

Submission to Senate Inquiry:

Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised

http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareQuality

Aged Care Crisis Inc.

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Introduction

Addressing the Terms of Reference

In this detailed submission we have developed a frame of analysis from which to briefly examine the problems in the system that make it so difficult to regulate – problems that Gregory warned would make the system impossible to regulate effectively in his 1993 report. We then do an in depth analysis of the reasons why regulation is failing so badly before looking at each of the regulatory bodies.

This enables us to address the issues in the references in greater depth and gives our submission greater coherence so making it more useful than simply writing around each point. During the analysis we look at what can be done to address the issues. We end by proposing changes that would address the major problems we identify in the system and in its regulation.

a. the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised;

In **Part 1** we list a number of recent examples in which the findings of failures were not identified at the regular 3 or 5 yearly accreditations and only followed complaints. We look at trends. During our analysis of regulation in **Part 2 and 3** we describe the history of accreditation, its many failures, often in adequately addressing the matters that families or staff have complained about. We compare it with regulation elsewhere.

b. the adequacy and effectiveness of complaints handling processes at a state and federal level, including consumer awareness and appropriate use of the available complaints mechanisms;

This is addressed in **Part 3** of our analysis.

c. concerns regarding standards of care reported to aged care providers and government agencies by staff and contract workers, medical officers, volunteers, family members and other healthcare or aged care providers receiving transferred patients, and the adequacy of responses and feedback arrangements;

It is clear from our analysis that many matters are not reported to providers because of the power imbalance and vulnerability of the residents. Whistleblowing staff lose their jobs and no one else will employ them. We propose changes that would address this.

d. the adequacy of medication handling practices and drug administration methods specific to aged care delivered at Oakden;

We have no knowledge of this at Oakden but we address the inadequate regulation of staffing numbers and skills, which is in large part responsible for this.

e. the adequacy of injury prevention, monitoring and reporting mechanisms and the need for mandatory reporting and data collection for serious injury and mortality incidents;

This relates to staffing, skills, motivation and corporate culture, which we examine as a regulatory issue. We propose changes that would address these deficiencies and create a more effective monitoring system.

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- f. the division of responsibility and accountability between residents (and their families), agency and permanent staff, aged care providers, and the state and the federal governments for reporting on and acting on adverse incidents; and**

Aged Care Crisis has been pressing for changes that would address issues in this area for several years. Our analysis leads on to proposals for creating a context within which all parties would work together and develop a platform where these responsibilities would be integrated and coordinated.

- g. any related matters.**

As indicated we do examine aspects of the aged care system that is being regulated, principally in appendices. In addition we examine the performance of the Department of Health and the potential of advocacy and visitors schemes to contribute to the protection of residents and the system. We look at the role of reviews, inquiries and consultancies to identify problems there that too often result in recommendations that are ultimately unhelpful, unrealistic or harmful.

Introduction

Published submissions

We have briefly examined some of the published submissions. These reveal a deep fault line in the way aged care is perceived – a fault line that we have drawn attention to for many years¹.

LASA for instance believes that we have a *“high performing and professional sector, supported by a workforce that is passionate about providing quality care for older Australians”*. It maintains that it is internationally *“recognised as being of good quality. Australia’s aged care system is highly regulated when compared internationally.”* It argues that *“the industry’s quality system is not broken”* and uses success in accreditation to justify this. This position is maintained in the face of a rising tide of information and experience that tells a very different story – something they are unable to acknowledge.

There is nothing unusual in this and we should not doubt their sincerity. As has happened on so many occasions in the past, they and the regulatory system they support are locked into patterns of thought they dare not challenge - patterns of thought that have lost touch with the real world the rest of us live in. This is only possible because they don’t collect and use real data.

The excellent submission by the Minister for Disability and Ageing in Victoria is congruent with that from the ALRC, the nursing unions in NSW and Queensland, and the Dieticians Association of Australia. They describe a substandard system that is failing Australians and a regulatory system that is not delivering.

We strongly support their assessments and their suggestions for change but they do not offer any means of delivering the benefits of their proposals to the bedsides other than through the failed current management and regulatory system.

Our analysis in our submission reveals that this system is incapable of delivering on their expectations, so that the desired benefits will not be attained. We argue instead for a system that will change the way aged care is managed, regulated and integrated by implementing and empowering it close to the bedside where it belongs – a system where these suggestions can be directly supported, implemented and evaluated.

¹ The Great Divide in perceptions about the corporate marketplace - Corporate Medicine web site 2004 <http://corpmedinfo.com/divide.html>
Widely contrasting views Inside Aged Care December 2016 <https://www.insideagedcare.com/aged-care-analysis/widely-contrasting-views>

Introduction

Overview of our submission

Our elderly are being provided substandard care, are neglected and suffer elder abuse at an unacceptable rate. This occurs *'at the bedside in our community and our nursing homes on an everyday basis'*.

We argue that to address this problem control of the system and its regulation needs to be *'at the bedside in our community and our nursing homes on an everyday basis'*. It should be integrated into aged care at this level.

In this submission we perform an in-depth analysis to show why:

- Pressures in our current aged care system are largely responsible for the incidence of failures;
- The regulatory system is not fit for purpose, and
- Calls to increase regulation using this system are not a real solution.

We need the sort of control and regulation that works and no one else is looking at how we might do this.

The most powerful form of control and regulation that we have is the social control that we exert over one another in our day-to-day interaction. The structure of our aged care system has disabled this form of control. Social control at this level has the power to prevent dysfunction, detect it as soon as it occurs and address it immediately when it does. Anything else is a fall-back position for when this fails.

We are advocating for a management and regulatory process that enables, empowers, supports and integrates these processes through interaction between citizens at the bedside, in the coffee rooms of our facilities, on social media, and wherever citizens meet and discuss the issues of the day. We want them to own and manage their aged care system.

We are faced by a political and market system that embraces innovation as a virtue, but which dismisses out of hand anything that comes from outside their own narrow patterns of thought. This is where all real innovation comes from.

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Aged Care Crisis has been monitoring and analysing failures in aged care since the 1990's. It has listened to families and to staff at the bedside. It has advised them of the difficulties in resolving issues using the regulatory system. We have made many submissions to inquiries and reviews in which we have addressed the inadequacy of regulation but with little impact.

There were fundamental flaws in the ideas that underpinned our aged care system when it was 'reformed' in the late 1990s. These have been elephants in the room at every inquiry with no one prepared to confront them. It is not surprising that the situation has steadily deteriorated and subsequent 'reforms' based on the same thinking have only made things worse. There have recently been multiple failures in homes that had quite recently been fully accredited. This once again draws attention to problems in the system including the flawed regulatory system.

Part 1: Regulation in context

Regulation of aged care cannot be taken out of context. It has to be seen within the context of changes in society, of the nature of the aged care system it regulates, and of the relationship it has with that aged care system.

When the system itself is seriously flawed and dysfunctional then relying on regulation without addressing the problems in the system is doomed to fail, particularly when the relationship between regulator and regulated is too close.

Approach: Our approach to aged care is to examine the patterns of thinking or 'discourses' that are adopted by those who control the aged care system, those who regulate it, those who work there and the communities where care is provided. What they do there is a consequence of how they think and understand what they are doing.

This provides important insights into what is happening, why the system is failing and what we need to do to address those failures.

Two major discourses are identified and they are in many ways incompatible. There is the traditional discourse of care, which resides in health and related professionals as well as the community. Then there is the free-market (often called neoliberal) discourse that is in ascendency. It has been adopted by economists, politicians and the marketplace – and been accepted as self-evident by many in the community.

Many of the recurrent problems in aged care can be seen as consequent on the incompatibility of these discourses and the dominance of free-market thinking in sectors that require the values and understandings of the discourse of care. This is addressed in Appendix 1.

Any 'solution' to the problems in aged care, whether in the provision of care or in regulation, is likely to fail until this dominant discourse compromises and provides space, legitimacy and parity of power to the discourse of care.

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Implications: There is growing evidence that community services are successful when they are 'owned' (*in the sense of identifying with and controlling*) by the community and that the role of government is not to manage but to support communities in managing their affairs. Australia has accepted this for its aboriginal citizens but the management structure within the free-market agenda denies this to aged care for the rest of us.

Communities identify with the discourse of care and need to manage care in their localities by working with, and having oversight and influence over the providers of care there. They need the power to control the discourse within which care is provided.

Communities need to have ownership of both data and regulation. Regulators should report to and be accountable to them. Without this, suspicion and distrust will inevitably grow.

System issues: The impact of the dominant marketplace managerial discourse can be traced down from government, to management and finally to the understandings at the bedside. When staff embrace and identify with this discourse then it radically alters the way people understand what they are doing when providing care. The practical consequences impact on the behaviour of staff there and so the everyday care that the aged receive. This is addressed in Appendix 2

This approach to the issues may be theoretical but the theoretical insights go to the heart of what is happening and give a deeper understanding of the very real adverse outcomes for the residents in these facilities that are far from theoretical.

One of the recent changes we find disturbing is an apparent shift in the incidence of failures in care from predominantly for-profit owned facilities to greater numbers of non-profit facilities and most recently government-operated facilities. This is one reason why there are an increasing number of public scandals. This is addressed in Appendix 3

This is compatible with other evidence showing the permeation of free-market thinking and management style in nonprofit and government facilities. This is coming at the expense of the discourse of care. The consequences are a changed culture, less staff and so less effective and empathic care.

Because these issues are background to the regulatory focus of this inquiry they are only addressed in outline in the body of the submission and then explained in appendices. They are however critically important when evaluating and creating a system within which a restructured regulatory system might be effective.

Part 2: Comparing regulation in the USA and Australia

Both the USA and Australian regulatory systems operate within societies dominated by the free-market/neoliberal discourse and have similar problems because of this. The development of dysfunctional practices within sectors subjected to the discourse (a discourse that believes in less regulation) has seen the growth of a greatly increased and centrally controlled regulatory system in all countries embracing neoliberalism.

Criminologists who study regulation now talk about 'regulatory capitalism' rather than 'neoliberalism'. As a consequence there are common issues that these countries share that render their regulation ineffective.

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The US and Australian regulatory systems were developed in very different social and historical contexts. While they have similar problems their structure and mode of operation is very different and this has an impact.

The USA focuses on deficiencies and reducing them. Australia focuses on achieving success and tries to ignore deficiencies. Comparing them illuminates the weaknesses of both approaches.

Comparing data collection

Accurate data is essential for managing any sector. In aged care it is essential for managing homes, for government, local community and provider policy, for consumer and community information, for public discourse, for the market to work, and to anchor regulatory effort to what is happening in homes and the sector.

Australia collects very little useful and reliable data and there is minimal transparency. In the USA a vast amount of objectively collected data is publicly available. In the UK the data is not as objective but large amounts are collected and it is immediately available to the public.

One of the consequences of this is that Australian citizens don't know what is happening in the sector and are slow to respond to failure. In the USA and the UK there is far more publicity and community anger at what is happening than in Australia. In the USA citizens actively sue substandard facilities.

Regulation of staffing

USA: In the USA, recommended minimum nursing staff levels in excess of 4 *hours per resident day (hprd)* have been published by the federal regulator, the *Centre for Medicare and Medicaid Services (CMS)* since 2000. These figures are based on extensive research and this research is ongoing.

Actual staffing numbers and skills are submitted quarterly² and published for each nursing home. Each nursing home is also inspected annually and 175 measures of care are evaluated and deficiencies in care are reported publicly.

Australia: In the late 1990s formal regulation in Australia was replaced by a system of 3-yearly (and more recently 5-yearly) accreditation. Staffing requirements were removed and the number of staff and their skill levels were left to the market to determine. How money was spent and how care was provided was in confidence. Failures in care were not tracked, recorded or published.

² CMS: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html>

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In the absence of regulatory requirements staffing guidance has been provided by benchmarks developed by marketplace financial advisers and not by academic research.

Overall, direct care nursing levels of around 2.9 hours per resident day (hprd) with too few trained nurses, fall a long way behind what was expected in the late 1980s and early 1990s, and below the 4.1 hprd minimum recommended in the USA.

Available regulatory data

USA: In the USA, 93% of all 15,000 CMS registered nursing homes are found to have deficiencies. The average number is 8.6 deficiencies per facility. 20% of nursing homes had serious deficiencies causing harm or placing residents in jeopardy. **Only 7% had no deficiencies.**

Results for every nursing home are published regularly and the public are urged to use this data.

Regulation focusses on deficiencies and avoiding them.

Australia: By comparison in Australia, 97.8% of nursing homes passed all the accreditation standards and only 2.2% failed any standards. Regulation focuses on successes and hides deficiencies.

- **The USA focuses on deficiencies.** It has a 93% rate of deficiencies with 20% having serious deficiencies.
- **Australia focuses on successes.** It has a 97.8% success rate. Is this plausible?

Significant facts

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

The USA has *“long identified staffing as one of the vital components of a nursing home’s ability to provide quality care”*³. Over time, CMS has utilised staffing data for a myriad of purposes in an effort to more accurately and effectively gauge its impact on quality of care in nursing homes.

Australia: Available figures show that Australian residents, on average, get half as much care from trained nurses and over an hour less care per day than in the USA. At the same time as resident acuity has increased in Australia, the number of trained nurses with the skills needed to care for them has steadily declined.

As the number and skills of nurses has declined, the acuity of residents has increased and reports of poor care grow. Contrast this with the success rate in meeting accreditation. This has increased from 64% to 97.8%.

None of this makes any sort of sense and we need to know what is actually happening.

³ Source: Centers for Medicare & Medicaid Services (CMS) <http://go.cms.gov/2frxXuQ>

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Conclusion

The glaring disparity between regulatory successes in the two countries in the face of staffing data that are going in opposite directions raises disturbing questions.

Staffing is the most critical determinant of care. Research studies indicate that good care cannot be provided with the sort of staffing provided in Australia.

Staffing is moving in opposite directions in the USA and Australia. Regulation is very different and may be partly responsible for this

The need for balance: While the focus of the USA is on data, transparency and choice it is clear that, while this is needed, it is not enough by itself. It has not produced a successful system.

Academics who have studied this argue that the benefits of transparency alone are marginal and that additional effective regulation is required. We argue that the context within which transparency occurs is critical if it is to be used effectively.

Like Aged Care Crisis, this school of thought argues that community relationships are important because research *“has long established that informal social controls can be very powerful”*

Part 3: Analysis of regulation of aged care in Australia

1. **The history of social responsibility:** The story of commercial and other threats to the professional, religious and community views that saw responsibility for the vulnerable as a social responsibility go back for more than 2000 years. While these values sometimes buckled they survived. The most serious challenge came in the 1970s when a free-market belief system that saw social responsibility as socialist and therefore evil grew and in the 1980s came to dominate western political thought.
 - a. We look at the way the politics of responsibility during the second half of the 20th century swung between those who were empathically motivated to care for the vulnerable and those who saw their care as a source of profit.
 - b. The development of a for-profit aged care market in the 1960s and 1970s was associated with the exposure of multiple failures in care.
 - c. A program of accountability and closer regulation followed in the 1980s and early 1990s. This saw considerable improvement in care and regulation. The market fought back successfully against these restrictions on what they considered to be their ‘democratic rights’.
 - i. Free-market beliefs triumphed in the 1997 election. The belief that social responsibility was socialist and therefore evil triumphed. This led to:
 - the abolition of both accountability and effective regulation
 - the repeal of the probity regulations that made trustworthiness and responsibility a requirement for aged care providers.
 - ii. These were replaced by:
 - accreditation, a process that was designed to support and not regulate and
 - an approved provider process that was market friendly.
 - d. Strong criticism and many warnings were ignored.

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- e. The growing concerns and the many failures in aged care since 1997 indicate that we are once again looking at the same sort of failures that were exposed in the 1980s and that we were warned about - and for the same reasons.
- f. We express our concern that social responsibility and accountability are no longer requirements in the aged care marketplace.

2. Regulation: Neoliberal free-market policy is all about less regulation, but the practical consequence of the problems created by this policy is that much more regulation under a number of guises has been attempted.

- a. This regulation has been centrally controlled and that control has been vested in the marketplace and those who think in the same way.
- b. The arguments made about increased regulation, a revolving door of industry friendly appointments, regulatory capture and ineffective regulation that seeks to avoid the exposure of embarrassing data in Australia are supported by research carried out by eminent criminologists. This research was ignored.
- c. A revolving door with industry has resulted in “regulatory capture” by the marketplace and the free-market/neoliberal discourse. These patterns of thinking are very different to the discourse of care. They display little insight into the essential nature of care. As a consequence, there is a startling lack of knowledge about care in senior management.
- d. Because regulation is now controlled and managed by those within society who adopt a single frame of understanding the principle of distributive justice has been breached.
- e. The USA and UK have similar free-market policies to Australia and in these countries the same problems have developed. Regulation has been ineffective.
- f. There has been widespread market failure and regulatory failure in services to other vulnerable sectors where the market has exploited their vulnerability. Aged care is not unique but the consequences are.

3. Conflicts for regulators: Regulating in this way has created major conflicts for those involved:

- a. While the political and market discourse demands that regulation be reduced to a minimum, the problems in the system demand more regulation and not less.
- b. There are strong pressures on regulation to protect the industry and the market from embarrassment. Exposure of the many failures not only challenges and embarrasses industry and government, but confronts those who are in charge of regulation. They too, are believers in the policy of less regulation.
- c. The claimed rigour of the regulatory process is the rock on which the systems legitimacy depends. This is used to counter criticisms of the system when failures occur. It is also the rock on which our claims to a world class system and our ambitions in the global aged care marketplace rest.

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- d. There is a deep conflict for those regulating. While they believe that they are regulating to improve standards and protect citizens, the pressure of their beliefs and the unspoken expectation that they will not embarrass government and marketplace are far more powerful. This leads to ritualisation and tokenism that undermines effective regulation. Coalface regulating staff who see what is happening and who try to act, are overruled by their superiors. Regulators ultimately regulate in the interests of the system and its participants, ahead of those it is there to serve.
- e. The extent to which the regulators are committed to meeting their responsibilities to government and the market is revealed in the way accreditation bodies have reported their data to hide and even counter evidence that would challenge governments claims and to support the illusion of 'world class' care.
- f. The extent to which the marketplace refuses to confront what is happening is reflected in their responses to failures and this in turn must impact on the advice that those on various government committees give to politicians who, because they see these people as credible, remain in denial.

4. **Abandoning the pretense to regulatory independence:** When failures have increased, when regulation has come under pressure and when doubt has crept in to the minds of regulators, government has abandoned all pretense of regulatory independence and put senior industry figures in charge.

- a. In the USA George Bush Jnr put the head of the group representing and lobbying for the big corporate companies running the system in charge of the body regulating health and aged care.
- b. In Australia, Tony Abbott put the nominally 'independent' accreditation agency back under the control of a government minister and put the CEO of LASA, the body representing and lobbying for the industry, in charge.

5. **Social control as effective regulation:** Formal regulation is far less effective than the face-to-face social control exerted in discourse with community members in direct contact with care. They approach the problems from a different point of view.

- a. In a civil society formal regulation is there to support but not replace the community. Both are necessary and should work together.
- b. Current managerial policies have negatively impacted the discourse on which social control depends so that there is little social control in aged care.
- c. As a consequence the most powerful mechanism we have for prevention and early control of dysfunctional behaviour has been rendered ineffective.

Accreditation

- 1. Accreditation was designed to assist motivated providers develop processes that improve care and not for any other purpose.
- 2. It was not intended to be a measure of standards of care, be a regulator or be used as a marketing tool. It has failed when required to perform any of these functions.
- 3. Accreditation in the USA had already failed on a number of occasions in health care in the USA before it was introduced for aged care in Australia. It was never the only regulator and when President Reagan tried to use it for regulation in aged care the US Congress blocked this.

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4. Accreditation has presided over and sanctioned a system where staffing levels and skills are so poor by international standards that it is impossible to provide good care and many failures are likely.
5. The government is planning to reduce accreditation and the number of standards and there is still no intention to properly collect objective data and make it publicly available.
6. A focus on consumer experience when assessing standards, while ignoring the clinical outcomes of care as is planned will result in a distorted view of what is happening in the sector.
7. There are multiple inadequacies in the accreditation process and these are listed.

The Complaints System

1. There has been intense and continuing unhappiness about the manner in which complaints have been handled.
2. It too, has been captured by the market and its discourse. Families faced by an impersonal system feel powerless when their complaints are 'trivialised'. It has in the past been criticised as *'user-unfriendly and unresponsive'*
3. The Walton Review of Complaints in 2009/10 was very critical but its recommendations compounded the problems by attempting resolution within a context where those who complained were powerless.
4. The important issue of retribution against residents whose families complain was not addressed.
5. The government responded to the critical report and the expected consequences by putting appeals to decisions about complaints in the hands of a safe commissioner from the industry.
6. There is a list of concerns about its ineffectiveness.

Missed opportunities to regulate effectively

1. The original proposals at the end of the 1980s for the advocacy scheme and the visitors scheme suggested that both would have powers of inspection and would contribute to regulation. Criminologists considered that they would be part of the regulatory process. These groups comprised community members and would have been a move towards distributive justice – a threat to the free-market discourse.
 - a. Government funded advocacy groups have been noticeably absent from the public exposure of failures in care or from system advocacy.
 - b. Research suggests that government pressure and contract restrictions were responsible for this.
 - c. The proposals for visitors were dubbed the *'community busybodies scheme'* by industry. It was turned into a companionship scheme for the elderly instead and barred from doing more.
 - d. The ALRC has recommended an expanded role for a community visitors scheme that is empowered to report elder abuse but not in nursing homes.
 - e. We believe than an opportunity to embrace community visitors and advocacy as co-regulators has been blocked over the years because it would have threatened the free-market discourse, which would have lost control.

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The Department of Health

1. The department is the main regulator and is responsible for imposing penalties. It is in a more controlling position and is closer to politicians. There have been serious issues raised:
 - a. Whistleblowers spoke out in 2012 about the way the funding system was being rorted and the way in which the health department blocked their attempts to have action taken.
 - b. The health department responded by educating instead of sanctioning.
 - c. A 2014 review of the Department of Health revealed a toxic culture in which unpopular information was not welcomed.
 - d. In our view this is a reflection of the conflict between its public responsibility to community and a more powerful unstated responsibility to protect industry and government.

Part of a systemic problem

1. The Gregory report in 1993 warned of the extreme difficulty of preventing the diversion of funds from care to profit in a free market aged care system.
2. The aged care system is fragmented, bureaucratised and controlled in a way that frustrates and inhibits the flexibility and the qualities that are needed for care.
3. The many failures in aged care are largely due to inadequate numbers as well as insufficient skilled staff, and the motivation of some staff. This is due to competition to be profitable rather than to care, an ineffective customer, a disengaged community and a regulator that protects the system rather than those it is charged to care for.
4. **Data collection: The failure to collect data about care and its failures, and the failure to make data transparently available has been one of the most corrosive features of our aged care system. Without it, the government and the market could not have maintained the legitimacy of this aged care system.**
 - a. The focus has been on collecting financial data at the expense of data about the care the system is there to provide.
 - b. This issue has been raised on multiple occasions without any attempt to address it. It is simply ignored and that can only be because deep down there is an awareness that this would threaten the discourse on which policy depends.
5. Ineffective regulation has become burdensome to the industry and it is not helping citizens.
6. The use of an unchecked free-market to provide care has resulted in a multitude of extra costs for both providers and consumers. It may be an efficient way of making money, but it is an inefficient method for providing care.

Responsibility

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

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Part 4: Inquiries, reviews and consultancies

The many inquiries, reviews and consultancies can be seen as part of the regulatory process by which aged care is supported, modified or changed. The politics around these processes in aged care related matters do not suggest true objectivity.

1. By appointing people who embrace the same discourse and so are seen to be credible they often ensure that policies are supported and alternate more suitable paths are not considered. These processes can be initiated
2. To reinforce policy and give planned policies legitimacy
3. To address negative publicity and give the impression that something will be done, at least until the publicity blows over.
4. Critical comments can be made more difficult by using a prescribed format that limits what can be said and/or by publishing it in an indigestible format.
5. By an opposition political party to counter the policies advocated by an inquiry or review set up by the government. Critical comment is usually more welcome.

Examples are given and it is suggested that at least one of the processes set up to investigate regulatory failures after Oakden was likely to be more concerned with addressing publicity and showing that something was being done than addressing the issues causing regulation to fail.

Part 5: Suggestions for change

1. The current aged care system has been created within a neoliberal free-market discourse and the discourse of care has been delegitimised and tokenised.
2. The values and motives required for effective care are vested in the professions and the community, which are the home of the discourse of care. Both have been excluded from policy and decisions.
3. To address the problems in care and in regulation it is essential that the discourse of care be fostered and become the driving discourse. It needs to have the legitimacy and power to deal with and evaluate the benefits of alternate discourses.
4. The separation of community from care by its commodification has built distrust. Reconnecting the community to care should restore trust.
5. Ownership in the sense of community involvement, control and responsibility has been shown to be important for successful community services and when this is absent they fail. Only ethnic communities enjoy this privilege.
6. Many major advances have been the product of strong community advocacy but a lack of ownership of the system has seen these movements collapse once their particular problem has been addressed. Their further potential contributions are lost. By bringing them into the system and giving them ownership we can build on this.
7. Many claim that civil society has been hollowed out and unable to fulfil its function of setting acceptable parameters of conduct in a capitalist democracy. Our proposals can be seen as a contribution to the participatory democracy movement, which seeks to address this.
8. We propose an alternative approach to regulation, one which embraces the community and harnesses their strengths to manage and regulate the industry.

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9. Proposals are made as to how that might be accomplished and how changes that are occurring in society can be harnessed to the effort. What we are seeking is a system that *“empowers and enables informal social control to work flexibly, in all its rich, innovative, contextual possibilities for variety”*.
10. The consequences of effectively moving in this direction would be:
 - a. Policy and management influenced by what is happening at the bedside rather than in the boardroom
 - b. Social control supported by formal regulation in a system based on distributive justice
 - c. A stable market that is not high risk.
 - d. Conformity to established traditional market theory
 - e. Resident control and choice without risk

Problems in implementation include:

1. The inability of the free-market/neoliberal discourse to confront evidence and logic, and accept that it must genuinely bow to and serve the discourse of care in this sector.
2. A hollowed out civil society in a post truth era – one that is ageist and has developed a cargo mentality. It expects market or government to deliver without effort on their part.
3. The very real risk that if adopted government will try to lead or manage the process rather than facilitate it – or try to market it rather than invite community to help them find ways of managing the system.
4. The lack of skills and knowledge in the community and the importance of involving those with skills.

Appendix 1: An approach to aged care and its regulation

This appendix explores our approach and the power of discourses in health and aged care. it examines:

1. The major discourses used in the aged care sector
2. The criticisms of the free-market/neoliberal discourse in the sector and the warnings that were ignored
3. The way this perspective is being used in research.
4. Examples of the power of discourse and the consequences

Appendix 2: Background to system failure in Australia

This appendix uses the failures at Oakden to explore the reasons why the aged care system itself is flawed and how this might be related to what happened at Oakden. This is the system that we are trying to regulate but which has a large measure of control and influence over its regulation.

The appendix explores the ideas and processes that resulted in this system and the changes made to it. It looks at liberalisation, choice, competition, efficiency and the impact of the focus on cost at the expense of care. It examines the role of these as well as the absence of data and the role of managerialism in building a system that has become the subject of ongoing scandals.

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Appendix 3: A Changing pattern of failures

Our impression is that there is a changing pattern of failures in aged care with an increasing proportion of nonprofit and even more recently government run facilities failing.

We look at why this seems to be happening and suggest that the greater marketization of aged care has put pressure on and created uncertainty and instability for these sectors. In order to survive they have operated more like for-profits and have increasingly embraced a managerial approach and discourse. The new managers have had little if any practical experience in care and are we suggest blind to the consequences of their decisions.

There has been a loss of mission and instead of being standard bearers and setting expected standards they are following the most aggressive for-profits in putting cost saving before care. Other possibilities are explored.

Appendix 4: The Government's Review into regulation

The government's appointment of a past director of the accreditation agency to review the regulatory system is examined to explore the likelihood that it will truly confront the problems in the system and its regulation. We cannot help being worried that this review is more about addressing the adverse publicity and protecting the discourse than in making the changes that are needed.

Appendix 5: Closing ranks and reaffirming the faith

Despite the looming clouds, the adverse publicity, the multiple reviews, inquiries and the many failures that confront the sector and challenge true believers, those who designed the government's *Aged Care Roadmap* are meeting in November to reaffirm their beliefs.

Their response to all this is to reassure any doubters that they will not be wavering in their determination to impose their system on Australia and its citizens. It is a clarion call to the faithful for "*The Next Phase of Aged Care Reform*", the 'reform' that is simply more of the same.

As our submission reveals this sort of reform is responsible for problems that have been exposed over and over and over again. There are none as blind as those who refuse to look.

Part 1: Regulation in context

1.1 Introduction

Aged Care Crisis and its members have been monitoring failures in health and aged care in the USA and Australia and analysing what is happening since the mid 1990s. One of us was actively involved in dealing with regulators and wrote several web pages about regulatory failure in the USA and Australia in 2000/1 and more specifically about the failure of accreditation in 2006/7⁴.

We have closely followed the development and implementation of aged care policy for many years and have been concerned at the unwillingness of the market and politicians of both major parties to listen to critics and address their many concerns.

In our view the problems revealed in the accreditation process are symptomatic of a wider structural problem in aged care that must be addressed.

This senate inquiry is a response to regulatory failure at Oakden: There is nothing unique about what happened at Oakden. It is representative of the problem of health and aged care regulatory failure that we have seen in Australia since the late 1990s and in the USA since the 1980s. It simply confirms our assessments and our analyses of the ineffective regulation of a dysfunctional system.

We were first contacted by the families of some who had been harmed at Oakden in 2007, but the system was so opaque and resistant to unwelcome information that there was little we could do to assist them. Over the years we have advised other families in other nursing homes of their options. While encouraging them to act we have warned them of the difficulties in having complaints addressed by the complaints system and faults rectified by the accreditation process.

Failed reviews and inquiries: We have been strong critics of aged care and its regulation. We have made submissions to the many reviews and inquiries into the problems in the aged care system and in its regulation⁵. Most have been ignored. Even when reviews have found problems and made recommendations, they have often not been implemented.

The system has been too busy promoting itself as world class and boasting of its rigorous regulation to acknowledge its deep flaws, let alone do anything about them.

Put simply, the aged care system is not working for the elderly, for those who provide care at the bedside, or for the community because of flawed policy by both parties.

Acknowledging the problems and then working constructively together with the broad community to rebuild the system in a sustainable way can remedy this.

⁴ 2000/1 web pages ---- http://www.corpmedinfo.com/regul_fails.html
http://www.corpmedinfo.com/reg_austr.html
http://www.corpmedinfo.com/regul_usa.html
http://www.corpmedinfo.com/oversight_failure.html
http://www.corpmedinfo.com/gov_oversight.html
2006/7 web pages ----- http://www.bmartin.cc/dissent/documents/health/nh_accreditation%20.html
http://www.corpmedinfo.com/tenet_accredit.html

⁵ **Aged Care Crisis Publications** <https://www.agedcarecrisis.com/publications>

Trust: Aged Care is a sector where trust and trustworthiness are vitally important but these are qualities that reside in socially connected communities. They are in short supply in the predatory marketplace. That our system depends on regulation for its legitimacy is testimony to the lack of trust in the system. We are well aware that strong criticism creates further distrust but we have little choice.

Serious problems: In our view the policies adopted in aged care were misconceived when they were introduced in 1997, ignored available evidence they were aware of, and were driven by ideological beliefs that were unsuited to this sector. The sector has been characterised by recurrent scandals⁶, which, in the absence of any reliable data, government and the industry have hosed down as rare exceptions and refused to accept as red flags to systemic failure.

The failure to confront the underlying problems since then has been due to the inability of those, who had invested their lives in these policies, to confront the flaws in the thinking that drove the ideology. That is now unravelling and this is reflected in the public's disenchantment with a political process that has been turned into a competitive marketplace⁷.

Finding a better way: Our analysis and efforts are not recriminatory but directed to understanding what has happened and opening debate that will lead to a way out of a system, where all the pressures are away from care, into one that is part of a cohesive community that is involved and in control of itself - focusing their attention on the care its more vulnerable members receive.

The regulatory process this committee is tasked with reviewing does not exist in a vacuum. It is a part of our society and a part of the aged care system. It cannot be taken out of context.

Attempting to regulate a system which is dysfunctional and where all of the pressures within the system are directed to circumventing that regulation makes effective regulation almost impossible.

Fixing a system that is flawed is more important than fixing its regulation, particularly when that regulation is not working in large part because of its relationship with the flawed system it is regulating. They must be addressed together. That is what we are pressing for.

A way forward: Currently we have a market and care is simply another commodity within it. We can only address this by accepting the real nature of care and acknowledging that it cannot be reduced to a commodity that is manipulated for profit.

Instead we need an aged care system that is underpinned by an understanding of human nature and our capacity to empathise. It must recognise the importance for the sector and society more widely, of developing social selves through relationships and responsible citizenship within society.

A market within this system must acknowledge its social responsibility and foster responsible citizenship among its staff. Communities must be in a position to insist on this and to do so they need to have control of the aged care services in their communities – own (ie identify with) them as their own.

⁶ **Scandal after Scandal** Inside Aged Care <https://www.insideagedcare.com/aged-care-analysis/19-years-of-care/scandal-after-scandal>

⁷ **It's time the government stopped trying to run the country like a private company** The Canberra Times, 30 Jan 2015

We have been forced to recognise the benefits of 'owning' for providing community services for other cultures (eg. Aboriginal services⁸ and in combating poverty and deprivation in the third world⁹), yet deny it for the majority of our citizens, by turning them into impersonal customers shopping for products.

Care is built around caring personal relationships. The value for both carer and cared for lies in those relationships.

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

We first touch briefly on other matters to make the point that this is part of a larger problem in aged care and human services generally. As the senate inquiry is about regulation we expand on these issues in a number of appendices so that they become contexts for our assessment of regulation. Addressing them is critical to dealing with the failure of regulation. We are pressing for changes that address both.

1.1.1 Hope for change

We are encouraged that both the recent elderly abuse report by the ALRC and the senate workforce review have finally recognised that there are serious issues in aged care.

We hope that the following **will finally challenge the presuppositions and patterns of thought that underpin our current aged care system and bring about real change** and the financial exploitation of retirement village residents as exposed in for-profit Aveo facilities¹⁰.

We hope that the spate of failures at times when regulators were not looking or expected will finally challenge the presuppositions and patterns of thought that underpin our current aged care system and bring real change. Some examples are:

- A.** the regulatory and care failures at government run Oakden; and
- B.** the recent similar failures at other facilities including:
 1. Findings of major failures at non-profit Ozanam Villa on the Gold Coast¹¹ following complaints after passing all standards 1 year before¹². Whistleblowers described the approach to accreditation visits¹³.
 2. Allegations of poor care and understaffing¹⁴ at a for-profit Tricare Bundaberg facility 8 months after full accreditation¹⁵.

⁸ **Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services** Productivity Commission Draft Report June 2017 pages 21-26 <http://www.pc.gov.au/inquiries/current/human-services/reforms/draft/human-services-reforms-draft.pdf>

⁹ **Partnering with consumers: national standards and lessons from other countries** Stephen D Gill and Melinda Gill. Med J Aust 2015; 203 (3): 134-136 <https://www.mja.com.au/journal/2015/203/3/partnering-consumers-national-standards-and-lessons-other-countries>

¹⁰ **Bleed them dry until they die** Sydney Morning Herald, Jun 2017 <http://www.smh.com.au/interactive/2017/retirement-racket/bleed-them-dry/>

¹¹ **Complaints pour in over inadequate care at Gold Coast aged-care facility** Gold Coast Bulletin 8 June 2016 <http://bit.ly/1U25V13>

¹² **Ozcare Ozanam Villa Burleigh** Aged Care Quality Agency 4 June 2015 <http://bit.ly/2wGqBGZ>

¹³ **Residents 'neglected'** Gold Coast Sun Central 15 June 2016

¹⁴ **Aged care nightmare: man's scrotum 'left bleeding'** daily Mercury 20 Feb 2017 <http://bit.ly/2wGqk77>

TriCare Bundaberg 'understaffed', patients receiving inadequate attention, families say - ABC News 10 March 2017 <http://www.abc.net.au/news/2017-03-10/aged-care-understaffing-concerns-bundaberg/8332278>

3. failure of palliative care and maggots¹⁶ in a for-profit Opal facility in Newcastle 22 months after full accreditation, and
4. Martindale¹⁷ in South Australia, a for-profit facility which was sanctioned for major failures only 2 months after being fully accredited for 3 years. It's owners have a past record of problems missed by regulators in 2007, but exposed by whistleblowers who went to the press¹⁸.
5. the nonprofit Southern Cross Ozanam facility in Canberra, where doctors at the local hospital were so horrified that they lodged a complaint¹⁹.
6. For-profit owned Hillside at Figtree sanctioned April 2017, one year after passing all 44 standards²⁰.
7. NSW government operated Garrawarra Centre at Waterfall sanctioned May 2017 only 3 months after passing all 44 standards²¹.

C. the financial exploitation of retirement village residents as exposed on ABC 4 Corners in for-profit Aveo facilities²².

Two points are worth noting:

1. While four of the nine nursing homes above are for-profit, two are nonprofit and three including Oakden are government owned. This we think reflects a changing pattern of failures over the last few years.
2. In these instances the major problems were not detected by regular scheduled accreditation visits but were a consequence of action by individuals.

Complaints are often supported by the press and/or social media campaigns. One is left wondering whether this is necessary to get action. To what extent is adverse publicity being addressed by regulators - rather than the deficiencies, the reasons for them and the suffering they cause?

All this raises questions about the efficacy of the regular 3 or 5 yearly prepared-for accreditation audits. They are of value to the government and providers in selling their wares locally and globally but not to residents, prospective residents or researchers, the people who need protection or data.

¹⁵ **Tricare Bundaberg** Quality Agency 23 June 2016 https://www.aacqa.gov.au/publications/reports#b_start=0&c7=&c5=TriCare+Bundaberg

¹⁶ **Call for more scrutiny in aged care, after maggots found on woman in nursing home north of Newcastle** ABC News 9 May 2017 <http://www.abc.net.au/news/2017-05-09/jayne-carter-opal-raymond-terrace-gardens-nursing-home-maggots/8509290>

¹⁷ **Serial offender aged care provider put residents at 'severe risk'** Sydney Morning Herald 28 May 2017 <http://www.smh.com.au/national/serial-offender-aged-care-provider-put-residents-at-severe-risk-20170526-gwe4z1.html>

¹⁸ **Nursing Homes** Today Tonight 24 July 2007 <https://www.todaytonightadelaide.com.au/stories/nursing-homes>

¹⁹ **Southern Cross Care rest home in Garran breached standards in government audit** The Canberra Times 9 Jun 2017 <http://bit.ly/2vUag5n>

Canberra Hospital urges investigation into Southern Cross Care nursing home - The Canberra Times 3 July 2017 <http://bit.ly/2uvCCi1>

²⁰ **Hillside could lose its approval as a provider of aged care services** Illawarra Mercury 1 May 2017

<http://www.illawarramercury.com.au/story/4630249/sanctions-imposed-at-figtree-aged-care-home/>

Where Hillside at Figtree failed its residents revealed Illawarra Mercury 31 May 2017

<http://www.illawarramercury.com.au/story/4698622/full-list-of-where-hillside-at-figtree-failed-its-residents-revealed/>

Hillside Accreditation reports https://www.aacqa.gov.au/publications/reports#b_start=0&c7=New+South+Wales&c5=Hillside+at+Figtree

²¹ **Sanctions at Garrawarra due to health and safety concerns** Illawarra Mercury 14 Jun 2017

<http://www.illawarramercury.com.au/story/4729296/sanctions-imposed-at-illawarra-aged-care-home/>

Garrawarra Accreditation reports https://www.aacqa.gov.au/publications/reports#b_start=0&c7=New+South+Wales&c5=Garrawarra

²² **Bleed them dry until they die** Sydney Morning Herald June 2017 <http://bit.ly/2fxnHB4>

1.1.2 System issues

We have a system where many are committed and even succeed in providing good care but that is in spite of the way the system is structured and managed. Consistent safe and effective care cannot be provided with the steadily falling number of skilled staff and the inadequate overall numbers. Both are way below international standards²³.

We don't have any staffing standards of our own. With this level of staffing it would be remarkable if there were not failures in care and if people were not being harmed - yet it is citizens and not our regulatory inspections that are detecting them and either lodging complaints or, when that fails, going to the media to have them addressed. We have a system in which all the pressures in the system are towards reducing staff and a regulator that ignores this.

Braithwaite et al who have studied our system extensively, in their 2007 book²⁴, wrote of the late 1990s that "*The media scandals were linked to failures of the accreditation regime to trigger any enforcement action against the nursing home in the face of over-whelming evidence of reckless neglect*" (page 190). In referring to regulation they said (Page 182) that "*new waves of nursing home scandals at the end of the 1990s and in 2006*", as well as criticism of accreditation saw more funding devoted to more frequent in-between visits".

In spite of that unhappiness with the system and the number of scandals have increased. It seems likely that both increased marketplace competition and an unwilling regulator are responsible for this – the latter certainly a factor in the case of Oakden whose ongoing failures in 2007 and since were not addressed.

It is clear that the cases creating so much publicity are not rare exceptions and they are not being detected during the 3 to 5 yearly formal audits. They are red flags to a system that has been failing for a long time and just the tip of an iceberg.

It is time to accept that the ideas on which our system and its regulation are based are deeply flawed and that they have not worked. Until we do that we cannot move on. Currently Australians are being sold more of the same and this is then called 'reform'.

Ownership lost: As trained managers and economists have taken control of aged care, the professionals actually responsible for care have been disempowered. They no longer have influence and control in the organisations where they work or over the care that is being given. They no longer 'own' the care they are providing or have control over how the money paid for care is used.

This disempowerment has major implications for the culture within facilities and the motivation of the staff providing care.

Regulatory failure: Compounding this is a distant regulatory system that seems to be more concerned about protecting the politicians and the sort of market they insist we have from challenge, and maintaining the illusion that we have a world class system than is rigorously regulated.

²³ Aged Care Crisis Supplementary submission to Senate Workforce Inquiry 29 Nov 2016 (pages 14 - 22)
https://www.agedcarecrisis.com/images/pdf/sub302ss2_ACC.pdf

²⁴ Braithwaite J et al *Regulating Aged Care* Edward Elgar Publishing Limited 2007 page 32

1.1.3 An approach to aged care and its regulation

In our analysis of aged care we have approached these issues, in particular the failure of regulation, by examining the patterns of thought and the frames of analysis on which decisions and action are based - also often called narratives. The term 'discourse' brings these ideas together and many recent studies of nursing care examine the consequences of the discourses that are used in the provision of care. We use that term in this submission.

The discourses, which we are a part of influence our thinking, the way we understand, the way we behave, the things we do and ultimately the sort of people we become. They mold our psychological DNA and so who we become, our identity.

Those with the power to control the discourse in any sector are able to influence and control the thinking of participants and so their actions and behaviour. This can be done by claiming to be a credible authority and then controlling information and its interpretation.

Being in a position of authority gives the power to control what is seen as credible or not credible, and what is excluded or unacceptable in the discourse. The ultimate power comes from controlling the way information is collected, analysed, presented and understood - what is reasonable to believe and what is unacceptable and ridiculed. This is essentially a step-by-step process of subliminal censorship.

Public information can expose problems in the discourse and challenge its legitimacy. This is threatening not only for those in power but for those citizens who have identified with the discourse, incorporated it into their mental DNA, and built their lives using it. This is a particular problem for them when the discourse no longer holds true and can be challenged. Democracy depends on the public having information and interpreting its significance independently. Without this we readily become victims of ideological discourses.

Dysfunctional ideologies are built around discourses, which lack universal validity and cause harm to some. Believers seek to censor, attack or discredit challenging information - often by shooting the messenger and imposing censorship. This has been happening in aged care.

Increasingly those doing social research into human services including health and aged care are analysing discourses to explain and understand what they are observing. We have found this to be a useful way of understanding²⁵ what has been happening in aged care in Australia and elsewhere, particularly why regulation is failing.

1.1.3.1 Discourses in aged care

We can identify two broad discourses in society and so in aged care and its regulation.

Discourse of Care: The original discourse of care goes back at least 2500 years to Hippocrates on the Greek Island of Cos. At its heart is a sense of social responsibility and in particular responsibility for those who are vulnerable. It resides in health professionals and the community and, although it has been influenced by them, it has coexisted with other discourses over the centuries. Professor Michael Fine and his associates²⁶ have engaged with and refined this discourse of care. They have stressed the vital role of close caring relationships and a system that supports their development.

²⁵ Foucault's insights in [Theory and Research in aged care](https://www.insideagedcare.com/aged-care-analysis/theory-and-research#Foucault) Inside Aged Care
<https://www.insideagedcare.com/aged-care-analysis/theory-and-research#Foucault>

²⁶ Professor Fine in [Theory and Research in aged care](https://www.insideagedcare.com/aged-care-analysis/theory-and-research#care) Inside Aged Care
<https://www.insideagedcare.com/aged-care-analysis/theory-and-research#care>

The Free-market Discourse: Often called neoliberal, this discourse developed among economists during the 1970s and was adopted by government for the management of markets and society in the 1980s. It is built on a denial of social responsibility in the market, replacing it with fiscal responsibility to investors. Its focus is on free and uncontrolled markets. Any form of regulation is seen to impede markets and to be undesirable – to be kept to a minimum.

This discourse has become all-inclusive because it embraced a new highly structured vision of managerial control. This was adopted, not only in the marketplace but across society – in government, in government run services like aged care, in nonprofit services and multiple other areas. This put its disciples in a position to control the discourse of those in any organisation, and so change the ways participants and particularly employees thought and behaved.

An increasing number of studies have examined the impact of this ‘New Management’ on the thinking and behaviour of staff in education, health and aged care. There has probably never been such an effective and pervasive system for controlling the content of discourse and so the way people relate to what they are doing.

Many in the USA and then in Australia warned of the consequences of this change for humanitarian services such as health and aged care because of its impact on our humanity and on relationships within society. Where free-market discourse has been forced to pay service to humanitarian objectives such as the discourse of care in aged care this has become largely tokenistic – the form of care without the substance.

We can understand why the dominance of this discourse has had profoundly negative consequences for aged care.

i **Appendix 1** explores the conflict between these discourses in greater depth. It includes several examples to illustrate the consequences.

1.1.3.2 The consequence for aged care

It is not so easy to understand why the free-market/neoliberal agenda has had a profound impact on regulation without looking at its impact on the operation of aged care first.

This can be summarised in point form.

1. The lessons of the past ignored
2. The abandonment of probity (social responsibility) as a requirement.
3. Humanitarian values replaced with commercial values.
4. Removal of restrictions on the operation of the market in the sector.
5. Replacement of social responsibility as the defining ethic with an individualistic ethic of choice but without enabling choice or protecting resident’s choices from being exploited by marketplace activities.
6. Controlling information leading to an absence of data on which to base choice.
7. Replacing humanitarian motivation with commercial competition and efficiency as the driving forces in the sector but without an understanding of the consequences.
8. Providers in the sector follow the needs of the market above the needs of the community and its members.

9. A top-down managerial structure that controls but does not respond to what happens at the bedside.
10. A process driven, task focused system rather than a person focused one - a change of discourse in which the meaning of care is lost.
11. Dysfunctional cultures due to the intrinsic conflict between free-market/neoliberal management and staff professional values developed during their training within the discourse of care.
12. Government's centralised, bureaucratised and process driven managerial approach is exemplified in the 'myagedcare' web site. It is an expression of the neoliberal mind.
13. Exposure of failures depends on courageous staff or families who speak out about failures in care.
14. Recurrent scandals as failures of care become endemic.

 **Appendix 2** explores these issues in more depth.

1.1.4 Changing patterns of failure

It is likely that increasing pressures within the system are impacting on sectors that are not traditionally interested in the marketplace. As they are forced to compete they are coming under increasing financial pressure and will seek ways of addressing this. That pressure is going to increase the pressures on regulators of care and make it more difficult for them. The greater the competitive pressures to survive in the system the more difficult regulation becomes.

The impact of profit pressures: Extensive international research particularly in the USA but also in Australia has linked both staffing levels and the incidence of failures to the pressures for profits. Government run and nonprofit providers have performed much better than facilities owned by market listed and private equity chains. Limited data from Australia has shown a similar pattern. We reviewed this research in our supplementary submission to the 2016 Senate Workforce Inquiry²⁷. Private Equity has created major problems and been directly or indirectly responsible for many failures in care in the UK²⁸.

Early failures: We have not taken out figures but it is our impression that early failures in care and scandals in the late 1990s and early 2000s were largely in smaller for-profit providers that lacked knowledge and ability. Since then, until recently, it has been the larger for-profit providers.

²⁷ **Aged Care Crisis Supplementary** submission to Senate Workforce Inquiry 29 Nov 2016 (pages 23 - 27)
https://www.agedcarecrisis.com/images/pdf/sub302ss2_ACC.pdf

²⁸ **Private Equity Inside Aged Care** <https://www.insideagedcare.com/aged-care-analysis/aged-care-marketplace/private-equity>

More non-profits: After the resurgence of neoliberalism in 2013 and the Living Longer Living Better 'reforms' in 2014, there was intensification of competition and rapid consolidation in aged care. This has put much more commercial pressure on nonprofits that are threatened with acquisition. There have been many more complaints from nurses and an increased number of failures in nonprofit facilities.

Recently government facilities: We are now seeing government nursing homes, traditionally the best staffed failing. The earlier list of recently failed homes illustrates the recent changes well.

There are some possible reasons for this.

- The threat of privatisation of public services places pressure on management to contain costs.
- The likelihood that neoliberal management pressures in the government sector have increased due to pressure from government.
- Management have become so out of touch with the discourse of care in government facilities that they do not understand the consequences of their staffing policies.

Oakden and the three other government facilities in the list have all had issues that can be directly related to staffing but as yet there has been no thorough investigation of this. The Francis inquiry in 2013 into the NHS National Health System Stafford Scandal in the UK exposed these issues and they were then found to be widespread in the NHS. It is very likely that this is what has been happening in Oakden and other government run facilities.

When nonprofits dominated and controlled the discourse of care they set the standards for what was acceptable conduct and how care was provided. The ascendancy of free-market thinking has been accompanied by the rapid growth of big corporations. They now decide what is acceptable conduct and how care is provided.

The process is reversed as the nonprofit and government sectors are captured by for-profit thinking and behaviour. The changing patterns of failures in care reflect this.

 **Appendix 3** explores these issues in greater depth.

1.1.5 A flawed regulatory system

Following the exposure of the failures in regulation at Oakden one of our members met with the aged care minister. Subsequent to this we prepared a detailed analysis of what had and was still happening to the regulatory system and made some suggestions about how this might be addressed. We sent this to the minister in June 2017.

In July 2017 The Kaiser Foundation in the USA published its most recent analysis of the massive US aged care databases. We used this to make a comparison between the regulation of staffing and standards as well as data collection in the USA and Australia.

In this submission we look first at this comparison between the USA and Australia. We then analyse the reasons for failure and this too draws some comparisons with the USA. This submission includes much of this previous material as well as new material.

Part 2: Comparing Australia with the USA and the UK

1.2 Comparing data collection

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

Data collection and reporting in Australia: 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.

Data collection and reporting in the USA: A large amount of data is readily available in open, accessible and machine-readable formats. In addition to viewing data online, data sets are available to download and also through an Application Programming Interface, or API, which lets developers connect other applications to the data in real time²⁹. We found information about deficiencies was available within 4 to 6 weeks

Data collection and reporting in the UK: The UK's Care Quality Commission (CQC) provides extensive data going back for 10 years. Visits are more frequent and unlike Australia all are published. Its site is updated weekly with comprehensive data, including the ability to download and analyse it, like the USA, it also has developer friendly API's.



Example: Attached are the accreditation reports for Oakden from the cyclical 3-yearly visits, over a 9-year period during which there were many failures in care and when residents were abused.

These are the reports that the public see and base their decisions on when placing a loved one in care:

1. **Accredited on 2 March 2016 - Up until 30 April 2019 (3 yrs) - 44/44 Standards**
(accreditation gained under CEO Nick Ryan's stewardship)
2. **Accredited on 4 March 2013 - Up until 30 April 2016 (3 yrs) - 44/44 Standards**
(accreditation gained under CEO Mark Brandon's stewardship)
3. **Accredited in March 2010 - Up until 30 April 2013 (3 yrs) - 44/44 Standards**
(accreditation gained under CEO Mark Brandon's stewardship)

1.3 Regulation: Staffing and failures in care

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

²⁹ Data.Medicare.gov: <https://data.medicare.gov/about>

1.3.1 Regulatory capitalism

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

In doing so both countries have taken care to keep it in 'safe hands'. In both countries, regulation has, to a significant degree, been captured and controlled by a dominant free-market discourse. Both systems are at risk of ritualism and tokenism. When this happens words and processes become a substitute for the real thing.

Differences: There are significant differences in the way this regulation has been set up and operates in the two countries. They have adopted different approaches to dealing with system failure.

- Regulation in the USA focuses on exposing deficiencies and encouraging prospective residents to use this information when choosing a nursing home.
- The regulatory system in Australia focuses on successes and hides deficiencies. While marketing choice as a virtue of the system it does not provide the information needed to make choices. Market pressures are unopposed.

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

Staffing requirements and regulation have been captured and controlled by the free-market discourse but not as extensively as in Australia. Needed reforms such as legislated minimum levels have been resisted or watered down.

Despite this, the essential structure of the regulatory system is based on the needs of residents and the intent to give them choice. Attempts by President Reagan to use accreditation as a regulator in aged care were strongly resisted by the public and blocked by the US congress.

In Australia: In contrast to the USA, regulation was designed and written behind closed doors in cooperation with industry 'stakeholders'. It was structured to serve the market and the politicians that depended on it for support and funding.

The response to intense community and political opposition in the late 1990s was to create a regulatory system whose primary objective was to protect free-market policies and serve as a marketing tool for politicians and providers in this marketplace. This was very successful in meeting the needs of politicians and the marketplace but not we believe, for residents and their families.

The role of accreditation was to keep information away from the public and the press, and to create a positive image. In doing so it needed to avoid the sort of failures that inevitably get to the media.

As staffing has fallen, as more scandals are reported in the press and as community unhappiness and anxiety has increased there have been exaggerated and unbelievable claims to better and better performance - claims that are unsupported by clear evidence. There is a startling discordance in perception between the free-market discourse and the discourse of care that can only be resolved by accurate data and genuine transparency.



The comparison using the Kaiser report provides a useful background to our analysis of regulation in Australia.

1.4 Regulating staffing in the USA and Australia

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

1.4.1 Staffing in the USA

Despite evidence and strong advocacy federal politicians have not legislated minimum staffing levels for the over 15,000 nursing homes registered to provide Medicare and Medicaid funded aged care in the USA. Instead, the CMS (Centre for Medicare and Medicaid Services) which regulates the sector sets out **recommended minimum staffing levels** that are required for safe care if residents are not to be harmed. These are based on careful research and expert opinion.

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

The CMS collects data from all 15,000 nursing homes and this is publicly available in a readily understandable format. The original data is stored on the large publicly available OSCAR and CASPER databases.

The CMS has ***“long identified staffing as one of the vital components of a nursing home’s ability to provide quality care”***³⁰. Over time, CMS has utilised staffing data for a myriad of purposes in an effort to more accurately and effectively gauge its impact on quality of care in nursing homes. They also collect and publish staffing information quarterly on their website to help consumers understand the level and differences of staffing in nursing homes.

The Kaiser Family Foundation, a nonprofit charity periodically reviews the database and reports its findings. These show that there has been some improvement in both the average numbers of skilled nursing staff and the total number of nurses over the years.

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

The most recent Kaiser Report³¹ dealing with the 7 years (2009 - 2015) was released in July 2017. The US figures in the graphs below are taken from that.

³⁰ Source: Centers for Medicare & Medicaid Services (CMS) <http://go.cms.gov/2frxXuQ>

³¹ **Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2015**. Henry J Kaiser Foundation July 2017
<http://files.kff.org/attachment/REPORT-Nursing-Facilities-Staffing-Residents-and-Facility-Deficiencies-2009-2015>

1.4.2 Staffing in Australia

There are no minimum staffing levels or skills specified in federal legislation in Australia and minimal data is collected and made public. There is also no recognition in the accreditation discourse in Australia, that staffing is critical to providing quality care.

Although the Quality Agency collects staffing data, this information is not disclosed publicly. Perhaps this is because its primary responsibility is to protect government from embarrassment.

Instead, staffing benchmarks have been developed by the marketplace and their financial advisors to serve their needs rather than that of the residents. These figures are based on financial considerations and the need to be competitive and not based on what residents actually need for good care. Australian studies based on actual data in 1985 and an analysis by academics in 2016 have generated figures that are close to the US recommendations.

Two financial entities, StewartBrown and Bentleys collect and analyse financial data from two self-selected groups of nursing homes who voluntarily supply it. Figures from their reports to the industry have recently become available to us. These inadequate financially based staffing benchmarks have been used by senior management of non-profit organisations as justification for reducing staffing across all of their nursing homes³².

They have even been used (unsuccessfully) as a defense in a Coroner's court when patients have died because of inadequate staffing³³. At a time when increasing acuity demands more staffing, more and more providers are reducing staff³⁴.

StewartBrown's benchmark figures fall a long way behind the scientifically assessed levels in the USA and Australia. Business managers use these benchmarking figures (and not the scientific assessed levels) to guide their staffing policies as well as to defend themselves against allegations of understaffing.

The benchmark in the graphs below is taken from StewartBrown's (SB) Dec 2015 report³⁵ and the figures in the graphs from its June 2016 report³⁶. The Bentleys figures are taken from a 2014 presentation to ACSA³⁷.

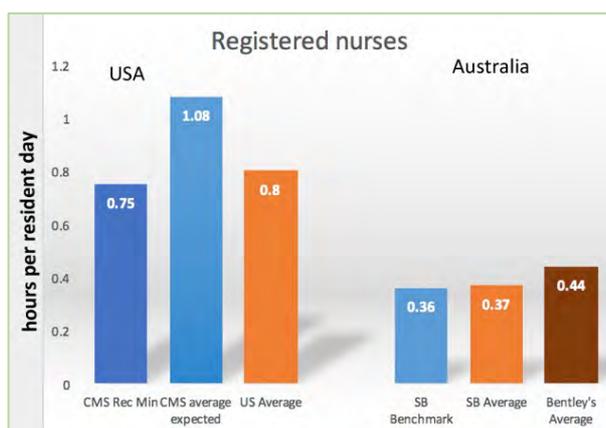


Chart 1: Comparison of Registered Nurses

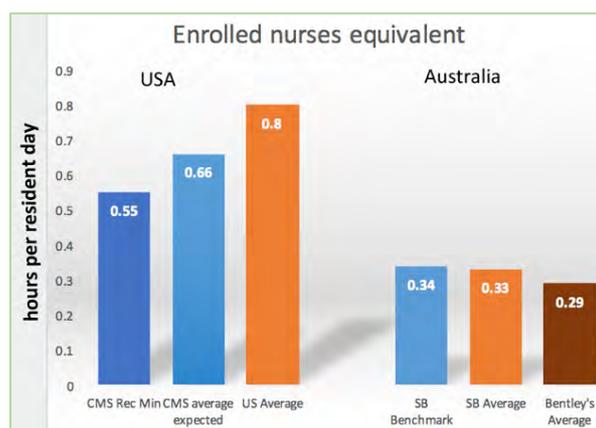


Chart 2: Comparison of Enrolled nurses equivalent

³² Southern Cross Care defends nursing home cuts, families hit back The Chinchilla News 13 Jul 2017 <http://bit.ly/2und9av>

³³ Westcott, Inquest into the death of Barbara Westcott Coroners Court Tasmania 1 September 2016 <http://bit.ly/2unfrdR>

³⁴ Bundaberg aged care job cuts present ethical dilemma, union says ABC News 20 Jul 2017 <http://ab.co/2vMXghT>

³⁵ Aged Care Financial Performance Survey Summary of Survey Outcomes StewartBrow December 2015 SB

³⁶ Aged Care Financial Performance Survey Residential Care Report StewartBrown - June 2016 - SB

³⁷ Peta Bourne presentation Aged Care Sustainability + benchmarks ACSA Finance Forum 30 October 2014 <http://bit.ly/2fAikly>

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

This amounts to:

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

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

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

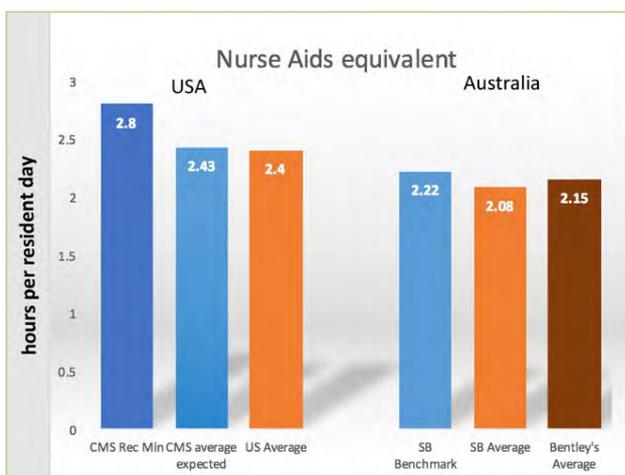


Chart 3: Comparison of Nurse Aids equivalent

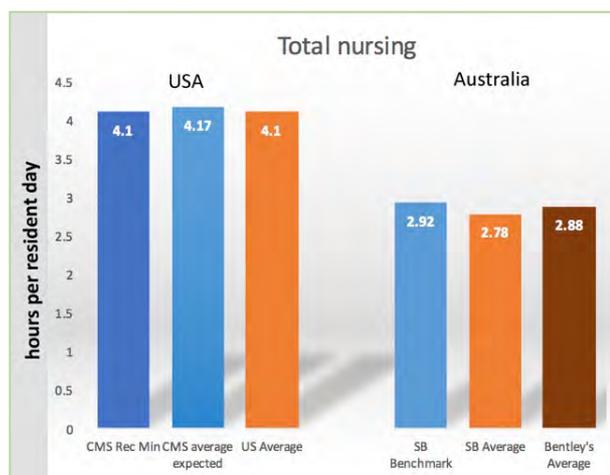


Chart 4: Comparison of Total nursing

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

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

A study in the USA looking at the number of unqualified nurse aids needed³⁸ found that, in addition to trained nurses, low workload facilities needed a minimum 2.8 hrpd and those with the highest workload needed 3.6 hrpd of nurse aids. Below this level an unacceptable and steadily increasing amount of care was omitted.

Australia's average total nursing numbers including qualified nurses fall below the lowest level of unqualified carers needed in low workload facilities.

³⁸ 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>

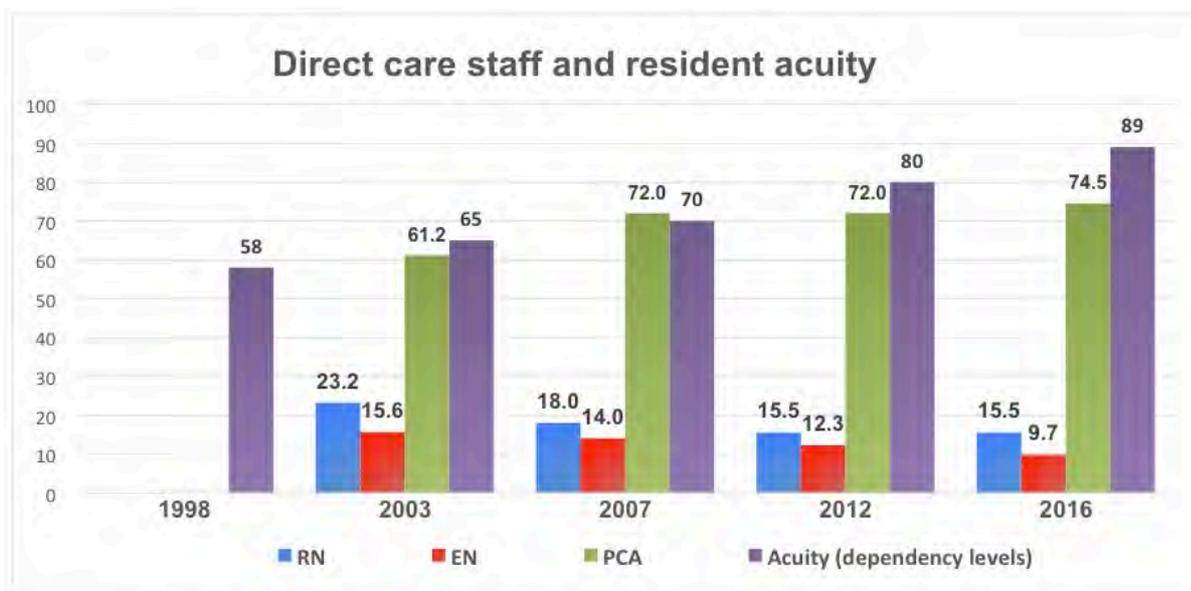


Chart 5: Nurses and resident acuity in Australia³⁹

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

At the same time Allied Health staff (Physiotherapy, Occupational therapy etc), not shown on the chart, have almost halved from 7.6% to 4%. These staff are important for maintaining function and quality of life.

On page 12 of SB's December 2015 review⁴⁰, 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 staff⁴¹ between 2004 and 2014. 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.

1.5 Failures in care in the USA and Australia

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

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

³⁹ Figures from the ANMF fact sheet website in 2016: http://anmf.org.au/documents/reports/Fact_Sheet_Snap_Shot_Aged_Care.pdf

⁴⁰ Aged Care Financial Performance Survey Summary of Survey Outcomes, December 2015 Review, StewartBrown

⁴¹ Peta Bourne presentation Aged Care Sustainability + benchmarks ACSA Finance Forum 30 October 2014 <http://bit.ly/2fAiKly>

The gradual increase in staffing over the years has been associated with a slow decrease in the incidence of deficiencies but in 2015 on average there were still 8.60 deficiencies per US nursing home. State averages for deficiencies ranged from 3 to 21 per facility.

Ninety three percent of nursing homes have some deficiencies. Only 7% of homes had no deficiencies. More serious deficiencies were instances of actual harm or jeopardy. One in 5 (20% of homes) had these serious deficiencies.

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

An example of an objective and comparable finding was pressure ulcers (bedsores) which occurred in 6.2% of residents in the USA.

This can be contrasted with the 26 to 42%, quoted by the Australian Department of Health in a consultation paper⁴² about plans to reduce the number of accreditation standards.

Strangely the department did not express any concern about these alarming figures. This is one of the most telling indicators of poor staffing.

Australia: Australia does not quantify specific failures in care but instead has scheduled cyclical accreditation/re-accreditation audits every 3 to 5 years that assesses 44 'quality standards'. The focus is on success in achieving accreditation rather than on deficiencies.

In addition, homes are also visited yearly or at other times if problems are reported, but the outcomes of these visits are not published and are confidential.

The Quality Agency in its 2015/16 Annual Report⁴³ boasts that "*more than 97 per cent of all residential aged care facilities that went through a full audit were assessed as meeting all expected outcomes of the 44 Accreditation Standards*". Only 2.2% of nursing homes in Australia were found to have not passed all 44 standards – to have any problems in meeting accreditation requirements.

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

Of the 2,678 nursing homes in Australia 46 (1.7%) had been accredited for less than 3 years indicating that there were some problems. The Department of Health⁴⁴ in its annual report indicates that it imposed 6 sanctions (0.22%) in a year during which each of the, 2,678 facilities would have been visited at least once.

⁴² **Single Aged care quality framework** Draft Aged Care Quality Standards Consultation Paper 2017 Department of Health Consultation for proposed changes March 2017

<https://consultations.health.gov.au/aged-care-access-and-quality-acaq/single-quality-framework-draft-standards/>

⁴³ **Annual Report 2015/16 Australian Aged Care Quality Agency** https://www.agedcarecrisis.com/images/ar/ar_acsaa_2015-2016.pdf

⁴⁴ **2015–16 Report on the Operation of the Aged Care Act 1997** Department of Health: <http://bit.ly/2tiErOv>

1.5.1 The Outcomes

The comparison with the USA is startling, as shown in the 2015/16 results in Charts 6 and 7.

■ Red shows the number with deficiencies or failing standards ■ Blue have no problems

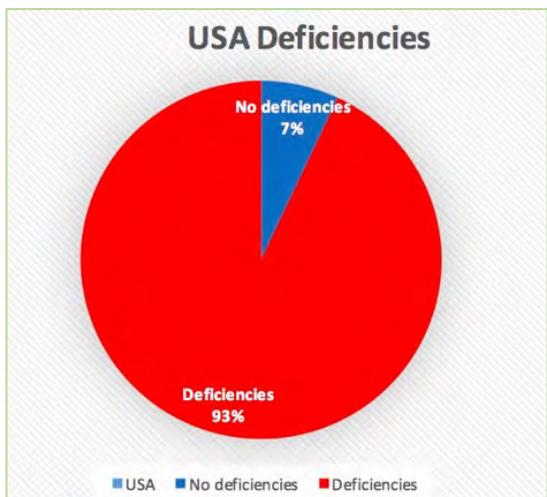


Chart 6: USA deficiencies = 93%

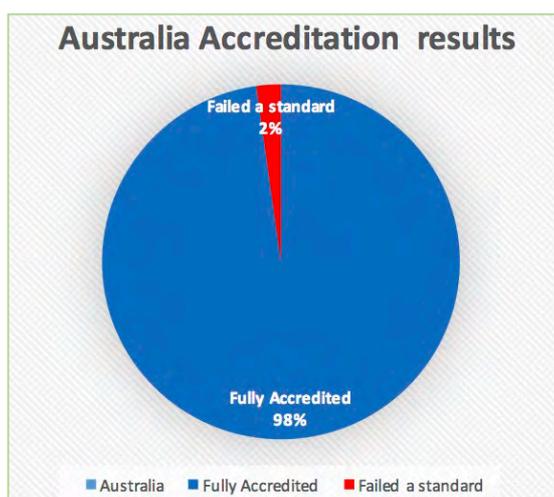


Chart 7: Australia deficiencies = 2%

Australia boasts of its ‘world class system’ and supports that by claiming a rigorous regulatory system. This is because it does not collect and publish data.

We challenge both assertions and can find no basis for them.

At the full yearly reviews in the USA, almost as many nursing homes (93%) had deficiencies as obtained a perfect score in Australia, where 97.8% of facilities passed all 44 standards at their regular 3-5 yearly accreditation/re-accreditation process.

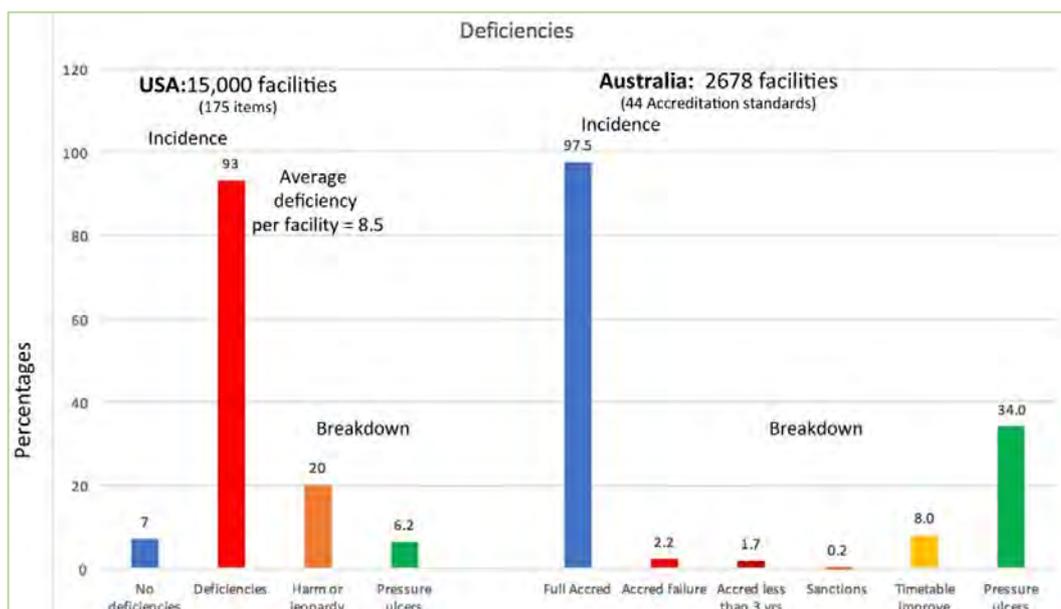


Chart 8 shows the difference in the regulatory approach between the USA and Australia

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

USA: In the USA 20% of deficiencies were severe enough to cause harm or create jeopardy. Only 7% had no deficiencies. In the real world you don't have perfection but this is clearly not good either! These figures are in keeping with the fact that about half of all US facilities fell below the safe minimum staffing levels and skills specified by the CMS. A panel of US experts and academics had advised even higher minimum levels for safe staffing⁴⁵ but this was not adopted.

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

In spite of the 1,900 pages⁴⁶ of Oakden-related documents from 2007 to date, including assessment contact reports, both announced and unannounced, referrals from the Department to the Agency, Oakden consistently passed all standards. The public knew nothing of this. These documents only became available after a Senate Order⁴⁷.

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

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

If we collected other comparable objective markers of poor care the comparisons might be similar. That this is probable is apparent from the message that nurses and family members who look and understand what is happening are sending⁴⁸. Academics who have studied the sector and then spoken out about widespread failures in providing care have been attacked and pressure put on their universities⁴⁹.

As staffing skills and numbers fall, more scandals have been exposed, more nurses have complained and more anxiety has been generated by press exposures⁵⁰, the rate of successful accreditation claimed by the Quality Agency has increased.

The success rate has gone from unbelievable to incredulous. It's as if the agency's performance is trying to keep up with the level of concern.



Chart 9: Quality Agency Annual Report 2015/16

Prospective residents cannot make choices when everyone gets full marks.

⁴⁵ Harrington, C., Kovner, C., Mezey, M., Kayser-Jones, J., et al. (2000). **Experts Recommend Minimum Nurse Staffing Standards for Nursing Facilities in the United States.** *The Gerontologist*. 40 (1): 5-16.

⁴⁶ Senate orders for production of documents—Oakden aged care service—Accreditation and assessment reports—<http://bit.ly/2qqH4vL>

⁴⁷ Senate Order - Motion - 10 May 2017: <http://bit.ly/2vSyQUc>

⁴⁸ **Those who know** Inside Aged Care <https://www.insideagedcare.com/aged-care-analysis/19-years-of-care/those-who-know>

⁴⁹ **Is this culturography?** Inside Aged Care <https://www.insideagedcare.com/aged-care-analysis/widely-contrasting-views/is-this-culturography>

⁵⁰ **Scandal after Scandal** Inside Aged Care <https://www.insideagedcare.com/aged-care-analysis/19-years-of-care/scandal-after-scandal>

1.5.2 Data reliability in Australia

Total data confusion: The difficulty in getting any accurate data in Australia is well illustrated by the federal health department's web site. A web page on the government's web site headed **Current Sanctions**⁵¹ and then "Display search results for Notices of Non-Compliance and Sanctions" was accessed on the 4 July 2017. It indicates that it is automatically updated. A total of 333 facilities were found and clicking on each gave details of the sanction or non-compliance.

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

Dodgy reporting in the past: In 2008 the minister and the agency reported that only 46 (1.6% of homes) had been non-compliant with all standards.⁵² It turned out that this was because of the way the agency reported its figures. There were in fact 199 (7%). The (then) minister was forced to correct her error. When a sample of these failures were examined, we found there were other discrepancies in the figures and in their interpretation. We suspect that the agency may still be reporting figures in the same deceptive way.

1.5.3 The consequences

USA: The consequence of focusing regulation on deficiencies has been that, despite even stronger commercial pressures than in Australia, staffing skills and levels have increased in the USA and there has been some improvement in the services provided.

Australia: The regulatory system focuses on successes and hides deficiencies. While accurate data is not collected in Australia, the available information shows that staffing numbers have remained low and the numbers with more costly trained nursing skills have markedly decreased.

There is much to suggest that Australia has allowed the nursing of the elderly to decline, leading to an aged care system that is in many ways inferior to that in the USA. If so then it has been very successful in hiding this from the public.

1.6 Regulation and data collection in the United Kingdom

The UK has traditionally had smaller more personal nursing homes where staff knew each resident intimately and caring relationships were much better than in Australia and the USA. That system was shattered when the free-market discourse was introduced by the Thatcher government in the 1980s, and particularly by the predatory activities of global and local private equity companies⁵³. There have been extensive and systemic failures in care⁵⁴.

⁵¹ **Current Sanctions** Department of Health: <http://bit.ly/2gNnqKu>

⁵² **Aged Care Report Card** Aged Care Crisis Dec 2008 <https://www.agedcarecrisis.com/news/research/108-aged-care-report-card>

⁵³ **Aged Care failures** Inside Aged Care

<https://www.insideagedcare.com/aged-care-analysis/aged-care-marketplace/aged-care-failures>

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

⁵⁴ **This Is The Shocking Face Of Abuse In Britain's Elderly Care System** Buzzfeed 30 Apr 2014 <http://www.buzzfeed.com/alanwhite/this-is-the-shocking-face-of-abuse-in-britains-elderly-care#.jtlGYJODJ>

The UK's regulatory system can also be seen as regulatory capitalism - centralised and distant from the bedside. While it does not use accreditation as a regulator it is more like Australia than the USA. Unlike the USA the UK's Care Quality Commission (CQC), which regulates all social services in the UK, does not collect data on outcomes but it does collect far more information than Australia and this is publicly available.

It is more useful because there is a spread of assessments, which might be more helpful for those choosing a nursing home.

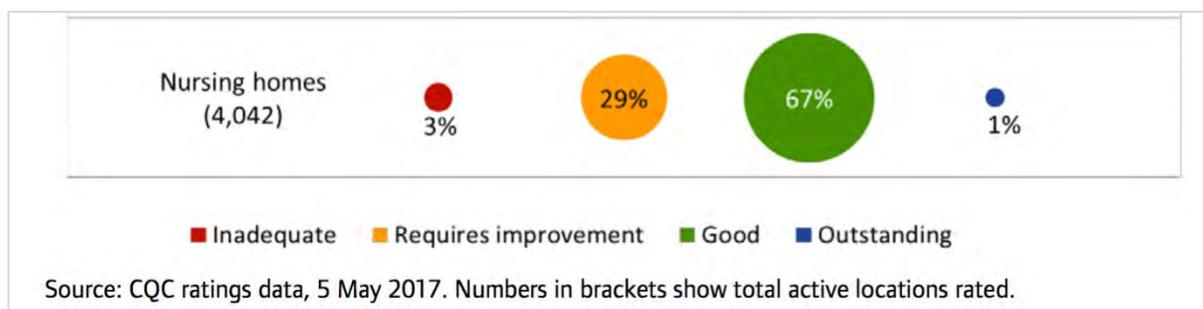


Chart 10: The UK's Care Quality Commission assessment Nursing Homes

Because there is more information available, the UK has not been as successful as Australia in hiding the extensive failures in the system and the consequences for residents. Criticisms of its regulator and the reporting of scandals are if anything greater than those in Australia.

The Daily Mail reported on 7 August 2017 that four in ten nursing homes were substandard⁵⁵. The worst offenders were private equity and for-profit BUPA, half of whose nursing homes were substandard. BUPA is also Australia's largest for-profit provider of aged care. The regulator, the Care Quality Commission (CQC) was described as toothless and strongly criticized as it had shut down only 6 of these substandard nursing homes in 2 years, giving repeated warnings instead.

The CQC has failed on multiple occasions⁵⁶ in much the same way as our accreditation system and probably for similar reasons. It has been strongly criticized in the press and by academics⁵⁷ writing for the Centre for Welfare Reform⁵⁸, a think tank that is pressing for greater community involvement and control of welfare services. There is strong pressure in the UK for greater community involvement and control⁵⁹.

The UK has now recognised how critical staffing is and the need for more research⁶⁰. It has commenced a major 3-year £100,000 research project into staffing to determine the number and skills of staff needed to provide good care⁶¹ - something the USA did 20 years ago and Australia is still doing its best to avoid or ignore.

⁵⁵ Four in ten care homes are not fit for purpose: Daily Mail 7 Aug 2017 <http://daily.ai/2un3KQc>
Vulnerable people left 'betrayed' by England's care and nursing homes The Guardian 6 July 2017
<https://www.theguardian.com/society/2017/jul/06/vulnerable-people-left-betrayed-by-englands-care-and-nursing-homes>

⁵⁶ Care home inspections are futile The Guardian, 1 May 2014 <http://bit.ly/2hGV59g>
The Care Quality Commission is not fit for purpose BMJ, 12 Dec 2014 <http://www.bmj.com/content/349/bmj.g7460>

⁵⁷ What's Wrong with CQC Centre for Welfare Reform <http://www.centreforwelfarereform.org/library/by-az/whats-wrong-with-cqc.html>

⁵⁸ Centre for Welfare Reform <http://www.centreforwelfarereform.org/about-us>

⁵⁹ Hilary Cottam: Social services are broken. How we can fix them: TED website <http://bit.ly/2hlcC0K>
Change Agents: The Older People's Participation Co-operative http://www.changeagents.coop/Change_AGEnts/Welcome.html

⁶⁰ ADVANCING CARE Research with care homes - Themed Review National Institute for Health Research July 2017
<http://www.dc.nihr.ac.uk/themed-reviews/advancing-care-themed-review.pdf>

⁶¹ Nurse researchers to try and identify 'optimal' staffing level for care home quality Nursing Times 2 August 2017
<https://www.nursingtimes.net/news/research-and-innovation/major-uk-study-to-focus-on-staffing-levels-in-care-homes/7020723.article>

1.7 A balanced solution

The intense focus on data collection in the USA has resulted in task-focused care directed to documenting and performing better on the 175 items measured and on the processes of care. Assessments of care are “*decoupled*” from care itself causing “*documentation or assessment of care to trump the provision of care*”. The caring relationships and the culture on which care depends are lost. An excessive focus on data collection (the regulatory trap) takes the focus away from more important parameters⁶².

But this does not mean that no data needs to be collected. Accurate data about actual care and quality of life anchors us to the real world and saves us from wandering into fantasy as seems to have happened in Australia.

Fine and Cardona writing in The Australian Ageing Agenda on 28 July 2017⁶³ argue that “*the market alone is not the solution to problems of quality*”. They indicate that “*there is also ample evidence that collecting and analysing clinical and social care data from aged care facility residents constitutes an essential step in the process of monitoring quality*”.

Social context and individualism: Professor Etzioni is an award winning US professor who has been called the “guru” of the communitarian movement”. This movement argues that a person's social identity and personality are largely molded by community relationships. There is a strong focus on community, civil society and social capital.

Etzioni argues that while public transparency (eg. in aged care in the USA) is useful there is little evidence of any more than minor benefits when it comes to enhancing choice because of other factors. It requires more than this and additional regulation is necessary. He indicates that “*Communitarianism has long established that informal social controls can be very powerful. People have a profound need for approval from others* - - - -”⁶⁴.

In our arguments when talking about identity we have used the term social selves linking it to social responsibility and responsible citizenship. We distinguish this from the other more individualistic selfish-self that is also a part of our identity, one that readily abandons social responsibility by escaping from the need for approval.

Selfish selves can be seen to characterise a small group of manipulative people classed as ‘*successful sociopaths*’ because they can be so plausible. They can rise to senior positions and become very problematic in vulnerable sectors because of their lack of empathy and any sense of social responsibility⁶⁵.

⁶² 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>

⁶³ **The market alone is not the solution to problems of quality** Australian Ageing Agenda 28 July 2017 <http://www.australianageingagenda.com.au/2017/07/28/market-alone-not-solution-problems-quality/>

⁶⁴ **Amitai Etzioni Is Transparency the Best Disinfectant?** The Journal of Political Philosophy doi: 10.1111/j.1467-9760.2010.00366.x <https://www2.gwu.edu/~ccps/etzioni/documents/295Transparency.pdf>
Communitarianism Wikipedia <https://en.wikipedia.org/wiki/Communitarianism>

⁶⁵ **Psychopathy in the workplace** Wikipedia https://en.wikipedia.org/wiki/Psychopathy_in_the_workplace

For example, an Australian dentist who ruthlessly exploited elderly residents in nursing homes for profit was so manipulative and persuasive that he was elected a Liberal Party councilor and a deputy mayor⁶⁶.

Aged Care Crisis approach: Like many in the UK we are pressing for an integrated and balanced holistic system set within a social discourse of care in the community. Here the different assessments and activities can be integrated and so balance one another. This cannot be achieved from the offices of multiple different regulatory organisations in Canberra.

It is the combination and integration of objective data collection, subjective experience, transparency, informal social controls and more formal regulation that we are arguing for – a situation where these different forms of control work with and support one another as both a regulatory and social support mechanism within the community.

They can be brought together and focused on individuals during everyday interaction. It is here that those providing care have a “profound need for approval”. Brought together and focused in this way they have the potential to provide a powerful holistic control and support system within civil society.

⁶⁶ **Dentist who preyed on nursing home residents could be back in two years** News.com 2 August 2017
<http://www.news.com.au/lifestyle/real-life/news-life/dentist-who-preyed-on-nursing-home-residents-could-be-back-in-two-years/news-story/65253007576d213609c560fe6f0a1550>

Part 3: an analysis of aged care regulation in Australia

1.8 Centrally controlled regulation

1.8.1 History of aged care and regulation

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

The only responsibility in the market was to make a profit for the investors and any interference with that impeded market performance⁶⁷. While claims are made to the contrary, this is the ethos on which discourse in our current marketplace is based. The problem with this is that unless restrained by a primary sense of social responsibility, the market readily comes to prey on society itself and particularly its more vulnerable members.

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

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

The abolition of the aged care probity regulations in Australia in 1997 was an affirmation that social responsibility was no longer a requirement.

This was done shortly after state hospital probity requirements had seen off several very unsavoury multinational health care companies. This sent a very clear message to the marketplace that aged care was no longer different. It was now a competitive free for all.

Any organisation with a track record for exploiting the vulnerability of trusting members of society can now buy Australian companies and appoint their own managers to follow their policies⁶⁸, provided the immediate management don't have a criminal history – yet!⁶⁹ The sector now depends almost entirely on the regulatory system to contain predatory tendencies.

⁶⁷ **The Social Responsibility of Business is to Increase its Profits** by Milton Friedman The New York Times Magazine, September 13, 1970. <http://www.colorado.edu/studentgroups/libertarians/issues/friedman-soc-resp-business.html>

⁶⁸ **Letter from Department of Health and Ageing** 20 Feb 2007 Corporate Medicine web site http://www.corpmedinfo.com/dca_obj2007.html

⁶⁹ **Officials 'asleep' on nursing care** - SMH - 13 Feb 2013: <http://bit.ly/2pYhh2B>

The battle to rebuild social responsibility in aged care in the 1980s: Private ownership of hospitals and nursing homes had grown in the 1960s and 1970s. In 1981 there was growing concern in the community about the ownership and operation of private hospitals and private nursing homes. These included allegations about the standards of care received in nursing homes. The reports *'painted a bleak and depressing picture of life in a nursing home and some articles raised serious allegations of ill treatment or lack of care. In addition, allegations that private nursing home proprietors were making excessive profits at the expense of patients had become common.'*⁷⁰

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

A champion of human rights and social responsibility, Senator Patricia Giles⁷¹, was chair of the Select Committee on Private Hospitals and Nursing Homes (1983–87). Trained as a nurse herself she understood the issues surrounding care.

Senator Giles was responsible for a 3-year review. It produced two reports⁷², which made significant recommendations on the ownership, administration and quality of care in nursing homes and private hospitals. These reports were critical of the failures in care in some private facilities. They felt that the only way to get the message to the Australian public was to publish the distressing photographs they were given and bring Australians *'face to face with the consequences of neglect of elderly and vulnerable individuals receiving insufficient nursing and insufficient care and suffering from poor management of nursing homes and poor nutrition'*.

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

Major reforms requiring much more accountability were introduced in the late 1980s and early 1990s

A method of calculating required staffing based on the acuity of residents was developed by Val Hardy and trialed by the Extended Care Society of Victoria. The community group Combined Pensioners and Superannuants Association (CPSA) were active in developing policy. Academic criminologist Prof John Braithwaite studied international regulation and developed a more effective regulatory system for Australia.

The market resists then triumphs: Corporate businessmen in aged care saw these regulations and the accountability as restricting their democratic rights in the marketplace. In the USA aged care had been reduced to a lucrative business like any other and Australian businessmen were envious. They claimed that these regulations impeded the successful operation of markets.

These businesses took government to court in the mid-1980s in order to overturn these restrictive regulations and lost their case. They were subsequently very active in supporting and funding the party that shared their views. This support was well rewarded when the Howard government gained power in 1996.

⁷⁰ Select Committee on Private Hospitals and Nursing Homes - Report (22 Feb 1985): <http://bit.ly/2rThtRd>

⁷¹ Giles, Patricia Jessie (1928–) Australian Senate Biographies <http://biography.senate.gov.au/giles-patricia-jessie/>

⁷² Select Committee On Private Hospitals And Nursing Homes 22 February 1985 Hansard p 61 <http://bit.ly/2qCFGL8>

In 1997, almost all accountability was abandoned and regulation was replaced by aged friendly accreditation. It was claimed that the new accreditation process would address any problems that the market did not fix itself.

The *Aged Care Act (1997)* setting up the new aged care system was written to serve the industry that had supported the party rather than citizens. Doug Moran⁷³, the largest corporate owner at the time, claimed to have written much of the legislation. Probity requirements were abolished.

Warnings ignored: There were many critics. The focus of Senator Brenda Gibbs⁷⁴ political activities was on the interests and needs of people with physical and mental disabilities as well as on unemployed people, the aged, the chronically ill, the physically and mentally impaired, and similar issues. The interests of these groups were being abandoned as the new political focus shifted to supporting the markets that in the early 1980s had exploited and harmed the groups about whom she was concerned. She warned of a return to those years.

On the 24 June 1997, Gibbs gave a telling and prophetic speech in parliament⁷⁵ in which she aptly referred to George Orwell's book '1984' as she described the way the words 'nursing care' had disappeared from the discourse about aged care. She spoke of '*managers with no nursing experience. No longer do nursing homes have to employ a qualified director of nursing who will ensure that professional standards are met*'. She referred to '*dramatically decreased guarantees of the level of care that residents will receive*' in a system where there would '*no longer be the checks and balances*'.

Gibbs asked '*who is going to ensure that the taxpayers' money that the government allocates to these nursing homes is properly spent on nursing care?*'. Even at that early stage the '*minister is going around claiming that accreditation will take care of everything*'. This is a claim that 20 years later is still repeatedly trotted out in the face of evidence that the system is failing. In the Bill there was '*a deliberate budget driven omission which fails to appreciate the health risk to residents in reducing or removing nurses.*'

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

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

In retrospect, Gibbs could have been describing aged care in 2017. Sadly Labor, while in the political wilderness after 1996, abandoned the principle of social responsibility to the vulnerable and when it regained power did nothing to address the issues. In the Productivity Review in 2010 and their subsequent Living Longer Living Better reforms in 2012/13 they embraced the free-market discourse and its solutions compounding the problems.

⁷³ **Matters of Public Importance - Nursing Homes** - House Hansard - 1 October 1997, Page 8926: <http://bit.ly/2qHgnq9>

⁷⁴ **Gibbs, Brenda (1947–)** Australian Senate Biographies <http://biography.senate.gov.au/gibbs-brenda/>

⁷⁵ Aged Care Bill 1997 Hansard Senator Gibbs 24 June 1997 page 5042 <http://bit.ly/2rfThau>

The last 20 years: Since 1997 there has been extensive rhetoric and impression management to create the perception that aged care has been improving. Luxury facilities have been built and impressive advertising brochures and websites developed. Most have accepted this claimed improvement uncritically. At the same time staffing has declined.

There have been ongoing and recurrent scandals and reports of poor care and elder abuse.⁷⁶ These have been brushed aside as rare exceptions. It is as if there are two different worlds.

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

In a system, where no reliable data about failures or actual standards of care is collected, we do not know if there has been any actual improvement in care or how badly it has deteriorated.

The growing unhappiness over the years has been attributed by industry to greater expectations by a more demanding population. That is likely to be wishful thinking.

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

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

1.8.2 The predatory market and regulation

The sort of regulation:

Free-market/neoliberal policy is based on the idea that regulation inhibits the markets capacity and its ability to innovate. To deliver its benefits it must be free of these restraints. Regulation should therefore be reduced.

An influential and charismatic US aged care empire builder, whose success in exploiting weakness in the system to grow his empire⁷⁷ was legendary until it collapsed in fraud scandals, was welcomed into Australia in 1997. He spread the message that "*government should butt out. If that happened, market forces would quickly resolve the problems in the industry*"⁷⁸.

⁷⁶ **Scandal after scandal** Inside Aged Care
<https://www.insideagedcare.com/aged-care-analysis/19-years-of-care/scandal-after-scandal>

⁷⁷ **Watch them grow, And grow** New Mexico Business Journal April 1996 Vol 20; No 4; pg15 http://www.corpmedinfo.com/chain_policy.html

⁷⁸ **Andy Turner wants the government out of health care, Period** New-Mexico Business Journal. April. 1996 April. 1996 Vol 20; No 4; pg 10
http://www.corpmedinfo.com/sun_the_fat.html

Prominent members of the aged care market still believe this and in their tweets suggest that Oakden illustrates it.

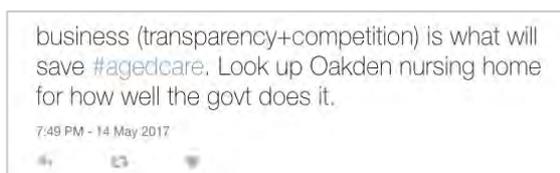


Figure 1: Twitter: <http://bit.ly/2rddWeK>

Despite this rhetoric, the predatory nature of the markets has forced increased regulation under a number of guises. Many analysts including Australian Criminologist John Braithwaite have considered this extensive regulation, rather than neoliberal theory, to be a defining feature of the era. They describe the last 40 years as the era of 'regulatory capitalism'⁷⁹.

One of the features of this regulation is the extensive input and control that industry has had into the design and implementation of the regulatory processes. Any regulation has needed the approval of industry stakeholders.

It has been designed within the thinking of the free-market/neoliberal discourse and many of those involved in formulating regulation would have been concerned about any consequences for them.

It has been centralised and controlled by government and industry. It has been industry friendly and sought to work with industry rather than monitor and confront. It has protected and not challenged the discourse.

The other feature of this system of regulation is the frequency with which it has failed to protect vulnerable sectors of the marketplace and the participants whether these are the customers, vulnerable employees or weaknesses in the funding system. Fraud and exploitation of vulnerable citizens is widespread⁸⁰. Aged care is only one example.

1.8.3 Structural issues

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

In Australia too:

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

Doug Moran may not have written the 1997 aged care regulations as he claimed, but there is no doubt that the market had a major input into and would have been heavily involved in the drafting of the regulations⁸¹.

Community bodies and social service organisations that criticised either lost their funding, or were so concerned they might lose it, that criticism was muted.

⁷⁹ **Neoliberalism Or Regulatory Capitalism** John Braithwaite - Occasional Paper 5 Regnet Occasional Papers October 2005 http://www.anu.edu.au/fellows/jbraithwaite/_documents/Articles/Neoliberalism_Regulatory_2005.pdf

⁸⁰ **Failed markets and culturoopathy** Inside Aged Care <http://bit.ly/2ryheHr>
Contracting government services to the market Inside Aged Care <http://bit.ly/2byL9ld>

⁸¹ **Matters of public importance - Nursing Homes** - House Hansard - 1 Oct 1997: <http://bit.ly/2qHgnq9>

Smaller and less representative community groups that embraced and supported providers and government reforms⁸² have been prominently promoted and well-funded by government grants, projects, tenders and representation on various committees. They are prominent when making policy announcements so creating the impression that the bulk of seniors are supporting the changes.

Revolving doors: Since 1997, government has appointed and been advised by a multitude of businessmen, accounting firms and economists. After the community aged care backlash in Australia in 1998, alternate views were marginalised and ‘credible’ discussion was contained within selected groups of like thinkers.

Policy has been driven by those the government thought they could trust because of their shared views. Alternate views have been left out in the cold. Society as an effective democratic force was undermined. Knowledge and capacity within the community was lost.

Braithwaite, who studied regulation in the USA, UK and Australia applied the term ‘*revolving door*’ to Australia. In their book he and coauthors state (page 176) that “*The post-1997 Australian regime is more captured by the industry than the English and US regimes. Things have to be bad for non-compliance to be recorded or strong criticisms to be made in an accreditation report.*”

They went on to show that in Australia all of the arms of the fragmented regulatory system have been captured by believers in markets and the neoliberal approach to social services.

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

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

1.9 Failures in aged care and regulation globally

It is interesting that, even though they have different systems of regulation for aged care, in all three countries (USA, UK and Australia), centrally controlled models of regulation have repeatedly and consistently failed citizens in this sector.

In these countries the free-market/neoliberal approach has changed the context of care from one of interaction and discourse to one of ‘payer and buyer’ or ‘salesman and customer’ and reliance on humanitarian motivation has been replaced by reliance on competition. These new paradigms are not directly applicable to aged care or to most human services.

⁸² Community Affairs Legislation Committee - 02/05/2013: <http://bit.ly/2qV2Ubx>
COTA finds itself representing providers (CPSA) 27 June 2013: <http://bit.ly/2r1op9N>

Despite the collection of vast amounts of data in the USA, there have been recurrent and ongoing problems in aged care and its regulation since the early 1980s at least. In the UK, the Care Quality Commission (CQC) has been repeatedly criticised and although it collects and reports on far more data than in Australia, it is no longer considered fit for purpose⁸³.

Criticism of aged care in Australia has not been as strong as in these countries and this may be because government and industry don't collect needed information. They control what is collected and how it is interpreted, and have made it far less transparent.

The absence of data about care has made it easier for believers in this system to attack and discredit their critics and to paper over failures when they occur. There is now a growing ground swell from community members on websites, blogs, social media and petition sites. The extensive unhappiness about the aged care system can no longer be ignored.

There have been extensive failures in other vulnerable sectors (eg: banking, vocational training sector, employment programs and the Catholic Church) and in other regulators (eg ASIC, which also has a reputation for working with the market rather than regulating it).

All this suggests that we should look at structural factors in policy and in the entire centralised regulatory system. We should start by understanding what is happening.

1.10 Regulatory Capture

Globally: Elsewhere⁸⁴ one of us has examined the way the free-market neoliberal 'discourse' (patterns of thought) spread into health and aged care in the USA and the adverse consequences of this. Many were exploited and suffered.

This discourse had captured the regulatory system, which was singularly ineffective and failed to detect what was happening. The spread of this discourse to Australia is described.

Australia: In a section "*The Politics of Capture*" on page 187 of his 2007 book, *Regulating Aged Care*⁸⁵, Braithwaite and his co-authors described the way in which regulation, and specifically accreditation, has been captured by the political and market discourse so that it has come to serve them rather than citizens.

Braithwaite et al indicated that the Department of Health in its annual report uses "percentage compliance as a performance indicator that must be seen to improve each year, driving compliance to ridiculously, artificially high levels over the years" (page 193). That means that as a regulator its performance is improved by its not acting when failures occur!

⁸³ **What's Wrong with CQC?** John Burton The Centre for Welfare Reform Jan 2017: <http://bit.ly/2qMSjC3>

⁸⁴ **Re-interpretation using Foucault** - Health and Aged Care - Inside Aged Care - May 2017 <http://bit.ly/2qeluuX>

⁸⁵ **Regulating Aged Care** by J. Braithwaite; T. Makkai; V. Braithwaite e.Books.com: <http://bit.ly/2rnUgU8>

The agency itself might argue that they are an accreditor and not a regulator but this is the department itself, the main regulator responsible for sanctions making this comment – an example of its thinking and the pressures put on the accreditation agency and its staff to meet this goal. The authors indicated “*Senior officers of the department argued to us quite unselfconsciously that ‘98 per cent of homes are fully compliant, up from 92 per cent in 2004’.*”

Braithwaite’s research team felt that “*This performance pressure helped make sense of our observation of indefensible ratings of compliance during our fieldwork*”. This is a graphic illustration of the way in which the free-market/neoliberal discourse impacts on regulation and renders it ineffective.

They quoted from comments by accreditation staff to show how accreditation had been dumbed down and their efforts to be effective frustrated by their superiors.

They noted “*finding non-compliance would be changed by their supervisors without the reason being explained*” and “*cynicism was nurtured about the wisdom of forthrightly writing non-compliance*”.

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

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

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

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

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

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

Source: Senator McLucas - Hansard - Environment And Heritage Legislation, 9 August 2001, Page 25978 <http://bit.ly/2fsOWwD>

Senator Chris Evans had raised the same issues in parliament⁸⁶ and also expressed “serious concerns about the seemingly favourable treatment of Millie Phillips’s nursing homes, Yagoona and the Ritz. We have agency staff allegedly saying to staff at nursing homes, ‘There’s no chance of you being shut down because we know Mrs Phillips has political connections.’ Mrs Phillips, alleged to be a friend of the minister, was a controversial owner of nursing homes and retirement villages⁸⁷.”

The *Sydney Morning Herald*⁸⁸ reported concern at a decision by the “Aged Care Standards and Accreditation Agency to overturn a decision by its assessors that the Yagoona home’s accreditation should be revoked for failing to meet care standards”. They also reported that “The Australian Nursing Homes and Extended Care Association, which represents private homes, said there was a “deep-seated perception within the [sector] that the [agency] is not an independent statutory body free from political and bureaucratic interference”. It had become “part of the compliance processes of the Department of Health and Aged Care rather than a free and independent quality improvement body”.

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

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

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

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

It has become increasingly clear that the success of the regulatory process has been the bulwark that supports and protects the free-market/neoliberal discourse and makes it legitimate. It is used to market the government’s policies globally and to counter criticism locally.

Without it the neoliberal agenda is exposed for the failure it has become in aged care. It has to be put into safe hands, hands that will protect policy and belief from embarrassing disclosures.

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

⁸⁶ [Senate Hansard - Answers to questions without notice - Aged Care Standards and Accreditation Agency: Appointments](http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=ld%3A%22chamber%2Fhansards%2F2001-06-26%2F0032%22)
<http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=ld%3A%22chamber%2Fhansards%2F2001-06-26%2F0032%22>

⁸⁷ [Milstern Health Care: Corporate Medicine web site 2006-10](http://www.corpmedinfo.com/nh_milstern.html) http://www.corpmedinfo.com/nh_milstern.html

⁸⁸ [Bishop Feels The Heat Over Nursing Homes. Sydney Morning Herald - 22 June 2001](#)



Example of ignorance:

Patrick Reid⁸⁹ who succeeded Nick Ryan as CEO of LASA and who was on the Ministerial Advisory Council on Ageing, on the Aged Care Sector Committee and Chairman, Aged Care Workforce Advisory Group, moved in 2016 to become Director - Aged Care, Community & Disability at StewartBrown, the large financial group collecting data, advising and lobbying for the industry.

In July 2016, on one of their reports, StewartBrown produced a graph of the average *Total Staff Hours* in facilities they surveyed and labelled it "Direct Care". Reid put this out on social media to counter widespread unhappiness about the direct care staffing in Australian nursing homes⁹⁰. It was sent to members of the senate who were running the Inquiry into the Aged Care Workforce.

Heather Witham, a senior executive with ACSA, used the same figures publicly to challenge criticism of the level of direct care by National Seniors⁹¹.

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

Incredibly, a CEO of LASA, who was advising government on workplace issues, as well as senior management at ACSA, did not know what direct care was. Heather Witham was previously a political adviser to Senator McLucas, a shadow minister for aged care.

The CEO of ACSA in 2016 had recently been an adviser to the Minister for Aged Care. There is a revolving door.

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

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

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

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

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

Is our industry being judged by its headlines? Have your say and share your view at #LASAevents RK Principal Victor Harcourt presenting on Innovative Fee Arrangements at the 2017 LASA VIC Conference today

Twitter posts - Learning about Innovative Fee Arrangements from @HarcourtLaw Vic Conference

The focus of industry is primarily on refuting any allegations and seldom on addressing them.

⁸⁹ Patrick Reid LinkedIn <https://au.linkedin.com/in/patrickwreid>

⁹⁰ Future of Australia's aged care sector workforce - Supplementary submission to Senate Workforce Inquiry 28 Nov 2016 Aged Care Crisis <http://bit.ly/2rEeSqM>

⁹¹ Peaks raise aged care staffing levels and skill mix with Senate inquiry Australian Ageing Agenda 9 Nov 2016: <http://bit.ly/2rpl05G>

1.11 Conflicted regulation

1.11.1 A policy of less regulation that depends on more regulation

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

At the same time the extent and quality of the regulatory process is a core justification for the policies of government and the practices of the market – the rock on which its legitimacy is based.

The regulatory process is used for marketing the system and is the first line of defense when failures in care are publicly criticised.

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

The response: The defensive response has been to deny failures or else forcefully claim that failures are isolated examples in a 'world class' system as revealed by successful performance in a vigorous and effective accreditation system.

That they are clear red flags to systemic problems in the system and that the regulatory system is deeply flawed are excluded from the discourse and from public rhetoric. Those who claim the system is failing are discredited.

1.11.2 Defending failures in care

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

Our industry bodies including ACSA, the body representing not-for-profits, have responded to criticism by pointing to our robust regulation⁹². ACSA has been particularly active in this and has attacked academics whose research has led them to identify serious deficiencies in the care being provided⁹³.

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

⁹² How Aged Care is perceived - Inside Aged Care: <http://bit.ly/2kiybTr>

⁹³ Is this culturopathy? Inside Aged Care - Nov 2016 - <http://bit.ly/2qe7eT2>



Recent example: Oakden, the Quality Agency and Industry

There has been extensive press coverage and strong public criticism of the failures of the accreditation process as regulator over more than 10 years at Oakden and again recently at Bundaberg, Newcastle and Martindale Nursing Home in South Australia. The latter home has been sanctioned,⁹⁴ passing only 14 of 44 standards⁹⁵ only 3 months after passing all standards⁹⁶.

Once again, it was not the regulators, but a community visitor whose complaint about Oakden resulted in an independent outside report that exposed what had been happening at the regularly accredited Oakden. Incredibly, the ink had barely dried on all this when ACSA, trotted out the neoliberal's article of faith by claiming that:

*"Aged care is a highly regulated industry and subject to rigorous accreditation standards by the Australian Aged Care Quality Agency (AACQA). This includes both regular scheduled site visits and unscheduled "spot-checks" to ensure that providers are meeting high standards"*⁹⁷.

On ABC 7.30 Report on 29 May 2017, when under pressure about the many failures, Sean Rooney, the current CEO of LASA defended this with *"the accreditation system is quite robust"*⁹⁸.

Truly, madly, deeply: It's like one of those old cracked vinyl records repeating their claims over and over again. The industry has been responding to criticism in this way for the last 19 years – a tried and trusted formula. They truly believe it – deeply and without doubt.

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

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

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

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

⁹⁴ Gawler Grande Views - My Aged Care <http://bit.ly/2wG0aRK>

⁹⁵ AACQA - Martindale Nursing Home - Audited 18 May 2017 (14/44): <http://bit.ly/2wzEZli>

⁹⁶ AACQA - Martindale Nursing Home - Audited 8 Feb 2017 (44/44): <http://bit.ly/2utBiQS>

⁹⁷ Statement regarding Oakden Older Persons Mental Health Service - ACSA media release - 21 Apr 2017 - <http://bit.ly/2rxJuNA>

⁹⁸ Daughter says mum died in nursing home due to lack of staff, former nurses say care standards not improving ABC News 29 May 2017 <http://www.abc.net.au/news/2017-05-29/preventable-nursing-home-deaths-skyrocket-care-standards-falling/8570096>

Australian Trade and Investment Commission (Austrade)

The Australian Government's Austrade website⁹⁹ proudly boasts of our aged care systems 'Industrial Strengths' claiming "The aged care system in Australia is one of the most thoroughly regulated in the world and is used as a model by many other countries".

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

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

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

1.12 A deep internal conflict for regulators

There is a less easily recognised and much deeper ontological conflict (at the heart of being and identity)¹⁰⁰. This is best illustrated by the accreditation system but is generally applicable.

The majority of those who manage the accreditation system are seen by the establishment and by much of society to be credible. They are appointed because they are believers in and support the discourse that underpins the free-market/neoliberal patterns of thought. They believe in what they are doing. Those who are critical are not seen as credible and are not appointed. Critics are marginalised and discredited.

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

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

The outcome: There is an intrinsic conflict that is not confronted.

On the one hand, those involved assert and believe that they are regulating in the interests of the residents. On the other, they have an unstated prior more important responsibility to their belief as expressed in the discourse, to maintaining the system and to government.

⁹⁹ Australian Trade and Investment Commission - Austrade - Aged Care: (accessed 25 May 2017) <https://www.austrade.gov.au/aged-care/>

¹⁰⁰ Re-interpretation using Foucault - Health and Aged Care - Inside Aged Care - May 2017 <http://bit.ly/2qeluuX>

Everyone's gut response is to stand behind what you believe. This is not an uncommon situation. Philosophers have confronted it. Social scientists have studied the strategies we use that enable us to cope with situations like this – the strategies we use that allow us to do what we must, while believing that we are doing what we should¹⁰¹.

The consequences for regulation and aged care in Australia

As a consequence of these pressures the entire regulatory system is deeply conflicted in meeting its public duty to maintain standards because its unstated primary responsibility is to support the government and the market system, as well as maintain the illusion that we have a world class system. To do so it must avoid adverse publicity and criticism which puts policy at risk.

The upshot of these conflicts is that participants believe in what they publicly claim they are doing. In practice this is challenged and undermined by the strong pressure to defend their ideological positions and not damage government and the market. To believe, they must go through the motions of regulation but without actually doing so. This is accomplished by ritualised processes and using processes and words as tokens for what should be there.

1.12.1 Ritualism and tokenism

Two strategies are commonly used to maintain legitimacy, neutralise alternate discourses and manage conflicting situations by ignoring the consequences of what we are required to do but don't want to know about. These are ritualism and tokenism.

Regulatory processes are created that claim to be effective. Instead the process becomes a substitute or token for what it is intended to accomplish. We get form where there should be substance.



Example: Dr Maree Bernoth, an academic who has worked in and studied the sector described this particularly well on ABC radio national in 2014¹⁰². She commented that

“I have witnessed a great disparity between what they say they do and what they actually do and that's not being picked up by the accreditors. The facilities can put on a face that is different to what is actually happening”.

This is a description of ritualism where words become tokens for something that is not there and this is accepted by accreditors who become part of this ritualised process.

When problems are identified, the response Bernoth describes is equally tokenistic:

“What can often happen is yes, they've changed their procedures, but no one knows about it, there's no education being provided, there's nothing to inform the care staff that there has been a change, and there's no one to follow up that the care staff are implementing the change”.

Bernoth described this tokenism extending to the complaints system as well:

“There's this bureaucratic speak where families who complain to them get this letter back that's full of bureaucratic language that doesn't show any appreciation for the stress and distress that the families have gone through. It pays token recognition to the complaint and it talks about things like; they've looked into the complaint and the facility has changed their policies or changed their procedures”.

¹⁰¹ **Culturopathy: A for-profit example** Inside Aged Care <http://bit.ly/2hPFWT2>

¹⁰² **Death in a five star nursing home** Transcript ABC Background Briefing audio programme 21 Sep 2014 <http://www.abc.net.au/radionational/programs/backgroundbriefing/2014-09-21/5753372>

Managed processes become a surrogate for our humanity.

Braithwaite and his coauthors identified ritualism as a major problem in aged care regulation. Their 2007 book 'Regulating Aged Care' was subtitled 'Ritualism and the New Pyramid' – the pyramid was his proposal for addressing these problems.

Our issue with Braithwaite's proposal is that it focuses on regulation rather than the problems that require so much regulation and should be fixed first. We argue that if the problems in aged care were addressed by changing the discourse then regulation would rest lightly, be less onerous and less would be needed. Both need attention but the system should be fixed first and regulation should be a part of and support that.

We can understand why regulation in aged care so readily becomes ritualised (ie. process driven without addressing the issues) and tokenised (words and the presence of processes substitute for what should be there).

These strategies allow the people involved to believe they are regulating effectively, but without doing so. The consequence is an oversight process that is easily gamed and this is glossed over.

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

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

1.12.2 The extent of this problem in Australia

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

Very worrying is the high success rate in accreditation when contrasted with the situation described by nurses and families.

That the nurses' concerns are well justified is confirmed by the recent release of staffing levels. These show that large numbers of Australian facilities are so poorly staffed that it is not possible for them to provide good care by international standards.

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

Example 1

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

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

Quality Agency support: The agency reports crude accreditation figures showing that for profit and not-for-profit owned facilities performed equally well. But even a cursory glance at the figures shows that when geographical distribution is factored in, the for-profit owned facilities must be failing much more frequently¹⁰³. Our analysis in 2008 revealed that when facilities in the same locations were compared for-profit owned facilities were failing between 2 to 4 times more often than non-profit.

Even after a UTS study (Baldwin et al) revealed that for-profit owned facilities were more than twice as likely to be sanctioned, the Agency responded by reporting that there was no difference in accreditation. When challenged on their analysis via phone, email and online¹⁰⁴, they refused to respond.

Example 2

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

Agency support: The Quality Agency and it's predecessor (Accreditation Agency) have consistently exaggerated the success of the sector by reporting their data as the number of failures not yet corrected on a single day each year. When failures were analysed over a 12-month period, we found that the actual number of failures over that year was roughly four times the figure given by the Agency. This was not a lie because of the small print - but the strategy used in reporting was deceptive and deliberately so¹⁰⁵.

1.13 Government response to problems in regulation

As indicated, 'credible' people from the sector have been put in control. But when faced by mounting evidence that the system is not working, even they begin to have their doubts and government itself then steps in to put regulation into even safer hands¹⁰⁶ – one's that won't rock the boat for them.

In the USA: The major regulator in the USA even in health care is not accreditation. The main regulator for health and aged care is the 'Center for Medicare and Medicaid Services' (CMMS). The CMMS contracts most of the regulation to the states or to private organisations but it collates the data that is collected¹⁰⁷. It levies fines and penalties¹⁰⁸.

¹⁰³ Aged care report card Aged Care Crisis 2008 <http://www.agedcarecrisis.com/news/research/108-aged-care-report-card>

¹⁰⁴ Quality Agency rejects ownership factor on accreditation - AAA 15 Mar 2015 (Comments): <http://bit.ly/2r4XG0E>

¹⁰⁵ When 46 failed homes really means 199: <https://www.agedcarecrisis.com/news/research/108-aged-care-report-card>

¹⁰⁶ See section 'Regulation is to protect the neoliberal state' in **Re-interpretation using Foucault** : Health and Aged Care Inside Aged Care May 2017 - <http://bit.ly/2qeluuX>

¹⁰⁷ Nursing Home Compare datasets: <https://data.medicare.gov/data/nursing-home-compare>

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

Government and market were threatened. In the early 2000s President George Bush put Thomas Scully, the head of the Federation of Health Care Systems in charge of the Center for Medicare and Medicaid Services. The federation is the powerful body that represents the large corporate health care chains that were rorting the system. It lobbies for them – truly the fox in charge of the hen house.

This was clearly not to protect the vulnerable but to harness the public relations skill of the industry to protect it and government.

We are left wondering if it was the president of the USA or the industry that initiated this appointment. How much of a hold did industry have over government? The appointment did not stop failures or criticism of the regulator.

In Australia: As Braithwaite showed the accreditation process has been under pressure since the late 1990's with intense criticism on multiple occasions. It has doubted its role and capacity to regulate but was forced into doing so by the bureaucracy.

Braithwaite quotes the chief executive of the agency as saying: *"We are not a regulator. The department is a regulator. We're an accreditor. We're about promoting quality of care."* The Auditor-General Audit Report No.42 2002-03 Performance Audit noted that even industry representatives *"have expressed concern over the Agency's dual roles as accreditor and educator"*.

The agency made a submission to the Productivity Commission in 2010. It indicated that its regulatory and accreditation roles were conflicted and incompatible. It asked to be relieved of its regulatory role – a request that the Commissioners did not accede to¹⁰⁹. We do not know what happened in regard to this unrest in the agency itself over the next 2 to 3 years.

In 2014 the pretense to an independent Accreditation Agency was abandoned. The Agency was transferred to a government department and the word 'Quality' added to its name.

Nick Ryan, the CEO of LASA, the industry body representing the for-profits (including the market listed and private equity owned facilities), was put in charge as CEO. The CEO now regulates and reports on the groups that, in his previous role, he was supporting and acting for. They may be sanctioned.

The Quality Agency is a major component of the regulatory process and one that the public depends on. Putting it under the control of someone who comes directly from the organisation representing the industry is truly the fox guarding the henhouse.

Note: Ryan replaced Mark Brandon (2002 - 2013) as CEO of the agency. Brandon's good relations with industry were confirmed when he became Chief Quality Officer for private

¹⁰⁸ Data.Medicare.gov: Penalties: <https://data.medicare.gov/Nursing-Home-Compare/Penalties/g6vv-u9sr>

¹⁰⁹ Care and management of younger and older Australians, Community Affairs References Committee (Hansard 14 Feb 2014); <http://bit.ly/1iyT2OH>

equity owned Estia Health. His knowledge about the accreditation process must have been useful. Would any one dare find a facility mentored by their previous boss wanting?

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

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

1.14 Effective regulation - broad issues in vulnerable sectors

The absence of effective social control:

The most effective form of regulation is undoubtedly the regulation that addresses dysfunctional thinking long before any harm is done. That regulation is the control that citizens exert over one another in everyday discourse.

They point out problems when suggestions are made, challenge policies that are flawed, and stigmatise those whose conduct becomes questionable. But this control can only be exerted when the people concerned are in regular communication and the differences in knowledge and power do not allow the discourse to be constrained and its content limited.

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

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

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

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

Reducing effective dialogue: A hierarchical management structure has spread across much of society. This has seen (particularly in aged care) one sector (or silo) of society dominate. Those most directly involved in care (the nurses and the families) are marginalised and discounted when they complain.

Information about policy and processes comes down from the top without anything unwelcome or critical going back up. There is a one-way discourse that is not challenged.

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

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

1.15 Accreditation

Oakden glaringly exposed how flawed our accreditation system is and how unsuited accreditation is as a regulatory process. It has been heavily criticised for years and the government is now planning to bring in a new truncated accreditation process for all aged care services under the guise of the Single Aged Care Quality Framework¹¹⁰. We do not see this as an improvement. We set out our concerns and made some suggestions in our submission to the consultation process¹¹¹. The accreditation system has gone from bad to worse.

1.15.1 Background

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

1.15.2 Australian accreditation within a global context

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

It has been appropriated by the marketing process and given roles that it was never designed to fulfil.

It has been used as a measure of standards of care, which it does not measure, and as a marketing tool for providers. This is deceptive because it is not a good measure of care, but simply a certification of the knowledge needed to provide good care.

¹¹⁰ Single Aged Care Quality Framework: <https://www.agedcarecrisis.com/news/384-single-aged-care-quality-framework-consultations>

¹¹¹ Single Aged Care Quality Framework - submission - Aged Care Crisis (21 Apr 2017): <http://bit.ly/2rOTlpV>

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

Example 1 - Marketing:

Example

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

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

Example

Example 2 - Measure of standards:

The Joint Commission for the Accreditation of Health Care Organisations (JCAHO) is the principle accreditation body for hospitals in the USA. All of these psychiatric hospitals were also accredited by the JCAHO.

What was happening at that time was glaringly obvious in readily available company documents yet the JCAHO failed to detect the administration of vast amounts of unnecessary and sometimes harmful treatment as well as this glaringly obvious fraud. On some occasions it even gave the names of those who had given them information to the provider, who was then able to victimise the complainant.

Like Australia's Quality Agency, it has been heavily criticised because of the number of industry representatives on its board and has over the years been used as a marketing tool by the big hospital groups.

Accreditation of aged care in Australia is not only extensively used as the only measure of standards, but also as a marketing tool by industry and government. It is used to counter criticism and discredit those who identify problems. It has been critical to maintaining the legitimacy of both government and market in the sector.

The need to protect the reputation of the aged care system has added an additional dimension. This has become increasingly important as Australia has entered into trade agreement and started selling aged care services across Asia. It is vital for the marketing of our aged care system in Asia.

1.15.3 Capturing accreditation

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

In this regard when referring to the accreditation process Braithwaite et al describes the consequences. “A number of informants mentioned a tendency not to put in the formal report information that was highly critical of the home” (page 178). Then later “The agency almost universally today manages to deal with problems of poor quality care while keeping them out of the media” (page 194).

1.15.4 Accreditation as regulator

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

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

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

This is a particular problem in Australia. The word ‘Quality Agency’ is illustrative of the problem – as Oakden and other failures reveal.

The Agency’s recent public consultation about ‘Quality’ was a good example of how this word is used as a token in glossy brochures when government or businesses market idealised hype rather than practical policy or good care.

What they did was come up with a plan to reduce accreditation from 44 standards to 8.

Others were wiser than Australia: In the 1980s President Ronald Reagan’s plans to use accreditation as the only regulator for aged care in the USA created a backlash and was blocked by the congress.

Australia is the only country that has used accreditation as the only regulator and it did so in the full knowledge of its failure to detect the problems in the psychiatric scandals.

The prime offender in that scandal entered Australia in 1991, at the same time as the scandal in the USA were exposed. It was the subject of a series of probity reviews and extensive publicity before it was forced to leave Australia in 1995/6. Politicians of both parties were sent documents and were fully informed. Information that raised issues about policy was unwelcome so ignored.

1.15.5 Accreditation and staffing

Staffing data: Australia was at the forefront of academic research in regulation (John Braithwaite¹¹²) in the 1990s and also in determining staffing levels – way ahead of the USA.

¹¹² **Regulating Aged Care** by J. Braithwaite; T. Makka; V. Braithwaite e.Books.com: <http://bit.ly/2rnUgU8>

As long ago as 1983/5, the Extended Care Society of Victoria produced a report¹¹³ built around work done by Val Hardy in Bendigo where they had developed a 'patient-nurse dependency' system designed to calculate the nursing time needed. The study addressed the problem of understaffing that left no time for interaction and relationships. This undermined both the motivation of staff and the quality of life of residents. There was a need for a model for calculating the amount of care needed.

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

They carefully evaluated the acuity – the amount of care needed by residents – on a scale of 1 to 5 and the amount of nursing time needed for each level of acuity. Using their system, any facility could assess the acuity of its residents and calculate the staffing requirements. This system was never adopted by the industry.

It was not until about 2000, 15 years later, that extensive studies in the USA during the late 1990s produced anything similar¹¹⁴. In Australia it took another 16 years before researchers in South Australia carried out a study for the nurses¹¹⁵. The latter two included assessments of the skill levels needed.

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

Even in 2003 the industry were collecting data about staffing which showed the reduction in staffing that occurred after the 1997 changes. Talking about quality of life, an industry representative¹¹⁶ told a parliamentary committee that *"Their (Bentleys) survey shows that the amount of time per resident per day has declined consistently over the last five years. So the amount of time that staff can spend talking to residents has been reduced"*.

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

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

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

¹¹³ **Patient care analysis** / presented by Extended Care Society of Victoria in conjunction with Bendigo Home and Hospital for the Aged
<http://trove.nla.gov.au/work/13159053>

¹¹⁴ **Future of Australia's aged care sector workforce - Supplementary submission** to Senate Workforce Inquiry 28 Nov 2016
Aged Care Crisis https://www.agedcarecrisis.com/images/pdf/sub302ss2_ACC.pdf

¹¹⁵ National Aged Care Staffing and Skills Mix Project Report 2016 - ANMF & Flinders and Adelaide universities

¹¹⁶ Review of Auditor-General's reports, fourth quarter 2002-03 - Joint Committee Of Public Accounts And Audit 18/08/2003
[http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;adv=yes;orderBy=customrank;page=0;query="mr bushrod";rec=1;resCount=Default](http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;adv=yes;orderBy=customrank;page=0;query=)

Extreme example - DIY staffing:

In 2012 there were astonishing revelations that no staff at all were rostered to look after residents in a Queensland nursing home for considerable lengths of time¹¹⁷. They were left to look after themselves. Aged Care Crisis used the revelation to ask the Minister, if he wasn't prepared to set safe or minimum staffing ratios and skills in aged care, to at least mandate transparency about how homes were staffed. This would allow family members to make informed decisions about aged care placement for their loved ones.

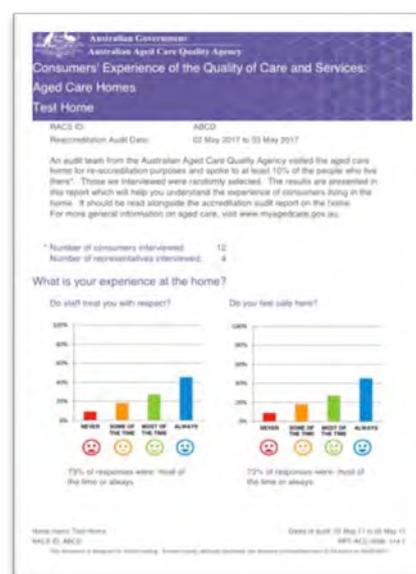
Staffing information remained opaque and the facility was not sanctioned.

1.15.6 Accreditation and the 'consumer experience'

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

We might see quality of life as the target of the market sector because that is where additional services beyond supporting wellness are provided.

Clinical care and quality of life are closely integrated. Quality of life must be set into the context of clinical needs, which should not depend on the vagaries of the market.



A rebellion against the 'medical model' of the past has failed to recognise that medical issues remain critical for wellbeing and so quality of life.

Because the number of failures in clinical care are not recorded and reported, there is no reliable means of assessing the adequacy of medical care and so "ensuring proper clinical and medical care standards are maintained and practised".

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

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

¹¹⁷ No staff for 10.5 hours per day (19 Dec 2012): <https://www.agedcarecrisis.com/opinion/articles/213-no-staff-for-10-5-hours-per-day>

Consumer feedback: The Agency's recent introduction of a proforma 'consumer experience report'¹¹⁸ imposes a strict formulaic style of feedback questions. The proforma used¹¹⁹ limits feedback to what the Agency wants, not what residents need. Surveys of this type have been undertaken by providers and others in the past and they fail to disclose what is clearly happening and causing so much unease.

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

A market based approach: The focus on users experience is very important, but when used alone is a simplistic administrator/managerial/marketplace approach to problems and reflects the continued denial of the importance of clinical skills and palliative care in this setting.

This approach is based on the illusion that ageing is normal and that people do not die from the same sort of organ failure that kills younger people and needs the same sort of support and care. Knowledgeable clinicians who have complained about this have been ignored.

Real support needed: Family members looking to place a loved one in care need local and personal advice from someone they can trust who has direct knowledge of the facility and can work with prospective residents by explaining both the clinical resources and performance they need as well as the opportunities for quality of life. They both need verifiable information including a transparent and standardised set of real-world measures of performance.

Those measures should include information on pressure injuries, infection rates, staffing levels, restraint levels, complaints made to the service and what the provider did to remedy the problems in addition to feedback from existing consumers.

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

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

Potential bias: The 'consumer experience reports' are devised from a small sample of people interviewed - approximately 10%. As is apparent from recent failures, many family members and staff are reluctant to speak out about failures in care as they are fearful of retribution. This 10% would be readily identified and it would be easier to recognise who had had the insight to be critical. There is a massive power imbalance¹²⁰.

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

¹¹⁸ Consumer Experience Reports: <https://www.aacqa.gov.au/publications/consumer-experience-reports>

¹¹⁹ Likert scale: <https://www.surveymonkey.com/mp/likert-scale/>

¹²⁰ Elderly in nursing homes tell of suffering in silence: <http://www.couriermail.com.au/news/elderly-tell-of-suffering-in-silence/news-story/81175ec1f133931e7c79ed93a9c691e0>

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

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

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

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

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

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

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

1.16 Inadequacies of the accreditation process in Australia

1. There is a **paradigm conflict** between accreditation and regulation with consequences for the way the service is provided.
2. **The measurement of process rather than outcomes.** We simply do not know whether the processes work, whether they are followed and how often they fail.
3. **The measurement itself is farcical.** It lacks sensitivity and scale. A measure in which over nearly 98% of those evaluated obtain full marks (97.8% or 100%) is meaningless. Having every result at one end of a Bell's curve is a test that does not discriminate.
4. **Lack of transparency:** Not only are the accreditation reports largely meaningless to the public and researchers, but until quite recently they spent only a very short period on the website before being replaced.
5. **There is no analyses of trends** for individual homes, company performance, ownership type performance, sector performance, or the multiple variables that apply. The department needs this information to advise government. It is essential for those undertaking research. The public needs it, so that it can debate rationally and effectively.
6. **Unannounced visits** which occur once a year show only what is happening on one day and not the other 364. Anecdotal stories suggest that few visits are unexpected. It is not possible to monitor and measure failures in care by occasional visits. These findings are not made public. An onsite regular presence is required and everyone should be looking at the data.
7. **The vast number of reports that appear on the agency website** are from formal planned visits. These are prepared for and are easily gamed. They do not as claimed, represent what normally happens. They are not standards.

8. **Ritualisation and Tokenism:** Any bureaucratised process, but particularly one where there are paradigm conflicts is at risk of “ritualisation”. The focus shifts to ticking the boxes and not on improving care. Processes become tokens for actual care.
9. **The foxes guarding the hen house.** The impact that having representatives of the sector on the board and in powerful positions in the agency – and the use of past, current or possibly prospective nursing home staff as assessors.
10. **Assessors can feel threatened:** No sensible assessor from one owner's nursing homes is going to produce negative findings on the homes of another large corporate provider whose executives are mates of their employer. Whistleblower's stories are a warning.
11. **Past assessors** have a number of lucrative employment opportunities because of their new skills. An assessor might be wary of compromising their future prospects. These problems arise because of the conflicting roles of the agency.

1.17 The Complaints system

We have concentrated on the accreditation system because the problems are currently so glaringly apparent. The complaints system¹²¹ has suffered from many of the same problems over the years and has been revised many times without addressing the core problems.

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

In their 2007 book Braithwaite et al said “*Australian complaints mostly do not trigger visits to nursing homes and are universally steered to dispute resolution strategies, excluding enforcement and sanctions. A 2005 Senate inquiry concluded the complaints process was user-unfriendly and unresponsive, with the Aged Care Lobby Group, for example, arguing that family members have given up on complaining because ‘their complaints are trivialised’*” (page 185).

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

Families feel powerless and fear that their family member in the facility will be victimised if they complain. Many become dispirited and give up.

¹²¹ Aged Care Complaints Commissioner (from 1 Jan 2016): <https://www.agedcarecomplaints.gov.au/about/>

For example, in 2005 the *Canberra Times* gave several examples and reported¹²²:

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

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

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

1.17.1 The 2009/10 Walton Review

The summary of a submission made by one of us¹²³ to the 2009 Walton review stated:

It is clear that there is insufficient information and that the accreditation and complaints processes are not working for the community.

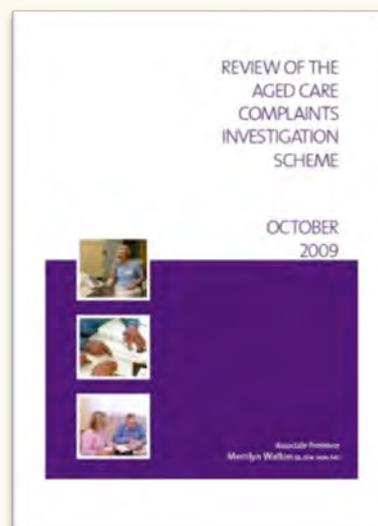
Four key problems for the Complaints Scheme are identified:

1. The disenfranchisement and disempowerment of the community
2. A lack of on-site empathic person to person communication
3. An excessive emphasis on process rather than resolution for the parties
4. An almost total lack of transparency

"It is suggested that the key to redesigning both accreditation and complaint handling is to place the community at the centre of both processes and give them responsibility".

And again:

"What must be done if accreditation, oversight and complaints are to work is to fully engage the community in the process and to produce valid information that will mean something to them".



The same 2009 submission to Walton commented that that complaints system "has not been positioned within frames of understanding and fields of relevance that they (ie families and residents) relate to". It suggested "both the accreditation agency and the complaints system were set up by the government in 1997 to counter criticisms that financial pressures in the market would compromise the quality of care. It was a political response to neutralize criticism - forced to operate and to show that it was successful". At the time we did not know that Braithwaite thought the same way

¹²² Call for probe into aged care paybacks *Canberra Times* 12 February 2005

¹²³ Wynne JM Submission to Review of the Aged Care Complaints Investigation Scheme 2009
http://www.corpmedinfo.com/wynne_cis_reviewfinal_web.pdf

An example of the disregard for the power difference is the way in which the review of the Aged Care Complaints Investigation Scheme, the Walton review in 2009-10¹²⁴, virtually destroyed the utility of the whole complaints system.

The Walton Review embraced our recommendation to place more focus on local resolution, but ignored supporting information on the logic behind this and the essential linked recommendation that the complainant should be supported and advised by a trained local facilitator with investigative powers.

Under the changes that were made following this review, confused, upset and unsupported families were forced to resolve issues with powerful providers who did not accept that there were problems. As a consequence, vulnerable families were further disadvantaged.

Walton has placed vulnerable people in an impossible position – a disastrous decision that made the situation worse. They learned not to complain and fewer did. This reduction was hailed as a success and not seen as the problem it was.¹²⁵

The submission to Walton had suggested that the complaints system would supervise and mentor local community representatives to support and protect the family and resident. This would address the power imbalance.

“The (complaint’s agency) supervisor will support and advise the (local) representative and the representative will report to and consult with the supervisor.

The representative will have the power to investigate the complaint and negotiate the issue with management. The representative will monitor and report to the complainant on the findings made, ensuring that steps are taken to prevent a reoccurrence”.

The neoliberal marketplace discourse concentrates on the ‘customer’ who has choice. It excludes the community. It does not see them as having responsibility. Braithwaite’s assessment suggests that the market sees community and the discourse it embraces as a threat to be resisted. Giving them a responsible role as was suggested in a 1989 report would be simply another ‘community busybodies scheme’.

The comment in the submission that ‘*At no stage have the underlying problems or the disenfranchisement of the community been addressed*’, made in the 2009 submission remains valid today.

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

¹²⁴ Review of the Aged Care Complaints Investigation Scheme - October 2009: <http://bit.ly/2qH2wQW>

¹²⁵ Evidence by Ms Smith (Dept Health) in ‘Care and management of younger and older Australians living with dementia and behavioural and psychiatric symptoms of dementia (BPSD)’ Senate Community Affairs References Committee - Wednesday, 17 July 2013
<http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22committees%2Fcommsen%2Fae6cedd9-97a5-4214-a9da-24e4bad3a174%2F0005%22>

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

Government responded to the revelations of the Walton Review by making Professor John Kelly, a lawyer who represented and advised the industry and who had been a director of a for-profit company, (temporarily) Aged Care Commissioner. He subsequently became CEO of ACSA where his strong views and support of the industry were revealed in his response to criticism and in his attack on academics whose research exposed problems in the system¹²⁶.

1.17.2 Current concerns:

- **Fear of reprisals** or other repercussions is a major deterrent to complaining as in this recent case where Regis denied that it had occurred¹²⁷.
- There is much to suggest that, when problems are identified, aged-care homes are required to **do little more than agree to make some amendments** to policies and procedures.
- Residents and families who have plucked up the courage to complain are **not dealt with sympathetically**. On occasion the only feedback they have received has come when facility management has informed them that the accreditation visit that resulted gave them full marks. They have had no explanation.
- There is **no resolution or compensation** for those who suffer from dementia or are frail when they have suffered injury, health consequences or abuse.
- Healthy individuals in the community can seek **redress and compensation** through the courts. Frail residents and their families become tied down in the complaints process which does not give them redress or penalise those at fault, who go unpunished.
- The **widespread overuse of chemical restraint**¹²⁸ and excess use of psychotropic drugs is not being contained or addressed by the accreditation or the complaints system. A recent study (HALT¹²⁹) led by UNSW researchers labelled the inappropriate use of antipsychotic drugs in Australian nursing homes as 'widespread'.
- **The very poor levels of staffing** in Australian facilities has not been impacted by the complaints system. The use of the courts by families, community groups and by employees using the Qui Tam laws in the USA has imposed a heavy penalty for poor care and understaffing.
- **A lack of transparency:** Data about the incidence and validity of complaints for each facility and provider are not published. Prospective residents and the community are kept in the dark. Their ability to choose wisely or to constrain the excesses of an aggressively competitive market are impeded.

¹²⁶ **Is this culturopathy?** Inside Aged Care <https://www.insideagedcare.com/aged-care-analysis/widely-contrasting-views/is-this-culturopathy>

¹²⁷ **Two aged care residents die after gastro outbreak** Nine News 9 August 2017
<http://www.9news.com.au/national/2017/08/09/18/21/two-aged-care-residents-die-after-gastro-outbreak?ocid=ninecomfb>

¹²⁸ **Widespread antipsychotic use in nursing homes unnecessary, trial shows** (26 Jul 2016):
<http://newsroom.unsw.edu.au/news/health/widespread-antipsychotic-use-nursing-homes-unnecessary-trial-shows>

¹²⁹ Jessop, T., Harrison, F., Cations, M., Draper, B., Chenoweth, L., Hilmer, S., . . . Brodaty, H. (2017). **Halting Antipsychotic Use in Long-Term care (HALT): A single-arm longitudinal study aiming to reduce inappropriate antipsychotic use in long-term care residents with behavioral and psychological symptoms of dementia.** *International Psychogeriatrics*, 1-13. doi:10.1017/S1041610217000084
<http://bit.ly/2rOLH4j>

- **Privacy** is an important consideration, but should not be used as an excuse or a barrier to transparency and accountability or as a way not to protect those who are unable to protect themselves.

1.18 Missed opportunities to regulate effectively

Both the complaints handling and the accreditation process were controlled by the marketplace and the politicians that supported it – those within the neoliberal regime. Braithwaite considered that they had been ‘captured’.

Braithwaite also looked at the advocacy service and at the visitors scheme both of which he considered should be part of the regulatory process. He commented on the government steering both from “*the rights perspective that gave them birth to a ‘partnership’ perspective with the industry to improve quality*” (Page 186).

1.18.1 Advocacy

It has puzzled Aged Care Crisis that those who are unhappy and complain to us, and the many press reports we read, seldom if ever mention advocates or the government’s subcontracted advocacy process. This group would be in direct contact with residents and know more about the situation in nursing homes than anyone else.

We thought that they would be drawn from the community and would embrace their values. They should be the first to point out problems and initiate action. In practice they seem to have no public face and if they performed any function at all it seemed to be to help keep the issues they address away from the public.

Aged Care Crisis made a two part submission¹³⁰ to the secretive behind closed door review of the advocacy process in 2015 suggesting that local communities be engaged and advocacy should work with them. The review process was highly controlled. We heard little more and like other critics were not invited to the not public consultation or workshop that we subsequently learned had followed.

We now realise that any public advocacy for individuals or for changing the system would threaten the neoliberal discourse. Government would seek to eliminate this threat. It seems that Braithwaite thought so too in 2007 after he spoke to them.

In writing about the advocacy system in 2005/6 Braithwaite et al said “*We were told if they criticize the government, it has a ‘long memory’. Their funding contracts with the government have clauses that explicitly fetter their capacity to criticize government policy without notice or even to criticize named providers who they believe should be closed. Government by contrast attempts to ensure this is advocacy with a small ‘a’*”(page 186).

In expanding on this they indicated that after 1997 “*More quietly, the advocacy organizations that had been the biggest thorns in the side of the industry had their government funding terminated*” (page 189).

We note that the development of advocacy owed much to the 1989 Ronald’s aged care report which preceded the 1993 Gregory report and recommended an advocacy service¹³¹ that was “*able to operate independently from industry organisations*”. Following this government made ‘grants to

¹³⁰ Review of Aged Care Advocacy Services (ACC Submission) Aged Care Crisis Sept 2015 <https://www.agedcarecrisis.com/solving-aged-care/contributions/aged-care-advocacy-services-review>

¹³¹ Background Paper Number 32 1993 . Residential Care for the Aged: An overview of Government policy from 1962 to 1993 <https://www.aph.gov.au/binaries/library/pubs/bp/1993/93bp32.pdf>

aged persons' organisations' to undertake advocacy. Ronald would not have known that 8 years later government would take control and use that to prevent advocates from operating "independently from industry organisations" as well as government.

The end result of the behind closed doors advocacy review in which community played little part has been the consolidation of the multiple separate state contracts into the Older Persons Advocacy Network (OPAN) a single "centrally governed and managed entity" funded by government "to deliver a new national service system"¹³². Its web sites reveal that advocacy is for individuals and their rights with a focus on education¹³³. There is no mention of a regulatory role, lodging complaints or of advocating about system failures. There will be processes and boundaries defining what advocates roles are.

This neoliberal solution seems to tie advocacy even closer and make it more dependent on government than ever and take it further from communities. This is what Aged Care Crisis tried to argue against.

1.18.2 Visitor's scheme

In exploring the potential for a community-based system we were interested in the Visitors schemes as a possible model, particularly that in the disability services scheme in Victoria prior to the NDIS. These visitors had considerable powers to enter facilities, peruse notes and documents and to initiate action and report it to government. They were a core component of the state regulatory scheme, independent and effective. Our ideas for community involvement in aged care owed much to this.

The visitor's scheme in aged care in contrast was little more than companionship for the lonely. They had no powers and no training. They did not initiate any complaints or action.

Braithwaite et al in their book suggested that Ronald's 1989 report might have wanted visitors to play a more active role in protecting residents and to be part of the regulatory process.

They indicated that under pressure from the industry the visitors scheme, which was dubbed the "community busybodies scheme" by industry was watered down.

As a consequence the government "insist that community visitors leave matters of compliance with standards to standards monitoring and stay away from legal conflicts with nursing homes to assert rights" (page 186).

It is worth noting that the recent final report of the ALRC (Australian Law reform Commission) into elder abuse¹³⁴ has looked at the inadequacy of our current regulations and has suggested an empowered visitors scheme as a strategy for reducing elder abuse. It considered an official visitors scheme for nursing homes but fell short of recommending it.

¹³² Federal funding shake-up confirms single national aged care advocacy provider 11 Jul 2017 <http://www.advocare.org.au/news/federal-funding-shakeup-confirms-single-national-aged-care-advocacy-provider/>

¹³³ What is Advocacy? OPAN web site http://www.opan.com.au/advocacy/#what_is_advocacy

¹³⁴ Elder Abuse— A National Legal Response pages 153-6 ALRC <https://www.alrc.gov.au/publications/elder-abuse-report>

Whistleblowing: Exposure of major failures in care is heavily dependent on families and staff who speak out by complaining or going to the media. Braithwaite felt that the rights of residents were not taken seriously and that *“the political neutering of advocates, makes whistle-blower protection for nursing home staff one imperative reform”* (Page 186). Protection for whistle blowers is still lacking.

1.19 The Department of Health

Ticking off fraud: Very similar regulatory problems were revealed in the department of health by the ABC 7.30 report on 16 August 2012¹³⁵. These revealed the extent to which the bureaucracy had been captured and come to serve the market and protect politicians from embarrassment rather than protect the community. In Australia the department is the ultimate regulator of aged care and imposes sanctions. It monitors financial matters.

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

The response: Instead of investigating after the television program, then stigmatising and penalising those responsible, the department elected to avoid publicity by 'educating' instead. Within 6 months the incidence had increased by another 4% and with nearly 20% of claims being incorrect. The department, talking to the *Senate Community Affairs Legislation Committee Estimates* on 13 February 2013¹³⁶ referred to this as *"incorrect claiming"* rather than fraud. The department were still *"offering workshops for providers and their staff who make claims and working with the industry"*.

It is difficult for a regulator to regulate when it sees its role as "working with the industry"

The nature of the department: Further insight into this was revealed in 2014. A Capability Review of the federal Department of Health and Ageing¹³⁷ found that *"- it is beset by a culture of 'inappropriate behaviour' including bullying and harassment, a command-and-control approach by top bosses and an environment where mistakes are not tolerated"*.

It was *"hierarchical and siloed"* and *"public servants were afraid of the consequences of mistakes or to break bad news to its leadership"*. There was a *"level of bullying and harassment they were told about and the reluctance of public servants at Health to make formal complaints"*.

On reflection, we can understand that rorting by providers was bad news, would have embarrassed government and would have been unwelcome. This is similar to what Braithwaite

¹³⁵ **Funding feeds profits over aged care** - ABC 7.30 Report, 16 Aug 2012 <http://www.abc.net.au/7.30/content/2012/s3569659.htm>

¹³⁶ **Senate Community Affairs Legislation Committee Estimates** - Wed 13 Feb, 2013

¹³⁷ **The federal Health Department: 80-hour weeks, bullying, command and control** The Canberra Times 8 Dec 2014 <http://www.canberratimes.com.au/national/public-service/the-federal-health-department-80hour-weeks-bullying-command-and-control-20141207-122cu8>

Capability Review - Dept of Health (Oct 2014):

https://www.apsc.gov.au/_data/assets/pdf_file/0005/64472/DoH-Capability-Review1.pdf

and others described, in accreditation. Here, assessors who failed nursing homes were not welcomed and were overruled.

In our view this was a department that was deeply conflicted by traditional public duty to act for citizens, when in reality it was required to protect government from embarrassment. The culture described is the logical consequence of saying one thing but having to do something very different.

A green light for rorting: It is hardly surprising that the system has been 'maximised' (but not called rorting) several times since then in Community packages (2013), the Dementia supplement (2014), Consumer Directed Care (2015), and then in 'complex health care' (2015)¹³⁸.

1.20 Other system problems

1.20.1 Part of a wider problem

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

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

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

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

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

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

¹³⁸ **Consequences of marketplace thinking: Slider 2: examples in Australia.** Inside Aged Care <https://www.insideagedcare.com/aged-care-analysis/aged-care-marketplace/aged-care-in-the-dark/consequences-of-marketplace-thinking-slider-2-examples-in-australia>

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

1.20.2 Data collection in Australia

Australia lags a long way behind the USA and the UK in the transparent collection and publication of data. In the USA the Nursing Home Compare¹³⁹ website allows the public to examine all of the data collected about nursing homes and home care. The entire data set¹⁴⁰ is available to the public and researchers.

The UK's Care Quality Commission¹⁴¹ (CQC) provides extensive data going back for 10 years as for example for Donisthorpe Hall¹⁴². Visits are more frequent and unlike Australia all are published. Its site is updated weekly¹⁴³ with comprehensive data, including the ability to download and analyse it.

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

Data is essential for managing facilities, for government, local community and provider policy, for consumer and community information, for public discourse, for the market to work, for research and to anchor regulatory effort to what is *actually* happening in the facilities and the sector. *The absence of useful data is a core problem in the sector and we can only assume that its absence is because it would challenge the discourse.*

1.20.2.1 The story of data in Australia

The first audit: In its 2002-3 audit of the accreditation agency the Australian National Audit Office¹⁴⁴ (ANAO) was critical of the failure to collect useful data to assess whether accreditation had any impact on care, monitor its own performance and measure quality of life.

It indicated that *“the Agency does not yet have a way to assess the outcome of its accreditation and monitoring work on the residential aged care industry”* and recommended that it *“plan an evaluation of the impact of accreditation on the quality of care in the residential care industry”* to *“provide the Agency with assurance that its management of the accreditation process is effective”*.

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

¹³⁹ Centre for Medicare - Nursing Home Compare: <http://www.medicare.gov/nursinghomecompare>

¹⁴⁰ Nursing Home Compare datasets <https://data.medicare.gov/data/nursing-home-compare>

¹⁴¹ Care Quality Commission - UK - <http://www.cqc.org.uk/content/fundamental-standards>

¹⁴² Donisthorpe Hall -- Care Quality Commission - UK - <http://www.cqc.org.uk/location/1-114958058/reports>

¹⁴³ CQC - Use our data - <http://www.cqc.org.uk/content/how-get-and-re-use-cqc-information-and-data>

¹⁴⁴ **Managing Residential Aged Care Accreditation** The Auditor-General Audit Report No.42 2002-03 Performance Audit Australian National Audit Office (ANAO) May 2003
Managing Residential Aged Care Accreditation **Review of the report** Corporate Medicine web site <http://www.corpmedinfo.com/agereport2003.html>

The senate debated the issues: These matters were raised in parliament during a hearing of the *Joint Committee Of Public Accounts And Audit* in August 2003¹⁴⁵ where the lack of consistency of audits was acknowledged and the failure to collect data to evaluate the accreditation process questioned. The industry and the agency indicated that they were addressing these issues.

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

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

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

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

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

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

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

Abandoning these good intentions: These lofty objectives were soon abandoned, perhaps when it was realised that it would destroy the discourse – the house of cards on which the system is built.

Those who complied would not have been competitive. Competitive pressures began to bite. Few if any of these good intentions were ever implemented.

¹⁴⁵ [Joint Committee of Public Accounts and Audit - Review of Auditor-General's reports, fourth quarter 2002-03 - 18 August 2003](http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=ld%3A%22committees%2Fcommjnt%2F6844%2F0003%22)
<http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=ld%3A%22committees%2Fcommjnt%2F6844%2F0003%22>

Senate Inquiry - 2005: Accreditation and complaints systems were heavily criticised in the June 2005 Senate Review of aged care¹⁴⁶. It was claimed that *“Evidence indicates that there is little systematic data that demonstrates how accreditation has impacted on quality of care. One submission noted that the Agency has ‘not produced any material which would provide the sector or the community with any level of assurance that the overall intention of accreditation in improving service quality has been achieved’.”* (Page 34)

Another review of accreditation: In 2007 the agency chose an accreditation friendly review body to give it a pat on the back and support it in not collecting, evaluating and reporting on failures in care¹⁴⁷. In a report loaded with jargon and positive language, failures in care had become “indicators”.

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

This was an assessment that saw accreditation as a process of assisting providers and not as a regulatory process.

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

1.20.2.2 The absence of data remains a huge problem

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

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

¹⁴⁶ Criticism of senate review “Quality and equity in aged care” June 2005 Corporate Medicine web site <http://www.corpmedinfo.com/agereport2005b.html>

¹⁴⁷ Criticism of “Evaluation of the impact of accreditation on the delivery of quality of care and quality of life” Corporate Medicine web site <http://www.corpmedinfo.com/agereport2007c.html>

ACSA 2013: In a 2013 report, ACSA¹⁴⁸ noted the extensive variability in financial performance and the absence of data about care.

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

Alzheimers Australia: In 2015 Carol Bennett the new CEO of Alzheimers Australia indicated¹⁴⁹ that *“Every research study around the world has demonstrated that where you do put in place quality measures and they are comparable, you drive system performance and that is what we need to do here.”*

In a radio interview¹⁵⁰ Bennet indicated that quality of care was one of the biggest gaping holes because we don't have *“a single measure of quality”* and without accurate data about care you cannot have choices. She could not understand why this was so. Researcher Dr Richard Baldwin supported her comments.

Industry surveys: The financial sector has consistently reported on the most profitable performers as the best performers in aged care. But they are careful never to set the staffing levels against this good financial performance.

Most profit comes from the income paid for care rather than for hotel services. StewartBrown reports both staffing levels and the wide difference in the money saved from the income derived from care without setting the two together. It requires little imagination to see that the good performers financially are likely to be poor performers in staffing and in providing care¹⁵¹. Staffing comprises about 70% of the cost of care.

Aged Care Crisis have emphasised the lack of data and the lack of transparency on many occasions over the years. This lies at the root of the failures in the aged care system.

If we had accurate data about the actual performance of providers and of the sector, then the problems that we are describing could be addressed and regulatory failure could be confronted.

We would have the data needed to develop a much better system and decide how much we were prepared to spend on it.

¹⁴⁸ **The financial viability and sustainability of the aged care sector** ACSA Report 2013
<https://opus.lib.uts.edu.au/bitstream/10453/36460/1/ACSAViabilityWhitePaper291113.pdf>

¹⁴⁹ **Call to protect vulnerable in shift to aged care market** Community Care Review 17 Nov 2015
<http://www.australianageingagenda.com.au/2015/11/17/call-to-protect-vulnerable-in-shift-to-aged-care-market/>

¹⁵⁰ **Better data needed to compare aged care** ABC Radio pm 24 Nov 2015 <http://www.abc.net.au/pm/content/2015/s4358621.htm>

¹⁵¹ **Future of Australia's aged care sector workforce - Supplementary submission to Senate Workforce Inquiry 28 Nov 2016** Aged Care Crisis pages 27 to 30 https://www.agedcarecrisis.com/images/pdf/sub302ss2_ACC.pdf

1.20.3 Regulation is 'burdensome'

The reduced regulation in order to appease the industry and reduce the perceived burden will make regulation even less effective than the current system.

It is interesting that in the highly regulated US system, with its extensive data collection, reporting and ways in which the data can be transparently downloaded and used¹⁵², we don't hear the industry complaining about it being 'burdensome'¹⁵³.

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

1.20.4 Wasting money

Growth before care: Additional funding provided in 2014 has not gone to staffing. This and money saved by reducing costs has been squandered in a feeding frenzy on the share market and by those aspiring to list on the share market. As in other countries, private equity has led the process¹⁵⁴. Money that might have gone to care is squandered on inflated prices paid to buy overpriced facilities in order to increase market dominance. Residents bonds have gone into this putting them at risk.

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

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

Extensive data shows that these aggressively competitive corporations provide poorer care¹⁵⁵ and that this policy will compromise care. The morality of this must be questioned.

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

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

¹⁵² Data.Medicare.gov - Getting help with datasets: <https://data.medicare.gov/get-started>

¹⁵³ Medicare.gov - Nursing Home Compare datasets: <https://data.medicare.gov/data/nursing-home-compare>

¹⁵⁴ Private Equity Inside Aged Care <https://www.insideagedcare.com/aged-care-analysis/aged-care-marketplace/private-equity>

¹⁵⁵ Aged Care Crisis Supplementary submission to Senate Workforce Inquiry 'Future of Australia's aged care sector workforce' pages 23-27 - 28 Nov 2016 <http://bit.ly/2rEeSqM>

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

Efficiency: The competitive free market is undoubtedly the most efficient way of making money but the claim that it has been the most efficient way of providing good care does not stand up to any sort of analysis. It is time to accept the wisdom of the last 2000 plus years and accept that markets in human services are very different to those of the bazaar. They need to be structured differently.

It takes time to care and develop the empathic relationships on which good care depends. A focus on financial efficiency rather than on care is destructive of care and so an inefficient use of money.

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

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

1.21 Final comment on regulation

Braithwaite and co-authors indicated in his 2007 book:

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

His concerns were ignored and we are now confronted 10 years later by the consequences. We continue to ignore this and simply do more of the same at our peril.

The Quality Agency should cease to be a regulator and regulation should be taken out of the hands of the market.

1.21.1 Who is responsible?

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

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

Retired politician Carmen Lawrence has written about the failure of our political system¹⁵⁶. As our analysis shows, we share her views. Aged care is a good example. A few phrases are indicative:

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

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

1.21.2 The political dilemma

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

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

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

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

¹⁵⁶ [The denial, the infantilising babble, and the fantasies that permeate politics](https://www.theguardian.com/commentisfree/2016/jan/30/the-denial-the-infantilising-babble-and-the-fantasies-that-permeate-politics) - The Guardian, 30 Jan 2017
<https://www.theguardian.com/commentisfree/2016/jan/30/the-denial-the-infantilising-babble-and-the-fantasies-that-permeate-politics>

Part 4: Reviews, inquiries and consultations

1.22 Reviews that give politicians what they want

The many reviews, inquiries and consultancies can be seen as part of the background regulatory process to the extent that they support policies, advise changes or challenge the status quo.

Since 1997 there have been a never ending series of reviews and inquiries¹⁵⁷ as well as consultants, many of them in order to further broad policies already decided on, or address negative publicity and give the impression that something is being done. Policies can be given legitimacy by appointing commissioners who embrace the desired discourse and share views.

Governments appoint those they see as being credible and reliable. Understandably these will be people who share government's views. Critics are not seen as credible. The appointment of consultants to advise or investigate works in much the same way.

When governments and society are in the grip of a discourse that cannot credibly be challenged because those it empowers work within that discourse. It is extremely difficult for an alternate discourse and its insights to make a contribution. In this situation it becomes an ideology.

Threatened believers set up their inquiries and community consultation in ways that discourage their critics and make it difficult to get traction. The latest strategy is to use web based text boxes for public submissions. These restrict responses by the nature of the specific questions asked for each text box entry. This limits the opportunity for analysis, references and criticism. When published these documents have no formatting and can be difficult to read and debate. Wide and critical community debate is frustrated.

There are other inquiries in the senate. They occur when the opposition holds a majority in the senate. They are set up to counter government inquiries or to air alternate views. These inquiries allow critics to be heard and to put an alternate points of view. It is an opportunity for critics and the community to put their arguments and have them aired. Because the report comes from the opposition, outcomes if any are delayed. They have even less impact when both government and opposition embrace the same overall discourse.

Example: A good example of this was the self- congratulatory report of the House of Representatives Standing Committee on Health and Ageing "*FUTURE AGEING : Report on a draft report of the 40th Parliament*" in March 2005. The labor controlled senate responded with the very critical Community Affairs References Committee inquiry "*Quality and equity in aged care*" in June 2005. It was an opportunity for those who understood what was happening in the sector to voice their concerns and be heard. But labor did nothing about the problems when it gained power in 2007.

¹⁵⁷ Publications Reviews and consultations Aged Care Crisis <https://www.agedcarecrisis.com/publications>
OH NO ! - NOT ANOTHER AGED CARE INQUIRYBUT THIS TIME IT MIGHT REALLY MATTER Corporate Medicine web site 2010/11
<http://www.corpmedinfo.com/agereport.html>

1.22.1 Reviews to address the publicity and not the problems

Reviews can also be used as a strategy to handle publicity and give the impression that something real is being done to address the problems and so allow a public backlash to die down.

Since about 2000 the basic tenets of the free-market/neoliberal discourse have seldom been directly challenged and these reviews can be used to reaffirm and promote the tenets of the discourse. The sacred cows are trotted out and the elephants kept hidden behind closed doors.

The Oakden scandal and the failure of the accreditation agency (now called the Quality Agency) has resulted in 4 reviews, so fragmenting the process:

1. **Review of the National Aged Care Quality Regulatory Processes¹⁵⁸**: An 'independent' Review by people appointed by the Minister for Aged care. Cynics will see this as a strategy to support accreditation, minimising the damage, waiting for the crisis to blow over and then reaffirm the discourse.
2. **An internal investigation by the Quality Agency¹⁵⁹** set up by its CEO Nick Ryan. It will be looking after the agency and its relationship with the marketplace. It will be concerned about publicity. (*behind closed doors*)
3. **There is an ICAC Investigation in South Australia¹⁶⁰** which is independent but will be focusing the management of Oakden by the government. (*behind closed doors*)
4. **This Senate Inquiry¹⁶¹** was called by a minor party and supported by the opposition. It counters that called by the minister and provides an opportunity for critics to make their arguments and stimulate debate. It is an opportunity to challenge the discourse and expose its consequences.

Our problem lies with the review called by the minister. This illustrates the problem with government reviews and the difficulties in generating real change. It deserves a closer look.

In this case a businesswoman, past liberal politician and someone who had been appointed to many bodies including the Accreditation Agency during the period when Oakden was being accredited was appointed to lead the inquiry. Her achievements have earned her an Order of Australia. Within the discourse she is highly credible and reliable and they see no problem with this. To an outsider it looks like the fox reorganising the hen house. We examine this example in detail in **Appendix 4**.

Both reviewers have already agreed to speak at an expensive meeting arranged for the elite of the industry in November 2017, which will no doubt receive publicity. See **Appendix 5**.

This is why the more independent senate inquiry is so important and so welcome.

¹⁵⁸ Call for submissions for the Review of the National Aged Care Quality Regulatory Processes - June 2017: <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2017-wyatt051.htm>

¹⁵⁹ Oakden closure: Aged care inspector questions agency's accreditation of troubled nursing home - 28 Apr 2017: <http://www.abc.net.au/news/2017-04-28/aged-care-quality-agency-oakden-accreditation-under-review/8481656>

¹⁶⁰ ICAC S.A. - Public Statement - Oakden - 30 May 2017: https://icac.sa.gov.au/sites/default/files/Public_Statement_30_May_2017.pdf

¹⁶¹ Senate Inquiry - http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareQuality

1.22.2 Lessons from the UK

The piecemeal investigations of what happened at Oakden remind one of the Mid-Staffs hospital scandal at Stafford hospital in the UK¹⁶². As in aged care in Australia decisions were made by management to reduce staffing without monitoring the consequences for care – a major reason for failed care. Here too a multitude of ignored warnings and failed oversight allowed serious problems to go unchecked.

When problems were finally detected there were another 5 piecemeal investigations of limited scope, perhaps in an attempt to limit the damage. It required a very active community movement¹⁶³ and one very critical review before the wide-ranging independent Francis Review¹⁶⁴ was finally commissioned. It identified systemic problems, which led to a major review of what was happening in the rest of the NHS and to many systemic changes and subsequent reviews¹⁶⁵ to see that changes were on track. This is not to suggest that aged care simply follow the same solutions.

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

This report could have been describing aged care in Australia.

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

What is required is a much broader review that distances itself from the prevailing wisdom of the free-market/neoliberal discourse and focuses on the evidence and the care given. It needs to be conducted by people who understand the nature of social processes as well as the nature of care. It should include or be advised by geriatricians and experienced nurses who have worked in the system.

Those who have been part of managing this system don’t qualify. As happened at Stafford, the managers of too many nursing homes focus on costs and profitability and don’t understand the relationships between staffing and care.

¹⁶² Mid Staffs hospital scandal: the essential guide The Guardian 6 February 2013 <http://bit.ly/2rSNhFu>

¹⁶³ Cure the BHS <http://www.curethenhs.co.uk/>

¹⁶⁴ Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report) UK Government 6 Feb 2013 <http://bit.ly/2s6eOmS>

¹⁶⁵ Government’s response UK Parliament <http://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN06690> - fullreport
About the Francis Inquiry The Health Foundation <http://www.health.org.uk/about-francis-inquiry>

Part 5: Finding a better way

1.23 Suggestions for change

While it is not a quick fix, our assessment is that the only really effective way of addressing these issues is for the government bureaucracy and the market to relinquish their tight grip on the aged care system and its regulation. That means embracing and empowering the community and rebuilding civil society as an active participant. We have not seen or heard of any alternative that addresses the issues we have identified in aged care.

We are under no illusions about the difficulties in moving in this direction or that if done ineptly it might run into trouble. No other proposal that we have heard or thought about offers any hope of addressing the basic flaws in our aged care system and this is why we are pressing for a carefully monitored move in this direction.

Some have indicated that what we propose is not practical but none have been prepared to respond and make that argument in debate. We believe that while they can highlight the difficulties they have no alternate to offer other than the same sort of system that we have today and about which they are complaining. That is not a real option.

1.23.1 Embracing Community

Aged care is a system whose effectiveness depends on community norms, values and empathy as well as the pattern of empathic and empowering relationships that form between all those involved in the caring process. These have been fractured by current policy. There are many criticisms of the inadequacy of government regulation and sound arguments for community and families to become involved and be supported by government in doing this themselves¹⁶⁶

1.23.2 Balancing different discourses

The discourse of caring¹⁶⁷ is very different to the current discourse of government and market. The management and regulation of aged care under the latter discourse has been a dismal failure.

Aged care should be returned to the discourse of care but clearly what can be accomplished might be limited by what is possible within the discourse of government, finances and market. Money is not unlimited.

At issue is the way available resources are used for maximum benefit, and the community's right to decide how much of our financial resources can be devoted to those in need. We also need a real debate about what personal contributions should be made and how the risks can be spread so that individuals, who through no fault of their own face massive costs when they age, can be protected.

¹⁶⁶ Regulation without State Dominance : A Public Health Model of Social Care Regulation? Bob Rhodes The Centre for Welfare Reform 2012 <http://bit.ly/2qUKY4Q>

¹⁶⁷ The Nature of Care Inside Aged Care April 2017 <https://www.insideagedcare.com/aged-care-analysis/theory-and-research/nature-of-care>

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

1.23.3 Reasons for advocating community involvement

Distrust in the marketplace: If we don't understand the issues or are unable to evaluate a product in the marketplace and instead have to depend on advertisements, providers and regulators then we come to distrust it. A study of consumer choice of healthy foods¹⁶⁸ found that distrust was related to *“physical and psychological displacement of production from consumption”*. The more people depended on marketing and regulation the greater the distrust. Those who were closer to food production were less distrustful. The authors suggested finding ways of *“reconnecting consumers to the methods and places of food production”*.

It is not difficult to see that this same problem exists in aged care and the more we have been subjected to marketing, the more we have come to depend on regulation and information from others, the more distrust has grown.

The way to address this distrust would be by *“reconnecting consumers to the methods and places”* of aged care provision and that might be easier to do in aged care than with food. It is what Aged Care Crisis is suggesting.

Our human nature: We are an existential species meaning that we have no choice but to exist, build our lives and become someone. We are social animals and in building our lives we join with others to build and control the social context within which we live – our communities and society.

This is often described as ‘owning’ the things that we and our communities do – being involved in designing and operating them, making them familiar and a part of our psyche. As with food if we don't own things we distrust them and feel left out.

After years of wasted effort and money we have finally recognized the importance of helping aboriginal people to design and manage human services for their communities and so to own them, This has been shown to work. It empowers them and gives them a voice.

Government initiated reviews and ownership: The recently published draft report of the Productivity Commission inquiry into competition in Human Services stresses the importance of ownership in providing services to aboriginal communities. The 2016 Senate workforce review also emphasised local community involvement and control for successful aboriginal aged care. They wrote about the benefits of involving CALD and LGBTI communities in aged care.

It seems that when it comes to aged care, which like childcare is so dependent on the nurturing of family and community, the rest of us do not have the same needs and do not benefit in the same way from ownership as marginal groups.

¹⁶⁸ [Reconnecting Australian consumers and producers: Identifying problems of distrust](https://doi.org/10.1016/j.foodpol.2012.07.005) Henderson J et al Food Policy · December 2012
DOI: 10.1016/j.foodpol.2012.07.005

Research: In 2015 Gill and Gill¹⁶⁹ wrote about partnering in delivering community services in Australia and other countries. They concluded that it was important that the community's concerns be given priority over those of the service provider. It was important that control was handed over to the community so that they engaged, learned about, identified with, innovated and in doing so came to "own" the service.

The key to success was the willingness to accept the noisy discussion and then trust the community by handing control of the service over to them.

One of the main reasons for failure was an unwillingness or inability to build relationships with the community and trust them. In many failed examples, community engagement was with selected individuals and not with the entire community. It became tokenistic - a self-serving illusion.

Community advocacy: Braithwaite et al describe the importance and the major role that community movements have had in reforming nursing home care, particularly in the USA, where they have been responsible for changing practices such as physical and chemical restraint.

He also emphasised the important roles that research and academic involvement in these community movements had played in showing the paths that could be followed.

On page 81 the authors indicated, *"we will suggest that the key to change lies within the dynamics of this social movement politics. Good regulatory scholarship can help with showing advocacy groups paths from ritualism to innovation. Moreover, it can persuade some regulators and progressive providers to promote alternative strategies, thereby creating the possibility of a plural coalition of advocates, providers, regulators and researchers who share that vision of a shift from ritualism to innovation that improves quality of life for the aged"*.

Note the diversity of points of view that this reflects. We can draw a parallel with the idea of 'distributive justice' and the creation of a 'constructivist context', one where differences between many discourses are examined and their merits and demerits balanced in reaching decisions.

This meeting of discourses in a context where power is balanced is what Aged Care Crisis is pressing for.

Braithwaite et al also noted that once the particular goal had been achieved these groups and the public movements melted away and did not make any other contributions. This is understandable because once achieved those involved no longer had any ownership of further developments and could not build their lives and identity further. They remained external to the system.

The authors explained (page 187-8) that Australian community involvement and advocacy in the 1980s played a major role but *"as the advocacy groups disengaged"*. This *"allowed them (ie. industry) to quickly take the upper hand in policy debates"*. Key recommendations of reports in 1989 and 1992 *"for unannounced inspections and a stepping up of enforcement at the peak of a responsive regulatory pyramid were not implemented by the government"*. A political climate developed where *"regulatory bureaucrats became wary of being viewed as anti-business"*.

¹⁶⁹ Partnering with consumers: national standards and lessons from other countries Stephen D Gill and Melinda Gill. Med J Aust 2015; 203 (3): 134-136 <https://www.mja.com.au/journal/2015/203/3/partnering-consumers-national-standards-and-lessons-other-countries>

The department “*decisively rejected the ‘raise the bar’ vision*”. By 1994 there were only “minimum standards” and “*pride was being taken as the percentages of nursing homes complying with the standards increased year by year*”. As a consequence “*the morale of inspectors was sapped by the failure to back their reports with the credible enforcement they deserved*”.

This is why we argue that, to maintain a strong permanent community role, the community should become a part of the aged care service. They should play an important role there – have ongoing responsibility and so ownership.

There are sound reasons for institutionalising “*community busybodies schemes*”. What they may lack in efficiency will be offset by the benefits for the elderly and their families, in building social capital and in maintaining society’s values and norms.

Control: There is now growing evidence that community services are most successful when they are planned, controlled and managed by the communities themselves. There are strong advocates for greater community involvement and control in the UK¹⁷⁰.

The role of national organisations serving communities and of government is to support and mentor without intruding directly unless that is absolutely essential.

Changes in society: Many are writing about the changes in society that have undermined civil society and responsible citizenship. Others write about the hollowing out of society and communities so that individuals are no longer involved in managing their communities. They lose skills, knowledge and confidence then interest. There is a loss of Social Capital. Eva Cox has written about this¹⁷¹ over the years.

Citizens no longer feel part of the democratic process and are distant from it. They no longer identify with or feel they have control over their own country, society or the community they live in.

They distrust their democracy. They don’t have ‘ownership’ of their lives or their world. As a consequence they have come to distrust government and all authority – called the post-truth era.

Neoliberalism and particularly managerialism can be seen to have contributed to the hollowing out and the sense of disenfranchisement.

That this was happening was recognised by many. Prior to the radical neoliberal revival in 2013, when it all stopped, Australia was a leader in the global Open Government movement and the Participatory Democracy movement. Both were a move towards transparency and the rebuilding of civil society by involving citizens in democratic decisions and the management of their communities.

¹⁷⁰ Centre for Welfare Reform <http://www.centreforwelfarereform.org/about-us> Hilary Cottam: Social services are broken. How we can fix them: TED website http://www.ted.com/talks/hilary_cottam_social_services_are_broken_how_we_can_fix_them
Change Agents: The Older People’s Participation Co-operative http://www.changeagents.coop/Change_AGEnts/Welcome.html

¹⁷¹ Eva Cox A TRULY CIVIL SOCIETY The 1995 Boyer Lectures https://www.crcresearch.org/files-crcresearch/File/cox_95.pdf

The movement to rebuild civil society is not dead. After reviewing the multitude of contradictory and confusing corporate and other researched models for developing the cities of the future, Professor Paul James and other organisers¹⁷² of the Ecocity World Summit, have said that “*it’s hard to see how a city can be good for all its people unless they are involved in its creation*”. They call for “*big and general public dialogue*”.

If we replaced the word “city” with the word aged care then “*it’s hard to see how **aged care** can be good for all its people unless they are involved in its creation*”.

We can also replace it in three of the four organizing principles they suggest.

- **Economics** – cities (**aged care**) should be based on an economy organised around the social needs of all citizens.
- **Politics** – cities (**aged care**) should have an enhanced emphasis on engaged and negotiated civic involvement.
- **Culture** – cities (**aged care**) should actively develop ongoing processes for dealing with the uncomfortable intersections of identity and difference.

We think that government in clinging to the neoliberal past has lost touch, not only with citizens, but with the future. It’s time to move forward to the future.

Aged Care Crisis’ proposals:

Aged Care Crisis is advocating the engagement of communities in the aged care process by involving them and giving them ownership. We argue that this would provide a way out of the blind alley that neoliberal policies have created in aged care.

Few in Australia recognise the extent of the problems in aged care or suggest a way of addressing them that might be effective. It cannot be grasped in sound grabs but becomes clear when the effort is made to gather and examine the evidence.

Neoliberalism leads to consolidation into large corporatisations which become institutionalized and as Braithwaite indicated this leads to ritualisation and control.

When the Pioneer Network to reform aged care was formed in the USA in 1997, a founding principle was that “Community is the antidote to institutionalisation”¹⁷³. This movement sits within the discourse of care and considers that “*Relationship is the fundamental building block of a transformed culture*” which is what we are pressing for.

Giving communities control of information and involving them in managing and controlling aged care would be an important contribution to both open government and participatory democracy. It would build relationships.

Because community and government would be working together to monitor and regulate the industry the principle of distributive justice would be upheld.

¹⁷² James P et al **What actually is a good city?** The Conversation 12 July 2017
<https://theconversation.com/what-actually-is-a-good-city-80677>

¹⁷³ **Our vision and Mission** Pioneer Network <https://www.pioneernetwork.net/about-us/mission-vision-values/>

Braithwaite et al argue (p100) that “*dialogic, local accountability based on broad outcome-oriented standards and well-resourced local advocacy is a more hopeful strategy than national accountability based on demands for detailed documentation and a myriad of inputs*”. Demands for more formal and rigorous government regulation create more ritualization for regulators and within nursing homes.

We are looking for a less disciplining industry culture accompanied by a social structure in which transparency, accountability, praise and censure are a part of everyday life. Like Braithwaite, we agree that simply calling for more and more rigorous data collection only compounds the problems and fuels ritualism but we need the sort of direct oversight and immediate action that works. We need enough objective data to pin our discourses to the world they are a part of and on which to base research and policy.

Social control exerted through the discourse of care in day-to-day social interaction is by far the most powerful form of regulation.

In this regard Braithwaite et al (page 144) express the view that “*It is possible to have formalism that empowers and enables informal social control to work flexibly, in all its rich, innovative, contextual possibilities for variety*”.

Our proposals are intended to create a context for dealing with differences of opinion and rebuilding social capital.

Instead of moving citizens into an institution, where they would be managed, the institution would be moved into a community. Both the institution and those who lived there would be a part of the community.

1.23.4 A way forward

We are pressing for a system that gradually, and not precipitously, moves the management of aged care into local areas. Here community should be supported and partnerships built between community and government - and then with providers.

The primary role of government would be to empower, support and mentor the communities, empowering them to take control of the services to the aged in their regions – to assume responsibility for the welfare of their members and work directly with providers in ensuring this.

In 2001 Kendig and Duckett¹⁷⁴ proposed that the financial management of aged care be undertaken locally. They outlined the many advantages of this including flexibility, responsiveness and much closer oversight. We agree that this would be desirable but the issues of data collection and regulatory oversight are even more pressing at this time.

¹⁷⁴ Australian directions in aged care: the generation of policies for generations of older people. Hal Kendig and Stephen Duckett Australian Health Policy Institute Commissioned Paper Series 2001/05 (NB We can supply a copy if needed)

Currently our major problems are market failure due to:

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

Our proposals are intended to address these issues.

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

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

(NB. Campbell's law¹⁷⁵ would not operate because the collection of data would be only a part of a wider assessment so placing data indicating failures in care into a wider more holistic assessment.)

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

¹⁷⁵ Campbell's law Wikipedia https://en.wikipedia.org/wiki/Campbell%27s_law

1.23.5 Outcomes

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

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

1.24 Wider community considerations

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

Instead of talking about bludgers and politicising unemployment rates we should be welcoming the opportunities offered and be planning sensibly for the future by building community and the opportunities there. Many of these communities may be virtual ones.

These people could find new meaning in life in working with others in the community in humanitarian endeavours. Some already do so. Civil society has been eroded by an excess of centralised control and organisation. Too many feel left out and irrelevant. Repair work is needed.

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

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

1.25 Problems in implementation

Problems in confronting entrenched discourse

The philosopher Foucault's analysis of discourse, power and governmentality shows how deeply discourse becomes imbedded in our personality and our identity and so controls our thinking – part of our psychological DNA.

The way that this has inhibited our ability to confront evidence and logic that challenges and disproves the discourse is readily understood.

That this happens has long been recognized in western philosophy, sociology and psychology. Theories have developed to explain it. Foucault makes it easier to grasp. It is interesting that this same insight was addressed by an Islamic Sufi philosopher Idries Kahn in his 1968 English book "Caravan of Dreams". In talking about those who needed to adopt change he indicated that unless the individual (and groups) had *"learned to locate and allow for the various patterns of coercive institutions, formal and also informal, which rule him. No matter what his reason says, he will always relapse into obedience to the coersive agency while its pattern is within him"*¹⁷⁶

The greatest difficulty will be for those who have built their lives using this discourse to the extent that "the pattern is within them".

We know that it is possible to challenge 'the pattern within' and change because it happened in South Africa during the 1990s but that was a rare example which averted a tragedy.

Do our current leaders have that sort of insight and what will it take to bring them to it? This is the greatest problem in making needed changes.

A hollowed out impotent society with a cargo culture

We do not underestimate the difficulties of doing this in a hollowed out society in the distrustful post-truth era.

We have passed through the era of the welfare state when the government provided. This was followed by the neoliberal/managerialist era when large corporations took over and everything was managed.

Together with more and more marketing and consumerism we seem to have developed a cargo cult which expects government or market to provide, solve every problem or meet our every need. We complain when this does not happen and we do not think that we should be involved. Too often we feel that we should be paid ourselves when we contribute to our society. Responsible citizenship is in short supply.

¹⁷⁶ Quoted by Doris Lessing in her 1994 autobiography *Under my Skin*

A lack of ownership comes with commodification

All this has resulted in a loss of social capital and the sense of ownership that involvement brings.

As the research with food showed this disengagement from what is happening in our society fuels anxiety and distrust – the post-truth era. This compounds the problem.

These issues must be confronted by re-engaging and rebuilding ‘a truly civil society’. Sociologist Eva Cox argues¹⁷⁷ that “*Time may be running out for political agendas that offer material rewards but not social well-being. More evidence is emerging of continuing damage to social stability and cohesion*”.

1.25.1 Implementation

When it comes to implementation nothing could be more counterproductive than another glowing marketing endeavor clothed in headlined words like ‘quality’, selling ideas to the community – another reform. There are two lessons from experience.

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

A cautious approach needed: Governments that have tried to involve citizens by selling them ideas or by allocating jobs to them have not been successful.

The current practice of selling policies should be replaced by engaging citizens and community in developing policies and services and then building and running them. They should be engaged in more subtle ways that offer them opportunities to grow and develop their identities by contributing and building social selves – owning their activities and the outcomes.

This will be difficult for the managerial class who will struggle to relinquish the control they now have!

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

¹⁷⁷ Eva Cox **Social stability is the missing link underpinning economic growth** The Conversation 1 September 2015
<https://theconversation.com/social-stability-is-the-missing-link-underpinning-economic-growth-46731>

Critically important to this will be the involvement of those with medical, nursing and other forms of expertise in each region in leading the way. As members of the community with skills their participation would be central to anything like this.

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

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

Appendix 1 : An approach to aged care and its regulation

In our analysis of aged care we approach these issues, in particular the failure of regulation, by examining the patterns of thought and the frames of analysis on which decisions and action are based.

The work of Philosopher Michel Foucault¹⁷⁸ has focused on the importance of what in the past have been described as ‘frames of reference’, ‘patterns of thought’ or ‘narratives’. *He includes them in what he calls* ‘discourses’. He shows how the discourses we use influence our thinking, the way we understand things, the way we behave, the things we do and ultimately the sort of people we become. It impacts our psychological DNA and so what we do, who we become and our identity.

Cultures: Discourses are particularly important within cultures and subcultures and play a key role in the different ways they understand the situations they confront and their approach to the things they do.

The power of discourse: Those with the power to control the discourse in any sector are able to influence and control the thinking of participants and so their actions and behaviour. Foucault calls this process of controlling the thinking of others and getting them to identify with your ideas, ‘governmentality’.

Dominant discourses put strong pressure on us to adapt and conform, sometimes when this is not in our interests or the interests of society.

We have developed strategies that allow us to avoid confronting our principles and escape the discomfort of doing so when the pressures are strong enough. Doctors have been under this sort of pressure for years¹⁷⁹ and some, particularly in the USA, have succumbed.

It is particularly important for those in power to control what is credible or not credible, and what is excluded or unacceptable in the discourse. They do this by controlling the way information is collected, analysed, presented and understood.

This influence is so deep and profound that we will often ignore evidence and logic in order to cling to a discourse that has become a part of who we are.

Conflicted discourses: As individuals we have difficulty in managing and working with multiple discourses particularly when they conceptualise things differently and require us to behave differently. We can find it stressful and get defensive when our discourses are challenged.

¹⁷⁸ Michel Foucault Wikipedia https://en.wikipedia.org/wiki/Michel_Foucault

¹⁷⁹ Wynne JM Belief versus Reality in Reforming Health Care Health Issues 2005, Number 83, pp. 9-13. <http://www.corpmedinfo.com/jmwynne83.pdf>

Appendices

Public information can expose problems in the discourse and challenge its legitimacy. This is threatening not only for those in power but for those citizens who have identified with the discourse and built their lives using it. All ideologies are built around discourses.

They seek to censor, attack or discredit challenging information often by shooting the messenger.

Research: Increasingly those doing social research into human services including health and aged care are using Foucault's ideas to explain and understand what they are observing when discourses collide. We have found this to be a useful way of understanding¹⁸⁰ what has been happening in aged care in Australia and elsewhere, particularly why regulation is failing.

1.26 Two broad discourses in aged care

Two major conflicting discourses are readily distinguished and they are not restricted to aged care.

The discourse of care

History: This traditional discourse dates back at least to Hippocrates about 2500 years ago and recognises the social responsibility we have when dealing with the vulnerable. In the 19th century churches and their morality exerted a powerful influence on the way people thought and their discourses built values and norms that protected the vulnerable and brought them care. The more modern version forms the ethical base of health care professionalism. It remains important within the larger community. While sometimes eroded and subverted over the centuries the ethic of care has stood the test of time.

Language and concepts: This discourse uses phrases like vulnerability, responsibility, empathy, relationships, responsible citizenship, trust and trustworthiness, probity, responsible capitalism etc. Its values are the core values of the community.

In this discourse, vulnerability and interdependence are set against an acknowledgement of the essentially predatory nature of markets and the need to restrain and control their behaviour.

This discourse resides in the community, and in the professionals and empathic employees who provide the hands on care. Traditionally these services have been the responsibility of the community and were provided by the community to its needy members.

Professor Fine and his associated have closely examined and teased out the nature of care and described the changing cultures of care¹⁸¹. In doing so they have refined the discourse of care. This important work is largely ignored by politicians.

¹⁸⁰ **Theory and Research in aged care** Inside Aged Care <https://www.insideagedcare.com/aged-care-analysis/theory-and-research#regulation>

¹⁸¹ **Articles associated with** - - "on web page **Theory and Research in aged care** Inside Aged Care

<https://www.insideagedcare.com/aged-care-analysis/theory-and-research#care>

The Nature of Care Inside Aged Care <https://www.insideagedcare.com/aged-care-analysis/theory-and-research/nature-of-care>

The free-market/neoliberal discourse

History: This is a discourse that originated in the 1970s and was underpinned by the strong assertion that social responsibility was socialist and therefore evil¹⁸². It impeded the operation of markets. The only responsibility was to investors.

In this it directly challenged the discourse of care, which depended on an ethic of social responsibility. Markets were self-correcting and interference by government and other regulators impeded this.

This discourse was embraced by politicians in the USA, the UK and then in Australia in the 1980s and 1990s. One of the first things done in 1997 in Australia when marketising aged care was to abolish the federal probity legislation.

This was the legal embodiment of the social responsibility required within the community's discourse of care. The probity regulations had specifically barred those whose track record displayed a lack of social responsibility (described as not being 'fit and proper') from providing aged care services.

Liberalisation: In the neoliberal discourse the process where the market was freed of regulation and social restraint was called 'liberalisation'. Sectors like aged care were 'liberalised' and the repeal of the probity legislation was the first step.

The second step was liberalization from accountability by abolishing state oversight and hiding staffing and financial data, which became commercial in confidence. The third step was liberalization from regulation by replacing it with accreditation.

It is interesting that US President Reagan who (with the UK's Thatcher) embraced the neoliberal discourse in the 1980s had tried twice to replace government regulation with accreditation in aged care. Both were followed by a savage community backlash and blocked by congress¹⁸³. In the USA accreditation is voluntary and unlike healthcare only about 10% of nursing homes are accredited. It is not used for regulation.

Language and concepts: The words used in the neoliberal discourse include free markets, competition, efficiency, choice, microeconomic reform, incentivisation and management - a top down controlling managerialism. Its values are the values of the free market system.

Neoliberalism has become particularly successful because its discourse has been driven and controlled by its managerial structure. This managerial structure and its thinking have been introduced into almost every sector, including governments at all levels and not-profit humanitarian endeavours.

Managerialism has been a powerful vehicle for controlling the content of discourse. It was imposed on health and aged care where the words and concepts of the neoliberal discourse replaced those of the discourse of care.

¹⁸² **The Social Responsibility of Business is to Increase its Profits** by Milton Friedman The New York Times Magazine, September 13, 1970. <http://www.colorado.edu/studentgroups/libertarians/issues/friedman-soc-resp-business.html>

The Origin Of 'The World's Dumbest Idea': Milton Friedman by Steve Denning Forbes Leadership 26 Jun 2013 <http://www.forbes.com/sites/stevedenning/2013/06/26/the-origin-of-the-worlds-dumbest-idea-milton-friedman/#41f8ea8f214c>

¹⁸³ Braithwaite J et al *Regulating Aged Care* Edward Elgar Publishing Limited 2007 page 32

Warnings: Academics and professionals from the discourses of responsible capitalism and civil society as well as the discourse of care in the USA and Australia were very critical and warned of the consequences. Their arguments and warnings were ignored

1.27 Criticism of neoliberalism in Australia

General: In 1995 Stuart Rees co-edited a book¹⁸⁴ "The Human costs of managerialism". This warned of the consequences of this managerialism for society. On pages 16 and 17 Rees describes the policy of controlling what Foucault calls discourse as *"all inclusive claims of 'culture management' with its emphasis on changing the culture of an organisation by paying attention to language, symbolism and ritual"*.

He wrote of managers waiting for opportunities to *"demonstrate their toughness and efficiency, their willingness to disparage old professional practices and traditions in the interests of a new corporatism"* and then *"Associated with this promotion and educational expansion is a corporate language and accompanying attitudes. These are the outcomes of preoccupation with management as the panacea for governments and organisations"*.

Health and aged care: At a surgical conference in 1996 one of us warned of the risks posed by the marketplace patterns of thought being introduced into medicine by US companies entering Australia¹⁸⁵ saying, *"The frames of reference through which we interpret the world we live in and the actions we take have a profound impact on the plans we make and their consequences - - - surgery cannot be immune"*.

Later in an appendix to a submission to the 2009 Walton Inquiry into complaints, one of us described the way the new words used in aged care changed the way it was understood saying:

"One consequence of these changes has been the (probably unconscious) use of linguistic strategies to remove the legitimacy of the community model. Words with associative meanings that bring out the unique and important humanitarian characteristics of the sector have been replaced with words without specific associations other than those common in commercial enterprises. The unique emotional content intrinsic to the sector has been removed".

Professor Stephen Leeder, eminent doctor and thinker within the discourse of care graphically described what was happening in the late 1990s as the transfusion of mad cow thinking¹⁸⁶ into every vein of our society. At the time Mad Cow Disease was jumping species to infect humans. It caused bizarre delusions and strange behaviour.

More recently academics have studied the impact of managerialism and the neoliberal discourse on the staff who provide care in health and other human services, some using Foucault's ideas¹⁸⁷. These reveal how staff adopt this discourse and try to identify with it. They study the problems caused by this and the way the challenge it poses to the training they received within the ethic of care plays out in everyday life in hospitals.

An example from health care illustrates the power of discourse, even in the face of overwhelming evidence in the USA and Australia.

¹⁸⁴ Stuart Rees and Gordon Rodley *'The Human Costs of Managerialism'* Pluto Press 1995 page 17

¹⁸⁵ *The impact of financial pressures on clinical care lessons from corporate medicine* Corporate Medicine website, 29 Dec 1996 <http://www.bmartin.cc/dissent/documents/health/corpmmed.html>

¹⁸⁶ Professor Stephen Leeder *'Mad-cow thinking - how far has it spread'* Australian Medicine 20 May 1996 p 6

¹⁸⁷ *The Nature of Care* Inside Aged Care <https://www.insideagedcare.com/aged-care-analysis/theory-and-research/nature-of-care>



Example: Tenet Healthcare¹⁸⁸ (at the time called NME), the example used to illustrate the risks for Australia at the surgical conference in 1996 was a US hospital company operating in Australia between 1991 and 1996. It pleaded guilty to criminal conduct in the USA in 1994 and failed state probity requirements in Australia the same year. It was being forced out of Australia in 1996.

This was not a rogue company but had been one of the most successful health care businesses in the USA. Like others it had a close revolving door with government. It embraced the neoliberal discourse and marketplace thinking. Its business practices were those of multiple other successful corporations and in health care they were enormously successful, particularly in psychiatry where the patients are particularly vulnerable. Vast quantities of the profitable care they provided was of little benefit to the patients.

In the 1980s it was also the largest provider of nursing homes in the USA and it had a significant impact in that sector.

Its managers, its thousands of staff including nurses and even doctors enthusiastically embraced its business thinking and it soon had a reputation for providing good care which even the patients, the insurers and the regulators accepted and did not challenge. Those who were not 'team players' (ie thought differently) were pushed aside. It was the darling of the marketplace and staff basked in the reflected glory as its share price rose. They adopted the discourse and identified with what they were doing.

It was an ordinary policeman, an outsider, who challenged this and initiated an investigation in psychiatric care and drug rehabilitation that spread across the USA and ended in criminal proceedings. Many were harmed.

By 1996 other countries were fully informed and soon after the presentation in 1996 the company abandoned its international operations and returned to the USA.

But only 6 years after it left Australia it happened all over again and there was another massive scandal in the USA. Most of this involved major surgical procedures, which is what one of us had warned about. One of this company's US hospitals carried out over 700 unnecessary major heart operations. This time it was a priest and not the regulators who saw what was happening and acted. The vice president directly responsible for this hospital had been CEO of this company in Australia between 1991 and 1996 and he had negotiated contracts with these doctors.

In 2003 soon after the second scandal a surgeon, who was pushed aside and lost his privileges at one of this company's US hospitals because he was not a team player, put it this way "Tenet has honed everything down to the fine art of making money. Tenet will do anything -- anything -- to make a profit."

The problem was that for Tenet this was legitimate and they saw nothing wrong with it. Their only responsibility was to their shareholders and in their internal reports to staff they were quite open about this. Most of the other health and aged care corporations thought and behaved similarly. Many paid large fines.

In Australia: When information about Tenet/NME became available in 1992 objections were lodged to hospital licenses for Tenet in all states on the basis of their lack of probity. In March 1993 the West Australian Department of health reviewed the information available. They warned their government of the risks of Tenet's business practices and that something like this might happen here stating "*there is a very serious threat to the*

¹⁸⁸ Tenet Healthcare & National Medical Enterprises Corporate Medicine web site http://www.corpmedinfo.com/entry_to_Tenet.html

Australian Hospital system through the introduction of NME (soon renamed Tenet Healthcare) as the major shareholder in the private hospital system.

They itemised the weaknesses that rendered our health system vulnerable then listed bounty payments, insurance fraud, abuse of patients, suspect accounting practices and the dominance of an intake culture as likely problems. Of several likely scenarios that might occur they listed “*expansion of ineffective in-patient programs in Psychiatry and medicine*”. They suggested “*inpatient programs for diabetes, asthma, allergy, hypertension, migraine and alcohol as examples*”.

The report concluded that Tenet’s investment “*poses a threat to the public, patients, public and private healthcare systems and to the State*. It was the authors “*firm view that a prima facie case exists that NME is not a fit and proper body to hold a hospital licence in Australia*. They recommended to the minister that the state government act but the West Australian government ignored this advice and it remained hidden. The department later released it under FOI.

The Australian company was paying \$1 million annually for the use of Tenet’s profitable business expertise and the services of a successful Tenet manager as CEO. Promised funding by banks for expansion at this time was contingent on the continuation of this contract and employment of this Tenet CEO. They were fully aware of the problems in the USA, the court actions there and the probity reviews in Australia but did not withdraw their support.

A NSW judge, who was later shown to have taken recently taken early retirement when investigated by ICAC because he was at risk of improper influence, was appointed to make the decision in NSW, where the health department advised the application be rejected. He approved the licenses against the health department’s advice and with token conditions they had told him they could not police. The banks loaned their money and the company attempted to expand into Queensland and Victoria.

Victoria did not accept the judge’s decision and did its own investigation. They barred the company from operating in Victoria on probity grounds. Tenet’s eventually departed in 1996, but only when more damning of information about the past business practices of its Australian Tenet CEO and directors became available.

It was a narrow escape for Australia and a telling illustration of the value of probity legislation. The tenacity of the battle by the marketplace and politicians to keep this company in Australia was a graphic illustration of the growing influence of the neoliberal discourse in the marketplace and in politics in Australia.

The lobbying and pressure placed on regulators who did their best illustrates the decline in social responsibility in politics and marketplace that accompanied the neoliberal discourse as it consolidated its hold in health and other human services even before the changes in 1997.

A discourse that could not be faulty: The problem for this company, for politicians and for the banks, was that none could accept that the neoliberal discourse and its business practices based on this discourse were responsible for what happened. Tenet did everything that the theory said it should do – and more.

They adopted a number of rationalisations, some shifting blame elsewhere. The industry saw the health care laws that they broke as an illegitimate restriction on marketplace activities which should have been liberalised. Many others in the USA sought ways of circumventing them and some were penalised for doing so.

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In Australia professional practices that protected against excessive commercialisation were seen as anticompetitive and were made illegal.

What they believed in and did was supported by the neoliberal discourse in politics and the marketplace. Neither politicians nor marketplace could question the discourse without losing credibility.

This company was not an isolated instance. The bulk of the US psychiatric industry were doing similar things and paid large fines. An even larger company Columbia/HCA was being courted by Australia in 1997 and had applied to the Foreign Investment and Review Board (FIRB) to invest \$1 billion in hospitals. This fell apart when whistleblower initiated FBI raids on its hospitals across the USA led to an even bigger scandal in its general hospitals.

Health Care fraud was by this time a bigger issue for the FBI than the drug trade and at one time more fraud money was recovered from health care than from any other sector.

None of this has had an impact on the legitimacy of the neoliberal discourse and it is still policy for health and aged care in the USA, the UK and Australia.

Some resistance: Australian surgeons and their colleagues did get the message and understood what was happening. They challenged government and used their market power as customers to put at least one large local company that adopted similar policies out of business. The tension between doctors, and the neoliberal discourse of politics and big corporations continues. The threat to health care in Australia was confronted and controlled but still remains. The danger is that younger doctors growing up within our neoliberal society will ignore the lessons of the past and not resist the ongoing pressures.

Regulation too: Neoliberal policy insists that regulation impedes the market and should therefore be reduced. Yet while they maintain this belief there has been a dramatic increase in regulation in all three countries and the examples given above illustrate why. This has become so extensive that criminologists and other academics who study this area consider that regulation rather than neoliberal policy has been a defining feature of the period. They write about 'Regulatory Capitalism' rather than neoliberalism.

A feature of this regulation is that it has been centralized and controlled by government and industry. It has been industry friendly and sought to work with industry rather than monitor and confront. It has protected and not challenged the discourse. There have been many regulatory failures particularly in health and aged care in the UK and the USA. In Australia health care has been much less affected than in these countries. Aged care has borne the brunt, perhaps because doctors have little influence here.

The way in which the regulation of aged care has been controlled and restricted by the free-market/neoliberal discourse is the subject of Part 3 of our submission.

Appendix 2: Background to system failure in Australia

Reasons for examining the system broadly

Oakden: To understand the problems at Oakden we need to consider whether it is part of a larger problem. In that case simply concentrating on Oakden and what happened there may be a waste of time and resources. System changes will be needed.

Regulation: To understand why regulation is failing we need to understand the sector that is being regulated. If the pressures to behave inappropriately are strong enough, if those being regulated have to circumvent the regulations to succeed or even survive, and if those being regulated do not identify with the needs of the system and its regulation and have other priorities, then regulation is going to be severely challenged and is likely to fail. In these circumstance, if regulation is controlled by those being regulated, regulators will find ways to collude with those regulated.

Obviously it will be more effective to fix the system than to struggle with regulation that is unlikely to work.

To understand how it came to this we need to examine what has happened in the aged care sector where Oakden operates and that regulators regulate, and see what the consequences are

Story of markets in the aged care sector

Social responsibility: The growth of neoliberalism and its marketplace recipes for all of society saw the abandonment of social responsibility as a consideration not only in the bazaar and used car trade but in human services like aged care.

There is growing evidence that uncontrolled markets in vulnerable human services, services where a sense of responsibility is required, are failing citizens. Aged care is a good example.

Lessons from the past ignored: Adverse experience with the commercialisation of aged care in Australia in the 1970s were ignored. The reforms of the 1980s made the aged care market accountable and monitored both staffing levels and performance. This limited profitability and these reforms were attacked by businessmen in the sector in the late 1980s and early 1990s. These reforms were eroded and finally abandoned in 1997.

A changed system: An aged care system driven by humanitarian values and supported by the empathic motives of the community and of staff who empathised and cared was turned into one based on commercial values in which providers of care competed to make a profit and used this to grow and increase their market share. Those who failed to compete successfully went under or were acquired.

Liberalisation: Laws that protected people by insisting on social responsibility were seen as obstructive of markets and so harmful. Liberalisation of the sector removed these obstructions and opened it to predatory commercial enterprises – even to high risk profit-driven private equity businesses.

Warnings were ignored¹⁸⁹. Having choice was expected to create competition, protect residents and make this work.

The aged care system we have

Choice: The elderly are urged to choose wisely but neither their vulnerability, their incapacity, the power imbalance, nor the lack of the information needed to make informed choice are considered. The idea of choice has become a token for the real thing and a triumph of marketing form over substance.

The community knowledge and support networks that should be there to support the elderly and watch over them have been replaced with a centralized computer interface marketing the wares offered in this market, and when needed an impersonal voice on the phone. The irony in the title 'myagedcare' cannot be lost on them!

Those who succeed in wisely choosing a provider who spends more on staff do not realise that this is at the expense of profit. Effective staffing reduces profitability and so competitiveness. It places residents at risk of being sold off to a private equity or other share market listed provider seeking to grow their portfolio.

The new owner's only interest in the resident's welfare in many instances is the profit that can be generated from them as the new owner cuts staff to 'turn the business around' and push up its stock price. It can use it as an asset to raise money to fund more growth or perhaps open an operation in China where even more money can be made.

This is some choice for the residents who have no say in any of this!

Competitive and efficiency pressures: The payment system is relatively controlled so that profitability comes from reducing costs. About 70% of the cost of effective care is nursing salaries.

Without an effective and informed customer to put poor performers out of business and an involved and active civil society to control unacceptable behaviour, profits have come at the expense of staff.

Financial efficiency driven by managers with little understanding of care compounds the problems.

Financial and job instability, an increasing workload and the pressure to provide care for which they are not trained lead to staff disillusionment and alienation. This impacts adversely on the cultures of care in the sector. Care becomes impersonal and task focused rather than person focused. Frustration is taken out on the residents and this can lead to elder abuse.

¹⁸⁹ Private equity investment in Australia : The Senate Standing Committee on Economics

August 2007 <http://www.corpmedinfo.com/agereport2007b.html>

Wynne JM Submission to the Senate Economics Committee <https://www.agedcarecrisis.com/images/subs/sub03.pdf>

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With competition driving staffing cuts, failures in care were inevitable and we are seeing many of them.

The rapid ageing of the population compounded by poor salaries and a loss of ownership over the care they provide are placing pressures on staff and impacting facility culture. These problems are being compounded instead of being addressed by the aged care system that we have.

The refusal by an industry, which must be profitable to survive, to confront these systemic problems has led to tokenistic efforts to address staffing issues. At a time when more staff are needed some are reducing staffing numbers and skills, putting nurses out of work.

The total cost of care: That efficiency and competition in the marketplace will produce the best services at the lowest cost is an unchallengeable tenet of the neoliberal agenda. But as the nonprofits are discovering there are significant financial and human as well as social costs to a competitive market in human services. The advice of the many consultants they now employ to help them to compete is not cheap.

Health care in the competitive US system is the most costly in the world yet WHO studies have shown that overall its health outcomes are inferior to the majority of developed countries.

In commenting on the high incidence of failures in aged care in the USA Braithwaite et al who has studied aged care in multiple countries (page 83) said *“the comparatively competitive, privatized, yet highly disciplinary American health system costs so much compared to many other nations, yet delivers worse health outcomes”*.

We have a similar neoliberal competitive free market model for aged care. Is it possible that, if we set total cost and real life outcomes against one another we would find that we too are facing the increased costs of the aged care bulge with one of the most financially inefficient health and aged care systems?

If so then this can only be because the application of the neoliberal discourse to health and aged care is deeply flawed.

Its legitimacy lies in its claim to efficiency but it is increasingly obvious that instead of providing good care at the best price it compromises the care that the system is there to provide.

Following the market rather than the care: In highly competitive markets there is no room for sentiment or for social responsibility. If you cannot compete then you cannot provide the service and those who need it do without. The nonprofits, the community organisations that regional Australia depends on are trapped by this.

To survive they must follow the money and grow to compete – be efficient rather than compassionate. The money lies in the big cities where the wealthy live.



Example: Two of the nonprofit facilities in the list of sanctioned companies listed at the beginning of our submission are operated by lay Catholic organisations - Ozcare (St Vincent de Paul) in Queensland and Southern Cross Care in Canberra. Reports and family accounts suggests that there were staffing and skills issues at both.

Both the ALRC Inquiry into elder abuse and the Senate Aged Care Workforce inquiry have identified major deficiencies in staff skills and numbers, as well as an overall shortage of nurses across the country. You would expect providers to be looking for staff - not firing them.

In spite of all this, Southern Cross Care in Queensland in July 2017 started cutting staff as part of a restructure. Busy daytime shifts were left with fewer staff. Press reports¹⁹⁰ indicated that *“the not-for-profit organisation would reduce the rostered hours for some staff, along with the length of many shifts”* with the result that *“the morning shift lose two nurses and one staff member cut from the afternoon shift”*. The nursing unions indicated that as they struggled to recruit and maintain staff numbers, the sector was *“pretty rife like this”*.

Southern Cross *“confirmed nursing shifts and hours will be reduced to align with current levels of funding”*. There have been large cuts in regional towns where the non-profit has *“slashed hundreds of hours from their fortnightly staff rosters”* because *“the sustainability of the vital service provided demands that the organisation is run efficiently”*.

It was not facility managers but *“the executive of Southern Cross”* that made the decision which was to *“ensure we can survive into the future”*. The unions rejected this claiming that at the same time providers were buying up buildings across the state *“because there is a lot of profit in it.”*

In response to community anger and criticism of its lack of consultation, Southern Cross defended themselves¹⁹¹ saying *“The cuts to staffing levels were underpinned by an Aged Care Financial Performance Survey written by consultants Stewart Brown in 2016”*. The local MP indicated that the *“decision to cut hours was “purely commercial”*. Stewart Brown is the company that does not know that hotel services are not direct care, an indication of the knowledge base it uses to set staffing standards for the industry in Australia.

Southern Cross is also selling smaller regional facilities but expanding two of its more upmarket facilities in Brisbane¹⁹². This is where the money is. In a highly competitive market, there is no room for sentiment or for the poor and vulnerable in regional areas. To survive you have to follow the money. It seems that, in this market, if you cannot beat them then you have to join them and appoint those managers who are willing to display *“their toughness and efficiency”*.

The impact of this on culture and motivation within these facilities will be as important as the actual pressure of work. Staff including facility managers themselves, no longer have any control over what they do – they lose ownership and are unable to identify with what they do. They cease to care.

¹⁹⁰ Southern Cross Care Queensland announce nursing cuts as part of restructure Brisbane Times 3 July 2017 <http://www.brisbanetimes.com.au/queensland/southern-cross-care-queensland-announce-nursing-cuts-as-part-of-restructure-20170703-gx3rkq.html>

Aged care cuts in Chinchilla and Taroom Chinchilla News 6 Jul 2017 <https://www.chinchillanews.com.au/news/aged-care-cuts-in-chinchilla-and-taroom/3197269/>

¹⁹¹ Southern Cross Care defends nursing home cuts, families hit back The Chinchilla News 13 Jul 2017 <https://www.chinchillanews.com.au/news/southern-cross-care-defends-nursing-home-cuts-fami/3199884/>

¹⁹² Southern Cross 2015/16 Annual Report page 6 http://sccqld.com.au/app/uploads/2016/12/Annual-Report-20152016-final_small.pdf

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This frustration and anger can be taken out on residents and creates a context where elder abuse is more likely and where other emotionally blunted staff are too disinterested to do anything about it. In many examples of elder abuse in facilities it has not been bad people but the context created by management that has been responsible.

Absence of data: This reduction in staffing has been facilitated by the failure to collect and publish data about staffing and care. In the USA not only are staff and care data collected and published but minimum safe levels are defined by the Centre for Medicare and Medicaid. Many US states have legislated minimum requirements.

Without this level of information and accountability to counter commercial pressures in Australia, staffing skills have been falling and total staffing ratios are well below levels that international benchmarks based on objective studies show pose a significant risk of failed care. Failures in care are therefore very probable.

Some data about staffing has recently become available. This shows that Australian residents receive less than half the care from trained nurses and an hour less nursing care each day than in the USA. We address the issue of staffing and the absence of any regulation to prevent suboptimal staffing in Part 2 of this submission.

Managerialism: In addition to this a centralised, bureaucratised and process driven managerial approach by government has resulted in an inflexible task focused, and impersonal management system that cannot adapt to individual needs and in which many now fall through the cracks.

Those who need help or who are unhappy are faced by an impersonal interface. A culture of care is frustrated.

Recurrent scandals: Not surprisingly the era since 1997 has been characterised by ongoing unhappiness about care punctuated by periodic and recurrent major scandals¹⁹³. In many instances it is whistleblowers rather than regulators who have exposed what is happening.

Instead of confronting this by acknowledging the problems the neoliberal discourse has denied events, claimed the irrefutable as rare exceptions and insisted that we had a world class system¹⁹⁴. Doubters who identified problems were not seen as legitimate. They rather than their arguments were discredited.

¹⁹³ Scandal after scandal <https://www.insideagedcare.com/aged-care-analysis/19-years-of-care/scandal-after-scandal>

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

¹⁹⁴ How Aged Care is perceived <https://www.insideagedcare.com/aged-care-analysis/widely-contrasting-views/how-aged-care-is-perceived>

Appendix 3: A changing pattern of failures

Distance from metropolitan centres is associated with a greater incidence of failures in care and sanctions. This does not seem to have changed but we have not studied this closely. While we have not kept accurate records of the figures our strong impression is that the pattern in metropolitan areas has been changing.

- a. Initially at the turn of the century the failures and scandals were largely restricted to smaller for-profit owned facilities, many in Victoria where the Kennett government in the early 1990s had enticed many looking for commercial opportunities but with little understanding of care to open nursing home businesses.
- b. As competition and consolidation increased from about 2006 there were increasing numbers of large competitive for-profit providers that failed sometimes dramatically.
- c. More recently, principally since the Abbott government was elected in 2013 and the Aged Care Roadmap was developed, we have seen more failures in nonprofits. Nurses at the bedside are complaining bitterly and many assert that there is now little difference.

The nonprofits are increasingly threatened by competitive market pressures. Many speakers and subjects at nonprofit provider group ACSA conferences are drawn from the marketplace and from the numerous consultant businesses. Nonprofits are increasingly using these market focused consultants¹⁹⁵ and following their advice. They are appointing managers with marketplace experience to senior positions. The example of Southern Cross Care described earlier illustrates why this is happening. It is not the only large nonprofit reducing staff. Blue Care is doing the same¹⁹⁶.

- d. In Australia government operated aged care services have generally been better staffed and had fewer problems. That three of the aged care facilities in the group of recent failures are run by government is therefore of considerable interest as it seems to reflect a new trend.

What happened at Oakden and is it representative?

Although we heard about abuse and neglect from some families about Oakden in 2007 we have no direct experience of what happened there and why, so are unable to comment on the specific reasons why abuse and neglect occurred or on medication issues other than to point to the obvious link with staffing skills and numbers.

We heard of a positive experience from one family prior to 2007 and learned that at this time there was a change in policy with a decision to employ international staff and 457 visa holders. What is clear is that, at least since then, there have been issues in staffing and in management and that residents were neglected and harmed.

These failures were not detected or effectively addressed by the regulatory process over several years. That at least seems to be representative of the regulatory failure that many have described over the years and which we analyse in **Part 3**.

¹⁹⁵ Experts advise on viability and sustainability - Australian Ageing Agenda, 18 Sep 2014
<http://www.australianageingagenda.com.au/2014/09/18/growing-pains/>

¹⁹⁶ Cuts leave aged care staff with blues <https://www.news-mail.com.au/news/cuts-leave-aged-care-staff-with-blues/3210237/>

We can only look at what is happening in the wider sector and in other government run services that have failed. We can see where they have failed and suggest that this may have happened at Oakden so that the committee can consider that possibility.

Other government owned facilities:

Garrawarra: We know that, at the NSW government's dementia specific facility at Garrawarra, the sanctions were related to serious concerns about 'behavioural management'. This will clearly be related to problems with nursing skills and possibly staff numbers as well.

Six weeks since the inspection the results have not yet been made public on the Quality Agency website so no one knows what was actually happening there – not the residents and families, not prospective resident's and not the community that should be vitally interested in the welfare of its members. By the time it is published the press and the public will have lost interest. As we will discuss in Part 3 there are strong pressures for the regulatory system to protect the system rather than promptly address issues and inform the public.

Wallsend Aged Care facility in NSW: Privacy and dignity issues suggest problems with staff and facility culture and a lack of empathy. The living environment was poor and repairs were not done. There were not enough staff to provide for residents needs in catering, cleaning and laundry services. The problems seem to lie with staffing and the way the facility is managed,

The NHS in the UK: A similar but more confronting instance of poor care and abuse occurred in health care at Stafford in the UK. It was extensively analysed in 2013. This may give some guidance about what might have happened at Oakden and these other facilities. It is discussed in Part 4 of the submission.

Considering neoliberalism and managerialism as root causes

Failure of the neoliberal agenda itself is one of the considerations that are generally excluded from the neoliberal discourse because for believers this cannot be seen to have failed. This has been the elephant in the room at almost every review and inquiry. It must be confronted.

Profit is not a driving force for government run facilities and hospitals. They have generally had better staff levels and been more resistant to staff cuts. But increasingly neoliberal governments have focused on cost cutting and on making all facilities compete in some way with the market operators. There is also a constant risk that if they spend more money they will be privatized and contracted to or sold off to the highest bidder. They bring in trained managers to keep costs down.

Warnings: More important, as Stuart Rees indicated in his 1995 book, management has become "*the panacea for governments*" and a managerialist approach has been introduced into all government services including hospitals and aged care. As the book explains management has become a separate skilled discipline with its own knowledge, procedures and processes within the neoliberal discourse. These are seen to be universally applicable to all sectors of society, with scant attention paid to the particular knowledge and problems of those sectors.

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Consequences: In health and aged care these managers may have little understanding of the needs of patients and residents. They may have even less insight into the consequences of the staff changes that they make, and the 'more efficient' rosters they design, for the care and the quality of life of residents.

There are some glaring examples which reveal how out of touch the senior managers, and those who advise government often are.

Senior managers no longer grow and learn within organisations. They are trained in universities and recruited from industry because of their success there or from government because of their contacts and influence.

Managers are trained to pursue financial success. A reduction in costs and an increase in profits enhances prestige and builds self-confidence. This readily leads to an arrogant certainty. They readily discount the views of those who warned against the practices.

In this market focused sector those who make money are promoted and those, who don't because they care, are overlooked.

Research: A number of research papers and doctoral theses have explored the experience and behaviour of health care staff as the neoliberal agenda was introduced – how they have responded to the new discourse as well as the new pressures and expectations. There is an overview of some of this work¹⁹⁷ and a link to short summaries of some of them on the Inside Aged Care web site.

A UK example: A good example of government managers who are out of touch with the sector that they manage is the National Health System Stafford Scandal in the UK. This was exposed by the Francis Inquiry in 2013.¹⁹⁸ In this instance managers had no insight into the adverse consequences of their staff cuts and the other changes for the patients. It is clear from the material and the report that these management problems were common across the NHS and not isolated to Stafford. Those interested in seeing whether something like this happened at Oakden might like to review this material. This is discussed in more depth in Part 4 of the submission.

¹⁹⁷ **Nurses experience of care** on inside Aged Care web page **Theory and Research in aged care** <https://www.insideagedcare.com/aged-care-analysis/theory-and-research#nurses>

See also A De Bellis' 2006 doctoral thesis **Behind Closed Doors** <http://theses.flinders.edu.au/uploads/approved/adt-SFU20061107.122002/public/02whole.pdf>

¹⁹⁸ Mid Staffs hospital scandal: the essential guide The Guardian 6 February 2013 <http://bit.ly/2rSNhFu>

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

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

Government's response UK Parliament – full report <http://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN06690>

About the Francis Inquiry The Health Foundation <http://www.health.org.uk/about-francis-inquiry>

Drawing inferences

The managerialist changes clearly apply to all providers of aged care but particularly to the larger ones – initially the market listed for-profit and private equity chains but as competitive pressures began to bite to the larger private for-profit and nonprofit as well.

The evidence over the years has consistently shown that commercial competitiveness and a focus on profitability have been associated with poor staffing and more failures in care. Anecdotally, it is becoming more and more apparent that nonprofits and more community minded for-profits are no longer setting the standards for care and for the sector. Instead they are embracing the neoliberal discourse and competing in the same way. The differences are narrowing but in the wrong direction. Instead of setting the standards the nonprofits are joining the for- profits.

We do not have the information needed to make an assessment of what happened at Oakden. If we look at the pattern of failures across the sector, at government policy, at the research, and at what happened in the NHS then it is clear that neoliberal management must be considered as a possible root cause. There is a clear association between problems in care and competition, efficiency and cost cutting.

With so many failures across all sectors of the aged care system over the years it is likely that there will be a common root cause. So while Oakden, Garrawarra and Wallsend may be found to be unrelated to the other failures it is likely that they will be linked to the same root cause. The most obvious candidate is the patterns of thinking within which they are now all managed.

That the neoliberal marketplace has exploited and harmed those in almost every sector where people are vulnerable¹⁹⁹, that this sort of thing was predicted and has occurred in countries that have adopted the neoliberal discourse in health and aged care makes this more likely.

¹⁹⁹ Failed markets and culturography on Inside aged care <http://bit.ly/2ryheHr>
Contracting government services to the market on Inside aged care <http://bit.ly/2byL9ld>

Appendix 4: Government's Review into regulation

Example: Appointment of Panel to review National Aged Care Quality Regulatory Processes²⁰⁰

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

Critical to the success of this review will be the discourse within which it is conducted. This will determine how they will interpret and understand the evidence they collect and the submissions that are made. The thinking that will inform the discourse is reflected in the careers of those appointed to conduct the review. Australian Kate Carnell has been appointed to review the regulatory process and New Zealand lawyer Professor Ron Paterson has been appointed to assist her²⁰¹.

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

Panel appointee: Kate Carnell (AO)

Carnell's career

1. Carnell²⁰² started her business life owning a **pharmacy business** and has a long record as a business woman at the **business end of health care**. Her other roles have been in management as chair of the ACT Branch of the Australian Pharmacy Guild.
2. Carnell had a career as a **liberal party politician and state premier** of the ACT. Her conduct here was strongly criticized by Crikey²⁰³. After a final financial scandal she resigned in 2000 rather than face a motion of no confidence. It was described as a career ending in 'ignominy and disgrace'. In spite of this, the Liberal party continued to support her and she was appointed to several important roles by government.
3. She was appointed to fill a vacancy on **the board of the NRMA** in 2001 but was defeated at the next election. She was reappointed to another vacancy but resigned before the next election, which she was expected to lose.
4. While the public did not seem to want her, politicians did. Soon after her political debacles she was appointed **chairperson of General Practice Education and Training Ltd** by the Health Minister Michael Wooldridge in 2001 and re-appointed by Wooldridge's successor Tony Abbott in 2004, so has served politicians well – a record for being a safe bet. She was rewarded for her efforts with an Officer of the **Order of Australia (AO)** in the Australia Day Honours list of 2006.
5. **Additional roles** have been CEO of the National Association of Forest Industries, the government funded Australian General Practice Network (AGPN), the industry sponsored Australian Food and Grocery Council (AFGC), Beyond Blue, and the Australian Chamber of Commerce and Industry. She has been a director of CRC Forestry and Australian Red Cross. In 2016 the government appointed her to be Small Business and Family Enterprise Ombudsman²⁰⁴, putting this sensitive post into 'safe' hands.

²⁰⁰ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2017-wyatt036.htm> (11 May 2017)

²⁰¹ **Appointment of Panel to review National Aged Care Quality Regulatory Processes:** <http://bit.ly/2q8BrSp>

²⁰² **Kate Carnell** - Wikipedia: https://en.wikipedia.org/wiki/Kate_Carnell; LinkedIn: <https://au.linkedin.com/in/kate-carnell-24ab4a15>

²⁰³ **The rare highs and many lows of Kate Carnell** - Crikey, 9 Sep 2002 - <http://bit.ly/2qDzscr>

²⁰⁴ **Kate Carnell quits business lobby to become first small business ombudsman** - SMH, 1 Feb 2016 <http://bit.ly/2qJD6Qv>

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6. Her **list of skills** offered to the marketplace on LinkedIn includes Policy, Strategic communications, Health Policy, Healthcare, Management, Public Relations, Corporate Communications, Media Relations, Marketing strategy and much more.
7. Carnell was a **director of the Accreditation Agency**²⁰⁵ during much of the period when Oakden's failures were overlooked and the agency reported its data out in a manner that most would consider deceptive²⁰⁶.

Carnell's background suggests that she is deeply rooted in the marketplace and neoliberal policy discourse. As a strong supporter of government and business with extensive experience she is just what the government needs. This is not to suggest that she is not motivated and will not do her best – but to question the patterns of thought she will bring to this.

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

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

Figure 2: LinkedIn (18 May 2017): <https://www.linkedin.com/pulse/maggots-abuse-aged-care-sector-rhonda-nay>

Panel appointee: Professor Ron Paterson

Professor Ron Paterson is:

1. A Professor of Law at Auckland University²⁰⁷ with legal degrees from Auckland and Oxford Universities. He is a Distinguished Visiting Fellow at the University of Melbourne; his expertise is in health law and ethics.
2. He is described as an *"international expert on complaints, healthcare quality and the regulation of health professions"* and as expert in *"patients rights, complaints, healthcare quality and the regulation of health professions"*.
3. He has written a book *"The Good Doctor - What Patients Want"*. He has conducted major Health reviews in Australia and New Zealand including one on the need for chaperones for the medical profession in Australia.
4. In New Zealand he was Deputy Director-General of Health 1999–2000, Health and Disability Commissioner 2000–2010, Chair of the Banking Ombudsman Scheme 2010–13, and Parliamentary Ombudsman 2013–16
5. It is interesting that he was appointed Parliamentary Ombudsman in 2013 then resigned in 2016²⁰⁸ after 3 years instead of 5 to return to his role as a Professor of Law at Auckland University and resume his work in the health sector. At the time, the Ombudsman's service had a reputation for slowness with a backlog of 650 investigations that had been pending for more than a year. A new Chief Ombudsman had undertaken to reduce that. Paterson had just released a damning report into the Government's handling of an inquiry into leaks from the

²⁰⁵ **Kate Carnell - Director, Aged Care Standards and Accreditation Agency** - 9 Dec 2008 - 8 Dec 2011 - (ACSAA Annual Report 2011 - 2012 - pg 51: <http://bit.ly/2froqUr>)

²⁰⁶ **Quality Agency rejects ownership factor on accreditation** - AAA 15 Mar 2015 (Comments): <http://bit.ly/2r4XG0E>
Aged Care Report Card - 2008 - When 46 homes really means 199: <http://bit.ly/2rqai25>

²⁰⁷ **Professor Ron Paterson** University of Auckland NZ <https://unidirectory.auckland.ac.nz/people/profile/r-paterson>

²⁰⁸ **Ombudsman Ron Paterson cuts short five-year term as office deals with investigations backlog** Stuff.co.nz 27 Jun 2016 <http://bit.ly/2rSN0CA>

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

Our concerns around the Review

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

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

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

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

Carnell's assistant Professor Paterson appears to be well qualified, but we know less about the details of his work and how the community experienced that. His book and an article about compassion²⁰⁹ reveal that he has some understanding and might appreciate the problems that have become so widespread in our current aged care system, where too often compassion is absent.

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

On the other hand as a lawyer and regulator, he may see this as primarily a regulatory matter and not consider the difficulty of regulating a system driven by pressures that conflict with the objectives. His knowledge of our accreditation system may be limited and he may not appreciate the problems.

We have just discovered that both Carnell and Paterson are already billed as speakers at an industry gathering arranged by COTA and ACSA supported by the Guild where all of the stalwarts in the sector will be gathering. Is this a sign that the industry knows where they are coming from and what they are likely to say – ensuring it gets widely promoted. This is in **Appendix 5**.

²⁰⁹ [Regulating for compassion?](http://bit.ly/2qPFCbm) Ron Paterson - Thomson Reuters, 2010 <http://bit.ly/2qPFCbm>

Appendix 5: Closing ranks and reaffirming the faith

It is fascinating to see true aged care believers in the neoliberal discourse gathering to re-affirm their faith as their failures confront them and clouds gather around them.

They are determined to press on with “*The Next Phase of Aged Care Reform*”.

COTA and ACSA, endorsed by the Aged Care Guild, an “*association of the nine largest Residential Aged Care for profit providers in the industry*” formed to further their interests, has arranged a meeting of the faithful for November 2017. The minister for aged care is speaking and giving it his support. His trusted reviewer of regulation, Kate Carnell is speaking, as is Ron Patterson. She is in charge of the review into aged care regulation that Wyatt has set up and Patterson is assisting her. They are giving the industry a heads up.

Other speakers are:

- Nick Ryan, previously in charge of LASA, the group representing providers but now CEO of the Quality Agency and responsible for protecting the community from those he recently worked for and supported.
- David Tune, the prime architect of the neoliberal free market *Aged Care Roadmap* they are selling to us is giving the keynote address.
- Two speakers from KPMG, a “*global network of professional firms providing Audit, Tax and Advisory services*”
- Two speakers from Stewart Brown, the organisation that collects data from the industry, lobbies for it and sets staffing benchmarks for managers to use. Its managers are so ignorant of staffing issues that they don’t know the difference between direct care and hotel services so that they lobby and argue using deceptive figures.
- Gary Barnier from Opal Aged Care, who appeared on ABC 7.30 Report²¹⁰ recently, is making a key contribution on the topic “***Building public & consumer confidence***”²¹¹.
- As well as a large numbers of senior executives from COTA, ACSA, executives from the large providers of care including Private Equity owned Allity, the professional business world and the Department of Health.

There are workshops on **customer experience** from marketplace advisers KPMG, on **Consumer Directed Care** by IRT who are senior’s lifestyle and care providers, **financial innovation** from two Stewart Brown partners. The thrust of the program is similar to many that ACSA have been running. This is the future aged care system they are determined to impose on us all. Its focus on reinforcing and reinvigorating the neoliberal discourse is clear from the speakers and topics.

²¹⁰ ABC 7.30 Report - Nursing homes with dozens of complaints against them still getting top marks (3 Aug 2017) <http://www.abc.net.au/7.30/content/2017/s4712742.htm>

²¹¹ The Next Phase of Aged Care Reform - Day 2: <http://www.criterionconferences.com/event/acr/agenda/>

Appendices

There is a session on 'embracing change', but there is no one there to propose real change:

This is a gathering of the Aged Care Sector Committee (the group who developed the idealistic market driven Aged Care Roadmap²¹²), the politicians, the large corporate leaders and their economic advisers.

They are coming together to regroup and to reaffirm their belief and determination and to reassure their supporters in ignoring and downplaying the hard facts, the logic and the growing anger in the community. The title is a clarion call to the faithful who may have developed any doubts.

The discourse is deep in their psychological DNA and the pattern of this 'coersive agency' is within them. To be sure that none of their struggling community critics will attend and challenge the message, they are charging between \$5,000 and \$7,000 depending on what you register for.

The Next Phase of Aged Care Reform²¹³

Prepare your organisation for the future of aged care (1st & 2nd Nov 2017, Sydney)

In partnership with:
COTA For older Australians
ACSA Aged & Community Services Australia

The Next Phase of Aged Care Reform

Prepare your organisation for the future of aged care
1st & 2nd November 2017, Sydney Boulevard Hotel

Key Speakers

 Hon Ken Wyatt AM, MP Minister for Aged Care & Indigenous Health AUSTRALIAN GOVERNMENT	 Hon Julie Collins, MP Shadow Minister, Ageing and Mental Health AUSTRALIAN GOVERNMENT
 Kate Carnell AO Lead Reviewer REVIEW OF NATIONAL AGED CARE QUALITY REGULATORY PROCESSES	 David Tune AO, PSM Chair THE AGED CARE SECTOR COMMITTEE
 David Armstrong Chief Executive Officer ALLITY	 Kevin Mercer Chief Executive Officer, Aged & Community Care MERCY HEALTH

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1300 316 882 registration@critterionconferences.com www.critterionconferences.com/event/acr/

How will the next phase of reform impact your organisation?

The aged care sector is going through a period of significant reform. While these reforms have been welcomed by the sector, the Roadmap continues to evolve and many continue to grapple with the changes.

This year has been monumental for the design of the next phase of reform, with significantly influential reviews completed or underway that will help shape the future of the sector.

The COTA Next Phase Aged Care Reform conference has been designed to delve into these monumental reviews to explore what they mean for your organisation and the future of aged care.

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Plus key contributions from:

Ian Yates AM COTA Australia	Professor Ron Paterson ONZM Review of National Aged Care Quality Regulatory Processes
Pat Sparrow ACSA	Professor Richard Rosewarne Applied Aged Care Solutions
Cameron O'Reilly Aged Care Guild	Rae Lamb Aged Care Complaints Commissioner
Nick Ryan Australian Aged Care Quality Agency	Nick Ryan Australian Aged Care Quality Agency
Professor Michael Woods University of Technology Sydney	Professor Michael Woods University of Technology Sydney
Professor Kostas Mavromaras Flinders University	Professor Kostas Mavromaras Flinders University
Gary Barrier Opal Aged Care	Gary Barrier Opal Aged Care
Andrea Coote Aged Care Quality Advisory Council	Andrea Coote Aged Care Quality Advisory Council
Professor Marita McCabe Australian Catholic University	Professor Marita McCabe Australian Catholic University
Matthew Hartley IRT	Matthew Hartley IRT
Andrew Sudholz Japara Healthcare	Andrew Sudholz Japara Healthcare
Paul Sadler ACSA & Presbyterian Aged Care NSW & ACT	Paul Sadler ACSA & Presbyterian Aged Care NSW & ACT
Peter Scutt Better Caring	Peter Scutt Better Caring
Grant Corderoy Stewart Brown	Grant Corderoy Stewart Brown
Greg Skelton PresCare	Greg Skelton PresCare
Senior Representatives Department of Health	Senior Representatives Department of Health

Topics to be explored:

- The Aged Care Legislated Review
- Review of National Aged Care Quality Regulatory Processes
- The Residential Aged Care Funding Review
- The Next Phase of Home Care Reform
- The Senate Inquiry into the Aged Care Workforce

"The [Aged Care Legislated] Review is an important step in assessing how the system has changed and adapted, and where we need to take the system in the future."
- The Hon Ken Wyatt AM, MP, Minister for Aged Care & Indigenous Health

Who will attend?

Board Members, Chief Executives & Senior Management including CFOs, COOs and General Managers and Directors responsible for:

- Residential Care
- Home and Community Care
- Strategy
- Finance
- Quality
- Operations
- ACFI

Sponsorship opportunities

Please contact Allen Yao at allen.yao@critterionconferences.com or phone 02 9239 5708 to find out more.

²¹² The Next Phase of Aged Care Reform - The Aged Care Roadmap (criticism of) Inside Aged Care
<https://www.insideagedcare.com/introduction/aged-care-roadmap>

²¹³ The Next Phase of Aged Care Reform - Criterion Conferences: <http://www.critterionconferences.com/event/acr/>
Brochure: <http://bit.ly/2vIP3jd>

The irony of it!

Just like the banks: The simultaneous exposure of more bank fraud is an invitation to compare the response of the aged care system with that of the banks.

The Commonwealth Bank is exposed as having exploited the banking system and its customers for the third time in order to increase its profits. Within days they announced record profits so that we can see just how profitable these practices are. It is clear that their practices are so profitable that they have not made any changes and do not intend to do so.

When you are so profitable there is little risk to senior management. Instead to give the impression of contrition they have taken token cuts to bonuses. Had there been a fall in profits due to a decision to behave ethically and responsibly then heads would probably have rolled. Its successful CEO is now skilled at deflecting the public's anger²¹⁴.

There is no more graphic example of the way in which social responsibility has been abandoned in our marketplace and of the way public anger at their conduct is ignored. This sort of thing is simply accepted as being the way the market operates. The discourse does not see it as reprehensible in any meaningful way. Aged care is not far behind when it comes to ignoring the public it is supposed to serve.

Civil society has lost its capacity to hold big companies to account and insist that they conform to community values. This capacity is what aged care is trying to rebuild in aged care where it is more important because it is lives and not money that is at stake.

²¹⁴ Interview with Ian Narev ABC 7.30 program 9 August 2017: <http://www.abc.net.au/7.30/content/2017/s4715896.htm>