

# Submission to:

## Inquiry into Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018

4 October 2018

**Aged Care Crisis (ACC)** welcomes the opportunity to make a submission to this very important Bill.

ACC are an independent group of Australian citizens. Members of our group are engaged with the aged-care sector in a variety of ways – as advocates, health professionals, legal experts, users of services and as volunteers. The tenor of much of our feedback indicates a high level of community concern relating to the neglect or mistreatment of aged care residents, appalling staff levels in aged care homes and the complete lack of information around direct care staffing.

### Introduction

ACC have been monitoring and analysing failures in aged care since the late 1990's. The origins of the many current failures can be traced back to the introduction of the 1997 *Aged Care Act*. Within a year or two problems were developing<sup>1</sup>. Recurrent glaring red flags to a deeply flawed system have been brushed aside ever since.

The importance of this Bill is demonstrated by the recent ABC 4-Corners two-part program "*Who Cares*"<sup>2</sup> and the decision to set up a Royal Commission. We strongly support it.

What has been revealed is that over the last 21 years the public has been deliberately and repeatedly deceived. They have been denied information and instead been misled by deceptive claims of a 'world class system'.

Trust is at an all-time low and many are even arguing that the Royal Commission is simply a delaying strategy before the election and will be used to hold public opinion at bay.

The one thing that the public must be given is accurate, reliable and verifiable information. This Bill is a litmus test of the industry and our politician's willingness to be transparent and work with the community in sorting out the mess that they have created by being so closely aligned with industry.

There can be no more industry led processes. This is only a small first step, but its importance in building a working relationship with society and its citizens cannot be over-estimated.

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<sup>1</sup> Hansard, 14 Feb 2002: <http://bit.ly/2BLc2Eg>  
The Riverside Scandal, Corporate Medicine website <http://bit.ly/2Rqmqu3>

<sup>2</sup> ABC Four Corners "Who Cares", Part 1 (17 Sep 2018): <https://ab.co/2DTbL8E>; Part 2 (24 Sep 2018): <https://ab.co/2NmsDE8>

It is society that elects politicians and community members are singularly unimpressed at the way government has been in bed with the market, has neglected society, and has joined the industry in deceiving us. This must now change and politicians must be seen to be ready to change

To appreciate how important this Bill is in pointing to a new future for aged care and for the wellbeing of our seniors, we need to look at the origins and historical background of aged care staffing in Australia.

## **Brief overview**

Effective staffing has been a matter of dispute for a long time and a large group of providers themselves were, during the 1980s, among the most active in openly evaluating resident acuity and publishing the number of staff needed. They identified serious failures in care and supported increased staffing ratios.

They fought a bitter battle with the federal government about adequate staffing during the late 1980s. Even federal government accepted that staffing should be assessed and funded on the basis of the resident's acuity but their interpretation of this was suspect.

An analysis of the history of aged care staffing in our submission shows that since the free-market/neoliberal movement swept into Australia during the mid-1980s, governments have become more concerned about economics and markets than with society and its best interests. As indicated, the federal government resisted the efforts of the industry in Victoria to improve staffing during the second half of the 1980s. This was in spite of appalling care in for-profit facilities exposed by the Giles inquiry in 1985<sup>3</sup>.

There was a radical change in the industry during the 1990s when a section of the aged care marketplace embraced the new belief in free markets. This was rapidly becoming a panacea for all our problems. This group broke away from the remainder of the industry. They adopted a very different primarily commercial approach.

This group led by industry tycoon Doug Moran<sup>4</sup> rapidly grew and came to dominate the whole sector. They captured a political discourse that was looking for a quick fix. In the 1980s the Labor Government resisted efforts to improve regulation and when a large section of the industry identified with these views the then opposition got into bed with them and led by John Howard they won the election in 1996.

Together they initiated and then imposed major changes that saw the sector marketised in the face of intense criticism and community unhappiness. Where providers had once sought to increase staffing, their primary aim became to reduce costs and this meant staffing.



**Government ignored everything that experience had told us about markets and everything we knew about the vulnerability of the sick and frail. They rejected the need to protect them from those who could not be trusted to put their interests ahead of their own. A revolving door developed that saw industry draft the regulations, populate government bodies and industry consultancies advise on policy.**

Incredibly, when staffing problems could no longer be hidden in 2016, it was the industry that had been responsible for the problems in staffing that was commissioned to propose a solution.

<sup>3</sup> Select Committee On Private Hospitals And Nursing Homes 22 February 1985 Hansard p 61 <http://bit.ly/2qCFGL8>

<sup>4</sup> Matters of Public Importance - Nursing Homes - House Hansard - 1 October 1997, Page 8926: <http://bit.ly/2qHgnq9>

**Over the 21 years since the introduction of the 1997 Aged Care Act we have seen:**

1. A sector that was once protected from those who could not be trusted, was opened to all comers regardless of their previous conduct provided they operated through a subsidiary that did not employ criminals.
2. Levels of nursing staff and particularly skilled staff decline to unsafe levels.
3. A disillusioned, overworked and unhappy workforce.
4. A system of aged care which is managed by managers who are not required to have any experience in aged care but are experts in business management. They have little if any insight into the consequences of what they are doing when they reduced staffing to meet financial benchmarks. They are appointed to government committees where they advise on policy for providing care.
5. Multiple failures in care have been met by endless assurances about our rigorous world class system. We have been told that failures, which were red flags, were rare exceptions
6. A regulatory system which is more concerned with protecting the government and the industry than the elderly.
7. A complaints system that has never adequately investigated complaints or acted on them. It has gone from bad to worse.
8. An accreditation process that we were told was a rigorous regulator. But this was a regulator that insisted it was not a regulator but an accreditor. Instead of regulating it has been supporting industry all the time. It kept telling government this but they did not listen.
9. A government department in charge of regulating all this whose focus was not to serve the public but to keep information about failures in care away from the public. It set an example by doing this itself.
10. An industry that repeatedly maximised the funding system (ie rorted when they could get away with it).
11. Throughout this entire period there has been collusion between government, regulators and industry to collect a minimum of data and keep most of it away from the public. Data about staffing and about failures in care has been lacking or hidden. When research has been done it has been ignored. We have been repeatedly deceived.

Staffing and the costs of staffing were consequences of, related to or hidden from the public by all this.



The last 20 years has seen the destruction of what in the early 1990s was still a system that compared well internationally and not the mirage that it has become. Central to the failure of the system exposed on 4-Corners has been the erosion of effective staffing.

It is important that those who are involved in making policy understand how this happened and why. **There are profound structural and conceptual issues that must be addressed.** We have exposed these in this submission by describing the history of staffing in Australia in more detail.

# 1 Enough is enough

It has taken 21 years and the appalling exposures on ABC 4Corners to reveal what has been happening in aged care and the extent to which this has been covered up, hidden and ignored by industry, by government and by multiple inquiries. Society is justifiably angry. This is our money and these are our fellow citizens, our parents, our spouses and our own future.

As a society and as citizens we are each responsible for our fellows when they are in need. Whoever is providing that care is directly responsible to us and not to government. Government's role is to build society and to support it – not to undermine it, assume its functions and then deceive it.



Control over the care that our family members receive has been taken away from us. What has been happening has been hidden from us. We have been fobbed off with lies and deceptive claims. We have every right to be angry and it is clear that society is now very angry. All trust has been lost. We must have total transparency about what is happening in each and every community.

What is required in the long term is:

1. Transparency and control over the way our money is spent in each nursing home and the right to decide how it is spent.
2. Accurate data about staffing.
3. Accurate data about failures in care so that we can be assured it is adequate.
4. All of this must be verifiable and that means that we and our accountants need access to financial data. Our delegate or representative needs to be on site regularly to see what is happening, assist in the collection of data, and (with family/resident permission) have access to confidential clinical and other data. We need to know exactly what is happening.
5. We need to know about and be involved when there are any problems, and have input into and oversight over the response to any deficiencies exposed.
6. Recipients of care and their family members need ongoing local support from their communities, not just when something goes horribly wrong.
7. We need a role in deciding who will be allowed to provide services in our community so that we can investigate their track record and their suitability, then choose a provider who will work with us.

As responsible citizens in a responsible democracy these are not only our rights but also our responsibilities. It is time that we insist that our rights are returned to us and that we accept our individual and collective responsibility for the society that we are a part of.

**Resources:** In our communities we have doctors, nurses and many others with knowledge and experience in providing care. We have the expertise in exercising our humanity that managers lack. We need to build society and develop community structures that allow us to take control of the sector and work with the families of our elderly and with providers to see that our fellow citizens get the best that resources allow.

The increasing demands of the young, who are also in need, means that they should receive some priority. We have a responsibility to our grandchildren too. We realise that rationing may be required. The sort of market that we are inheriting is poorly equipped to do that. We will need to have tight control over that to see that it is done fairly and honestly.

This is not to exclude markets but to control their excesses. We cannot allow profiteering at the expense of our elderly citizens, particularly when rationing is needed. As with any financial arrangement, reasonable profits must be negotiated with each community that is ultimately responsible for its members.



This Bill requiring open disclosure of staffing levels is an essential first step in a long process of change that must ultimately reposition aged care within communities. A failure to pass this bill will be a clear sign to the community that government and industry are not going to change their ways and that our society needs to respond accordingly.

Reporting staffing ratios by professional qualification for those who care directly for residents is straightforward and not complicated. Reporting in this way will allow us to draw on a vast pool of international research when making policy. This Inquiry is a critical first step in achieving this.

The remainder of our submission explores the history of aged care to illustrate how this situation came about.

## Glossary and abbreviations

ACC	Aged Care Crisis
ACCC	Aged Care Complaint Commissioner
CVS	Community Visitor Scheme
PCV	Principal Community Visitor
Quality Agency, The Agency, agency	Australian Aged Care Quality Agency (formerly known as the Aged Care Standards and Accreditation Agency)
The Department, department	The Department of Health (formerly known as the Department of Health and Ageing)
Pressure injuries	Alternative names: Decubitus Ulcers, Pressure Ulcers, Pressure Sores, Bed Sores, pressure injuries, Dermal Ulcers, Pressure Wounds
SB	StewartBrown
RN	Registered Nurse (equivalent in the USA and Australia)
AIN	Assistant In Nursing
CNA	Certified Nursing Assistant
CNA, NA	Certified Nursing Assistant, Nursing Assistant
LVNs/LPNs	Licensed vocational/practical nurses (USA) <i>(Equivalent to enrolled and certified nurses in Australia)</i>
PCW, PCA	Personal Care Worker, Personal Care Attendant, Personal Care Assistant (Level III or less)
hprpd	<b>hours per resident per day</b>
CMS	The <b>Centers for Medicare &amp; Medicaid Services (CMS)</b> , previously known as the <b>Health Care Financing Administration (HCFA)</b> , is a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. <i>In addition to these programs, CMS has other responsibilities, including the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), quality standards in long-term care facilities (more commonly referred to as nursing homes) through its survey and certification process, clinical laboratory quality standards under the Clinical Laboratory Improvement Amendments, and oversight of HealthCare.gov.</i>
OSCAR CASPER	The <b>Online Survey, Certification and Reporting (OSCAR)</b> system was an administrative database of the <b>Centers for Medicare and Medicaid Services (CMS)</b> for many years (in the USA). Effective July 2012, the OSCAR system was replaced by the <b>Certification and Survey Provider Enhanced Reporting (CASPER)</b> system and the <b>Quality Improvement Evaluation System (QIES)</b> .
Kaiser Foundation	The Henry J. Kaiser Family Foundation (KFF), or just Kaiser Family Foundation, is an American non-profit organisation, headquartered in Menlo Park, California. It focuses on major health care issues facing the nation, as well as U.S. role in global health policy.
Nursing Home Compare	Official USA government website that allows consumers to compare information about nursing homes. It contains quality of care and staffing information for all 15,000 plus Medicare and Medicaid participating nursing homes.

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## 2 History of staffing in Australia

A November 1988 industry report<sup>5</sup> in Victoria describes the early history of government funding in Australia as well as a dispute between providers of aged care in Victoria and the Commonwealth Government.

### 2.1 The very beginning

The Commonwealth Government's first involvement in aged care was in 1954 when it provided a 50% subsidy to religious and charitable organisations *"to encourage and assist the provision of suitable homes for the aged person"*.

Additional assistance was given to provide services to the elderly in hostels (low care) in 1969 and 1984, and in nursing homes in 1963, 1969 and in 1974 when a *"Deficit financing scheme"* was introduced for the Voluntary Care sector and a *"Participating scheme"* for for-profit homes. The *"Government assured the Voluntary Care sector that funding for staff would not be reduced below the existing level"*.

The **Deficit financing scheme** was based on an approved annual budgeted expenditure paid monthly with adjustments at the end of the year *"to make up the difference between approved and actual expenditure"*.

The **Participating scheme** payments were based on the *"actual operating expenditure incurred by each nursing home"*.

In 1975 the government set up a working party on *"Guidelines for Private Nursing Homes"* to *"establish uniform staffing standards for all states"*. These determined the funding for all states except for Victoria, which dissented and obtained a higher level. Projections were made into the 21st century. Concerns about costs saw several parliamentary reviews over the next few years.

### 2.2 1983/4: Industry's in-depth analysis

There were concerns about failures in care with considerable adverse criticism culminating in the damning Giles 1985 Report<sup>6</sup>. This found major problems in for-profit nursing homes.

An extensive two-stage study of nursing requirements was done by the industry<sup>7</sup> in Victoria. This was based on resident acuity. It was done in two stages in 1983 and 1984 (17 nursing homes for Stage 1 and 23 for stage 2). It included all sectors of the industry in Victoria and reported in 1985.

It noted that *"most institutions were operating at minimal or less than minimal levels"*. The study was based on the assumption that residents were entitled to receive direct nursing care from qualified staff. They defined 5 levels of acuity and concluded that the amount of care required for each resident each day extended from 35 min for level 1 to 280 min (4.7 hrs) for level 5.

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<sup>5</sup> Report To Board Of Management, Anne Caudle Centre On Victorian Aged Services Peak Council, NB Perrin Nov 1988

<sup>6</sup> Select Committee on Private Hospitals and Nursing Homes - Report (22 Feb 1985): <http://bit.ly/2rThtRd>

<sup>7</sup> Patient Care Analysis, Extended Care Society Of Victoria, V Hardy et al 1985

In 1984 38% of residents fell into level 4 or 5 and an average expectation would be a level of 3.8 hrs per resident day. Over 90% of patients would fall into this category today so the required staffing would be much higher.

## **2.3 1997/8: Battle with government by providers in Victoria**

In this dispute it was the industry in Victoria, supported by clinical staff that collected and used data on staffing, acuity and the outcomes of care to fight for better staffing and improved care. That can be contrasted with the situation today in which staffing recommendations are made by accounting firms and neither industry nor government collect or use data about staffing or outcomes. Both do their best to keep information away from the public and staffing to a minimum.

Following the release of a Review of Nursing Homes and Hostels in March 1986, the minister had encouragingly indicated that the focus should be on a *“reasonable and appropriate standard of care which should focus not only, as in the past, on staffing and other inputs, but on consumer outcomes reflecting the quality of life provided for the client”*. It seems that his colleagues saw the opportunity to balance their budgets without raising taxes as more important.

### **2.3.1 Departmental ignorance**

In 1987, the Department of Community Services announced its intention to provide funding to *“cover the direct nursing and paramedical staff salaries”*. Consultations soon showed that *“the personnel responsible for the scheme did not have any understanding of the functioning of nursing homes and hostels”*. They were *“reticent to reveal any hard data”* and not prepared to *“reveal any specific information as to the elements of the scheme”*.

It later became clear that they were looking at paying about 2.4 hrs per resident day across all facilities in Australia. The industry in Victoria warned of the consequences, which would result in a 30% reduction of funding for staff in Victoria.

They were alarmed when the Chairman of a steering committee indicated that *“‘quality of care’ would be in line with the level of funding available and there would be no increase in funding”*.

### **2.3.2 Comparable with 2018?**

These are criticisms we feel might well be applicable today. But today we have a government without experience getting its advice from owners, managers and consultants who have had little if any direct experience in caring themselves and don't use outcomes data. Staffing decisions are made on the basis of funding as well as profitability and not on the basis of the care needed. They are not assessed using outcomes and these are not measured.

### **2.3.3 Consultations**

The Commonwealth/State Joint Working Party on standards declined to include provider members who had done the research on the Working Party or discuss their proposals with them. Only limited consultations were held.

Government accepted that staffing be based on acuity. It developed its own 5-step resident classification system but supplied little information about how this was done. It became clear that they were talking about 17.1 hrs per week (2.4 hrs per day). The industry in Victoria wanted 27 hours (3.9 hrs per day).

### **2.3.4 A Peak Council**

The industry in Victoria formed a Peak Council and commissioned an independent “*Quality of Care in Nursing Homes Study*”. This revealed “*some alarming trends*” which suggested inadequate staffing. Repeated meetings were held with the minister “*with minimal success*”.

A strategy where the “*Commonwealth Government's media department constantly conducted a press campaign to support their proposal and denigrated the nursing home industry and any other organisation opposing its view*” is little different to what happens today except that it is the industry that now does this to those who speak up for better staffing.

### **2.3.5 Position Paper**

The Victorian Aged Care Services Peak Council published a position paper in April 1987. They indicated that that “*Clarification of the minimum standard of care required by the various departmental organisations - - - is well overdue*”. They supported “*more regulated growth in commonwealth funding, tied to the provision of care.*” They rejected the government proposal on the basis that it “*does not provide quality of care and life guidelines necessary to make them effective*” commenting on the lack of data to support their position.

It is interesting that in Victoria at that time “*ward assistants or nurse assistants are not permitted to participate in the nursing of patients unlike other states*”. How times have changed!

The documents in our possession do not tell us what the final outcome of all this was.

## **2.4 Other developments in the 1980s**

There was some division between providers with a portion of the for-profit sector led by industry leader Doug Moran being influenced by the new free market policies that were being introduced into the USA and the UK.

This part of the industry took action against the government in 1986 claiming its tight regulation and control breached their rights and was unconstitutional. They lost their case. As subsequent events reveal this group had a very different approach to the regulation of staffing levels that Victoria supported. As far as we are aware Victoria and its Peak Industry body was not involved in the 1986 action.

Criminologist researcher Professor John Braithwaite<sup>8</sup> writes about the Ronald Review, which reported in 1989. He indicates that the report advised and supported funding of an active community rights based advocacy service as well as an empowered community based visitors scheme, both contributing to the regulatory process. Had they been introduced and been effective today their more regular on site presence might have exposed staffing deficiencies and led to action long ago. We might have been spared a Royal Commission.

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<sup>8</sup> Braithwaite J et al *Regulating Aged Care* Edward Elgar Publishing Limited 2007

## 2.5 The early 1990s

### 2.5.1 Visitors

The proposal for an empowered visitors scheme was ridiculed by industry as a “*community busybody scheme*”. The plans were frustrated by the growing influence of industry. Industry were supported by the Keating government as it embraced the new free market thinking that saw regulation as harming the market.

### 2.5.2 The erosion of advocacy

Ronald’s plans for the advocacy system were introduced during the 1990s but were later reduced by regulations that limited the sort of advocacy aged care advocates could do.

When after 1997 other advocacy groups critical of policy lost their funding, the aged care advocacy groups became anxious about their funding. They avoided advocacy that might result in publicity that threatened government or the reputation of the industry.

Braithwaite was told by advocates that the government have a long memory. He described this as advocacy with a small “a”.



We wonder whether the consolidation of advocacy under a single organisation, OPAN, in 2016 will increase effectiveness of advocacy or facilitate tighter control of what is advocated.

It is worrying that in spite of the many examples of abuse and neglect in nursing homes, the incidence of abuse in nursing homes was quickly discounted in the recently published “*Abuse of older people: A community response final report*”. This was prepared after a conference of advocates, government and providers.

The report focused instead on financial abuse in the community. OPAN has received a \$2 million government grant for this project. Elder abuse in nursing homes is something that embarrasses government.

### 2.5.3 Regulation

Fragmentation of the industry continued with aged care provider Doug Moran leading a group that became more and more influential. At this time an evidence based regulatory system was developed that advocated more frequent onsite observation and sought to increase the frequency of visits by the regulators.

Free market thinking saw regulation as interfering with the successful operation of the market. Industry found this burdensome and objected. Government did not support more frequent visits.

At this time there were staffing requirements and total transparency about how government money was spent so that the amount spent on staffing was known. We know that about thirty percent or more of nursing home staff in Victoria were registered nurses.

## 2.5.4 Warning: The 1993 Gregory report

The Gregory Report reviewed the different options for the future of aged care. In reviewing the free market option, it concluded 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”*<sup>9</sup>.

## 2.5.5 Warning: Managerialism and its consequences 1995/6

In 1995 Rees and Rodley edited a multi-author book which described what was happening across society. Its title was *“The Human Costs of Managerialism: Advocating the recovery of humanity”*. Its thesis was that the managers spreading the new patterns of neoliberal thinking, their processes and the cultures they created were destructive of our society and our humanity.

Management was a discipline that was claimed to be universally applicable and little if any knowledge of the sector being regulated was required. We are reaping the consequences of ignoring the warnings. We have managers in aged care who are impervious to the consequences of their actions and others advising government. Some of what Rees himself said is illuminating when we consider what has happened.

"(Managers) - - - waiting in the wings for the call to demonstrate their toughness and efficiency, their willingness to disparage old professional practices and traditions in the interests of a new corporatism."

"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."

"The claim to moral neutrality and scientific objectivity suits an age in which economy has come to be regarded as more important than society and in which a brand of economics has claimed scientific qualities."

"In private corporations and in public sector services there are numerous examples of assumptions about the universal value of management."

" - - - the all inclusive claims of "culture management" with its emphasis on changing the culture of an organisation by paying attention to language, symbolism and ritual (Peters and Waterman 1982)"

"Even as claims are made about democracy in organisations, the style of decision-making is towards secrecy and control. Even as the rhetoric about greater devolution is heard, the tendency is to control decisions from the centre, to set managers apart, to develop their own cultures, language, symbols and networks."

**Source:** Quotes from Stuart Rees in *"The Fraud and the Fiction"* in *"The Human Costs of Managerialism"* Pluto Press 1995 pages 16,17 and 21/22

<sup>9</sup> Quoted in Chapter 6 Ensuring quality of care in Report On Funding Of Aged Care Institutions, Parliament of Australia 1997  
[http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/Completed\\_inquiries/1996-99/aged/report/c06](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/1996-99/aged/report/c06)

The medical profession was alarmed by what was happening.

Two eminent doctors are among those who wrote about it:

"The government should not assume the professions resolute adherence to ethics in the face of economic loss."

"Such competition is lethal for standards; it is not in the public interest. It is this message that the medical profession must clearly convey to patients."

"With the price of services as the sole determinant of health care, ethics will fail and standards will fall. Governments will establish standards bureaucracies, despite inadequate methods for assessing quality. Money will be diverted from patient care to the ever increasing bureaucracies, while professionalism declines."

*Source: Dr Peter C Arnold, Chairman, Federal Council, AMA (MJA 2/9/96 page 272)*

By virtue of a mind-set, intelligent reasoning about risk control seems to have been abandoned - as though economic rationalism was, like mad-cow disease<sup>10</sup>, itself a form of encephalopathy.

We are entering a phase of life in Australia when "business thinking" will be transfused into every possible vein, compatible or not.

*Source: Professor Stephen Leeder "Mad-cow thinking - how far has it spread" Australian Medicine 20/5/96 page 6*

The medical profession stood firm, resisting government in 1998 and then using their market power to put the largest corporate private provider of hospital care out of business when it followed this path. Health care has been adversely effected but it could be much worse. They had no market power in aged care.

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<sup>10</sup> Mad Cow Disease acquired from eating beef from infected cows had caused panic across the world. It was characterised by strange movements and bizarre delusions.

## Example of the consequences

Industry bodies find themselves supporting all sorts of do-good bodies and this helps in branding and marketing. This may be because of their credibility or the sponsorship money they bring.

**Example:** LASA is a supporter<sup>11</sup> of *The Lantern Project* which actively promotes “*quality of life of older Australians through good food and nutrition*”. They publish their research and advice in the LASA magazine “Fusion”.

They are also represented on government advisory committees where they are accepted as authorities or ‘*subject matter experts*’.



Three examples are illustrative:

1. The CEO of LASA is currently on the Aged Care Sector Committee,<sup>12</sup> the central group that advises government.
2. The CEO of BUPA was chair of the powerful Aged Care Guild representing the 8 largest corporate providers. He was “*appointed by Cabinet of the Commonwealth Government as an independent expert for the Aged Care Financing Authority to assist in the reform of the Australia’s aged care system in 2012*”. He was involved in setting up the funding system for the \$3.7 billion *Living Longer Living Better* reforms. He was CEO of Estia when it was alleged to be a prime offender in ‘maximising’ funding from this system. This was the final straw that caused government to step in and reduce funding to the sector. The minister was less polite. She called it rorting.
3. The previous CEO of LASA was made CEO of the Quality Agency in 2014 when its independence was abolished and it became part of a government department.

All of the aged care reforms implemented so far have been industry-led, including the *Living Longer Living Better* reforms, the *Aged Care Roadmap*, and more recently the ‘industry-led’ *Aged Care Workforce*. Leaders from the industry or from the wider business world are appointed to do this because of their reputations in the business world.

Without experience, data, and a willingness to listen to contrary messages coming up from the coalface, managers and politicians are effectively shielded from the consequences of their actions. They are free to create and be innovative without regard to anything other than the financial consequences. We should not be surprised at what has happened.

Nowhere was this more evident was when industry group leader CEO of LASA who represents private and not-for-profit nursing homes, was interviewed on ABC 4Corners “Who Cares” (Part 1) program.

When asked, he had no idea on direct care needs, nutrition or staffing levels. His organisation supports *The Lantern Project*. He gives evidence to government inquiries and speaks publicly for the industry across the range of aged care topics. He sits on the Aged Care Sector Committee and advises government.

<sup>11</sup> The Lantern Project, <http://thelanternproject.com.au/about-the-lantern-project-australia/#projectmembers>

<sup>12</sup> Aged Care Sector Committee: <http://bit.ly/2QuxIMz>

Part of that interview is below. When challenged about food he was equally out of touch. His responses have sparked anger across the internet:

Anne Connolly: If you're talking about high care, for example if you're talking about 30 high-care people in a unit, how many registered nurses and how many carers should be available to them.

Sean Rooney: Well, I don't know. It depends on what their specific needs are. The point...

Anne Connolly: If they're high care and they're bedridden, they can't move.

Sean Rooney: Well, you would expect that would require a higher number of carers than people that aren't in that situation.

Anne Connolly: What number? What number do you need?

Sean Rooney: **It's not for me to know. I'm not a clinician. It's not my role to be able to determine that.**

Anne Connolly: One of the other things that's coming back from staff members is they've told us on average they have about five to six minutes to get somebody up out of bed, showered, dressed and to breakfast. Do you think that's acceptable?

Sean Rooney: Well, it depends on who the person is.

Anne Connolly: An old, frail person. Someone in residential aged care in their late 80s or 90s

Sean Rooney: Well I, I ... but, everybody is different.

The problem here is that neither government nor these managers are aware of their deficiencies. They are trained to be confident in their roles so are unwilling to confront criticism.

## 2.6 The 1997 legislation

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

*Adam Smith: The Wealth of Nations, 1776.*

The now powerful for-profit industry bankrolled the Howard government who gained power in 1996. Howard took off from where Keating had ended. All previous warnings about markets and our knowledge about them was ignored.

The industry clearly had a major role in drafting the *Aged Care Act* in 1997. Doug Moran later claimed that he had written the Act himself<sup>13</sup>. He became angry when the government, faced by intense criticism and a massive community backlash, retreated from some of the clauses he had written. Moran was a dominating character who boasted that when he needed something done he would go to state premiers and tell them to sort it out for him - it is clear they did! Was Howard different?

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<sup>13</sup> Matters of Public Importance - Nursing Homes - House Hansard - 1 October 1997, Page 8926: <http://bit.ly/2qHgnq9>

### 2.6.1 Free market (Neoliberal) policy<sup>14</sup>

Unrestrained free-market ideology became unchallenged when the Howard Government was elected in 1996.

The policy espoused and encouraged 'innovation'. The entrepreneur was king. Small government and absent regulation were the order of the day leaving the bureaucracy hollowed out and unable to research and advise government.

Government became dependent on appointments from industry and consultants from the marketplace to do research and advise it on policy. The entire political process including its regulation was populated and its thinking captured by the marketplace discourse. Braithwaite described the way regulation had been captured and warned of the consequences in his 2007 book.

Any impediment to the market's operation was condemned. The power of the unions in protecting workers was seen as a restriction on the market. The community's expectation that those who provided care to the vulnerable be restricted to those who were 'of good standing' and so trustworthy was seen as restricting the market's operation. Anyone prepared to invest was welcomed.

All accountability for how government money was spent was removed in 1997, as were the rigorous probity requirements that had protected the sector.

### 2.6.2 More Warnings

There was strong criticism in the parliament particularly of the lack of accountability for staffing and the inadequacy of the proposed accreditation process to do so. There was a community backlash and Howard only narrowly won the next election.



Senator Gibbs<sup>15</sup> was a strong advocate for the vulnerable and disadvantaged. She realised what was going to happen in aged care and spoke out strongly when the 1997 Aged Care Bill<sup>16</sup> was introduced. She gave a telling and prophetic speech in parliament 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.

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<sup>14</sup> **Free market ideology:** Few realise that neoliberal free market thinking built on the philosophy of individualism promoted by US philosopher and author Ayn Rand. She praised selfishness, considered that altruism had no place and attacked any sort of control by society describing it as the 'collective'. It limited and frustrated the contributions that individuals made. President Reagan adopted her views.

Economist Milton Friedman adopted a similar position claiming that social responsibility in business was socialist and that businessmen only had one responsibility and that was to make money for shareholders. He became advisor to both President Regan and Prime Minister Thatcher who turned these ideas into policy. Thatcher even asserted that there was no such thing as society. The belief in the primacy of markets developed metaphysical properties. If left to their own devices, a hidden hand would fix any problems and ensure they were always beneficial. If markets did not work then they were not free enough.

**Managerialism:** The policy was associated with and driven through society by a new cadre of managers trained in the new patterns of thought. Management became a discipline of its own independent of the sector that it was managing. Little if any knowledge of the sector was required and managers moved freely from senior positions in one sector to another. The market became dominant and highly structured and the civil society that had once controlled the excesses of the market was pushed aside. Those who study the phenomenon describe Civil Society as being 'hollowed out' – a shell of what it should be.

<sup>15</sup> **Gibbs, Brenda (1947– )** Australian Senate Biographies <http://biography.senate.gov.au/gibbs-brenda/>

<sup>16</sup> Aged Care Bill 1997, Hansard, Senator Gibbs, 24 Jun 1997, page 5042 <http://bit.ly/2rfThau>

Prophetically 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 was describing a system where those who make policy, those who make decisions and those who manage care not only lack the information needed but have no practical experience in the provision of care. She was describing 2018.**

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 21 years later is still repeatedly trotted out in the face of evidence that the system is failing. **The flawed regulatory process is used for marketing the system and is the first line of defense when failures in care are publicly criticised.**

In the Bill there was *'a deliberate budget driven omission which fails to appreciate the health risk to residents in reducing or removing nurses.'* In 2018 we know that levels of staffing and particularly skilled staff have steadily decreased at the same time as resident acuity has dramatically increased since the introduction of the 1997 Aged Care Act.

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

**Those whom our aged care system has failed including many staff, would agree that Gibbs was prophetic in describing 2018. The recent ABC Four Corners program "Who Cares" confirm it.**



**1999**

In 1997/8 the very successful US Aged Care Company, Sun Healthcare, bought into Australian hospitals. FOI documents revealed its plans to enter into aged care in Australia. During 1998 and early 1999 a vast amount of material was collected about the failures, not only of Sun Healthcare but of all the large US corporate aged care providers.

Many hundreds were sent to sections of the Department of Health and to both major political parties together with descriptions of the way that marketization had led to the problems described. While they may not have read them neither government can claim that they were not fully informed about the likely consequences of what they were doing and given every opportunity to rethink policy. Sun Healthcare failed a probity review in Victoria and then entered bankruptcy in the USA and Australia.

This material forms the basis of an in depth analysis of the US Aged Care system in multiple web pages written in 2000<sup>17</sup>. On the first page summarising this it says:

*“These web pages make the content of the material I was sent available to Australian citizens. I am hopeful that they will draw the obvious conclusions and force our politicians to confront not only what has happened but the reasons why it has happened”.*

These pages have been referred to and referenced in submissions to many aged care inquiries.

### **2.6.3 Staffing**

The bulk of funding continued to be provided by government and this was fixed. Providers could not compete by providing better services and charging more for them. The only way to compete and increase profits was by reducing costs through “efficiency”. Seventy percent of costs were nursing staff and they consequently bore the brunt of the changes. The levels have now fallen to 55% to 60% of expenditure as a consequence.

All accountability for how government money was spent in the marketplace was abolished so that there was no check on the amount spent on staffing. Some staffing requirements were still specified and because of this there was still some reluctance to invest.

The founder of the US aged Care success story, Sun Healthcare visited Australia and met politicians. He had been trained by the recurrent health care offender Tenet Healthcare (Previously National Medical Enterprises) in the 1980s when it was one of the largest providers of aged care in the USA. He had no doubts about his appealing dogma, was charismatic, and a very successful US entrepreneur.

His particular brand of snake oil was that government should butt out and leave the sector to industry. There was plenty of fat in the system and they would soon sort it out. You did not for example, *“expensive trained nurses to provide the simple care needed”*. Politicians and businessmen were soon repeating his ideas, which were music to their ears.

In 1998 all remaining staffing requirements were removed and it was left to the regulators to decide whether there were sufficient staff.

The Unions remained powerful and cohesive. They tried to resist staff reduction. Large investors including the banks and private equity were reluctant to invest because of their power. The government introduced the unpopular “Work Choices” legislation in 2005/6. This reduced the power of the unions. These groups then invested heavily.

The proportion of staff and ratio of trained nurses to residents have steadily declined since 1998. There was no change when there was a large injection of funding accompanying the *Living Longer Living Better* (LLLBB) reforms between 2013 to 2015. It was the private equity investors and the owners of companies that listed on the share market who lived better - not the residents in nursing homes!

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<sup>17</sup> Aged care & nursing homes (USA). Corporate Medicine web site 2000 [http://www.corpmedinfo.com/access\\_aged.html](http://www.corpmedinfo.com/access_aged.html)

## 2.6.4 The importance of staffing

The appealing message from Sun Healthcare is perhaps why there has been an undercurrent belief which is periodically and repeatedly asserted claiming that aged care is a normal process, is not health care or not medical care and nursing homes are not hospitals. It is of course medical care and a nursing home is a 'hospital' to the extent that it needs skilled nurses, paramedical staff and doctors with experience of aged care.

It is of course, much more as it is the resident's home. It is also a focus on the quality of life, but medical care has always been all about enabling quality of life so this too should be a focus of medical staff as well as many others. That is what they are there for. We realise that the medical care of residents is often poor, partly because of ageism, of poor facilities and pay for doctors and of lack of interest and training in aged and palliative care. The system does not support good medical care.

Nursing staff that are there every day are the primary social contact and therefore primarily responsible for both care and for the regular interaction and relationships that give life meaning and quality.

In the marketplace, quality of care is more profitable because additional services, many involving 'choices' can be a lucrative source of income. Their natural inclination will be to criticise medical care and to talk up quality of life as something separate.

Unlike Australia, the US government openly acknowledge that staffing levels and skills are the most critical determinants of care<sup>18</sup>. They also recognise the significance of employee turnover and tenure as a "*vital component of quality care for nursing home residents*". **They set out recommended minimum staffing levels that are required for safe care if residents are not to be harmed - based on careful research and expert opinion.** It has made staffing and care data available for nearly 20 years.

Recommended minimum safe staffing levels have been established to ensure that residents are not harmed. These are based on careful research and expert opinion. Extensive staffing and care data has been available in the USA for nearly 20 years<sup>19</sup>. In Australia, there has been a 21-year battle to keep this sort of information away from those who need to know it.

When we have accurate staffing data we can perform the research needed to refine our staffing guidelines and keep the public informed. We can tap into and use international research to guide us.

Sector claims of "*unreasonable additional administrative costs and red tape*"<sup>20</sup> are baseless and a furphy. Staffing data is already being collected and reported to the sector on a regular basis by financial institutions<sup>21</sup>. The Quality Agency has been collecting this information for around 10 years. It promised the sector that this information would not be made public.

When it comes to the collection and reporting of financial data or development of benchmarks based on them, no one complains that it is 'problematic or 'burdensome'.

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<sup>18</sup> CMS.gov (Centers for Medicare & Medicaid Services) - Staffing Data: <http://go.cms.gov/2frxXuQ>

<sup>19</sup> Nursing Home Compare datasets: <https://data.medicare.gov/data/nursing-home-compare>

<sup>20</sup> **New bill calls for providers to publish staff numbers by job description**, Aust Ageing Agenda, 22 Aug 2018 <http://bit.ly/2Ngi5Xj>

<sup>21</sup> Financial benchmarking: <http://bit.ly/2y0nzjY>

This data is conveniently trotted out prior to<sup>22</sup>, and during inquiry appearances<sup>23</sup>, coronial inquest<sup>24</sup>, industry talkfests or when asking governments for more money<sup>25</sup>. Financially based staffing benchmarks have even been used by non-profit organisations as justification for reducing staffing<sup>26</sup> across nursing homes.

Average direct care nursing levels in Australia are about 2.8 hours per resident day (hprd) with care by trained nurses providing only a fraction of that. This falls a long way behind what research showed was needed in the 1980s, and well below the 4.1 (hprd) minimum recommended in the USA.

Staffing levels, particularly the number of trained nurses, have fallen to unsafe levels in many homes in Australia over the last 21 years. In comparison, US residents receive twice as much care from trained nurses and more than a third more nursing care overall. This makes it impossible for our system to be world class or to be providing the care our residents need.

Dr Kidd, who has provided care to residents in nursing homes since the 1990s, spoke for the AMA at the House of Reps Inquiry on 11th May. He said *"It's definitely worse now than it was 20 years ago"*<sup>27</sup>.

## 2.7 The consequences of current policy for staffing

Staffing levels have been kept out of sight but SB has been collecting data from about 8-900 of the over 2,000 providers in Australia who would voluntarily disclose since 2007. This only became available to us at the time of the workforce inquiry in 2016. The nursing unions also kept some data.

Data collected by the unions over the years shows that there has been a 53% increase in the number of high care residents needing more skilled staff. This has been accompanied by a 35% decline in the skilled nursing staff (Registered and Enrolled nurses) needed to provide that care. There has been a 22% increase in cheaper Personal Care Assistants who don't have the skills that are needed.

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<sup>22</sup> Staffing data: <http://bit.ly/2NWfQxF>

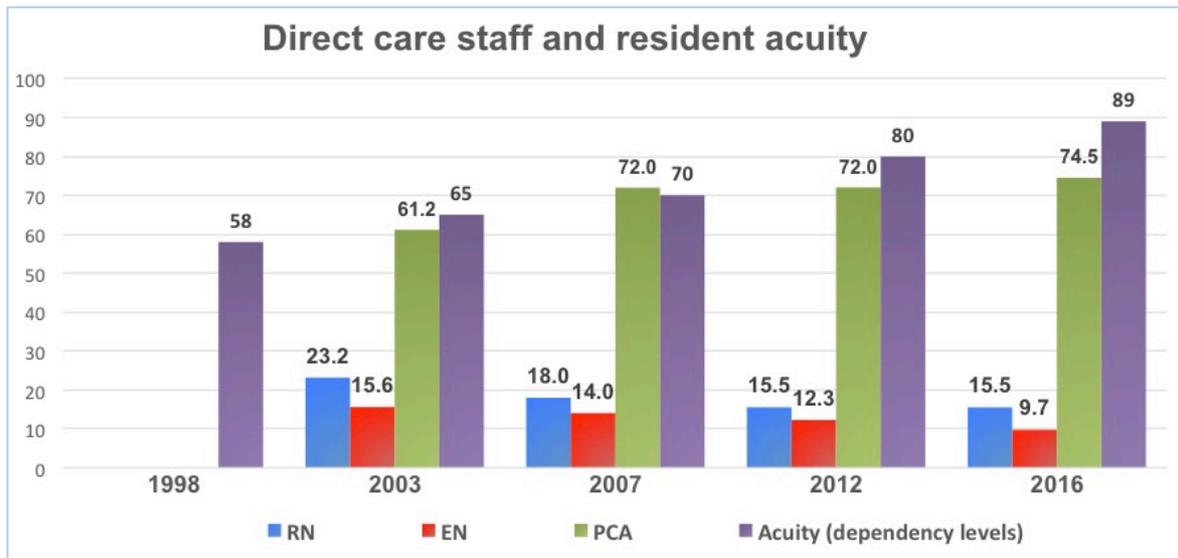
<sup>23</sup> Inquiry: <http://bit.ly/2NXsQ5Z>

<sup>24</sup> Coroner's inquest: <http://bit.ly/2unfrdR> (pgs 45-46)

<sup>25</sup> SB 2017 Registration Kit *"The results of the survey may also be used for other purposes. It is likely that summary data will be used by industry bodies to lobby Government and in the formulation of policy."* <http://bit.ly/2AhDiPx>

<sup>26</sup> **Southern Cross Care defends nursing home cuts, families hit back**, 13 Jul 2017, *Chinchilla News* <http://bit.ly/2xV9uEs>

<sup>27</sup> House of Reps Inquiry, 11 may 2018: <http://bit.ly/2LDHgpN>



In contrast the USA, which has recommended minimum levels and publishes detailed staffing data, has seen a slow increase in staffing levels so that their average level is now almost equal to their minimum recommended level. This is over an hour (one third) more nursing care than the average resident in Australia gets and double the amount of care by trained nurses. The figures show the hours per resident day.

	USA: CMS Recommended Minimum	AU: SB Recommended Benchmarks	USA: US Average	AU: SB Average
Registered Nurses	0.75	0.36	0.8	0.37
Enrolled Nurses (equivalent)	0.55	0.34	0.8	0.33
Nurse Aids (equivalent, eg PCAs)	2.8	2.22	2.4	2.08
<b>Total nursing time:</b>	<b>4.1 hrs</b>	<b>2.9 hrs</b>	<b>4.0 hrs</b>	<b>2.8 hrs</b>

\*Total rounded to 1 decimal point.

CMS<sup>28</sup> = Centre for Medicare and Medicaid Services (15,000 facilities) SB<sup>29</sup> = StewartBrown (approx. 800 facilities)

The US recommendation of 4.1 hours per resident day is based on 8 years of careful clinical research and then close observation and re-evaluation over the next 16 years. The Australian levels of 2.9 used as a guide by providers is a financial benchmark set by an accounting firm. This level would be considered unsafe in the USA and would be associated with an unacceptable level of failures in care.

Recurrent complaints about inadequate levels and skills of staff in Australia have been vigorously denied by governments and industry.

### 2.7.1 The consequences for residents, families and the system

Despite the endless rhetoric and promises of choice, people don't have the data they need to make informed choices about aged care placement<sup>30</sup>. We don't have the information to manage staffing and care, to deal with complaints, to investigate, to do research, to regulate effectively or to make policy. Staffing is the most critical determinant of care and we all need to know about this.

<sup>28</sup> Nursing Facilities, Staffing, Residents & Facility Deficiencies, 2009 through 2015. Henry J Kaiser Foundation Jul 2017 <http://kaiserf.am/2D3X1Df>

<sup>29</sup> Aged Care Financial Performance Survey Summary of Survey Outcomes StewartBrown December 2015 SB  
Aged Care Financial Performance Survey Residential Care Report StewartBrown - June 2016 - SB

<sup>30</sup> Aged care ratings do not tell what you need to know about Australian nursing homes, ABC Investigations, 2 May 2018 <https://ab.co/2uXYSDh>

The aged-care sector has opposed this<sup>31</sup> on the basis that staffing and care are 'too complex'. **This is an argument for collecting and studying data, not for hiding it.** Both the community and the workforce have had enough. We need sunlight.

## **2.7.2 An industry led taskforce to solve the staffing problem**

Intense criticism about staffing led to the 2016 Aged Care Workforce Inquiry<sup>32</sup> which revealed that there were indeed major deficiencies in the number and training of staff. Much of the criticism was that the industry was putting profits before care and that they, and the managerial culture were largely responsible for what had happened. These were the organisations whose influence led to the removal of all nursing requirements in 1998 and then to the Work Choices legislation that that prevented the unions from resisting staff cuts.

Incredibly, the government then set up an industry driven taskforce to develop a policy to address the problem. They brought in John Pollaers to lead the industry driven process. He is a very successful businessman who had experience with Pacific Brands and then made his name in the global business world. He has helped government on a number of occasions. The taskforce was stacked with industry, government and other supporters of the system.

This faith in industry managers, boards and consultants is a reflection of the way the sector has been run for 20 years. These are the people who have consistently been appointed to advise government and help them make decisions. The vast majority have management, market and financial qualifications and experience. Few have any experience in actually providing care particularly aged care. These are the people that the discourse sees as credible and effective.

This is entirely consistent with neoliberal thinking. These are the people they see as credible and on whose advice they rely. They turn to them whenever they have a problem they can't deal with themselves. This inability to think outside a particular pattern of ideas is called paradigm paralysis. That this paradigm paralysis lies at the root of our political and regulatory failures across society is readily apparent. As a consequence our citizens are ready to move on into the 21<sup>st</sup> century while the political process is locked into the 20<sup>th</sup> century and its obsolete ideologies.

**An exercise in public relations:** The process commenced with a summit meeting to which advocacy groups including Aged Care Crisis were invited. It was disturbing that the first discussion session started not with data, but with a motivational and branding exercise. It was led after the introductory session by a *“Global business strategist and cultural anthropologist”* and a *“global brand strategist”* who addresses *“the cultural phenomenon of branding and its power to unite, define and dramatically dictate people’s behaviours within companies and communities”*.

This effectively countered any tendency on the part of participants to be truly introspective, to look critically and in depth at what was happening and challenge the neoliberal discourse on which policy and corporate success depended.

Many of those attending were young and would have had limited experience, yet no basic data about current staffing levels was supplied nor did anyone give information about the history of aged care and the way it had developed.

Data should have been available from the nursing unions and from StewartBrown and Bentleys who both collect it. This would have shown the extent of the problem and led to a discussion about what was actually required.

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<sup>31</sup> New bill calls for providers to publish staff numbers by job description, Aust Ageing Agenda, 22 Aug 2018 <http://bit.ly/2Ngj5Xj>

<sup>32</sup> Future of Australia's aged care sector workforce Inquiry: <http://bit.ly/2Oy6Xd0>

As a consequence, the sessions dissolved into the sharing of often feel good opinions and did not come to grips with the issues. Those advocacy groups like Aged Care Crisis who were critical of the process were not invited back to the second summit.

We are left with the impression that all of the real discussion took place in the taskforce itself and that these summits were feel good publicity exercises to show that they had discussed widely and everyone had input and felt good about it.

## 2017/18: The taskforce report<sup>33</sup>

The taskforce report was interesting because it did write about many of the problems in staffing and it did propose a large number of processes for retraining, recruiting and addressing its objectives. It also spoke about providing good care so was also a motivational document.

We think the problem with the report is that this is an industry led and organised “reform” process and it is doing it for the industry. It starts off by indicating at the start of the second paragraph that **“This strategy- developed with the industry, for the industry”**. That is its problem. The report at one point even indicates that it is *“working for the collective good of the industry”* (page 98). It has *“identified a shared and unifying belief for the industry”*.

**We are not persuaded that the collective interest of the residents, their families and the community received as much attention.**

The report carefully avoids giving actual staffing data and ratios for Australia or comparing them to show how poorly they compare with the USA and Canada. This data had been sent directly to Pollaers. There was no attempt to develop any sort of formula to calculate what would be required in different situations, or to collect the sort of data that would allow anyone to evaluate whether it was adequate. So it takes us no further in the debate about how to regulate staffing.



**It skates around the issue of ratios and like every industry body, it rejects them. We must remember that the profitability of the sector depends on its ability to save money on staffing. This is what attracted many of them to the industry and without it their shareholders will not get the profits they are used to - or the managers their bonuses.**

A number of small points illustrate the problem:

1. The report refers uncritically to 55 to 60% of provider expenses as being employee related, whereas 70% or more would probably be needed for good care given the increasing acuity of the residents over the years. To a businessman, this is efficiency and not understaffing.
2. It uncritically adopts the industry argument that the sector is *“experiencing rising consumer expectations and other significant changes, much outside its direct control”*. For 20 years industry and government have been advertising their ‘world class’ system. Glossy brochures, magnificent websites and television advertisements have been promising an impossible lifestyle and experience – and of course the unrealistic *“wish for greater choice”* when the residents who are lucky enough to have made a good choice have no choice about who they will be sold off to as the industry consolidates. If this is a problem, then they created it.

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<sup>33</sup> A Matter of Care Report of the Aged Care Workforce Strategy Taskforce, June 2018

3. There are the usual claims to a “*tightly regulated market*” when it is clear it is anything but.
4. There is no attempt to even consider the possibility that the “*negative societal attitudes to ageing and public portrayals of ageing*” are well deserved because the problems in the system are systemic and closely tied to the marketised structure and the neoliberal ideology on which it is based.

The report does create processes and multiple committees to implement its reforms and drive the processes.

The major and most critical reform and the one it all depends on is “**A voluntary aged care industry code of practice**”.

*“An expert with extensive experience in drafting and consulting on industry self-regulatory codes was commissioned to assist the taskforce in preparing a principles-based code for the aged care industry”.*



Following the recent scandals exposing the exploitation of vulnerable citizens in multiple failed markets in Australia, particularly the exposure of banking self-regulation by the Royal Commission, we are expected to accept self-regulation in aged care. Surely we are not as gullible as that.

This is the same industry that persuaded government to remove financial accountability in 1997, remove the final vestiges of staffing requirements in 1998, and then were reluctant to invest in 2005 until the Unions fighting to improve staffing were disempowered by “*Work Choices*”.

This is the same industry that has been denying failures and understaffing for 21 years – an industry whose failures have just been exposed on 4-Corners. They have shown that they cannot be trusted and they have the nerve to come back and ask us to trust them once more.

This is a managerialist report. There are many good ideas (working and career opportunities are very important), but they are set within the wrong context.

The possibility of a competitive profit driven industry adopting voluntary codes in order to achieve the lofty goals must be small. One wonders whether there will be funding left over for staff when the costs of the management structures and processes being put in place are added to this expensive taskforce exercise.

**Who is responsible for aged care and what drives it?:** Aged care is every person and every community’s responsibility and it is through involvement and “ownership” that citizens build their values and learn to empathize. Staff are drawn from these communities. They are motivated by the altruism and values in those communities. They are rewarded by the relationships they form in caring. This is not the language of managerialism or how business thinks. It gets little attention in this report. Values are ignored and altruism languishes.

Increasingly we are learning that social services are better when local communities have sufficient control to give them a sense of ownership. Remote aboriginal communities get token involvement and perhaps some ownership. The rest of us are denied this.



## 2017/18: The taskforce report<sup>34</sup>

**Comment:** This is a report for the large corporate providers, for large nursing homes, and for a government that supports consolidation in the face of evidence. Both large corporatised businesses, and large nursing homes are generally associated with poorer outcomes.

Pollaers is well meaning and used his business experience and knowledge as best he could but his was the wrong experience for the job. It is not his fault but the government's because they picked the man who would give them what they and their backers wanted.

## 2.8 Regulatory failure

Central to policy in 1997 was the belief that regulation interfered with the successful operation of the market and inhibited the hidden hand, which somehow made it fix everything and be beneficial. The regulatory system was set up to support providers and not regulate them. Adverse publicity was challenging for both government and industry. There was a revolving door so making the regulatory system even more averse to publicity. In spite of this it was claimed that the regulatory system would ensure that staffing was adequate.

### 2.8.1 Complaints

The process driven centralised complaints system was unable to meet the needs of citizens and since 1997 has been a constant cause of complaint and unhappiness. Since the Walton Review in 2010 things have gone from bad to much worse. Accounts suggest that assessors do not have the clinical skills needed<sup>35</sup>.

This review advised local resolution and as a consequence the complaints have been referred back to the provider to resolve with the family, who were at a disadvantage. The power imbalance and fear of retribution deterred most. There was no one there to support them and this has got steadily worse. The number of site visits by the complaints system has decreased from over 3000 a year to only 50.

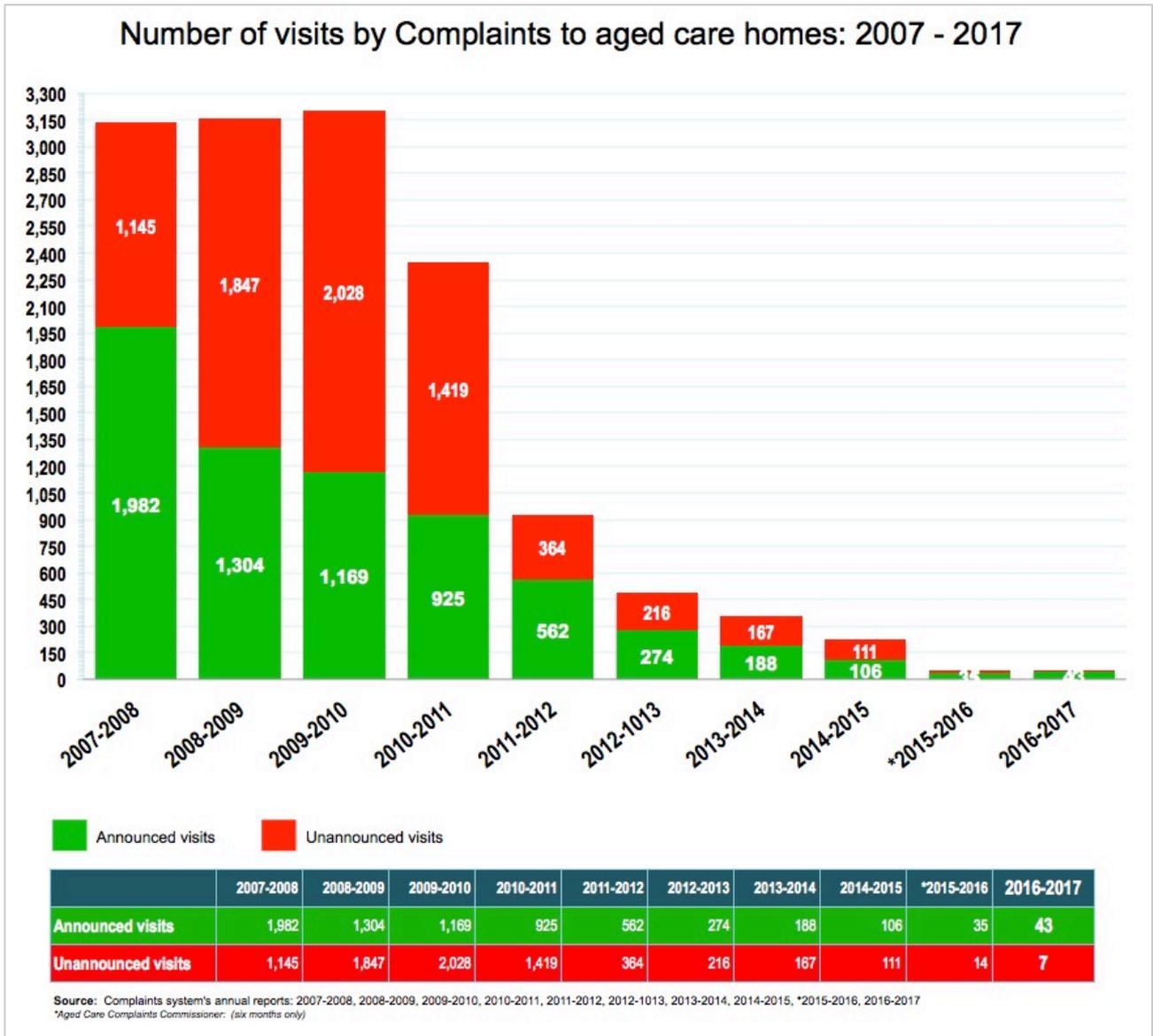


**Many of these complaints would have been related to staffing problems, yet no one went to the homes to check on staff levels.**

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<sup>34</sup> A Matter of Care Report of the Aged Care Workforce Strategy Taskforce June 2018

<sup>35</sup> Aged Care complaints kept secret, SMH, 27 Sep 2014: <http://bit.ly/2CQQA0Q>



**Figure 1:** Source - Aged Care Complaints Commissioner's Annual reports: 2007 up to and including 2017

## 2.8.2 Accreditation

Since its earliest days this was a regulator that was conflicted as to what it was there for and who it was serving - government, the industry or Australian citizens.

### **An independent regulator that is not independent<sup>36</sup>**

When the agency was set up it was supposed to be independent but there were soon many accusations that it was stacked and that the minister interfered. Then there were the many industry representatives involved in the whole process – not something that looks good for a regulator and inspires confidence.

In 2001 The minister Bronwyn Bishop was accused of appointing three of her circle including her Liberal Party campaign director to the board of the agency.

She was accused of favouritism. *The Guardian* reported “*The agency was accused of leniency towards her friend Aged care operator NameXYZ - - ACSAA assessors are said to have told the staff of one of the homes that "the owner knows people, nothing will be done"*. Both homes were subsequently given generous reprieves of several months to achieve accreditation standard.

It may be coincidental, but it is interesting that both *NameABC*'s nursing homes continued to be fully accredited over the years until after Bishop retired from parliament amidst a scandal over travel expenses. Both of *NameXYZ*'s nursing homes were found to have failed multiple standards and were quietly closed down in late 2017.

An industry spokesman also spoke out in 2001 indicating that the agency was “*originally intended to act as an independent body*” but “*is now effectively functioning as an arm of Senator Bishop's Department*”.

The chair of the agency had resigned and she spoke out. Dr Penny Flett, “*claimed public confidence had been 'shattered' in the Aged Care Standard Accreditation Agency because it was unable to do its job independently of government*” and that “*the agency is not free to decide how it is going to do things.*” On another occasion she said “*The agency is not independent enough and I do not know of any similar body that has to bear the control that this agency has to deal with.*”

When challenged in parliament, Bishop responded by pointing out that Dr Flett was “*also the chief executive officer of a group of homes known as Brightwater*” and that “*it was better to have a chairman who was not a provider, in order that the board could properly get around its business of compliance*”. We agree with that too. There has been a revolving door of providers on the agency.

We note that after the Oakden facility failed accreditation in 2007 and the nurse supervisors walked away because the agency interfered in what they were doing, a South Australian provider took over its supervision. Its CEO was on the Accreditation Agency. Oakden remained fully accredited until 2016 when a state investigation revealed appalling failures during that period after a family member blew the whistle.

The agency's distinguished CEO between 2002 and 2013, Mark Brandon OAM<sup>37</sup> held senior executive and consulting roles in government, in private health insurance and aged care before, during and since that period. He was very much an establishment figure.

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<sup>36</sup> Questions without notice House of Representatives 21 June 2001 <http://bit.ly/2O7rohG>  
Aged care scandals erupt again *The Guardian* June 27, 2001 <http://cpa.org.au/z-archive/g2001/1051aged.html>  
Handle with Care, *Sydney Morning Herald*. 23 June, 2001

<sup>37</sup> Mark Brandon OAM *Linkedin* <https://au.linkedin.com/in/mark-brandon-oam-7411741>

He had very good relations with the industry which he insisted he was helping and not accrediting. In 2015 he became Chief Quality Officer for private equity owned and market listed company Estia Healthcare. His expertise would have been useful, but we wonder if any assessor would dare find a facility mentored by their previous boss wanting? This would have been a greater asset.

This is a body where too many of those on its board or even its assessors had links with the industry or government over the years. There are claims that *“dozens of aged-care executives are moonlighting as inspectors”* and that many others assessors are also consultants to the industry<sup>38</sup>. Many stakeholders with an interest were there but their interests were not always the residents.

In 2014, all pretense at independence was abandoned. The agency was transferred to a department and a stalwart from the industry put in charge.

### **A regulator that does not regulate**

In 1997 accreditation replaced the close state oversight that providers were so unhappy about. Accreditation had already failed as a regulator in health care in the USA and been rejected for aged care in the 1980s.

The minister in 1997 made it clear that accreditation was to help providers maintain standards and was not to act as a policeman. It was set up as a theoretically independent body, whose members were appointed by government.

At the same time as criticism of the system from families, from staff whistleblowers and in parliamentary inquiries grew over the years, government and industry strongly proclaimed its rigor as a regulator in order to discredit criticism or market our system to potential international customers. **Accreditation became the rock on which the systems legitimacy rested.** This is why the revelations of its failure at Oakden were so confronting.

Throughout this period when government were talking up its regulatory vigour, the agency itself was stubbornly contradicting this. It told anyone who would listen (eg. Professor J Braithwaite when investigating in 2005) that it was an accreditor and not a regulator. It stubbornly continued to accredit and not regulate. It pursued its own strategy of continuous improvement.

In 2011, the Productivity Commission recommended a single central regulatory body similar to the *“tough new aged care cop – the Aged Care Quality and Safety Commission”* that the current minister, Ken Wyatt is introducing. The accreditation agency strongly opposed this in its 2011 submission<sup>39</sup> arguing that it was not a regulator. There was a bold heading in its submission *“Is the accreditation body a regulator? – No”*<sup>40</sup>.

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<sup>38</sup> **Aged-care executives two-timing as auditors, in potential conflict of interest**, Courier Mail 20 Feb 2018 (paywall) <http://bit.ly/2oHwzVF>

<sup>39</sup> Aged Care Standards And Accreditation Agency Response to the Productivity Commission Draft Report March 2011 <http://bit.ly/2mg21ZY>

<sup>40</sup> **Submission By Aged Care Standards And Accreditation Agency** in response to draft report Productivity Commission Mar 2011 (pg 5) <https://www.pc.gov.au/inquiries/completed/aged-care/submissions/subdr763.pdf>

It insisted that:

“The general use of the word ‘regulator’ as a primary or even secondary role of ACSAA is not correct and it misrepresents the Accreditation Agency’s mandated roles - - - **The Accreditation Agency does not ‘investigate non-compliance’ with standards**”.

And then:

“**The proposed model of the PC Report would effectively place two functions that are inherently contradictory into one organisation:- regulatory function and accreditation function**”

It indicated that it was better to *“keep a clear and distinct distance from the regulatory functions”*. We agree.

In 2014 the Agency lost its independence and was moved into a government department and the word **“Quality”** added to its name. The CEO of the independent agency was replaced in the new Quality Agency by a leading industry figure, the CEO of LASA. There was no secret about who was calling the shots and pulling the strings.

We have heard no more about its not being a regulator. It has continued to accredit and instead of increasing its regulatory effort and collecting objective data, the number of standards to be measured has been reduced from 44 to 8 under the “Single Aged Care Quality Framework”<sup>41</sup> due to begin in 1 July 2019.

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<sup>41</sup> ACC submission: <http://bit.ly/2vosLxM>

The agency assiduously met its policy of continuous improvement. Its annual report proudly displayed its success in improving.

Its success in accrediting had increased from 64% to a near perfect 97.8% of all nursing homes getting a perfect pass rate for all of its 44 standards by 2015.

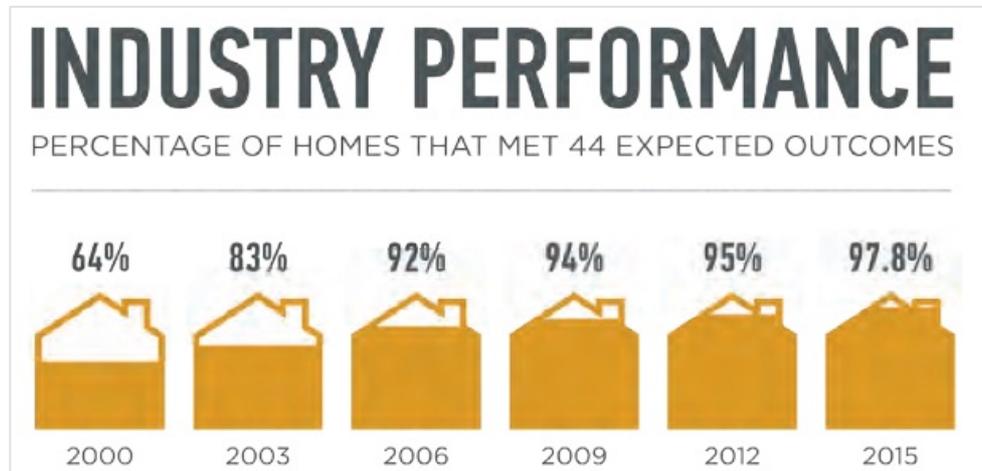


Figure 2: Source - Aged Care Complaints Commissioner's Annual reports: 2007 up to and including 2017.

If we return to what was happening with staffing, we can see that as the acuity of the residents increased by 53% and the trained staff needed to look after them fell by 35%, accreditation success increased by 53% too.

**This would be an incredible achievement if it actually represented what was happening.**

It becomes even more interesting when we compare this with regulatory findings in the USA where they report 175 measures of care including outcomes and failures quarterly. Regulators go in to check annually.

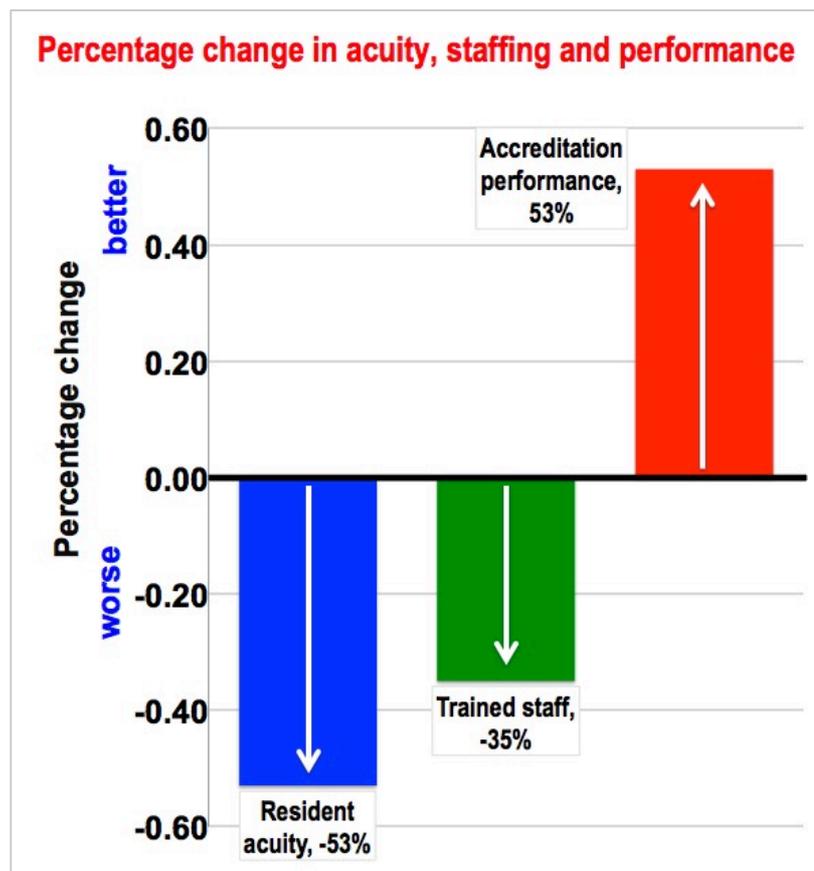


Figure 3: Incredible achievement: Resident acuity increased and trained staff reduced, at the same time as accreditation success increased

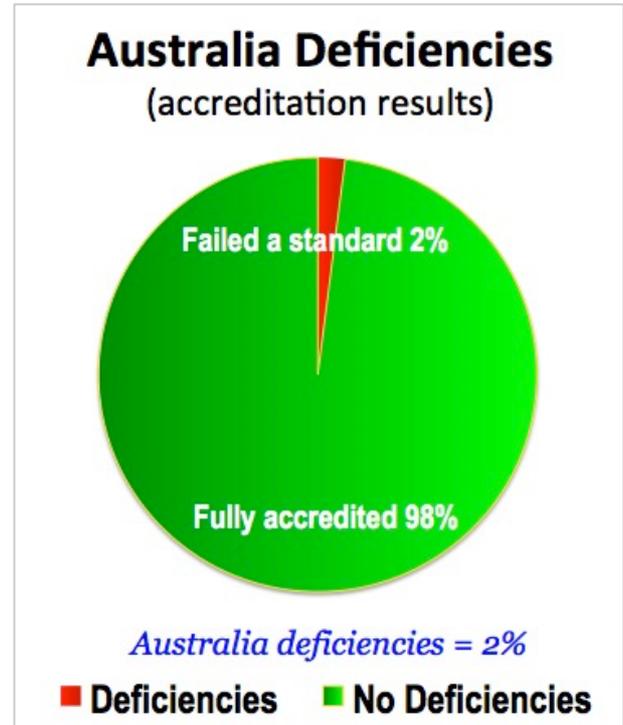
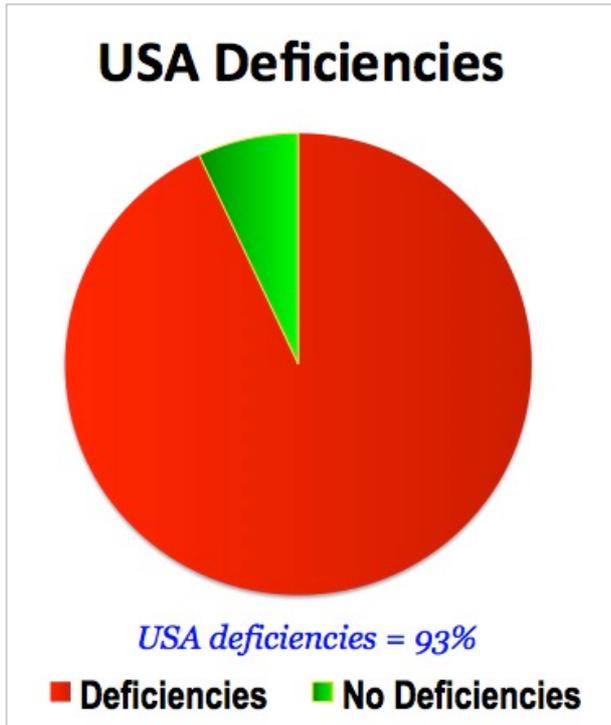
We can contrast Australia’s 97.8% success rate and 2.2% of failures with the US system where, in spite of double the number of trained staff and a third more care overall, only 7% get a perfect score and 93% of homes had a deficiency. Of these, 20% were serious enough to cause harm or create jeopardy.



Red shows the number with deficiencies or failing standards



Green have no problems



Can we accept that our regulatory system is ‘world class’ or do we believe the many staff and families who have given us a very different picture and accept that the monumental failures at Oakden are a good reflection of what has been happening with accreditation for many years.

Professor Braithwaite and his team reported their observational study in 2007. They were scathing about accreditation and warned that the whole regulatory process had been captured by business values.

**Response to Oakden:** We know that the Quality Agency is capable of detecting problems and addressing them. Since Oakden there has been a blowtorch applied. The rate of detection of failures in care has increased by a large percentage<sup>42</sup> and this is not because the facilities have changed the way they operate.



Accreditation was the process that the government and industry have repeatedly claimed would see that staffing levels were adequate. Our elderly residents and their families have depended on this regulatory body to see that there were adequate numbers of suitable staff to care for them. But all the time this was a body that did not regulate and insisted on using a process that was incompatible with regulation. The public were deliberately deceived.

<sup>42</sup> **Aged-care system on life support**, The Australian, 19 Sep 2018 reported a 177% increase in serious risk detection and 292% increase in the incidence of facilities that refused to comply with rules.

### 2.8.3 The Department

The department is the centre of the regulatory hub. It sets the tone and the direction that regulation takes. The Accreditation Agency repeatedly indicated that the department was the regulator and not the agency.

We got a rare glimpse into the way the health department operates and the regulatory ethos it sets for the rest of the regulators in 2012.

Nurses employed by the department were responsible for monitoring the services that were being provided. They were disgusted by the rotting that was occurring and by being ignored. They spoke out on ABC 7.30<sup>43</sup>. They indicated that when they remonstrated about the way the system was being rotted, they were told to look the other way. Adverse publicity was a clearly a greater problem than rotting.

When questioned later in parliament the department acknowledged that the problem was getting worse but they were “educating”<sup>44</sup>. This was a body that was there for the industry, helping it to keep out of trouble. It was not there for citizens. It was not regulating for them.

Its various committees were populated by a revolving door of industry figures. It was beholden to these partners. The priority has been to keep anything that challenged under wraps. Braithwaite also commented on its success in doing this.

Keeping staffing costs low was both government and industry policy. Government and the regulatory bodies it appoints have done their best to assist industry and make allowances.

## 2.9 An absence of data

It is difficult not to conclude that in 1997 our politicians would, when their policies were under pressure, abandon the principles of science and modern planning. They did not collect any data about the outcomes of their policies. Instead we got managed regulatory processes that protected them. Even when data was available it was ignored.

In May 2003 a review of the quality agency by the Australian National Audit Office (ANAO)<sup>45</sup> was critical of its failure to collect objective data so that it could evaluate the effectiveness of its accreditation processes. When questioned in parliament later that year<sup>46</sup> industry leaders and the department promised our politicians that they would do so. They claimed that many were already doing so.

This never happened and we can only wonder what they found that stopped them. The Accreditation Agency assisted by arranging a Review<sup>47</sup> by an external consultant in 2007. It advised that failures in care were ‘indicators’ and were not to be used as measures of care.

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<sup>43</sup> Funding feeds profits over aged care - ABC 7.30 Report, 16 Aug 2012 <http://www.abc.net.au/7.30/content/2012/s3569659.htm>

<sup>44</sup> Senate Community Affairs Legislation Committee Estimates - Wed 13 Feb, 2013

<sup>45</sup> Managing Residential Aged Care Accreditation Auditor General by Aus Nat Audit Office (ANAO) 2003 <http://bit.ly/2Qw1xwB>

<sup>46</sup> Joint Committee of Public Accounts and Audit - Review of Auditor-General's reports, fourth quarter 2002-03 - 18 August 2003 <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22committees%2Fcommjnt%2F6844%2F0003%22>

<sup>47</sup> Review - Evaluation of the impact of accreditation 2007 Corporate Medicine web site <http://corpmedinfo.com/agereport2007c.html>

## 2.9.1 What the limited data available reveals about staffing

We can draw some conclusions if we look at data like pressure injuries because pressure injuries are preventable. If poorly treated pressure injuries<sup>48</sup> are serious and in this group of people can and often do cause death. They are prevented by careful and meticulous nursing care. Their incidence is a barometer revealing insufficient staff and/or inadequate nursing skills.

Studies done in the 1990s before the changes in 1997 reported incidences of 3.4% and 5.4% (average 4.4%). Studies done in 2003 and 2005 reported an incidence of 26% and 42% (average 34%). This suggests an 8 fold increase in the first 8 years of the *1997 Aged Care Act*. No steps were taken to verify this or act on it. Staffing levels continued to fall. A recent segment on 3RRR digital in Melbourne<sup>49</sup> quoted a current incidence of 42% in the 176 Victorian government owned nursing homes where data is collected.

This is interesting because research published in a 2018 paper<sup>50</sup> by Henderson J et al addresses staffing issues. This shows that the Victorian government facilities were much better staffed than private facilities. This suggests that the general levels may be even higher.

Because the data collected in Australia was of *“insufficient rigour for use in research”* these authors could not do research that could be compared with international data, which *“largely uses objective outcome measures”*. Instead they had to use an assessment of the care that staff reported they had missed. They could not even collect *“objective numerical data on occasions of missed care”*. The absence of data in Australia reduces our research to this sad level.

The study showed that Registered and Enrolled Nurses in Government homes which had legislated minimum staffing levels (ie Victoria) cared for half as many residents as those in both for-profit and non-profit homes. When it came to missed care they found that *“Staff working within government owned facilities report significantly less missed care than those working in either not-for-profit and for-profit facilities”* where there was little difference.

Respondents included *“- - skin breakdown due to extended time in wet pads and limited pressure area care”* as well as *“neglected wound care”* as among the consequences of deficient staffing.



This data suggests that pressure injuries are likely to be considerably higher than 42% in for-profit and nonprofit nursing homes. If this is so it is a terrible indictment of what has been happening to staffing. It is what you might expect when the increased acuity of residents and the decline in staffing are considered.

The tragedy is that this does not result in an outcry and immediate action to document the incidence and the reasons for failure objectively across the country.

<sup>48</sup> Pressure injuries: <https://www.agedcarecrisis.com/care-issues/pressure-injuries>

<sup>49</sup> Breakfasters – 17 September 2018 102.7FM, 3RRR Digital in Melbourne  
<https://www.rrr.org.au/explore/programs/breakfasters/episodes/4788-breakfasters-17-september-2018>

<sup>50</sup> Henderson et al *The impact of facility ownership on nurses’ and care workers’ perceptions of missed care in Australian residential aged care* Aust J Soc Issues 2018;1–17

## 2.9.2 Changing patterns of staffing in Australia

International data shows that failures in care are closely related to staffing levels and ratios. In the USA data about care is collected. There have been many studies that show the relationship of increased pressure for profit and of corporatised chains to poor staffing and failures in care. A rapid increase in private equity ownership has led to studies that show them to be the worst performers<sup>51</sup>.

The Centre for Medicare & Medicaid Services publicly displays data<sup>52</sup> on its Nursing Home Compare website. This has consistently shown the difference in both staffing and outcomes between for-profit and non-profit:

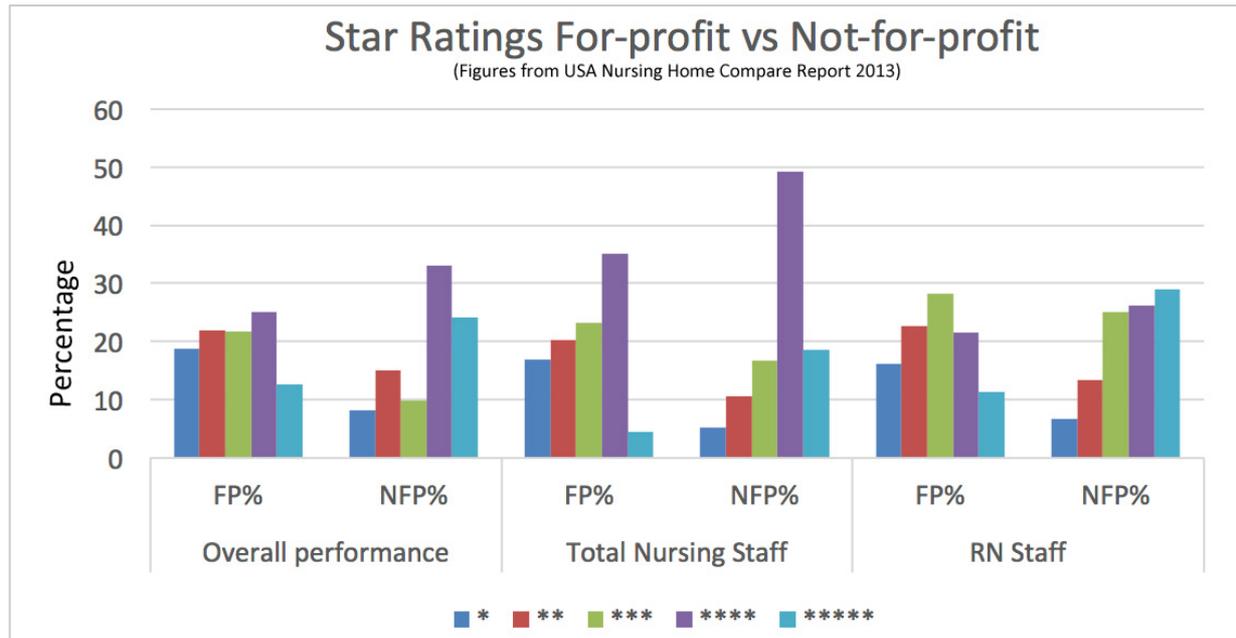


Figure 4: Analysis of performance when comparing for-profit vs not-for-profit

Two charts taken from a 2013 presentation by Professor Charlene Harrington illustrate this well.

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

<sup>51</sup> Harrington H, Olney B, Carrillo H, and Kang T Nurse Staffing and Deficiencies in the Largest For-Profit Nursing Home Chains and Chains Owned by Private Equity Companies Health Research and Education Trust 2011 DOI: 10.1111/j.1475-6773.2011.01311.  
<https://www.ncbi.nlm.nih.gov/pubmed/22091627>

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

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

<sup>52</sup> Nursing home data compendium 2015 edition Centre for Medicare & Medicaid Services <http://go.cms.gov/2f5STGH>

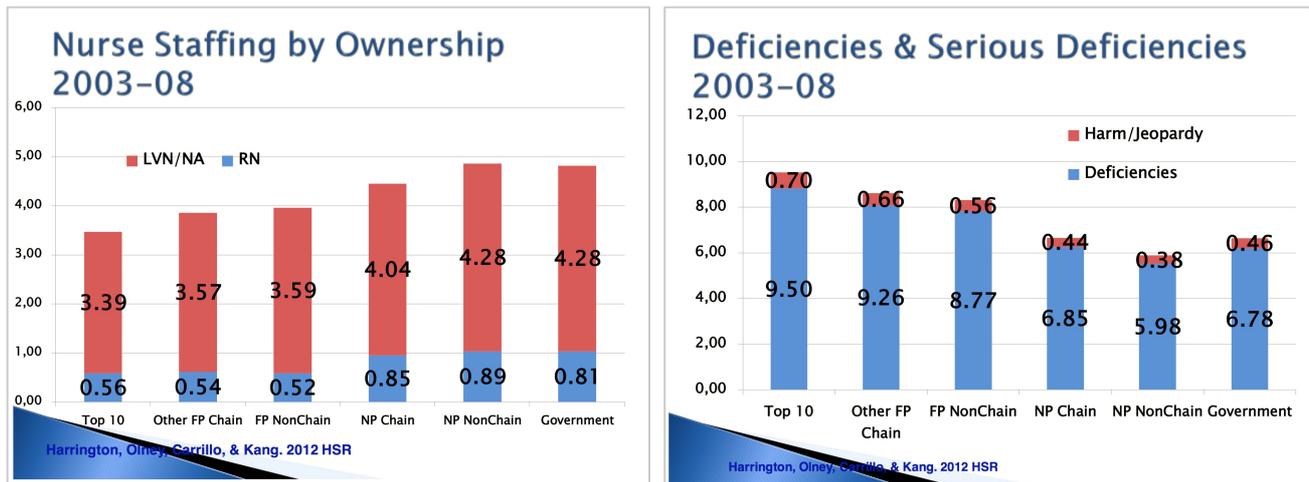


Figure 5: 2013 presentation by Professor Charlene Harrington

The staffing figures in Canada<sup>53</sup> show a similar trend with only the for-profit owned facilities having unsafe levels comparable with Australia.

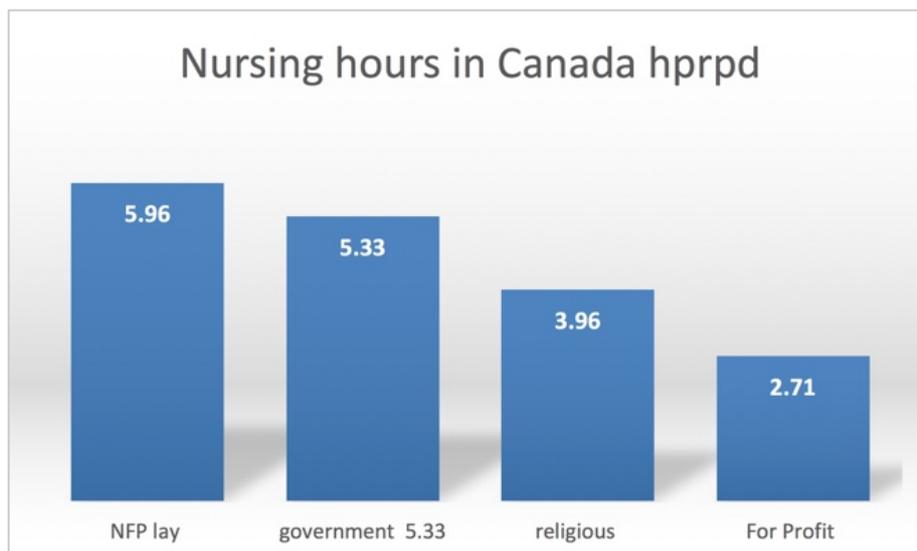


Figure 6: Banerjee A. An Overview of Long-Term Care in Canada and Selected Provinces and Territories

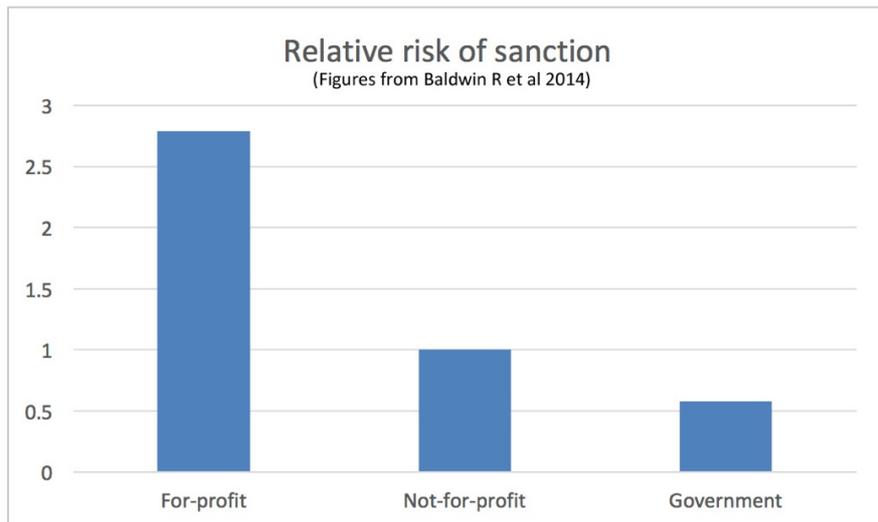
In Australia it has been strenuously asserted that ownership has no impact on the performance of nursing homes but this has not been verified by data. This has not been our impression when looking at the several scandals that have occurred over the years.

Earlier data suggests that until recently there has been a difference. Henderson et al report that “Richardson and Martin (2004) identified significantly less total staffing with for-profit organisations having fewer staff per residential bed”.

Baldwin et al<sup>54</sup> showed that between 2003 and 2012 for-profit owned nursing homes were more than twice as likely to be sanctioned than nonprofit owned nursing homes.

<sup>53</sup> Banerjee A. An Overview of Long-Term Care in Canada and Selected Provinces and Territories, Women and Health Care Reform October 2007 <http://bit.ly/2fRhone>

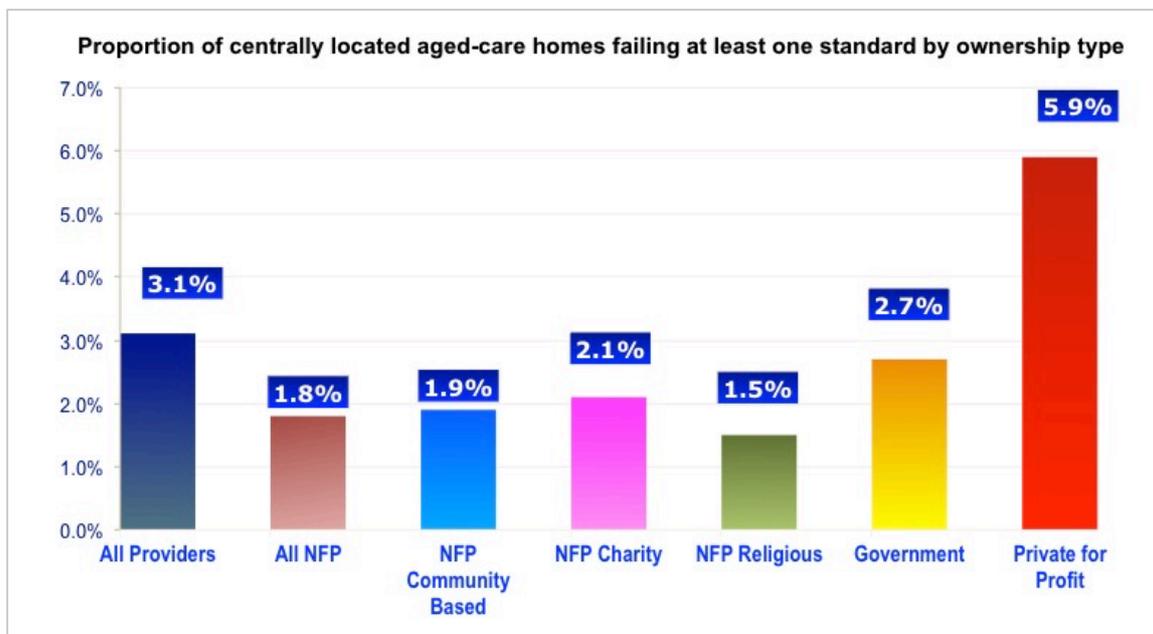
<sup>54</sup> Baldwin, R., Chenoweth, L., de la Rama, M. and Liu, Z. (2015b) ‘Quality failures in residential aged care in Australia: the relationship between structural factors and regulation imposed sanctions’, Australasian Journal on Ageing, 34 (4), E7–12.



The accreditation agency has consistently produced reports that showed that rural and remote facilities performed poorly in accreditation but that there was little difference between ownership types.

The latter claim was misleading. As there were almost no for-profit facilities in rural and remote areas, the performance in metropolitan areas must have been several times better in nonprofits for the whole sample to be equal.

In 2008 we succeeded in snatching a small sample of accreditation failures in care before they were removed from the Agency’s website. At the time, reports were removed as soon as the problem had been corrected. This material confirmed that, when properly analysed and when like was compared with like, nonprofits performed several times better. Accreditation data confirmed international trends<sup>55</sup>.



*Figure 7: Aged Care Report Card*

<sup>55</sup> Aged care report card, Aged Care Crisis 2008 <http://www.agedcarecrisis.com/news/research/108-aged-care-report-card>

This finding illustrates the way in which the agency skewed its data analysis to reinforce government arguments. The data itself is not reliable. It was still reporting data in the same way in 2014 in an attempt to question Baldwin's findings. In Australia these differences cannot be correlated with staffing levels because we do not collect data. The data we do collect is not fit for purpose.

**A change in policy puts pressure on nonprofit staffing:** In the USA the publication of both staffing and outcome data allows researchers to compare staffing and outcomes, a luxury that Australians are denied. The collection of this sort of data has seen a slow improvement in overall staffing and in the incidence of failures in the USA. In the absence of publicly available data, Australian staffing levels have steadily declined.

Although only about 12% of families in the USA actually use the Nursing Home Compare web site, this has a flow on effect and creates a niche market. Nonprofits can exploit this and maintain their mission. They continue to staff and perform better.

Australia's failure to collect data and the government's assertions claiming there was no difference, have left the nonprofits at the mercy of competitive and efficiency pressures that drive performance towards a uniform mediocrity.

**Reforms bolster the aged care pressure cooker:** The *Living Longer Living Better* reforms introduced in 2013/14 increased commercial competitive pressures in order to drive consolidation and make the sector globally competitive in the Asian service marketplace. Henderson et al report that ninety two per cent "*of aged care beds purchased in 2010–2015 were purchased by for-profit service providers*". Many of those purchased would have been nonprofit.

This threat put much greater pressure on staffing and on care forcing the nonprofits to join a rush to the bottom. This has enabled the larger groups to survive but this has been at the expense of staffing and care.

There have been multiple press reports and the unions have documented extensive staff reductions in nonprofits across the country but particularly in Queensland. This has been accompanied by many more failures in care being detected by the agency and by whistleblowers going to the press.

Many more of these are in nonprofits and in government run facilities in those states that do not require minimum staffing levels in the facilities that are not yet privatised.

Henderson et al's study confirms this trend. They found that the ratios of staff to residents was slightly worse in not-for-profit owned facilities than for-profit but there was little difference in missed care between them. The commonest reason given for missed care was deficient staffing.



That we have to rely on the sort of data that Henderson et al collected to deduce what is happening in Australian Nursing Homes and that it required two ABC 4Corners programs to show the real state of aged care is an indictment of our government and our business leaders.

That we have no reliable data in Australia that allows us to evaluate whether our staffing is adequate and to document the effectiveness of the care they give is a disgrace.

### 3 Managerialism

We have already addressed some of this as it relates to aged care but there is more to consider. It is a management philosophy and a set of practices that originated in a belief in the freedom of the individual and of self-interest in the marketplace. It saw society as obstructive. The emphasis on individual freedom can be contrasted with its more subtle control of society. It has been more controlling than most previous ideologies. What analysts were concerned about was the impact of the patterns of thought on our humanity, our value systems and our culture. The title of Rees and Rodley's multi-author book described what was happening was "*The Human Costs of Managerialism: Advocating the recovery of humanity*".

Staff are part of our society and this loss of humanity impacts on staffing in a number of ways.

1. Managerialism's denigration and disregard for society and its focus on the individual leads it to use self-interest as the driving force in controlling and motivating behaviour and so reaching its objectives. In a sector that relies on altruism, empathy and caring relationships this creates a culture that is unsuited for care.

There is a conflict with community and nursing values, and the motivations that are the basis of care. This can result in a change in the values of some staff and alienation in others. A number of studies<sup>56</sup> have looked at the impact of management on nurses patterns of thinking and the discourses they use as they carry out their duties.

2. As indicated earlier management has become a separate discipline that is claimed to be universally applicable. It was separate from the discipline where it would be applied. It was based on the idea that the principles of competition, efficiency and cultural change were universally applicable. Knowledge of a particular sector was not required.

Managers and owners have been drawn into senior levels in aged care because of their success elsewhere and not because of any knowledge of aged care. Performance was measured in economic outcomes. This lack of insight into the sector is readily apparent when we see the assertions that are made about staffing by managers, owners and accountants.

Staffing advice and decisions about staff numbers and skills are made by these managers and their accountants. Success is measured in profitability and this gives them the confidence to discount others views, disregard problems and attack critics.

3. Managers seek to control and contain complexity by designing processes that manage it. This is not possible in human services and too many fall through the cracks. It leads to a process driven and task focused service that dehumanises and ignores our complexity. It is ill-suited to the sector and carers come to carry out the tasks efficiently without concern for the person being cared, described as task focused rather than person focused.
4. Managerialism has captured the society, for which it has little regard and taken over the management of its affairs which are increasingly commodified. This has profound consequences for the knowledge, skills and confidence of citizens. The complexities of processes are daunting. Citizens detach from the affairs of their communities.

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<sup>56</sup> Nurses under pressure Inside Aged Care 2017 <http://bit.ly/2DdNrDy>

Community values are no longer exercised and so are lost. This impacts on the motivation and thinking of community members who are employed as staff. More importantly it leads to a loss in knowledge and undermines the confidence that citizens need to understand that their members are being misused and abused and then do something about it.

Over the centuries much has been written and learned about caring and particularly caring relationships. More recently Professor Fine has closely studied them in aged care<sup>57</sup>. It is not through complex processes but through the relationships we form in society, through our ability to reflect on and imagine the life of the other, and to empathise with them that we deal with the complex nature of human behaviour, the circumstances of the other and of the care they need.

Relationships and the values that guide conduct are the product of society and not management. Those who analyse these things consider that our society has been hollowed out and rendered ineffective.

There is a vast amount of information about society and its operation, about our psychology and how we respond in different situations, how we influence one another and about the history of the sector – even knowledge about the essentially predatory nature of markets. All of this has been disregarded. This impacts on the structure of the sector, on its culture, and on society itself. Staff come into contact at all levels and are impacted, usually adversely.

Good care obviously does occur but it is in spite of and not because of the system. We just don't know how often because there is no data.

**NOTE:**

Many of these issues have been explored in greater depth in some of our recent submissions to other inquiries. In this submission we have focused on the implication of this material for staffing. For more in-depth analysis please see the following submissions:

- 2<sup>nd</sup> Supplementary submission to the Senate Standing Committees on Community Affairs Workforce inquiry 28 Nov 2016 <http://bit.ly/2rEeSqM>
- Submission to the Senate Community Affairs References Committee Inquiry into Regulation after Oakden August 2017 <http://bit.ly/2A4Uu6x>
- Submission to the House of Representatives Standing Committee on Health, Aged Care and Sport Inquiry into the quality of care, March 2018 <http://bit.ly/2l69uZv>

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<sup>57</sup> The Nature of Care Inside Aged Care web page <https://www.insideagedcare.com/aged-care-analysis/theory-and-research/nature-of-care>

## 4 Appendix 1

### Article: It's time to clear the air on aged care

*Author: Lynda Saltarelli, Aged Care Crisis*

*This article was first published in Fairfax newspapers on 4 September 2018.*

After 21 years of opacity about staffing and care, the aged-care community and workforce needs and deserves guaranteed clarity.

MP Rebekha Sharkie has recently introduced a Bill (which has now progressed to an Inquiry) requiring every aged care home to disclose and publish quarterly staff/resident ratios, providing some much-needed transparency to aged care.

The aged-care sector has opposed this<sup>58</sup> on the basis that staffing and care are 'too complex'. This is an argument for collecting and studying data, not for hiding it. Australia has endured 21 years of opacity about staffing and care<sup>59</sup>. Both the community and the workforce have had enough. We need sunlight.

Accurate data is essential for debating policy and for a market to work. In 2003, the sector promised parliament it would collect data about the care<sup>60</sup> provided in aged-care facilities but soon reneged on this promise. Regulators later sanctioned this.

#### The importance of staffing data

In the absence of legislation specifying required staffing levels or skills, MP Rebekha Sharkie's Staffing Disclosure Bill is important and should be strongly supported.

When we have accurate staffing data we can perform the research needed to refine our staffing guidelines and keep the public informed. Sector claims of "*unreasonable additional administrative costs and red tape*" are baseless and a furphy.

It should be noted that staffing data is already being collected and reported to the sector on a regular basis by financial institutions<sup>61</sup>. The Quality Agency has been collecting this information for around 10 years. It promised the sector that this information would not be made public.

When it comes to the collection and reporting of financial data or development of benchmarks based on them, no one complains that it is 'problematic or 'burdensome'. This data is conveniently trotted out prior to<sup>62</sup>, and during inquiry appearances<sup>63</sup>, coronial inquest<sup>64</sup>, industry talkfests or when asking governments for more money<sup>65</sup>. Financially based staffing benchmarks have even been used by non-profit organisations as justification for reducing staffing<sup>66</sup> across nursing homes.

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<sup>58</sup> New bill calls for providers to publish staff numbers by job description, Aust Ageing Agenda, 22 Aug 2018 <http://bit.ly/2Ngi5Xj>

<sup>59</sup> Aged care ratings do not tell what you need to know about Australian nursing homes, ABC Investigations, 2 May 2018 <https://ab.co/2uXYSDh>

<sup>60</sup> Hansard: <http://bit.ly/2DX3pgb>

<sup>61</sup> Financial benchmarking: <http://bit.ly/2y0nzjY>

<sup>62</sup> Staffing data: <http://bit.ly/2NWfQxF>

<sup>63</sup> Inquiry: <http://bit.ly/2NXsQ5Z>

<sup>64</sup> Coroner's inquest: <http://bit.ly/2unfrdR> (pgs 45-46)

<sup>65</sup> SB 2017 Registration Kit "The results of the survey may also be used for other purposes. It is likely that summary data will be used by industry bodies to lobby Government and in the formulation of policy." <http://bit.ly/2AhDiPx>

<sup>66</sup> Southern Cross Care defends nursing home cuts, families hit back, 13 Jul 2017, Chinchilla News <http://bit.ly/2xV9uEs>

Unlike Australia, the US government openly acknowledges that staffing levels and skills are "*the most critical determinants of care*"<sup>67</sup>. It also recognises the significance of employee turnover and tenure as "*a vital component of quality care for nursing home residents*".

Recommended minimum safe staffing levels have been established to ensure that residents are not harmed. These are based on careful research and expert opinion. Extensive staffing and care data has been available in the USA for nearly 20 years<sup>68</sup>. In Australia, there has been a 21-year battle to keep this sort of information away from those who need to know it.

Staffing levels, particularly the number of trained nurses, have fallen to unsafe levels in many homes in Australia over the last 21 years. In comparison, US residents receive twice as much care from trained nurses and more than a third more nursing care overall. This makes it impossible for our system to be world class or to be providing the care our residents need.

Dr Kidd, who has provided care to residents in nursing homes since the 1990s, spoke for the AMA at the House of Reps Inquiry on 11th May. He said "*It's definitely worse now than it was 20 years ago*"<sup>69</sup>.

Average direct care nursing levels are about 2.9 hours per resident day (hprd) with care by trained nurses providing only a fraction of that. This falls a long way behind what was expected in the late 1980s and early 1990s, and well below the 4.1 (hprd) minimum recommended in the USA.

**Reporting staffing ratios by professional qualification for those who care directly for residents is straightforward and not complicated. Reporting in this way will allow us to draw on a vast pool of international research when making policy. This Inquiry is a critical first step in achieving this.**

## **We need data about care too**

The CEO of Alzheimer's Australia in 2015 indicated that quality of care was one of the biggest gaping holes in aged care because we don't have "a single measure of quality"<sup>70</sup> and without accurate data about care you cannot have choices.

The aged-care sector argues against fixed ratios on the basis that staffing varies with the frailty of residents. That too is an argument for collecting accurate data about resident frailty and care outcomes. Such data tells us whether staffing is adequate. It allows us to develop reliable guidelines for variation in frailty and then check that they are being followed when failures in care occur.

Providers and government regulators have avoided collecting and publishing outcomes data to date. This opacity and secrecy is one reason why regulation has failed citizens so often. After 21 years of opacity and years of pressure there are plans to collect some data and release it, but the lack of enthusiasm is revealed by the delays in doing so.

It took nearly four years for a complex process to develop just three indicators. It needed the assistance of a large and expensive accounting firm. To entice them providers were promised that the results would not be published.

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<sup>67</sup> US Government - CMS (Centers for Medicare & Medicaid Services) <http://go.cms.gov/2frxXuQ>, Staffing Data Submission

<sup>68</sup> Nursing Home Compare datasets: <https://data.medicare.gov/data/nursing-home-compare>

<sup>69</sup> House of Reps Inquiry, 11 may 2018: <http://bit.ly/2LDHgpN>

<sup>70</sup> Better data needed to compare aged care, ABC PM, 24 Nov 2015: <http://www.abc.net.au/pm/content/2015/s4358621.htm>

The lack of enthusiasm is apparent from the small number, one-tenth of homes in Australia, that participated in the voluntary pilot for the *National Aged Care Quality Indicator Programme*.<sup>71</sup> Only 18 per cent of those were for-profit showing which group has most to fear from transparency.

In contrast the Victorian Government, which is responsible for approximately 170 aged-care homes, has been collecting data on five clinical care indicators since 2006<sup>72</sup> - *pressure injuries, restraint use, falls, unplanned weight loss and the use of nine or more medications*.

## Conclusion

The absence of data has made it impossible to formulate policies that are based on evidence rather than wishful thinking. It has been impossible to make informed choice and has exposed many vulnerable citizens to the risk of exploitation by profit-focused operators. Staffing skills and numbers have fallen to dangerous levels and people are being harmed.

**After 21 years of the same policy, this proposed Bill would, if successful, be a major turning point. The public should place strong pressure on their representatives to ensure that it is supported and passed. They should then maintain the pressure to ensure the next step is the collection of accurate and verifiable data about care.**

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<sup>71</sup> National Aged Care Quality Indicator Programme: <http://bit.ly/2MwrXke>

<sup>72</sup> Victorian Government - Quality indicators in public sector residential aged care services, <http://bit.ly/2PdXmFu>

## Article: Spin trumps evidence in driving aged care policy

Author: J Michael Wynne MB.ChB.,FRCS.,FRACS.,Grad Cert Ed, Aged Care Crisis

This article was first published on Michael West's investigative journalism website on 1 Aug 2018.

At the current Senate Inquiry into 'Financial and tax practices of for-profit aged care providers', there was plenty of spin but little evidence by industry bodies that real reform has been delivered by the 2011 Productivity Commission's 'Aged Care Roadmap'. In this opinion piece, **Michael Wynne** of Aged Care Crisis, an independent volunteer organisation which advocates for aged care residents, argues that the roadmap has failed, should be thrown out and work commenced with the caring professions to develop a more sensible system.

Some interesting but unsupported claims were made by industry organisations at the public Senate hearing on 17 July 2018 into '*Financial and tax practices of for-profit aged care providers*' — an inquiry by the Economics References Committee.

Sean Rooney, CEO of the industry body Leading Aged Services Australia, representing providers of care asserted twice that "*we do have a good aged-care system in this country*". And from Matthew Richter, CEO of the Aged Care Guild, the body representing the eight largest corporate businesses in the sector — "*We have demonstrated how private aged-care providers in Australia are delivering high standards of care*".

Both claim that the recommendations of the 2011 Productivity Commission report 'Caring for older Australians' were beneficial. The report was conducted by an economist. It reaffirmed the market principles of the 1997 "reforms" and gave the industry everything it wanted. This led to the industry-developed reforms and then to the industry/government policy document the 'Aged Care Roadmap'<sup>73</sup>.

Both Rooney and Richter expressed support for all this and reminded government that this was the plan they had all agreed on.

### But how valid was all this?

If we look at the roadmap we see that it "*is market based and consumer driven*". It claims

*"Contestability of delivery will promote quality, productivity, efficiency, innovation and value for money services that are responsive to consumer needs and preferences".*

In addition to this

*"a light touch approach to regulation will give providers freedom to be innovative in how they deliver services."*

Then finally

*"Consumers will drive quality and innovation by exercising choice" and*

*"There will be a strong focus on positive images of aged care."*

But these are the same general policies that drove the Howard government to make the changes that they made in 1997. We have heard them over and over again since then — hardly reform. They have been imposed in the face of warnings that the customers, now called "consumers", lacked knowledge, were vulnerable and were easily confused. Most were not in a position to contest anything let alone drive quality or really make choices.

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<sup>73</sup> Aged Care Roadmap: <https://agedcare.health.gov.au/aged-care-reform/aged-care-roadmap>

The system created failed to collect any useful measures of care, so even those with the capacity to make choices could not do so. We have had many crises in care since 1997 and each has been followed by government reviews and then the inevitable reforms that were simply more of the same. How valid is all this?

## **The aged care system after 20 years of market policy**

**Nurses who provide the care** have been complaining about working conditions and their inability to provide the care needed since the early 2000s. No one has listened. Nurses and families making submissions to the senate workforce inquiry in 2016 desperately pleaded for help. Others pleaded with the [Carnell Patterson Review](#).

They said things like *“please, please open your eyes, your hearts, your minds” ... “Please, please change things” ... “a hidden humanitarian crisis” ... “an industry that has been hijacked by big business. Care of our residents and staff come a very distant second” ... “There is no care what so ever and I include management in that statement. In fact management is the worst”.*

*“It is horrendous the deceit that prevails and anyone who is prepared to speak up to uncover it, is quickly ‘short shrifted’ out of the home”... “facilities with magnificent interior design and no staff! Please can we focus on humanity for residents, rather than ‘glamour””. In a comment on an article about aged care “the things I saw in nursing homes will haunt me forever.”*

[Dr Richard Kidd](#) who has provided care in nursing homes since the early 1990s [said](#) that care is worse now than it was 20 years ago. Dr Tony Bartone, another GP and now president of the Australian Medical Association, has also been providing care in nursing homes. He [said](#) *“the current aged care workforce does not have the capability, capacity, and connectedness to adequately meet the needs of older people”.*

Well-trained nursing staff are very critical of the *“light touch approach to regulation”*. Clinical nurse consultants working in the industry have been scathing about the lack of clinical attention in accreditation visits. These overlook problems in infection control, nutrition, hydration and skin care.

## **What data is available?**

Like Australia, the USA aged care system is market driven. In an attempt to constrain the consequences an extensive data collection and oversight system is in place. It is useful to compare the two.

**Comparing staff.** Safe minimum staffing levels based on careful research have been recommended in the USA for 20 years. Studies in Australia showing similar requirements done in 1985 and 2016 are rejected by industry. Instead, we use benchmarks, developed by financiers, to advise more than an hour less care each day.

On average, US nursing home residents get twice as much care from trained nurses as Australian residents and over a third (1 hour) more total nursing care each day than in Australia.

In Australia, the number of sicker high care residents needing skilled nurses has increased by 53 per cent at the same time as the number of trained nurses needed to provide that care has fallen by 35 per cent. But incredibly during the same period accreditation performance has increased 53 per cent to near perfect levels. So are they all wrong and does reducing staff improve care?

**Comparing failures in care.** In the USA, 175 items of data about care are collected on all 15,000 nursing homes and reported quarterly. This is checked when facilities are evaluated yearly. In Australia, only 48 accreditation processes are evaluated three to five yearly but data showing

failures in care are not collected. From 1 July this year, the number reduced to eight. Whilst Agency staff visit yearly, these findings will not be published — only the result of the reaccreditation three or five yearly cyclical site audits will be. This is no more than is currently available.

In spite of far superior staffing, only seven per cent of US nursing homes get a perfect score compared with 98 per cent in Australia. In the USA, 93 per cent have some problems and 20 per cent are serious. In Australia just two per cent have problems. Doing so much more with so many less staff is simply not possible.

In 2010, a prominent member of the industry was furious when a visiting US academic [asserted](#) that in Australia “*there is little regulation to protect the rights of elderly residents*” and that he “*would not put any elderly relative, or indeed even a family pet, into a residential aged care facility because of the chronic abuse, neglect and exploitation rampant in our aged care facilities.*”

Outsiders can often see more clearly than we can.

Unlike Aust, the US govt openly acknowledge StaffingLevels&Skills R the most critical determinants of care. They also recognise significance of employee turnover & tenure as a “vital component of quality care 4 NursingHome residents” <https://t.co/aBulkSugap>  
[pic.twitter.com/2cUSSMnP8i](https://t.co/aBulkSugap)

— Aged Care Crisis (@agedcarecrisis) [April 12, 2018](#)

## Conclusions

In our society, our trusted banks have been exposed by the royal commission as ruthlessly exploiting the vulnerable. A multitude of franchising businesses like 7-Eleven stores, pizza companies as well as many others, have exploited vulnerable students, tourists and visa holders. The banks including AMP, the worst offender, have invested heavily in aged care. Multiple franchising companies are entering aged care to offer us “choices”.

Is the aged care market really different? Are we still going to believe the confident businessmen, managers and politicians isolated in their offices? Would we be wiser to believe the anxious staff providing care — the families who know enough to identify problems and the available data about staffing?

Politicians and businessmen have invested their lives in this Aged Care Roadmap and have much to lose. Could it be that the policy of “**there will be a strong focus on positive images of aged care**” has been too pervasive and gone much too far? Only blind believers and the gullible are persuaded. The roadmap was the industry’s policy and not our policy and the illusions they marketed at us were enticing.

After 20 years, it is time to look at the warnings that were ignored, to throw out this failed roadmap and work with the caring professions to develop a more sensible aged care system. Government is not capable of doing it alone. The community will need to lead the way.

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*J Michael Wynne MB.ChB.,FRCS.,FRACS.,Grad Cert Ed*

*Michael Wynne is a retired academic surgeon from Queensland. He has had a long interest in dysfunctional social systems and has written two web sites examining corporate behaviour. During the 1990s he was a whistle blower and actively researched US health and aged care companies that were being welcomed into Australia. He collected data for state probity regulators. This contributed to these companies leaving or abandoning plans to operate in Australia.*

*Since the turn of the century he has tracked aged care in Australia and has been writing submissions to inquiries and reviews. The Aged Care Crisis’ submission can be [read here](#).*

## Article: Aged Care - corporate conflicts run deep

*Author: J Michael Wynne MB.ChB.,FRCS.,FRACS.,Grad Cert Ed, Aged Care Crisis*

*This article was first published on Michael West's investigative journalism website on 16 Jul 2018.*

Eldercare profits are at record levels, numbers of trained nurses are down by a third, and the number of residents who need special care are up 50 per cent. The Senate Inquiry into the Financial and Tax Practices of For-Profit Aged-Care Providers kicks off tomorrow. Is the system broken? Are taxpayers getting value for money? In this opinion piece, **Michael Wynne** of [Aged Care Crisis](#), an independent volunteer organisation which advocates for aged care residents, writes that cost-cutting and the pursuit of profits often come at the expense of care. As ageing demographics are exploding, the system needs an overhaul.

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

*Adam Smith: The Wealth of Nations, 1776.*

There have recently been revelations that aged care companies who receive their money from the taxpayer have not been paying tax on this money. The issue [is being investigated by a Senate Committee](#). Companies, including those providing aged care, are accused of forming webs of companies and of using them to move money that might have gone to care or taxes into offshore tax havens.

This inquiry is important because it exposes the links between aged care and the practices of the companies and banks that have been making headlines over the last few years. It opens broad issues in society and in policy for examination.

Managing the tension between our self-interest on the one hand and our responsibilities as citizens, has been at the heart of our development as a civilisation. We have balanced these competing pressures in order to harness personal ambition on the one hand and to be socially responsible, maintain integrity, and protect the vulnerable and our society on the other.

Aged Care Crisis (ACC) is a community organisation that has been studying how and why this has changed so dramatically over the last 20 years. It has made many submissions, including to this most recent Senate Inquiry into financial and tax practices of for-profit aged care providers.

### **A social revolution with consequences**

In the late 1900s an economic cult developed around markets. This turned the wisdom of hundreds of years on its head. The cult claimed unrestrained markets driven entirely by self-interest created good outcomes. There was a “hidden hand” with mythical properties. If unchecked by regulation or the need to be responsible the self-interested would bring benefits wherever they pursued their interests.

Ronald Reagan and Margaret Thatcher, perhaps in the early stages of dementia, and then John Howard in Australia, embraced the cult. They ignored the lessons of history and many warnings when they aligned themselves with the big businesses whose “hidden hands” they believed would solve their problems. They became admired leaders by spreading the cult of self-interest that business now espoused into every sector of our society.

The pressures of strong competition, efficiency, a multitude of professional marketplace advisors and an army of new managers trained in the new patterns of thinking left no room for reflecting on society, responsible conduct, compassion or empathy — the attributes of a civilised society.

Those who struggled to maintain a caring community have been belittled and pushed aside.

It should not surprise us that the market has now turned on the vulnerable citizens that society once cared for and is exploiting them ruthlessly. The funding system, the tax system, customers and employees including tourists, students and other visa holders have all been ruthlessly exploited by predatory businesses.

These include those we trust like the banks, franchising companies, educators, job support organisations, food preparation, farmers and even charities.

### **The most vulnerable**

The most vulnerable of all are the frail elderly. Not far behind are the underpaid nurses who care for them in our nursing homes. This was the sector where most trouble with policy could be anticipated. To counter potential problems, information has been sanitised or else kept from the public. The role of industry led regulators was compromised by their need to protect government and industry from embarrassing publicity.

It is only through whistle-blowers or when an outside regulator becomes involved as happened at Oakden in South Australia that the full extent of what is happening in aged care has been revealed. Nurses and families who have the knowledge to understand have been describing this as a human tragedy for years. They see unnecessary suffering and needless early deaths.

Their assessments are confirmed by data showing that Australians get half the amount of care from trained nurses and a third less total nursing care than for example the US. International studies show that safe and effective care cannot be provided with this level of staffing.

### **The senate inquiry into tax evasion**

ACC's submission seeks to persuade this inquiry that what is happening in aged care is linked to what is happening in society. Both are logical consequences of policy.

ACC has tracked the patterns of thinking responsible to their origins and then through the US by multiple channels to aged care in Australia. The submissions expose the links between the banks, many of whom have been major investors in aged care, the pool of common directors that they all share, the aggressively commercial private equity companies and the franchising companies targeting home care.

There are a multitude of dubious accounting, financial, legal and other groups schooled in the patterns of thought. They act as consultants and policy advisors to government, as well as companies seeking advice on tax, corporate structure or other matters. Some have tarnished global histories that rival the banks. Their self-interest is closely tied to the system they advised us to adopt.

[The submission](#) describes the close links and conflicts of interests as the leaders in the industry wrote the new regulations in 1997, sit on government committees, advise and influence government. They replace the independent bureaucrats who should be giving that advice.

It describes the threat that staffing requirements and the power of the unions posed to the profits of the providers. Government gave way to industry pressure, removing all staffing constraints and limited the power of the unions. The report shows how over the years the numbers of trained nurses has fallen by a third as the proportion of residents who need skilled care has risen by 50 per cent.

## **Resolving the issues**

It is clear that in aged care we need accurate information about staffing skills and levels, about how our money is being spent, about the number and nature of complaints and about the number of failures in care. But to make this market work we also need an effective customer and informed community that can use that information to bring strong pressure to bear on the providers of care in our communities.

The government has shown itself to be incapable of this.

Aged care offers a unique opportunity to reflect on what is happening in our society and on the plight of the vulnerable who are being exploited. We can bring back compassion and empathy. These are our spouses, parents and the members of our community who work in care. This is happening in our communities under our noses every day.

We visit those places to see our families and some of that care is provided in our homes. These sectors most readily engage our sense of social responsibility and our compassion for others, the qualities lacking in our market controlled society today. We have a unique opportunity to initiate the long process back to a responsible and caring society.

Aged Care Crisis is suggesting to the Senate Committee that they seize this opportunity by requiring the regulators to have empowered representatives in the community acting as the front line for their activities. There needs to be someone on site regularly to tell them what is happening.

This would ensure that the community, which is on site regularly, would have direct local access and local knowledge. It would be in a strong position to put pressure on government and market to meet its requirement for social responsibility and compassion.

*J Michael Wynne MB.ChB.,FRCS.,FRACS.,Grad Cert Ed: Michael Wynne is a retired academic surgeon from Queensland. He has had a long interest in dysfunctional social systems and has written two web sites examining corporate behaviour. During the 1990s he was a whistle blower and actively researched US health and aged care companies that were being welcomed into Australia. He collected data for state probity regulators. This contributed to these companies leaving or abandoning plans to operate in Australia. Since the turn of the century he has tracked aged care in Australia and has been writing submissions to inquiries and reviews.  
The ACC submission can be read here: <http://bit.ly/2zQU2uu>*