

6 December 2018

Second submission to Senate Inquiry:

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

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

We thank the committee for calling for additional submissions so giving us an opportunity to revisit and update the issues we addressed in our previous submission. Much has happened since then to confirm the validity of our assessment and the potential benefit of the path forward that we are advocating.

In that submission we were highly critical of the care provided and of the regulatory process. We analysed the reasons for the failure of the system and its regulation.

Much has happened in the 15 months since then which confirms just how poor the system has been and how regulation has failed. The responses of industry and the political system graphically illustrate the “paradigm paralysis” that is so typical of failed social systems. It reveals an inability to think outside narrow patterns of thought and confront the real issues responsible for what has happened.

We commence our second submission by examining our report in the light of developments since then. We have made multiple submissions to other inquiries during that time and corresponded with the minister and with industry figures. We will draw on some of those. There have been developments and we will draw on these within the context of our original submission.

We stress that our arguments are not ideological or a call for nationalisation. They are an acknowledgement that what we have done has failed because it ignored hundreds of years of human knowledge and misunderstood the nature of man.

Aged care should not become a focus of more political grandstanding but a consensus driven carefully managed and supported change in direction, one that creates a practical context at the bedside from which new policies can grow. These will need to consider the viability of the providers and even accept the need for some rationing. We must not compromise the future of our younger generations.

Inquiry Terms of reference:

- a) the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised;
- b) the adequacy and effectiveness of complaints handling processes at a state and federal level, including consumer awareness and appropriate use of the available complaints mechanisms;
- c) concerns regarding standards of care reported to aged care providers and government agencies by staff and contract workers, medical officers, volunteers, family members and other healthcare or aged care providers receiving transferred patients, and the adequacy of responses and feedback arrangements;
- d) the adequacy of medication handling practices and drug administration methods specific to aged care delivered at Oakden;
- e) the adequacy of injury prevention, monitoring and reporting mechanisms and the need for mandatory reporting and data collection for serious injury and mortality incidents;
- f) the division of responsibility and accountability between residents (and their families), agency and permanent staff, aged care providers, and the state and the federal governments for reporting on and acting on adverse incidents; and
- g) any related matters.

Glossary and abbreviations

Term	Description
ACC	Aged Care Crisis Inc.
ACCC	Aged Care Complaints Commissioner
CVS	Community Visitor Scheme
Quality Agency, The Agency	Australian Aged Care Quality Agency (formerly known as the Aged Care Standards and Accreditation Agency)
The Department	Department of Health (formerly known as the Department of Health and Ageing)
Professor John Braithwaite	Professor John Braithwaite (criminologist) ¹ is a Distinguished Professor at the Australian National University (ANU). Braithwaite is the recipient of a number of international awards and prizes for his work, including an honorary doctorate and the Prix Emile Durkheim, International Society of Criminology, for lifetime contributions to criminology (2005). In his 2007 book on Regulating Aged Care ² , eminent criminologist Braithwaite describing how regulation in Australia (ie accreditation) was being captured by business interests.
NACA	National Aged Care Alliance (representative body of aged care organisations)
Aged Care Guild	Aged Care Guild (industry representative group)
ACSA	Aged Care Services Australia (industry representative group)
LASA	Leading Aged Services Australia (industry representative group)
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) (Equivalent to enrolled and certified nurses in Australia)
PCW, PCA	Personal Care Worker, Personal Care Attendant, Personal Care Assistant (Level III or less)
hprpd, hprd	hours per resident per day
Regulatory capture	Regulatory capture ³ is a form of government failure which occurs when a regulatory agency, created to act in the public interest, instead advances the commercial or political concerns of special interest groups that dominate the industry or sector it is charged with regulating.
Revolving door	In politics, the " revolving door " is a movement of personnel between roles as legislators and regulators, on one hand, and members of the industries affected by the legislation and regulation, on the other.

¹ Professor John Braithwaite (criminologist): [https://en.wikipedia.org/wiki/John_Braithwaite_\(criminologist\)](https://en.wikipedia.org/wiki/John_Braithwaite_(criminologist))

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

³ Wikipedia: https://en.wikipedia.org/wiki/Regulatory_capture

Introduction

Term	Description
Neoliberal	<p>Neoliberals advocate minimal government spending, minimal taxation, minimal regulations, and minimal direct involvement in the economy. Neoliberals believe market forces naturally fill many areas of jurisdiction for the highest overall gain. They place their faith in the individual rather than in society and value success above compassion.</p> <p>The belief that allowing the wealthy to extract more money from the labor of other people will lead to better conditions for those people.</p> <p><i>The US economy holds more to neoliberal ideals than any other nation.</i></p>
Neoliberalism	<p>Neoliberalism⁴ is an economic ideology centered around the values of a global economy, or globalisation: free market, free trade, and the unrestricted flow of capital. It refers to a political-economic philosophy that has had major implications for government policies beginning in the 1970s and increasingly prominent since 1980 - that de-emphasises or rejects government intervention in the economy, focusing instead on structured free-market methods, and fewer restrictions on business operations and that the most important class of rights to expand are those of property enforcement, and of opening nations to entry by multinational corporations.</p> <p>In a broader sense it is used to describe the movement towards using the market to achieve a wide range of social ends previously filled by government and civil society.</p> <p>It is generally hostile to protectionism, social democracy and socialism. It is often at odds with fair trade and other movements that argue that labor rights and social justice should have a greater priority in international relations and economics. The focus on globalisation and economic performance has drawn attention away from its local consequences for society and individuals.</p>
Paradigm paralysis	<p>Paradigm paralysis refers to the refusal or inability to think or see outside or beyond the current framework or way of thinking or seeing or perceiving things. Paradigm paralysis is often used to indicate a general lack of cognitive flexibility and adaptability of thinking.</p>

⁴ Urban Dictionary: <https://www.urbandictionary.com/define.php?term=Neo-Liberal>

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Executive Summary

Our second submission is based on our first submission and addresses new developments using the same structure. We refer to what we said there and build on that, drawing on some of the submissions we have made to other inquiries since then.

Part 1: Regulation in context

In Part 1 of our original submission⁵ and in Appendices we focused on inappropriate patterns of thinking and their impact on aged care. We looked at the social pressures that developed using the concepts of discourse, power and governmentality (control) and showed their impact not only on regulation but on the entire sector. We stressed that this was a whole of society problem of which aged care was a vulnerable part and that this should be addressed.

New insights

In this submission we take our analysis further by pointing out that this discourse originated from a mid 20th century philosophy that promoted selfishness and condemned altruism and social responsibility. It rejected society as a vital influence in our lives. These are the foundations of our humanity and the driving force in caring for the vulnerable. The market solution that was imposed on the aged care sector left no room for any of this.

The subsequent 'liberalisation' (freeing) of the individual from the shackles of society resulted in major changes in government, in regulation and in society. We now have to address the problems created by this misunderstanding of the nature of mankind and society. Understanding how and why this happened is important in doing this. We address this in **Appendix 1** of this submission.

Subsequent developments

In this submission we point out that subsequent developments in society (eg. the banks that invest in aged care) and in aged care (eg the ABC two part 4Corners program) confirm the accuracy of our analysis and assessments.

Instead of confronting these developments government and industry remain in denial and focus on the adverse publicity as the primary problem. They are still insisting that the foundations of the aged care roadmap are sound. They have responded with political rhetoric and good news stories. Under intense media and public scrutiny, the Quality Agency has suddenly discovered far more failures in care.

⁵ Aged Care Crisis submission: <https://www.aph.gov.au/DocumentStore.ashx?id=0b82626c-5677-48c7-b025-df10d5af63b7&subId=560850>

Regulatory changes

The government and the review it commissioned have acknowledged that there have been problems. They have refused to accept that they are symptoms of the failure of policy due to the misconceptions on which it is based. Both have ignored the evidence and the logic.

The government have followed the advice of the 2010 Productivity Commission report which advised the formation of a single regulator by combining complaints, department and accreditation. This report was made within the free market discourse and its recommendations led to the *Living Longer Living Better* reforms which compounded the problems in the sector.

The recommendation that these bodies be amalgamated was firmly rejected by the Accreditation Agency at the time on the basis that accreditation is not a regulatory process and is compromised by being linked to regulation. That criticism was and still is valid.

Combining three failed reluctant regulators into one without addressing the core problems responsible for their failures is not a solution. It is not the tough new cop that the minister boasts of.

Reducing 44 standards to 8 is neoliberal minimalist regulation thinking in action. While changing to unannounced visits sounds attractive and puts pressure on providers the evidence does not suggest that this will make a big difference.

What we are witnessing is a political system that is trapped within the confines of a narrow belief system, from which it cannot break free. It does not have a new policy to replace the one that is crumbling around them. This is a well-recognised problem called “paradigm paralysis”.

The Workforce Taskforce

Another example of this paradigm paralysis was when government made the industry, whose self-interest was the driving force in the steady erosion of staffing and care, responsible for addressing this problem. It was their influence and control of government that made it possible for them to do this in the face of opposition from staff and community.

The report that eventuated from the taskforce produced little if any data and while it acknowledged the need for better staffing it did not recommend any legislation. It relied on a voluntary code of conduct to induce an industry, whose mode of operation was based on a rejection of responsibility, to take action which would impair their profitability. This sort of thing has been happening for 20 years. While supporting engagement with the community, this report fell a long way short of what is required in this sector.

Part 2: Comparing Australia with the USA and the UK

In our first submission in August 2017 we examined trends in staffing and compared this with other countries in order to show the failure of regulation. We have updated this and made several submissions to other inquiries since August 2017. We draw on this in order to update what we said then and show more clearly how extensively the regulatory system has failed.

In this submission we:

1. Contrast the remarkable success in achieving accreditation in Australia, with the high rate of deficiencies detected in the USA, a country whose residents get twice as much care from trained nurses and over a third more nursing care overall.
2. We document the growing tide of complaints coming from nurses and families over the last 10 years and contrast that with the exaggerated claims of government and industry, and with the paucity of data collection in Australia.
3. We analyse the pressures coming from industry and how government responded to this to illustrate the role of both in the steady deterioration in staffing.
4. We have updated and refreshed staffing data to better illustrate the changes that have occurred and the failure of the Quality Agency, the body responsible for ensuring that staffing and care was adequate, to do anything about it.
5. We document the steady decline in the frequency with which the complaints system visited nursing homes in order to investigate the validity of complaints and the reasons for them. They made no attempt to see whether deficient staffing, the cause of most failures, was responsible.
6. We recommend a genuine acknowledgement of the extent of the failures and the reasons for them. The parties involved need to accept responsibility, acknowledge their inability to address the problems and support a fundamental shift in policy that will enable the community to do so.
7. This should include a radical restructuring of the regulatory system that will include not only legislated minimum staffing levels but transparent verifiable and ongoing oversight to ensure their adequacy.
8. Any solution should acknowledge the impact that the weakening and loss of legitimacy of society that has accompanied free market policies has had. It will need to reestablish the balance between individualism and civil society. This is a vital element in our civilization and our democracy.

Part 3: An analysis of aged care regulation in Australia

In our first submission we did a detailed analysis of our regulatory system to explain the reasons for its failure.

In this submission we re-emphasise the revolving door between market and government and the regulatory capture that resulted. We remind you of the sort of regulation that developed under free market policies and its many failures. Analysts call it regulatory capitalism. These are issues that must be addressed but are still being ignored. We summarise the criticisms made by regulatory authority Professor John Braithwaite in his 2007 book *Regulating Aged Care*⁶. These are still valid and are being ignored.

We examine the recent regulatory changes that have been made by government in the light of our criticism and in the light of the arguments insisting that accreditation and regulation were incompatible that were made by the accreditation agency in 2010. We agree and advocate for a proper regulator.

Advocacy: In our first submission we describe Braithwaite's concern about the way in which the effectiveness of advocacy as a potential regulator had been undermined turning it into advocacy with a small 'a'.

In this submission we document the recent attacks on advocacy and the attempt to constrain it. This has been largely focused on advocates in the disability sector.

We look at the formation of OPAN, a network of nine advocacy groups. We document its interaction with government, and its rejection of what government wanted. Particularly interesting is what happened when OPAN was recently awarded \$2 million to address elder abuse.

COTA, the smaller seniors group that sits on NACA, approves government policy and gives it the stamp of community approval, joined the advocacy groups in designing the program for this. The final plans were drafted at a meeting where the industry groups LASA and ACSA were also participants and government departments were observers.

Over the last few years there has been intense interest in neglect and abuse in nursing homes and in disability care. Research has been done and the lack of data exposed. Inquiries have been held and multiple submissions made. The media have published disclosures that have been damaging for government and industry.

We were particularly interested in the way the focus of the meeting, where the final plans were drafted in cooperation with industry bodies and with government observers, was turned away from the abuse in nursing homes that has caused so much anxiety in the community. It focused instead on financial abuse in the community.

We argue that the financial and social forces (big brother looking on) that operated to protect the interests of the powerful at this meeting are a good illustration of the way politics, money and power have played out in our whole regulatory system at the expense of the interests of society.

⁶ *Regulating Aged Care* by J. Braithwaite; T. Makka; V. Braithwaite e.Books.com: <http://bit.ly/2rnUgU8>

Part 4: Reviews, inquiries and consultations

We refer to the issues and criticisms we made of these processes and indicate that the conduct of inquiries since that time have been no different. We are hopeful about the Royal Commission but express some anxiety about its initial steps in going to the industry ahead of the community whose unhappiness was responsible for its existence.

Part 5: Finding a better way

In our first submission we advocated for local communities to be empowered and to play a far greater role in regulating aged care.

In this submission we revisit, reassert our view and join others who argue that the only way out of the blind alley that we have gone down is the re-empowerment, rebuilding and re-involvement of civil society. We argue that this is most urgent in aged care and that aged care is better placed than any other sector to lead the way.

We argue that the care of the vulnerable is the responsibility of every citizen, every community and every society – every one of us. Those providing care are our agents and responsible to us for what they do. Our capacity to oversee our agents to ensure they meet our requirements has been removed and we must insist it is restored.

Close involvement, regular engagement, frequent interaction and the exercise of the normal processes of social control are more effective at preventing and detecting failures and then quickly addressing them than any central regulatory system. It is the best early warning system. Civil society is well placed to do so in aged care. Formal regulation should support and be there for when failures persist.

Your committee has been urged by others to set up an empowered visitors scheme in aged care. We strongly support this but argue that these visitors should be part of an empowered ‘community hub’ – a structured community response to the problems in aged care.

We complete our submission by describing and diagrammatically illustrating our suggestion that much of the management and oversight of aged care should be moved into local communities. Government’s role is to support civil society and not usurp its role in a civilised society. We give our reasons for this and explain why it is likely to work.

Appendix 1: The origins of current free market belief

We briefly examine the mid 20th century philosophy that gave rise to the discourse and policies that have failed us. This placed the individual above society, promoted selfishness, and rejected altruism and social responsibility – in essence our humanity. It rejected any sort of control over the individual and in particular condemned society as something primitive from which individuals were escaping.

Aged Care depends on altruism, social responsibility and a humane society. We describe the consequences for society and aged care specifically of this misrepresentation of the human condition.

We examine the way in which the discourse and policies based on it are imploding as society reacts to the policy failures. Analysts seeking solutions and a way forward are turning to the community to find a way out. Aged care is well placed to lead the way.

Appendix 2: Quality Agency assessments

We have included pages 27 to 37 of our submission to the House of Representatives inquiry into Quality of Care⁷. In this we did an analysis of the performance of accreditation visits using data from a Quality Agency presentation and from '*Regulatory Performance Data*' supplied to the Senate Committee by the Quality Agency.

We compare the agency's findings when assessing performance in areas where other data shows there are major failings. We show how ineffectual the process has been and that unannounced visits have in the past been only marginally better than announced visits.

Appendix 3: It's time to clear the air on care

This article explains the importance of data about staffing and about care in order to prevent the sort of problems that have occurred in Australia.

Appendix 4: Aged Care: corporate conflicts run deep

This is a published article that describes what has been happening in aged care as a consequence of the policies introduced in 1997 and why it has become so problematic.

⁷ Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia (Mar 2018) <http://bit.ly/2l69uZv>

Recommendations

In making our recommendations we indicate which of the terms of reference we are addressing. The numbering does not reflect the order in which these issues are addressed in the submission.

A. Accepting responsibility

Recommendation A1. That problems in aged care, the policy failures, the consequences, and the reason for their failure be formally and publicly acknowledged.

Explanation: Without an acknowledgement, arguments, recrimination and anger will drag on for years and during this time there will be ongoing obfuscation and resistance while society and particularly the aged, continue to suffer. We need to draw a line and move on.

This is little different to colonisation where the patterns of thought and the policies they gave rise to harmed millions of aboriginals – an issue that continued to dog Australia until the Rudd apology accepted what had happened.

Those responsible for what is happening today are no more culpable than the early colonist. As in that case, continuing resistance to acknowledging what had happened when its impact was understood was culpable. Defensive denial delayed change. Acceptance permits objective analysis of what has happened and logical steps to address the problems.

Terms of reference: all

B. Rebuilding society

Recommendation B1. That the prime focus of change should be the rebuilding, empowerment, involvement and education of civil society so that it can effectively assume its proper place and its role in a responsible capitalist democracy.

Explanation: This is the first step in addressing the harm done in the mid 20th century. Civil society is the source and repository of our norms and values, altruism, empathy and responsible citizenship. When not exercised and used they whither and slip from consciousness. We are all impoverished by its absence and many suffer as a consequence. We need only look around us.

Terms of reference: all

Recommendation B2 At the earliest opportunity community structures should be established, become involved and then progressively take more control over aged care in their locality, ensuring that their agents, the providers, are meeting their expectations.

Explanation: Aged care is well suited to making this change. Values, norms and the development of empathy and altruism are the product of human action and interaction by socially conscious humans in real life situations. Aged care is not only well suited to their regeneration, it has suffered most and will benefit most. Diffusion more widely will follow.

Terms of reference: all

C. Preparatory measures

Recommendation C1. That steps be taken at the earliest opportunity to legislate recommended ratios and levels of staff based on acuity, and that a strategy be in place to evaluate clinical performance and quality of life in an ongoing manner so that adjustments can be made. This evaluation should be in close cooperation with staff and empowered visitors.

Recommendation C2. That the measurement of staffing levels be ongoing, objective and verified locally so ensuring transparency and utilisation when families make choices.

Explanations: Staffing shortage makes any improvement very difficult. It must be given priority. It will be important to involve local communities in this as soon as possible. Their encouragement, continued involvement and support of staff through recruitment, through work experience, training and then service to their local communities will be important.

Terms of reference: c, d, e, f and g.

Recommendation C3. That the Aged Care Roadmap be abandoned and a broad commitment made to work with communities in managing and providing aged care service. Providers in each locality should be required to cooperatively work with them in doing so.

Explanation: This need not reflect immediate disruptive changes but a long term commitment to progressively change from an aggressively competitive but unstable market to a more cooperative rivalry in a stable and fully accountable market. This is no place for entrepreneurs who want to make a killing. Providers will prosper to the extent that they meet the expectations of the community and its members. This is how markets are supposed to work.

Terms of reference: (g)

Recommendation C4. That accreditation should be relieved of its regulatory role and a new central regulator developed along the lines that we suggest.

Explanation: Clearly the current regulatory system should not be abolished overnight and should continue to operate as change occurs and the new system is able to take over. Accreditation should be beneficial but its continuation in some form to assist motivated providers should depend on its performance in doing what it was designed to do.

Terms of reference: (a)

Recommendation C5. That complaints should be investigated and handled locally by an empowered local community visitor. The role of a central complaints body should be to mentor support and advise the visitor and only intercede when this was necessary to resolve intractable disputes.

Terms of reference: (b), (f)

Recommendation C6. That the point of contact for advocacy be the empowered visitor whose personal knowledge and capacity to examine data and talk to staff will be an asset in resolving issues. Advocacy groups should support and work with the visitor and the local community on whose behalf they advocate for the recipients of care.

Explanation: We envisage that advocacy groups would have local members who would be part of the community hub and so already be working with the visitors. There may be some duplication to address as visitors would already be looking after and supporting those receiving aged care.

Terms of reference: (c,) (f,) (g)

Recommendation C7. That elder abuse services capitalise on the local knowledge of the visitors and the community groups involved in managing aged care locally. They should work in close association with and through them.

Terms of reference: (c), (f), (g)

D. Central Representation

Recommendation D1. That as local community groups grow, gain knowledge and experience and re-educate themselves, they elect a central body to manage their affairs, collate data, deal with bodies representing others, and seek representation on advisory and decision making bodies.

Explanation: If the enormous resources of our multifaceted communities with their many points of view and capacity to innovate are to be harnessed they need to be channeled into the system at the highest level. It is essential that they and their academic members and partners be involved in the collation and analysis in data coming from the nursing homes. This will ensure its accuracy, transparency and objectivity and facilitate research. This will put them in an independent position to work with and advise government.

Terms of reference: All

E. Central government management and regulation

Explanation. A move from central control to supported local ownership and control. Note that, while claiming less regulation, the failures of neoliberalism have actually resulted in greatly increased but ineffective regulation – termed ‘regulatory capitalism’. Our proposal will require less formal regulation and be less burdensome.

Terms of reference: all

Recommendation E. That central organisations gradually relinquish their controlling role and organise themselves as training, mentoring, support and backup organisations for local services - delegating services whenever possible and only stepping in when local services need help or cannot manage.

Recommendation E1. That accreditation be replaced with a new restructured regulator in the newly formed “Aged Care Quality and Safety Commission”. That the Commissions central integration be reflected in its new local responsibilities. That it lead the way in delegating and integrating its regulatory and oversight activities locally, but retain responsibility for imposing sanctions.

Explanation: This arrangement would counter the revolving door problem, be an early warning system and satisfy the principle of distributive justice (many points of view).

Recommendation E2. That the management of finance be reviewed with a view to working through local communities as their knowledge and sophistication grows.

Recommendation E3. That the advising and informing of residents and families as well as assessing prospective residents be done locally when possible, increasing as sophistication grows.

Recommendations E4. That there be supervisory visits as well as audits and other assessments as needed and they be conducted in cooperation with the visitors and local hub whose data would form the basis for decisions. Most regulatory audits are likely to be a response to concerns and information from the visitors

F. Local organisation

Explanation. A move from central control to supported local ownership and control

Terms of reference: all

Recommendation F. That an empowered visitors scheme be set up and that these visitors be appointed from within local community groups or, if not present, would set out to create local community groups of skilled people and others with interest or past experience in aged care or similar services.

Recommendation F1. That legislation be passed to give visitors the powers needed.

Recommendation F2. That visitors and the central community hub work closely with residents, families and community as well as staff and liaise regularly with local management to discuss issues. They should become the local source of information.

Recommendation F3. That the oversight of care, the collection of data, the handling and resolution of complaints and advocacy be the responsibility of the visitor supported and assisted by skilled people in the community, mentored by central government and reporting to the central community hub.

Recommendation F4. That the visitor and hub be trained, mentored and supported by the central organisations as well as available local medical, nursing and other expertise.

Recommendation F5. That the hub and visitor be responsible to and report transparently to both their local communities, central organisations and government.

Recommendation F6. That the local hub working with the visitor act as an integrator and controlling body for aged care in the region and liaise with other services such as health care and disability services.

Explanation. A move from central control to supported local ownership and control

Terms of reference: all

Part 1: Regulation in context

1.1 A systemic problem

In the introduction to our first submission made to this Inquiry in March 2017 (page 20 to 21), we indicated that Oakden was not unique but representative of problems in the sector that have been ongoing for 20 years. They were due to structural and policy flaws that were not being confronted. The response to failures has been to tinker with the system and ignore the underlying flaws.

In that submission (*Pages 24-25 and Appendix 1 starting on page 96*) we examined the patterns of thought that had been introduced into aged care starting in the late 1980s and their impact on aged care and particularly its regulation.

New insights: We have performed further analysis into the development of the ideas that lie behind our aged care system. This gives additional insights into what has happened in society more broadly but particularly to human services like aged care.

In the mid 1900s a philosophy that promoted individual self-interest, praised selfishness and condemned altruism and social responsibility became popular and influential in sections of society. It was highly critical of any control over individual effort and was very negative about collective activity in society, particularly when it attempted to control the activity of individuals. It considered the control which society exerted over the excesses of the individual to be socialist.

Government regulation was considered to inhibit the success of individuals and business. It was abolished or reduced to a bare minimum. Society came to have less and less influence and its role and involvement in the life and affairs of the nation has been reduced.

In the 1980s these ideas were enthusiastically embraced by President Reagan in the USA and Prime Minister Thatcher in the UK as well as by businessmen. Society and markets were restructured along these lines. Australia rapidly followed and we are the inheritors of this. The system that resulted is called neoliberalism and we are all trapped in it. Aged care has suffered much more than other sectors.

These ideas are still alive and well in the Trump administration, our society, the market and beyond⁸. Multiple disturbing fault lines (eg. bank scandals, exploitation of the vulnerable in other sectors, and failures aged care) have opened up in our society. Many are examining the important role that the changes made in the 20th century have played in these events and struggling to think of ways to address what has happened⁹.

While few would now openly condemn altruism or social responsibility the system that has been created has left little room for them. Their expression takes time and this impacts on profitability and there is no provision for them in the competitive marketplace.

This has had a profound negative impact on our society and on human services like aged care. History and common sense tell us that an effective customer and an involved community are needed to constrain the competitive pressures that drive this free market to behave irresponsibly.

⁸ This is what happens when you take Ayn Rand seriously PBS News Hour 18 Feb 2016 <https://to.pbs.org/2EgQfdA>
The new age of Ayn Rand: how she won over Trump and Silicon Valley. The Guardian 11 April 2017 <http://bit.ly/2FXiwHw>

⁹ See Appendix 1

In **Appendix 1** of this submission we have briefly examined the philosophical ideas that gave rise to the patterns of thought that critics now call free-markets, economic rationalism or neoliberalism. We explain the consequences for society and aged care.

We include a published article **"Aged Care: corporate conflicts run deep"** in **Appendix 4**. This explains how this impacts aged care in practice.

1.2 Developments since August 2017

Since our first submission there have been many more failures in aged care. The community is increasingly recognising this and become far more vocal in complaining. Two ABC Four Corner's programs¹⁰ have exposed the extent of the failures in care and the abuse of the elderly in nursing homes. The rising public anger saw a government under pressure set up a Royal Commission into aged care.

Stimulated by strong criticism of their past failures and community anger, the accreditation agency have detected many more problems in care and sanctioned many more facilities than in the past. They have *"closed almost one aged-care service a month"*¹¹.

This has exposed their past failures by showing that it has been possible to detect failures in care, even within the limiting framework within which they operate. It is now in their own and governments interests to do so. If things are allowed to 'return to normal' and 'small government' philosophy reasserts itself, regulatory enthusiasm will cool off, the number of problems identified will fall and they may use this to show how well the current changes have worked.

Continued denial: Government and industry have been unwilling to accept the real significance of what has happened. As we predicted, they have tried to downplay the real extent of the problems. They have continued to claim that we have a "world class system" and that most nursing homes provide good care. **Available information does not support this.**

Members of the aged care industry reassure one another that what we have seen is not representative. They blame the publicity for the predicament in which they find themselves. Instead of introspection and a genuine attempt to address their failures and the reasons for the problems, they are calling for positive stories to counter the publicity and blaming a lack of funding. ACSA even *"launched a social media campaign to showcase positive aged care stories"*¹². They are in denial.

The 'startling discordance' in perception between industry and those at the coalface that we previously described remain. The inappropriateness of the principles and prescriptions of the Aged Care Roadmap¹³ are not confronted¹⁴.

¹⁰ Who Care's ABC Four Corners Part 1 <https://ab.co/2AVdwNL> ; Part 2: <https://ab.co/2AUnWgO>

¹¹ 'No explanation, no excuse': tackling a crisis that has been ignored for years, The Australian 17 Sept 2018

¹² ACSA launches aged care storytelling platform Australian Ageing Agenda 4 Sept 2018 <http://bit.ly/2FZXnwg>

¹³ Aged care Roadmap Inside Aged Care May 2017 <https://www.insideagedcare.com/introduction/aged-care-roadmap>

¹⁴ Spin trumps evidence in driving aged care policy, Dr Michael Wynne, Michael West website, <http://bit.ly/2M4QxHH>

From Government too: The newly appointed head of the Aged Care Quality and Safety Commission has, without time to properly evaluate the situation, simply accepted the government and industry's views.

When interviewed¹⁵ she denied widespread problems, stating *“There is not a problem of quality universally”* and *“We have some providers who aren't fulfilling their responsibilities”*. This was even before she began her new role as Aged Care Quality and Safety Commissioner¹⁶. This fuels our concern that the government still sees this as a problem of image and not care and has appointed someone to address that.

Recommendation C3: That the Aged Care Roadmap be abandoned and a broad commitment made to work with communities in managing and providing aged care service. Providers in each locality should be required to cooperatively work with them in doing so.

1.3 Regulatory changes

As we feared (*pages 83 and Appendices 4 & 5 on pages 112 to 117 of our first submission*¹⁷) the Carnell/Paterson Review remained tightly constrained by the Neoliberal discourse and responded by simply moving the regulatory pieces about and ignoring the underlying problems. The same people from the same organisations employing the same underlying discourse and roadmap are still in place.

As we indicated in Appendix 5 of our previous submission, even before the report was handed down the government, the industry and the reviewers were planning a meeting to reaffirm the Aged Care Roadmap. Accreditation is still considered to be the primary regulator carrying out inspections and that is not a reform.

The major change, central integration of the regulators into what government has called the “Aged Care Quality and Safety Commission” offers some potential benefits but without fundamental changes, the revolving door with industry will ensure that they continue to serve industry above community.

Fusing three failed regulators into one simply saddles the new body with the problems of all three. The single format will certainly make it easier to contain disturbing findings and so keep the public in the dark.

Describing this minimalist regulatory change as *“Australia's tough new aged care cop”*¹⁸ is a good illustration of the way in which unrealistic catchphrases and sound grabs become a substitute for political debate. This misleading and exaggerated catch phrase was republished on industry related websites as well as in most major metropolitan and many smaller regional newspapers across the nations. The ‘reforms’ are a damp squib. Much more is required and this must include changes on the ground.

¹⁵ Nursing home survey: Food, safety biggest concerns for residents, The Courier-Mail, 6 Dec 2018: <http://bit.ly/2E0RSL0>

¹⁶ New Era in Aged Care Begins with First Quality and Safety Commissioner Announced (media release) <http://bit.ly/2QBk7a1>

¹⁷ First submission to Senate Inquiry (March 2017): <http://bit.ly/2Don7Bu>

¹⁸ \$106 million boost to support older Australians with better care Dept. Health Media Release 12 Sept 2018 <https://health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2018-wyatt127.htm>

1.3.1 Unannounced visits

We have long been strong advocates for unannounced visits but we have recently discovered data that has forced us to revise our position. In our submission to the House of Representatives Quality of Care Inquiry into failures in care¹⁹, we analysed new information about accreditation assessments²⁰. Recent data supplied by the Quality Agency revealed that only 14% of failures were first detected by an audit.

Of the remainder, in 12% risk profiling had alerted the agency to possible problems. In 74%, the Quality Agency had received information alerting them to problems from other sources and then confirmed it. A 14% hit rate in detecting problems themselves does not support claims that the process itself is rigorous, effective or world class.

When the number of visits are set against the success rate in detecting problems the rate of success is only a fraction of a percent. This is most apparent when we compare this with data showing the high incidence of problems like malnutrition and pressure injuries, both very dependent on effective staffing.

We reviewed some of the data supplied to senate estimates in our submission to the Inquiry into Quality of Care and include our analysis of “**Quality Agency assessments**” (pages 27 to 37 from the submission made to that Inquiry²¹) in **Appendix 2** of this submission.

An additional document²² supplied to the senate contains a report outlining details of failures in outcomes not met over a five-year timeframe. We have looked at that data and it seems to be congruent with our earlier analysis.

When the success of unannounced visits are compared with announced visits, the number of additional problems identified per visit were only marginally greater. **The claims for accreditation as an effective oversight process and the benefits of unannounced visits are not supported by the agency’s own data.**

1.3.2 Unannounced but not unexpected

We also need to distinguish between unannounced and unexpected. Given the nature and the way accreditation is done, unannounced visits are often not unexpected. Most facilities would have a general idea about when the visitors are likely to arrive and can prepare.

Conclusion: We remain unimpressed with the changes made in the regulatory process. They do not address the problems responsible for the failures. Our analysis suggests that in the immediate future there will be more rigor and more problems will be detected but this will not last. The structural problems will remain and the social pressures underlying the processes will in time reassert themselves. The cycle of scandals and then regulatory reform will start all over again.

Accreditation is a process intended to assist motivated providers improve. It is not and has never been a regulatory process. It should not be included in a regulatory system. We need a proper regulator.

¹⁹ Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia (Mar 2018) <http://bit.ly/2l69uZv>

²⁰ Part 1.3 (pages 27 to 37) Submission to Standing Committee on Health, Aged Care and Sport. Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia March 2018
<https://www.apf.gov.au/DocumentStore.ashx?id=7ee65a97-5cb3-4de1-8cfd-26cb377408be&subId=564157>

²¹ Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia (Mar 2018) <http://bit.ly/2l69uZv>

²² Answers To Estimates Questions On Notice Health Portfolio Budget Estimates 2017 - 2018, 30 May 2017 <http://bit.ly/2EfEio9>

1.4 Staffing issues and regulation

Our first August 2017 submission to your senate inquiry was largely based on material and analysis that we had earlier supplied to the minister and then included in our submission to the Carnell/Patterson review²³. It included the data on staffing and the criticisms made by Braithwaite in 2007. While their report quoted from Braithwaite to support their arguments, his damning criticisms which we had drawn attention to were ignored. No action was taken to address them.

The workforce taskforce: Incredibly after the 2016 workforce inquiry, the task of addressing the disastrous staffing situation revealed was delegated to the same industry that was largely responsible for the situation. Aged Care Crisis supplied Professor Pollaers with Australian staffing data and tables comparing them with international data. These showed just how bad the situation was.

Not unexpectedly:

- the report that eventuated did not publish the data that showed what had happened and the role that industry had played,
- the future of staffing was dependent on a **voluntary code of conduct** by the companies responsible for what had happened and whose profitability and existence depended on keeping costs down, and
- it resulted in more costly committees and processes peopled with many of the same people responsible for the system that we have.

Recommendation D1: That as local community groups grow, gain knowledge and experience and re-educate themselves, they elect a central body to manage their affairs, collate data, deal with bodies representing others, and seek representation on advisory and decision making bodies.

Other inquiries and reviews have similarly identified the failures and proposed solutions. They are treating the symptoms without examining and addressing the flaws in policy and structure that are responsible.

Our concerns, our assessment of the situation and our fears about the response of industry and government have been confirmed (*see Part 4 and Appendix 4 of our first submission*).

1.5 The Royal Commission into Aged Care

We remain hopeful that the appointees to the Royal Commission have been selected for their independence and objectivity and not because they are aligned with the dominant discourse and so are seen to be credible.

This is a Royal Commission that resulted from the pressure generated by community advocacy and the staff and family members across Australia who stepped up to speak out about their experiences. We contributed to the terms of reference and many of us registered with the Commission following its early promise to keep those interested informed.

²³ Review of National Aged Care Quality Regulatory Processes 22 July 2017 https://agedcarecrisis.com/images/pdf/Attach_RNQRP.pdf

We have heard nothing from the Commission despite subscribing to the updates. We have found out from other sources that the Commission is speaking to industry groups and requesting information and submissions from the industry. This will give industry an opportunity to define the issues and set the discourse of the inquiry.

The industry is busy organising to do just this and are employing legal and other experts so that they speak with one voice.



This puts the community, family members and advocacy groups at a substantial disadvantage. We feel that it is these groups that should set the discourse and raise the issues to which the industry then responds.

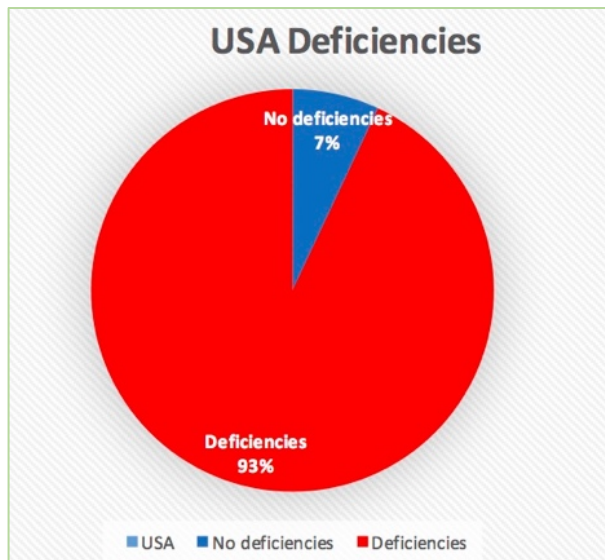
Industry have been told that their submissions will not be protected from defamation. If this also applies to staff and families, it will deter large numbers from making submissions. Many have been threatened by providers and there is widespread anxiety about this. This is why so many do not speak out publicly.

Part 2: Comparing Australia with the USA and the UK

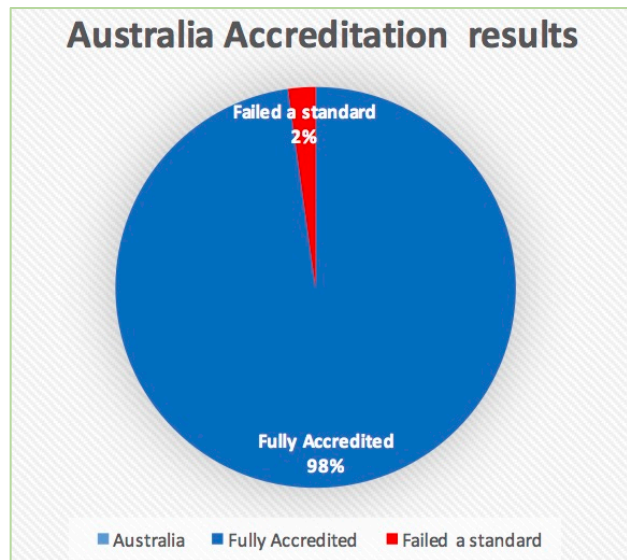
In our first submission we compared regulatory rigor in the two countries and showed that in spite of much better staffing, the USA had only 7% of facilities that had no deficiencies. (page 36)²⁴.

The remaining 93% has an average of 8.5 deficiencies and in 20% these were serious. In contrast only 2% are found to have deficiencies in Australia and 98% have perfect scores.

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



Left Chart: USA deficiencies = 93%



Right Chart: Australia deficiencies = 2%

2.1 Staffing and regulation

In our first submission we emphasised the enormity of this by comparing staffing data for the USA with recently revealed data for Australia. We showed that residents in the USA received twice as much care from trained nurses and a third more nursing care overall than residents in Australia.

International data indicates that Australia's staffing levels would be associated with an unacceptable incidence of failures in care. Unlike the USA staffing levels in Australia are not regulated and adequacy depends entirely on the Quality Agency's assessment.

Since our first submission to this Inquiry, we explored these issues further in our submissions to the House of Representatives Inquiry into Quality of Care²⁵. On page 19 and in **Appendix 1** of that submission we focused on the extensive record of ongoing unhappiness and endless but ignored complaints over the last 20 years. These came from nurses and families, those who saw what was happening. We contrasted these with the exaggerated claims and assertions of politicians and industry.

²⁴ First submission to Senate Inquiry (March 2017): <http://bit.ly/2Don7Bu>

²⁵ ACC Submission to Standing Committee on Health, Aged Care and Sport. Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia March 2018 <http://bit.ly/2l69uZv>

A recently prepared slide (below) encapsulates the problem and the absence of any data that showed what was actually happening.

Incompatible Views	An absence of data
<p>A 'World Class' aged care system</p> <ul style="list-style-type: none">• Politicians - a very, very thorough accreditation system (2000)• Industry - the most robust quality systems anywhere in the world (2012)• The Austrade website - A global benchmark for best practice - strong government funding - robust framework for accreditation, quality and regulation (2015)• Federal minister Ken Wyatt says we have a world-class system (2018)• Industry - a good system - delivering high standards of care (2018)	<p>CEO Alzheimers Australia: "We still don't have a single measure of quality in aged care services, and this is critical - - one of the biggest challenges facing aged care. (2015)</p> <p>Researcher: "very little, or none basically, - - should have a much better system in place around the measurement of data. (2015)</p> <p>Researcher: "(In Australia data is of) insufficient rigour for use in research (2018)</p>
<p>A system to be ashamed of</p> <ul style="list-style-type: none">• Nurses - the tragedy of our nursing homes - a huge indictment on our society - many acts of brutality and cruelty - care falls short by most facilities (2005)• Nurses - some mind boggling disgraceful care. - open their eyes to the horror that exists - It is a disgraceful situation (2008-12)• Nurses - Please, please change things. - truly a hidden humanitarian crisis. (2016)• Chairman AMA Council of General Practice - It's definitely worse now than it was 20 years ago (2018)	

In the absence of valid data about standards of care, we showed that staffing data and regulatory failure adequately confirmed the validity of the nurse's complaints. We looked at the role that regulatory failure had played in allowing this to happen. We quoted from nurses who had real experiences of accreditation and complaints to illustrate. Subsequent events have confirmed our assessment.

In our submission to the Inquiry into Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018²⁶ we traced the story of staffing and the conflicts about adequate staffing from the 1950s to the present. We explained the changing patterns of conflicts between government, industry and staff. We looked at the ongoing pressures on staffing over the years and the efforts to provide adequate staffing levels. We addressed regulatory failure in this context.

We have argued for regulatory reform that sets minimum staffing requirements and for total transparency. Since 2008 we have consistently argued for communities to play a greater role in aged care. This was in order to counter and control the perverse incentives in the system that were responsible for poor staffing and failed care.

²⁶ ACC Submission to: Inquiry into Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018 4 October 2018
<https://www.agedcarecrisis.com/images/subs/Sub026-Aged-Care-Crisis-Inc.pdf>

Additional Background: By 1996 the free-market neoliberal discourse was firmly established in Australia. The government was committed to marketising health and aged care.

The problem for the market was that income came largely from government and was fixed. Profits and so competition for growth and success could only come by reducing costs. This was restricted by the regulation of staffing numbers (comprising 70% of costs).

Industry was reluctant to invest unless they could control costs. The 1997 legislation that industry co-wrote abolished probity requirements, removed all accountability for how taxpayer funding was spent and removed all staffing requirements. Investors obliged.

The unions remained powerful and resisted reductions in staffing when negotiating wage agreements. This was a deterrent to the banks and entrepreneurial investors including private equity who were still reluctant to invest heavily.

Comments In 2004:²⁷

throughout the industry there is an expectation that within a couple of years, the Government will be forced to relax the regulatory controls that limit the operators' revenues. Either that, or it will have to substantially increase the money it is prepared to spend on aged care.

- if there is some deregulation of the system, then the future is very bright. At the moment, the business is severely challenged because we effectively have a cap on income but we can't control the expenses."

Comments In 2005:²⁸

KPMG's Mr Arundell argued it was the combination of fixed government revenue and fixed costs -- largely nursing wage agreements -- that created risk in the sector.

"Both your costs and your revenues are regulated," he said. "What you are finding is the difficulty in making a margin between those two elements which are out of your control."

The government responded and drastically reduced the power of the unions by introducing their unpopular "work choices" legislation in 2005. More of these private groups then entered the sector²⁹.

At this time there was a strong and very appealing illusion that that ageing was a normal process and not a disease. Residents did not need expensive nursing staff to look after them. Money was being wasted. This became a part of the discourse.

This illusion was fueled by a very charismatic and successful US entrepreneur who bought into an Australian Health Care company in 1997. He indicated his intention to enter aged care and persuaded our politicians that there was plenty of fat (ie waste of money) in health and aged care including in nursing staff³⁰.

²⁷ Grey Expectations Business Review Weekly 1 April 2004

²⁸ Riding the Wave - The Australian 31 March 2005

²⁹ Aged care money may be heading in wrong direction The Age 17 Sept 2007

³⁰ Andy Turner wants the government out of health care, Period New -Mexico Business Journal. April. 1996 Vol 20; No 4: pg 10
http://www.corpmedinfo.com/sun_the_fat.html

His US company was soon involved in one of the recurrent fraud and poor care scandals in the USA. It failed a probity review in Victoria before entering bankruptcy in both countries. The company and its founder were discredited but attractive illusions live on and we still hear similar self-serving assertions from some industry leaders today.

A provider who is a leading member of LASA asserted that *“Age is not a Disease – Aged Care does NOT belong in the Healthcare Domain”*³¹.

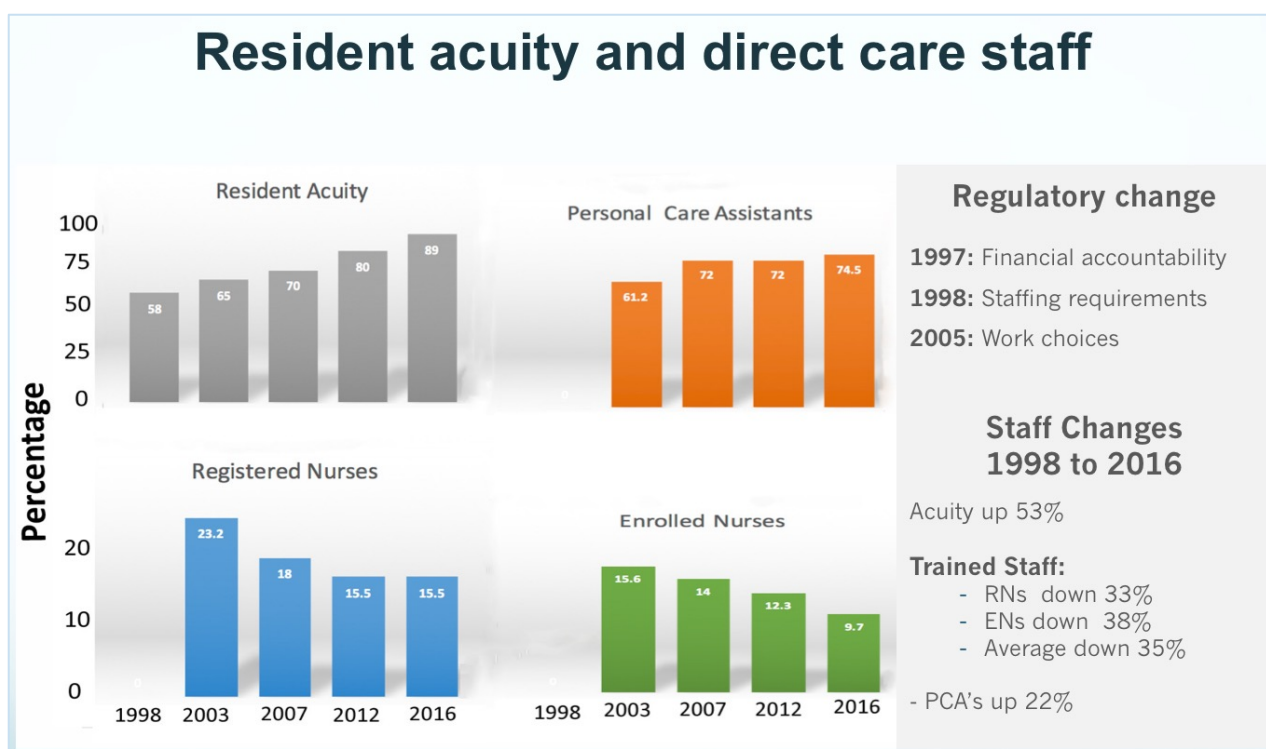
The decline in staffing and the role of both politicians and industry is apparent when we consider the data against this background. We re-emphasize these points because of their importance.

2.2 Updating staffing data

We have recently re-charted data to better highlight the impact of the patterns of thought and the changes described above as well as the extent of the failure of the accreditation process over the years. This was the process that was charged with determining whether staffing in our aged care facilities was ‘adequate’. Their failure was monumental.

The chart (below), shows the changes in acuity and the structure of nursing staff over the years.

Figure 1: Resident acuity and direct care staff



A newly released report³² from the “Bankwest Curtin Economics Centre” shows a similar large increase in acuity accompanied by a poor and declining proportion of trained nurses in Western Australia and their substitution with low skilled workers.

³¹ ASX Aged Care in Australia - the Future, 9 Sep 2016 <http://bit.ly/2qNzbG3>

³² Aged care workforce not keeping up with high care demand Media Release 7 Dec 2018
<https://bcec.edu.au/media/aged-care-workforce-not-keeping-up-with-high-care-demand/>

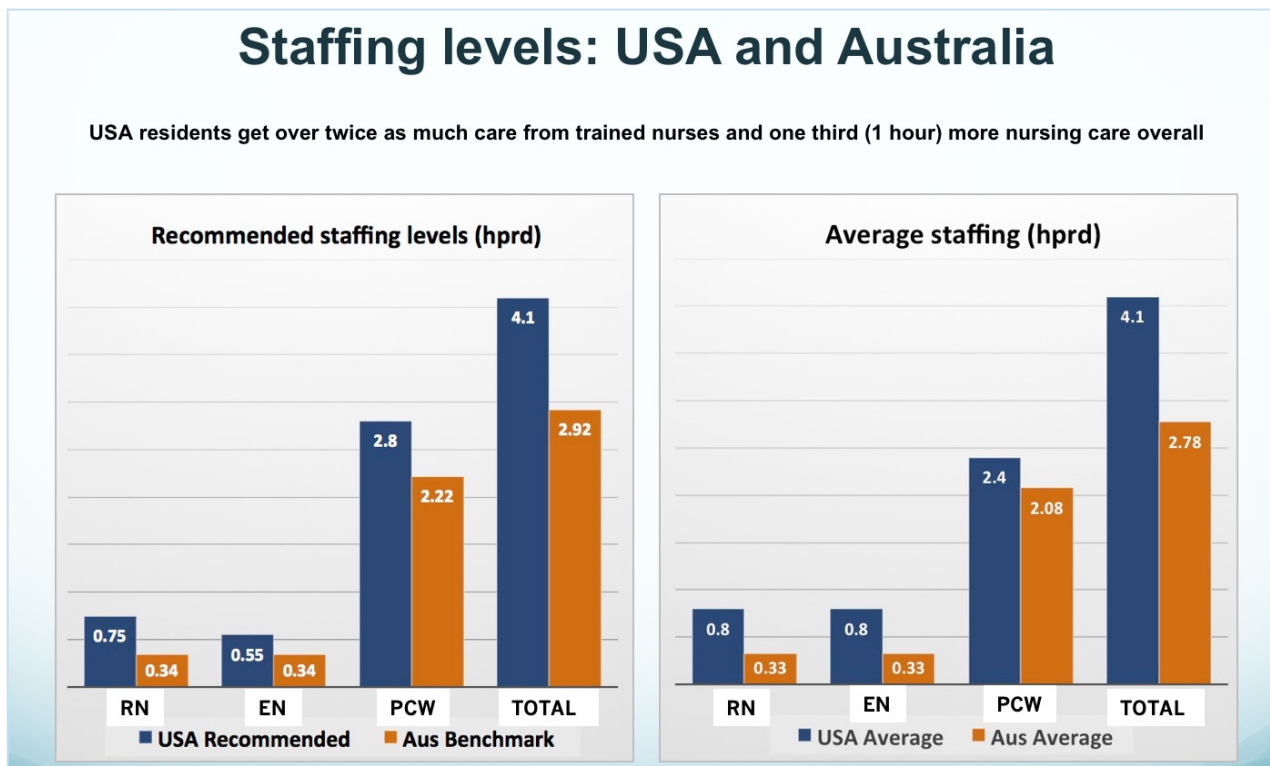
To Health and Happiness: WA's Healthcare Industry Future, Report Curtin Economics Centre, Dec 2018
<https://bcec.edu.au/assets/2018/12/BCEC-To-Health-and-Happiness-Report.pdf>

The chart (below) on the left compares the US minimum recommendations, based on careful study over many years, with StewartBrown's benchmarks based on financial metrics. The figures show Registered Nurses, Enrolled Nurses and Personal Care Workers as hours per resident per day.

US figures are comparable with studies reported by the industry in Victoria in 1985 prior to the triumph of neoliberalism and a study done for the unions in South Australia in 2016. Both studies have been ignored.

The chart on the right compares average staffing levels showing that US citizens get twice the care from trained nurses, more care from personal care assistants and more than a third more nursing care overall.

Figure 2: Staffing levels: USA and Australia



A recent investigation of poor care and staffing in Pennsylvania USA³³, classified staffing as very good, good, low, very low and dangerously low. **Most, if not all of the dangerously low staffing ratios were still above 3 hours per resident per day.**

In Australia, the adopted benchmark is 2.9 and the average 2.8 hours per resident per day (based on financial requirements).

In the USA the majority of our facilities would be considered to have dangerously low staffing levels.

³³ New Name, Same Nightmare (series of articles) <http://stillfailingthefrail.pennlive.com>

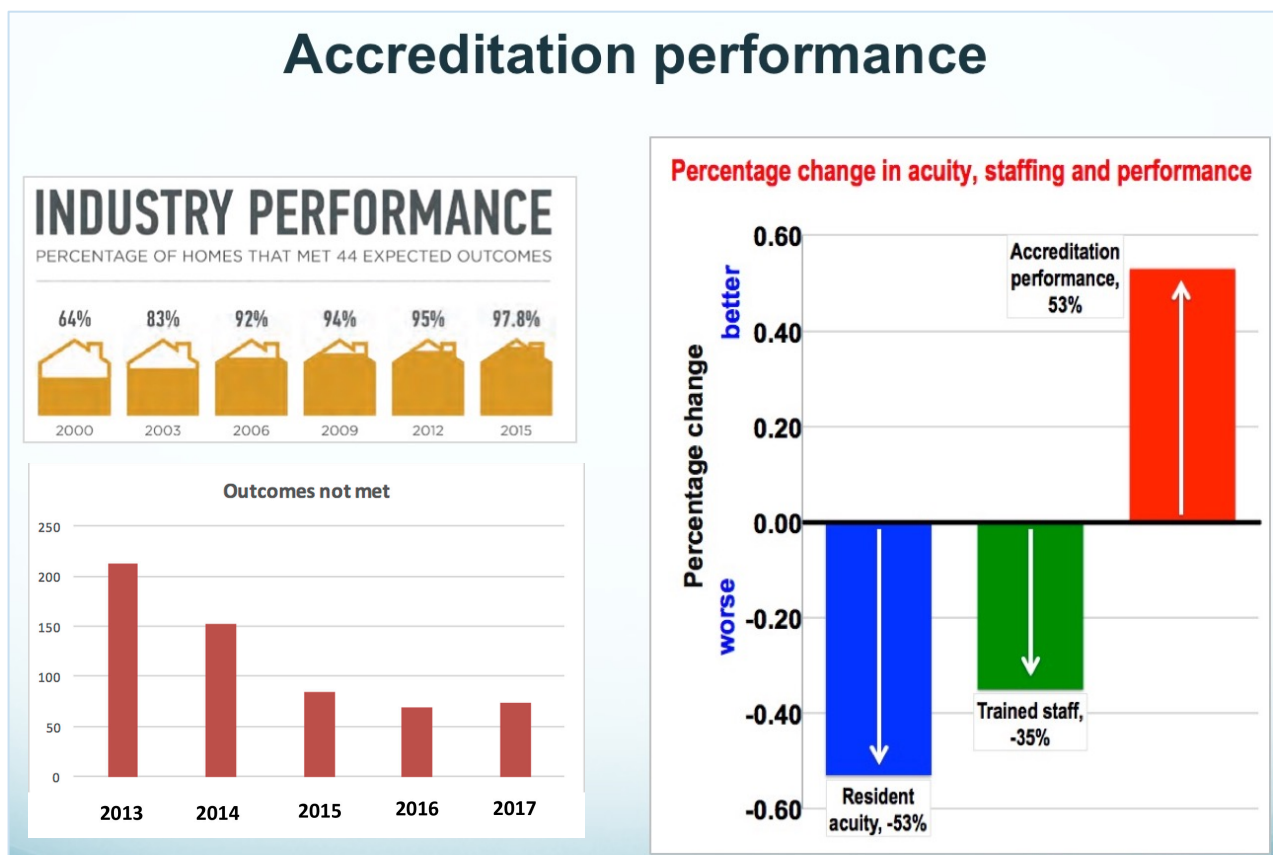
Accreditation performance

- “Industry Performance”:** The upper graphic to the left on the slide (below) is from the Quality Agency’s 2016 annual report where it boasts of its ever-increasing success in accreditation.

The percentage of success (to near perfection at 97.8%) is based on the 5 years of data supplied by the Quality Agency to your Senate Committee. It shows how the success rate in detecting failures was still falling steadily prior to Oakden in 2016. The beginning of the rapid increase in the detection of failures starting in 2017 is shown in the final column. The figures for 2017/18 when available will show this better.
- “Outcomes not met”:** The lower graphic on the left show how the detection of failures continued to fall during each year ending in June until the Oakden scandal in late 2017. It climbed steeply into 2018.
- “Changes in acuity, staffing and performance”:** The bar graph on the right tracking the change in acuity, staffing and performance, contrasts the success of accreditation above the line with the increasing acuity of residents and the decline in the skilled staff needed to care for them below the line.

The figures speak for the credibility of the accreditation process and the reliability of the experiences of the nurses.

Figure 3: Accreditation performance



2.3 Addressing staffing

Staffing is a critical regulatory issue and must be properly addressed. When we look at the history of the sector since 1997 the reason why the Workforce Taskforce delegated to industry failed to confront the figures and the role of industry in creating the problem is readily understood.

Recommendation C1: That steps be taken at the earliest opportunity to legislate recommended ratios and levels of staff based on acuity, and that a strategy be in place to evaluate clinical performance and quality of life in an ongoing manner so that adjustments can be made. This evaluation should be in close cooperation with staff and empowered visitors.

Recommendation C2: That the measurement of staffing levels be ongoing, objective and verified locally so ensuring transparency and utilisation when families make choices.

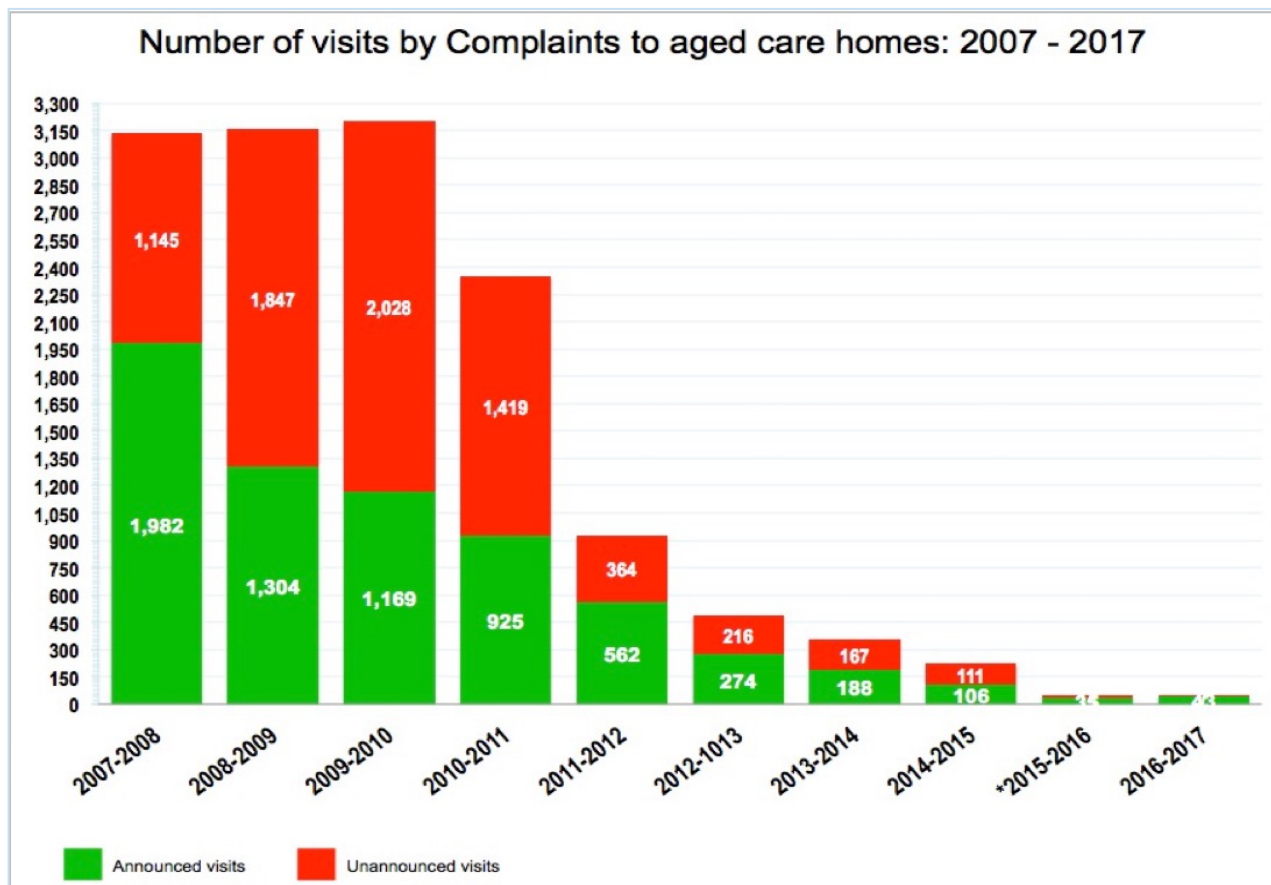
2.4 The Complaints system

The other body that we would expect to check up on staffing levels would be the repeatedly revamped complaints system. They receive thousands of complaints each year and many would be about staffing or a consequence of staffing deficiencies.

You would expect them to explore the issues and assess the adequacy of staffing. But since the Walton Review in 2009 it has been policy to refer complaints back to the facility complained about to investigate and resolve. Without going to the facilities, it is impossible to assess staffing.

The figures in the chart (below) show the steady decline in announced and unannounced visits by the Complaints system from over 3,000 per year to less than 100 since the Walton review.

Figure 4: Complaints system visits (source: Complaints annual reports 2007 - 2017)



Recommendation C5: That complaints should be investigated and handled locally by an empowered local community visitor. The role of a central complaints body should be to mentor support and advise the visitor and only intercede when this was necessary to resolve intractable disputes.

2.5 Conclusion

What is revealed is that the public have been consistently misled by politicians, the bureaucracy, market leaders and the regulatory processes that they have created. They have overseen and supported a system that has not only failed society but has harmed many citizens, turned a blind eye to failures, ignored ongoing criticisms, denied evidence and attacked critics. Society has every right to be angry about this.

We argue that this failure is a result of social pathology and our vulnerability to simplistic appealing ideologies. Those responsible are themselves victims so it is not a case of blame but an urgent need to acknowledge what has happened and accept responsibility. Multiple other sectors in our society have been victims but the personal costs have not been as high as aged care.

As Carmen Lawrence, experienced politician and now a Professor of Psychology, recently indicated³⁴ any long term solution to the problems we have that does not understand human behaviour, understand and address the lessons from history and address the ideological factors that underpin the system, will not be a permanent solution.

2.6 Where to from here

The first step in addressing any problem is to identify and acknowledge what the problem is and understand how it occurred.

Society deserves an honest acknowledgement of what has happened and also an acceptance that government and the market are incapable of addressing the problem alone. They need the assistance of the community. Steps should be taken to work with, rebuild and re-empower our hollowed out communities then work with them to establish and structure an effective civil society.

By doing so we should be able to expeditiously rebuild a responsible capitalist democracy that will be better positioned to meet the challenges of the 21st century.

Societies across the world are deeply disillusioned and crying out for a new way forward, one which they are a part of, and with which they can identify³⁵. Society works best when it is involved and has a goal.

These changes will not be easy and they will take time. Aged citizens have not only paid a higher cost but urgent change is needed to protect them. The sector supplies services in every community and in our homes. Society is better placed here than in any other sector to reclaim its traditional role. We should start re-empowering and rebuilding the community and civil society across the country around aged care.

³⁴ The denial, the infantilising babble, and the fantasies that permeate politics - The Guardian, 30 Jan 2017
<https://www.theguardian.com/commentisfree/2016/jan/30/the-denial-the-infantilising-babble-and-the-fantasies-that-permeate-politics>

³⁵ Out of the Wreckage: A New Politics for an Age of Crisis. George Mombiot lecture on You Tube
https://www.youtube.com/watch?v=uE63Y7srr_Y

Recommendation A1: That problems in aged care, the policy failures, the consequences, and the reason for their failure be formally and publicly acknowledged.

Recommendation B1: That the prime focus of change should be the rebuilding, empowerment, involvement and education of civil society so that it can effectively assume its proper place and its role in a responsible capitalist democracy.

Recommendation B2: At the earliest opportunity community structures should be established, become involved and then progressively take more control over aged care in their locality, ensuring that their agents, the providers, are meeting their expectations.

Part 3: An analysis of aged care regulation in Australia

In this part of our first August 2017 submission we described the history of social responsibility. We have already commented and added some additional material earlier in this submission.

In that first submission we wrote a critical analysis of current regulation in order to explain its contradictions and the reason for its failure. Little if anything has been done since to address these problems. We described how a process that was intended to work with providers and assist them was turned into a rigorous regulator and became the rock on which the regulators legitimacy depended.

We described the revolving door with industry and the extent to which both government and regulators have been captured by the neoliberal discourse. There has been no attempt to address this issue since then. If anything it has increased. The same familiar faces from the family of believers are still well represented on every new body created, whether by the workforce taskforce or any other government body. The powerful industry is still protecting its patch.

We examined what has been called regulatory capitalism and explained why it had been ineffective in most countries. We looked at the ascendancy of managers with no experience of aged care and their role in advising government. This has since been well illustrated by the lack of knowledge and insight displayed by the CEO of LASA when interviewed on the Four Corners program exposing failures and abuse in nursing homes. He sits on the Aged Care Sector Committee and advises government.

We itemised and commented on the main problems with the accreditation and complaints system. Later in that section we looked at the problems and failures in the department of health and aged care.

We described criminologist John Braithwaite's disturbing finding when he studied regulation in Australia. The slide below, attempts to capture the essence of his criticism. Little has changed.

Figure 5: 2007 report of study of regulation by Prof. John Braithwaite et al 'Regulating Aged Care'

2007 Report of study of regulation in Australia

Neoliberal principles

- **non-intervention by the state**
- minimal regulation

The Accreditation Agency **clung to the ideology that it was a child born of industry deregulation**

A 'revolving door' (with industry) - The post-1997 **Australian regime is more captured by the industry** than the English and US regimes. Things have to be bad for non-compliance to be recorded or strong criticisms to be made in an accreditation report. - - - our **observation of indefensible ratings of compliance** during our fieldwork.

Australian complaints mostly do not trigger visits to nursing homes and are universally steered to dispute resolution strategies ---- (The system) was user-unfriendly and unresponsive.

- - - today business values are capturing regulatory values more than the reverse - - - , **the community should be concerned.**

Source: Braithwaite J et al 'Regulating Aged Care' Edward Elgar Publishing Limited 2007

From 1998 until 2014 when its independence was removed and the industry put in charge, the members of this regulatory rock insisted that they were not a regulator, but an accreditor, that the two were incompatible and that it was there to help and support the industry not regulate it.

3.1 Regulatory changes since August 2017

As the committee will be aware there have been multiple inquiries and reviews since our first submission to your committee. The government has elected to act on the recommendations of the Carnell/Patterson review that it set up. As indicated this was highly selective of the issues that it addressed and its recommendations were constrained by its adherence to the neoliberal discourse. It did not address the issues responsible for regulatory failure.

At the time we wrote a criticism of its report. This is included in an attachment³⁶ to our submission to the House of Representative's Inquiry into the Quality of Care³⁷.

Department, Accreditation and Complaints: Amalgamation of the health department with the accreditation and complaints systems into a single regulatory entity was first advised by the 2011 Productivity Commission Report.

It was strongly opposed by the Accreditation Agency at the time. They rejected this on the basis that accreditation and regulation are incompatible. They claimed that accreditation should not be associated in any way with regulation as this impeded its effectiveness.

The quote below encapsulates its assertions. It expresses the position that it had held since 1998. They are equally applicable to the government's new regulatory body.

Is the Accreditation body a regulatory? - No

“... The Accreditation Agency does not ‘investigate non-compliance’ with standards ...”

The proposed model of the Productivity Commission Report would effectively place two functions that are inherently contradictory into one organisation - - regulatory function and accreditation function.

(Need to) *keep a clear and distinct distance from the regulatory functions.*

Source: Accreditation Agency submission to the 2011 Productivity Commission Inquiry “Caring for Older Australians”

The Carnell/Patterson review made the same recommendation and the government has now legislated the creation of a single regulator. The Quality Agency, now part of a government department and managed by a recent CEO from LASA, did not object.

As indicated we believe this was a retrogressive step and its benefits will be primarily for the government and industry that designed and supported it. It will be in a better position to contain the adverse publicity, which they see as the problem.

³⁶ Pages 60 to 92 ‘Community managed aged care: An analysis’ **Attachment to ACC submission to The Inquiry into Quality of Care in Residential Aged Care Facilities in Australia** by the House of Representatives Standing Committee on Health, Aged Care and Sport March 2018 <https://www.aph.gov.au/DocumentStore.ashx?id=04bdb6a4-52ac-4ac7-bd62-731b235f3abf&subId=564157>

³⁷ Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia (Mar 2018) <http://bit.ly/2l69uZv>

The recently introduced “Single Aged Care Quality Framework” will also change the accreditation standards reducing them from 44 to 8 and applying them to both aged care and home care. We see no advantage in the reduced standards and we argue that the whole process should be replaced with a real regulator. This change is simply the continued application of Neoliberal policy to reduce or eliminate regulation and any other impediment to market freedom. The Royal Australian College of GPs is also critical³⁸.

Accreditation as a regulator failed in health care in the USA on multiple occasions. It was rejected as a regulator of aged care in the USA for good reasons. If we are to regulate effectively in Australia then it must be replaced with an effective regulator. If it is retained as well then accreditation must be allowed to do what it was designed to do and its utility properly evaluated.

Recommendation C4: That accreditation should be relieved of its regulatory role and a new central regulator developed along the lines that we suggest.

3.2 Advocacy

In our August 2017 submission we described early attempts to use the regulatory potential of Advocates and Visitors who were regularly on site. This was opposed by industry and abandoned. We noted Braithwaite’s assessment that the potential of the advocacy service and official visitors to expose failures and deficiencies had been limited by legislation and discouraged by the potential impact that embarrassing industry or government might have on their funding.

We described the recent consolidation of aged care under a single group, the Older Persons Advocacy Network (OPAN) and expressed some doubts about this.

New developments in advocacy: There is much to suggest that Braithwaite’s concerns about the muzzling of advocates by threats to their funding was well founded and that this is still happening.

There has recently been widespread anxiety in those advocacy groups critical of current policy, particularly those advocating for the NDIS. Those on the right of politics do not believe that critical advocacy should be considered a charitable activity and be funded by governments. There have been subtle and not so subtle steps to discourage unwelcome criticism by advocates.

In 2015 the Abbott government (Minister Fifield) selected five disability groups who would give it advice³⁹. It included them under the ‘National Cross Disability Alliance’ and funded them well. It was not the community but government who selected who should be supported and allowed to advocate. This deprived the many disabled who supported the other advocacy groups of a voice.

In 2017 the NSW government did a *“total funding cut to dozens of NSW organisations that advocate for people with a disability”*. This impacted their viability⁴⁰.

There was alarm when Gary Jones, one of the strongest critics of the public funding of advocacy organisations was appointed to head the Australian Charities and Not-for-Profits Commission⁴¹.

³⁸ New Quality Standards for Aged Care released 28 Nov 2018 <http://bit.ly/2rw9Tdb>

³⁹ Disability Groups Split on New ‘Alliance’ Probono 10 Feb 2015 <http://bit.ly/2FX4hCN>

⁴⁰ Plea for Premier to reverse disability funding cuts as pressure mounts Sydney Morning Herald 17 Nov 2017 <http://bit.ly/2Q77u7t>

⁴¹ Who is Gary Johns? Probono 7 Dec 2017 <https://probonoaustralia.com.au/news/2017/12/who-is-gary-johns/>

Government accused of trying to ‘silence’ charity sector with new commissioner ABC News 7 Dec 2017 <http://bit.ly/2zADZQP>

Petition Calls for Gary Johns to Resign as ACNC Head Probono 11 Dec 2017 <http://bit.ly/2FVhKEI>

There are more subtle ways of inhibiting the independence of advocacy groups. Some advocacy groups can make themselves more independent by owning a profit making subsidiary or being engaged in profit generating activities in order to fund their advocacy or other philanthropic activities. They can be discouraged from being outspoken or of becoming too independent by challenging their registration as a charitable organisation⁴².

Perspectives on the restraints on advocacy: There are different ways of looking at this

1. If we look at the original discourse and its philosophical beginnings (Appendix 1), we see an attack on “the collective” (society) and a denigration of community criticism and control. We can understand that the inheritors of this philosophy would have a very negative view of public discussion, criticism and advocacy and seek to discredit and contain it. They would not understand that these activities are the foundation of our democracy and that it is their approach that has not only led to the decline of civil society but in doing so eroded our democracy.
2. When we look at the social dynamics we can see this as the defensive response of an ideology that is failing and under threat. It is seeking to protect itself.

Advocacy in aged care: The structure of the Older Persons Advocacy Network (OPAN) is interesting⁴³. It was an alliance of nine advocacy groups drawn from each state and two from the Northern territory that worked together. Most of these would have been the groups that government had previously contracted advocacy to.

In 2015/16 they resisted attempts by government to have a single amalgamated entity provide advocacy in aged care as well as proposals to exclude some areas including elder abuse from their role. These seem to be attempts to increase control and limit their role. Publicity of neglect and abuse in aged care services was becoming embarrassing.

In 2017 OPAN won the governments tender to provide advocacy services across Australia. It has an office in each states to which citizens are directed and it passes the contacts on to members of the network. OPAN is a registered company. It controls and allocates the funding under the terms of a memorandum of understanding signed with the nine members. There are other advocacy groups but we do not know how they are funded.

Addressing elder abuse: As in other western countries elder abuse has become a problem and it seems that it is increasing. Government has responded to public interest and publicity by providing funding and support. There is little data but press coverage including the Four Corners program suggests that much of this occurs in nursing homes, but it is hidden because it does not have to be reported. The research done shows a much higher incidence of sexual abuse and other assaults than expected.

There has been intense interest in Elder Abuse and multiple inquiries. Much of that has focused on Nursing Homes because of the many confronting examples and the failure to collect information which would show what was happening in the sector. In the equally vulnerable disability sector there have been many examples of abuse and inquiries have been confronting. Most would expect nursing homes to be a major focus of attention.

Many submissions to Elder Abuse and other inquiries have raised these issues.

The Gary Johns appointment The Saturday Paper 16 Dec 2017 <http://bit.ly/2EdC74C>

⁴² Page 14 Annual Information Statement 2016 National Seniors Australia Ltd | Australian Charities and Not-for-profits Commission
<https://www.acnc.gov.au/charity/04c5d176cd5831f81c72b98587b39103#financials-documents>

⁴³ Review Of Opan Elder Abuse Advocacy And Prevention Programs: Final Report for OPAN 17 Nov 2017 <http://bit.ly/2UgPKoB>

Related articles:

- It's hard to think about, but frail older women in nursing homes get sexually abused too. The Conversation 22 Nov 2018 <http://bit.ly/2FVXbyl>
- Redressing quality and safety in aged care Hospital and Healthcare 13 Nov 2018 <http://bit.ly/2Q6CHaF>
- Violence between residents in nursing homes can lead to death and demands our attention The Conversation 14 Nov 2017 <http://bit.ly/2SpFLLL>
- Identifying Institutional Elder Abuse In Australia Through Coronial And Other Death Review Processes, Macquarie Law Journal Vol 18 page 35 2018
- Nature and Extent of External-Cause Deaths of Nursing Home Residents in Victoria, Australia Ibrahim J et al JAGS 2015 pages 1-9
- Elder abuse in New South Wales Legislative Council General Purpose Standing Committee June 2016 <http://bit.ly/2QaAISA>
- Elder Abuse— A National Legal Response Final Report ALRC May 2017 <http://bit.ly/2t3Gkjm>
- Violence, abuse and neglect against people with disability in institutional and residential settings Senate Community Affairs References Committee Report Nov 2015 <http://bit.ly/2RvgNui>

OPAN was given \$2 Million by the government⁴⁴ to develop an elder abuse prevention program. The program was finalised at a meeting in February 2018 and documented in a report ***‘Abuse of Older people: A Community Response’***⁴⁵.

The group who worked together on the program comprised five advocacy groups and COTA, the smaller community group that sits on NACA, gets most of its funding from government and has become the public face for older Australians in promoting government policy.

Participants at the forum included industry bodies LASA and ACSA as well as COTA. Government departments were there as observers.

From one point of view these groups can be seen as interested parties, but to skeptics this was big brother making sure that the money went where they wanted it and was not going to embarrass their vested interests.

It is therefore interesting to see how the issue of elder abuse in nursing homes was addressed. The government who were funding it and the industry who provided aged care were both likely to be embarrassed by findings of abuse. Both were either participants or observers at the meeting.

When we read the report we found that the issue of abuse in nursing homes was discounted and largely ignored.

The report states that *“The financial exploitation of older people is the most common reported”* and suggests that *“the vast majority of elder abuse occurs against those older persons not living in an aged care facility”*.

It is also interesting the way the issues of staffing, neglect and elder abuse in nursing homes were dodged in the report by claiming it was complex, warning of unintended consequences and that, in the face of the evidence which they are fully aware of, *“aged-care industry peaks do not necessarily support”* the recommendation that optimal aged care staffing levels be determined and published. Even screening employees was likely to have *“negative consequences that may occur if this recommendation is implemented”* etc.

⁴⁴ \$2 Million in Extra Support to Tackle Elder Abuse Ministerial Media Release 8 August 2018 <http://bit.ly/2U2bl3X>

⁴⁵ Abuse of Older people: A Community Response May 2018 <http://bit.ly/2Sl6qcy>

It is difficult not to conclude that the powerful peaks LASA, ACSA, COTA, providers and others involved in the design of the present aged care system, ultimately decided what should be considered to be elder abuse. Government departments were among those listed as observers. It is not surprising no one seriously challenged this.

We are not suggesting that there was any malign intent but that it illustrates the ways in which the interests of the community and what it would want can be subverted by the intrusion of powerful political and commercial forces and their beliefs. The independent wider community were not there to support the advocacy groups who seem to have been constrained by funding and the expectations of the powerful rather than those of the community.

It is the interplay of similar processes and forces that have been responsible for the failure of regulation in aged care.

Recommendation C6: That the point of contact for advocacy be the empowered visitor whose personal knowledge and capacity to examine data and talk to staff will be an asset in resolving issues. Advocacy groups should support and work with the visitor and the local community on whose behalf they advocate for the recipients of care.

Recommendation C7: That elder abuse services capitalise on the local knowledge of the visitors and the community groups involved in managing aged care locally. They should work in close association with and through them.

Part 4: Reviews, inquiries and consultations

We believe that the issues we referred to in Part 4 and in Appendices 3 and 4 in our first submission have been confirmed by subsequent events. We commented briefly on what has happened earlier in this submission where we referred to the Royal Commission expressing hope but some concern.

Part 5: Finding a better way

If we examine society and the history of caring services we can see that these are the product of our humanity and our collective responsibility as citizens – of civil society. It depends on our human capacity to imagine the misfortune of others, empathise, form caring relationships and so develop a sense of altruism as individuals and as community. It is driven, motivated and constrained by the altruistic values and norms that society developed.

We consider that care and assistance to the vulnerable has always been and still remains our responsibility as empathic individuals and responsible communities (civil society). Anyone who provides care is acting as our agents and is directly responsible to us.

A system whose origins lie in a belief in self-interest and the denigration of altruism and the 'collective' has turned this on its head. We are seeking changes that will enable us to exercise this responsibility and ensure that our agents meet our requirements.

Since about 2008 we have made submissions suggesting ways in which aged care can be returned to the control and oversight of our communities and in which government supports and works with communities in this sector - rather than the market. Their interests are often served by exploiting vulnerabilities in the community. Aged care is the most vulnerable. We addressed this in Part 5 of our first submission.

We expanded on this further in Part 3 and 4 (pages 57 to 62) of our submission to the House of Representatives Inquiry into Quality of Care⁴⁶. In an attachment to that submission⁴⁷ we outlined our proposals and then analysed the evidence given to your committee at the public hearing into the failures at Oakden in Adelaide on 21st Nov 2017.

We showed how our proposal would have either prevented, or detected and responded rapidly to what was described. We also examined the Nous and Carnell/Paterson reports. We show that our proposal would address not only the problems they identified but those they overlooked much more effectively than the recommendations they made.

5.1 Further developments

There have been other developments since we made our previous submission. These have revealed pathways through which changes like this might be better introduced.

A systemic problem: What is happening is not unique to aged care. There have recently been several books and many articles analysing what has happened in society and in politics. Analysts have examined the free market (neoliberal) policies responsible⁴⁸.

⁴⁶ Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia (Mar 2018) <http://bit.ly/2l69uZv>

⁴⁷ Community managed aged care. An analysis. Attachment to Submission to Quality of Care Inquiry (House of Representatives) <http://bit.ly/2RJyFla>

⁴⁸ See Appendix 1

Citizens have lost all faith in a system that is bogged down in the 1980s and unable to move forward. This distrust has been called the post-truth era⁴⁹ because so much misinformation has resulted in intense distrust of any information they are given. Confused citizens are vulnerable and anxious. They are grabbing at any conman offering simplistic but attractive ideas. This is an unstable and potentially dangerous state of affairs.

At the same time we have a political system that is characterised by ideological obsolescence and paradigm paralysis – an inability to think in any other way and offer a path forward. This has occurred at a time of rapid change which has left them even further behind. The political system itself does not have a solution to the problems that have been created.

This is not a unique situation and a path forward will eventually come from involved and informed citizens. What is unique is the erosion of civil society and the intellectual limitations that have accompanied it so that society is not ready to assume its role. It is going to be much more difficult as a consequence.

The tragedy of this is that, at a time when our salvation lies in rebuilding and empowering civil society, we are not supporting it and instead are constraining it. The prime minister has criticised and ridiculed students who have become involved and who are protesting about what they see is happening. They are the future and we must embrace and encourage their altruism and involvement.

Referring to what has happened and the way democracy has been kidnapped by the neoliberal discourse a moral philosopher⁵⁰ has asked *“Is there any way to free democracy and citizens from their stealthy, wealthy, elite captors?”*. He then goes on to suggest:

“But the key to renewal surely lies in new democratic mechanisms and forms of citizen participation that are capable of ending the concentrations of power that are kidnapping our democracies and victimising their citizens”.

Others have made similar criticisms and looked hopefully to the community - but with some despair when they realise the difficulties.

Aged care is where the failures in the discourse are most evident and where its legitimacy is most vulnerable to challenge. It is carried out in our communities and in our homes. The service is directly given to our vulnerable fellow citizens, our parents and ultimately ourselves.

It is a sector which more readily than any other lends itself to the rebuilding and re-empowerment of civil society. It is the best place to start on what is undeniably going to be a long and difficult process. There is no other path and politicians ultimately have no option but to acknowledge what has happened and the errors made.

An acknowledgement: We can accept that this was not intentional but what has happened in society and in aged care in particular can no longer be denied. It is not the first time this sort of thing has happened.

The longer this denial goes on the worse it will get. It is not about finding someone to blame but about accepting responsibility for the errors of the past and then engaging with and supporting society as it sorts out the mess. Further denial will be unforgivable, culpable and deserving of community anger.

⁴⁹ Post-Truth Politics And Why The Antidote Isn't Simply 'Fact-Checking' And Truth Sydney Democracy Network 27 Mar 2018 <http://sydneydemocracynetwork.org/article-post-truth-politics-and-why-the-antidote-isnt-simply-fact-checking-and-truth/>

The post-truth era of Trump is just what Nietzsche predicted The Conversation 15 Dec 2016 <http://bit.ly/2zJbhxo>

⁵⁰ Kidnapped democracy: how can citizens escape? Feenstra R A The Conversation 26 Apr 2018 <http://bit.ly/2KhL4ZK>

A way forward in aged care

The Public Guardian in Queensland as well as the Public Advocates in Queensland and Victoria⁵¹ have all made submissions to, and been interviewed by parliamentary committees. They have urged the adoption of an empowered visitors scheme as a pivotal part of the regulatory process – one suggests it should be government funded and the other prefers a voluntary system.

Such a system is still vulnerable to capture by industry and government and, when government funded, can be compromised by pressures from politicians who receive support from and are funded by industry.

In South Australia both the advocacy and empowered state visitors scheme looked past what was happening at Oakden for several years, the latter being taken on guided tours by the facility. It is apparent that they had little contact with the families and communities so did not know what was happening.

An empowered visitors scheme aligns well with our own views. The system in Victoria had influenced our thinking. Some funding particularly of the actual empowered visitors would be desirable. They can be shielded from capture and political interference by drawing the visitors from the largely voluntary community organisations that we are pressing for. This will ensure there are political costs to interference and that failures like Oakden do not occur.

The visitors need to be closely associated with family and community groups so that they hear of any concerns and can quickly and independently follow them up. The community too should be actively involved with older citizens.

While maintaining confidentiality, the empowered visitors would be mentored by skilled people in the community as well as central regulators. They would oversee and assist in data collection by the facilities and report both to the community and government regulators.

This will ensure the collection of adequate data and the transparency that has been so lacking and allowed the problems in staffing to develop (**Appendix 3**). This is the essential data needed to support and validate the *Consumer Experience* surveys. Such data, while valuable in pointing to problems, has been notoriously unreliable in detecting major failure in the USA where it was outsiders and the press that alerted authorities to the exploitation of the vulnerable in health and aged care as well as unnecessary major surgery in hundreds of patients.

Community structures such as the Community Aged Care Hub we have proposed should organise and oversee these activities. As many of the advisory and oversight activities as possible should be moved to these organisations.

⁵¹ **Public Advocate Queensland** Submission to the Standing Committee on Health, Aged Care and Sport Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia February 2018 <http://bit.ly/2UhYI4J>

Queensland Public Guardian. Submission 68 to the Senate Community Affairs References Committee August 2017, Quality of care in residential aged-care facilities in Australia Standing Committee On Health, Aged Care And Sport Hearing 26 April 2018 (Siegel-Brown N, Burgess M,) <http://bit.ly/2DRSPCT>

SIEGEL-BROWN, Ms Natalie, Public Guardian, Office of the Public Guardian Queensland and BURGESS, Ms Mary, Public Advocate, Office of the Public Advocate Queensland to Public Hearing Standing Committee On Health, Aged Care And Sport House Of Representatives 26 Apr 2018 Brisbane <http://bit.ly/2rweufr>

Office of the Public Advocate Victoria Submission 35 to the Standing Committee on Health, Aged Care and Sport Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia February 2018 <http://bit.ly/2Po8X3J>

PEARCE, Ms Colleen, Public Advocate, Office of the Public Advocate Victoria to Standing Committee on Health, Aged Care and Sport Public Hearing 6 March 2018 Melbourne <http://bit.ly/2QBP2D5>

As indicated earlier the Quality Agency's own data shows how ineffective centralised oversight and intermittent inspections are and that they need other sources of information in order to be effective. The visitors and community groups would be a very effective early warning system in informing the regulators.

Social control and the development of discourse

The community should have a working relationship with managers in the sector and should engage regularly with them. The normal processes of social interaction and social control that have been eroded by the neoliberal discourse must be rebuilt.

In functioning capitalist democracies it is the social control through informal relationships and discourse that is most effective and nuanced in detecting aberrant ideas and practices, and in addressing any failures at source.

Communities need the support and guidance from academics and government but it is the discourse and influence coming from those close to care who see what is happening that addresses issues. It is the power created by an effective and organised 'collective' of which they, as customers and responsible citizens, are a part which drives this into the board room and into policy.

The much less sensitive formal regulatory process is needed for when this fails but in a system that is functioning well it would rest lightly. Braithwaite put this well⁵².

It is possible to have formalism that empowers and enables informal social control to work flexibly, in all its rich, innovative, contextual possibilities for variety.

Resources

As a community we are living longer and after retirement most of us still have 15 to 20 years of productive life remaining. We have a large resource of experience some of it in other social services, caring professions and even aged care to draw on.

Personal identities that have been built on individual effort (selfish selves) have nowhere to progress. These people are in a position to develop their social selves through new activities and understandings. Involvement stimulates further learning, interest and social engagement. This is far more effective than centralised efforts to "educate the public".

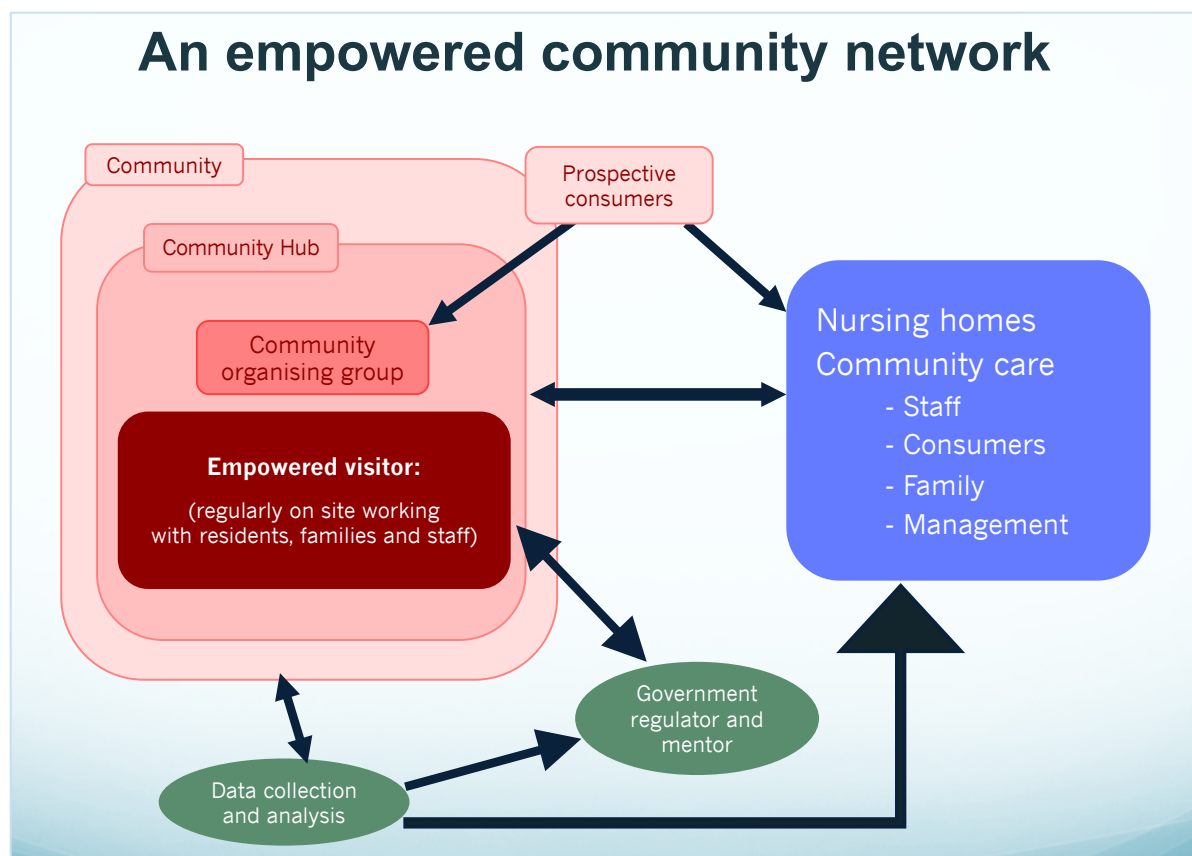
We have a pool of idle skills and experience to draw on that is currently being squandered.

Setting in train such a process

We are pressing for the adoption of a regulatory process built around and supporting an empowered visitors scheme (see chart below). These visitors should be drawn from the communities and be a part of community groups who would assume many of the functions of the current system in dealing with families and residents, informing, advising and supporting.

It is here that information, advice, advocacy, complaints and regulatory oversight services would benefit from integration. It would create a context within which these services would be readily accessible, and where available information would be more effectively evaluated and used.

⁵² Braithwaite J et al *Regulating Aged Care*, Edward Elgar Publishing Limited 2007



We envisage that empowered visitors would be regularly on site and would be working with staff. They would be involved in handling complaints and other issues that arise in the facilities. They and the community would be in a position to work with their agents, the providers of care - to assist them and ensure that together they are providing the service that they expect to the best of their ability. When political changes are needed this would bring the community in to support and advocate for it.

This is a constructivist, cooperative and supportive approach and not a confrontational one.

Organising aged care: While this is not a regulatory issue, the centralised MyAgedCare website and central organisation is process driven, cumbersome and not friendly. People fall through the cracks.

A study in Europe⁵³ has noted that, while it stimulated providers to perform better, only 12% of families in the USA use the Nursing Home Compare web site when selecting a nursing home. Hospitals often did not use it either when placing patients.

The authors examined what was happening in 7 countries in Europe and found that most sought the *“advice of family and friends, social services, visits and chats with care staff, and feedback from other users and their relatives”* and did not use internet services. This is compatible with other research and with an understanding of the nature of humankind.

As we have indicated current policy is based on a misunderstanding of the nature of man and society that emerged as a powerful force in the mid 20th century. This must be addressed if we are to move forward this century and building community is vital to progress.

⁵³ The public gets what the public wants: experiences of public reporting in long-term care in Europe Rodrigues R et al Health Policy, 116 (1). pp. 84-94. ISSN 0168-8510

In 2016 one of us reviewed the relevance of a 2001 paper prepared for the Australian Health Institute at the University of Sydney by Kendig and Duckett. This described the considerable advantages in providing and paying for services by local integration and managing funding locally⁵⁴. This should be reconsidered.

We know that in aboriginal services and when providing aid⁵⁵, the involvement of community in the design, management and control of the service is critically important to success. It is the involvement that brings ownership and builds social selves that motivate. The evidence that this sort of thing works indicates that it is likely to do so in aged care as well.

Recommendation E: That central organisations gradually relinquish their controlling role and organise themselves as training, mentoring, support and backup organisations for local services - delegating services whenever possible and only stepping in when local services need help or cannot manage.

Recommendation E1: That accreditation be replaced with a new restructured regulator in the newly formed “Aged Care Quality and Safety Commission”. That the Commissions central integration be reflected in its new local responsibilities. That it lead the way in delegating and integrating its regulatory and oversight activities locally, but retain responsibility for imposing sanctions.

Recommendation E2: That the management of finance be reviewed with a view to working through local communities as their knowledge and sophistication grows.

Recommendation E3: That the advising and informing of residents and families as well as assessing prospective residents be done locally when possible, increasing as sophistication grows.

Recommendations E4: That there be supervisory visits as well as audits and other assessments as needed and they be conducted in cooperation with the visitors and local hub whose data would form the basis for decisions. Most regulatory audits are likely to be a response to concerns and information from the visitors.

⁵⁴ Section ‘Advice that was ignored’ on web page ‘Response to early failures’ Inside Aged care July 2016 <http://bit.ly/2KXP6be>

Original article: Australian directions in aged care: the generation of policies for generations of older people. Kendig H and Duckett 2001. <http://bit.ly/2AW21pp>

⁵⁵ Partnering with consumers: national standards and lessons from other countries Stephen D Gill and Melinda Gill. Med J Aust 2015; 203 (3): 134-136 <https://www.mja.com.au/journal/2015/203/3/partnering-consumers-national-standards-and-lessons-other-countries>

Recommendation F: That an empowered visitors scheme be set up and that these visitors be appointed from within local community groups or, if not present, would set out to create local community groups of skilled people and others with interest or past experience in aged care or similar services.

Recommendation F1: That legislation be passed to give visitors the powers needed.

Recommendation F2: That visitors and the central community hub work closely with residents, families and community as well as staff and liaise regularly with local management to discuss issues. They should become the local source of information.

Recommendation F3: That the oversight of care, the collection of data, the handling and resolution of complaints and advocacy be the responsibility of the visitor supported and assisted by skilled people in the community, mentored by central government and reporting to the central community hub.

Recommendation F4: That the visitor and hub be trained, mentored and supported by the central organisations as well as available local medical, nursing and other expertise.

Recommendation F5: That the hub and visitor be responsible to and report transparently to both their local communities, central organisations and government.

Recommendation F6: That the local hub working with the visitor act as an integrator and controlling body for aged care in the region and liaise with other services such as health care and disability services.

Appendix 1: The origins of current free market belief

In our first submission in 2017 we used Foucault's insights (*Pages 24-25 and Appendix 1 starting on page 96*) into the nature of discourse as a framework for explaining and understanding the way the patterns of ideas that lie behind policy became so powerful and influential. This resulted in an illogical one-size fits all approach to policy. This ignored the consequences for society and in particular aged care.

Update: Our further research reveals that this discourse was built on the thinking of a populist philosopher, Ayn Rand, and an economist Milton Friedman who had similar ideas. She had a very negative attitude towards and condemned society and the control it and its values exerted over individuals and the marketplace⁵⁶. She described it as collectivism.

Collectivism is the tribal premise of primordial savages - - -

*-----
If man started as a social animal — isn't all progress and civilization directed toward making him an individual?*

Her philosophy placed individual self-interest above society, praised selfishness and condemned altruism and social responsibility. A recent critical article⁵⁷ examined the growing influence of her books and ideas in the political and business worlds. It claimed that "*her hand is guiding the rulers of our age*", particularly President Trump and his circle. It indicated

Hers is an ideology that denounces altruism, elevates individualism into a faith and gives a spurious moral licence to raw selfishness.

Economists, led by Friedman picked up many of these ideas and promoted them. Friedman asserted⁵⁸.

- - the doctrine of "social responsibility" - - - does not differ in philosophy from the most explicitly collectivist doctrine

*-----
I have called it a "fundamentally subversive doctrine" in a free society,*

*-----
- - - there is one and only one social responsibility of business – to use its resources and engage in activities designed to increase its profits so long as it stays within the rules of the game.*

This 'insight' became so popular and his influence so great that Friedman was awarded the Nobel prize for economics.

These ideas strongly influenced both President Reagan in the USA and Prime Minister Thatcher in the UK. Friedman was an advisor to both. They were introduced into politics and into the discourse that formed the basis of a revival of free market (neoliberal) policies. They were adopted across the world.

⁵⁶ This is what happens when you take Ayn Rand seriously PBS News Hour 18 Feb 2016 <https://to.pbs.org/2EgQfdA>

⁵⁷ The new age of Ayn Rand: how she won over Trump and Silicon Valley. The Guardian 11 April 2017 <http://bit.ly/2FXiwHw>

⁵⁸ Two Paradigms of Capitalism : Ayn Rand and Milton Friedman <http://bit.ly/2zMaZpH>
The Social Responsibility of Business is to Increase its Profits NY Times 13 Sept 1970 <http://umich.edu/~thecore/doc/Friedman.pdf>

The central tenet was that individual effort and particularly the market were the driving force in society and that any sort of constraint and regulation impeded this. Small government and minimal if any regulation became core beliefs. Society lost its legitimacy and has been described as hollowed out.

Aged Care previously constrained by values and expectations, and subject to processes of social control was 'liberalised' and restructured within this new discourse – one that condemned altruism and social responsibility.

Neoliberalism's end days?: Unsurprisingly modern economic critics now describe Friedman's ideas as the 'world's dumbest idea'⁵⁹. Criticism of "*the Anglo-American celebration of 'possessive individualism' and its repudiation of community and society*"⁶⁰ is growing rapidly with claims that neoliberalism has "*started to self-destruct*" and assertions that

"The time is ripe for some creative imagining of a new post-neoliberal world that will repair neoliberalism's vast and catastrophic failures while laying the groundwork for an Australia that can play a leading role in the making of a cosmopolitan and co-operative world".

Many see a new and better future in "*the enlivening of international civil society*". The resurrection of civil society is the only way out of this that anyone is offering. It seems to be the only way forward, particularly for human services but that is anathema to neoliberal fundamentalism⁶¹. It won't be easy but we need to start somewhere and soon. The frail elderly have suffered more than any other sector and we argue that aged care is where the rebuilding of civil society should start.

But first we need to consider what the consequences have been for society and how aged care fits into that context. If we are to finally address the serious problems that exist we cannot isolate aged care from the context within which it operates when that context is the source of the problems. We have to take that head on too. That means rebuilding and placing civil society in a position where it controls what happens in this aged care marketplace – and then help to globalise that change.

⁵⁹ The Origin Of 'The World's Dumbest Idea': Milton Friedman by Steve Denning Forbes Leadership 26 Jun 2013 <http://bit.ly/2SkvnF8>

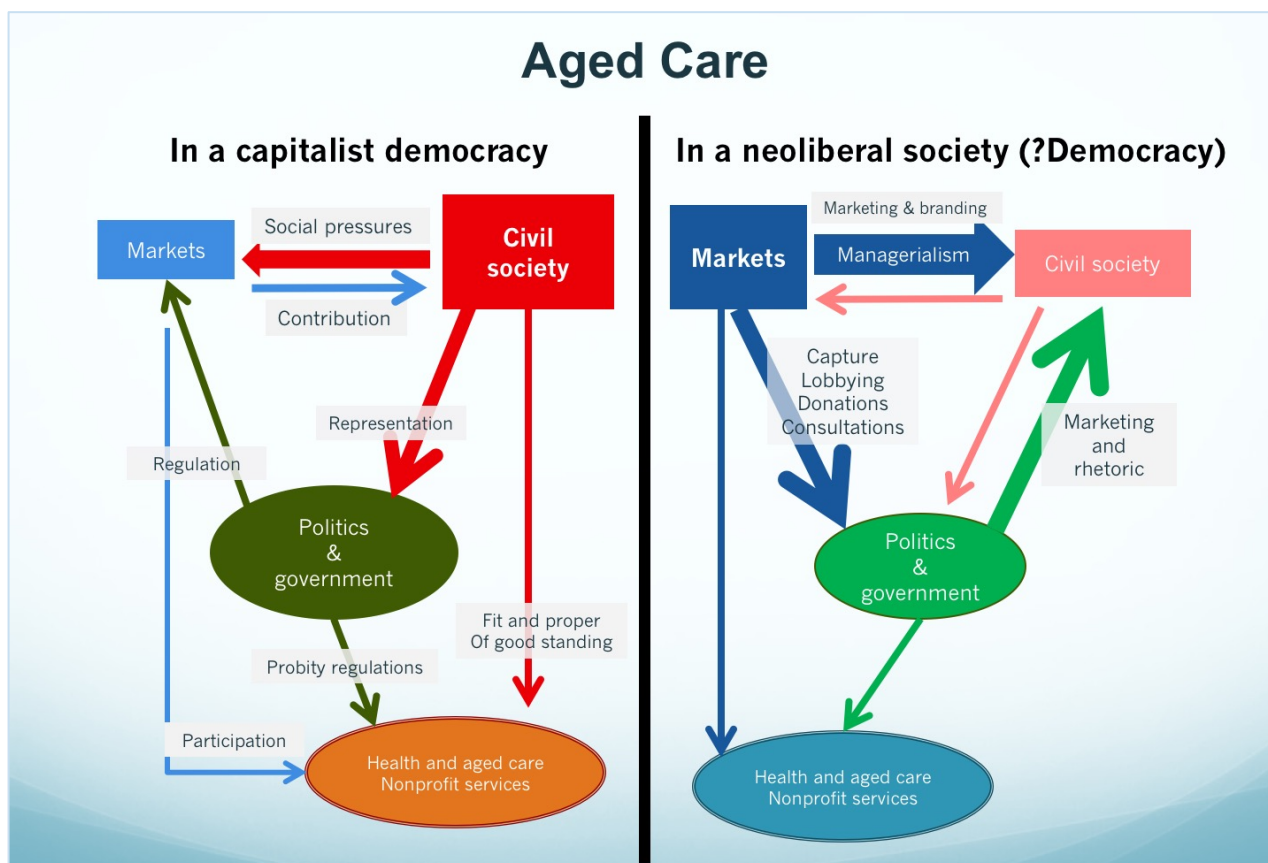
⁶⁰ If we are reaching neoliberal capitalism's end days, what comes next? The Conversation 6 Feb 2017 <http://bit.ly/2SpDeRL>
Even the IMF Now Admits Neoliberalism Has Failed Fortune 4 June 2016 <http://fortune.com/2016/06/03/imf-neoliberalism-failing/>
Neoliberalism – the ideology at the root of all our problems The Guardian 15 April 2016 <http://bit.ly/2FSuQJ6>

⁶¹ When Will 'The World's Dumbest Idea' Die? Steve Denning Forbes 5 July 2013 <http://bit.ly/2QgN8IT>

The broad consequences for society

In the diagram below we have tried to conceptualise the main features of a responsible capitalist democracy and compare/contrast it with a neoliberal state to show the impact that this philosophy had. The different colours represent the primary participants, markets, civil society and government.

The size of the boxes/ovals and arrows, and the intensity of the colours represent their status, power and influence, as well as the strength of the social forces that operate. It shows how aged care was moved from its societal context where it was controlled, to a market context where it was ineffectively controlled by a central regulator who did not believe in regulation.



Contradictions: The care of the vulnerable in aged care has traditionally been, and we believe still should be, the responsibility of every citizen as an individual and as part of a responsible collective (civil society). It has been underpinned by our capacity to imagine the life of these others and empathise with them. It depends on the altruism that this empathy creates and the caring relations that are formed as a consequence.

Since the 1990s it has been appropriated by a system whose origins and design was underpinned by a rejection of any sort of collectivism, of altruism and of social responsibility. There was little room for caring relationships. We should not be surprised that the adverse consequences for society and for vulnerable sectors like aged care have been profound.

Coping with contradictions: Despite its origins and design structure, the neoliberal systems credibility depends on persuading others that it does embrace the traditional approach to care and those providing that care have to persuade themselves that this is so.

Today few in the sector would identify with the original philosophical tenets of selfishness, and the rejection of altruism and social responsibility. Most would claim to be motivated by values and to be serving society and they need to convince the public of this.

The structures set up left little room for the expression of any of this and none of it was profitable. The response in this situation has been to tokenise and ritualise, then retreat into process in order to maintain belief and limit conflict.

There is nothing new about this situation. Psychologists, sociologists and philosophers have over the last two centuries analysed and described the strategies individuals use to cope with and prosper in situations like this even when what they are doing is harming others.

Appendix 2: Quality Agency assessments

The following content is derived from our submission to the House of Representatives Inquiry into Quality of Aged Care (pages 27 to 37 of our published submission)⁶².

In this we did an analysis of the performance of accreditation visits using data from a Quality Agency presentation and from 'Regulatory Performance Data' supplied to the senate review of the agency. We compared the Agency's findings when assessing performance in areas where other data shows there are major failings. We show how ineffectual the process has been and that unannounced visits have in the past been only marginally better than announced visits

2.1 Quality Agency assessments

The Quality Agency's own data shows the lack of utility of the inspections performed by the Agency.

The source of information that resulted in adverse findings

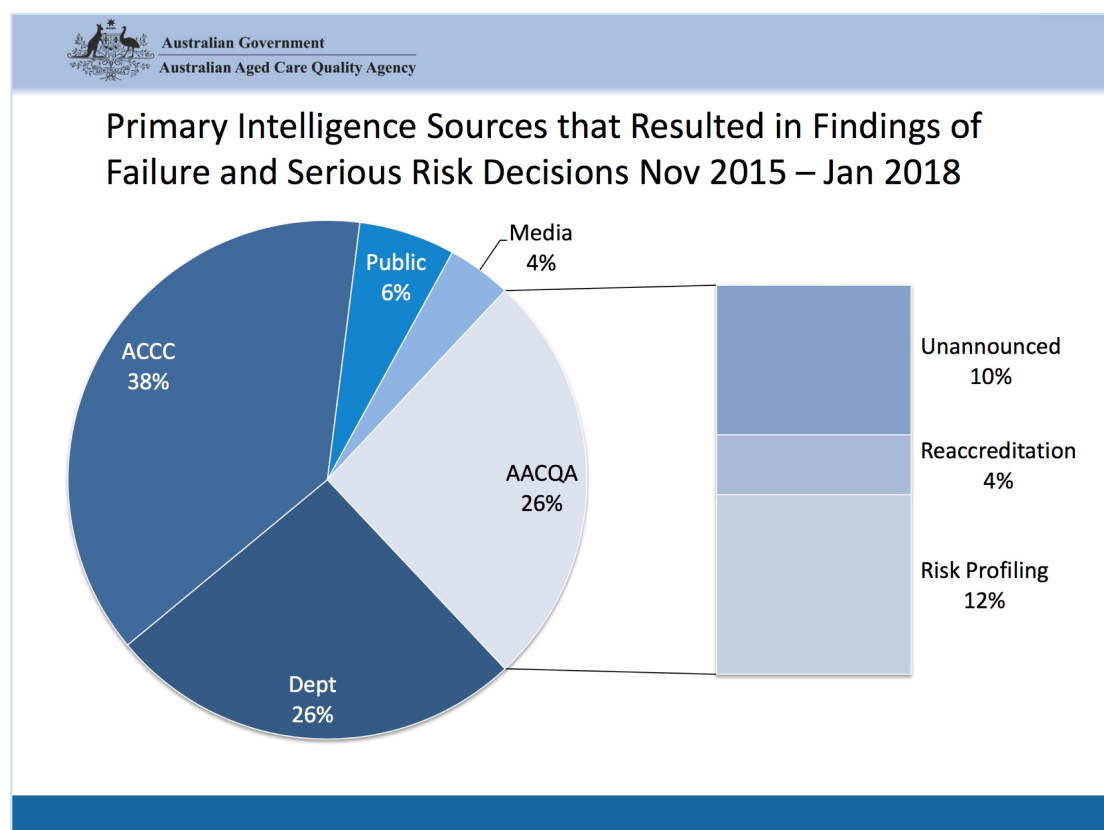
Data drawn from Nov 2015 to Jan 2018 (just over 2 years) were presented to industry at a LASA conference by the Quality Agency in 2018⁶³. This shows that in the vast majority of cases problems were only found when the agency had been told about a problem. They did not discover it themselves.

The **Primary Intelligence Source** for 74% of the *"findings of failures and serious risk decisions"* came from other outside sources including the Complaints Commissioner (38%), the department (26%), directly from the public (6%) and the Media (4%).

All of this information would have come indirectly from someone (families, friends, staff etc.) who knew or saw what was happening and who lodged a complaint, spoke to the department or perhaps to a politician.

⁶² Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia (Mar 2018) <http://bit.ly/2l69uZv>

⁶³ Presentation: Lessons from Regulatory Case Studies - Ann Wunsch, Quality Agency to LASA conference, Feb 2018: <http://bit.ly/2FeMeWT>



Source: Lessons from Regulatory Case Studies, Quality Agency, presentation to LASA conference Feb 2018 <http://bit.ly/2FeMeWT>

Only 26% of the findings were initially identified by the agency. In 12%, risk profiling and not their inspection alerted them to problems. Only 4% were detected at re-accreditation visits and 10% at unannounced visits.

The loudly trumpeted Carnell/Paterson reform to move all oversight to unannounced visits, which discovers only 10% of failures is not convincing.

Detection of problems by agency visits

Data from this same presentation gave the number of visits and the number of occasions when a problem was identified.

Another report titled *Regulatory Performance Data*⁶⁴ supplied to the Senate inquiry into Oakden gave more information for the financial years 2013/14 to April 2017 - just under 4 years so almost double the time although the two sets of data overlap. The percentage of failures found has been calculated for both in the table below:

Type of visit	Presentation (Nov 2015 to Jan 2018)		Report (2013/14 fin yr to Apr 2017)	
	Number	Failure detected	Number	Failure detected
Reaccreditation	1001	33 (3.3%)	3146	69 (2.2%)
Review audits	70	40 (57%)	90	70 (78%)
Announced contacts	816	11 (1.3%)	3507	46 (1.3%)
Unannounced contacts	4616	84 (1.8%)	11362	169 (1.5%)

⁶⁴ "Regulatory performance data" part of AACQA submission (number 42) Aug 2017 to Senate Inquiry "Effectiveness of the Aged Care Quality Assessment and accreditation" <http://bit.ly/2Fex0Bk>

- Note that **Review audits** are performed in response to information supplied to the agency and here the finding of failure was much higher 57% and 78% respectively.
- In contrast, re-accreditation audits yielded 3.3% and 2.2%
- Announced assessment contacts yielded 1.3% in both
- Unannounced assessment contacts yielded 1.8% and 1.5%

When visits were unannounced this increased the chances of detecting problems by only 0.5% and 0.2%. Compare these figures with the 93% detection annually in the USA - and 20% were serious.

The *Regulatory Performance Data* report also gave the number who had failed each standard. We have expressed them as a percentage of the total of all assessment visits made including audits (18,105) during the four-year period.

We concentrate here on important clinical indicators because there seems to be so little interest in and knowledge of clinical issues at all levels of the regulatory process. There are claims that assessors have little, if any clinical knowledge, that “*dozens of aged-care executives are moonlighting as inspectors*” and that many others assessors are also consultants to the industry⁶⁵. We wondered why the Quality Agency had recently removed assessor’s names from their public reports.

There is no data about clinical outcomes that these untrained assessors can use as a benchmark when deciding what is acceptable. Clinical issues and clinical outcomes are simply ignored and there seems to be a dearth of clinical knowledge and skills. Some examples illustrate this.

Standard	Number in 18,105 assessments	Percent detecting a problem	Clinical incidence
Medication Management	86	0.47%	
Pain Management	29	0.16%	
Nutrition and Hydration	24	0.13%	40 to 80% malnourished
Skin Care	31	0.17%	Pressure injuries in 2005 = 26 and 44%

Medication and pain management are two of the most criticised outcomes and are dependent on staffing skills and numbers, which we know are deficient. This claimed low incidence of failures (0.47% and 0.16%) if real would be way beyond any other country - world-class care beyond what is possible.

But this is not what is being measured here and one wonders at the utility of these measurements – other than as a marketing and branding exercise for the industry.

Pressure injuries and malnutrition are interdependent clinical issues. Malnutrition predisposes to pressure injuries and the loss of fluid, inflammation and sepsis associated with pressure injuries have a “catabolic” effect (breaking down tissues) which increases malnutrition and makes it much more difficult to treat. Both have a devastating impact on quality of life and mortality. The incidence of both can be markedly reduced by sufficient staff with knowledge and motivation.

⁶⁵ Aged-care executives two-timing as auditors, in potential conflict of interest, Courier Mail 20 Feb 2018 (paywall) <http://bit.ly/2oHwzVF>

Pressure injuries are largely preventable with adequate trained staffing and **Malnutrition** can be kept to a minimum with good tasty food and enough attentive staff. Clearly the assessors are not looking at the residents or their charts and/or have not got the basic clinical nous to look at what is happening. To be even remotely credible, an assessment of care must include a clinical assessment of the residents receiving it and that cannot be happening.

2.1.1 Example: Pressure injuries

To appreciate the problem, we need only ask about the incidence of pressure injuries, one of the strongest indicators showing that nursing care is deficient.

In giving a speech in 2017, the Minister quoted an incidence of 32%⁶⁶. When his speech was transcribed on the department website, it appeared as 10.3%⁶⁷. When his advisers were asked for the source of these varying figures, the 10% figure was removed from the transcript⁶⁸.

When pressed, they then referred to figures between 3.4 and 5.4%⁶⁹ that were quoted in 2006. These were in fact, figures taken from the 1990s when staffing was better (and tied to funding) and state regulators were rigorous.

The most recent figures Aged Care Crisis could find were quoted in 2009 but came from studies done in 2004 and 2006 that examined data from 2003 and 2005. The actual figures 8 years after the 1997 reforms were 26 and 46% (average 34% close to the minister's figure of 32%).

If these figures are correct, then the 8 times jump from 4.4% to 34% only 8 years after the system was changed is alarming. We can only wonder what they are now. But alarm bells did not ring and instead of addressing it and monitoring progress it was ignored.

In the USA they collect data from 15,000 nursing homes each year and the average is currently 6%. There is a vast database of information in the USA that we can learn from but we need to know what our own figures are to do that. The only conclusion a sensible person can reach is that the industry knows but is not telling.

Pressure injuries are one of the voluntary quality indicators being collected but not published. It depends on enough staff who recognise its significance and know how to prevent it which can be done most of the time. Someone must know what the average number in this selected group are, but no one is saying. The nurses are telling us about it but no one is listening.

For example, in a submission to the Carnell/Paterson Inquiry a nurse who was a clinical consultant was very critical of the care given and of the failure of the accreditation process, which was described as 'deeply flawed'⁷⁰.

The consultant wrote "*I witness appalling standards of care on a daily basis*".

⁶⁶ Minister's speech - AACQA - Better Practice Conference, Oct 2017 - find video excerpt: <http://bit.ly/2CFnkQ1>

⁶⁷ Minister's speech - AACQA - Better Practice Conference, Oct 2017 - original publication (pg 4): <http://bit.ly/2Aozvdl>

⁶⁸ Minister's speech - AACQA - Better Practice Conference, Oct 2017 - updated speech transcript: <http://bit.ly/2IU6iDj>

⁶⁹ 2006 RACGP Silver Book: <https://www.racgp.org.au/your-practice/guidelines/silverbook/common-clinical-conditions/pressure-ulcers/#216>

⁷⁰ Submission Response 617437173 to Carnell/Paterson Review: <http://bit.ly/2DZ6hrT>

In writing about Skin Care:

I attended a recently accredited facility. While all their wound care documentation was satisfactorily completed, further investigation revealed that:

- ***Over 60% of bed-bound residents had serious pressure injuries***
- *Over 90% of incontinent residents had skin rashes and fungal infections*
- *They were using inappropriate wound care products and techniques*
- *All wounds had deteriorated since they were first identified due to incorrect care practices*
- *Simple skin tears became chronic ulcers. Pressure injuries deteriorated into wounds that are commonly found in third world environments.*
- *The facility simply accepted their high rate of these preventable injuries and had not actioned any alternative strategies*
- *I'll wager \$1000 that in any facility I attend, at least 50% of the air pressure mattresses will be either set incorrectly or malfunctioning. Most of them will have broken parts and have not been serviced for many years. Care staff have not been trained in their correct use.*

The Agency's own data reveals that in a little under four years from the 2013/14 financial year to April 2017 the Quality Agency did 18,105 assessments of nursing homes.⁷¹ During this period the Agency detected 31 problems in skin care – just 0.17% of visits.

Pressure injuries have dressings on them and are recorded in the notes so are easy to detect and evaluate. Facilities are accredited without looking at either. This is a vast amount of effort and money wasted for no purpose.

⁷¹ **Regulatory Performance Data April 2017** attached to Quality Agency submission to Senate Committee Inquiry into the Effectiveness of the Aged Care Quality Assessment and accreditation framework. . August 2017 <http://bit.ly/2Fex0Bk>

2.1.2 Example: Malnutrition

Malnutrition is a good example of what is happening and the ineffectiveness of our regulation. There has been recent publicity about malnutrition and research to support its incidence.

The importance of malnutrition in undermining wellbeing, predisposing to multiple medical problems and limiting quality of life has been largely ignored. In 2010 the Dietitians Association of Australia indicated⁷² that:

Nutrition status largely determines quality of life, independence and overall health of older adults - - - -. Despite the importance of nutrition, there is no current food and nutrition policy for Australians, let alone for older Australians.

- - unintentional weight loss places individuals at greater risk for clinical complications such as increased risk of falls and fractures; increased risk of osteoporosis, infections and pressure ulcers; increased rates of depression; decreased mobility, morbidity and mortality; delayed healing from acute episodic events, prolonged and increased frequency of hospitalisation and decreased quality of life

The association indicated that *“Malnutrition is recognised by DAA as the major nutritional concern amongst older Australians”* and that it was *“associated with adverse clinical outcomes and costs”*. In spite of this *“there is no coordinated approach to addressing the issues of older Australians”*. They recommended that *“the Commonwealth monitor nutritional status across the aged care system and report on the prevalence of malnutrition”*. This has not happened.

Measuring Malnutrition: The incidence of malnutrition varies with the type of assessment used but the most reliable seems to be to record the *“percentage of weight loss over a specific period”*⁷³ with over 5% in a month or 10% in 6 months raising concern. That should be readily accomplished. A literature review shows wide variation in incidence but indicates that approximately 20% of residents in nursing homes have malnutrition⁷⁴.

Factors influencing malnutrition included *“food budget, staffing, social activities, and family bringing meals to residents”*. The *“association between malnutrition and mortality among nursing home residents is especially clear”* and the literature *“clearly indicates that malnutrition leads to earlier mortality”*. In addition *“staff training studies demonstrated clear benefits on malnutrition indices.”* Low staffing levels are associated with malnutrition⁷⁵.

Incidence in Australia: The incidence varies across Australia. Most accept that about half (50%) are malnourished. A poster presentation in 2005⁷⁶ suggested a prevalence *“of malnutrition in the elderly appears to be disturbingly high: between 40% to 60% and as high as 85% has been reported”*. Those recently hospitalized, living alone or in residential care are at most risk. They found that *“Less than 10% of residents were seen by a dietitian and 19% were seen by a speech pathologist”* and *“only 20% were weighed monthly”*. They commented on the lack of skill among staff and time pressures as problems.

⁷² Submission from the Dietitians Association of Australia to the Productivity Commission: Caring for Older Australians 10 Aug 2010 <https://www.pc.gov.au/inquiries/completed/aged-care/submissions/sub371.pdf>

⁷³ Prevalence and Measures of Nutritional Compromise Among Nursing Home Patients: Weight Loss, Low Body Mass Index, Malnutrition, and Feeding Dependency, A Systematic Review of the Literature C.L. Bell et al. / JAMDA 14 (2013) 94e100

⁷⁴ Malnutrition in the nursing home Bell C L, Lee A S W, Tamura B K www.co-clinicalnutrition.com Volume 18 Number 1 January 2015

⁷⁵ Low staffing level is associated with malnutrition in long-term residential care homes J Woo, I Chi, E Hui, F Chan and A Sham European Journal of Clinical Nutrition (2005) 59, 474–479

⁷⁶ Aged Care Nursing and Nutrition Issues Gaskill D et al. (2005) Aged care nursing and nutrition issues. [poster]

A 2007 study of 6 nursing homes in Queensland found “*a median of 50.0% and 49.2% of residents of aged care facilities were found to be malnourished*” in two separate audits. Another in 2008 of 8 nursing homes and 350 residents found “*43.1% moderately malnourished and 6.4% severely malnourished*”.⁷⁷

A 2014 study of nursing homes in Canberra⁷⁸ found a lower figure reporting “*20% as moderately malnourished, and 2% severely malnourished*” but this study excluded high-risk residents including those who were cognitively impaired and medically unfit. This is a significant proportion of residents who are likely to be malnourished, so that the studies are not really comparable. What is clear is that the incidence in Australia is higher than the 20% found in comparable countries.

Profit, food and nutrition: Groups of dieticians and citizens such as The Lantern Project⁷⁹ have taken a proactive approach by trying to encourage and persuade providers to do the right thing and motivate them to improve the diet for residents by making it more nutritious and attractive. They are well aware that motivation is constrained by commercial imperatives.. Their own study⁸⁰ working with SB has examined just this issue. It reveals that in Australia nursing homes on average spend only \$6.08 on “*the raw food and ingredients budget*”. This was much less than in other countries as well as the budget for food in prisons.

As cost of living and so food increased over the two years of the study the budget for fresh food had decreased by 30 cents per person per day. This has been accompanied by an increase in food supplements which are less effective in addressing malnutrition. The authors indicate that “*Increasing the aged care profit margin by reducing food spend impacts the quality of resident care and can contribute to malnutrition rates in aged care*”.

The incidence can be reduced: In another study⁸¹ affirming that half of all residents were malnourished and that this was in part due to inadequate dietary intake, the authors showed that a variety of strategies “*can help prevent decline in residents’ nutritional status. Food and nutritional issues should be identified early and managed on admission and regularly in the RAC setting*”. They affirmed that nursing staff’s inability to “*identify and recognise malnutrition as a formidable problem in the RAC setting results in them not prioritising nutrition care for the residents*”

Publicity: The report that only \$6.08 was spent on food each day was picked up and ran in the press⁸² stimulating the president of the AMA to comment that “*My children’s guinea pigs get fresh*

⁷⁷ **Prevalence of malnutrition in adults in Queensland public hospitals and residential aged care facilities** Banks M et al Nutrition & Dietetics Volume 64, Issue 3 September 2007 Pages 172–178

Malnutrition prevalence and nutrition issues in residential aged care facilities Gaskill D et al, Australasian Journal on Ageing Volume 27, Issue 4 December 2008 Pages 189–19

⁷⁸ **Malnutrition prevalence and nutrition issues in five Australian Residential Aged Care Facilities.** Kellett J et al 13th National Conference of Emerging Researchers in Ageing Conference Paper Nov 2014

⁷⁹ **The Lantern Project** <http://thelanternproject.com.au/>

⁸⁰ **The Lantern Project’s Value Study** <https://vimeo.com/237917664>

What does it cost to feed aged care residents in Australia? HUGO C et al, Nutrition & Dietetics 2018; 75: 6–10

⁸¹ Agarwal E. **Optimising nutrition in residential aged care: A narrative review:** Retrieved from <http://dx.doi.org/doi:10.1016/j.maturitas.2016.06.013>

⁸² **Prisoners and pets fed better than people in aged care homes** Courier Mail 11 Feb 2018

Nutrition in aged care facilities. AMA President, Dr Michael Gannon, Channel Nine, Today Show with Louise Momber, 12 February 2018 <https://ama.com.au/media/transcript-dr-gannon-channel-9-today-nutrition-aged-care-facilities>

Fish nuggets, sloppy beef stew, liquid lemon jelly and chunks of sausage with gravy: Nursing home workers share appalling photos of \$6 meals dished out to elderly residents Daily Mail 13 Feb 2018 <http://dailymail.com.au/2CB779v>

Weighing Up The Aged Care Costs Letters to the editor: Courier Mail 15 Feb 2018

Aged care providers must prioritise care over cash The Daily Telegraph 20 Feb 2018: (paywall) <http://bit.ly/2sluLkC>

ingredients and more money spent on them. It's a national disgrace the way we treat our aged."
Others compared this with company profits.

Many supplied photos which were published. Some family members described their own experiences including their first meal.

"Then the evening meal arrived. It comprised two cheerios, with nothing else on the plate. Perhaps Mum no longer cared much about what she was given to eat. Certainly, she did not complain.

I saw many other woeful meal offerings there, but the image of that first dinner still brings me to tears. Food to meet the nutritional needs of residents? Hardly.

Despite our efforts to find an appropriate facility, I felt we had failed Mum".

The response: The industry response⁸³ was interesting drawing on the infallibility of the Quality Agency where *"nutrition is a key consideration in this process"*, indicating that *"Malnutrition Screening Tool (MST) is employed in all facilities"*, that elderly women *"have a much lower calorie requirement"* than prisoners, and that it is *"not true to say that aged care providers are making huge profits"*. We have repeatedly stressed the very different interpretations put on facts by those whose view of the same events is based on very different 'discourses' (patterns of thought). This illustrates the point well.

The Quality Agency and regulation: So where was the Quality Agency during all of this and what was it doing about this? During the just under 4 years when they performed 18,105 assessments of one sort or another, they only found 24 failures in hydration and nutrition. Although 50% of residents were malnourished, they found a problem in only 0.13 of these visits. This does not sound like a rigorous process that anyone could depend on! Was this because their staff have no clinical knowledge, because it was tick and flick, or because their job was to keep a lid on things and not rock the boat?

Explaining it to parliament: The issue of food, nutrition and cost cutting has been going on for years. There were university studies and press reports in 2010. The previous CEO of the agency was grilled about this by the Community Affairs Legislation Committee⁸⁴. When asked about *"accreditation standards for food"* he indicated that in the previous year *"we identified 40 homes with noncompliance in nutrition and hydration"*. When pressed he admitted that *"No-one actually regulates what they can and cannot do eat"*. When pressed about *"who regulates foods, and who is responsible for this in nursing homes that receive subsidies"* the answer was that it was not the department or federal government.

The accreditation process assessed **"performance against the standards which take into account nutrition and hydration"**. The questioning senator stressed that the research findings were quite explicit and revealed *"very serious circumstances."* She asked specifically *"Do you measure nutrition levels as part of the accreditation process, Mr Brandon?"*.

The answer was:

"No, we do not measure nutrition levels. We look at the standards which we expect will stop malnutrition actually happening".

⁸³ Aged Care Peak Body Says Food Claims Are Misleading LASA Media Release 12 Feb 2018 <http://bit.ly/2EJAigp>
Aged-care residents 'need less food' than prisoners The Courier Mail 13 Feb 2018

⁸⁴ Community Affairs Legislation Committee 02/06/2010 Health And Ageing Portfolio Aged Care and Standards and Accreditation Agency
<http://bit.ly/2otvzET>

Promises made to be broken: Only 3 years earlier in 2007, a consultant had advised the agency that measurable outcomes like nutritional state were “indicators” and not to be used as a measure of performance. The industry had promised parliament that they would collect this data but parliament had already forgotten this.

The senator had earlier asked *“What are you actually doing to make sure that stories like this do not appear in the newspaper?”* As cynics who have researched the regulatory background our answer would be *“making sure no one knows about it.”*

In spite of all this attention in 2010, not much has changed in the last 7 years. It is still business as usual. Unless we change the regulator, we will have to go through it all over again in another 7 years.

The CEO of a nonprofit, who resigned from the Health Department, struggles to provide good care and manages to provide 4.3 hours of nursing per resident per day, is critical of SB’s benchmarks. He wrote in LinkedIn⁸⁵ *“I have worked for providers that hit the SB benchmark for food and I would not eat there”*. He added that *“the accreditation process for ensuring meals are appropriate has been a joke for years and its about time we stop trying to defend the indefensible”*.

The lack of data: Oversight without data is like being in a dark room without a light. Without measuring nutrition and assessing its progress there is no means of telling whether the processes in place are working or whether the measures the agency requires providers to meet or the assessments done are of any value at all. The limited data available suggests that there is a large investment of people, time and money in these processes and that all of it is being wasted. It would be better spent elsewhere.

A local community solution: Most communities have trained nurses, doctors even dieticians and nutritionists who could help the empowered community visitors that we are pressing for to assess nutritional state. It does not require a university degree to check that residents are weighed and how much they are losing, see what is being done to maintain nutrition and then discuss it with a mentor to see if more can be done. This is what we believe should be happening.

We have a government that talks up innovation without having a system of data collection that can determine whether an innovation is beneficial or harmful. Managers can and do ‘innovate’ in aged care in order to ‘improve performance’ which is measured in cost savings while consequences for residents are ignored.

In our proposal we would be harnessing the skills of the local community to look at the actual failures in these areas and insisting that providers organize staffing and training. They would be reporting to community and government, and when needed calling on the accreditation agency to assist the providers which is their proper role.

Comment on the Quality Agency

The agency’s own data shows that the Quality Agency’s oversight process during accreditation is singularly ineffective. Vast amounts are spent with little regulatory benefit. Unannounced visits resulted in only minor benefit. The utility of the Carnell recommendation to move to only unannounced visits and its adoption by the minister is not supported by the Quality Agency’s data. It is no more than an attempt to placate critics and it reduces the burden for the industry, something they have wanted for years.

⁸⁵ LinkedIn: <http://bit.ly/2F0tlm4>

The data shows that unless alerted to problems the accreditation process was an exceptionally ineffective regulator. The vast majority of problems were not detected by accreditation audits or assessment contacts. The assessors had to be told what to look for in 76 + 12(from risk profiling) = 88% of instances. The accreditation processes themselves detected only 14% of the problem cases – a vast waste of resources that could be devoted to care.

It takes knowledge, great courage and dedication for residents, families and staff to speak out and it is clear that they do not think that the problems they complain about are being addressed by the agency.

The agency's own data when set against staffing data shows that failures in care are likely to be widespread and that only a fraction of this is detected. This data has been collectable for 20 years. Why has it taken so long and only become available when public anger demanded it?

The accreditation data shows quite clearly that as a regulator of care and quality of life the Quality Agency is not fit for purpose. What is needed is a much better system that detects failures in care and then does something about them. The changes we suggest are intended to do just that. Far more problems would be identified and only review audits would be needed. These could be done by another agency or even the department itself after consultation with the community group. The agency could focus on training and support. The community organisation we propose would work with them to evaluate implementation and success. We do not know if accreditation is useful and if so how useful. We need data to set against what it is costing us.

The problem has been that making it a regulator has introduced incentives that undermine the entire process and encourage gaming. Our proposal seeks to relieve accreditation of its regulatory role and create a context which strongly motivates providers and makes gaming impossible. We can then see how well it works.

2.1.3 Complaints handling

The Carnell/Paterson report shows (Pg 41) that probably roughly 0.35% of about 3,500 formal complaints in a year result in a review audit by the Quality Agency.

The report documents (Pg 174) that in the 2016/17 year only 50 site visits (1.4% of 3500) were made by the complaints system.

This does not suggest that information supplied by staff and families is being vigorously followed up. A constant complaint about the complaints system over the years has been its failure to achieve any outcomes.

The report itself indicated that *“Many respondents had no confidence in the complaints-handling processes”*. (Pg 171)

In addition *“the lack of staff was a major contributor to the number of complaints made around quality of care. It was noted that this situation negatively impacts staff morale”* (Pg 173)

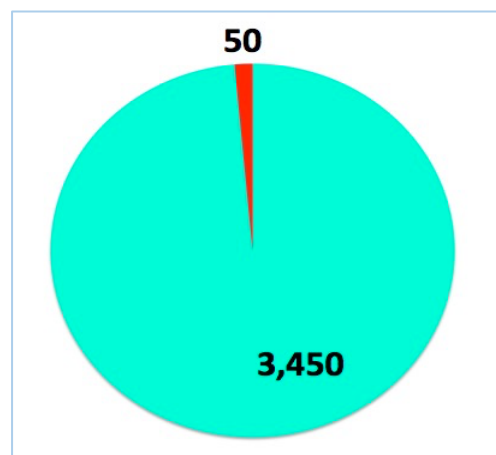


Figure: 1.4% of complaints resulted in site visits by Complaints system

A lack of clinical expertise: In a submission to the Carnell/Paterson review, a clinical consultant who complained to the complaints system about the care being given described the experience⁸⁶,

“It took ten days for the complaints officer to contact me. They showed little insight into the situation we were alerting them to and were reluctant to take any immediate action. The complaints scheme provided details of the complainant to the provider which resulted in us losing our service contract with the provider. Frustrated with the process, we withdrew our involvement in the case and the matter was not pursued further by the department”.

The scheme divulged - - - all the details of the complaint to the provider. They also arranged for an onsite visit in two weeks! This gave the provider ample time to address the issues presented...”

Once again the problem is a lack of knowledge and experience among those responsible for responding to complaints and the patterns of thinking adopted in both the industry and the regulator.

In a recent case the coroner was very critical of the Complaints system’s investigation of the death of a patient beaten to death by a fellow resident with dementia⁸⁷ where a nurse behaved inappropriately then claimed the injury was self-inflicted and failed to act properly. While the full report is not yet available it is likely that this is another example of a lack of clinical skill and knowledge.

Nurses making complaints have complained about the lack of clinical knowledge in the complaints system for years. For example, an experienced nurse was phoned by a complaints officer who *“began lecturing me about bed sores not being preventable”*⁸⁸ – an attitude that comes from the free market managerialist discourse. Those who think otherwise are not credible and can be disregarded.

The difficulty for families: Problems for families include the complexity, the distance from the facility, fear of personal consequences and that the family member will be victimized discourage families from complaining. They lack power and confidence in a system created by turning care into a commodity and a discourse that promotes it’s excellence and discredits those who challenge that.

Family members of residents at Oakden described the difficulties in making a complaint *“- the confusion experienced about where to lodge a complaint, how to lodge a complaint and whether it's safe to lodge a complaint”* **During the 10 years of abuse and neglect not one family member complained to the complaints system.** A clinical consultant described how a nurse who wanted to complain was deterred from doing so by intimidation and said *“Look, I don't want to make any more troubles, it's bad enough.”*

Many simply give up and do not pursue their complaints. There is no one there to support the residents and families when they really need help and support in building confidence, advice when taking action and backing from those with clinical expertise when they confront those who have none. This is the sort of change that Aged Care Crisis is pressing for.

⁸⁶ Submission Response 617437173 to Carnell/Paterson Review: <http://bit.ly/2DZ6hrT>

⁸⁷ Nursing home resident lay dying in her bed for hours after attack by patient 9 News 26 Feb 2018 <http://bit.ly/2GQD9Rk>

⁸⁸ Aged Care complaints kept secret (Sydney Morning Herald, 27 Sep 2014) <http://bit.ly/2CQQA0Q>

2.1.4 Conclusions

The available indirect data indicates that we would find extensive problems in the care provided to residents in nursing homes if we collected data transparently and did a thorough assessment. We simply do not know quite how extensive serious failures in care have been in the past or are now but there can be no doubt that they are widespread.

What these figures do show is that regulation in Australia has been totally ineffective and that care has generally been inadequate. They tell us why it has been so poor.

We have a system that has deceived us. It is protecting an industry that is not delivering and as a community we should be furious.

If we at Aged Care Crisis had not seen and studied similar situations we would be angry too. It is important to understand that this is not a unique situation. It is not about evil people but about the way normal, well-intentioned people behave when they are trapped in a system they believe in but which is flawed.

We have written more and at length in other submissions. We have shown that attempts to address the problems by tinkering with the system do not address core problems in the patterns of belief on which it is based and the processes that are based on them. Proposals such as more unannounced visits, Quality Indicators and Star ratings (both of which are self-reported so easily gamed) will have marginal if any benefit unless the underlying problems in the system are addressed.

Appendix 3: It's time to clear the air on aged care

Created: 04 September 2018 Source: <http://bit.ly/2O4fG6n>

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 Inquiry⁸⁹) 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 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. 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 provided in aged-care facilities but soon reneged on this promise. Regulators later sanctioned this.

Related: *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 importance of staffing data

In the absence of legislation specifying required staffing levels or skills, MP Rebekha Sharkie's Staffing Disclosure Inquiry 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. 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, and during inquiry appearances, coronial inquests, industry talkfests or when asking governments for more money. Financially based staffing benchmarks have even been used by non-profit organisations as justification for reducing staffing across nursing homes.

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

⁸⁹ Inquiry into the Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018 <http://bit.ly/2DTIlyz>

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. 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"*.

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"* 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.

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. 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 - *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.

Appendix 4: Aged Care: corporate conflicts run deep

Created: 16 July 2018 | Source: <https://www.michaelwest.com.au/aged-care-corporate-conflicts-run-deep/>

This is a published article that describes what has been happening in aged care as a consequence of the policies introduced in 1997 and why it has become so problematic.

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

Aged Care Crisis

<https://www.agedcarecrisis.com>

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.

ACC submissions to the Finance and Tax Practices of for-profit aged care providers can be found here:

https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Economics/Taxpractices-agedcare/Submissions