"Caring for Older Australians"

A Critical Examination of the

Productivity Commission Report
Released June 2011

J Michael Wynne
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SUMMARY

The Commissioners have carried out a diligent and thorough examination of aged care in Australia and have carefully studied a vast amount of information and hundreds of submissions with great care.

Their Report is detailed and thorough in addressing these issues and makes a large number of important and useful recommendations that will improve the system.

The Report is created within the economic rationalist system of belief and the many assertions made in regard to the self evident validity of these beliefs are not supported with evidence or reasoned arguments. The criticism that the necessary conditions for a competitive market to succeed are not present is not addressed. The validity of a market is simply asserted.

These patterns of thought directly contradict traditional community humanitarian values and norms; the patterns of thinking and the expectations of the community who expect something very different.

Providers of care must appear to provide the sort of care that the community expects, while serving a very different and demanding master - the market. The Report is trapped in this same situation and fails because the commissioners do not address it.

There is consequently a deeply divisive fissure running through the new structure that the commission is recommending. It is likely to give rise to tensions, disturbances and undesirable practices.

The commission has given total control of the system to a single independent structure the Australian Aged Care Commission (AACC). This body will advise government, set prices, approve providers, assist them in setting up processes, provide oversight, regulate, penalize, handle complaints, gather information, disseminate information and advise potential customers.

It is far from clear to whom the system will be accountable or how its officers will be selected or appointed. This is critically important as they will have total control over the aged care system, and of all of the information that comes out of it.

While accountability and transparency is stressed in the Report, the structure and the extent of the control exerted belies this. The AACC is designed to protect the new aged care system and the AACC from the sort of criticism and exposure of recurrent failures that has dogged the present system. This is a format that has self deception and inflexibility built into it, and so ultimate failure.

This is exactly what happened in 1997. This why it took 14 years before government was finally forced to do something. Because the commissioners were selected from those who identified with the system, we are getting a variation of the same flawed solution. How long will it take this time?

These issues and their consequences are explored in this critique.

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1. INTRODUCTION

This is an excellent report, excellent for the providers of aged care, excellent for the politicians, and very plausible to the majority of Australians. The inquiry has been conducted with great diligence and all the submissions have been carefully considered.

The Report's recommendations are carefully constructed and will very probably result in some overall improvement in the care of the elderly and in the quality of their lives. It is better than its critics dared to hope.

The commissioners have done an excellent job within the constraints of the establishment views that dominate our society, a set of views to which they subscribe and which is integral to the subculture of which they are a part.

I am flattered and pleased that my submissions and those of the Aged Care Crisis Centre, which I support, have been quoted so often, and that the Report addresses so many of the issues I raised better than I had hoped.

This is also a deeply flawed report, limited by the dominant views of its authors and the subculture in which they live. It directly contradicts the patterns of thinking and the expectations of the majority of the Australian public as they understand health and aged care. It is not the radical change that its proponents claim.

It is a rearrangement of the parts of a failed system in an attempt to make it more closely comply with the view of the world to which the authors and those, to whom they are immediately responsible, belong. By doing so they attempt to mitigate many of the problems that have developed, consequent on that world view. It nevertheless still exposes the frail elderly to unacceptable risk. The core problems remain.

The commissioners are selling this to the Australian public and in order to do so they gloss over and attempt to minimize the contradictions at its heart.

1.1 EXPLANATION

To make the second argument I need to look very carefully at the logic of the arguments that underpins this report, and draw on the evidence and perspectives built up during the 20 plus years that I have spent examining dysfunction in the health and aged care system.

I would like to stress that this is an analysis rather than a criticism. It is an attempt to look at the Report through a different prism, to see what this reveals. The hands of the commissioners were tied. Even had they seen things differently, they could not have followed this path and remained credible in the eyes of their peers and those who would be charged with implementing their recommendations.

I apologize for first explaining some very basic understanding of the nature of being human and of elementary logic in overly simple terms and at some length. Its not that readers won't know these things, but that they won't have them at the front of their minds and won't otherwise look at the Report differently.

They are fundamental to critically examining the Report from a different point of view. They are so often, almost routinely, overlooked. My argument is that this is what the Report does.

1.1.1 A Theoretical and Historical Basis for Criticism

This Criticism is based on an approach to understanding ideas and the way these have played out in the history of aged care.

To keep this critique short I have put this introduction into a separate article entitled "A Basis for Criticism". I summarize that here but for a better understanding you should follow the link by clicking on it.

This separate document briefly **explains the concepts** of

- the concept of a world view and the way in which the ideas we use to understand things affects the way we deal with them.
- the logical concepts of category errors and necessary conditions and the way we ignore them when developing an ideology.
- belief systems, how they are developed and when they become an ideology.
- the way we create and embrace meaningful ideas, the importance of cohesive ideas to create a stable world, the social and cultural factors.
- the concept of dissonance (angst) that occurs when the ideas we live by are challenged or disproven.
- the strategies we can use to deal with this dissonance without changing our ideas - essential to maintain most ideologies.
- The way personality structure, the pressures in the context in which we find ourselves, and our tolerance of dissonance influence the way we respond to this dissonance. At one extreme we use our intelligence to reflect, challenge and try to resolve the contradictions. At the other we employ strategies such as compartmentalization, use our intelligence to rationalize, or try to destroy the messenger.

The separate document then gives a **historical outline of the patterns of thinking and cultures** that have impacted on health and aged care over the last 2500 years.

Milestones include

- the hippocratic understanding of disparity in power between patient and doctor and the development of a culture based on a system of ethics, which placed the patient first and promoted fairness in dealing with misfortune as represented by the ethic of "caring according to need and charging according to means".
- how society became involved in care and adopted these norms and values with the church becoming the vehicle for providing facilities.
- how these ethical structures have bent and been compromised by a succession of dysfunctional ideologies, but have been durable recovering afterwards.
- how the rising cost of medicine brought government and other groups into the sector to fund the provision of facilities and pay for care - so moving policy and decision making away from the coalface of care.
- how the availability of this new money brought profit seeking individuals and big corporations into the sector.
- the way marketplace understandings became an ideology, sometimes called economic rationalism and how this was seen to be the way to reform health care - even though the necessary conditions for a market to work successfully did not exist.
- the way in which economic rationalists blamed doctors for the high cost of care, gained control of doctors salaries and their careers in the USA.
- the way in which this allowed corporate entities to take control of the way care was provided to patients by doctors in the USA, how this increased the cost of healthcare and resulted in a succession of scandals about care as well as extensive fraud.
- the arrival of economic rationalism in Australia.

- how doctors in Australia successfully resisted corporate and government efforts to gain control of their careers and incomes so retaining power over the treatment of patients and, as importantly, where they were treated - the concept of “leverage” forcing the market managers to justify their decisions and confront criticism.
- how these doctors now had the power to confront large corporations, protect their patients, limit conduct which they considered threatened the system, and used their power to punish transgressions.
- how economic rationalism radically altered the ideas that underpinned aged care and the way in which the Aged Care Act 1997 turned aged care into a market system.
- the flaws in the new system and the way it was protected from criticism and change
- how the absence of any group with leverage has left aged care at the mercy of market forces.
- the way in which church and community not-for-profit groups have been colonized by market managers and their leverage reduced.
- an examination of the very different views about standards of care between politicians and the market on the one hand and an increasingly aware community on the other.

The separate document describes a **classification of aged care providers** based on whether their primary objective was humanitarian of commercial - two mutually exclusive patterns of thinking as profit and care come from the same pool of money. The categories are

- not-for-profit including subgroups of government, community and church
- for-profit including the following categories
  - Private for-profit
  - Market listed corporate for-profit
  - Private equity

The separate document returns to a theoretical perspective in order to use this background to understand the important **consequences of the paradigm conflict** that is created by the requirement that providers of health care

- operate within competitive marketplace patterns of thinking (paradigm) placing profit first,.
- also need to be a credible part of the community and their success depends on showing that they embrace the community paradigm which emphases cooperation and places care first

The separate document **explains that**

- this means that they must do one thing but, at the same time, believe that they are doing the very opposite
- to be genuine and have a sense of integrity those providing care must believe they are operating within the community paradigm while making decisions using the market paradigm - corporate and personal success depends on this.
- this creates intense dissonance and how compartmentalization, rationalization and other strategies are employed to accomplish this.
- the way in which empowered customers or another group empowered because they have leverage can force the market managers to confront the contradictions in what they propose to do - so that they modify or abandon their proposed actions - so restraining market forces and creating the power balance (a necessary condition) on which a successful market can be created.
- how paradigm conflicts like this create a context, in which successful sociopaths, and others at the non-reflective end of the psychological spectrum,

succeed, because they manage to bury the paradigm conflict most successfully using the strategies described - and so are more profitable.

- how this context favors the expression of these psychological characteristics, moving individuals in organizations to the right of the continuum of behavior, so that a dysfunctional subculture is built up.
- how dissonance in those who are more reflective results in alienation and demoralization, causing many to go elsewhere.
- how these characteristics allow poor care and practices that compromised care to be ignored and also render participants more likely to indulge in and justify fraud.
- how this explains what happened in health and aged care in the USA but did not happened in health care in Australia.
- how it helps us to understand what has been happening in aged care and the risks inherent in the model of aged care proposed by the productivity commission in 2011

2 ANALYZING THE REPORT

2.1 **The Point of View**

All three commissioners come from, are associated with the providers of aged care, or are closely allied with marketplace thinking. The idea of this being a competitive market that is not working, as it should, and which needs to be readjusted to make it more market-like underpins the Report. They don't question the validity of a market in frailty and misfortune. If they did they would lose credibility in the marketplace and in parliament. The universal applicability of markets is a "self evident truth" that is asserted in this Report on multiple occasions and in multiple ways. It is never questioned or challenged.

Robert Kuttner, US analyst, in his 1997 criticism of the new fundamentalism associated with economic rationalism points out that if everything is a market and if market principles are universal then if anything is wrong it must be insufficiently market like. This is a no-fail system for guaranteeing that theory trumps evidence. (*Kuttner R "The Limits of Markets" The American Prospect No 31 Mar-Apr 1997: p 28-41 http://prospect.org/cs/articles?articleId=4845*)

My first criticism then is that while the commissioners do acknowledge the possibility of exploitation, at no point do they examine the rational for a market in aged care, nor the possibility that the problems in the system are because market theory is not applicable to the sector.

I can't accuse them of ignoring objective scientific evidence. The 1997 aged care act ensured that there would be none. While they examine what has been done in foreign aged care markets, they do not examine the failures in aged care, or the reasons for these failures.

2.2 The primary focus of this Report

The primary focus of this Report is to find enough money to make a market work. It has to be profitable and so worthwhile for local and multinational for-profit groups to supply aged care to Australians. A major attraction for the market is the capital they can raise from the market and from banks to build and expand the system.

In contrast not-for-profit operators struggle to find capital. A byproduct of this approach is that not-for-profit groups are disadvantaged. Their number and their influence are eroded. Their paradigms lose legitimacy.

For corporate for-profit groups the trade in human decrepitude is a market to be exploited. If it is not profitable then they will not come and there will be no care for the elderly. The majority of for-profit groups are here for the money not for the frail elderly. Unless there is financial benefit they will do only what they have to but no more - a recipe for mediocrity. The Report does not address this.

This is not to suggest that the commissioners fail to consider the interests and well being of the frail elderly, but this is done within the constraints of what a market can do, and of marketplace thinking.

2.3 My main interests

My main interests in this Report lie in

1. The way in which the Report deals with the intrinsic contradictions and conflicts that arise in a market where the necessary conditions for a market to

work do not exist. Do they confront and examine these and if not what strategies do they use to avoid doing so.

2. What do they do about the disparities in power that cause market failure? Do they deal with this? Who is the real customer?
3. What are the risks to the customer and the community?
4. How are vulnerable customers empowered? Will this be effective and if not how will they be protected?
5. How have they addressed the issues I raised in my submissions.

2.4 A Report is not what you get

We need to remember that this is only a report - the first step in a long process. We don't yet know whether the government will reject the Report, whether they will accept it, or whether they will pick and choose. Will they implement the recommendations in ways that will make them work? Their success will depend on the details.

2.5 Who has influence now?

While this was the final opportunity for citizens to make their points, the provider organizations, and particularly the big companies have a powerful lobby and will continue to use it. We know from past experience that the marketplace is now so powerful that it is extremely difficult for government to take action without consultation and agreement from the market. What will they allow the government to do?

3 EXAMINING THE REPORT

3.1 VULNERABILITY AND POWER

3.1.1 Defining Market Failure

The first interesting point emerges before the Report even begins - in the Glossary. (page xvii)

The definition of Market Failure given by the Report is narrow; referring only to "**inefficiency in allocating resources**". It says

> "**Market failure can be caused by information asymmetries, externalities and public goods**."

If the customer is in there somewhere it's not obvious. Does that tell us something?

3.1.2 Market failure in health and aged care

By far the most common cause of market failure in health and aged care (for the customer) has been the imbalance of power between the provider and the customer. There is a vast amount of evidence for this.

The elderly have declining mental abilities, few family members have real knowledge, and decisions are often made under extreme stress after a medical crisis. The community is conditioned to trust the providers of aged care and to expect them to act in their best interests. They do not expect to encounter "used car salesmen" but too often they do. They do not expect to have to research the complex issues in depth.

Aged care is difficult for the customer to evaluate. Ambience and physical resources appeal to them. They often fail to understand the importance of staffing and care.

3.1.3 The impaired customer

That the commissioners are actually aware that people are vulnerable is revealed in vol 1 on page 71 when the Report refers to the need for government involvement, to (among other things) "correct market failures (information gaps and the protection of vulnerable consumers)." The Report discusses their vulnerability on page 75 where it looks at areas where aged care "lacks features of an ideal market". But the Report does not use this to challenge the validity of the more open market they recommend.

In the section on the aged care Gateway and information (vol 2 pages 130-4) the Report does examine the vulnerability and the difficulties that older Australians have in getting and evaluating information. It makes a very genuine attempt to meet this need for more information and to make in meaningful. What it suggests is commendable if it happens, but being a customer requires much more than knowledge.

The Report does not set this vulnerability against its expectation that frail oldies at the end of their lives will be the sort of empowered customers that the commissioners claim will make their system work. The commission is asking more of the elderly, than is reasonable; - much more than frail people at the end of their lives should be asked to do.

We all expect to be cared for when we are no longer able to fend for ourselves, and trust the community in this. We don't expect to be turned into wary customers, nor will most of us be capable of this, even when we have access to information.

3.1.3 The impaired family

This is the first time many family members have to confront their own mortality. This is stressful. At the same time the torrents of their own personal and intimate past lives converge bringing together an emotional cascade of love, hate, sibling rivalry, marital conflict, irritation, fights, disengagement, rebellion, and above all guilt at what might have been - the emotional debris of many lives now thrown together again.

They are not equipped to make important decisions or to endure what is usually going to be an arduous, drawn out and draining period in their lives. Their behavior and response when making decisions can be unpredictable, and lack objectivity. Stress can make them unreasonably angry on the one hand or induce them to disengage when they should be acting strongly on behalf of someone, who may be at the heart of this emotional maelstrom.

3.1.4 Other examples in the Report

In vol 1 on pages 93 and 94 the Report talks about the role of the "consumer" in facilitating competition and promoting markets but it skirts around the full implications of vulnerability. When it does it looks to government as the "protector" - a lack of confidence in what it expects of them.

In vol 2 on page 190 in a section considering "current measures to ensure quality of care" it starts by describing the vulnerability of the frail aged.

On page 166 of vol 2, in introducing a section on the model of care and support in greater detail, the Report introduces this by saying

> **"The Commission's reformed model of care and support services seeks to provide greater continuity of care and empower older people to exercise greater choice."**

At no point to they confront the depth of the issue and make the argument for a market.

3.1.5 Rejecting my response to the Draft Report

The assertion above rejects my suggestion (http://www.pc.gov.au/projects/inquiry/aged-care/submissions then select DR568) that the commission create a system in which the community played a central role and were empowered to be the real customer. I did not consider that the frail elderly could ever be sufficiently empowered. I wanted a system where paradigm conflicts would be confronted in a similar way to our hospitals.

I distinguished between consumers, who received the care, and the community as customer, adviser and mediator. In referring to accreditation, complaints and other sections of the system I asked them to rewrite sections

> **p4**
> **" - - with particular attention how each can be linked into the community in such a way that all of these structures are directed to redressing the imbalance of market power between providers, on the one hand and local consumers and local communities on the other.**
>
> **The information in the appendices of the Draft Report should be drawn into the Report to show how the new structure will empower and support the consumers and customers."**

I was concerned that the new system would be as unyielding and unresponsive to challenges and the views of the community as its predecessor. I tried to make the system more adaptable and amenable to change by pressing for much greater participation by the community locally and centrally. On page 23 and 24 I said

> **p23**
> **"I am persuaded that short of a revolution the only way to address this problem and to institutionalize progressive change is to design a system in which all representative parties have 'leverage'.**
>
> **By this I mean that there is a common imperative in making the system work, but all sides have the power to block the other. Those with fixed positions then have no choice but to critically confront the arguments and the logic of the other participants and accept evidence and logic.**
> **----------**
> **This is another cogent argument for structuring the relationships between visitors, advocates and community and for giving them a role in the regulatory structure, both centrally and peripherally."**
> **----------**
> **p24**
> **"Both logic and theory support empowering consumers and customers in their relationship with providers. If innovative changes are to be discussed, tried, tested and then spread through the system then the leverage enjoyed by staff, community and providers should be balanced in each local setting and that balanced leverage should be replicated centrally."**

3.1.6 A protected System

Another major problem in my view is that the entire information gathering, complaints handling, and regulatory process is being conducted through subsections of the same AACC that is supplying and interpreting information. How reliable will that information be when it would reveal that the system was not working, that the market was dysfunctional or that other sections of the AACC have failed? Advocacy services will be government funded and accessed through the Gateway. Will their independence and effectiveness, when they need to take on the AACC on a residents behalf, be compromised? It is far from clear where the proposed visitors would fit into this and whether they would be in a position to exert real influence.

Formal as well as informal aged care started as, and has always been a responsibility of the community, and government's role has been to support them in this with funding and structure. Nursing homes and their owners provide care for and on behalf of the community and as such should be responsible and accountable to the community. The community should be the real customer.

The pages in this Report dealing with vulnerability and with markets refer to consumers and government, but the community is hardly mentioned in the context of empowerment. They don't seem to have a role. How will they be able to play a role in aged care when they are excluded? How will paradigm conflicts be resolved when their protagonists are kept so well apart?

3.1.7 Does failed training raise issues about failed care?

The commission clearly identifies the failures in training consequent on a number of profit-focused groups who provide training to personal carers over an excessively short period. This is a vulnerable group. Many are from foreign countries. The training colleges do so without providing the students with practical training or

undertaking practical assessments. These "qualified" graduates do not have the required skills. These carers, often immigrants, are being short changed so that the groups that claim to train and certify them can be more profitable.

The commission does not consider the possibility that many of the problems in the aged care system are because the frail elderly are being short changed, and for the same reasons. It prefers to think about a “world class system”.

3.2 TERMINOLOGY

Because this is being handled as a market I am deliberately using the word customer here. This is the second essential participant in a functioning market, the one who has the power to decide whether the person selling the product will succeed. The Report instead talks throughout about consumers and residents, words widely used to soften harsh commercial realities, and the imbalance of power intrinsic to the word "patient". "Nursing homes" which also emphasize the vulnerability of residents and their need for nursing have become "residential aged care facilities", a place where people live rather than somewhere where they are nursed. The Report is simply using the language set up in the 1997 act, but it does say something about where the thinking is coming from and the way the contradictions are addressed.

These are the words used today and I will end up by using them too.

3.3 STANDARDS AND THE MARKET

3.3.1 The Commissions position

The commissioners seem to have difficulty in handling the question of standards of care.

On the one hand they try to maintain the illusion of Australia as a world leader, and claim that aged care has been improving over the years. Claims like this are based on the assertions of those in the sector and the findings of an accreditation agency that does not report actual care. There is no concrete evidence that this is so and, if true, it does not say much for what is happening in the rest of the world, or of what happened before.

On the other side is the mounting outcry about failures in care and the views of those who have returned to the sector after years of absence. These are strongly supported by the well-documented overall decrease in both the number and skill levels of staff. This cannot be glossed over by vague generalizations, by claims that aged care recipients are demanding more, or by hinting that failures due to insufficient staff are overcome by increased efficiency. Submissions to the productivity commission raise issues that point to widespread problems.

3.3.1.1 Rationalizing the conflict

The commission avoids confronting this by talking about some variation in the quality of care. This is only a small step up from the Howard governments claim in 2006 that the rape of elderly residents and other scandalous behavior in nursing homes were isolated events in a world-class system - and not red flags to widespread dysfunction.

Variation in quality of care is not supported by the accreditation agency's findings. These point to a uniformly high "quality" of care with the majority of homes meeting all 44 standards and only a small number of assessment failures.

The commission fails to consider the possibility that the accreditation process is deeply flawed and unreliable, that the system is dysfunctional and that the standards of care if they were measured are far below what we should expect. They failed to consider the possibility that this was due to the creation of a deeply flawed and dysfunctional system when changes were made in 1997. This argument was made in at least one submission but it was not confronted. (see submission 368 page 17)

If the Commissioners do not recognize the depth of the malaise, then their solutions become questionable.

3.3.2 Does the pressure for profit compromise care?

Only one study, that I know of, in Australia, has attempted to examine the performance of the different types of provider of nursing home care by looking at a number of accreditation reports. Although this study was limited and the results tentative it suggested that, when variables were controlled, nursing homes owned by for-profit groups were 3 or 4 times more likely to fail at least one accreditation standard. This accords in a general way with the findings of a number of studies in the USA over the last 16 years. (Aged Care Report Card: www.agedcarecrisis.com/aged-care-report-card)

This was drawn to the attention of the inquiry. They chose not to explore this issue.

Were this finding confirmed, by examining more accreditation reports and looking at objectively collected data, then it would have opened up issues surrounding the provision of humanitarian services through a mechanism that tapped into and depended on personal greed and the primacy of profit. It would be very useful information for "customers" buying aged care services, empowering them to make informed decisions that would force for-profit groups to compete on standards or else go under. Was this a Pandora's box the Commission dared not open?

3.4 POLICY OBJECTIVES

When it comes to policy objectives the Report cannot be faulted. All of this falls into the community paradigm. There is no conflict about what we all want. The commissioners are strongly motivated to provide this. It all comes out smoothly and is very convincing. They are on safe territory and compartmentalization allows them to slip bits of market ideology into this so that it looks as if there is no conflict. Dissonance is reduced.

The way some of the issues are referred to and the words used reveal where the issues are that might be compromised by the marketplace paradigm.

3.4.1 Community and Residential Care

The Report strongly supports the desire of the vast majority of Australians to age in their own homes where this is possible. The major reform in the Report is in its expansion of services that will be provided in the community.

The Report fails to explore the major differences between care at home and care in nursing homes. In the home setting most of the elderly are much fitter and mentally able. They are in control. They are surrounded by family, and other informal carers. These people are involved and in time become more knowledgeable. They deal directly with those who come to help them. If they genuinely have choice they may well have the power to act as effective customers; so the arguments against a market in decrepitude are less compelling.

Nursing home care is very different. The "residents" are much frailer, and, as more people age at home, they will become more so. Their life expectancy is short so most are there for a short time only. Far more of them have dementia. Admission is often precipitated by a sudden deterioration or hospital admission. Decisions are made under considerable pressure. Relatives are not there to supervise care and do not see what is happening. Residents and their families are more readily short changed or exploited.

Putting nursing homes into the same conceptual package as home care blurs the distinctions and the risks.

3.4.2 Choice and Consumer-directed care

The way the issues are framed is a good example of the way the differences between community and residential care are blurred. Quite clearly the needs of the elderly differ widely. They do need to have input and control over the care that is provided to them and yes choice and direction.

3.4.2.1 Social service view

If this were a social service (eg. Medicare) we would be talking about what people needed, how we could broaden the range of services, and how to pay for it. As a community we would be happy to pay for the choices our elderly made, but we would be reluctant to contribute to their whims when these were for something that did not benefit the resident or was not needed. It would be a waste of our money. They should pay for this themselves if they wanted it. As a community we would want to engage with those receiving care and give them control over how this happens. Their satisfaction is important for the quality of their lives and so to us.

3.4.2.2 Market view

When, on the other hand, we are dealing with a market the thinking is different. The focus changes from need to choice. It is not so much about meeting need as meeting demand. Demand is generated by marketing. The market wants to sell the customer whatever they can be tempted to buy, whether it is needed or not. They want to make money. In the home setting there may well be sufficient customer power to choose wisely and even ensure that what is offered is needed. In a nursing home this power evaporates. Impaired residents and anxious family are vulnerable. They can be sold services they don't need.

3.4.2.3 Potential Consequences

I am reminded of a hospital in the USA where patients who were worried that they might develop heart disease were sold very major operations they did not need. Some died, others were harmed.

> **Example:-** In this hospital enthusiastic managers marketed and promoted treatment by deluded doctors. The company advertised its cardiac screening service, and marketed the skills of doctors who made money for them to the public. Two doctors, with questionable training, had persuaded themselves that what they saw on normal angiograms (X-rays) was abnormal. Their consequent financial success and the high public profile they were given reinforced the delusion. This became the most profitable hospital in the USA, drawing patients from far afield.
>
> Managers shielded the doctors from intervention by hospital colleagues who realized what was happening, from criticism from the profession at a competing hospital, and from accreditation and state oversight. These

managers were strongly supported by the company board. They poured millions of dollars into expanding the cardiac centre because it was generating vast profits. This was seen to be a benefit from the recently adopted corporate policy of focusing on sophisticated specialist services, where a regulatory loophole permitted overcharging and large profits.

It was only in 2003, after over 700 anxious people had undergone major heart operations, which they did not need, that the bubble burst. Many had normal hearts and had responded to the advertised cardiac screening program, which capitalized on their anxiety. The company vice-president who oversaw and participated in all this had been CEO of this company's Australian arm during the 1990s. An investigation by an Australian state regulator had warned that there was a risk that this might happen in Australia. He was ignored.

The focus on early detection and treatment was very appealing and desirable. It would have been strongly supported. The corporate drive for profit turned it into a disaster. That may be an extreme example but red flag examples usually reveal what is happening in less obvious ways. Like screening for heart disease, what the commissioners are offering here is also enormously appealing. Everyone wants to be able to choose what happens to them.

3.4.2.4 Whose needs will be met?

The focus on early detection and on aggressive rehabilitation for the elderly to restore function is commendable. There is a risk that the market will identify that as a potential gold mine and sell services to people who don't need them or where they have no prospect of success. How can that be controlled in a marketplace?

My worry about this is that while the commissioners might really believe that they are doing this in the interest of the residents, the underlying need driving these changes is not that of the residents but that of the market. Its a way of finding more money for the providers and so making the nursing home market more attractive for them.

3.4.2.5 Distorting the system

The risks for residents then is that the choices residents are offered will be ones that are profitable for the provider but may not meet the needs of the resident. Some may even be harmful. Needs that are not profitable will not be met.

The other risk for residents is that staff and resources will be diverted from providing essential care and used instead to provide for choices that are more profitable. The dominant need of frail nursing home residents is expensive, unprofitable, labor intensive, nursing care. The commissioners may rationalize that the companies will use the funds generated from the extra services chosen by residents and their families to employ more nurses. This is not how the market works.

Example: In the 1990s vast aged care empires were established in the USA by providing profitable step down care in nursing homes. "Therapists" of every description were recruited from around the world to meet this "demand". There was extensive over-servicing and vast profits were made.

Resources were diverted to exploit this market and the frail elderly residents in the homes were neglected. There were too few nurses to care for them. They rationalized that you do not need trained nurses to wipe bottoms.

The profits were not used to fund better care for the frail elderly but to feed the market and build glossy administrative towers. When government finally

turned off the funding tap, the demand evaporated. Thousands of therapists were unemployed and companies that had borrowed in order to compete in this lucrative market went under.

It is worth noting that the Report, in volume 2 page 356 proposes, that various additional health services and "step down care" be provided in nursing homes in Australia. If this is more profitable for providers and less stressful for staff than caring for frail and demented people then it is likely the focus will shift away from the latter, who will be neglected.

3.4.2.6 Potential monopolies

Will the providers who own the nursing home have a monopoly or will customers be able to choose services from another cheaper and better provider when they need them? It's all just too convoluted and messy to conceptualize. When these increasingly frail aging customers become even frailer and finally discover that they need these extra services they will be trapped. Unscrupulous providers can capitalize on their vulnerability and fleece them as they did with bonds.

3.4.2.7 Criticism of choice

My criticism is not about giving people more choice. That is a good thing. Its about using this, and its obvious appeal, as a means of generating funds with which to feed the market and to attract more investment. A market in misfortune and decrepitude is not something the Australian public warms to. My concern is that the focus on choice is really about protecting a market that is not doing well.

3.4.3 Addressing Paradigm Conflicts - Compartmentalization and Rationalization

These are the strategies we all use when arguing for something we believe in but which is not supported by evidence. The assertions are sometimes most forcefully made in just those contexts where they are most vulnerable to challenge.

Throughout this Report statements underpinning market ideology are slipped into discussions of community services as if they were self evident and unchallengeable truths. We have all been conditioned to thinking in this way because of the way the rest of life is built around markets. We all go shopping and these concepts apply. It sounds so sensible - that is until we start to think about it, and few read deeply enough to do that.

In many instances this market paradigm introduces contradictory pressures that will undermine what is being suggested. The market would not in fact do what is inferred. Strongly asserting an ideology's underlying "universal truths" without examining them is a way of dealing with dissonance. In aged care the claims would only be valid if there was an effective, knowledgeable and powerful customer.

Here are nine examples from the many in the Report.

Example 1.
On page xxix under "Consumer-directed care", the Report says

> **"In addition, competition amongst providers in a system where consumers can exercise choice leads to a more dynamic system, with enhanced incentives for greater efficiency, innovation and quality."**

It was an opportunity to bring in competition as a universal "good". They could present the conflicting underlying ideology within the community paradigm so making it look congruent.

There is ample evidence that when the necessary condition of an effective customer is not present competition for ever larger profits - the incentive - leads to inefficiency, innovative ways of exploiting the vulnerability of citizens and poor standards of care - the very opposite of what is claimed.

> Example 1a: During the 1980s in the USA thousands of trusting people, many of them children, were needlessly enticed into corporate owned psychiatric hospitals, They were persuaded to stay there for as long as their insurance lasted. They were given vast amounts of unnecessary and unproven "therapy" and many were harmed. Insurers were defrauded very "efficiently". Patterns of thinking were developed that made this not only justifiable but desirable. Those who were part of the system were persuaded that they were providing needed care and embraced this enthusiastically. Dissenters were discredited and their careers destroyed.

Example 2.
On page xxxiii under "Opening up the supply of care and accommodation to enhance choice" we find

> **"In the Commission's view, competition** *(when choosing between competing providers)* **would be a powerful incentive for providers to improve quality and efficiency, and to offer care solutions that best address the needs of individuals. "**

In most of Australia the biggest consideration is geography; being in a familiar suburb near friends or near family. The supply of nursing homes is irregular and infrequent. Freeing up supply is not going to change this dramatically. Only the wealthy, whose suburbs will be targeted, are likely to have much choice.

Unless their choice is based on real standards, on actual staffing and unless those staffing ratios are maintained (as ownership by corporations and private equity groups, intent on cutting costs, come and go) it is unlikely to improve the efficiency of care or its quality.

Care vs Cost:- When the dubious profits from improved care are set against the losses from the increased staffing and improved salaries needed to provide this, the latter are greater by far. It would require some radical restructuring and a very different sort of customer to make competition effective in increasing staffing.

Mergers, Takeovers and Choice:- One of the most glaring examples of compartmentalization is revealed in the way choice is promoted as the basis for choosing a nursing home.

Market listed and private equity groups make their money by buying and selling off facilities. As financial strategies change, the portfolio of nursing homes is rationalized to meet market objectives and changing corporate policies, whether these have to do with diversification or with building niche markets.

Nursing homes are bought and sold, management is restructured and services are adjusted to meet marketplace policy. This is an ongoing process in the corporate world and more so for private equity. It happens all the time.

What the residents wanted and what they have selected is all too often temporary and illusionary. They really have no choice. They are at the mercy of the market and the current corporate owners.

The Report suggest on page xxxvi that frail elderly residents nearing the end of their lives can simply move on to another nursing home. This is a good example of how far they have removed themselves from the world of residents at the end of their lives in nursing homes.

Example 3
The Commissioners know all this and support this as "consolidation" claiming in vol 2 page 490 that

> **" - - efficient and dynamic providers taking over from those that do not have sustainable business models."**

They blandly say this, but avoid confronting the conflict inherent in their promotion of choice when selecting a nursing home. They ignore the fact that the efficiency that they are talking about and the models they are referring to are about making profits and not care. They conveniently ignore the fact that these are not the same thing, and in fact are often inversely related.

Example 4
The myth is restated on page xLviii. In referring to quality variations in the current system the Report claims that the current system

> **"allows operators who only meet the minimum standards to survive, but who in a more competitive market might otherwise fail."**

and then the Report claims that the reforms proposed will promote high quality care among other things by

> **"greater consumer choice, more competition and more responsive service providers."**

Well nothing trumps reason, common sense and evidence quite as well as belief! There is abundance evidence, much of it in health and aged care, that without an empowered customer, competitive pressures foster understaffing, dysfunctional practices, and a generally mediocre standard of care. This is what you would expect when the competition is for profit rather than care, and failure to increase profit results in corporate death. When care fails you get a slap on the wrist and "help" from your friendly accreditation agency to fix it. There's not much competition here!

Example 5
To reinforce the myth the Report repeatedly refers to "empowered" older people implying that the planned reforms will give them sufficient power to assess their needs and make a competitive market work. (see for example Schedule B page LV)

Well maybe pigs can fly but few of us are going to kick one hard enough to send it off. Some in the community may be empowered enough to get the pig off the ground but not those in nursing homes. Aged care is ultimately for all of us, not just for the strong.

The "range of dimensions" on which these now empowered customers will compete. are given in the 4th bullet point in the right hand column of Schedule B. They include professional and relationship skills *(does that include marketing skill?),* cultural awareness and languages, quality of food and other services, and responsiveness to particular requests. Standards of care is missing. What happened to all that talk about the information Gateway and the empowered consumer.

It will be too late once the resident has made that fatal decision, and hopeless 6 months later when a new owner takes over.

Instead in the same section there are references to accreditation, as well as approved quality and safety standards. In spite of all the hype this suggests that care is not going to be competed for but will still depend on the same processes of accreditation, and oversight. They really can't have it both ways.

Oh and the quality and price of the extra choices that will be offered to these "empowered" older customers will be set by the provider so will not be monitored. (5th bullet right column page LV))

This table is filled with contradictions that are compartmentalized and not confronted. Many of the contradictions that pervade the entire Report are revealed in this summary.

Example 6
If we proceed to the second page of the same Schedule B in the left column 5th bullet we are told that as oldies we will benefit from the improved quality of care which the reforms (yes and competition is among those listed) will bring. Then in the 9th column we are assured that older Australians can

> **"be confident that the Australian Aged Care Commission is monitoring the quality of care by providers - - -" etc**

I have spoken of the importance of "customer beware" in the jungle of the marketplace. The history of aged care since 1997, the many reviews and the submissions to the commission attest to the failure of regulatory processes over and over again - the need to be aware and distrustful of the whole process.

The Walton Report is scathing in its assessment of the complaints system. The review of the accreditation system was either so critical, or so vulnerable to criticism itself that it could not be publicly released to those making submissions to the productivity commission.

The commission has advised reducing regulation and made few if any major changes to the oversight and regulatory processes - none that are likely to make them really effective. Customers have every reason for applying the "customer beware" dictum and ensuring that they are fully informed and distrustful.

Is this an example of "if we say so it must be so" - the extreme end of the "reflective vs dogmatic" parameter I described in my introduction?

This new Australian Aged Care Commission (AACC) is deciding what should be measured, doing the assessments such as they are, evaluating them, and then deciding what information should be released to the public. It is a closed box that looks as if it is designed to protect the system from exposure and criticism. Not much different to what we had before.

Example 7
This compartmentalization is also revealed in the Report's assessment of the existing aged care system. Its difficult to change and fix something when you don't consider the reasons why it has failed. In the key points in the section on the current system (Vol 1 page 13) we get.

> **"Australia's aged care system has evolved in an ad hoc way in response to: the increasing and changing needs and demands of older people;**

failures in risk management; political compromises; and concern to contain public expenditure to sustainable levels."

Well not really. The aged care system was changed radically in 1997. There was nothing ad hoc about it. It was carefully planned and executed. Starting about 3 years later there have been a succession of irrational statements and inappropriate legislative responses. These were in response to recurrent crises and pressures that developed in the system - largely as a result of those changes.

The Report fails to consider the likelihood that the problems were because the system was flawed. They ignore the possibility that the responses were inappropriate (even ad hoc) because those responsible were not prepared to even consider the possibility that the system was at fault. Is what we are getting now going to be any different?

Example 8
Another strategy by those promoting an ideology is to forcefully state the presuppositions that underpin an ideology as if they are incontrovertible and incontestable certainties. A situation, really an atmosphere, is created in which those who challenge this strip themselves of credibility. Competition is used in this way as are several other key "self-evident" words, throughout this Report. For example in Vol 1 on page 136 in the section on improving efficiency, the Report uses several of these words. It asserts that

"current arrangements such as supply constraints., do anything but encourage competition between providers or provide incentives for innovation. Moreover, - - - - , addressing impediments to competition would provide scope for improving productivity and enhancing competition."

We are talking about a humanitarian commitment, the involvement of a community - cooperating in a common desire to care for their less fortunate fellows. What can anyone possibly compete about that would not create rivalry and conflict; that would not undermine and compromise the cooperative effort and shared values and norms of service and compassion that underpin the care of frail fellows.

The words "compete" or "competition" appeared at least once in volume 2 on 83 pages. "Cooperate" or "cooperation" appeared on 8 paged and 3 of those were in the name of an organization.

"Incentives" are used in a similar way and become the self-evident solution in situations where people need to be motivated. The word appeared on 75 pages. "Motive" appeared twice. The driving motivational forces in providing care are empathy and compassion. That bribery with financial enticements cheapens and trivializes what is desired is ignored. That turning humanitarianism into a commercial transaction separated from its human context cheapens it, and is counterproductive, is never confronted.

Efficiency is another unchallengeable good that covers a multitude of sins especially when it is driven by the imperative to compete for more profit. It is a no-fail rationalization for reducing staffing and other costs while compartmentalizing, or not seeing, the consequences. It is present on 83 pages.

All of these phrases and assertions interleave with "sound good" words and paragraphs. I have no doubt that there is a genuine focus on objectives that aim to address the problems and bring better care. The problem is the unstated "belief" that the two are interdependent and not contradictory. Components from each of the

mental compartments are tied so tightly together with the same rosy ribbons that their incompatibility and inconsistency is obscured.

Example 9
On Page 490 volume 2 the Commission welcomes increased consolidation into larger units.

> **"The Commission expects that this consolidation will continue, with efficient and dynamic providers taking over from those that do not have sustainable business models. This will provide further economies of scale and scope, benefiting both consumers and the taxpayer."**

When market oriented groups like the Commission talk of consolidation they are talking about mergers and takeovers. These may create a major risk. Local not-for-profit or community groups that spend on care can be acquired by an aggressive profit focused market listed or private equity competitor. The focus shifts to cost cutting rather than care. Residents who chose carefully and wisely can find they had no choice in the sale of their care to an operator from hell.

Multinationals are a particular risk as their distant shareholders are not impacted by adverse publicity in another country. One private equity group has recently been accused in the press of stripping the assets from a subsidiary in a second country, pushing up its profits by locking it into long term arrangements before selling. It was left unstable and vulnerable to the first market downturn.

3.4.4 Opening up supply and a free market

We clearly need more nursing homes to accommodate the looming age bulge, but worrying to the government is the failure of the market to take up the places offered by the government. It is the lack of profitability not the lack of supply that is restricting investment.

The commission uses this as an argument for removing all restrictions on supply - a market fundamental justified because a free market is claimed to be self regulating. The claim (page xLii) that this is "essential to the success of the reforms" is pretty thin when no one is taking up what is on offer. The reforms are also making more money available by raiding the family home, offering choices, and reducing oversight. That will be the attraction.

These changes, they claim, will free up the market and solve the problems - a statement of faith in the implicit belief that a free market is the preferred means of providing health and aged care. Evidence does not support this. Barlett and Steele widely praised award winning New York Times investigative journalists have carefully examined the consequences for health care. Their conclusion

> **Much of the turmoil is a direct result of a national policy to run health care like a business, a misguided notion promoted by Washington over the last two decades that the free market and for-profit health care would restrain costs and bring high-quality care to all. On both counts, the experiment has failed miserably. In the meantime tens of billions of dollars - money that could have gone into patient care - has been drained from consumers and corporate subscribers and transferred to investors, executives, and others who have a stake in perpetuating this myth.**
> ***Critical Condition: How Health Care in America Became Big Business & Bad Medicine*** *by Barlett & Steele p 4 (Doubleday Nov 2004)*

3.4.4.5 Déjà vu

We heard all these claims about a free market in 1997, but now it seems they did not go far enough. If a market does not work then it must be that its not sufficiently market like and must be made to conform. A vicious circle of cyclical deteriorating care and then more free market reform is set up. This is the story of health and aged care in the USA!

The way the market might respond to unrestricted supply when the necessary conditions do not exist is illustrated by an example.

> **Example:** Around the beginning of the 1980s there was anxiety in the USA because of a perceived need for much more psychiatric care. Children and adolescents were seen to need this most of all. The market was not meeting this need.
>
> Government responded by lifting restraints on supply, lifting regulatory restrictions and improving insurance, particularly for children whose insurance for psychiatric illness was extended from 1 month to 6 months.
>
> In the enthusiasm to build there was soon an oversupply of beds. Corporations responded by mounting a television scare campaign promoting screening clinics for psychological problems. The prime objective of these clinics, often located in schools, was to persuade people, particularly children into hospital.
>
> Bounties were paid for admissions to hospital. Bounty hunters as far away as Canada made good profits sending insured people to the USA. One company even started kidnapping children.
>
> Every day, while in hospital large amounts of unneeded therapy was given. Children were kept in hospital for long periods. This was harmful. Vast profits were made and stock prices soared. Analysts waxed lyrical. Corporate leaders were lauded, given privileged positions at the political table, and rewarded with university honors, lectures and appointments.
>
> The profit spiral finally imploded when a policeman believed the parents of a kidnapped adolescent, rather than the hospital that had arranged the kidnapping. A state senator decided to investigate what was happening.

The commission do propose a gradual reduction in supply restrictions but I wonder what will happen as the aged care bulge passes and beds are empty.

3.4.5 Funding of Aged Care

My prime interest is, not how aged care is funded, but how, and by whom, it is provided. The money has to be found and one way or another we need to find it. My only concern is that it should be fair, but that is not the concern of the market. They simply want more and they can get more from individuals than they will from government! My interest here is the strategies used to justify what they decide.

3.4.5.1 The reason for the inquiry

The unwillingness of the government to raise taxes and fully fund aged care to the extent demanded by the marketplace is the force driving this inquiry. This has brought the providers to the table demanding change. They want access to the vast wealth locked up in the houses of middle Australia. For older Australians, their

homes, worked and saved for, have the same sort of iconic status as the land has for the original Australians. They want to pass it to the next generation.

Government has finally bowed to the marketplace lobby and has agreed to this agenda. Is it a Freudian slip that on page 112 volume 2 the Report admits that this is what the government wants from them

> **However, if the Government requires care recipients with low income, but with assets, to contribute to their care costs, a vehicle is required - - - -**

The productivity commission, whose previous reviews have advised tapping into the family home, was chosen to find a way that can be sold to the Australian public. We should worry that once they have their feet in the door the market will want more and more.

3.4.5.2 The railway track

There are arguments for asking those who can afford it, to make a contribution to their care. Co-contributions are claimed to limit unnecessary usage. People should certainly be asked to pay for extra luxuries. The community's empathy extends to good care, attending to the needs of the elderly, not to their whims and particular lifestyle extravagances.

It is clear that the family home was always going to be the target of this inquiry and that to get it past the public the commission would have to means test it and protect those family and dependents still living in the house. This discussion is a long and circuitous railway track running from A to B. The train was always going to arrive at B. So it is not surprising that this is what the commission ended with.

This necessity has resulted in a complex and unwieldy system of funding and regulating. This includes breaking up a continuum or costs into artificial compartments, which will be difficult to monitor or control. There will be opportunities for cost shifting between these compartments as competitors strive to increase profitability. Someone, almost certainly the frail customers will pay more.

3.4.5.3 Fair like our health system

I do not want to get involved with all the detailed arguments and rationalizations involved, and all the views discussed. It is enough to make some simple points about the solution and how all this complexity could have been avoided.

Under the section who should pay in Vol 2 on pages 16, and then 19 the Report says

> **"The principles underlying the funding arrangements for aged care health services should be the same as those applying to other health care services."**
>
> ---
>
> **"While aged care costs are reasonably predictable at a population level, they are less so at the individual level."**
>
> ---
>
> **"- - - - points to the need for a risk/cost pooling or sharing mechanism"**

But well no not quite what is being proposed:- Yes! Yes! Most would agree. But then the Report deviates from this to suggest that Australians should pay if they can but be protected if they can't. That is not the same thing at all. They talk about equity and talk about intergenerational equity. Somehow they claim that what is essentially an inequitable and variable, if means tested ante-mortem tax that some pay and

others don't, is something that is fair. Apart from anything else its unpredictable will make estate planning difficult for many

Being fair:- Frailty and dementia are lottery items like disease. Some of us get them and others don't - in spite of anything we do. The person who has a quick death escapes and does not enter a nursing home. A person who draws the straw with dementia may spend years there and have the value to their house significantly eroded through the government's scheme, so that it has to be sold when the debt is finally paid. Long made family plans and dynastic traditions in middle Australia can be fractured. And this means tested and capped draw down on the house is only a foot in the door.

No one can predict that they will end in a nursing home and so be expected to pay accommodation charges twice, to keep their partner at home, and assure succession. That is not predictable as claimed on page 13 of Vol 2.

Because ill health is unpredictable the Australian health system ensures that every Australian has basic health care covered by Medicare and a public hospital system providing accommodation that is open to everyone. The private system is available for those who want more than the basics supplied by the community through their contributions. People can insure to cover this additional expense if they wanted to.

Medicare has been so popular that the economic rationalists have dared not tamper with it. It has been affordable. The public hospital system was so popular that government had to prop up the private insurers with public moneys so that the private system could compete.

Accommodation bonds, 1997 revisited:- There is a remarkable bit of rationalization about accommodation bonds on page 36 of volume 2 when describing the public revolt against accommodation bonds in 1997/8.

> **- - - - , but the proposal was quickly retracted as a number of baby boomers (supported by various stakeholder groups) strongly objected to the prospect of losing control over their inheritance."**

Fascinating that a massive public revolt at a grossly unfair tax, which only those unfortunate enough to live to become frail and demented would have to pay, is now attributed to those greedy and wealthy baby boomers, who in 1997 were still 15 to 25 years away from thinking about a nursing home - and those stakeholders (is that code for political opponemts?) who supported them.

I always thought that it was the Aussie battlers, many of them much nearer to the nursing home threat, whose support Howard had used to gain power, who now saw him grabbing the only asset they had, one they cherished. He was depriving their children unfairly, while others with children would escape. Could I have been so wrong - or does this tell us something about the commissioners and where they are coming from!

Missing the point:- In the section on "Drawing on Family Equity" (ie the home) they quote a number of provider as well as one community organizations to claim that Australian's no longer have the same attachment to the family home and so would be more likely to agree to accept this. But the issue is one about the values of fairness and equity - that people are not penalized for misfortunes over which they have no control. That is the Australian way but it is not put to Australians in this context.

A Fair funding model:- An equitable Medicare type system could be provided by a general post-mortem levy based on assets, (with some protections), sufficient to cover the basic costs of good care and nursing home accommodation. This would

be known in advance. Savings and estate planning could be adapted to accommodate it. Those who wanted more luxury could save accordingly. It would be equitable. The intergenerational equity about which the commissioners were so concerned would be fully addressed.

This sensible way of funding was suggested by Michael Fine (page 112 vol 2). He too had reservations about this antemortem raid on homes.

> **"- In particular through the levy of a modest estate duty following death, - - - - , Australia is the only advanced economy without such duties. The wisdom of attempting to introduce payments based on housing equity for aged care in their absence is dubious."**

But government has blocked this:- Fascinating and revealing is that the only reason for rejecting this given on the same page is that the Government requires low income people to pay for their care. What else have the commissioners appointed to this inquiry been told that they have to do?

> **However, if the Government requires care recipients with low income, but with assets, to contribute to their care costs, a vehicle is required - - - -**

Benefits:- With a postmortem levy there would be no need to complicate the issue by fragmenting the needs of the elderly. The levy could be adjusted to cover the costs of all the care needed and to pay for expansion. If co-payments were thought to have benefits they could be added. I recall that there was little evidence to support this.

A system like this would call for financial accountability and so be less profitable and more efficient. But the corporate marketplace might be wary about investing as there would be less latitude to manipulate the system for profit. This option was never considered and this may be why. When profit is the determining consideration you have to meet this essential need!

3.4.6 Removing Onerous Regulations and oversight processes

3.4.6.1 How onerous is it?

Providers and also staff have complained bitterly about the regulation of aged care. You can understand that both might be uncomfortable with processes that expose their shortcomings, and so rationalize and press for their removal.

The Report accedes to this view. On page 13 of Volume 1 it says

> **"Regulation of the sector is extensive in scope and intensive in its detail."**

Whether this is actually so is far from clear. This is exactly what was said in 1997 when corporations wanted to get rid of objective oversight and accountability in staffing ratios. A free unregulated market was set up to do this. Almost all of the regulations requiring transparency and accountability were removed and replaced with less onerous processes. Little useful information about care came out of this reformed system. More has come from nurse whistleblowers and newspapers. Yet now we have more of the same claims!

3.4.6.2 The problems

I agree that current regulations don't work and simply muddy the waters. As explained earlier the system was not intended to work but was set up in 1997 to make it look as if it was rigorous and would detect failures in care. History and many submissions indicate that it has not done that.

Most of the information actually needed is or should be collected by providers themselves as part of their regular activities. In the age of computers disclosure is not onerous. It simply needs regular random verification.

A multitude of complaints in the past attest to the failure of the accreditation system as a regulatory process. The Walton review exposed the complaints system as a process that did not work. What would she have found if she had looked at regulation and the accreditation process?

The idea that the system should be accountable and open to inspection is played out in name only. Reports by, for example, the accreditation agency, have been deceptive if not actually dishonest; from its inception.

3.4.6.3 Deceiving the public

This deception was only exposed, in 2009. The Aged Care Crisis Centre collected accreditation reports and compared them with the minister's reports to the public. The agency and the minister were underreporting by a large number and they both knew it. They were colluding in deceiving the public. (See http://www.agedcarecrisis.com/aged-care-report-card)

3.4.6.4 Ad Hoc regulations

The "ad hoc" regulations introduced in response to the multiple crises that the inquiry refers to, but ignores when it makes its extravagant claims about "quality of care", were inappropriate because they so carefully avoided addressing the reasons for the failures and simply played to public demand that something be done.

So yes the regulations that don't work should be removed provided that the reasons for the scandals that prompted them are properly examined and the root causes identified and addressed.

I did not see any reference to the 2006 rape scandal that precipitated regulations requiring compulsory police checks on staff (but not on management). The commission might not have wanted to open that raw wound again, but if it does not do so, and reassess what happened and why, then it cannot convincingly remove what was done then and claim to have addressed the problems in the system.

So the whole regulatory structure needs to be dismembered and redone, but in addition the way the system is conceptualized, and the way people think about it needs to change,

The issues are

1. Whether the core problems have been examined

2. Whether the changes recommended address them

3. Whether the government will have the will to follow the recommendations

4. Whether the powerful provider and corporate lobbies will allow the government to do so.

5. Finally, if the recommendations actually get as far as this, whether, what the commission suggests, will work is ultimately going to depend on the details - the way that the new system is implemented on the ground.

This is where its easiest to rationalize and justify. This is the coalface where the people on the ground come into direct contact with the contradictions at the heart of the system. This is where they come into conflict with aggressive managers who claim the high ground and who confidently assert the validity of what they are doing and ridicule the less credible concerns.

3.4.6.5 Regulators are vulnerable too

Those on the ground are going to need a powerful support mechanism if they are not to be brow beaten or even converted to the management's position. There is much to suggest that this was a core problem in the current complaints system, and possibly the accreditation system. It extended, from managers in DOHA's complaint system, down to the investigators themselves. Nursing home managers were almost always viewed as more credible than the resident's families or the whistle blowing nurses in conflict with management.

In my submissions I suggested changes that would give the staff employed to investigate complaints and monitor standards strong local and where necessary on site support. The commissioners chose not to discuss these suggestions in their Report. I like to think that they would have been effective but might well have been strongly opposed by the provider lobby.

3.5 RESTRUCTURING THE AGED CARE SYSTEM

3.5.1 Whether the core problems have been examined?

No one could possibly complain that the commission has not looked closely at their submissions, that they did not give them some attention, and that they did not address most if not all of the concerns.

As I have indicated before the Reports skates around the fundamental paradigm conflict between the way the community sees and expects the system to operate and the way the market requires it to operate. Were it to actually do so then it might well be able to take the steps needed to confront and deal directly with the contradictions. As a consequence it speaks with the voice of the community but does what the market demands. It slips its market views and prescriptions into the community dialogue.

It cannot escape the problems that do exist and consequently does make many recommendations that are positive and useful. If they are implemented they will have a positive impact.

3.5.2 Gathering Information

3.5.2.1 An important recommendation

One of the strongest criticisms by multiple critics is the lack of information about what has been happening in aged care, about a lack of transparency in the information that is available, and about the obtuse and un-meaningful way it is made available.

The most important of the recommendations made by the commission in regard to nursing homes relate to the collection of more objective information and to creating a

clearinghouse where all the information is collected together, processed and presented to the public in a comprehensible and transparent way. The steps described under Policy and Research (Page LXXIX), particularly relating to common definitions, data bases, outcomes based standards and available information are all simply basic good governance to meet expected accountability to the community.

3.5.2.2 Risks

While these recommendations are in keeping with suggestions many of us made, a critical component is missing.

There are major risks in placing the control of information under the control of an individual or a closed group of individuals. Processing information requires interpretation. Interpretation is never totally objective as information is always interpreted within some framework of understanding.

Whoever controls the information controls the system. There will be a lot of effort devoted to getting the people whom power-brokers want into positions where they can control information and present it in the way they want. A structure like this is always at risk.

However objective the clearinghouse may try to be it is likely to present only one way of looking at the information. It will not be seen to be objective by those with a different perspective. As explained earlier there will be strong pressure to fudge issues when the AACC's activities are revealed to be wanting and it is being criticized.

3.5.2.3 Dealing with contrary views

On pages 402/3 in Vol 2 the Commission acknowledges the Aged Care Crisis Centre's contrary view and concerns about having all facets of regulation and information handling under the AACC. It also acknowledges mine about the difficulties in changing an entrenched culture. It justifies ignoring these on the basis that "responsive regulation" is difficult to achieve when the components are structurally separated. It claims that regulation would be enhanced, by keeping them together and strong leadership would overcome cultural problems. Is this a rationalization?

In spite of these claims the Commission envisages that the current board of directors would remain as advisers. It counters the risk of their perpetuating the culture by appointing one or more consumer representatives. Without a coordinated community group based around the coal face to represent the community, these appointments might well be no more than window dressing, and have little impact. Who will appoint them?

3.5.2.4 Ignoring a solution

I was careful in my submission to press for the focus for the collection of information about care to be moved into the community. I suggested it be collected under the oversight of an influential community group, who would be party to the information sent to the clearinghouse. It would also act for the clearinghouse locally in disseminating information, and advising prospective residents. So the information would go in and out through organized local groups. Transparency would be assured and differences of opinion fed back up the system.

In what I suggested all oversight and data collection would be conducted as a joint venture between community and the AACC. This would meet their objective of "responsive regulation", but without the risks inherent in a monolithic organization that is not required to justify its position.

On page 145 of volume 2 the Report says that the Gateway would

> **deliver its services through a locally devolved network of Gateway centres. Each of these local centres would provide information, needs assessment and care coordination and draw heavily on local knowledge.**

and on page 150

> **- - and their operation may be subcontracted to third party operators including other government agencies or non-government private entities.**

On the same page 150 the Report quotes from my submission in regard to the importance of people with knowledge of local providers being involved. This centrally controlled local system is very different to that I suggested. The individuals who do the assessments of standards of care and quality of life will not be there to share their assessments. As importantly the community will not "own" the information and be sure it is verifiable so may, perhaps with good reason, distrust it. My submission aimed to empower communities so that they had the power to be the effective customers.

I suggested that the local community groups should also have representation in the Gateway. This would ensure adequate representation by a multitude of points of view so that the information would reflect all their needs. It is not sufficient to simply appoint a "community representative" to this body. It needs to be a powerful representation by a powerful community organization involved at the coalface of aged care.

3.5.2.5 Feedback

Top/down structures are seldom truly democratic. They are always at high risk of being out of touch and of dysfunction. In my submissions I proposed an intersecting bottom/up structure wherein community structures close to and more directly involved at the coalface, exerted some control and had representation all the way up the system. This is democracy. It creates the balance of power and points of view essential for democratic systems to work.

The Report talks of objective data and of transparency but does not actually spell out the details. These details will be far more critical than any of the recommendations made. Once the system is set up there is no feedback loop through which the community can indicate its displeasure at what it is being told, and require this clearinghouse to give them the information they need. Democracy is not just about votes. Its about representation and participation throughout the system we live in, so people feel and are involved.

In Vol 2 on page 409 in the section on communicating with stakeholders the Commission stresses the need to have strong internal feedback loops. The providers will be pressing their interests at every opportunity, but the Report stresses feedback from consumers and their representatives. It is far from clear how these representatives would be selected and by whom they would be appointed. The community structure I suggested would have institutionalized a feedback loop with those most focused on the welfare of the aged and directly involved in aged care close to the coalface.

3.5.3 The Complaints System

Professor Walton's review of the complaints system is damning and the commission has accepted her recommendations. They have advised it be removed from DOHA and that Walton's recommendations be implemented through a separate division of the new independent regulatory body.

My argument with this is not with what they propose but that this too is being set up as a top/down system, in which this new agency will send people to investigate complaints. It suffers from some of the same problems. While Walton stresses the importance of local mediation, she leaves this in the hands of the providers. There is no knowledgable local person to facilitate this and ensure that the family are not intimidated, and that they are not stopped by the fear that their efforts will compromise the care their relative gets. These have been problems in the current system. Telephonic contact is not enough.

I suggested a bottom up component for this as well. Initial mediation should be facilitated and monitored in the community, who would also collect information early on, long before the central agency became involved in a formal complaint. Most issues would be resolved locally on site and not by fly in fly out investigators.

3.5.4 Accreditation and regulation

3.5.4.1 Wishful assertions

One of my difficulties is that the Commission, on page 194 volume 2, starts from a position, which precludes it from acting effectively.

> **- - - one of the strengths of the Australian aged care system is the accreditation and quality assurance framework. DOHA described Australia's quality framework as being one of the best in the world.**

Critics see accreditation as a tool for improvement when providers are motivated but as a failed regulator when they are not. As a regulator it has failed in the USA and in Australia. Even the accreditation agency does not consider itself to be a regulator. It is a weakness not a strength - an example of asserting the opposite of the major weakness of an argument as if it was an unchallengeable truth.

One of the strategies employed when under threat by those at the dogmatic end of my spectrum of individual behavior is to make strong claims and assertions in areas of greatest weakness - so strongly as to challenge anyone to have the temerity to disagree.

> Example:- In 1993 a US company, whose probity was being investigated by NSW Health Department made exaggerated assertions in regard to major deficiencies then being exposed in the USA of which NSW was aware. At the time NSW Health accepted them without question.
>
> There is no doubt in my mind that the claims were made in all sincerity, but in the face of the obvious. Examination of the company's internal documents revealed these assertions to be integral to the delusional patterns of thought and rationalizations on which the company's subculture was built.

3.5.4.2 Accreditations problems

Accreditation processes were designed to assist motivated facilities improve their standards of care and as such they are closely aligned with the facilities they serve. They were never designed as regulators nor as an oversight mechanism. There is a glaring conflict of interest. As a regulator it has been a dismal failure. Actual care, not

processes, is the measure of standards. As the 2007 Campbell review revealed accreditation does not measure care as such. It works by inference.

In my view the accreditation system is the major deficiency in the regulation of aged care in Australia and the reason why regulation has not worked.

The patterns of thinking that underpin the accreditation process are not suited to the collection and collation of real data. Simply advising that more objective data be collected and then moving the accreditation agency from its own "independent" structure into one of the arms of the recommended new "independent" AACC's regulatory arm of the commission's new system is not going to change the way accreditors think and operate (page xLvi). Its going to be simply more of the same.

The Accreditation Agency asserted very strongly in its response to the draft Report (subdr763.pdf) that it was not a regulatory body and clearly did not want to regulate. On page 395 Vol 2 the Commission indicates that ACSAA emphasized that

> **"- - - its key responsibility centres on supporting and encouraging quality improvements through a strongly collaborative approach with stakeholders. It argues that this activity does not align with an inspectorial approach."**

This seems self evident. I agree with this as did the Auditor Generals review of the agency performed in 2003. The Commission however rejects this out of hand.

> **"The Commission's view, however is that under a 'responsive regulation' model, these two roles can work in harmony"**

It goes further on page 401 asserting that

> **"one of the primary functions of ACSAA is a regulatory one"**

So we have a regulator who claims its primary allegiance is to the providers of care and which does not want to regulate. It is being told that regulation is one of its primary functions. Can we expect it to do that well? Its a big ask for "strong leadership" to turn that around as the Commission so confidently claimed.

3.5.4.3 What the Commission does

The Commission is removing the regulatory and disciplinary function from DOHA and giving it to the Accreditation agency in its new home with the AACC, a group that simply wants to help the providers not punish them. It is also being put in charge of the approved provider process. I quote from page xLvi (but note also Figure 4 on the next page).

> **"Alongside the AACC's education and compliance activities it *(ie the old Aged Care Standards and Acreditation Agency)* would also determine enforcement sanctions, drawing from a broad range of enforcement tools."**

It is not clear how all this is going to work and as such it is likely that the same processes will be followed. It seems that accreditation findings are still to form the basis of the regulatory and oversight process but will be complemented by a much greater focus on "quality indicators" which the reviewers in 2007 thought it was inappropriate to collect.

3.5.4.4 Will this work?

Apart from the inadequacy of the accreditation process both the accreditation visits and the visits by the DOHA regulatory agency have been infrequent, disruptive and put everyone in the nursing home on their best behavior. They are not a measure of the day to day performance of a nursing home. Will this be any different?

In my view this arrangement is retrogressive and will exacerbate the problems we already have. ***The commission is emasculating regulation and instead relying on the market power of the individual isolated frail elderly to control dysfunction through market forces.***

From the point of view of the frail elderly, if they fully understood what was in store for them, oversight of the care they receive is probably the most important reform required. Instead the commission is simply moving the pieces about and compounding the problems by "reducing onerous oversight".

3.5.4.5 A better way was suggested

In my submissions I suggested that the accreditation agency be tasked with educating and assisting the nursing homes in setting up processes to improve care. They should have no part in assessing care or regulating

There is abundant nursing and medical expertise as well as families with extensive experience in the community. Retirees and people raising families are well positioned to provide regular oversight provided they have free access to the nursing homes and can do so in their own time.

I urged the commissioners to support the creation of strong community structures to employ and support these people to mediate complaints, monitor care, and verify reported data. They would advise and coordinate services locally.

The Commission addresses this issue on pages 424-6 by recommending a new expanded and empowered Community Visitors Program but this will not control data nor is it clear how much power they will have and whether they will be involved in helping prospective residents to choose.

3.5.4.6 More compartmentalization

There is another example of compartmentalization on page 202 in vol 2

> **Stronger competitive pressures should provide an incentive for providers to find more cost effective ways to meet the requirements of the compliance framework. This in turn could mean better care for recipients and a more attractive environment for staff.**

My experience examining failures in accreditation is that competitive pressures for profit drive competitors to find ever more ingenious ways to learn of planned unannounced visits, and of controlling or otherwise subverting the process. The pressures for profit at the coalface destroy morale while at the same time blunting any pressure for improved staffing. The assertion by the Report in the face of the obvious is disturbing. In the absence of a powerful "customer" competition for profit introduces pressures towards general mediocrity.

3.5.4.7 Objective observations

The Commission gives welcome attention to measuring and recording what is actually happening in aged care in volume 2 on pages 216 and 217. That this is to

be bundled into the same section of the AACC and be part of accreditation is far from reassuring. On page 218 we get

> **The Commission recommends that the quality assurance framework for aged care, and the accreditation role of the AACC be expanded to include collecting, collating and disseminating quality performance indicators.**

The patterns of thinking within the accreditation agency are well formed and will be difficult to change. Ideas that underpin the way accreditation operates (see Campbell Report 2007) are not congruent with effective recording of objective data. Their role in supporting and helping providers adopt processes creates tension when their teaching proves ineffective, and particularly when processes don't achieve the desired objective outcomes, so challenging the effectiveness of their efforts.

3.5.4.8 Consequences

If DOHA was not considered to be an appropriate regulator then we may be jumping from the pan into the fire. I am not persuaded that this new arrangement will be an improvement. We needed another independent Walton Report but got this instead. I worry that the providers are now so powerful that they are in a position to veto what the government knows it should do. Could the preservation of the accreditation process be another requirement that the government expected the commission to meet?

In my submissions I urged the Commission to place the collection of data, and the examination of compliance with processes, when failures occurred, within the framework of a community organization. The central regulator would act as trainer and mentor. Data would be automatically fed to the accreditation process for remediation.

3.5.5 Care, quality of life and onerous regulation

3.5.5.1 What data?

The ultimate goal is a good quality of life. Good care is a prerequisite for this but does not always result in a good quality of life. Some care can be measured but other parameters of care and quality of life must be assessed more subjectively

The collection of data on standards of care and quality of life is not always simple. This comprises

> 1. Objective measures of care include the incidence of pressure sores, weight loss, contractures, medication errors, time to answer call bells etc. Also a record of claimed and actual nursing numbers and skills and the funds spent on care and quality of life services.
>
> 2. Observations of what happens in nursing homes including how incontinence care is provided, and how staff relate to residents. Whether the processes set in place during accreditation are actually followed and how this relates to failures in care.
>
> 3. Subjective assessments of relationships and quality of life. These are readily apparent to those who regularly visit and talk to residents and staff.

3.5.5.2 How to collect data

The first item includes data that is or should be collected by every clinically and financially responsible nursing home, or aged care corporation as part of their financial and clinical governance.

As I indicated in my preliminary comments the sort of people who too often succeed in a health or aged care market avoid unpalatable information. They will make every effort not to collect it.

Agreed core data that every nursing home should be collecting should be specified as being among the minimum required. There should be a system of regular on site monitoring to ensure that this is accurately collected.

The second and third items require regular ongoing observations of day by day activities. Fly in fly out visits once or twice a year will spook staff, come on a bad day or on a good one. Its inaccurate and unfair to everyone. Its obvious that that is what is going to continue.

In my view a major advance would be to replace the infrequent but disruptive announced or unannounced visits by accreditation or regulatory agencies with regular informal attendance by trained members of the community, talking to nurses, patients and looking at records - people who would be part of the everyday furniture who would see what happened on a day by day basis. This is what I suggested.

This would remove the "onerous" from oversight and regulation. It would be far more effective. They would be in a position to report back to the regulator and accreditation arms at a much earlier stage of dysfunction so that remediation could be prompt and effective. They would be supported by the community group, of which they would be a part. A regular onsite presence would reduce the frequency of the disturbing failures, which have bedeviled oversight by the accreditation agency.

3.5.5.3 Financial Accountability

Expecting nursing homes to supply a copy of their financial statements on request is not going to be sufficiently useful or understood by the majority of residents. Other formats such as a graph showing the moneys spent on care across the sector with the nursing homes of interest highlighted would be far more useful.

Financial statements should be verified at the community level and fed centrally where data would be collated and reported back. Financial information and, if needed, audited statements can be provided by local advisers.

3.5.5.4 Visitors

The creation of independent, well trained visitors modeled on those in other sectors in some states is highly commended, as is the support for advocacy services. The visitors and advocacy services are to be funded by DOHA. To whom will they be responsible and to whom would they report? How would they integrate with the AACC regulator and the community. What leverage would they have? I suggested that they be integrated through the community structure I proposed. This would give them a voice and leverage.

3.5.6 The approved provider process

In 1997 the probity requirements for aged care were abolished.

3.5.6.1 Probity reviews

Probity reviews such as those in state health departments examine the conduct of the applicants for licenses and consider whether they can be trusted to operate in vulnerable sectors where citizens are at risk. Decisions are based on the level of control they will have in the new company and so also on its subsidiaries. Control is measured by the financial stake the investor will have. This determines the role they will play in making decisions and appointing staff who will do their bidding - financial stake is a measure of their influence.

3.5.6.2 Approved provider status

All this was turned on its head by the approved provider process even in its later revised form. Financial control became a non-issue. The risk posed by unsuitable owners who appointed managers and made financial decisions was ignored. Instead the focus was diverted to the managers they appointed and the subsidiary company providing care. It is far from clear how the "suitability" of the owners who control the money is assessed. We do know that the owner, who is permitted a criminal record, is required to appoint managers who do not yet have a criminal history to their subsidiaries - to do what the owners want.

As owners do not have to seek approval, corporate owners who have criminal records or who have failed a state probity review are free to buy up as much of our aged care system as they like provided they buy up subsidiaries that already have approved status. Having approved provider status is therefore an attractive commodity for sale, especially for those with a record of exploiting the vulnerable. Owners that would not and have not met state probity requirements have purchased Australian aged care companies without undergoing any form of assessment.

Applications for approved provider status are commercial in confidence so there is no opportunity for anyone with knowledge of an applicants misdeeds or unsuitability to supply this. It is clear that regulators rarely do internet searches.

3.5.6.3 FIRB

The Foreign Investment Review Board (FIRB) vets foreign investments into companies worth in excess of $280 million. Because of our special arrangement with the USA, US companies are only vetted if they invest in companies whose value exceeds $1005 million, way in excess of the value of any of our aged care groups. US aged care and investment corporations have particularly poor probity records. Probity is not a criterion for providing health and aged care or for ownership in the USA.

3.5.6.4 The Commission's response

The commissioners were made aware of these issues but chose not to mention them in their Report. They simply recommended that the existing approved provider processes be transferred to their regulatory body and put in with the accreditation agency - hardly reform.

I suggested to the commissioners that the approved provider status be revamped, that it be public, and that participants of the communities whose facilities were being purchased should have representation. They should have some "choice".

3.5.7 Workforce and resource Issues

3.5.7.1 Staffing and markets

The most critical issue for standards of care and quality of life is the number, skill and motivation of staff. The commission makes many very useful proposals to make staff more skilled, more motivated, and better paid. They are welcomed. It refused to impose mandatory staffing levels as advocated by many of those concerned about the standards of care provided, and by the many reports of understaffing.

Contrary to the Commission's claim, on page 370 in volume 2, the existing accreditation process has not been a successful mechanism in inducing providers to staff appropriately. It's pressures are no match for the pressure for profit. It has quite obviously not worked.

This is a market and all of the pressures in this marketplace are towards fewer and less skilled staff and lower salaries. The commissioners know (page 350 vol 2) from some of the submissions that while there is a shortage of staff, there are also trained people looking for work and many interested in working more hours.

The number of nursing staff with skills has fallen steadily over the years. The clear message is that some sections of the market are capitalizing on the shortage to make more money and not even employing what is available. It is deskilling and not trying to attract. It is far from clear how this new system will check to see that increased funding reaches staff rather than shareholders, and that skilled staff are employed and welcomed.

When pressures for profit impact on the working environment, staff are alienated and turnover increases as does the use of agency staff. Staff turnover is a useful measure of nurse satisfaction and a marker of poor care. It would be interesting to compare not-for-profit with for-profit nursing homes. I recall that in the USA turnover was higher in for-profit facilities. On page 358 in Vol 2 the Commission considers variability in management as a cause of staff turnover.

> **The variability of management within the aged care sector is an important determinant of the attractiveness of individual service providers as places of employment**

They did not indicate which sectors had management with poor staff retention.

3.5.7.2 Mediocrity

Support for the assertion on page 352 that

> **"- - - - to ensure the best use of scarce workforce resources, wherever possible, services should be delivered by staff with the most cost effective training and qualifications to provide safe, quality care."**

sits a little uncomfortably with a claimed focus on striving for ever better care to meet the "continuous improvement" focus of accreditation. Surely they should be striving and competing to employ ever better qualified staff, rather than settling for mediocrity?

The accreditation process discourages better staffing. When profit and not care are the driving force, then the accreditation bar, which everyone passes, simply has to be met. It becomes a minimum requirement not a measure of excellence - a recipe for mediocrity. It does not have a range sufficient to measure achievement. Exceeding it by improving staffing is not efficient or competitive.

3.5.7.3 Transparent staffing

On page 206 of volume 2 the Commission

> **"suggests facilities should be required to publish staff qualifications and skills together with a profile of care recipients."**

I indicated in my submission that the commission would lack credibility if it promoted a competitive market but did not subject staffing levels and skills to market forces. This suggestion is therefore very welcome, but it is only a suggestion and not a recommendation. Whether it will get past the lobbying and be incorporated in the regulations remains to be seen.

Will the figures be published in the context of a range of acceptable staffing levels for the care profiles of the nursing home? Are staff turnover rates to be disclosed as well?

3.5.7.4 Transparent funding of care

It is refreshing and welcome that later on page 218 of volume 2 the Commission also recommends enhancing

> **"transparency and accountability about funds spent on care."**

3.5.7.5 Customers and staffing

If this market system is to work for care then sellers must compete to provide better staffing. That will only happen when the profits from having more staff significantly exceed the savings from not employing them. Increasing care staff's salaries is going to increase the disincentive.

Will the Gateway collect information about staffing and if so how? Will nursing homes publicly display the names of staff on duty and will there be any way of collecting it and verifying it. How will a system based on occasional visits for accreditation and oversight reliably monitor the record of staff on duty?

That market pressures from the frail elderly customer - even with the better information available - will be sufficient to make better staffing more profitable than understaffing is expecting a lot.

On page 207 of volume 2 the Commission again asserts its intention that

> **"care recipients will play an increasingly important role in driving improvements in the quality of care because they will generally have the choice to take their entitlements elsewhere if they are not happy with the quality of care."**

These are frail and demented people are clinging onto the stability of their environments in order to grasp and control their lives. They have built important relationships with overworked and thinly stretched staff who are trying. Expecting them to shop around and go elsewhere just so that the system will work better is a big ask!

3.5.7.6 Poaching nurses

Finally the Commission supports and indicates that "employing aged care workers from overseas is likely to pay significant dividends in the future." Most of these workers come from poor or developing countries whose need for nurses and other skilled carers are far greater than ours. Is it ethical to undermine their professional

mission to care for the most needy - their own people - by enticing them to come to Australia with incentives?

3.6 WHO CONTROLS THE AACC

3.6.1 The AACC - leaders and culture

There is much in the Report about the independence of the AACC. But no group is independent of the culture and the society in which it lives - or at least of some faction in that culture. They are all controlled in some way. So, by whom, is this new independent structure to be controlled. Control is a key concern, when considering probity or even suitability.

The new independent structure, that is being controlled, should be independent but that is a contradiction. So who will control? I had difficulty in understanding how officers and managers would be selected; what the criterion would be, and who would decide on who was appointed.

There are many groups that would seek influence. There are patterns of ideology that might be establishment favorites and so much more credible. Those who embrace their ideas are going to be more credible so likely to be selected.

From which sectors of society will the selection panel, and the executives they select, be drawn. Will those from the current establishment, the same establishment that drafted this Report, be equipped to see when things are going wrong and challenge the underling assumptions when they are responsible? When will their experience be a help, and when a hindrance in addressing issues?

Each organization develops its own culture, its own pattern of beliefs and its own way of doing things. These soon become institutionalized and are difficult to change. When the cultural base is narrow it may even become an ideology. If unchallenged it is prone to become arrogant and dysfunctional. From which sections of society will this culture develop?

If the current accreditation agency, and its inclusion as the primary regulator, is an example of what we can expect then we should be particularly concerned about the monolithic structure that the commissioners have proposed.

3.6.2 The consequences

The Commission's Report places the entire aged care system under the control of a select few who recommend how much and who should pay, decide who qualify for care, decide what information the public will be given and regulate the provision of care. While this may remove some of the current conflicts of interest, it opens up the possibility of many more, particularly when ambitious employees stake out their empires, and when the system comes under criticism as it inevitably will. There is no oversight of the monitor and regulator. This is not a recipe for long-term success.

This is a system that reflects the dissonance reduction strategies of the commissioners. It is protected from challenge and criticism. It is designed to be this way. It will be shielded from alternate points of view. In many ways this is a replay of what happened in 1997.

3.6.3 Balance and democracy

Because of these risks, I suggested a transecting bottom/up structure for the AACC. This would have a much wider church and be represented at all levels. It would be in

a position to challenge and bring new insights. It would ensure that the culture was broadly based, open and more reflective. It would provide balance.

A system with a broad church would be well equipped to respond to failures and altered circumstances by changing itself.

3.7 CONFRONTING THE CHALLENGE OF MARKETS

3.7.1 Did the Commission consider my suggestions?

Well I can't be sure but they did not respond in the Report

3.7.1.1 A fete accompli

I am well aware that it is too late to change the market system. We are now in the same situation as the US government found itself in with both health and aged care. In that country there have been large corporate scandals and massive fraud. The collapse and closure of these companies would have disrupted services and many frail elderly might have ended on the streets. They had no choice but to negotiate reduced fines and prop up the companies.

We are heading the same way. The powers in the aged care corporate market can hold the government and even the society, which they should serve, to ransom. We now have to pay them what they ask.

3.7.1.2 What can we do

What we can do is to accept that in spite of the efforts made by the commission isolated frail seniors and their anxious families will never be informed and powerful customers with sufficient clout to confront large corporations and their trained minions.

I suggested, that we create a customer who has the frail elderly's interest at heart and who has real power. The history of our health system shows that risk can be significantly reduced. In these de facto "joint ventures", two interdependent groups of participants, with conflicting ways of thinking, each has leverage. They confront each other and must justify their decisions to the other before they can be acted on. This occurs in the corridors of the hospitals and not in the board room. This is a clear precedent that works.

3.7.1.3 Joint Venture with the AACC

I suggested to the commission that they should develop and foster local community structures in such a way that both the regulatory system and the provision of aged care would be joint interdependent ventures within the community. Different communities would structure these differently depending on their cultural needs.

By jointly controlling regulation and information, and also having central representation in the new AACC a structured community group would be in a powerful position to put their points of view within the corridors of the AACC and press for change.

3.7.1.4 Joint Ventures in aged care

The community groups would have access to the nursing homes and the community. They would know what was happening there. They would have a key role in supplying patients with information, and in advising them about nursing homes and community care.

These community organizations would potentially have a major impact on each nursing home's bottom line - in much the same way as hospital specialists do. The nursing homes would need the support of the community as much as the community needed nursing homes. Local groups would be better placed to support and help their seniors.

Disagreements would be hammered out at the coalface in the corridors of the nursing homes and on the streets of the local town or city. Decisions made in distant boardrooms, or agreed at meetings between large organizations, would be filtered through a rigorous disseminated process located close to the coalface.

An added bonus would be the social capital generated by this sort of community involvement.

3.7.1.5 Integration of services

The Report does seek to bridge the gaps between aged care, health, disability and other humanitarian services. Local community structures would be well placed to see that this happens and provide support.

3.7.1.6 The Commissions response

While the Report does quote me at a number of points and addresses several of the issues, it fails to refer to the key issues I raised or the solutions I proposed. I believe that the proposals I made would directly address major deficiencies in this Report.

3.7.2 What the Commission recommends

3.7.2.1 The good with the bad

This is a vast 700 page report and I can only touch briefly on key deficiencies, and of necessity be a little dogmatic. There is a great deal that is very good in this Report. Its section on the sort of life we should be providing to older Australians is excellent. It deals with the issues of community care, suitable housing, age friendly environments, medical care, palliative care, mental illness, distance, of disadvantage, of special groups like the young, those with different sexual orientation and those with different cultural backgrounds. It recognizes the need that older people have to control their lives, and the importance of cultural context for this. Importantly it looks at the stresses on informal carers, even if it does not confront the limits of their role as customers.

The Report seeks to integrate the services provided so that people do not fall through cracks, yet makes no attempt to integrate the community activities or create a structure where community concerns can be defined and then translated into action. Carers, advocates, visitors and volunteers are each considered in isolation and separate from those who are formally charged with collecting information, monitoring care and providing information to the consumers.

3.7.2.2 Complexity

The complex adjustments made to address the difficulties in all of these sectors are because of the imperative to run this as a competitive market. Additional payments, and financial incentives have to be manipulated in order to attract the market or to counter inappropriate incentives driven by pressures for profit. If it were driven by our empathic desire to serve those in need, then the services and the money might logically follow, although there would still be some distractors.

The market system has to entice by playing on greed and then counter adverse outcomes by counter-incentives and penalties. This requires a complex array of economic levers and counter-levers - incentives. Its difficult to do all this and with the same breath claim efficiency!

It might have been much simpler and much cheaper had the Commission been given the latitude to opt for a fair and equitable postmortem tax and then used the funds to pay for the services that were needed by a diverse range of frail citizens.

The imperative to make this a free unregulated market introduces the sort of complexity and distraction that we could do without. This can only have adverse consequences for cost and care.

3.7.2.3 Loss of social capital

The focus on competition for profit rather than the values in society distorts the way we think about our humanitarian responsibilities and so the motives that should drive care. The social need of the community to cooperate in protecting its members and attending to their needs is forgotten - as is the importance of this for the wellbeing of the elderly.

A system based on greed must not only confront these distractors, it has to compensate for the lack of empathic motivation by playing on their greed and then counter adverse outcomes by counterincentives and penalties. Its difficult to do all this and with the same breath claim efficiency!

3.7.2.4 Retirement villages

It is disappointing that the Commission does not really address the problems in retirement villages. Many of these villages also contain nursing home and temporary respite facilities so have to deal with two separate sets of regulators. Some residents have to face years of inaction by state regulators and large expenses if they wish to enforce their rights when these are abused. They may have selected a rogue operator or, more commonly, been acquired by one. This is something over which they have no control.

3.7.2.5 The Visitors Scheme

A very important recommendations, but one that gets very little discussion or detail in the Report is the recommendation that a visitors scheme similar to that in some of the state disability services be introduced. A number of submissions had urged this.

Critically important to the success of such a scheme will be the details. What powers of investigation will they have, how will they be structured, to whom will they be responsible and what power will they have to force consideration of their findings and to confront corporate power? These issues are not addressed. In my view visitors and advocacy groups should be integrated into the community structure I suggested.

Support for the frail aged person in this Report is fragmented across multiple organizations, none of which have real market power. By integrating all these services into community structures we would create a group with enough power to hold both the AACC and the providers to account. That is not what these commissioners want.

4 CONCLUSION

In conclusion then the commission has made some very useful recommendation, but they have refused to confront what is undoubtedly one of the key issues for aged care. This is the failure to meet one of the most important of the necessary conditions for a market to work; a balance between the powers of the seller and the buyer.

While choosing to enhance and embrace a market system for aged care, the Commission has ignored what they know deep down is a key concept underpinning the success of any market - a fundamental principle of which they are well aware. This is a real balance of power between the seller and the customer.

What the Report has recommended will be beneficial in many respects but it exposes the aged care system and those it claims to serve to risks that cannot be justified. It ignored advice to this effect.

This was not a deliberate conscious strategy but a common and very human pattern of behavior. It is nevertheless a betrayal of the Australian public whose interests they claimed to protect, and their duty it was to serve.

The commission has created a body which controls every facet of the system, including the collection of information, its processing, its publication, and the advice given to vulnerable aged care “customers”. This creates a context likely to compromise objectivity, reduce transparency, misinform, and resist change. It looks remarkably like the system it claims to reform.