Submission to Royal Commission into Aged Care Quality and Safety

https://agedcare.royalcommission.gov.au

Aged Care Crisis Inc.

8 October 2019

1 Background

1.1 Terms of Reference

Aged Care Crisis made a submission into the Terms of Reference (TOR) process for this Royal Commission, which drew attention to structural problems in the aged care system[1].

We recommended the following additional terms of reference:

1. **Evaluation of structural issues** in the aged care sector that might have led to past and present instances of failures in care. This should determine whether current structure and management practices are congruent with community values and with our knowledge of the behaviour of individuals, communities, society and market entities.

2. **Evaluation of past and present policies** including the **L**iving **L**onger **L**iving **B**etter (**LLLB**) reforms and the Aged Care Roadmap to assess their effectiveness in the light of the ongoing problems in care, current and past research and the known behaviour of individuals, communities, society and market entities.

3. **Evaluation of potential changes** that would address any issues identified in these areas as well as any potential problems that need to be managed.

4. **Examine the role of whistleblowers in the sector** with attention to receiving the support they need, their protection and to suitable recompense when they suffer as a consequence of speaking out.

In our explanatory note we drew attention to structural problems in the 1997 legislation, the Living Longer Living Better reforms and the Aged Care Roadmap. These were part of a wider societal problem of failure of markets in vulnerable sectors.

We drew attention to red flags, poor staffing, failed regulation, absence of data, the use of financial metrics as a measure of care and the problems of managers without knowledge or experience. We urged consultation with a *"broad range of academic expertise with insight into our human condition and the nature of society"* to evaluate what was happening.

Assurances from the Minister: At a Consumers Roundtable meeting[2] of advocacy groups with the Minister, we made the same points, including that "***there are major problems in the structure of the entire system and the concepts on which it is based"***.   We were supported by others and received an assurance from the Minister that the Royal Commission would examine and address structural problems in the system.

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[1] Submission to Royal Commission - Terms of Reference: https://www.agedcarecrisis.com/images/subs/tor-rc.pdf
[2] Consumers Roundtable: 1pm - 2pm; Thursday, 27 September 2018, 20-25 participants.

In examining the final TORs in the 'Letters patent', we saw that these issues were covered in the TORs including:

a. (the causes of any systemic failures, and any actions that should be taken in response),

b. (how best to deliver aged care services),

c. (future challenges and opportunities)

d. (what - - the wider community can do to strengthen the system),

f. (how best to deliver aged care services in a sustainable way),

g. (any matter reasonably incidental),

j. (barriers they face in accessing and receiving high quality aged care services), and

m. (innovative models in delivering aged care services).

We remain concerned that in TOR (e), the Commission is directed to focus on the neoliberal market's mantra for *'greater choice, control and independence'*. We would have preferred that the focus was on the essential trusting and caring relationships that are the basis of care. The problem with neoliberal markets is that there is no allowance for these and little concern for the vulnerable people who depend on them.

As revealed by witnesses appearing before the Royal Commission, many residents and their families do not have the capacity or the resources to operate in this marketplace and make choices there.

Some Aged Care Crisis members have a long experience of health and aged care systems that have failed citizens. As a group, Aged Care Crisis have studied the aged care system in Australia and collected information about it for nearly two decades.

We were invited to provide a Witness Statement of evidence to the Royal Commission. In this we indicated our experience and expanded on the matters raised with the Minister. The aged care system was one of many that were flawed because of the application of policies based on patterns of thinking that were unsuited to the sector. We pointed to the discordance between those with power and those who experienced the system. We described the aggressive behaviour of those with power when they were challenged. We stressed that this was only possible because of the lack of data and we gave examples of the ways it had been controlled.

We supplied data that revealed that Australian staffing was so poor that staffing in over half of our nursing homes would be classified as dangerously low – the poorest of 5 groups in the USA where data was collected and staffing levels were based on data about outcomes. This classification was done in consultation with a leading academic who has been involved in studying the relationships between care and staffing for over 30 years.

We also supplied data which showed the inadequacy of the regulation of aged care in Australia and explained why this was a consequence of the sort of market created. We explained the way in which patterns of thinking had developed and been applied to all markets including aged care, without attention to the likely consequences for the vulnerable.

Many warnings were ignored. We showed how these played out in practice and resulted in poor staffing and in failed care.   None of this was new as many have made the same criticisms about society and about the failures in care. We simply joined the dots between the two. We indicated that we would supply more information in due course. We were not one of those selected to give evidence.

1.2 Latest Senate Report

The report of the Senate Community Affairs Committee into the effectiveness of regulation dated April 2019 has finally accepted that care (particularly clinical care) is very poor, that the very poor staffing levels and skills are responsible, that there is a dearth of data due to the failure to collect it, that the regulators have failed miserably, and that vulnerable residents and their families are left stranded in a complex and impersonal system without readily available support.

It failed in that its interpretation of the causes of the clinical failures and regulatory problems was ultimately unhelpful and like previous reports it attempted to address these issues within the same discourse and the same sort of regulation that has been failing for 20 years. It confirms the information we made in our statement to the Royal Commission but finds ways of denying the causes that lie in a policy that has nothing to do with care.

2 Response to the Terms of Reference (TOR)

a. Care. There is extensive criticism of care by staff and families and many abuses have been exposed. This has been going on since 1997. Serious problems are confirmed by the recent senate report as is the role of poor staffing in causing this. There is insufficient data to determine its full extent.

The obvious root cause of multiple similar market failures in vulnerable sectors is a misunderstanding of the nature of markets, the care sector and human behaviour.

Toxic cultures, poor care and incidents of abuse are readily understood as due to the incompatibility between the dominant neoliberal discourse and values of the market, when contrasted with the discourse and values of the trained staff who provide the care that residents need. This is readily apparent when we examine our human nature, the insights from basic social science and the history of the aged care sector.

We argue that care of the vulnerable is primarily a responsibility of the community and its members. Those who provide care are their agents. These providers should be directly responsible to them. Government is not capable of adequately filling this role.

For 20 years, aged care in Australia:

- has been managed by an accreditation process that has insisted it was incompatible with regulation and did not regulate;

- a complaints system that has been repeatedly reviewed because of its failures; and

- a department where whistleblowers spoke out when they were told to ignore fraud.

It is staff and family whistleblowers assisted by the press that have drawn failures to the attention of the public.

We argue that the only way to address the failed market and unsuitable discourse is to move the overall management and oversight of aged care into local communities and give those communities a role in supporting residents, monitoring their care and overseeing data collection. They would address issues with management on behalf of residents and the community. We suggest it be built around empowered local visitors supported by local medical, nursing and other expertise. This will address the power imbalance and vulnerability in the failed market and ensure that the discourse of care is dominant. The structure of aged care needs to be changed to enable this.

b. Disabilities and dementia: In addition to TOR (a) above, evidence suggests that the young disabled should not be in nursing homes. Both the young disabled and those physically able with dementia are better cared for and supported by familiar dementia or disability staff in small 10 to 15 bed units. They can be geographically near larger units adequately staffed with RN's and other trained nurses in a position to provide oversight and support when needed (eg. physical deterioration). The current trend to build large many bedded profit focused units is ill suited to the sector but particularly to this group.

c. - i. Care at home: The same underlying problems identified in TOR (a) apply. Most would prefer to stay at home if they can. The local community based organisation we have suggested would be much better suited to a supervisory role overseeing the care and quality of life. Involvement brings compassion and voluntary assistance. Community involvement in care generates social capital. The current system has eroded this.

ii. Remote, rural and regional: These communities might need more support from outside experts. That they need to be controlled by involved culturally appropriate communities is well recognised. There are no grounds for denying this to communities in the rest of Australia. The cultural divide between caring communities and big money is as wide, if not wider, than that between indigenous communities and the rest of Australia. The same principles should be applied to both.

d. Families and community should form community structures working with local government and empowered visitors to manage the sector and support their local agents (the aged care providers), to ensure that they are meeting community expectations. Government's role will be to provide broad oversight by supporting, mentoring and in formal regulatory support.

e. Person-centred: The suggestion in TOR (a) restores a discourse of care. This will replace the depersonalising instrumental relationships of the neoliberal market with the important intimate personal relationships of care – the sort of supportive relationships that have been studied and developed within the caring professions over thousands of years. These are the foundations of person centred care. They are the basis for empathy and consequently both central to and the intrinsic motivating reward of the discourse of care. Choice, control and independence are a product of that trusting relationship.

f. Sustainability and innovation: What we have suggested provides a wider forum within which to innovate, one that is not constrained by an ideological discourse and personal ambition. It provides a working environment which will attract staff, ensure they are not exploited and reward them in many interpersonal ways.

g. Other matters. It is essential to avoid the mistakes of 1997 (when precipitate changes based on ideology were imposed without collecting data or monitoring impacts). We need a goal, but it needs to be done in careful steps, trialing, measuring, involving, adjusting and developing. *Commercial in confidence* is inappropriate in this sector. Total transparency and cooperation are required.

h. i. Our recommendations apply to all aged care services and probably to disability services as well.

j. Workforce: In our suggestion, the community would be there for the staff, supporting and motivating them. When there are disputes they would be in a position to mediate with management to ensure all parties are fairly treated. They would ensure that staff are protected when they speak out.

k. Barriers: The elderly and their families would be dealing with local people face to face and not the distant and frustrating MyAgedCare system.

l. Interface with other services: The local community and visitors would use their personal contacts so building trust ensuring local integration and that the vulnerable person was put first by all groups.

m. Innovation: The community would ensure that their agents shared innovative ideas and that they were not 'in confidence' in order to compete in making a profit.

n. previous inquiries. Our proposals are based on a study of the failure of previous reviews and proposals. We have made submissions to a majority of them.

3 Witnesses: Requests to those invited to appear by the Commission

Witnesses invited to present to the commission were asked to express an opinion about eleven items **a** to **k**:

a. b. and c. Meeting the needs of consumers, community and the future: It is clear from the staffing levels that the system cannot be meeting the needs of consumers. The accounts of staff and families and the findings of the Senate review confirm this. Without data its extent is unknown. It is poorly equipped to provide care because of understaffing and structural issues in the system and its regulation.

d. What way and why: The wrong sort of relationships, the wrong sort of cultures and the wrong patterns of thinking imposed on the sector and on its regulation. It drives staff away.

e. The recent regulatory changes: These changes are simply the same sort of regulations by the same groups of people who think in the same way. They are a stopgap and not a solution. We consider that functioning systems should be built around patterns of thinking suited to the sector. Formal regulation should support and give legitimacy to the normal day-to-day social pressures that constrain bad behaviour and address problems at source.

We consider it unlikely that any central regulatory structure could successfully regulate such an intimately personal process effectively or stop what is happening in aged care. To change this there needs to be a redistribution of power and a change in the patterns of thinking in the sector. We need to re-enable effective local social control.

f. Most important issues over next 20 years: Anyone providing aged care is providing it on behalf of the community and are their agents. The patterns of thinking (the discourse) should be theirs. Management and staff should identify with this discourse. The community must be able to hold their agents to account. Funding and policy should be based on the needs of care and not the market. Rationing of some sort seems inevitable and such a system could adapt to it

Under the current system the pressures of rationing would see care rationed even more extensively than it is today in order to fuel the profits of providers.

g. Suggest changes: See responses to TOR (a) to TOR (n) and Witness (e). and (f).

h. Introducing changes: By building community around an empowered visitor's scheme in a careful step by step closely monitored open ended process where success builds on success and is not constrained or distracted by unrelated discourses.

i. Other models: There have been a number of spontaneous community initiated care projects as well as staff led and controlled projects that have worked well in Australia and elsewhere. The Eden alternative philosophy, the Buurtzorg model and the Montessori approach provide alternatives but they need to be liberated from the constraints imposed by current discourse and then carefully evaluated and compared.

j. Quality and safety: Safety is clearly important but it needs to be balanced against the benefits for quality of life and for physical well-being that taking risks might bring. 'Quality' is an appropriate aspirational term for use in those areas where measurement is not possible. 'Standards' is a much better term, particularly when talking about regulation or outcomes. 'Quality' should not in our view be used to describe a body (eg Quality Agency) or be attached to standards because they are not the same thing and can mislead.

Quality has positive associative meanings that have been used in marketing and branding. It has become an integral part of the branding of regulation and governance processes associated with neoliberal thinking (often called regulatory capitalism). Its over-use in the post-truth era raises suspicion and further distrust. In our view its use should be reduced in the sector.

k. Culture of respect: Respect comes from empathic engagement and the development of close relationships within society. The discourse of the late 20th century reduced intimate and personal relationships in society to contractual relationships based on mutual self-interest.

For some it promoted selfishness as a virtue and condemned altruism. These changes undermined society and changed the nature of citizens. The post-truth era has seen a polarisation of opinion and behaviour that impedes engagement and trusting relationships. Our proposal seeks to reverse this process but it won't happen overnight.

4 Information requested from those making submissions

The first set of issues are largely covered in our comments and suggestions above. These issues would all be better managed locally but with central support when needed. Local services and expertise are far better placed to assist in addressing these issues.

The remaining questions in this submission form are all directed to families and staff to give them an opportunity to tell of their personal experiences. Our submission embraces all of these issues.

Advocacy: There is a clear perception that government controls unwelcome criticism and uses its power to select the advocacy groups it wants to provide advocacy services. While promoting innovation it uses funding, appointments to regulatory bodies and a myriad of aged care committees to marginalise critics. This discourages innovations that challenge to policy.

4.1 Addressing all these issues

Because of the criticisms after our first contact with the Commission, we have prepared a detailed and fully documented analysis of the history of aged care in Australia carefully examining and explaining where it went wrong, the reasons for failure and the basis for the proposed structural changes that we advocate. We are not aware of anyone else who has provided the Commission with a systematic analysis of this nature. We hope that the Royal Commission will find it useful.

This covers:

1. A basic understanding of the nature of mankind and society, of the way in which social pressures induce citizens to conform to patterns of belief, and of the strategies individuals use in order to accede when under pressure. They do things that are not in the best interests of society, of other individuals or even themselves. We briefly note the history of the patterns of belief that shaped the late 20th century and their consequences.

2. The history of aged care in Australia describing the policies that impacted on the sector and their consequences, their relationship to other policy and to developments in other countries. The consequences for the sector are examined in detail and are supported by available data. The reasons for market failure are explored in the light of current knowledge of individual and societal behaviour.

3. Structural changes are suggested based on the insights from this analysis using societal and regulatory approaches that are more suited to the sector.

ATTACHED:

Why Aged Care is failing: An analysis of the history of aged care and proposals for change

Why aged care is failing

An analysis of the history of aged care and proposals for change

It is clear that our aged care system is not working and we need to understand why.

We want to make it clear that in this analysis we are not blaming any of those involved in designing our aged care system or in managing it.

We admire and do not blame the many dedicated people who try to make it work and sometimes succeed. We are describing social pathology, a social system that is not working. We are talking about how good people create such a system and how others believe in what they have designed. Participants do their best to do good things in spite of a system that tries to prevent them from doing so.

We cannot address social pathology without criticising what others have done and we know that that will upset them and that some will interpret it as personal criticism. They will angrily reject it. We are all human and as such we may well have behaved similarly in the same situation. We wish there was some other way. If we sound frustrated and criticise forcefully it's because we are and because these things need to be strongly criticised to show what has happened. We have been writing about this for a long time.

The 20th century has been one of the most traumatic and bloody in human history. Much of that carnage came from people who believed in something and persuaded others to follow. We argue that our early 21st century society is trapped by a misconceived belief system that originated among economists in the troubled times of the early 20th century. It gained ascendency during the late 20th century and came to dominate policy in countries across the world more successfully than any previous belief systems. If not as bloody, it has many of the same 20th century features and many citizens have been harmed.

We struggle to find a way out of this trap and into the 21st century. Many are critical and are writing about it but don't know what to suggest. The best way of finding a path to follow without repeating the failures of the 20th century is to closely examine what happened, look at what critics said at the time and learn from it.

While these beliefs have made many of us more affluent than ever before they have harmed many others. Aged care is the most vulnerable of all and has suffered more than most other sectors of society. It is a good place to examine what has happened and think about how we can move forward.

Over the last 21 years, aged care in Australia has been characterised by confident claims to world-class care and a rigorous regulatory system. Those involved clearly had no doubts. At the same time there have been accounts of poor care and abuse from families and staff. This has been punctuated by periodic media scandals.

That these are red flags to a deeper malaise have been denied, discounted and when denial is impossible claimed to be rare exceptions or due to 'bad apples'.

Those who have spoken out have been attacked and discredited locally in the nursing homes or publicly by the leaders of the industry. This unhappiness has escalated and there is now no doubt who was correct.

A number of inquiries since 2000 have identified problems in staffing, and in the various arms of the regulators, but reasons for these problems have not been explored.

When changes have been recommended, they have focused on minor changes in regulation and avoided exploring or confronting contradictions and flaws in the system itself. Recommendations have often not been implemented by government.

This pattern of behaviour is not unique and has characterised many of the destructive ideologies of the 20th century. Their critics have been ignored and often silenced, even killed. Believers have targeted other citizens who have been harmed and sometimes millions have died.

The same patterns of system failure and behaviour, but without the physical violence and imprisonment, are readily apparent in the banking industry in the USA, UK and Australia, in health and aged care in the USA and in aged care in the UK and Australia. There are similar problems in multiple other sectors where citizens are vulnerable.

It is clear that there must be common forces and common practices that are responsible. In the wars and tragedies of the 20th century the root causes were irrational ideologies based on ideas that were illusionary and not supported by evidence, logic or reason. This suggests that there are shared beliefs in these three countries that are responsible for the failures in their systems.

The one thing these countries and these sectors share is a system based on the use of competitive markets to drive efficiency. Numerous critical comments in aged care blame market pressures for problems.

There have always been markets of sorts in these sectors. The risks of markets generally, and in these sectors particularly, have been recognised for hundreds of years. Their tendency to be predatory has been largely controlled by social pressures and regulation so that their benefits could be harnessed and the risks avoided. We need to explore why this changed.

After the great depression and the Second World War, we had a 40-year period of social and market stability where things were relatively stable. Then in the 1980s and 1990s markets turned on society and started cannibalising it by targeting the low-lying fruit – its vulnerable sectors and vulnerable members. Multiple efforts to control this behaviour have failed.

If we are going to address this problem then we need to use our knowledge of the social sciences and the way people behave to explore the history of this market, and the way it has been implemented in aged care. When we look at the belief system that gave it birth it had the same sort of logical flaws and bizarre illusionary ideas. It arose in a similar context to that which characterised previous 20th century belief systems.

We need to understand why it has failed in vulnerable sectors and how the processes played out in practice in each one. We will then be in a better position to make the sort of changes that allow us to control what has happened in aged care and similar vulnerable sectors without destroying the other benefits that markets have for society.

Those who, like the believers of the 20th century, have seen only the benefits of the increased market activity, and been blind to the harm caused to others will find a critical examination of this market challenging.

Social change always challenges prevailing belief and some are hurt. Political processes, government and Productivity Commission inquiries, and even previous Royal Commissions have not challenged the belief in uncontrolled markets and the broader impact of the philosophy that lies behind that. All have failed us.

Very concerning is our unwillingness to acknowledge our failures and then ask serious questions about how this happened, the role of human behaviour in this, and the way it has impacted on social structures – to dig down to find reasons and gain insight before making changes.

We embrace the complex knowledge and technology that lets us explore space. We have had less complex knowledge that allows us to explore and understand ourselves and our society for many years – yet we reject it and choose to behave foolishly instead.

We attach this to our submission in the hope that the Royal Commission will go beyond community catharsis in exposing and stigmatising failures in care and then tinkering with regulation. We are asking it to rise to this challenge by examining the impact of the patterns of thinking that we use to structure our society on aged care. In making change we need to be mindful that some will suffer and need support.   It should not be the most vulnerable in society.

Glossary and abbreviations

Term	Description
ACC	Aged Care Crisis Inc.
CVS	Community Visitor Scheme
ACQSC	Australian Aged Care Quality and Safety Commission *encompassing: Accreditation, Complaints;* *Aged care provider approvals (1 Jan 2020)*
The Department	Department of Health *(formerly known as the Department of Health and Ageing)*
Professor John Braithwaite	Professor John Braithwaite (criminologist)[1] is a Distinguished Professor at the Australian National University (ANU). Braithwaite is the recipient of a number of international awards and prizes for his work, including an honorary doctorate and the Prix Emile Durkheim, International Society of Criminology, for lifetime contributions to criminology (2005). In his 2007 book on ***Regulating Aged Care***[2], eminent criminologist Braithwaite describing how regulation in Australia (ie accreditation) was being captured by business interests.
NACAP	The National Aged Care Advocacy Program[3] (NACAP) is funded by the Australian Government under the *Aged Care Act 1997*. It provides free, independent and confidential advocacy support and information to older people (and their representatives) receiving, or seeking to receive, Australian Government funded aged care services. From 1 July 2017, the Older Persons Advocacy Network (OPAN) has been engaged to deliver the NACAP as a single national provider. OPAN delivers NACAP through its network of nine service delivery organisations across Australia. Each provides a nationally consistent model of independent advocacy, information and education focused on the rights of older Australians in need of care.
OPAN	The Older Persons Advocacy Network[4] (OPAN) is a national network comprised of nine state and territory organisations that have been delivering advocacy, information and education services to older people in metropolitan, regional, rural and remote Australia for over 25 years.
NACA	National Aged Care Alliance
ACG	Aged Care Guild (industry representative group)
ACSA	Aged Care Services Australia (industry representative group)
LASA	Leading Aged Services Australia (industry representative group)
Aged Care Roadmap	The Australian Government set up the *Aged Care Sector Committee* in April 2015. It was tasked with the creation of a 'roadmap' for the progression of the market driven and controlled, and centrally structured and organised Living Longer Living Better (LLLB) aged care reforms that commenced in 2014.
Aged Care Financing Authority	The Aged Care Financing Authority[5] (ACFA) provides advice to the government on funding and financing issues, informed by consultation with a select group of consumers, aged care industry and finance sectors.

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

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

[3] The National Aged Care Advocacy Program: https://agedcare.health.gov.au/support-services/the-national-aged-care-advocacy-program

[4] Older Persons Advocacy Network: https://opan.com.au/

[5] Aged Care Financing Authority: http://bit.ly/2VfwMzA

Term	Description
LLLB	Living Longer Living Better - The industry's contribution to the government's roadmap through NACA (National Aged Care Alliance) is a long one. It started with the joint development of the Living Longer Living Better (LLLB) reforms. This was based on the recommendations of the 2011 Productivity Commission Report *"Caring for Older Australians"*. In addition, individual members of the industry consulted and worked closely with government. They were appointed to government bodies.
Aged Care Sector Committee	The Aged Care Sector Committee[6] provides advice to the Government on aged care policy development and implementation. It also acts as the mechanism for consultation between the Australian Government and the aged care sector. Committee members consult within their own memberships and constituencies to ensure stakeholder views inform the policy development process.
Aged Care Complaints Commissioner Consultative Committee	The Aged Care Complaints Commissioner established the Aged Care Complaints Commissioner Consultative Committee to support the Commissioner's education and complaints functions. The committee gives advice, feedback and ideas, as well as broader service provider and service user representatives. NACA and industry are well represented on this committee.
Aged Care Quality and Safety Advisory Council	The Advisory Council[7] provides advice to the Aged Care Quality and Safety Commissioner in relation to the Commissioner's functions and may also advise the Minister in relation to these functions.
RN	Registered Nurse (equivalent in the USA and Australia)
EN	Enrolled Nurse (Australia)
AIN	Assistant In Nursing
CNA, NA	Certified Nursing Assistant, Nursing Assistant
LVNs/LPNs	Licensed vocational/practical nurses (USA) *(Equivalent to enrolled and certified nurses in Australia)*
PCW, PCA	Personal Care Worker, Personal Care Attendant, Personal Care Assistant *(Level III or less)*
hprpd, hprd	**h**ours **p**er **r**esident **p**er **d**ay
Regulatory capture	**Regulatory capture**[8] is a form of government failure which occurs when a regulatory agency, created to act in the public interest, instead advances the commercial or political concerns of special interest groups that dominate the industry or sector it is charged with regulating.
Revolving door	In politics, the **"revolving door"** is a movement of personnel between roles as legislators and regulators, on one hand, and members of the industries affected by the legislation and regulation, on the other.
Managerialism	This is a belief system based on the premise that management is both the optimal form of organizational governance and the main vehicle for organizational success. It claims a body of knowledge sufficiently removed from the technical specifics that it is transferable from organization to organization and is effective without specific knowledge. It has claimed neoliberalism as its own and has become the mechanism for driving neoliberal thinking through markets, government and society.

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[6] Aged Care Sector Committee: http://bit.ly/2Mhz3Gq

[7] Aged Care Quality and Safety Advisory Council: http://bit.ly/2Vbz3LX

[8] Wikipedia: https://en.wikipedia.org/wiki/Regulatory_capture

Term	Description
Neoliberalism	This is a word that has had many meanings and is often equated with "*resurgence of 19th-century ideas associated with laissez-faire economic liberalism and free market capitalism*" (Wikipedia). We use it to describe a wider 20th century libertarian philosophy that, under the guise of freedom, places the self-interested individual above society and sees self-focused unrestricted activity as creating humanity's future. It condemns "the collective" which it considers to be controlling of individual freedom and so "socialist". As such it creates tension with responsible citizenship in a civil society and with democracy itself. The philosophy is expressed primarily through free markets, competition, economic efficiency, small government, minimal regulation, as well as cooperation with and reliance on market mechanisms to structure society and government.
Social Darwinism	Social Darwinism is a 19th century theory that attempted to apply concepts of natural selection and survival of the fittest to sociology and politics. The concepts fail because Darwinism describes a random process of selection. Human's in contrast plan and create logical social contexts by considering the logical consequences of their actions. The term is usually used negatively to criticise a social context that ignores logical consequences and instead selects, empowers and rewards people who are poorly suited for the intended activity and/or drives the more suitable away.
FIRB	Foreign Investment Review Board
FBI	Federal Bureau of Investigation in the USA
ACFI	The Aged Care Funding Instrument[9] (ACFI) assesses the relative care needs of residents and is the mechanism for allocating the Government subsidy to aged care providers for delivering care to residents. The ACFI replaced the former Resident Classification Scale (RCS) on 20 March 2008. The instrument consists of 12 care need questions, some of which have specified assessment tools.

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[9]   Aged Care Funding Instrument: http://bit.ly/2ARFevz

Table of Contents

1 Executive Summary

1.1 Introduction

In our introduction we document and describe the contrasting and incompatible views and descriptions in the sector. There are the politicians, the bureaucracy, the regulators and the industry leaders who manage and control the provision of aged care. They have no doubts about the exemplary nature of the system and the care they provide and there are no reasons to doubt their sincerity. They deny and when that is impossible, talk of bad apples, isolated incidents and rare exceptions.

On the other side are the academics who have studied the sector, the staff who have genuinely tried to provide care and are horrified at what they find, the doctors, the residents and families of those the system has failed, and of outsiders who have looked in on the system. They have not been believed and have been discredited and sometimes aggressively attacked. The unhappiness and the volume of complaints has steadily increased and there can no longer be any logical doubt about what has happened.

In the introduction we give typical examples drawn from all the participants over the last 20 years to illustrate the problem. It is important to note the absence of any publicly available data to resolve the differences. That is a feature of 20th century failed social systems. They all develop ways of censoring or controlling the sort of data that is available. Comparisons can be made with the well-studied health care scandals of the 1990s in the USA.

Speaking out from within these high-risk systems is always hazardous. It is interesting that the flood of criticism in aged care has enabled a few providers who have seen and accepted what has been happening to speak up and talk about it.

While only a proportion of those in the system speak out about failures, this should not tarnish their credibility. This reluctance by citizens to acknowledge that the system they believe in has failed, has been a feature of all of these 20th century 'system failures'. This is why systems, where many have been harmed, have endured for many years.

This is also why many of those who fall foul of the system call on the failed structures (eg regulators) to address the problem. They too believe and are reluctant to challenge so cannot accept that these structures are part of the problem and incapable of doing so. They shrink from complexity and from action that confronts. The inquiries and reviews by Government, Productivity Commission inquiries and even Royal Commissions are also reluctant to address challenging root causes – often described as elephants in the room.

Social scientists have studied these issues. Social scientists and philosophers like Michel Foucault write about the way the powerful establishment controls knowledge and so discourses (the way we think). Citizens are 'governed' by these discourses and they control the way citizens think and behave. Social scientists have also studied the psychological and social strategies we use to justify complying when these discourses require us to do things that are harmful. Thinking differently and challenging a discourse when it is harmful is always challenging and only a minority will do so.

The Royal Commission into Banking has been criticised by academics for tinkering with the regulations and regulators while failing to properly address the problems that lie within the structure of the system. They predict failure and another inquiry in 10 to 15 years.

The Royal Commission into Aged Care Quality and Safety, is also drawn from an establishment group and not from the caring professions. In this submission we are quite specifically providing an alternative perspective and criticising the establishment discourse. We challenge the Commissioners to look with new eyes and to break the mould by advising the sort of changes that will gradually alter the way the system operates and so finally break the cycle of failed inquiries followed by more scandals.

Opinions about the Royal Commission: It is interesting to examine the criticisms and the expectations that various participants in this debate have of the Royal Commission. These range from those who are calling on it to address the obvious visible failures and problems, those who see neoliberal thinking as the problem to be addressed, those who doubt the Commission's capacity or criticise its lack of insight and experience.

Then there are those members of the industry establishment whose interests are tied to the current government reforms. They expect the Commission to simply endorse these. None of them offer concrete suggestions that would address the actual problems in the system.

The analysis: Our analysis uses examples to illustrate issues but it's focus is on the causes of system failure and what can be done about them. Many have already written about these issues.

We address this by:

1. Describing some basic social science concepts that we use to illuminate what has happened in aged care.

2. Examining the origins, history and the beliefs of neoliberalism and managerialism, the two belief systems that over the last 40 years have changed much of the Western world - particularly the USA, UK and Australia. We look at the criticisms that have been made of them

3. We trace the history of aged care in Australia and the introduction of neoliberalism and managerialism in the restructuring of aged care, starting in the early 1990s through to the present.

4. We examine the pressures that have been introduced into the system and their consequences for data collection, staffing, the nature of care and regulation.

5. We look at regulatory principles that have been ignored and then propose changes that the analysis suggest will not only address the failures in regulation but alter the discourse (patterns of thought) and so the mode of operation of the sector. It will create a context where the risks of the sector falling victim to another ill-suited belief system will be reduced.

1.2   Society, Neoliberalism and Managerialism

1.2.1   Social Processes: Self and Society

We briefly explore:

- The nature of individual humans as social animals formed by their society. The two are inextricably linked and humans maintain and build society. Together they build social selves and social values like altruism - values that control our selfish selves and keep us in check when we might cause harm. These are the values that define and motivate the caring professions.

- The manner in which we create order and meaning in the world and the importance of both to us – to the extent that we will fabricate order and meaning when existing order breaks down and leaves a vacuum.

- Our extreme vulnerability to illusionary and often harmful patterns of thinking that provide some meaning and order – how such ideas spread and dominate and we cling onto them.

- We examine the way in which discourses (patterns of thinking) spread and take control of society and the way it thinks and behaves.

- We look at the pressures exerted by discourses and the psychological strategies we use to conform and believe even when what we are required to do is harmful to others.

- We look at the processes of conversion or rejection when a new discourse that is unsuited to the sector is imposed over an existing one that is suited. We note the impact of this on cultures and behaviour (eg. toxic cultures)

- We look at the nature of evil and the way in which discourses define what is evil to the extent that the worst things are often done by people who believe in what they are doing and are not constrained by conscience.

- We examine the nature of the discourse of care that has governed sectors like aged care and trace it back over 2500 years documenting periods when other discourses came to dominate it.

- We note the arrival of the neoliberal discourse and what one eminent doctor described as *"transfusing mad cow thinking into every vein in society"*

To understand the problems that developed we need to understand the history and discourses of neoliberalism and managerialism.

1.2.2   Neoliberalism, Managerialism and their consequences

1.2.2.1 Neoliberalism

Neoliberalism is considered to be about markets and is often spoken of as a belief in free markets. It is much more than this. It is a philosophy of life that has had a profound impact on the sort of people we are and on society. Starting in the 1930s, it was obsessed with the movements that resulted in the dictatorships of the time. For them this was not a problem within the societies. Instead they saw this as the inevitable consequence of collective action by citizens. This they claimed, inevitably resulted in totalitarianism. They condemned any sort of 'collectivism' and in time that included society and even democracy although it was more guarded about this.

It became an ideology of extreme individualism and any restriction of the freedom of the individual was targeted including society and the government that represented society. Society was pushed aside and its influence reduced. It insisted that government be as small as possible and not interfere in any way. Markets became the medium through which this individualism was expressed and the only way in which individuals could be free.

The belief embraced small government, minimal regulation and non-interference in the market. It was a matter of belief that markets would always work and correct themselves, provided that any restraining influences were removed.

For many, selfishness became a virtue and altruism was condemned as a disease that came from society. Society and its value systems were the enemy. Human relationships were redefined. The values that motivate care and on which a cooperative society depended were rejected.

Many of these ideas were adopted by Thatcher in the UK and Reagan in the USA in the 1980s. Market, government and society was restructured along these lines and this included aged care. There was no place for the vulnerable or for the values that underpinned care in the sort of market that was introduced. We discuss the strategies we use to accommodate to this deep unstated conflict within a system that was intended to care and the likely outcomes. The consequences were predictable.

1.2.2.2 Managerialism

This was an older discipline that adopted Neoliberalism as its own. It became the vehicle for spreading and imposing neoliberal thinking and policy across markets, government and the rest of society regardless of its suitability. It became a one size fits all model.

Managerialism was a model of control that saw managers who claimed superior knowledge assume control of all facets of every organisation on the basis that they had superior universal skills. The processes and practices they used were universally applicable and beneficial. Knowledge of the sector managed was not required.

It is ironical that neoliberalism which promised individual freedom, was adopted by a process driven system whose mode of operation was to control and limit the freedom of individuals in the interests of the organisation, whose freedom and success they protected. Its critics see its impersonal attitude, its processes and its deliberate strategy of changing cultures to a more neoliberal one as a threat to our humanity.

Education and the caring services are sectors where knowledge and understanding of the sectors and the role of individuals in them are critically important yet the professionals who have that knowledge have been pushed aside. In aged care these managers and their associates have taken control and are the public faces of the sector. They are the people that a small government without expertise consult and who help them make policy (eg. aged care roadmap) and decisions. Few seem to have the knowledge and skills needed to do that.

In *Appendix 4* we give an overview of neoliberalism and managerialism in greater depth and trace these policies through to the present time describing the multiple serious failures in society globally and in Australia in particular.

1.3   The story of aged care

1.3.1   From welfare to markets

1950s to 1982: The post-war welfare state in the 1950s saw governments take a role in funding services that were provided by church groups to the aged. As happened in other countries the private sector saw the commercial opportunities this funding provided and rapidly expanded in the 1960s and 1970s. Political support for both groups waxed and waned over the years.

The fault lines in the system soon opened up:

- The government's primary concerns about containing costs as the population aged and nursing home occupancy grew. The funding system was repeatedly changed.

- Concerns about for-profit facilities being paid for residents who did not need to be there and overcharging. Unlike other markets, additional funding did not go to improving care.

- The pressure on the budget led to the creation of hostels for the mobile aged and a focus on care at home to contain costs. Over the years the increased employment of women the primary carers has put pressure on home care which has required more support.

1982 to 1993: The influential 1982 Macleay report set the new Hawke government on a reform agenda. The publication of many reports of glaring failures in the for-profit sector starting in the 1970s led to the damning Giles report in 1985 with extensive publicity. This showed glaring failures in the for-profit sector.

A major restructuring and oversight program was carried out. This was followed by assessment reports from Ronald 1989, Braithwaite 1990 and 1993, Macri 1993 and Gregory 1993.

- A forerunner of the ACAT system of assessing residents needs was set up and new models of funding developed.

- Increased focus on home care with the HACC program.

- A focus on special needs and dementia

- Setting up national standards (31 of them)

- Residential classification around acuity was developed for both funding and staffing and there were some minimum requirements.

- Committed providers, particularly in Victoria who considered that staffing was inadequate, did careful studies based on acuity. They pressed government for more and a standoff occurred. At that time, only trained nurses provided care in Victoria. There were wide differences between what government was prepared to pay for and what providers considered necessary.

- In the 1990s, private industry was allowed to operate hostels and they were upgraded to be more like nursing homes.

- Increased funding for staff training.

- Day therapy centres for seniors.

- Funding for upgrading older facilities

- There were ongoing tensions because the sector spanned both state and federal responsibilities.

- Another problem was that accommodation and social support was separated from health care and often managed by different departments.

Regulation: During this period a new more intense regulatory system was developed. It was based on a greater assessment of outcomes, an investigative approach and increasingly frequent visits in order to steadily improve standards. Studies suggested it was superior to regulations in the USA and UK.

Neoliberal ideas were by now, having an impact and in 1987 an industry group challenged these new regulations on the basis that this regulatory interference was unconstitutional. They lost their case in the High Court. The reforms seemed to have worked and it looked as if a stable and sustainable situation had been created.

1993 to 1997: Hawke had been replaced by the more hawkish market focused Keating in 1991. Neoliberalism was now well established and globalising. The Hillmer inquiry reported in 1992.

National Competition Policy was adopted and the national Competition Council created. Keating became increasingly unpopular.

The public backlash that had put pressure on providers had passed and an anti-regulation faction led by Doug Moran gained ascendency and reasserted itself, taking control of the agenda. The pressures for less and not more regulation started and the increased frequency of visits was blocked leaving those who had developed it bitterly disappointed.

The steady decline in trained staff started during these years.

During this period the industry lobbied and funded the opposition coalition party. Many senior industry and political figures were members of the HR Nichols society formed in 1986 in response to the accord, and the industrial relations system created by the Hawke government. This had given unions unprecedented power and allowed widespread fraud. Keating was very unpopular and society accepted and aligned themselves with the liberal/national coalition.

Academia and the professions became alarmed by the impact that managerialism and neoliberalism was already having for society, particularly for education and the caring sectors. They warned of the consequences.

A new conservative government: Howard conducted a low-key election campaign allowing Keating to lose the election but after he gained power in 1996 it was anything but low key. The new government mounted an aggressive attack on union power and adopted an uncompromising neoliberal and managerial agenda across all of society. There were several confrontations and fraud actions so steadily reducing the power of the unions. The nursing unions struggled to resist pressure and maintain staffing levels in aged care.

The conflict in health care: The medical profession were alarmed when the new Health Minister spelled out the government's new neoliberal competition driven policies for health care in May 1996 (aged care was considered to be a part of health care). Senior members spoke out strongly and articles were written warning of the consequences. They were well aware of what had happened to their colleagues in the USA and that this had enabled extensive fraud at the expense of patients.

In 1997, the government welcomed a massive US hospital owner as well as a very profitable aged care provider who were buying hospitals in Australia. Members of the medical profession collected information and visited the USA to gather more. Objections were lodged with the Foreign Investment Review Board (FIRB) and state probity regulators whose role was to assess whether prospective owners were fit and proper persons and could be trusted in this vulnerable sector. They performed well under pressure.

This held things up and the hospital company abandoned its planned $1 billion investment after the FBI swept through its hospitals as part of a massive fraud investigation in the USA. The aged care company failed a probity review in Victoria. At the same time, the US government took action against it. It went bankrupt in the USA and Australia so never entered aged care.

In 1998 there was a heated standoff when the minister attempted to force the profession into signing contracts with corporate providers and insurers. These were similar to those that had limited doctor's independence in protecting their patients in the USA. Despite threats, doctors stood their ground and won.

In 2002 Australia's largest hospital owner, which was strongly supported by the minister adopted strategies similar to the US companies. The doctors took their patients elsewhere and put the company out of business. The careers of the health minister and the CEO of the company came to an end in a public scandal that both were involved in.

The doctors had stamped their authority on permissible conduct in hospitals. Although neoliberalism has had a significant impact, health care has not followed the USA. Doctors did not have the same power in aged care.

1.3.2   The Howard Government and The 1997 *Aged Care Act*

The new government ignored the historical warnings of the father of economics, Adam Smith. He described markets as an order of men with **"an interest to deceive and even oppress the public"**. They virtually allowed them to write the new regulations. They have relied on the advice of the industry in making policy ever since. Industry has been at the table whenever changes are made.

We need to remember that this was the sort of market that was created by people that had seen society as a threat and pushed it aside. They had denigrated the values and norms that motivated the sector. These values were the foundation of the caring process.

- **A market:** The sector was turned into a competitive market and the for-profit sector was strongly supported.

- **All accountability** for how money was spent was abolished.

- **Probity gone:** One of the first things the government did was to quietly abolish the federal aged care probity regulations restricting ownership and replace them with an industry friendly 'Approved Provider' process. This opened the sector to all and sundry. The welcome mat was laid out.

  Over subsequent years, the approved provider section in the department was supplied with data about four multinational groups planning to enter aged care in Australia as owners and asked to assess their probity. On each occasion, the department indicated that they did not have the powers needed to address this.

- **Regulation gone:** Carefully designed regulation was abandoned and replaced with an industry friendly process, accreditation. This was designed to assist and not police.

- **Ageing in place:** Hostels became nursing homes and operated in the same way.

- **Shifting costs:** Those who could afford it were expected to pay more of the cost and the home care sector was expanded.

- **Staffing:** All staffing requirements were removed.

A bizarre logic: The government funded the system. With increasing cost and the aged care bulge, this meant that funding would be limited and so in effect rationed. They relied on market competition driven efficiency to keep costs down and 70% of the cost was care staff.

Staffing came under pressure because profits came from squeezing them. Providers could pretty well do whatever they could get away with to make a profit. In addition, disillusion was built into the system. However good the care, the process of dying does not resemble the images created by competitive marketing and branding.

Criticism: There was strong criticism in parliament and in the community. The potential failures were pointed out. Critics stressed the threat to staffing and the likely consequences of the lack of knowledge of managers. A return to the horrors of the Giles report was predicted.

The bureaucracy: Perhaps as a result of this pressure, no data collection or monitoring of the system was instituted and any information released publicly was tightly controlled.

The entire bureaucracy felt threatened by any publicity. Over the years it has gone out of its way to create a positive image and avoid adverse publicity.

A policy of small government saw the bureaucracy truncated and lose its independence. Senior managers with experience were replaced with trusted believers from the sector.   Increasingly government depended on industry reviews and industry consultants to operate the system and make policy.

Conflicts of interest once a major concern, were seen as legitimate. Conflicted senior businessmen were appointed to government positions. Consultants who engaged in questionable conduct across the globe were employed to investigate and to advise

The impact on staffing: Government funding is fixed and any competitive advantage in making profits comes from reducing staff, which comprise 70% of costs, or consumables like incontinence pads and food. Investors would not invest unless they could control their costs and government helped them hide what they were doing by removing all accountability. Keeping staff costs low was the key to success. Many companies and some banks invested. Accounts of understaffing and failures in care increased steadily during the next few years.

The nursing unions retained some power and were able to resist some of the pressure to reduce staffing and so limit profitability. Those who had invested struggled to make as much profit as they had expected. Private equity and other banks held off. By 2005, this was a problem and government obliged by introducing the unpopular WorkChoices[10] laws which further reduced union power. The private equity and big banks invested heavily.   Academics in Victoria studying the sector wrote about the way staffing levels were declining.

Choice: The new system was marketed to the public as giving them choice but without any useful information on which to base choice this was an illusion. If they picked on a good nursing home that staffed well it was unlikely to be competitive. The profitable resident could be sold on to a provider that did not have the same scruples – some choice!

A hierarchy of illusions: Dysfunctional systems based on illusions inevitably bump up against the real world. More illusions are developed to address this. In failed systems there are often a hierarchy of them. When challenged on the abolition of probity regulations, owners buying an Australian company were described as "passive investors", implying that they had no impact on care.

To justify what they were doing with staffing, more illusions need to be developed. One unfortunate illusion used to justify poor staffing was that ageing was a *'normal process and not a disease'*.   Hence, you did not need expensive trained nurses to look after residents.

The charismatic founder of Sun Healthcare, the US aged care company that entered Australia in 1997 had built his successful company on this illusion claiming that you did not need skilled staff. He also rorted the US funding system. The Minister for Aged Care was soon quietly echoing these ideas to providers. The Minister of Health fell for another of his claims about step down care.

The profitability of the industry and the competitiveness of providers has depended on and still depends on being able to control staffing costs. Industry and government have desperately resisted every effort to get them to disclose staffing levels or for government to protect residents by legislating for staffing ratios.

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[10]   WorkChoices, Wikipedia, https://en.wikipedia.org/wiki/WorkChoices

Without that opacity, the pot of gold would dry up. They have to justify this to themselves so they still cling to the illusion that because death was inevitable, you did not die from diseased and failing organs. Ansell Strategic, a company that makes money by advising aged care providers on running a profitable business, has assertively argued similar nonsense in its submission to the Royal Commission. It is arguing this now publicly in the press.

1.3.3 Labor back in power in 2007

The WorkChoices legislation had a major impact on many voters and was very unpopular. The Rudd Labor government regained power in 2007. It put aged care in the too hard basket and passed only token regulations in 2008 claiming that this would control owners. Rudd angered the mining industry and then published a blistering attack on neoliberalism. This was not supported by his party. He was soon replaced by Gillard.

Labor got behind and supported the aged care system instead. There were escalating failures in aged care and another Productivity Commission Inquiry was set up in 2010 (*Caring for Older Australians*). It reported in 2011. The even more marketised Living Longer Living Better (LLLB) reforms did little for the residents and the care they needed. There was bipartisan support.

1.3.4 Liberals under Abbott re-elected in 2013

The leadership debacles in Labor saw the coalition under Tony Abbott elected to power in 2013. He came from the extreme right of the Howard government where he had been Minister for Health under Howard. Radical neoliberalism was back with competition, deregulation and marketisation ratchetted up to the top of policy.

The Living Longer Living Better (LLLB) reforms were sold to the public as providing choice and the new Aged Care Roadmap developed with the industry was a model of neoliberal intent and thinking. As it turned out, it was the industry and its interests that the LLLB reforms were really being applied to - not the residents who continue to suffer. More money was taken from residents. The bonds for high care residents that Howard had retreated from were brought back.

In the market's view, this immature market required consolidation. Abbott needed large competitive companies to compete in China and the rest of Asia if he was to capitalise on the trade agreements his government were negotiating. The sector was strongly funded to consolidate through competition.

Private equity and the share market became the driving forces in aged care. Increasingly the word 'care' became a token for something that was lacking. The number of failures in care reported in the press grew steadily.

The survival of smaller and non-profit providers was threatened, forcing them to focus on profitability rather than care.

The regulatory system was gutted to 'reduce red tape' and there was soon repeated rorting of the funding system. The number of failures in care reported in the press grew steadily.

Abbott was extremely unpopular in the electorate and was replaced by more moderate Turnbull. The rorting of the system was stopped and funding to the sector was reduced to prevent it. The industry was left to carry the debts that were incurred in the frantic competition to consolidate. Public anger at the rapidly deteriorating situation in the banks and in aged care continued to grow.

Turnbull was toppled in a right wing coup, which backfired and Morrison became Prime Minister. The situation in the banks and aged care escalated. First there was Oakden, followed by more failures and multiple inquiries, growing anger and lack of confidence in what was happening.

The public were not placated by this frantic series of reviews and inquiries or the sort of regulatory changes proposed. Finally there was the two-part ABC Four Corners program.

With an upcoming election these issues needed to be addressed. The bank problem and then later aged care, were parked with Royal Commissions. They did not become election issues. The Banking Royal Commission did not address the real issues in the sector but many are hoping the one into aged care will do so.

1.4 The consequences of neoliberal policy and managerialism in aged care

The story of seniors organisations: Three major seniors organisation have represented seniors in Australia, National Seniors (established 1976), Council on the Ageing (COTA established in 1957) and the Combined Pensioners and Superannuant's Association (CPSA established 1931). CPSA had played a major role prior to 1997 but it strongly opposed the 1997 changes and soon lost much of its government funding. It remains critical of current policy.

COTA and its Chief Executive strongly identified with government's neoliberal agenda. They have been leaders in working with government, developing free market policy and in promoting these policies to the community. They have been represented on most government bodies. COTA's strength comes from its many affiliations rather than its individual membership. It receives much of its funding from government and industry.

An attempted merger between National Seniors and COTA broke down in 2004 because of irreconcilable differences. When the National Aged Care Alliance (NACA) was formed in 2000, CPSA and National Seniors withdrew because there was a gag clause preventing them from criticising decisions reached by the majority. COTA became a leading force in NACA and so in formulating government policy.

National Seniors has the largest individual membership and gets much of its funding from serving its members. It has steered a middle course and been less openly critical so has had some representation. Its influence on policy has been limited.

1.4.1 Inquiries that make things worse

Neoliberalism's belief that markets always correct themselves unless interfered with is a tautology because it can never be wrong. When a market fails it can only be because it is being interfered with and this interference must be removed. If this belief is false and the market is the problem, then removing the things that are restraining it will make the situation worse.

The Productivity Commission is a body formed to manage the economy and the market. Its Commissioners are usually economists. Failing markets are referred to them for advice. There were escalating problems in the early 2000s and we saw the Hogan Inquiry. Its economic prescriptions made the situation worse and the cycle of failures and government reviews started all over again. It was finally sent back to the Productivity Commission in 2010 with another economist as Commissioner.

It is not surprising that both made the situation worse than it had been before. The 2010/11 Productivity Commission's report, which was so enthusiastically pursued by the Abbott government, saw the system spin out of control as the funding system was pillaged, regulation gutted and care deteriorated. An establishment that believed in what it was doing continued to deny this was happening.

1.4.2 Political policies and their consequences

Consolidation: The economists' assessment that this was an immature market needing consolidation and the promise of riches in Asia generated strong pressures, particularly on the smaller providers. They provide better care but make less money so are vulnerable to takeover. Their survival was threatened. In a 2015 analysts, Bentley's put a blow torch behind their anxiety by predicting in conferences that the number of providers would be halved from 1,200 in 2014 to 600 before 2021 and halved again to 300 before 2031.

This was an existential threat for most of the providers in the sector, particularly the nonprofit providers. Good income streams were essential for survival and that came at the expense of care.

There was a marked increase in rorting of the extra funding provided as the helpful regulators did little and the budget blew out. The Turnbull government finally stepped in and stopped the extra funding. The share market boom collapsed. The big market groups had had their fingers in the cookie jar. They tried to keep their profits going and perhaps service their loans by finding ways of charging the residents more and tightly controlling staffing. The government had to step in to stop the overcharging.

The impact of the consolidation pressures on nonprofits: Nonprofits were the most threatened and the pressures on them to think and behave like for-profits increased. The way they accommodated to these pressures and did this is reflected in documents describing their discussions. It is also revealed in the discussion surrounding attempts to get nonprofits to join for-profits by forming a single body *Leading Aged Care Services* (LASA) to represent the whole sector.

Business consultants saw the opportunities and were soon fanning nonprofit's fears by explaining what would happen if they did not change – proffering their services in doing so.

Accountants and managers from the for-profit sector were employed or made CEOs. Presentations at nonprofit industry conferences were dominated by lawyers and business consultants of all types, with much less attention paid to care.

Adaptation strategies: Large and small nonprofits merged defensively to increase their power to resist acquisition. They sometimes became predatory acquiring other nonprofits. Others entered into advantageous relationships with for-profits. Nonprofits copied for-profits in building palatial facilities to attract the very wealthy who could pay large bonds, making themselves less dependent on the vagaries of government funding.

Large nonprofits reduced the staffing in their facilities and they justified this using the strongly criticised benchmarks and averages of StewartBrown, a financial institution advising the industry. StewartBrown's stature and credibility would have grown as a result of its many presentations and its cooperation with the nonprofit sector.

Marketisation and outcomes: A study of nursing homes in Australia in 1993 had found that poor performance was related to pressure to meet financial goals. For-profits performed poorly. This study confirmed that *"a fish rots from the head".* A study of nursing homes in the USA in 1994 soon confirmed this. Multiple international studies since then have confirmed that for-profits staff more poorly and have more failures in care. This is related to the strength of the profit pressures in each type of provider. A literature review of international sources done in Australia showed that *"as competition increased, quality overall decreased"*.

To support their policy of marketisation, politicians and providers in Australia have insisted that ownership has no impact on care. When asked directly about this, the Accreditation Agency responded that they did not have any data showing a diffference. The figures they published did not show much difference.

As indicated, access to reliable data in Australia was blocked by government in 1997 under various pretexts. Some staffing data collected by industry has only recently become available. The data collected by the accreditation bodies in Australia is of poor quality, unverified and unsuited to a proper analysis so is not used by those academics doing an analysis. If used, it is only indicative and not conclusive. A recent study of missed care in Victoria suggests staffing was worst in nonprofits which is what you might expect from the recent pressures on them.

There has been some limited data in Australia suggesting better performance by nonprofits over the years. Aged Care Crisis had obtained a very small sample of accreditation results in 2008 and, when variables were considered, for-profits failed at least one standard 2 to 3 times as often as other groups.

Sanctions indicate poor care more reliably than accreditation. A 2014 study of sanctions between 1999 and 2012, showed that for-profits were more than twice as likely to be sanctioned. The Agency promptly came to the for-profit industry's defense by presenting accreditation data that showed no difference. When challenged and asked how they had done their analysis they did not respond.

In spite of the increased pressure on them since 2014, recently obtained data from the Agency confirms that for-profits are still the worst performers in the sector (see later).

1.4.3   Regulatory changes in 2014 and 2015

The Abbott government adopted an aggressive 'Red Tape Reduction' plan with the object of reducing the cost of regulation in Australia by $1 billion a year. They claimed that complex regulations *"inhibit providers from delivering even higher levels of quality care"*. Targets were set and there was a twice-yearly Red Tape Repeal Day for getting rid of unwanted regulation.

This plan was strongly supported by aged care providers, the business council, and financial analysts and advisers. Aged care was one of the first to be targeted. The Aged Care Sector Committee and National Aged Care Alliance (NACA) were engaged in the task.

In 2015, David Tune was appointed to lead the Aged Care Sector Committee because of his financial and administrative experience. His first task was to develop the Aged Care Roadmap.

Available data: Glen Rees, a previous CEO of Alzheimers Australia complained that (as in 1997) no attempt had been made to evaluate the outcomes of the LLLB reforms. Aged Care Crisis has been tracking available data in government reports to see what the consequences have been.

Regulation: The reports show that industry performance in accreditation has continued to improve with the number of facility failures falling from 5% in 2012 to only 2.2% in 2016. But over this period the number of accreditation visits has fallen by 30%.

Starting after the Walton Review in 2009-10 and continuing after 2012, the number of visits by the Complaints system has fallen from 3147 to 40 in 2016-17. When combined, the total number of visits has fallen by 57% since 2010. It is clear that no one has been going out to see what the complaints are all about and what lies behind them.

Exemplary Performance or regulatory ineffectiveness: Recently available data shows that following the LLLB reforms and the red tape reductions, the numbers failing to meet all standards fell from 7.6% of all facilities in 2012-13 to 2.7% in 2016-17. The number being sanctioned fell from 0.94% to 0.19% in 2015-16 before increasing again to 0.49% in 2016-17.

In 2018, addition information about the facilities that failed over the previous 5 years became available. We pooled them so that we had sufficient numbers for analysis. We confirmed that facilities in outer regional and remote regions performed much more poorly than inner regional and cities in meeting accreditation and being sanctioned.

Impact of ownership: We had expected the pressures on nonprofits to have reduced their performance to levels comparable with for-profits. To our surprise, when we examined the incidence of failure to meet all standards and sanctions separately in the inner and outer groups, we found that in both the inner and the outer groups, the for-profit owned facilities performed between one third to three times worse than nonprofits and government facilities.

This confirmed a small study we did in 2008 and the 1999 to 2012 study of sanctions by Baldwin. Both are in keeping with the findings of the1993 study by Braithwaite and international studies since 1994. **Appendix 2** contains our full analysis.

The big differences in the type of ownership between inner and outer facilities masked the extent of the difference between ownership types.

Had the agency analysed their figures properly by considering this variable in 2015, they would have detected this. They would have been able to confirm Baldwin's findings instead of challenging them.

> **As Baldwin indicated, this sort of analysis is vitally important for making policy. It is doubly so when it shows that the policy is flawed and produces worse outcomes.**

1.4.4 Care in Australia compared with international findings

International information sources: Studies done in the USA and Europe show that the great majority of families and residents do not use internet-based data resources and do not understand the significance of the data. They use word of mouth and local advice when choosing an aged care provider. These public data sets are however useful in shaming poor providers and in making them want to do better. They result in improved staffing and care and are useful for research.

The US Nursing Home Compare web site has been useful for nonprofits because it has created a niche market of probably better-educated people who do use the site and choose. They can maintain their mission and good staffing better than nonprofits do in Australia. We did not see information about whether this enables them to continue their mission to serve the poor and the disadvantaged.

MyAgedCare in Australia is a managerialist creation. It is process driven, impersonal and people fall through the cracks. It has been extensively criticised but instead of realising that it is not fit for the purpose for which it has been created, more money is being wasted in improving it. International data shows it should become a data resource for research, for policy and for those who advise families locally.

Problems in care in Queensland: There has been a large amount of bad publicity describing large reductions in staff in nonprofit groups as well as many more failures in care. The Queensland Nursing Union conducted a survey of its members. It found one in seven nursing homes failed inspections and unearthed dreadful standards of care due to understaffing.

Missed care in Victoria: A study has shown better staff ratios and less missed care in government facilities. Nonprofits had the worst staff ratios, which also suggests that their standards were falling.

1.5   Staffing Levels in Australia

We do not have detailed staffing figures prior to 2003 so cannot quantify what happened after the 1997 changes, but there was a fall between 1993 and 2003. Allegations of deteriorating staffing were were being made soon after 1997 and appeared in the media.

Increasing need but decreasing staff: When corrected to include nursing staff only, staffing figures between 2003 and 2016 from the reliable National Institute of Labour Studies (NILS) show a 35% (one third) decrease in the proportion of trained nurses in aged care over that period.

At the same time, acuity as estimated by the ANMF using the proportion of high care residents, has increased steadily by 53% since 1998. The proportion of Personal Care Assistants (PCAs) increased by 22%.

This means that as the number of frail and sick residents needing skilled care increased steadily by over 50%, the number of trained nurses needed to care for them (if extrapolated to 1998) decreased by at least a third and were replaced by much less skilled PCA's.

Within that, the increase in acuity was steady. There was a rapid decline in registered nurses and an increase in PCA's between 2003 and 2007, the period when work-choices was introduced.

The percentage of registered nurses steadied after 2012, the period when there was a public outcry about the need for registered nurses to be on duty at all times and a hotly disputed and politically charged inquiry in NSW. But at the same time, the number of enrolled nurses continued to decline rapidly.

This decrease in staffing was confirmed by leaked information from the confidential Bentley's reports in 2015 and 2016. These also revealed the contrast with the dramatic increase in profitability of the providers who claimed more money for the increasing number of frail residents. Bentley's proudly attributed this to the sectors greatly increased efficiency! *The Conversation* contributed to the debate rather more critically using similar figures.

Staffing and facility size: Data from annual reports shows that since 2007 the number of nursing homes across Australia has declined by 5.4% at the same time as the number of beds in them has increased by 11%. This probably reflects the shift to the larger, sometimes several hundred bedded, facilities by the larger companies driving consolidation and efficiency.

This efficiency is often accompanied by low staffing and has been described internationally as warehousing, wrinkle ranching, or by some Australian nurses as 'people farming'. Smaller facilities generally provide better care and a compromise with efficiency should probably not exceed 100 beds.

Is there really a shortage of nurses?: We should take note when those nurse academics who study the sector say that registered nurses are leaving in droves because of the sort of environment they are working in.

When you find yourself in an environment where the culture and your core values are under pressure, you don't stay.

Reports that large numbers of newly trained nurses cannot find work months after graduation suggests that nursing homes don't really want to address the problem and take the trouble of training up new nurses and giving them experience. It would increase costs.

Alternate figures: The industry and those business organisations that advise and support them have tried to claim that they are not compromising care and that there are an adequate number of staff in their facilities. They have supplied the Commission with voluntarily disclosed figures generated by StewartBrown from some 800 facilities, a majority of them nonprofit.

These show marginal increases in registered nurses hours since 2012 and in total numbers, but nothing that could meet the increased acuity. In making these claims ACSA supplied the Agency only with StewartBrown figures since 2012 and only figures for enrolled nurses since 2015. The earlier figures showing just how poor staffing levels have been were omitted. StewartBrown collects this self reported data in order to assist their clients in lobbying government and influencing policy' so there is potential for some inadvertent confirmation bias.

This sector compromised their integrity in 2016 at the time of the workforce inquiry. StewartBrown labelled figures incorrectly on a chart in their June 2016 report. These added almost an hour of extra staff time that was not direct nursing care. They labelled it 'direct care' so making Australian figures look comparable with international figures.

This was deliberate because they had previously labelled staffing data correctly and another chart in that report did so. They were used by StewartBrown on social media and by ACSA to counter arguments of poor direct care staffing. We suspect that these figures were to be offered to the senate inquiry but they were immediately challenged and the senate committee warned of the deception.

We suspect that this reflects the ignorance about care of the businessmen and managers in the sector and of a past LASA CEO and member of the Aged Care Sector Committee, by then with StewartBrown. They did not appreciate the enormity of what they were doing and the consequence for thousands of residents had their figures been received and accepted by the Senate. One of the problems with belief systems that use illusions to justify what they do is that they so readily slip over into this sort of thing – even before they have developed a justification.

International staffing comparisons: Unlike Australia, the USA, when adopting a neoliberal market in aged care, maintained a regulatory system that collected data and published it openly so its many flaws were exposed. Its figures and recommendations are based on years of research and ongoing monitoring of progress. Many states have mandatory ratios but due to pressure from industry they are inadequate. We quote an article that sets out the evidence.

Data shows that Australian staffing levels are hopelessly inadequate when Australian benchmarks generated by financial businesses are compared with US recommended levels of staffing based on studies of the needs of residents. The same difference is reflected in average staffing levels and we used StewartBrown's figures for comparison.

In both sets of figures, US residents receive twice as much care from trained nurses as Australian residents and one third (one hour) more nursing care overall.

A seasoned US researcher, who was among those who did the studies setting recommendations and who has published extensively on staffing, worked with a state group seeking to make data comprehensible to families. They divided staff levels into 5 groups from very good to dangerously low.

Over half of Australian nursing homes would fall into the dangerously low group. With levels like this there are likely to be large numbers of failures in care – usually described as 'missed care'.

The studies done in Victoria in 1985, when acuity was much less, more closely approximate US levels as do the recent studies done in South Australia. Neither were accepted by government and their industry advisers.

> **In a system like ours where perverse incentives have so badly compromised staffing and care, minimum and recommended ratios linked to acuity have become essential, at least until major structural changes are made. Funding is already done in this way and staffing ratios could be linked to that.**

1.6   How bad is care?

The negative neoliberal attitudes to altruism and society and the underlying principles on which the aged care marketplace are based, need to be considered. The logical expectation is that they would lead to failures in care. We realise there will always be those whose values remain and who will strive and even succeed in providing care in the face of perverse pressures in the system.

Without data, we do not know how bad it is and must rely on whistleblowing from families and staff. There have been many of these and multiple red flags.

There are a number of moral issues that need attention. These include:

- The morality of placing so much responsibility and stress on to family carers in the push to provide care at home. This seriously disrupts the lives and future careers of family carers - usually daughters.

- The morality of spending too much on the elderly when there is also a great need to support the young.

Few elderly want to destroy the lives of their children or compromise the future of their grandchildren.

- The morality of forcing people to make choices under great stress without good local support and good information.

- The unfairness of a consolidating system where those who choose wisely and get good care face a high probability of being sold off to a commercially successful provider whose success is based on providing substandard care.

- The absence of good and effective local support for residents and families when care is bad and requires immediate action.

- The appropriateness of the centralised MyAgedCare system – an example of managerialism's obsession with processes and control.

We have an aged care system fashioned within the vision of a belief system which misrepresents the nature of care and disregards the needs of those it should be serving.

A home or a hospital: A major cause of poor care has been the illusion expressed by Ansell Strategic that *"Residential aged care is a home and not a hospital"*. They use it to argue against ratios. The correct and accurate name for these institutions which neoliberal thinking changed is 'Nursing Home'. That means a home within which hospital quality nursing care is provided. It is both.

The recent Senate Inquiry condemned this illusion and correctly blamed it for failures in care, but it evaded the challenge to neoliberal belief by blaming this on structural issues in the 1990s which would have played only a minor part. We support the debunking but not the explanation.

This illusion is a consequence of self-serving neoliberal thinking originating in providers in the USA, then adopted by global business corporations. These advised US health and aged care companies to play on politician's pain (ie paying for services) when selling their products to other countries. We describe how a charismatic US businessman who had built an empire this way came to Australia and sold his message to politicians. The messsage was that there was plenty of fat in the system including in nursing and that this could be reduced by handing the problem to business. Politicians were soon saying similar things and basing policy on it.

The current business model and so the profitability of the sector is underpinned by this illusion. This has been sanctioned by politicians and the captured accreditation process. They will desperately defend it. We will not get good care until these illusionary beliefs are discredited and discarded.

Two geriatricians have identified the way health and aged care have been separated. They have described the adverse consequences. The 2013 Senior Australian of the year, a palliative care specialist, suggested a solution in 2014, which Aged Care Crisis supported but it did not find favour.

In order to understand the power of illusions and why they do so much harm, we have used the insights of French Philosopher Michel Foucault. We use his concept of discourse. He describes how those who have power control the interpretation and flow of knowledge. This enables them to define what is acceptable and credible in the discourse and what is off limits and unacceptable. By doing this they are able to control the way citizens think and behave. Using the strongly asserted illusion that ageing is not a disease and a nursing home is not a hospital to avoid providing costly but needed care is a good example.

Others have looked at the strategies used by citizens as they become successful by conforming to the requirements of the discourse even when this is harmful to others and society. The business advisors, owners and managers are further away from the coalface of care. It is easier for them to employ these strategies to avoid confronting the consequences of the things they do. It is more difficult for nurses.

Home Care: Policies in this sector**,** where services have traditionally been provided by community and non-profits, have seen the sector rapidly marketised and refinanced along neoliberal lines. As in other parts of aged care, this is driving out the community who no longer have a role. This is having a profoundly negative impact on society, eroding social capital as it drives volunteers out of the sector.   In his submission, Professor Fine has appealed to the Commission to stop this and we strongly agree.

Consumer Directed Care, while appealing and giving a sense of control, has pushed up the cost and not produced benefits. Recipients get less care and not more. Funds are limited and the system does not permit prioritisation based on need. Instead, it creates a long waiting list of people badly in need of services while others do not use all of the funding they have been allocated.

Professor Fine has written about the social consequences and in his submission has urged the commission to advise against proceeding with the proposed "reforms". We are concerned that the types of for-profit providers entering the sector will exploit the vulnerabilities in it.

The UK has introduced a similar funding system for disability care. It has not worked and has been strongly criticised.

1.7   Aged Care Data in Australia

Many have been critical at the absence of data in aged care. What has happened could not have lasted for 21 years had accurate data been collected and the changes been closely monitored and objectively reviewed. The strong pressures to avoid confronting data have been described.

An audit of the Accreditation Agency in 2003 criticised the failure to collect and use objective data.

At a subsequent parliamentary hearing, both the industry and the department promised to collect data and indicated that some were already doing so. That never happened. We can only imagine what was revealed.

The complex theoretical ideas that underpinned accreditation did not include the collection of that sort of data. Using data to regulate impeded the process of accreditation. Failures were only indicators that processes were not working.

In 2007, the Agency employed consultants who confirmed this and advised against collecting and using these indicators to measure performance.   Many calls to collect data over the years have been ignored.

When the pressures to collect data increased and Quality Indicators were proposed it was KPMG, another business advisor who carried out the reviews and gave the advice on a clinical issue. Presumably this was because the commercial consequences were a problem for the industry and this outweighed clinical considerations.

Misinterpreting data: The one set of real data that is collected is financial performance and that is reported to the market. Invariable those who are making large profits are considered to be good performers. This is readily reinterpreted as good and reliable in providing care. In the absence of other data the public perceives them as good and dependable and chooses them.

This profit is much more likely to come from reducing staffing and so care. StewartBrown for example, collects both staffing levels and financial data and reports on financial performance. In none of its reports does it compare financial performance with staffing levels. This would show what was happening and providers would go elsewhere for help.

Quality Indicators (QIs): The government is making much of the use of quality indicators. They have finally agreed to implement them some time in the future. While that is a step forward, there are many problems that have been revealed overseas. Self-reported QIs that impact financial performance have not worked in the USA. Some of the worst providers were top scorers.

In addition QIs can distort services by directing resources away from other care needs. They can result in 'cream skimming' – ie, not admitting those at risk of failing them.

The data trap: There is a very real problem called 'the data trap' that is evident in the USA and Canada. Care is not only about outcomes but is underpinned by caring cultures and caring relationships with residents which allow both carers and cared-for to build identity and meaning into their lives. These cannot be measured and they are readily sacrificed in competing to perform well. Professor Michael Fine has written about issues like this and the difficulty that market culture creates for this.

Consumer reviews and ratings: The views of those using the system are always important but they too have their pitfalls, particularly when they are done within a market frame and are underpinned by neoliberal choice theory. They are useful but cannot be depended on to detect problems. Citizens are very reluctant to criticise particularly when this challenges discourse because it becomes terrifying "*to think that the system is deeply flawed*". They are also aware of the dedication of stressed staff and grateful for their efforts. There is the fear of retaliatory action.

A multitude of different digital feedback services have been developed including 'trip adviser' style ones. While they can be useful, they usually depend on funding by industry so are readily captured and there are a number of other problems.

Data and the accreditation process: To understand the problems here we need to consider multiple factors including revolving doors, regulatory capture, the neoliberal discourse, fear of challenge as well as neoliberal belief in less regulation and in using self-regulation instead. The belief that aged care is not a disease is reflected in the type of accreditors employed and in the lack of attention to clinical failures.

We illustrate the problem by examining the agency's own figures and showing how seldom they identify problems when other sources show there are problems.

Medication failures and pain management are two major concerns in the sector, but only 0.47% and 0.16% of visits detected a problem. Pressure injuries and malnutrition are interrelated as each increases the risk of the other.

While studies show that 40 to 80% of residents in Australia are malnourished, (international figures are 20%), problems with hydration and nutrition are identified in only 0.13% of visits.

There is total confusion about the incidence of pressure injuries, but some studies show figures of up to 44% (US incidence in 15,000 facilities is 6%). These figures suggest an eight times increase within eight years of the 1997 reforms. It was previously studied in the mid 1990s. Problems with skin care are detected in only 0.17% of visits by the agency.

We examine the confusion surrounding pressure injuries by describing the minister and the department's confusion when the minister spoke about it. Those making policy could not access information.

It is hard to miss pressure injuries if you actually look at the residents who are immobile. A limited 2018 study examining the development of pressure injuries can be interpreted as suggesting a figure of between 30% and 48% developing a new pressure injury each year.

Malnutrition is dependent on both the quality and type of food and also on staffing because so many frail residents need help and encouragement. We describe the concerns of dieticians and the studies of malnutrition done. There have been many issues with the quality of food and a study showed the small amount that providers were spending on food.

In response to intense publicity, industry claimed that the elderly needed less food and that the rigorous accreditation process did not reveal any problems. Questioned in a parliamentary hearing after a similar problem was exposed in 2010, the CEO of the agency admitted *"we do not measure nutrition levels".*

1.8 Regulatory failure

The regulatory system and particularly the accreditation process is a child of the neoliberal discourse. When government documents are examined it is clear that regulation has been more about working with and appeasing the market than protecting the vulnerable people it provides care to.

Unlike other regulators, accreditation assessors go on site at least every year and certify suitability. Accreditation is consequently at the heart of regulation and others accept and act on its findings. It is a regulator whether it accepts this or not.

Accreditation is a process designed to assist and not to regulate. The two functions are mutually exclusive and it has never regulated effectively in any country that we are aware of. It was rejected as a regulator in aged care in the USA.

Performance: The accreditation process has performed magnificently when success in getting accredited is a measure of its performance rather than that of the industry it accredits. Since 2000, its success rate has increased by 53% so that 97.8% of providers passed all standards. As we have described, this was done in the face of a 53% increase in resident acuity and a greater than 35% decrease in the proportion of the trained staff needed to care for them. The dramatic improvement to near perfect levels was associated with a decline in the number of visits made by the agency since 2012.

This becomes even less plausible when we consider that using a different form of assessment in the USA with its superior staffing only 7% pass all standards. Of the 93% who fail, an average of 6 to 8 measures are failed and 20% of facilities have serious failures. When citizens do use this data to make choices they have a means of differentiating providers. With only 44 standards and only 2.2% having any issues choice is impeded. This will become much worse when the number of standards is reduced to 8.

Lack of utility of Agency data: The Agency's own data shows that 74% of problems are detected *after* someone has told the agency about the problems. This information would have come indirectly from those at or near nursing homes. A further 12% come from risk profiling. Of the remaining 14%, only 4% are found during reaccreditation visits and 10% from unannounced visits.

Unannounced visits are more frequent than full audits and detect fewer problems per contact visit (1.5% to 1.8% of visits) than re-accreditation visits (2.2% to 3.3% of visits). The Review Audits when problems are suspected, confirm problems in 57% to 78% of visits and seem to be efficient.

Accreditation is a costly exercise. It might be far more effective and cheaper to have on site oversight so that regulators can be notified earlier and more often when there are issues to address. The figures do not support a dramatic improvement by making all visits unannounced, although it will help.

There is a revolving door of assessors from industry and frequent relationships between parties. Visits may be unannounced, but that does not mean they are unexpected. Following Oakden many more failures are being detected. The pressure of public opinion will maintain the regulatory pressure but experience suggests that this will change when they lose interest.

We are pressing for an empowered local visitors scheme where the visitors work with communities and families so that they are alerted to what is happening. This will ensure that the pressure of public expectation is maintained locally in communities and regulators learn of problems as soon as they develop. Accreditation should be relieved of its regulatory and data collection roles but should be accessed against performance as revealed by independently collected outcomes.

1.8.1 Social dynamics of regulatory failure

When the system is seriously flawed because of perverse pressures within it, then relying on formal regulation without fixing the problems, is unlikely to be effective. There will be collusion in outwitting regulators. We itemise the way perverse pressures and processes have been introduced and the way in which restraining influences have been removed.

Regulatory Capitalism: Those who study regulation claim that the response to the problems created by neoliberalism has been to greatly increase regulation. This regulation has focused on processes of self-regulation and assisting, supporting and steering the market through industry regulatory networks. While claiming less regulation we actually have more of the sort of regulation that does not work.

When the multiple market failures in Australia over the last 20 years are considered, it is clear that this sort of regulating is not working and we need to consider why. Regulation of Aged Care is only a part of the problem.

Regulatory expert John Braithwaite and his team did an observational study of aged care regulation and published their findings in a book in 2007. They identified multiple failings which they described and explained. Little has changed and we draw on their findings and expertise.

The Revolving Door: The erosion of government bureaucracy has seen a loss of expertise. There has been far greater reliance on professional advisers in the marketplace and on a revolving door between market and bureaucracy. Increasingly government relies on the market to give it advice and tell it what to do. There has also been a revolving door between politics and the market.

Conflicts of interests, which would once have created an outcry, are accepted as normal and the press does not notice. Community groups that supported the discourse and worked with government, have done well and been welcomed to the table. Those who could be trusted to comply with the discourse prospered. Advocacy groups that were critical have not been supported and their funding has been threatened.

Regulatory Capture: Braithwaite et al described the way in which the regulatory system had been captured by marketplace thinking. It thought and identified with what they did. It came to serve them rather than citizens. The success of accreditation in reducing the number of failures was a measure of success and evidence of their achieving *"continuous improvement"*. The authors described the negative impact of this on the way the agency and department regulated. They warned Australians about what was happening but no one was listening.

More recently, a researcher studying the difference between the Australian system and that in the UK found that our system was far more centralised and so far more readily captured by a professionalised lobby system. The response of government and their marketplace advisers to the recent scandals has been to increase the centralisation of the regulatory system so making it easier to control what happens and address the publicity, which seems to be the problem for them.

None of this is new. It has been happening since 1997. As early as 2001 the opposition described the incestuous relationships that existed. There were many conflicted appointments. A different sort of marketplace and a different sort of regulator is required.

Examples. Revolving doors, conflict of interest and capture are illustrated with multiple examples to show their extent, how they work and their consequences. The perverse incentives created by the neoliberal market generates conflicts of interest that extend across the entire system from policy makers to the bedside.

Conflicted regulation: Aged care has been faced with a deeply conflicted regulatory system. On the one hand politicians and the relulators they appointed did not believe in regulation and thought it harmful. On the other, the more the system fails, the more the public demand for stronger regulation grows. In response a system, which was designed to help providers and which believed in less regulation, became the rigorous regulator that protected vulnerable residents. But there has also been a prior more pressing but unstated imperative they all share and that is to protect the discourse from challenge. The Quality Agency's effectiveness in successful accreditation showed those who believed in what was being done just how good the system was. This was never going to be sustainable.

The way people in a dysfunctional system like this respond is to adopt ritualized processes (eg tick and flick) that go through the movements of regulation. These processes become the tokens for what should be done or sometimes even what it is incapable of doing. Braithwaite's book is subtitled *"Ritualism and the New Pyramid"*. Managed and ritualised processes readily become a surrogate for our humanity - creating more illusions.

The other response to this situation is to create an opaque system where information is managed and illusions created to avoid critics rocking the boat. The idea of a 'world class' system and the idea that we have a rigorous regulator can be seen as two more illusionary beliefs in the hierarchy of illusions on which the legitimacy of the system depends. When one illusion falters then the whole house of cards is threatened and another must be found to prop it up.

1.8.2   Exploring the regulatory illusion further

We trace the way the Accreditation Agency struggled to maintain its faith in the discourse and be an accreditor and not a regulator in the face of the regulatory illusions. We trace this through:

- the policy of minimal regulation and the agency's intended role as supportive to the industry in 1997,

- the public outcry in 1998,

- the concerns of the Auditor General in 2003 that the agency was deeply conflicted,

- Braithwaite et al's observations in their 2007 book,

- the Agency's struggle against the Productivity Commissions recommendation in 2010/11 that the Agency become part of a single regulator was unsuccessful. The agency argued that regulation and accreditation were incompatible and combining them into one organisation undermined both. That recommendation was not implemented until 2018.

- the removal of the Agency's independence by moving it back to a department, renaming it The Australian Aged Care Quality Agency (AACQA) and putting an industry heavyweight in charge in 2014,

- its failures exposed for all to see by Oakden in 2016 and the conflict in its roles described in 2017 by those involved with the Oakden debacle,

- its passive acceptance when it was included in a single regulatory body, the Aged Care Quality and Safety Commission, in 2018 - as had been advised by the Productivity Commission in 2011, and finally

- this new Commission's predictable failure as demonstrated by what happened at Earle Haven and at the Royal Commission hearings in Brisbane.

1.8.3 The different regulatory roles

Accreditation: We have used accreditation to illustrate what has been happening to regulation. We list some of the criticisms made of the agency over the years.

The Complaints system was initially part of the department, where there was a conflict of interest. It has been plagued by problems and unhappiness over the years. It has been reviewed and changes made many times.

It too has been captured and influenced by the views of providers. Braithwaite was very critical in 2007 as was Walton who identified many of the problems in 2009-10. She recommended local resolution between the complainant and the provider without making any arrangement to support the complainant.

This recommendation and the red tape reduction program saw families with little power and knowledge sent back to sort it out with the providers - an imbalance of power. It compounded the problems for families and did not address the underlying problems.

After Walton and red tape reduction, the number of visits to go and investigate what was happening fell from thousands to less than 100. Those who complained were attacked. There was a perception that this retribution extended to the family member in care with many 'payback incidents'. A list of current concerns is included.

The Department of Health: This is the main regulator[11], but it seems more intent on supporting and working with providers than regulating them. The extent of this problem was revealed in 2012 when its own staff who had identified fraud where residents were being used like a 'cash cow' were told to look the other way as it was not their money. They spoke out in the media instead.

A subsequent *Capability Review* in 2014 revealed the problem as a toxic culture where staff were afraid to break bad news like this to its leadership. The publicity from the exposure of fraud by providers would have been very bad news for government. This seems to have encouraged the providers as rorting of the funding system increased rapidly.

In our discussion of regulation, we have described how the ministers plans to address the problem of chemical restraint were watered down by the department after seeking approval from industry and rejecting a call for wider community consultation.

The Approved Provider process: Government probity requirements once gave legislative support to the community's expectations that only people (owners and providers) who could be trusted to deal with the vulnerable would be permitted to do so. During the 1990s, government free market policies in health care were frustrated when several large multinational health care corporations entering Australia were blocked by state probity assessments.

> **In 1997, federal aged care probity requirements were repealed and replaced with an approved provider process which vetted only providers. Anyone could buy a nursing home company without being vetted, provided it was already approved. This opened the sector to the free market.**
>
> **Corporations whose conduct might have raised probity concerns were welcomed. The regulator was advised of our concerns about several companies, but did not have the power to act. In several instances of failure, owners were responsible.**

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[11] With powers transferred to the ACQSC from the 1 January 2020.

The problems of a lack of probity by those with control over care have been compounded by the growing number of companies using corporate webs and indulging in related party transactions.

The more extensive use of subcontracting and franchising creates more problems. The holder of Approved Provider status might be controlled by an owner in one instance, or have limited influence over the care provided by a subcontractor on the other. The particular subsidiary or subcontractor holding approved provider status might have limited influence over the care provided.

The lack of utility of the process and its inability to protect the sector and the residents it was there to serve from groups unsuited to the sector was revealed in the recent Earle Haven scandal.

1.8.4 Missed opportunities to regulate effectively

Advocates and official visitors are on site more often and should see and hear what has been happening but they do not have a regulatory role.

Advocacy with a small 'a': We seldom hear any mention of advocates in the reports of serious failures in care, but they must deal with many who approach them. Somehow, we never hear much of these as they seem to be kept away from the public. Anne Connolly the journalist who examined failures in depth in preparation for her Four Corner's programs 'Who Care's' challenged them about this at a conference in 2019.

The Aged Rights Advocacy Service (ARAS) failed to detect problems at Oakden. It advocated for residents on 14 occasions between 2007-2017[12], did four staff training sessions and had six meetings with residents and their representatives. There were close ties with COTA in South Australia and federally. ARAS shared three senior members of that organisation over the years. While there should not be a conflict of interest, COTA has been a very strong supporter and formulator of government policy on NACA and the Sector Committee and this policy has been failing for 20 years. They have identified with the government's neoliberal ideas and there may have been some pressure on them not to rock the boat.

There is also a revolving door between advocacy groups, industry organisations and bodies representing them, including a business contracting services to government and regulators. In a system driven by a discourse that creates perverse incentives, we feel this becomes problematic.

Braithwaite examined advocacy and spoke to advocates who told him that their contracts prevented them from criticising government or providers. If they did, they suspected their funding would be threatened. Braithwaite et al considered this was advocacy with a small 'a'.

> **These researchers indicated that community advocacy had been supported by the 1989 Ronald Inquiry, which advocated that government should fund advocacy and so make it independent of providers.**
>
> **They did not realise that government would later use funding to control advocacy itself. The government in 1997 removed funding from those groups that criticised it and that has continued.**

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[12] Answers to Questions on Notice: https://www.aph.gov.au/DocumentStore.ashx?id=7ddd28e3-6335-4eb5-88aa-f77f41f4d9ab

More recently, advocacy groups in the NDIS have become very worried about this. A strong critic of any funding of advocates who criticise policy has been put in charge of the organisation regulating charities. We can see this approach to advocacy as the legacy of the neoliberal condemnation of the 'collective' and its resistance to any restraint or influence from society.

In aged care government has funded nine state advocacy groups. They resisted pressure from government to merge into one and to exclude elder abuse from their role. Instead a single group 'Older Persons Advocacy Network' (OPAN) was formed and it won the contract for Australia. It holds the funds, receives calls from the public and delegates advocacy services to its nine members.

There has been increasing awareness of elder abuse. OPAN won a $2 million contract to develop an elder abuse program. The exposure of frequent elder abuse, often in the form of neglect in disability and aged care services, has been embarrassing to government and industry.

An elder abuse program was developed by five advocacy groups and COTA. The program that was developed was finalised at a meeting of advocacy groups and industry groups LASA and ACSA. Government were observers.

The group were quickly assured by industry that the *"vast majority of elder abuse"* occurs in those *"not living in an aged care facility"*. It was mostly financial and in the community. In contrast in 2015, the WHO had found that globally *"those living in residential aged care may be at particular risk.* The program was directed primarily at the community and away from nursing homes. Big brother who was funding OPAN's advocacy and this program was watching.

An empowered visitor's scheme: Empowered visitors schemes have operated successfully in other sectors in Queensland and Victoria. In South Australia, they were the group that exposed what was happening at Oakden because it was also a mental facility which had empowered visitors. They were extremely tardy in doing so because they had little, if any contact with residents and families. It is only when a family sought them out after some years that they looked properly. In aged care visitors only provide company for the lonely and play no role in regulation.

According to Braithwaite, Ronald in 1989 had proposed such an empowered visitors scheme for aged care. Industry strongly rejected it calling it the *"community busybodies scheme"* – perhaps seen as a threat from the collective! The Australian Law Reform Commission suggested such a scheme for aged care but fell short of recommending it. The Public Guardian in Queensland as well as the Public Advocates in Queensland and Victoria have urged the adoption of such a scheme in aged care.

Aged Care Crisis strongly supports such a scheme, but because of the need to avoid capture and to build community, we believe it should be drawn from local communities and work closely with community organisations in addressing aged care issues in their communities.

Visitors need to be primarily responsible to community. If they are funded and not voluntary, then funding should be structured through local community organisations so that the process is protected from the vagaries of politics.

Whistleblowing: Whistleblowers are the primary source of community information about serious problems in the industry. We agree with Braithwaite that *"the political neutering of advocates, makes whistle-blower protection for nursing home staff one imperative reform".*

1.8.5   Regulatory Failure and Capture is not unique to Australia

We briefly look at the failures of regulation and particularly accreditation in the USA and note that a revolving door and regulatory capture preceded that in Australia by several years.

In the United Kingdom there have been massive scandals and extensive failures in care. The Care Quality Commission (CQC) has been extensively criticised as not fit for purpose. Whistleblowers have described the difficulties they experienced.

The regulatory trap: We may appear to have been praising the data collection and regulation in the USA but that is only because it exposes what has been happening. The problem of the data trap is present in the USA and in Canada. This is because in such systems, assessments of care are "*decoupled"* from care itself causing "*documentation or assessment of care to trump the provision of care*". The essential caring relationships and the culture on which care depends are lost. These cannot be measured.

The collection of data "*constitutes an essential step in the process of monitoring quality*". It is essential for broad oversight and policy development. But data and regulation isolated from context can be harmful. It needs to be independently collected, evaluated and used on site and in context in the first instance and that is what we are advocating.

1.9   Effective regulation - broad issues in vulnerable sectors

Elephants in the room: In every dysfunctional system there are things that are not seen as credible or not discussed because they would challenge deeply held beliefs. They are the elephants in the room. We identify some that have been at most inquiries and we feel that the Ryal Commission should focus on.

    A. Focusing on regulation instead of the system of care that has failed and the more challenging reasons for this.

    B. Ignoring the discourse that underpins both the system and its regulation.

    C. The absence of critical comment from social scientists who understand these issues.

1.9.1   Social Control

We argue that the most effective form of regulation is the regulation that begins long before dysfunction develops so that it does not happen. This is the values and norms of conduct and behaviour that a responsible community insists on from its members. These are passed from member to member through genuinely empathic relationships with their fellows and their community. Those who are part of that community are under pressure to comply and continuous involvement with that community challenges deviation. The community responds immediately when problems develop.

Functioning communities have the capacity to roll back the harm done by neoliberal ideas and change the discourse of those who have adopted those ideas. The most effective control is exerted by a discourse that is appropriate to the sector. Formal regulation is there to support this process and step in when it fails. Neoliberalism has destroyed that.

We note that an academic discipline 'communitarianism' which understands the role of communities expresses similar views.   We discuss issues surrounding social control.

1.9.2   The culture of care and the relationships of care

The literature debating the power imbalance in professional caring and the nature of the caring relationships needed in that context goes back 2500 years.   These caring relationships are built on trust and trustworthiness. A host of professional and community ethical and value-based structures (eg probity) have been established to support and protect them.

These relationships and not choice form the basis of care. Choice and control are supported and encompassed within those relationships. There can be gentle guidance. These relationships have been harmed by neoliberalism.

Professor Fine has written extensively about caring relationships and caring cultures and focused on aged care. He has stressed the great difficulty in forming them in the sort of marketplace we have created in aged care.

We examine the problem of silos and the difficulty created by managerialism in this context.

Responding to neoliberalism and managerialism in the wider society: Critics who have studied and analysed these developments outside aged care are pressing for the rebuilding, re-engaging and participation of society in its affairs. Processes include the co-production of services and the co-evaluation of outcomes.

The sort of education that builds the capacity to analyse critically has been eroded by a managerial focus on training, as contrasted with education, and this needs to be addressed urgently. This broad approach to rebuilding society and democracy has been called deliberative democracy.

Effective system change must come from those who are situated and work close to the real world - those who see and understand what is happening there. They more readily see the consequences of policies but need to be freed from the pressures of a discourse that denies them. This is a process that starts at the bottom. Power comes from knowledge and experience and our communities have been pushed aside and denied this. They need to be the source of both.

Government's role should be to support and build community and not undermine or assume its roles.

1.10 Finding a way forward

The problems with the new Aged Care Quality and Safety Commission

We examine the *'tough new cop on the beat'* and do not consider that it is fit for purpose. Simply moving the pieces about, putting them into a single body and making claims about it does not address any of the real reasons that this system is failing. It simply makes it easier for the discourse to control what people say or do and prevent breakaway ideas. It is clear from the evidence to the Royal Commission that its thinking and mode of operation has not changed. This is an example of paradigm paralysis – where government is trapped in a discourse and is unable to think outside it.

Society must rise to the challenge: Those challenging neoliberalism look to society to address this and confront the problems created. Braithwaite has written about the success of community movements in achieving specific goals. He describes the difficulty in their maintaining momentum once the issue that they rallied around is addressed. He too has supported institutionalised local accountability and local advocacy.

For lasting change, permanent engagement of communities is required and they need to have control and 'ownership' of the service if they are to maintain their engagement. This has been

shown to be essential for indigenous communities and for success when aid agencies work with local communities in other countries and cultures. It is clear that it works, yet we deny it to our own communities.

In the UK there is a strong movement, supported by academic expertise, for adopting a community-based approach. It is interesting that a paper published in Australia in 2001 advocated for a local community based approach to funding and organising aged care. The authors describe the advantages.

The arguments for community 'ownership' of aged care: Responsibility for the care of vulnerable citizens lies with every responsible citizen and every community and it is their empathy and their values that are the foundation of this care. Those who provide that care are our agents and are responsible to us.

The capacity to see that our agents do what we expect them to do and embrace our values has been taken away from us. It should be given back. This does not exclude the market but it recreates the 'necessary conditions' for a market to work in the service of citizens - conditions that neoliberalism disregarded.

1.11 A Community Aged Care Hub: A structure embracing local 'ownership'

There are many advantages to the integration and management of services locally close to where the care is being provided. The nuances and needs of individuals within the sector can be much better managed when they are handled by those in close contact. This is not to suggest that it will be easy or will always work. Considerable support may be needed in the early stages. It cannot be precipitate and it will take time. Attempts to take control will defeat the process.

We cannot conceive of any other way in which the deep flaws in the current system can be addressed and no one has suggested a viable alternative.

1.11.1 A template for change

Ownership of the process of change and the development of a different system has become essential. Each community should contribute in creating the services its members need. This is not a quick fix but a long-term goal, a path into the future

Empowered visitors: As a starting point, a community group or hub could be built around an empowered visitors scheme with investigative powers. Visitors will be granted approval to see documents by the resident or family. Such visitors would come from the community whenever possible and would work with family, community, staff and providers.

They would be supported by local or nearby expertise and by a central regulatory mentor. They would oversee what was happening in the facilities and in the community and play a key role in working with staff and management to collect data transparently. They would be responsible to their community and be part of a group working with families and using their direct knowledge of facilities to support and advise them.

A community group or 'hub' could be developed with input from local councils, and community organisations - including seniors and worker's organisations whose input and contribution would be welcomed. They would play a role in organising and integrating aged care services locally and in addressing issues that arise in any local service.

Other central services like advocacy, accreditation and regulation would work through and with the hub and the visitors in delivering their services. They would support the hubs and advise but not control. This would bring these services directly to the bedside.

They would be there for those in need to turn to. They would be working with staff and so be in a position to mediate on their behalf when there are problems.

Such hubs would elect representatives to a central organisation that would support and integrate the service provided by the hubs, collect, collate and analyse data and report that back to community, providers and government transparently. They would work centrally with provider groups and government in addressing system problems and policy.

This will go a long way to meet the necessary conditions for a market to work for citizens. These are an informed and effective customer and an involved community. It will empower the community to hold its agents to account.

REITs: There are potential advantages in separating the ownership of facilities from the provision of care by encouraging the use of separate Real Estate Investment Trusts (REITs). Market forces would become more effective because changing providers or closing them down would be easier that shutting down facilities. Only management would change. Communities might well contract with a REIT to build and maintain facilities and a separate provider to provide those services. If a provider did not meet expectations, it could be changed with minimal disruption.

Some profit driven investors might struggle in a system that requires rationing without compromising care. Their investment and profits could be retained by becoming REITs so avoiding the perverse incentives that currently impact on care.

Legal redress: We support the development of an arbitration system and a legal avenue for securing redress when people are harmed through negligence or irresponsibility.

Central Regulation: Accreditation should be separated from government, be funded by providers, and be evaluated for its effectiveness using objective data. Government or a government-funded regulator would have a central mentoring role. It would remain the regulator but work with communities when applying sanctions.

Such a system would give the community the power to confront and control the discourse and make the discourse of care and the values on which it is based, the dominant force in this sector.

1.11.2 Practical applications of our proposals

We use the evidence given to the Royal Commission by Professor Paterson to define five key problems that he identified and discussed as problematic. We explain how our proposal would be more effective in addressing these problems than any others so far proposed.

These are:

1. Protection of the recipients of care
2. Ineffective complaints handling
3. The lack of information and transparency
4. Regulatory inadequacy
5. Public participation

In doing so we are criticising an enormously complicated process that is failing because it is too far away from the complex and varied situation that it is trying to manage and regulate. We are advocating that it be replaced by a simple local on-site process that has the capacity to see and understand the situation on the ground. It would be able to respond rapidly and flexibly to this and use limited resources for maximum benefit. Central processes cannot do this but should be there to support it.

Brief summary of Appendices:

Appendix 1: Consulting

Consultancies by KPMG

We use KPMG as an example to explore the nature of the consultancies used by government because it has been the main group used in aged care in Australia. We look at the many services that it has provided in aged care then examine the many disturbing reports about its activities across the world. We express our concern about the value and validity of these commercially driven financial consultants and particularly KPMG.in evaluating matters related to the care of vulnerable seniors.

Appendix 2: Analysis of data

Analysis of 5 years (2012-13 to 2016-17) accreditation and sanctions data

This is our analysis of health department data that became available when it was released to Senator Polley. If demonstrates the much higher failure rate in for-profit owned facilities.

Appendix 3: Expectations of the Royal Commission

What people expect of the Royal Commission

This examines publicly available views to see what the expectations from the Royal Commission are. There are many who are hoping that the Royal Commission will pull something creative out of the hat to deal with a difficult situation. None have made any suggestions as to how that can be done. This seems to confirm that there is no quick fix. The only people who have a clear idea of what they want are government and provider peaks. They want a rubber stamp and not change. That is not a solution.

Appendix 4: Neoliberalism and managerialism

Neoliberalism, Managerialism and their legacy

We include here an overview of a detailed examination of the many criticisms and arguments made about what are really philosophies of life rather that market theories. Those philosophies have been expressed through markets but their influence extends much wider.

This is a largely point form outline of the first draft of a paper examining the criticisms of these belief systems and looking at the consequences for society.

Appendix 5: Letter to Minister for Aged Care Mark Butler, 21 August 2012

This challenges the Productivity Commission Report and list the steps needed to address the failures that are starting to develop.

1.12 Recommendations

Long term Recommendation 1: Neoliberalism, managerialism

Problem: The many problems in aged care have their origins in the way that society and aged care in particular has been structured to exclude community and the essential role they play in functioning societies. Care of vulnerable citizens is a community responsibility but that responsibility has been taken from them.

Recommendation 1. That the system be restructured to empower local communities and harness the expertise within them so that they can hold those who provide care to their vulnerable fellow citizens to account. Providers should be their agents and provide care on their behalf.

Long term Recommendations 2: Consultants and experts

Problem: Probity and necessary expertise in consultants and industry 'experts'.

Recommendation 2a: That an independent bureaucracy be rebuilt so that less reliance is placed on consultants and government appointees in aged care.

Recommendation 2b: That a probity review and an assessment of potential conflict of interest should be included when using consultants and industry 'experts' in matters of public interest.

Recommendation 2c: That when using consultants and industry 'experts' in human services like aged care, the choice should be based primarily on expertise in the provision of the caring service and not economics. Economic and managerial expertise should be supportive and advisory – not controlling or decisive as in current practice.

Recommendation 2d: That community be rebuilt and that independent expert groups created from community, professions and universities be developed to advise on issues that are not economic.

Recommendation 3 – economics put before care

Problem: The focus of federal government planning is almost entirely focused on economics and markets. Policies are formulated within this framework. Human and societal considerations are neglected.

Recommendation 3: That policy and management of aged care be moved to state, regional and local bodies that are more atuned to addressing social and humanitarian domians.

Long term Recommendation 4: Power and Policy making

Problem: The power of those who currently advise government and make policy; their lack of practical experience, expertise and knowledge.

Recommendation4: That the professional and community structures within the sector be rebuilt and re-involved and in time become the primary source of advice for government.

Short-term recommendations 5: Staffing Issues

Problem: Perverse incentives driving staffing levels down and compromising care require urgent attention.

Recommendation 5a: That minimum safe levels based on acuity be established and published and facilities be required to report their staffing levels against this.

Recommendation 5b: That minimum required levels be legislated based on the best that can be afforded without compromising other generations at this time with the object of increasing them to minimum safe levels when possible.

Recommendation 5c: That a process for the regular on site objective verification of any self-reported levels be established (eg. Empowered visitors)

Recommendation 5d: That a process be set in place for the ongoing re-evaluation of these levels in the light of outcomes and advancing technology.

Recommendation 5e: That sufficient staffing data be collected in a way that is compatible with international data so that the results of international studies can inform policy and deceptive claims about being world class cannot be made.

Recommendations 6 to 8: Care

Long term recommendation 6: An inappropriate discourse

Problem: The dominance of a controlling discourse whose origins lie in a philosophy of individualism that has delegitimised the role of society and the values that it builds and uses to restrain self-interest that harms. This philosophy has in the past promoted selfishness as a value and altruism as a disease. These are fundamental to caring.

Recommendation 6: That a strategy be developed to bring community and its values back into the sector and make a discourse of care the controlling and organising discourse.   To do that will require structural changes that alter the balance of power in the sector. The community and the professions should be in a position to insist their values dominate.

Long term recommendation 7: Vulnerability and capacity

Problem: The vulnerability and frequent lack of capacity of:
* the elderly, their families and friends making choices,
* recipients of care in facilities or at home,
* their families who speak out, and
* the nurses who are not supported by management when they press for issues to be addressed.

Recommendation 7: There needs to be a local and regularly on site system of support from people with knowledge of the local situation, the local providers and the available resources and options. Those who provide this support need access to skilled advice.

Long term recommendation 8 – Culture and relationships

Problem: The need to develop a caring culture and caring relationships.

Recommendation 8a: While we are not advocating flagrant inefficiency adequate time should be allowed for relationships to form and a caring culture to form around them.

Recommendation 8b: This is a sector where cooperation should dominate competition and any competition should be directed towards being more cooperative in working with one another and with community. Data and problems must be shared and discussed.

Short term recommendation 9 - Misinterpretations

Problem: Confusing financial data with good care

Recommendation 9: Financial insitutions reporting profitability should be required to compare this data with staffing and report that too.

Long term recommendations 10: Data

Problem: Data aversion, secrecy, inability to accept what has happened and widespread community distrust as a consequence. Commercial in confidence inhibits transparency and fuels distrust.

Recommendation 10a: The only effective way of addressing this is total transparency and the only way of getting total transparency is to put those who need to have the information in charge of collecting it and evaluating it.

Recommendation 10b: The primary evaluation of data and performance should be made by local people with some clinical, social and accounting knowledge. They should be supported and assisted by outside experts when needed. That data should then be coordinated centrally and its significance for policy determined.

Recommendation 10c: The best way of regaining trust is to make those whose trust has been shattered responsible for undoing the damage. The role of experts is to help them to understand what needs to be done and allow them to implement and be involved in controlling the changes.

Recommendation 10d: When you are the agent and partner of the community you have to be totally open to them. Commercial in confidence must be abolished if a genuine engagement is to be made.

Long Term Recommendation 11

Problem: The existence in the sector of unsuitable corporate bodies and individuals who do not have the skills or who cannot be trusted to provide empathic care. These include complex webs, related parties, subcontracting and franchising.

Recommendation 11a: That community have a major input in deciding who is to provide caring services in their communities and that they be in a position to assess the suitability and trustworthiness of those who provide care on their behalf.

Recommendation 11b: Once patterns of probity requirements have been tried and tested in real life situations they can be given legislative and regulatory support

Recommendations 12 to 15: Failed regulation

Long term recommendation 12: A broken regulator

Problem*: A regulatory system that is not working because it is incapable of regulating a system driven by strong perverse incentives where success can depend on outwitting the regulators. This is compounded by a centralised system designed to assist rather than police, that is fearful of publicity. It is characterized by a revolving door with those it regulates resulting in regulatory capture. It is beset by multiple conflicting priorities that undermine its effectiveness.

Instead of decentralising to provide a diversity of perspectives to counter capture and adopting a regulatory and policing approach, it has responded to failure by greater centralisation so closing ranks and increasing its vulnerabilities. It has lost credibility in the community it serves.

Recommendation 12a: The pro-industry approach exemplified by accreditation should be abandoned. Regulation should be restructured to focus on detecting failures, applying suitable sanctions and deliberately exposing the perpetrators and their thinking to public ignominy. An important role of formal regulation is setting the standards of acceptable conduct by stigmatizing those who flagrantly breach them. Society and other potential offenders who may have adopted the same patterns of thinking rethink and reorient their approach to services. This keeps discourses on track and prevents them from straying into harmful fantasy by rationalising what they do.

Recommendation 12b: Accreditation should cease to be a regulator and it should be replaced by an effective regulator capable of policing the sector. It would be better to have a separate regulator at least until the department is strengthened to make it more independent of political pressure and less susceptible to capture and discourse.

Recommendation 12c: The problem of capture by a single discourse should be addressed by adopting the principle of distributive justice so that conduct is examined from multiple different perspectives and discourses. Placing the primary regulator in educated communities would do this.

Recommendation 12d: The regulatory system should contribute to the rebuilding of civil society so that the perverse incentives within the prevailing discourse in the sector are neutralized by alternate discourses relevant to the sector. When civil society is working effectively issues are confronted at source. Formal regulation rests lightly and is seldom needed. A society should not have to depend on regulation to make it work. It is only a backstop.

Long term recommendation 13 – other regulatory options

Problem: Missed opportunities to regulate locally on site

Recommendation 13: Strategies should be developed to embrace the regulatory potential of advocates and visitors by releasing them from the constraints currently imposed and empowering them. We recommend that this be addressed using the same principle of decentralised distributed justice. They should be empowered and be delivered together locally in cooperation with communities.

Long term recommendation 14: Whistleblowing

Problem: Whistleblowers targeted and silenced

Recommendation 14a: Whistleblower protections are badly needed and should be enacted

Recommendation 14b: In aged care there should be a local regularly on-site support system in place to support whistle blowers, reward them and protect them from retribution

Long term recommendation 15 – The regulatory trap

Problem 15: Regulation that diverts attention from care

Recommendation 15: The initial collection of data should be independently but cooperatively collected on site and be reviewed and assessed by those who are on site and aware of the local situation. Trends can be detected and examined in the total context of care and not in isolation. Central integration and broader analysis should follow.

Recommendations 16 to 21 - Effective regulation

Long term recommendation 16: Social control

Problem: The absence of effective social control

Recommendation 16: We recommend the development of community structures that become well-informed and discuss issues between themselves and with providers on a level playing field. The providers are their agents and complete openness would be required. They should work together in maintaining and improving the services for those they care for.

Long term recommendation 17: Culture

Problem: The dominance of a culture that sees individuals as self-interested and has resulted in a society that places self-interest above social responsibility.

Recommendation 17: Rebuild social selves by building social structures that give citizens more contact with each other in addressing issues that evoke empathy and responsible behaviour – ie. with those who are vulnerable and need help. This is critical to rebuild empathy and altruism within society.

Long term recommendation 18: Culture and care

Problem: Toxic cultures and task focused care

Recommendation 18: Create a context where staff are released from the pressures of a controlling discourse and can express their discourses of care, imagine the lives of those they care for, develop their empathy and so become altruistic. Support from, and a relationship with, communities and empowered visitors would ensure this. Creating a culture of care and developing social selves through caring relationships will make the sector more popular for prospective staff.

Long term recommendation 19 - Silos

Problem: Development of silos and one size fits all solutions. The risk of more illusions.

Recommendation 19: What we are advocating is described as a 'constructivist' approach in education. This has its origins in a study of the sociology of knowledge. This examines the way we are stimulated to learn and how, when freed from outside pressures and preconceptions we look for information, engage with each other in groups to look at problems and so build knowledge and examine different perspectives.

This approach builds stable societies and breaks down the barriers created by silos. The intent is to construct a society that engages and is equipped to handle the complexities of society. This is also a response to post-truth and populism. It creates a context where different patterns of thinking and discourses are evaluated against one another and used where appropriate. It can also be considered as developing critical thinking and as part of 'deliberative democracy'.

Long term recommendation 20 - Change

Problem: Handling change

Recommendation 20: Change challenges discourse and requires new discourses. This requires confrontation and often a change of power, but once that process is initiated those previously holding power and embracing a discourse that has failed need to be engaged with constructively and empathically. There will be important insights that need to be retained. Ultimately they should be included in the discussion and in making changes.

It is important not to throw out the baby with the bath water and respond by adopting another one size fits all discourse. The Intent is to create a context where different perspectives are balanced and seen in the context of their relevance. Effective change comes from an engaged, stable and fully informed society, and not from populist leaders or from the artificial creation of crises for political advantage.

Long term recommendation 21 Supporting social control

Problem: Central regulation inhibiting social control

Recommendation 21a: The role of government and central regulation is to support and build society and not to assume its functions. Ultimately government and regulators will be drawn from this society and the effectiveness of government and central regulation will depend on the sort of society that they foster. Government's role is to support and build society. When needed regulators need to step in and take action that stigmatises breaches of society's codes of conduct to show how unacceptable they are.   When society functions well this should seldom be necessary.

Recommendation 21b: Society is a cooperative partnership between individuals. Government and central regulators have a critically important role managing the balance between them and in ensuring that individuals rights are protected and society does not turn on individuals with alternate views or lifestyles. We are not advocating for socialism or populism but for balance. Responsible citizenship means protecting the rights of others to be individuals and when society is dysfunctional and fails to do so itself government and regulators must step in.

Long term recommendation 22 - Involving community

Problem: Getting and maintaining community involvement

Recommendation 22: A hands off approach. Humans are existential beings who create and recreate themselves through involvement and in doing this build identity. To accomplish this they need an important and controlling role. Studies confirm the importance of the 'ownership' of activities. The most difficult role in reform will be that of regulators and government who mentor. Success will depend on their ability to resist their urge to interfere and take over but instead support and supply information then sit on their hands until asked to help with problems. This will be most of the time - even when some mistakes are made.

Recommendations 23 to 26 - Building a community network

Long term recommendation 23: Local integration

Problem: Creating a local context where multiple roles and activities are integrated within a local organisation – resisting the legacy of managerialism.

Recommendation 23a: That an empowered visitors scheme be established within communities and that they, local government and local organisations cooperate in building a community organisation that includes local expertise to oversee and manage aged care in that locality.

Recommendation 23b: That this be a partnership between central government and community in which government increasingly, but depending on the capacity of the local organisation, provides its services through local communities and hands them responsibility.

Recommendation 23c: That the visitors have a joint responsibility to the community and government reporting to both.

Recommendation 23d: That visitors and community are often on site and there to support residents and staff and work with managers to be sure that they are operating the facilities and providing the sort of care that they expect their agents to provide

Recommendation 23e: Some funding will be required depending on how much this organisation takes on. The service should be primarily voluntary to ensure its independence from government. If the visitors are paid which seems desirable this should be through local organisations which should appoint them and be shielded from political interference.

Recommendation 23f: Funding. We support smaller government and less regulation, not as a belief system but when society works so well that formal regulation is seldom needed. A society that relies on regulation is a sick society that needs attention. Some of the funding saved should go to supporting, providing educational resources and building community.

Long term recommendation 24 – Central representation and power

Problem: Central integration and a role in policy

Recommendation 24: That the community hub organisations have central representation on a representative body that would work directly with government and provider organisations. It would provide a resource of knowledgeable citizens with the experience to advise and assist with policy.

Long term recommendation 25 - a failed market and REITs

Problem: Making a failed market work

Recommendation 25: Effective customers and an involved community are necessary conditions for a market to work, particularly when there are vulnerabilities. They must have the power to decide whether the service meets their requirements and if not change providers. Moving to a system where providers and owners of facilities are separated by using REITs will allow the market to work more effectively for communities and their older members. It would provide a way for those whose focus on large profits is not supported to exit the sector. It provides a mechanism where the share market and private equity can invest and support the system without the perverse incentives they create compromising care.

Long term recommendation 26 – risks of precipitate change

Problem: Difficulty in making major structural changes

Recommendation 26: Major changes should not be made precipitously as was done in 1997. Changes should be made incrementally both geographically and in the extent of implementation. Some areas would lead the way by developing and trialling new structures. Forty years of belief and 30 years of system change cannot be abandoned overnight. We should learn from and not repeat the mistakes made in 1997.