-deficiencies/>

¹⁰⁸ Pradhan R, Weech-Maldonado R, Harman J S, Al-Amin M, Hyer K Private Equity Ownership of Nursing Homes: Implications for Quality Journal of Health Care Finance Vol 42 no 2 June/July 2014 pages 1-14 <http://healthfinancejournal.com/index.php/johcf/article/view/12/15>

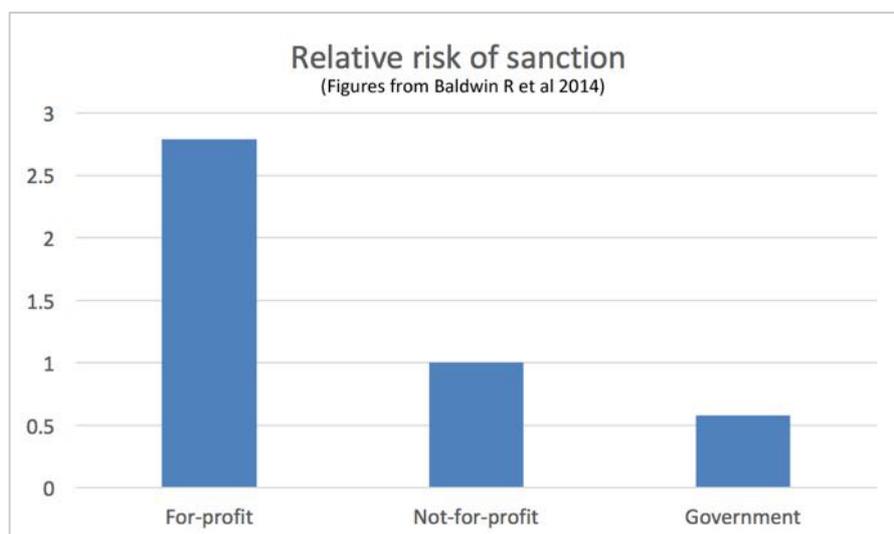
Private Equity has been a major problem in the UK¹⁰⁹ and is blamed for much of the disastrous state of their aged care system. Problems have recently developed in Private Equity owned facilities in Australia (*Footnote: 109*).

3.9 Analysis of structure and staffing in the Australia

The 2014 Kaiser commission report¹¹⁰ of which Harrington was a co-author and its supplemental tables¹¹¹ was able to provide detailed data on 175 types of deficiency over the years 2009 to 2014. Australia does not collect this sort of data and similar analysis is not possible. Available evidence suggests that if it did the findings in Australia would be similar. We do not have the data to compare staffing in Australia but the likelihood that a similar situation exists must be high.

Sanctions: Baldwin et al in 2014¹¹² compared the incidence of sanctions in Australia. They showed that the relative risk that for-profit facilities would be sanctioned for failures in care was 4.8 times that of government facilities and 2.79 times that of not-for-profit facilities (**Figure 10**). In a subsequent article and several opinion pieces, the direction current Australian policy is taking us is questioned.

Figure 10: Study comparing incidence of sanctioned nursing homes in Australia by ownership type



Accreditation: We consider that the accreditation process yields only low quality data because it is primarily based on surveys of processes after weeks (sometimes months) of pre-planned visits. The majority are prepared for well in advance. On the basis of its crude figures, the Quality Agency claims that the performance of for-profit and not-for-profit nursing homes is equal¹¹³. It documents wide differences between metropolitan and regional facilities. As there are almost no for-profit facilities in regional (or remote) areas (4% in 2008), not-for-profits must be performing several times better than for profits.

¹⁰⁹ Private Equity - Inside Aged Care: <https://www.insideagedcare.com/aged-care-analysis/aged-care-marketplace/private-equity>

¹¹⁰ Harrington C and Carrillo H. Nursing Facilities, Staffng, Residents and Facility Deficiencies, 2009 Through 2014 The Kaiser Commission on Medicaid and the Uninsured <http://bit.ly/2gACZEr>

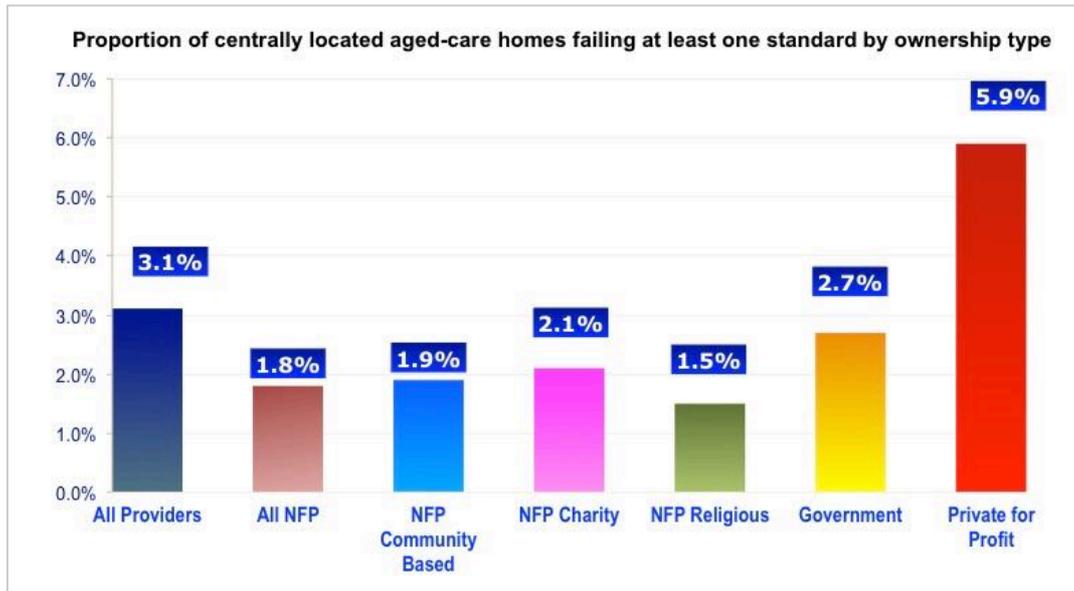
¹¹¹ Harrington C, Carrillo H. Nursing Facilities, Staffng, August 2015 Residents and Facility Deficiencies, 2009 Through 2014 Kaiser Supplemental tables Commission on Medicaid and the uninsured <http://bit.ly/2ggYPY>

¹¹² Quality failures in residential aged care in Australia: The relationship between structural factors and regulation imposed sanctions Baldwin R et al Australasian Journal on Ageing 22 May 2014 <http://onlinelibrary.wiley.com/doi/10.1111/ajag.12165/abstract>

¹¹³ Quality Agency rejects ownership factor on accreditation Australian Ageing Agenda, 25 Mar 2015 <http://bit.ly/2fvux4v>

Aged Care Crisis confirmed this¹¹⁴ in an analysis examining only centrally located facilities performed in 2008. For profits failed an accreditation standard 3.3 times as often as not-for-profit facilities and 3.9 times as often as religious facilities. We think it likely that this difference would have narrowed since 2008 because of the increased pressure put on not-for-profits to compete with for-profits in the marketplace and their adoption of similar policies and practices.

Figure 11: Analysis of centrally located nursing homes failing at least one standard by ownership type



3.10 Comparing profitability and staffing in Australia

A. The marketplace perspective

SB separates off the income and expenses for care because this is where most of the profits and losses are made. The other areas of provider's operations make a lesser contribution and do not vary widely. It collects its data in order to assist managers to be more profitable and avoid losses. Its data is also for providers to use in lobbying¹¹⁵.

The thrust of its assessments is that to be profitable the costs of care must be kept to a minimum and those who spend too much on care will not be able to compete or to grow and so will not be viable. They will go under. They appreciate that some may not be as profit focused as others but they nevertheless see room for improvement. They indicate that the major driver of profitability in residential aged care continues to be the ability to get the balance between care income and the costs of care right.

Methods of analysis

Bands: SB divides facilities into five bands based on the income paid by government and by residents towards their care so it also roughly represents the acuity of the residents and the amount of care they need. Band 1 facilities have an income of over \$172 per bed day and band 5 of less than \$127 with \$15 increments between bands.

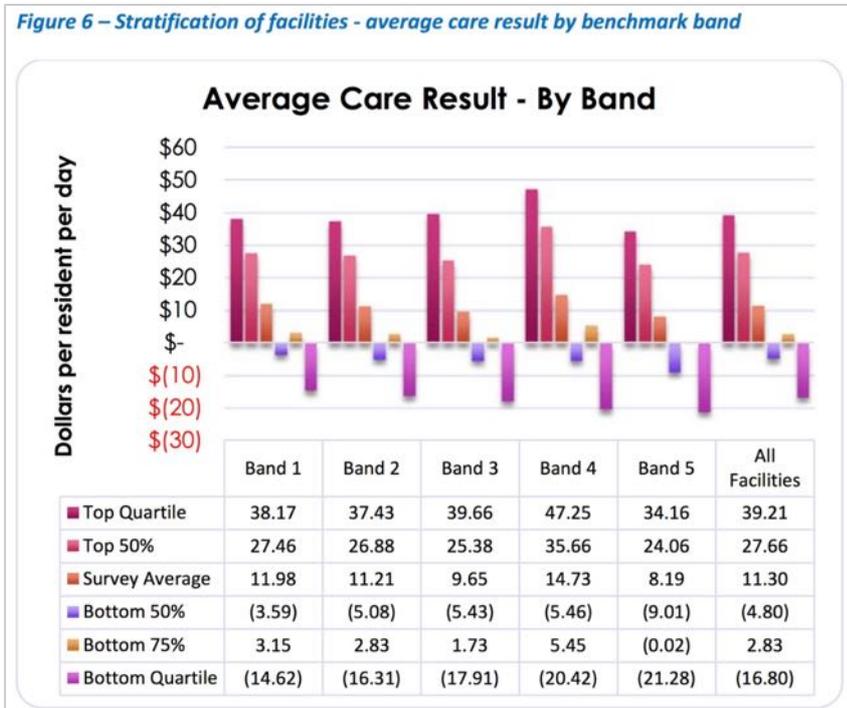
Quartiles: It also divides the facilities into quartiles based on their profitability. By comparing the quartiles in each band the profits and losses made from the same income from care can be compared.

¹¹⁴ Aged care report card Aged Care Crisis 2008 <http://www.agedcarecrisis.com/news/research/108-aged-care-report-card>

¹¹⁵ Aged Care Financial Performance Survey - Registration Kit 2016, pg2: Background & Purpose of Survey <http://bit.ly/2gomLhx>

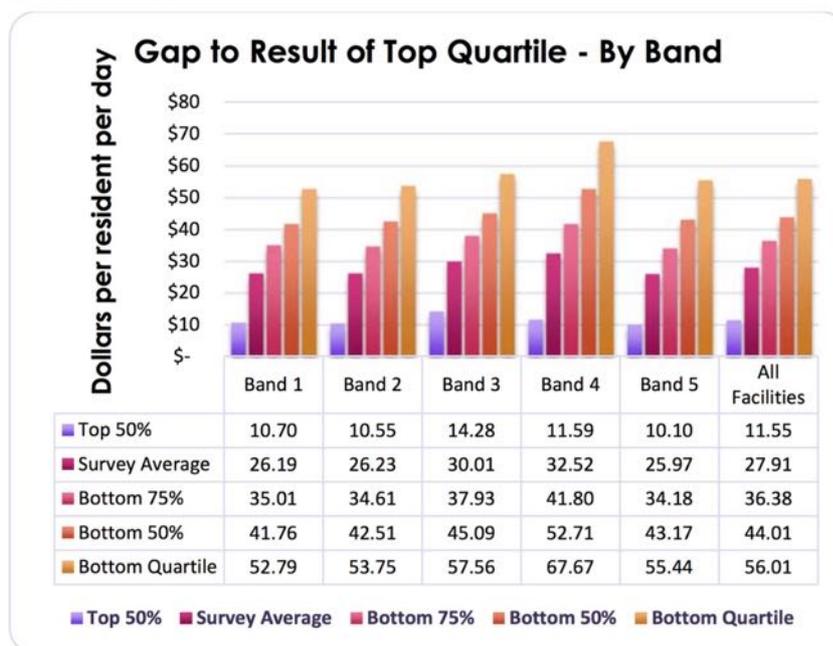
As can be seen from the December 2015¹¹⁶ charts (below) there are very wide differences in all bands with the top quartile earning on average \$56 more profit per resident per day than the bottom quartile who are making a loss. In a hundred-bed nursing home this is a \$2 million difference each year. To remain viable these groups must be tapping into other sources of income and prioritising the needs of their residents. They are also prioritising care over growth. SB's view is "For those in the bottom quartile, the answer can't continue to be 'do nothing'". It all comes down to how costs are managed in each facility.

Figure 6 – Stratification of facilities - average care result by benchmark band



This chart compares various combinations of the four quartiles. As we can see on average, 25% are doing very well, 50% of the providers are not making a profit and 25% are making large losses

Figure 7 - Gap in care result between top quartile average and the average of other groups in survey



This chart represents the money that lower quartiles are not making because their managers are not paying enough attention to cost saving. They are losing up to \$56 per person per day in potential profit

¹¹⁶ Aged Care Financial Performance Survey Summary of Survey Outcomes December 2015 Review - SB

Clearly many are more intent on ensuring that the residents they are there to serve get the care that they need and cannot bring themselves to abandon their responsibility to their residents. They are putting the interests of the residents ahead of their own interests and embracing traditional medical and community values and ethics when dealing with the vulnerable.

Missing data:

How that money is being spent is not revealed but as staff are the biggest cost much of it is probably being spent there. It would be very interesting and socially responsible to also analyse and chart the staffing ratios in each of these quartiles and see the difference. It is quite likely that the staffing levels and resident outcomes, if they were measured as they are in the USA, would be inversely proportional to profitability – but we don't know for sure.

If those who are being successful are doing so by providing poor care and those who are failing are those who are providing the best care, then this would be critically important information for policy makers, community and customers. The community might expect a socially responsible organisation to collect this information and initiate debate. But that is not how the modern market thinks or works. Its own interests take precedence over it and its officers social responsibility as citizens. Increasingly corporations demand loyalty to the corporation above society from its employees.

B. The community perspective

If this was a community organization collecting and analysing this information on behalf of prospective residents or simply an intelligent family looking for the best for a parent, they would all rate the amount of money that a facility was spending on care very highly. In dividing the providers into quartiles the top quartile would not be the one that made the most profit but the one that spent the most on care, employed the best staff and provided the best care. The ones that spent the least on care would be the bottom quartile.

Obviously this group of citizens would want to know that the money was being spent on care and to employ more and better staff and not on corporate banquets and perks. They might also be wise to check that the provider had the resources to maintain the service.

Were the same material to be collected and reported by a community-focused organisation they might label it differently as in the two charts below: In making recommendations they would focus on the second graph.

- The top quartile would be those providers spending the most on care.
- There would be additional charts showing where the money went and recording the staffing in hours per resident per day for each group.
- They would take a very negative view of facilities and managers that kept staffing levels too low and standards of care to a minimum in order to make more money. More traditional community values and norms would find this unacceptable.

Figure 6 – Stratification of facilities - Average money saved by reducing staff and services to residents by benchmark band

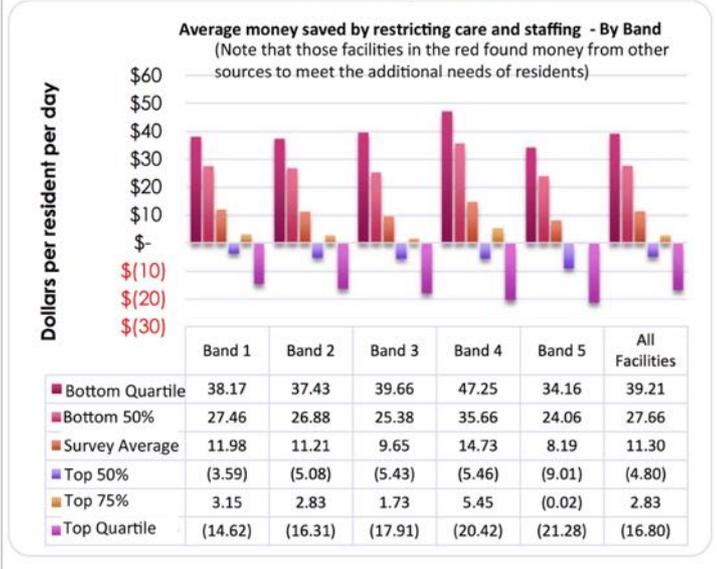
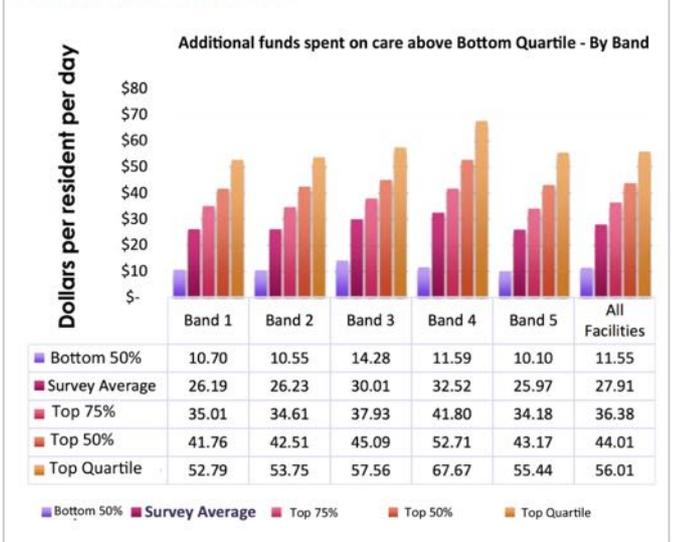


Figure 7 Additional funding provided to care between bottom quartile average and the average of other groups in survey



i Comment:

Market theorists assure us that the market system operates to reward those who serve us well and put those who don't out of business. But it also tells us that to make it do that we need effective customers to ensure that the market meets their needs and a community (civil society) that decides on the sort of behaviour that is acceptable. Without that we find that those who serve their customers are put out of business and those who exploit their vulnerability prosper. Is this happening here? In this situation self-interest dominates and social responsibility is abandoned.

Aged Care Crisis suggests that restructuring the system so that market theory works properly is the best way of addressing the failed aged care market system and fixing staffing.

4 Conclusions

In the USA: In contrast to Australia, the USA has developed a vast and complex oversight system with yearly visits by regulators and a vast amount of self-reported data. Failures are disclosed and poor service is discouraged with fines and sanctions. All of this is analysed and posted on the Nursing Home Compare web site.

There are a number of issues of interest:

1. This vast regulatory system has resulted in a steady improvement in overall staffing levels and in the measured outcomes but too many nursing homes still fall short and the system is still readily exploited by opportunists.
2. The USA does not measure the culture of the facilities and companies, the relationships within the facilities and with residents, nor do they assess quality of life.
3. As the Nursing Home Compare web site indicates and others are at pains to emphasize the self-reported data is subject to bias and prospective residents need to be careful in making choices.
4. While many will try to use the Nursing Home Compare site, the data presented there is complex and many will have difficulty with this. Its efficacy and influence in improving staffing and care is not confirmed and many prospective residents remain vulnerable to impressive marketing and skilled salesmanship.
5. Many states have minimum staffing levels although they are not adequate. When adequate they have improved staffing levels and performance.
6. The most important determinant of staffing and care is the pressure from owners to put profit ahead of care and to compete successfully by doing this. In this sort of marketplace this must be done. The most profit driven make profits by reducing costs so have fewer and less skilled staff and perform more poorly on measures of care.
7. Instead of making changes that would address the problems created by market pressures and vulnerable customers the USA has resorted to increased bureaucracy and regulatory vigour with some steady improvement but this depends on maintaining this pressure. The UK has followed the same policy with less vigour and in the face of a crisis created by reduced funding and high risk conduct by private equity has failed to improve its standards of care.
8. A focus on funding rather than care has limited progress in addressing staffing issues.

In Australia: Unlike the USA, Australia has tried to hide its failures with both politicians and industry making claims to excellence in the absence of data. There are a number of points that need to be made.

Government and industry have denied problems and resorted to secrecy in that they have:

1. ignored criticism of the accreditation system by claiming that it is "robust" which it clearly is not. It is easily gamed and does not assess outcomes or produce useful data.
2. ignored calls to collect data properly, instead they have steadily reduced regulatory oversight. When data is collected it is kept in corporate and government silos.
3. refused to address staffing issues either by setting minimum staffing levels or by collecting and publishing them.
4. presented data in ways that create a positive image of the sector instead of addressing the issues revealed (eg quality agency reporting of data).
5. Promoted '*choice*' as the way of the future without showing any willingness to provide the information needed to make choices or the resources needed to support the vulnerable in doing so.
6. A focus on funding rather than care has moved the attention away from staffing and care.

In addition:

1. Australian nursing homes employ half the number of trained nursing staff compared with the USA and fewer personal care assistants. These levels of staffing pose a significant risk for residents.
2. Large sums are spent on consultants and on subcontractors in order to improve marketing and other marketplace activities including maximising funding from government. More money is spent on feedback websites, which while useful, are at risk of bias and too fragmented. Then there are the lawyers, financial advisers and companies offering to help you find the right nursing home. All of this increases the cost of care and leaves less money for improved staffing. It is a burden imposed by the system we have developed.
3. While we don't evaluate ownership and pretend it does not matter, the available evidence and the data available from the industry strongly suggests that the drive for profits is having the same impact on staffing and care as in the USA but we do nothing to counter it.
4. There is little prospect of getting effective change in staffing while the pressures for profits remain strong and there is little incentive in the marketplace to provide good care. Increased funding will help those who are struggling to provide good care and are losing money because of it. But for others it will simply mean more profits and care will not be improved.

More generally:

1. Self-reported data is unreliable.
2. Focusing on objective measures in what is essentially an intensely personal and intersubjective service can distort the service provided and fail to assess key components of the service.
3. The highly structured centrally controlled system is focused on processes and tasks rather than people. This creates an impersonal system, which distances us from our humanity, discourages inter-subjectivity and empathy. This is poorly suited to the sector and this influences the way that staff think and behave adversely.
4. Highly competitive corporatised markets by their very nature follow the money and are there when it is plentiful. This creates a serious risk to the system because when times are tough then the first target is staffing because that is the easiest cost to cut. The next move is to move investment elsewhere and vacate the sector so putting far more pressure on the system as a whole and particularly on staffing and care. This is what has happened to the UK aged care marketplace, which is in dire straits.

A way forward in Australia: Aged Care Crisis is pressing for a closer, more flexible and participatory system of regulation and oversight that can prevent the problems revealed in the USA. What we propose would allow monitoring, measuring and then balancing measurable figures against more subjective assessments of culture and relationships. It would build on and extend the Australian government's own policy of partnerships¹¹⁷ between health care providers, consumers and community. It includes and builds on proposals¹¹⁸ made by Senior Australian of the Year in 2013, Professor Maddock's. It proposes an empowered local management and regulatory system to work closely with both government and the providers.

While underpinned by re-empowered customers and community, its approach would be participatory and constructive. Its intent would be to challenge strongly but constructively and then work with and support the process of improvement.

¹¹⁷ Safety and Quality Improvement Guide Standard 2: Partnering with Consumers, October 2012 (Australian Commission on Safety and Quality in Health Care): <http://bit.ly/2fvgnN1>

¹¹⁸ Big challenge requires bold thinking: Maddocks <http://bit.ly/2fyaohl>

A far broader assessment of the sort of service provided and the quality of life could be obtained. The local on-site community structure we are suggesting would be less intrusive and less onerous. They would make the collection of objective data more accurate. It would be ongoing and part of everyday activities.

It would create a context where the important work into the assessment of the more difficult to assess parameters of care that was commenced in a study by Braithwaite and Braithwaite¹¹⁹ in 1995 can be incorporated. They found this to be superior to the USA system. We would be able to build on their findings. This would also be of great assistance to motivated providers in helping them to improve services and work closely with the community.

What we are suggesting would ensure total transparency. In advising prospective residents it would bring both the personal experiences of those who had regularly visited these facilities and the data collected into the room during one on one discussion. Information about the facilities would be disseminated into the community and it would increase everyone's understanding. Staffing issues and workplace conditions would be readily assessed and strong pressure applied to remedy any deficiencies or problems identified.

¹¹⁹ Braithwaite J and Braithwaite V The Politics Of Legalism : Rules Versus Standards In Nursing-Home Regulation: Social & Legal Studies (SAGE, London, Thousand Oaks, CA and New Delhi), Vol. 4 (1995), 307-341

5 Recommendations

Aged Care Crisis feels that while short-term measures to address the immediate problem in staffing may be needed, long-term policy decisions are needed. Serious thought and community debate is needed to find a better way forward, one that engages the community and does not ignore market theory.

The accreditation process is by its very nature unsuited to the sort of system that is required and its staff belong to a different and entrenched culture. We would strongly oppose any attempt to graft effective changes onto the Quality Agency, which should focus on accreditation. A separate government or independent body should assume supervision and responsibility and it should work closely with community as suggested by Braithwaite in his papers ^{120 121}.

In planning we should start by considering what we wish to achieve and then see how best to organise and fund it so that the market works for staffing and care, and is not under pressure to compromise both. We can understand that care might be limited by the availability of funds. It should not simply be structured in order to meet financial objectives or ideological preconceptions. We should learn from the USA and the UK and not simply copy them.

Social benefits: We suggest that care of the vulnerable is the responsibility of the community and that involvement in community services builds community values and cohesion. We suggest a gradual step-by-step move be made to transfer the control, management and oversight of most aged care services from central government to local organisations that would be supported by government but largely drawn from local communities. By doing this we would make good staffing, good care and quality of life critical for success in this market. The incentives would be realigned in favour of staffing and care and not be continuously pulled in the opposite direction.

Possible ways in which this might work are suggested in Appendix A.

¹²⁰ Braithwaite J. Regulation and Quality in Aged Care: a Cross-National Perspective Australian Journal on Ageing 17 (4) Nov 1998 page 172 http://www.anu.edu.au/fellows/jbraithwaite/_documents/Articles/Regulation_Quality_1998.pdf

¹²¹ Braithwaite J Accountability and Governance under the New Regulatory State; Accountability in Australian Government Symposium in the Australian Journal of Public Administration 58(1):90-97, March 1999 http://johnbraithwaite.com/wp-content/uploads/2016/03/Accountability_Governance_1999.pdf

Appendix A: A community controlled aged care marketplace

We have suggested a structure in which government works through local community services in order to integrate the fragmented central services currently provided by bringing them together in the community and at the bedside. We can see many advantages.

1. **Funding:** Kendig and Duckett¹²² in 2001 “proposed that all Commonwealth and State funds for aged care services be pooled into a single fund to be managed at regional level”. They extolled the many advantages of this in creating a flexible and accountable funding system that could be tailored to individual needs and not be subject to what we now call maximising (ie legal rorting). People would not fall through the cracks as is happening now.
2. **Civil society:** Building a strong and knowledgeable civil society structure that would set the parameters of acceptable conduct would ensure that social responsibility became an issue. This community organisation would advise and inform prospective customers empowering them to be effective customers. When they were unable to do so themselves there would be someone to look out for them. Control in decision-making (rather than salesmanship) would enhance their lives and allow them to make sensible choices. Market theory would operate.
3. **Control:** To be effective and underpin community empowerment the community would need to have a measure of control over which providers of care they would welcome into their community. A system of local approval of providers would be necessary. Social responsibility, a good track record and a willingness to work with community would be a key considerations in decisions made.
4. **Tackling the bulge:** Such a system might not generate the same funding for growth as the current competitive one and the unpredictable share market. Perhaps a system where REITs (Real Estate Investment Trusts) would raise funds from the market and would build new facilities, which the community then leased, would allow the market to capitalize on the opportunity to grow while also meeting need. The market would still make a major contribution to infrastructure. The community would contract with a separate provider to staff and operate the facilities. Providers of care would have to work closely with communities and meet their expectations.
5. **Data collection:** A critical role would be to work with facilities in collecting accurate data about care and quality of life and so avoid the bias of self-reported data. The important work into assessing the culture of the organization and the patterns of relationships commenced by Braithwaite and Braithwaite in 1995 would be facilitated because the community would be forming relationships with residents, families, staff, and management and would be in regular contact so that this would be an ongoing process. Total transparency would be ensured.
6. **Oversight, regulation, accreditation, complaints handling and advocacy.** These could all be integrated in the community and taken directly to the bedside so responding immediately and flexibly to the needs of the situation. Continuous improvement would become part of everyday life and the responses would be immediate once problems were identified. Our centralised processes are currently failing Australians far too often.
7. **Social control:** The most powerful and flexible form of control that we have over one another is the control that groups of people have over one another as they interact and define what is acceptable. Dysfunctional practices or inappropriate conduct is detected early and confronted so does not become institutionalized.

In writing about the changing face of government and regulation in 1999 Braithwaite speaks of “a dialogue that without threatening distrust, naturally exposes abuse of power to community disapproval”. In regard to regulating nursing homes he speaks of including “residents groups and advocacy groups in nursing home regulation”.

¹²² Australian directions in aged care: the generation of policies for generations of older people. Kendig H and Duckett S Australian Health Policy Institute University of Sydney 2001 <http://bit.ly/2fv1xd9>

Our proposal takes those ideas into the much more challenging situation that we have now. It re-emphasises Braithwaite's¹²³ recognition that effective discourse must be underpinned by power. Provider power is far more deeply entrenched than when Braithwaite wrote this.

To confront this and be heard the community needs to have greater power. Like De Bellis, Braithwaite also refers to Foucault, the philosopher who has explored the nature of power, in support of his arguments. He also sets this within a broad view of participatory democracy which in its proper place can enhance accountability.

The unstated message must be that *"we want to work with you to help you care for our parents and neighbours. If you don't want to work with us on this then we don't want you here"*.

8. **Integration:** The many fragmented centrally controlled activities perform sub-optimally. By integrating them locally they would work with one another and the entire service could be improved.
9. **Flexibility:** The current models of ageing are not meeting community expectations and new ways of living the later years of life are developing. By encouraging local community control of the funding the government would allow a diversification of services and stimulate innovation. Instead of a follower of failed systems elsewhere we could lead the way.
10. **Burden:** By representing government and working with providers to provide a service to help them improve, the regulatory burden would be lifted and be focused on outcomes more than process.
11. **Funding mechanisms:** This suggestion is not intended to alter the way the sector is funded by government and resident but rather the way its expenditure is managed and controlled in order to make this more effective and accountable. Nor is it intended to impact on the residents right to control their own lives and choose how they spend their money. It is intended to guide and protect them so that they can do so safely.
12. **Economic downturn:** In times of need the community would be there to support and help.
13. **Staffing:** The community would be working closely with staff in the facilities and would have a sound grasp of both the acuity of residents and the adequacy of staffing. Recommended ratios based on acuity would be helpful as they would be able to use these as leverage if staffing is inadequate and problems are occurring.

¹²³ Braithwaite J Accountability and Governance under the New Regulatory State; Accountability in Australian Government Symposium in the Australian Journal of Public Administration 58(1):90-97, March 1999:
http://johnbraithwaite.com/wp-content/uploads/2016/03/Accountability_Governance_1999.pdf

Appendix B: Personality, social responsibility and staffing

One of us has had a long interest in dysfunctional systems. He has at various times closely followed the corporatization of health and aged care in the USA and in Australia. He has examined market failure in other vulnerable sectors.

One of the features of markets without effective customers is the way it attracts and encourages the development of an omnipotent confidence as well as a self-righteous and arrogant certainty about what they are doing. This is underpinned and reinforced by financial success. It is interest driven and all attention is focused on the corporate objectives. They have no doubts and experience no discomfort with this. We humans have a propensity to behave like this when we can escape the critical eye of our fellows. Those who are most likely to behave like this gravitate to vulnerable sectors where there is no one to oppose them and constrain their excesses.

Corporate image and personal self-image are central concerns and a culture develops where almost anything is acceptable. Social responsibility and personal integrity are early victims. There is a 2001 web page¹²⁴ describing this with links to multiple examples. Their forceful, assertiveness, certainty and financial success give them a credibility that is difficult to confront and resist. This credibility gives them community and political influence.

They are unable to see things the way anyone else does and employ almost every psychological strategy in the book to protect themselves from insight – wilful blindness, compartmentalization, rationalization, aggression, labelling (attacking the messenger) etc. They can ridicule contrary views and logic and because they are forceful and have no doubts they are difficult to argue against.

Example: One of the largest and most dysfunctional and fraud prone US hospital chains entered Australia in 1991. A quasi-religious group that had little credibility supplied good verifiable data to NSW Health objecting to the granting of hospital licences. NSW Health elected to ignore the evidence and accept the glowing claims assertively set out in letters from this highly credible company, one of the largest in the USA. They granted licences. It was only later when ABC's Four Corners ran an expose of the company's conduct and they were supplied with documents, which they could have sourced themselves, that they realised they had made a mistake.

A founder and director of this company responded on the Four Corners program making elaborate claims to excellence. When giving evidence in a US court case he was confronted with his less than frank response in Australia. He simply brushed it aside saying that he was "singing to the choir". For him and his company this was simply the way business was conducted. He did not see anything wrong with misleading others.

When a massive scandal involving the exploitation of children developed in the company's hospitals in Texas he saw this as no more than a media beat up and so a publicity problem. For him the widely advertised and acclaimed (by financial analysts) services provided could not possibly be the problem. He flew to Texas to sort it. Instead of going to the hospitals he went to a public relations firm to counter this then flew back to headquarters. He freely admitted this in court. It was how he dealt with issues.

This arrogance and self-confident certainty is readily apparent in the way senior industry figures in aged care in Australia respond to complaints about poor care by denial, by calling for good news stories¹²⁵ and by referring to them as 'isolated instances'¹²⁶ among all the good care they give.^{127 128}

¹²⁴ Introduction to Sociopathy Corporate Medicine web site 2001-6 <http://www.bmartin.cc/dissent/documents/health/sociopathy.html>

¹²⁵ We're hiring! Aged care needs 'positive image' campaign to attract workers - senate told (Australian Ageing Agenda) 11 Mar 2016 <http://bit.ly/2goHamB>

They strongly deny allegations and attack the messenger. This extends down to the nursing homes where family members who are concerned about the care their parents are receiving can be banned from visiting them^{129 130 131}.

They see persistence as libellous and threaten lawsuits against those who complain too persistently¹³². Academics who's research findings have prompted them to speak out, have been attacked^{133 134 135 136} and their universities have been urged to stop them from criticising.

The committee can decide for themselves whether the use of inflated figures for direct care staffing to confront criticisms about staffing and the response to being challenged about this in the interchange in the comments in response to the article "*Peaks raise aged care staffing levels and skill mix with Senate inquiry*"¹³⁷ on 9 November 2016 illustrate this mindset. Was this socially responsible conduct?

If you look at the way SB reported the difference in profitability without also reporting the staffing ratios we might wonder if this is responsible behaviour. But the need to do so probably never occurred to them because the market does not think this way.

One of the consequences of our proposal would be the creation of a context where these people would have to deal with citizens who actually know what is happening and have power. If they don't address their concerns they are unlikely be successful. Staffing issues would be central to discussions and the concerns of staff would be addressed in a context where their interest and contribution would be valued and accepted.

¹²⁶ Aged care Radio National 11 June 2016 - <http://ab.co/1S4GiKJ>

¹²⁷ New laws loom on nursing home rape The Age, 22 Feb 2006 <http://bit.ly/2fxVYOt>

¹²⁸ Aged Care providers as a whole are being tarnished by the claims of a few: <http://bit.ly/2fMn4iC>

¹²⁹ Nursing home 'banned me from seeing mum' The Australian August 28, 2015 <http://bit.ly/1hlO1Vc>

¹³⁰ Aged care residents and families 'bullied by facility staff' after complaining about treatment, advocacy group says problem widespread ABC News 28 Sep 2015 <http://ab.co/2fYWWUs>

¹³¹ Woman denied access to dying mother condemns 'monstrous display of evil' by nursing homes ABC News 9 Oct 2015 <http://ab.co/1MgJ0yl>

¹³² Aged Care Crisis - ABC Lateline, 15 Jul 2013 <http://ab.co/2gtcApp>

¹³³ Questions raised over how national changes will impact aged care sector - ABC News, 1 Aug 2014 <http://ab.co/1p18iFI>

¹³⁴ Academic scaremongering with unsubstantiated claims (ACSA Media release, 31 July 2014) <http://bit.ly/2goh5Up>

¹³⁵ Experts agree on aged abuse The Advertiser, 7 Feb 2007 <http://bit.ly/2gGPCHy>

¹³⁶ Update on the recent Aged Care Publicity - Extract: ACCS - Snippets, Volume 7 Issue 2, Feb 2007 <http://bit.ly/2ffhwAY>

¹³⁷ Comment on "Peaks raise aged care staffing levels and skill mix with Senate inquiry" - Australian Ageing Agenda, 9 Nov 2016 <http://bit.ly/2fnKDwT>