Single Aged Care Quality Framework – Draft Aged Care Quality Standards

Closes 21 April 2017
Opened 9 March 2017
Contact qualityagedcare@health.gov.au

Overview

The Australian Government is committed to the quality of care of older people and considers the health, safety and welfare of aged care recipients a high priority. As part of reforms to the aged care system, the government is developing an end-to-end, market-based system with the sector, where competition and ultimately the consumer, drives quality. This includes a Single Aged Care Quality Framework with:

- a single set of aged care standards for all aged care services
- a streamlined approach for assessing provider performance against quality standards
- improved information on quality to help consumers to make choices about the care and services they need.

A new single set of standards

The Consultation Paper with a draft set of aged care standards and rationale is attached below for feedback.

Note: consultation on the options for assessing performance against aged care quality standards is also open and can be accessed at:

https://consultations.health.gov.au/aged-care-access-and-quality-acaq/single-quality-framework-assessing-performance

General questions about the draft standards

Please give us your views on the draft standards by answering the questions below. You will also have an opportunity to provide feedback on each standard in the next section.

10. Do the consumer outcomes in the draft standards reflect the matters that are most important to consumers?

- ○ **No**

Why? Do you have any suggestions about how they could be improved?

The consumer outcomes in the draft standards ignore the essential requirements that are needed to make these attainable. They reflect a very limited form of populist 'market-speak'. They do not adequately recognise the vulnerability of the elderly and their families or the important role of the community in relationship to markets and politics within capitalist democracies.

The basic assumptions underlying current aged care policy and the proposed Single Aged Care Quality Framework are questionable because their value is overstated and because necessary pre-conditions are not being met.

Essential pre-conditions:

- Maintaining the health and wellbeing of the elderly by ensuring the **basic staffing and other resources** needed. There are clear international guidelines that are being ignored and there are no plans to meet them[1]. 'Sufficient' is not a standard. Standards should reflect acuity and available research[2] and not support or shield mediocrity as currently happens. It is clear that the standards are not, as claimed, based on demonstratively effective international standards or regulation.

  While the USA, which collects data and makes it publicly available, does not meet these standards, our residents receive less than half as much care from trained nurses, and over an hour's less nursing care of any kind than in the USA.

  We have a sector where there is no information about staffing or the frequency with which suboptimal care is given. This is the information families' need when making informed choices.

- Research indicates that the next most important factor in successful care is the **relationships** between the elderly and those who care for them. Trust and trustworthiness must be central.

- An equally important consideration is **control** because the elderly person's mental stability and their quality of life depend on their ability to manage their environment and what they do there – to feel on top.

- **A stable environment** is important if the elderly are to maintain control, mental stability and a sense of self. **Shopping around** might sound attractive and conceptually appealing, but in practice the disruption and angst created makes it an unrealistic option for the elderly. It is a last resort.

- The final omitted important consideration for the vulnerable person is **support** because this both empowers the person and mediates inappropriate or antisocial behaviour. It protects them from themselves and others.

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1 Future of Australia's aged care sector workforce - Supplementary submission https://www.agedcarecrisis.com/images/pdf/sub302ss2_ACC.pdf

2 National Aged Care Staffing and Skills Mix Project Report 2016 http://www.anmf.org.au/documents/reports/National_Aged_Care_Staffing_Skills_Mix_Project_Report_2016.pdf

These necessary preconditions are not considered or adequately catered for in the currently structured competitive market system and in these standards.

These are essential for the effective implementation of a policy that includes the availability of **choice and flexibility** in this sort of marketplace. The preservation of **dignity and identity** are also dependent on trusting relationships, control and the support of people we can trust.

Support and community

Because of the pressures introduced by competition for profit over service, successful markets depend on a measure of distrust and customer empowerment. In this sort of market self-interest and self-preservation undermine altruism and civic responsibility.

In the 1993 report to government on which the 1997 reforms[3] were based, Gregory indicated the difficulties in regulating a free market in aged care. He noted that *"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*". That problem remains and the proposed Single Aged Care Quality Framework does not address it.

To counter this:

- An effective, empowered and **supported customer** with advice based on first-hand local knowledge of the services provided is essential for a competitive market built around choice in this sector. Current aged care policy and these standards fail to address the inherent vulnerability of the elderly and their families. They ignore our human inability to handle complexity during times of stress. The trusted support of knowledgeable people they know and trust is needed to empower them.

  In spite of the extensive availability of data in the USA and a 20-year focus on encouraging choice, major problems persist. The poorest performers in staffing and in care remain the most profitable and the most successful in the competitive marketplace. This is because the focus is on the consumers rather than the community support needed to be effective. US citizens are not getting the local support needed to use this data effectively.

- Such a market also requires oversight by an effective civil society (community) that is involved with and supportive of its members when they are in need. Such a society has the power as well as the close regular contact needed to exert it. Patterns of relationships between the providers of care and the local communities are needed to ensure the adoption of community values and norms by the marketplace. This would ensure that the market operates within their expectations and altruism is not undermined by self-interest.

Missing fundamentals

Missing from the documentation and the standards is any reference to, or place for, **the community** that in a civil society is ultimately responsible for the wellbeing and care of its vulnerable members. We have a society that has of necessity delegated aged care services to government and the marketplace. That does not absolve it from its responsibility for ensuring that both meet its norms and values. Both have regularly failed to do so.

The current proposals seek to marginalise the community and so escape these constraints. The term 'consumers' does not adequately embrace 'community'. The documentation talks of support, but how this will be provided is not indicated. If this is to be delegated to the market, then it will not effectively counter self-interest.

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[3] Report on funding of aged care institutions (June 1997) - Chapter 6 - 4.19 http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/1996-99/aged/report/c06

11. Are the organisation statements and requirements in the draft standards achievable for providers?

- ○ **Don't know**

Why? Do you have any suggestions about how they could be improved?

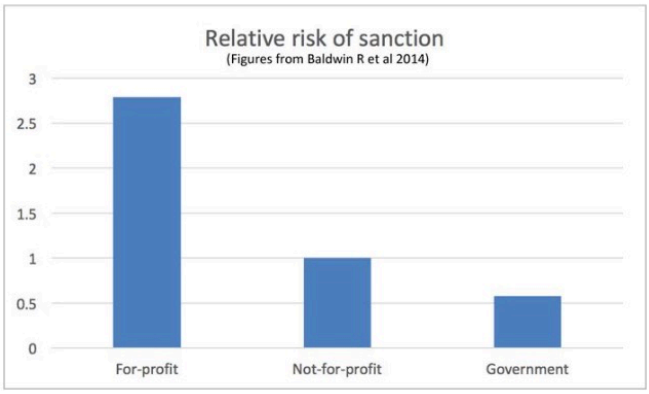
While strongly motivated providers may meet these standards, they will struggle to compete against those who don't provide the resources needed to do so. The standards are so vague and non-specific, that they will be easily gamed.

It is particularly worrying that providers *"will be required to demonstrate that they have achieved the outcomes".* It is what happens on the many days when they are not 'demonstrating' that is critically important. Gaming is already a major problem.

Incongruent with market outcomes: This is an aspirational document whose lofty objectives will inspire many and put them at loggerheads with the policies and practices of their organisation. Without very effective customers and a community that can insist on its expectations being met, those who adopt them will cease to be competitive.

Profit vs Care: There is a risk that pressures for profit and survival will increasingly make gaming the system essential for success. International data shows that the more profitable the providers the poorer the staffing levels and the greater number of failures in care. When corrected for other variables such as distance, for profit providers in Australia fail at least one accreditation standard and are likely to be sanctioned for failures two to three times as often as non-profit facilities[4].

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



The 2016 National Aged Care Workforce Census and Survey in Australia[5] found that *"Staffing ratios in for-profit facilities are lower than in not-for-profit facilities. Government facilities have the highest ratio, 0.85 direct care workers per residential place in 2016".* This confirms the relationship between staffing and pressure for profit in Australia.

It is clear that in Australia, as in the international sector, competitive pressures for profit in aged care impact negatively on care. Current regulation has failed to address this. This reduced and depleted oversight system will make it even more difficult to address this threat to care. What is required is a locally based regulatory system that works with the community and reports to it.

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4 Aged Care Crisis - Supplementary submission to the Inquiry into Australia's Aged Care Workforce (2016) - (pg 26 - 27): https://www.agedcarecrisis.com/images/pdf/sub302ss2_ACC.pdf

5 2016 National Aged Care Workforce Census and Survey: https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/03_2017/nacwcs_final_report_290317.pdf

International lessons: There has been intense criticism of the UK based Care Quality Commission which is a much more rigorous but similarly centralised regulator in the UK. A critical analysis published by The Centre for Social Reform[6] claims that it is not effective, not responsive, does not understand relationships, misses abuse, makes poor judgements, produces poor reports and more. The analysis argues for *"a locally rooted system where inspectors have real relationships with people and homes"* and that people who have *"real experience of care, should be central to the whole process".* It should be responsible to local communities. That is similar to what Aged Care Crisis has been urging for Australia.

Additional points:

- This is an aspirational document whose lofty objectives will inspire many and put them at loggerheads with the policies and practices of their organisation. Without very effective customers and a community that can insist on its expectations being met, those who adopt them will cease to be competitive.
- Effective collection of data on staffing and failures in care is essential for effectively managing an aged care facility and for clinical governance. Collection and evaluation of this data should be done in cooperation with and be verifiable by local regulators. Although the Quality Agency collects some staffing information when on site, this information is not made publicly available and is so infrequently done it is of little use in it's present format.
- The proposal does nothing to address the power imbalance between providers and consumers.
- This change may give prospective residents unrealistic expectations, which will not be realised, and so create future anger. Staff who are expected to meet these objectives and who, because of staff shortages or profit priorities, are unable to do so, will be frustrated and disillusioned. Staffing levels will suffer and ultimately so will care.

12. Are the draft standards measurable?

- ○ **No**

Why? Do you have any suggestions about how they could be improved?

The documents is built on aspirational ideas designed to support and give legitimacy to a particular pattern of thinking that is being used to structure aged care. It is not based on data. The proposals are vague, non-specific and there is little information about assessment.

There are no plans to collect verifiable and reliable data or to examine the logical inconsistencies intrinsic to the thinking on which policy is based and the relevance of this to the sector. Instead, a one size fits all model is being applied. That is a recipe for ultimate disillusionment. A market without any measure by which to measure services is not going to work for consumers. Subjective assessments are only of value when they are based on regular contact and interaction with residents and staff and they must be set against other objective data.

To measure and evaluate these 'standards' in any meaningful way would require the ongoing presence of people who are ongoing participants in their evaluation. This is what Aged Care Crisis is proposing. It aims to make an ongoing assessment of these and other parameters in a regular and painless manner.

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

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6 http://www.centreforwelfarereform.org/library/by-date/whats-wrong-with-cqc.html

13. Are there any gaps in the draft standards? If so, what are they?

- ○ **Yes**

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 will be largely subjective and the infrequency of assessments makes this unreliable. Subjective assessments based on a regular presence are useful and can be related to objective data, which can be verified. Further collection of objective data can follow.

With the reduced regulation in order to appease the industry and reduce the perceived burden, it will be 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 used[7], we don't hear the industry complaining about it being 'burdensome'[8].

Without an effective means of assessment, talking about standards is deceptive. Too often such a regulatory system uses words and processes as tokens for what should be there. This may be an attempt to follow suggestions made by Professor John Braithwaite. His assessments are based in part on his US research and the failure of extensive data collection to work there.

This research failed to reveal the extent to which regulation in the USA and Australia can now be seen to have failed because it has been "captured" within and constrained by the neoliberal agenda. This is now readily understood using the insights from Foucault's concept of governmentality[9].

Braithwaite's methodology is valuable but needs to be applied within a 21st century framework and the realities of a very different 21st century marketplace. It needs to be anchored to objective data to prevent tokenism and free it from the embrace of neoliberal ideology. It should be transparently accountable to a community that is not trapped within neoliberal ideology.

In the USA, as is happening in Australia today, citizens were offered extensive data and urged to use it to make choices. They did not have the capacity and were too stressed to do so. They did not have the local knowledgeable support and advice that might have made this work.

14. Is the wording and the intent of the draft standards clear?

- ○ **Yes, mostly**

Why? Do you have any suggestions about how they could be improved?

The wording is clear. It is the capacity to deliver on the aspirational content that is highly problematic.

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

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

9 Inside Aged Care: https://www.insideagedcare.com/

15. Are any draft standards or requirements NOT relevant to the following services? If so, please provide details below.

- Residential care
- Home care
- Commonwealth Home Support Programme services
- Transition care
- National Aboriginal and Torres Strait Islander Program services
- Multi-purpose services
- Innovative care services
- Short term restorative care services

As overall goals for these sectors, the aspirations are appealing but for the assessment of the actual care in each sector they are inadequate. If there was a means of continuous engagement, data collection and assessment of performance and outcomes in each of these sectors, then what is proposed would be useful for accreditation but not for regulation.

Accreditation as Regulation: This document exposes the flaw in attempting to use accreditation as a regulatory mechanism in vulnerable sectors. Control of the predatory nature of markets depends primarily on social control in the community and effective regulation is required both to enable this, to support it and to step in when it fails. Regulation is not a substitute for direct social control in the community. Accreditation is a supportive activity and not a regulatory process. No other country uses it in this way.

The (then) Accreditation Agency recognised this itself in 2010. In its submission to the Productivity Commission it asked unsuccessfully to be relieved of its regulatory role. Government's response to this different and unwelcome perspective within the Agency was to put accreditation directly under government control and put a leading figure from the industry in charge of the process.

This has done nothing to increase confidence in the process. Reducing the number of standards from 44 to 8 using the same accreditation system further undermines confidence in its effectiveness.

Giving comfort to poor services: There is no more graphic illustration of the harm caused by confusing accreditation with regulation than the state operated Oakden nursing home in South Australia. An independent review by the state's Chief Psychiatrist has revealed how between 2005 and 2017 the accreditation process was used by the state to justify the continued operation of the facility in the face of clear warnings and multiple red flags. The facility was *"up to 44 staff members short"* and for years *"has had insufficient access to Social Work, Occupational Therapy, Psychology and Clinical Pharmacy services that would be critical for ensuring the service provided a high level of safe care"*. Residents in this dementia unit had been abused for many years.

The *Adelaide's InDaily* describes how unreliable "periodic reviews" are and the way in which accreditation "gave comfort" to the state's managers. Community groups like Aged Care Crisis and others have been writing about this for almost as many years.

> "We've met the accreditation standards and as recently as February 2016 we were re-accredited up until 2019."
>
> But according to the review, the reliance on "failed accreditation" promoted a "sense of comfort" that Oakden was performing well, when it wasn't.
>
> The review reads: "It is an important lesson for all involved in trying to ensure that the best care is provided that reliance only on periodic reviews, such as accreditation, leads to a sense of comfort that may not be meritorious."
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> From as early as 2005 until the present day, "the review did not find an appreciable difference in the overall level of clinical outcomes over that entire period".
>
> "Put another way, the problems in 2016 are seen as far back as one looks."
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> ***Source:*** *How the State Government failed SA's most vulnerable at Oakden (InDaily, 21 Apr 2017)* *http://indaily.com.au/news/2017/04/21/state-government-failed-sas-vulnerable-oakden*

Specific suggestions about each draft standard

If you have any additional comments on how to improve any of the individual draft standards and requirements, please provide these in the relevant spaces below.

16. Do you have any specific suggestions in relation to draft Standard 1: Consumer dignity, autonomy and choice? If so, what are they?

These are essential in a modern 21st century service but as indicated in Question 10[10], a failure to address the necessary preconditions in policy and in assessment standards makes both their implementation and assessment problematic. These preconditions include basic staffing and other resources, trusting and trustworthy relationships, control of environment and care, a stable environment, and trusted and informed support.

The issue here is not what is desired, but how it can possibly be assessed by such infrequent visits. The performance of this important standard would be readily apparent to someone outside the organisation that has an ongoing role in the facilities working with staff and residents. Objective examples directly observed would support subjective perception. Any problems identified could be addressed immediately and not be dependent on the chance that an occasional visitor would identify them.

Additional points:

- In residential services particularly, increasing frailty, illness or dementia limit engagement, autonomy and choice, often making them impossible or at best a tokenistic mechanism for impression management. Kindness and empathy become more important than autonomy and choice.
- Choice requires the sort of accurate data that is not available in Australia. Use of the word in the current Australian context is tokenism.
- As illustrated in the USA extensive data availability does not result in effective choice. Data needs to be collated with local knowledge and assessments made by knowledgeable trusted advisers.
- Choices are often made under intense stress and pressure from hospitals - a time we turn to someone we think we can trust. The marketplace does not meet this criterion. Few can evaluate complex issues at this time. No provision is made for trusted and independent community support.
- Self-reported data by providers is at high risk of bias and there have been major problems with this in the US aged care marketplace. Some of the best data has subsequently being shown to come from very poor providers. In the USA consumers are repeatedly warned about unreliable data so undermining confidence. The depths to which industry and industry associations will stoop to deception is described in a submission to the Aged Care Sector Workforce inquiry[11].

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10 Q 10: Do the consumer outcomes in the draft standards reflect the matters that are most important to consumers?

11 Future of Australia's aged care sector workforce - Supplementary submission (November 2016) https://www.agedcarecrisis.com/images/pdf/sub302ss2_ACC.pdf

- Almost 100% of nursing homes currently pass all the accreditation standards making it impossible for consumers to discriminate. This will be an even greater problem with an even more uninformative spread of outcomes when there are only 8 standards. This will further impede the capacity to choose.
- There must be grave concerns that the market will exploit the hype about choice in order to advertise and sell consumers services or care they do not need. Glaring examples by several major very profitable hospital corporations in the USA, include thousands of adults and children unnecessarily tricked into admitting themselves to psychiatric hospitals where they were over-serviced and harmed in the late 1980s[12]. More recently at the turn of the century many hundreds of patients were persuaded to have unnecessary open-heart operations that they did not need[13].

17. Do you have any specific suggestions in relation to draft Standard 2: Ongoing assessment and planning with consumers? If so, what are they?

This is an area of particular concern and there are several issues here including exposure to exploitation.

Participation and control are clearly important for many, but in a sector where health and mental capacity are steadily declining (and in nursing homes severely impaired) and where relatives may have little understanding, this can become very problematic and there is room for residents to be exploited. There are a number of issues:

- Plans may be based on funding opportunities rather than care.
- Funding is a crude process and plans have already been constrained by funding restrictions so that the best care was not provided.
- Allied Health Services are often not consulted in drawing up plans so that patients' needs for re-ablement, dental care and physical maintenance can be ignored.
- Plans may be tokenistic and bear little relationship to the actual care provided.
- Research has shown that plans are often not kept up to date and are frequently disregarded.
- Overworked staff may not have the time or inclination to use these plans, which become part of a burdensome process.

The proposed standards and accreditation system cannot adequately monitor this[14]. Once again it is important that a local organisation linked closely to community values have general oversight. They would use their knowledge of the family and staff, and the conditions in each facility to work with the family stepping in to assist and advise when necessary. It would be apparent to them whether the plans were being followed. If funding was inappropriate they could negotiate exceptions or if it was commonplace advocate for change. They would mediate good care.

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12 http://www.bmartin.cc/dissent/documents/health/corpmed.html

13 http://www.bmartin.cc/dissent/documents/health/tenet_redding.html

14 Oakden nursing home closure: Mental Health Minister Leesa Vlahos vows to 'clean up this mess' (21 Apr 2017) http://www.abc.net.au/news/2017-04-21/oakden-nursing-home-leesa-vlahos-vows-to-clean-up-mess/8460302

18. Do you have any specific suggestions in relation to draft Standard 3: Delivering personal care and/or clinical care? If so, what are they?

This is a very broad standard because it includes a vast and varied set of standards related to multiple facets of care. This approach may reflect an attempt to implement Braithwaite's ideas of a small number of flexible standards supported by flexible investigation. This may have worked in the 1990s before our aggressively competitive market and neoliberal marketplace governance took the sector in its iron grip.

Clinical expectations should be much more clearly specified. These should be linked to clinical management and governance. This requires the collection of a sensible amount of solid verifiable data so that care and oversight are pinned to the real life context. An effective market requires accurate data tied to a set of significant objective measurements. Its accuracy needs to be overseen and verified by a regularly onsite local community based organisation. This data needs to be available to local communities within a broad multifaceted oversight system that avoids the trap of Campbell's Law. Within this context of regular contact, subjective impressions can be valuable because they will be the trigger for Braithwaite's investigative approach.

The additional benefit of this is that the local regulator would be working with the provider and they would establish a working relationship. Issues would be immediately addressed in the person-to-person manner that Braithwaite showed was so effective. Vast amounts of complex bureaucracy would become unnecessary.

This standard needs to be closely integrated with **Standard 7, Human Resources**. Extensive research and years of international experience have shown the close link between staffing levels and care, the need for an adequate number of registered nurses and the relationship between acuity and the need for increased staffing numbers and skills. This data and data showing the very significant benefits of adequate minimum staffing ratios have been available internationally since 2000 and recently confirmed by an ANMF[15] study in Australia. Australian staffing levels reveal that our residents on average receive half a much care from trained and registered nurses and an hour less nursing care each day than in the USA[16].

The extent of this staffing problem is revealed by the complacent comment in the consultation paper that there is a 26% to 42% incidence of pressure ulcers in our nursing homes – an indictment of the care given there. That these poor figures are so casually accepted and acknowledged, reflects the extent to which neoliberal ideas have taken control of our quality system and normalised what would once have been considered totally unacceptable. That is the sort of data that needs to be available for each facility and that a community organisation with knowledgeable members should be working with providers to address.

Without adequate staffing and basic care, dignity, choice, control, relationships, lifestyle and facility culture all suffer creating a vicious cycle of increasing alienation and mediocrity. **Standards 3 and 7.** But staffing alone is not enough. More is needed.

Research into the nature of care has revealed the importance of the interdependent relationships between those who care and those who are cared for. The difficulty in building these important relationships within the neoliberal market driven and managed employment system has been repeatedly stressed[17].

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15 ANMF: National Aged Care Staffing and Skills Mix Project Report 2016: http://www.anmf.org.au/documents/reports/National_Aged_Care_Staffing_Skills_Mix_Project_Report_2016.pdf

16 Aged Care Crisis: Future of Australia's aged care sector workforce - Supplementary submission (November 2016) https://www.agedcarecrisis.com/images/pdf/sub302ss2_ACC.pdf

17 The Nature of Care: https://www.insideagedcare.com/aged-care-analysis/the-nature-of-care

19. Do you have any specific suggestions in relation to draft Standard 4: Delivering lifestyle services and supports? If so, what are they?

Resident lifestyle is critically linked to relationships, particularly the everyday relationships with the staff caring for them, with family and friends and with the community. Studies have shown the benefits of engagement in community activities and of bringing community and children to the aged care facilities. This is underpinned by adequate staffing and care.

Life is about continuously reaffirming and building identity through engagement in activities and in building and maintaining relationships. Lifestyle activities should cater to the varied interests, mental capacity and physical abilities of the residents.

20. Do you have any specific suggestions in relation to draft Standard 5: Service environment? If so, what are they?

The service environment can be seen as referring to the physical environment (eg. single rooms or distance of room from nurses). The wishes of the resident may conflict with the needs of care and the capacity of staff to oversee and manage the resident. Privacy is critical, but sometimes negotiation may be needed to press for easier oversight and closer care.

Equally important is the cultural environment. Sufficient adequately trained, motivated and satisfied staffing is essential. Cultural problems frequently originate with management, sometimes in the facility, but often at a corporate level. Nothing destroys motivation like understaffing or restructuring in order to generate large profits at the expense of workplace conditions and the care of residents.

21. Do you have any specific suggestions in relation to draft Standard 6: Feedback and complaints? If so, what are they?

The current system of unsupported local complaints resolution, based on Walton's review of the complaints scheme has failed miserably. There is a massive power imbalance. 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. When complaints are made to the complaints system the responses have been impersonal, process driven and unsatisfactory to the resident.

It is critically important to have local independent community involvement in the feedback and complaints system. Complaints and concerns should be handled in close cooperation with a knowledgeable local community body who would work with residents and nurses to smooth the feedback system, mediate complaints and protect residents and staff from retribution.

22. Do you have any specific suggestions in relation to draft Standard 7: Human resources? If so, what are they?

This standard is linked to every other standard because all are adversely impacted by the grossly under-skilled and numerically inadequate staffing ratios in Australia. Minimum staffing levels are essential. Increasing acuity and a greater focus on person centred and consumer directed care place a greater load on staff. This has not been met by an adequate increase in skills or staff numbers. Management has frequently compounded the problem by their approach to staff and care. Too often management has been in the hands of accountants rather than clinicians.
An additional problem has been the rationing of consumables or food as a cost cutting measure. The extent of this is revealed by the nurses who describe rationing of diapers to incontinent residents.

Clearly funds are limited yet we are trapped into a competitive unregulated free market which quite clearly (when neoliberal dogma is ignored) is the most expensive and inefficient way of providing care. This is not to suggest that the market should be excluded.

What is required is a very different sort of market. Giving the community a measure of control would go a long way towards this. Having to meet the community's expectations in order to survive would place their interests above those of shareholders. This would hopefully drive the market from its current highly competitive high risk format into a more stable low risk one that would not be disadvantaged by being socially responsible.

23. Do you have any specific suggestions in relation to draft Standard 8: Organisational governance? If so, what are they?

In a neoliberal free market system, economic expertise is highly valued and clinical competence undervalued to the extent that managers in some companies have been fired for being "too clinical". Boards are dominated by economists and when clinicians are appointed they are market oriented. The focus inevitably turns to cost cutting and efficiencies. Staffing comprises 70% of costs and is the first to suffer. Care suffers because of the decisions made.

Informed supported and empowered customers and an involved and effective community with a measure of control over the providers who provide services to their community would be the best antidote. It is clear that some are profiteering and that those who genuinely provide good care are unable to compete so are struggling to survive. This is a perverse form of social Darwinism.

Other Comments

Please provide details below about any other suggestions or comments you may have about the draft standards.

24. Do you have any other comments or suggestions about the draft standards?

Additional points

1. **Questionable logic:** The logic of creating new regulatory structures and asking for comment, before multiple important reviews that will alter the nature of care and support legislative changes have reported, is difficult to understand. This is accompanied by aggressive rhetoric indicating what the changes will be. One wonders why these reviews seek community input when policy decisions have already been made. All this suggests that these consultation processes are a way of legitimising decisions that have already been made. Little attention will be paid to dissenting submissions.

2. **Less regulation:** The reduction of regulation at the same time as competition is deliberately increased creates greater pressure and more opportunity to game the system. This is very disturbing.

3. **Ideals and standards:** An idealistic wish list is something we can all relate to. Aspirational documents are motivating and this is particularly useful in education so is something that an accreditation body might use to inspire dedicated providers of care and then check to ensure that they know what to do. The concerns here are that this is primarily about selling aged care to the community in an attempt to defuse criticism of serious and systemic underlying problems that are being ignored.

4. **Regulations captured:** On page 197/8 of his 2007 book on regulating aged care criminologist Braithwaite describing how regulation in Australia (ie accreditation) was being captured by business interests. He indicated that "*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*". When the history of health and aged care regulation in the USA and Australia is reviewed using modern concepts of "discourse, power, and governmentality" regulation can be seen to have been tightly structured, contained and imprisoned within the confines of neoliberal discourse since 1997. What is proposed does not get regulation out of its prison[18].

5. **Failed central regulation:** The unhappiness with and the failures of the current regulatory structures (quality agency and the complaints system) to meet the expectations of the community must be set against their centralised organisational structure and distance from the community. They are process driven, impersonal and out of touch. A radical rethink of the underlying philosophy followed by a fundamental restructure is required. What we are getting is repackaged ideology.

6. There is growing evidence that community services are most successful when they are controlled and managed by local communities and that the role of government should be to support and mentor these communities. But it is equally important to realise that this is something that grows and needs nurturing. It cannot be imposed. These organisations should encourage and progressively work through local groups and services.

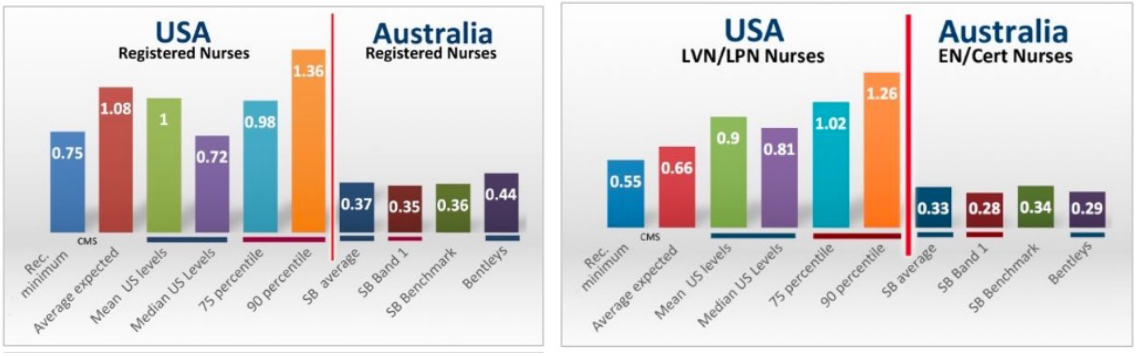
[18] Re-interpretation using Foucault: https://www.insideagedcare.com/aged-care-analysis/re-interpretation-using-foucault

7. **Divided perceptions:** This document will create further opportunities for image creation – marketing and branding – deceptive images that the providers, their staff and even families, too often accept as representative of the care provided. The dominance of branding in the absence of reliable public data to pin it to reality has led to a deep divide in the way aged care is conceptualised and understood.

   On the one hand are those who embrace the images - the providers, the politicians who support them and even many staff and residents who embrace the images, rather than what they see. On the other are academics who have studied the sector and those who have direct experiences of failures in the system. These include residents and families who experience its failures and the staff who are aware of what actual care should and could be. They form a very different view of the system.

   We have a sector where there is no information about the frequency with which suboptimal care is given, but where we now know our residents receive less than half as much care from trained nurses, and over an hour's less nursing care of any kind than in the USA. Who should we believe, the bureaucrats who run the system or those who are actually giving the care? We argue that "**the focus is clearly the wrong one**" and that we need one that collects data, which tells us what is happening, and is responsible to the community it serves.

   Figure: Australia and the USA: Comparison of staffing levels (pg 21-22) [19]



8. **A recipe for mediocrity:** The proposed 8 standards suffer from the same core problems that have plagued the current 44 standards. The creation of a minimum hurdle which must be passed so that management can get on with the important business of competing in this marketplace. A system built around the minimum you can get away with has been a recipe for mediocrity. If properly structured and monitored regularly, then in a system with 44 measurements it might have been possible to create some sort of graded assessment of performance that was useful for customers "shopping around" for the best option. With only 8 there is little prospect of doing that.

9. **Finding a way forward:** Aged care is a multifaceted and complex service and a clear basic objective method of assessment is needed to fall back on but this should not fall into the trap of data for data's sake. As such, measurable outcomes and parameters of service including the incidence of failures in care need to be monitored. While both clinical and financial accounting are important, clinical accounting is more important than financial accounting because that is what ultimately matters. This is the responsibility of every provider, but because of the pressures created by the marketplace, some regular independent oversight is needed and this would be best achieved by community working closely with the provider in clinical auditing.

   Such a system should complement the perceptions and subjective assessments of independent people with knowledge, drawn from the community and responsible to the

[19] Aged Care Crisis: Future of Australia's aged care sector workforce - Supplementary submission (November 2016) https://www.agedcarecrisis.com/images/pdf/sub302ss2_ACC.pdf

community. It is their perceptions that will drive the market and these perceptions will be anchored by solid data.

10. **Placing the community at the heart of aged care**: Aged Care Crisis in its several submissions and on our websites are pressing for a system that engages the community itself in aged care and puts them in a controlling position working with providers and customers to collect data and to advise and protect customers. By giving the community a central role in managing, data collection, complaints handling and regulation and building this into the market structure we can improve their grasp of what is important and address the several issues raised above. This would become the community arm of regulation and management. It is likely that the community involvement will be dominated by those who have had past experience either as relatives, carers or as clinicians.

    Regulation would operate directly at the coalface in discourse between community, management, staff and consumers. Unsavoury conduct, inappropriate ideas, illogical beliefs and pressures to save money in ways that threatened care would be stigmatised and held up to ridicule – the effective way in which we as a society control behaviour and ensure that we all adhere to values. Strategies that would improve care and quality of life or stretch resources for maximum benefit would have a strong supporter, whose advocacy could not be ignored without a good reason.

    Our proposal will support consumers to be effective customers and also enable civil society to set the limits of acceptable conduct. By being directly involved in aged care the community in effect becomes a significant peer with a different perspective. The principle of non-hierarchical accountability will apply.

Please send your submission to:

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