Response

to the Productivity Commission's Inquiry Draft Report:

Caring for Older Australians

J M Wynne MB. ChB, FRCS, FRACS, Grad Cert Ed (UQ)

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1 Summary

> *Big money has crowded out authentic participation.*
> *Commercial values have encroached on civic values.*
>
> *Robert Kuttner 1997* (**see:** References)*

This response to the Draft Report accepts that, while markets create serious problems when used to drive health and aged care, we now have a market. It must be made to work so that the negative consequences are minimised.

The Draft Report does make a number of major and important recommendations.

However, while seeking to make the aged care system more market like it does so on behalf of the providers and not the consumers (residents and families) and customers (the local communities).

Market theory is based on a balance of market power between the seller and the buyers. It is the buyers as a group who hold ultimate power. Their decisions determine whether the seller will prosper, survive or go under. Unless the necessary conditions are met a market will not work. Unless the buyer has market power the market will fail to work for the buyer and society. The argument against a market in decrepitude is that the necessary conditions cannot be met.

If we are to have a market then every effort must be made to meet them. Aged care will only succeed as a market to the extent that the necessary conditions for market theory to operate can be created by restructuring the system. At the moment they are not being met. Resorting to central regulation and oversight has not been effective. There are always conflicts of interest and they are too far from the customer to be effective.

The Draft Report makes no attempt to give the vulnerable consumer or the customer market power. Market forces are structured to encourage understaffing rather than reward well staffed facilities. As a consequence this report lacks conceptual integrity and intellectual honesty.

This is not because the Commissioners are themselves dishonest or are not motivated to care for the elderly. It is because they share a common background and a similar view of the world. These changes are not underpinned by any new thinking, or any new understandings. Reform is directed to patching and rearranging the pieces. This is not real reform.

What was lacking was a Commissioner with very different perspective to act as a devils advocate by challenging, opening up new ideas, and leading discussion that would open up new insights and understanding. This is a "responsive" report as contrasted with the "constructivist" one that was called for.

In my response to the Draft Report I have tried to fill this role of devils advocate by challenging the Commissioners' thinking, and then following the consequences of that to suggest logical changes to what they recommend.

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3 Recommendations

3.1 Marketplace dishonestly and the customer

The Commissioners are urged to redraft their recommendations and restructure their new regulatory authority to give more detail as to what exactly they are recommending with particular reference to:

- the accreditation process,
- the objective monitoring of standards of care,
- the assessments made by knowledgeable individual in each region,
- the complaints system,
- transparency, and
- the structures to advise and support consumers and customers

with particular attention how each can be linked into the community in such a way that all of these structures are directed to redressing the imbalance of market power between providers, on the one hand and local consumers and local communities on the other.

The information in the appendices of the Draft Report should be drawn into the report to show how the new structure will empower and support the consumers and customers.

3.2 Market integrity and staffing

The Commissioners are urged to structure the system such that market pressures drive providers to better staffing, countering the current economic incentives to under staff and deskill.

3.3 The Complaints system and the market

The Commissioners are urged to describe how the recommendation made by Professor Walton's review will be incorporated into the new system with particular reference to its potential to empower the consumer and the customer when they make choices.

3.4 Data collection and transparency

3.4.1 Objective data

The Commissioners are urged to abandon the use of the unreliable accreditation process to collect data. Instead, the providers should be required to disclose both financial data and the objective clinical performance data that they collect.

The accuracy of this data should be verified by trained local agents with full and regular access to the clinical and financial records of the facilities in their region.

3.4.2 Difficult to measure data

There are many aspects of residential care that do not lend themselves to objective measurement but which are readily apparent to a trained regular visitor, but not to an occasional one. Local agents should observe and record their observations.

3.4.3 Market forces should be applied to the accreditation agency

Once objective standards of care and the observations of local assessors replace the accreditation process as the best measure of care in the minds of consumers and the community, it will be the providers who decide whether accreditation is a process that improves their services and whether they will pay for it.

3.5 Visitors, advocates and volunteers should be structured into the system

The Commissioners are urged to bring visitors, advocates and volunteers in from the cold by structuring them so that they work closely with local regulators in monitoring nursing homes and in feeding the findings to the regulator and back into the community to empower consumers and customers.

3.6 Consumers' market power should be augmented

Consumers should be advised and helped by the same groups of people (local monitors/visitors/advocates) who are monitoring standards of care in local facilities.

3.7 Leverage

The Commissioners are urged to create a fluid system where all parties have balanced leverage so that innovation, adaptability and critical evaluation are integral to the system.

3.8 Approved Provider Process

Serious deficiencies in this process should be addressed by restoring probity as a consideration, having a mechanism for review, and having local community representation when assessing approved provider status.

3.9 Additional Issues

The Commissioners are urged to consider a number of additional issues and give them some attention. These include the risk that staff will be funneled away from care and into extra services offered as choices, the risks of cost shifting, the risk that the economically wise will spend off their assets rather than pay for accommodation, issues regarding registration and training of staff, how regulatory staff will be selected, how consumers will direct choices, the risks when facilities are traded in the market, issues of education versus marketing, as well as who and what seniors would perceive as trustworthy when they seek advice.

4 Introduction: Hopes Dashed

This Productivity Commission Inquiry with its instructions to redesign the aged care system promised so much that long time critics of residential care, who have seen red flag after red flag discounted, and inquiry after inquiry go past without much hope, had, at last, dared to hope.

Within the first few pages of this Draft Report their hopes were dashed. We read that the concerns about deteriorating standards of care were to be ignored on the basis that stakeholders considered that care had improved. This was to be a replay of the Hogan review, with its unsupported assumptions.

I do not want to blame the Commissioners who have done their best within their understanding of the way the system is working. We all see things from the perspective of our own experience and are reluctant to challenge that with the insights from others.

My experience comes from direct contact with, as well as, a study of situations in which the way people understand their situations (their view of the world) has had a profound effect on outcomes. This is why I expressed concerned, in my earlier submission, at the overrepresentation of the industry on the Commission.

This report is the logical consequence of insiders doing their best. An inquiry of this sort should always have some outsider representative. There must be a devils advocate to challenge and to present conflicting views.

4.1 The problems of funding

There is a continuing perception that also seems to underpin this submission. This is that because we have an ageing population and a diminishing work force, we face such a massive cost blowout that we cannot afford to provide the sort of care for the elderly that we would like to. This argument is never set against our growing wealth.

Australia has never been wealthier; its giant corporations are making vast profits and its prospects look excellent. This is likely to go on until well after the baby boomer bulge has passed. There should be no problem in paying for aged care. Other countries already spend much more. The problem is getting value for money and not wasting it.

There are two major problems with the suggested changes in funding:

- The first is the lack of transparency. We are not going to learn how public money is spent.
- The second is the failure to extract concessions that empower consumers and customers in return for improved funding and the removal of onerous regulations. They were put there for a reason and must be replaced with something better.

4.2 Recording the views of critics without empowering them

The Draft Report certainly documents some of the concerns expressed in the submissions, but I have reservations as to whether the proposed changes in structure will be effective in addressing the critical issues raised. There is insufficient detail or conviction in the recommendations on oversight. Without more information it is difficult to see how the changes will work to balance the system and empower consumers and customers.

4.3 The Draft Report ignores market theory

The Commissioners identify strongly with market theory and seek to make aged care more market like. Yet in doing so they betray the very essence of market theory. They plan to enhance the power and opportunities for the providers without showing how the consumer and customer will be empowered in the same way. In my view this reveals a lack of intellectual integrity. I realise that the Commissioners do not see it that way and that this is not intentional.

I do not believe that a competitive market in misfortune and frailty is ethical or that it is the best way to provide care to the vulnerable. Evidence strongly indicates that it puts the vulnerable at risk and is a less efficient way to use resources. I accept that it is now a fact of life and that it must be made to work. This criticism of the Draft Report therefore makes suggestions that aim to empower the consumer and customer so that this market works for them as well as for providers. Simply giving them choices does not do this. This Draft Report fails badly in this regard.

This supplementary submission makes the argument that unless the customer and consumer have, both market power and leverage, then a market will not work to their benefit. This is a simple restatement of basic market theory.

The market will fail to deliver its benefits to the extent that consumers and customers are unable to fulfil their marketplace role effectively. Their ability to do so, as the report documents but largely ignores, is already limited. Particular care should be taken to balance this by giving them greater access to information and greater power than would be needed in other sectors.

The Draft Report does address several of the problems in our current system and that is welcomed. What it proposes is an improvement. But at the same time it exposes the elderly to an increased risk of exploitation - more than is acceptable. It is not a fundamental reform in that it brings no new insights to the process. It lacks integrity in that it is selective in the way in which it applies its thinking.

5 Addressing deficiencies in the Draft Report

5.1 Major beneficial changes are proposed but some lack specificity

- The move to give greater support to those wanting to stay in their own homes is a great step forward provided it is not misused and does not become dysfunctional. We should be careful not to keep people at home when they can no longer be properly cared for there, or when the strain on family carers is excessive. All too often enthusiasm goes too far. We should not return to an era when one or more family members were expected to give up their own futures in order to care for aging relatives.

  We should remember that the enthusiasm to place psychiatric patients in a more suitable community setting and close psychiatric hospitals benefitted some but ended with many on the streets and in our prisons.

- The proposal to move the regulation of aged care from the Department Of Health and Ageing to an independent body is another giant step provided this is accompanied by real change in the way those at the helm think, and the way these processes are set up.

  It is unfair of the Commission to seek comment from the public when it has not yet properly thought out its proposals or given any response to multiple complaints of failure made to this and previous inquiries.

  I am not persuaded that it will ultimately become more than a change of hats. The Draft Report gives more attention and conviction to changing the funding system than it does to changing the regulation and oversight of care. No doubt this is because there is considerable tension with providers who are pressing for more money and resisting oversight claiming it is burdensome. An independent review would not bow to these pressures.

5.2 Transparency

Real transparency would be another giant step forward. Repeated reviews have advised this and multiple promises made with little real outcomes. It is unlikely that simply urging this on this new regulating body will be any more successful than similar urging in the past. It requires a whole new way of thinking and that is not apparent. The only certain way of accomplishing this is to make those who need to know part of the process of data collection.

5.3 Concern about Residential Care

Many of the proposed changes are tailored to those receiving care at home. Residents and families will certainly be in a better position to form reasonable opinions and choose between different options. Because the services occur in the family homes, among family and friends, they can be more closely monitored. The availability of more options to choose from will be a plus. There is a reasonable prospect of the changes working effectively, and while my comments are relevant they have less applicability.

The major concerns I have relate to residential care where choice is limited and difficult to exercise. This is because of increasingly sick and frail residents (who are not in a position to pick and choose), their frequent admission as a result of a health crisis, more anxious families, and greater difficulty in monitoring care.

While options to meet different needs should be available it is others who will guide the family. Residents are at greater risk from competitive commercial pressures and from companies selling snake oil choices.

The primary interest in residential care must be in staffing because it largely determines the sort of care provided, comfort, palliation and quality of life.

There must be concern that moving the focus form residential care to community care will entice staff to move to this more congenial environment, so that the seriously debilitated in residential care will receive even less care.

Simply moving the regulatory pieces about and re-arranging them as the Commission plans is not going to bring the fundamental change promised by the rhetoric. Change is a process that goes much deeper than structure. Fundamental is a broadening of, and a fundamental change in the way we conceptualise and understand what we are doing. Change is based on new insights and building new structures around them. I do not see this here.

As a potential octogenarian, I am depressed by this Draft Report. There seems less and less prospect of an easy exit, and more likelihood that I will linger on to 85 and go into a "residential care facility".

Here I will be confronted by choices others will make and be vulnerable to the staffing problems this report fails to adequately address.

I will have to carefully consider my options while I still have the option of determining my own exit. Once in a facility, options like that will not be readily available. I will look at the financial and other costs to my family and the prospects that a life in such a facility will have sufficient meaning to justify it.

5.4 Language and framework

> *Kuttner maintains that there is at the core of the celebration of markets a relentless tautology. If everything is a market and market principles are universal then if anything is wrong it "must be insufficiently market like. This is a no-fail system for guaranteeing that theory trumps evidence." and "It does not occur that the theory mis-specifies human behaviour." He asserts that "real people also have civic and social selves."*
>
> *from Robert Kuttner 1997**

As I read this Draft Report I found the dominance of many words disturbing because they reflected a state of mind.

They included:

- **Demand** (instead of need)
  - if generation X, Y and Z are as empathic as current seniors then they will respond to the needs of their parents and grandparents. Like current seniors they will be offended and alienated by demands from baby boomers and others, who have had a good life, and now demand greater luxury at their expense, than they have themselves.
- **Choice** (instead of options or alternatives, and code for "open slather")
- **Incentives** (instead of reward for services, and a code for kickbacks and bribes).
- **Stakeholders** (instead of citizens and code for vested interests),
- **Competition** (instead of friendly rivalry and contrasted with cooperation). The likelihood that the problems we have at the moment are consequent on the way 14 years of marketplace competition has shaped the market is ignored. The report wants to use competition to reshape it once again (*page 167 of the Draft Report*)
- **Efficiency** (as a demigod but also a threat to humanitarian services where quality of life and relief of suffering depend on the gift of time simply to "be there" for the other).
- finally, **Liberalisation** (the god of the market and code for removing the protections set in place to protect the vulnerable).

Equally disturbing is the repetition of marketplace gibberish as on page XLII. It is claimed that competition will cause poorer operators to fail. In the health care sector, care should be driven by empathy and ethical concerns. We would expect ethical operators who refuse to play marketplace games that make money, like cherry picking, to fail. Experience elsewhere shows that that is what frequently happens. As the debacle with bonds illustrates this happens because the clients/consumers/customers have no market power.

This review plans to remove restrictions on the number of aged care beds. The argument that financiers, who are not interested in taking up offers for beds, will build more nursing homes if restrictions on the number are removed is fatuous. They will do so because they will be allowed to sell the elderly more services and so make more money – and this is what the Commission is encouraging.

Instead of more oversight to ensure that the choices offered are those needed, regulatory restraints, introduced to protect vulnerable residents will be removed. This is on the basis that the events, which triggered these regulations, were isolated events and not red flags to a deeper malaise.

I am more disturbed by the thinking here than the actual removal of regulations because I don't believe they work effectively. Many were inappropriate, and a way of avoiding actually investigating and then addressing the problems in the system. Nevertheless regulations should not be removed without first examining and addressing the issues to which they were a response – issues about which the Commissioners are in denial.

I am very disturbed that "providers" are to be encouraged to be "innovative" in providing choices to 85 year old vulnerable residents and their families. They will be free to try to sell them whatever they can in order to become more profitable. This will make nursing homes a viable investment for the bankers, whose only interest is financial. The suggestion is that this will increase profitability and so make the system sustainable.

My experience indicates that these changes will place the elderly at an unacceptable risk because many of the choices they will be encouraged to choose will be offered because they are profitable and not because they will benefit them.

> *The conundrum of the market for health care is a signal example of an oft-neglected insight known as the General Theory of the Second Best. The theory, propounded by the economists Richard Lipsey and Kelvin Lancaster in 1956, holds that when a particular market departs significantly from a pure market, attempts to marketize partially can leave us worse off.*
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> *If the health care system is already a far cry from a free market on both the demand side and the supply side, removing one regulation and thereby making the health system more superficially market-like may well simply increase opportunism and inefficiency.*
>
> *Robert Kuttner 1997**

5.4.1 Examples (see *Appendix B* for more detail)

There are many examples in the health and aged care marketplace.

In the USA when restrictions on psychiatric beds were lifted the parents of hundreds, if not thousands of children were conned into admitting their children into psychiatric hospitals where they were over-serviced and harmed. In aged care resources were diverted to employing therapists to provide vast amounts of unnecessary but profitable therapies while nursing staff were cut and the frail elderly neglected. In health care many hundreds of patients were subjected to unnecessary heart bypass operations, making the company responsible enormously wealthy. In each of these instances surveillance by multiple bodies was ineffective. Vast fortunes were built on these and similar practices. Those who could not compete were acquired.

In the USA each decade has had its set of scandals and in each of these instances, large numbers of participants have believed in what they were doing. All of the companies indulging in these activities were share market icons and highly credible in political circles. One had a past presidential candidate on its board, and then later the brother of the president.

While similar dysfunction in Australia has been less flagrant, it has not been immune. A succession of failures in aged care consequent on staffing problems have been exposed by whistle blowers and not by regulatory agencies, sometimes soon after successful accreditation. More profitable recipients of care have been cherry picked in Australian hospitals and nursing homes. The not-so-profitable lost out. Authorities ignored this unethical practice, so making it legitimate to ignore the ethics of the sector and game the system if it was legal,

While the Commissioners do address the issue of cherry picking, they fail to forcefully condemn these practices as unethical and name the offenders. This gives legitimacy to those who breech society's ethical restraints when they can get away with it. Conduct is driven by regulation rather than morality.

5.4.2 Logic

As the 2002 Romanow Commission (**see:** *References*) in Canada found, there is no evidence of any benefit from a health or aged care system driven by a competitive market. The arguments for such a system in health care are based on category errors. There is abundant evidence that it places the vulnerable at risk, and that current regulatory frameworks are ineffective. Systems driven by markets are more costly, when contrasted with other systems.

The evidence that a competitive market in health and aged care puts vulnerable people at risk is overwhelming. The more market-like, the more stringent, intrusive and onerous for all parties, formal regulatory oversight must be. This Hobson's dilemma is the price we have all paid for a market in misfortune. If we must drive the system with competitive market pressures then we should explore alternative ways of protecting the vulnerable.

The examples I have given show that regulations have not been effective when structured and organised centrally whether by giant insurers, by governments or by "independent" accreditation agencies. It is time we learned some lessons. Either we move away from markets or we try different ways of regulating and monitoring the care provided. The Commissioners have ignored my argument that it is more sensible to base oversight locally in the community close to the consumers and customers, and to harness the community by turning them into the customer to whom the service is accountable.

If we must have a market then, I urge the Commissioners to pay heed to market theory and harness market forces to protect the vulnerable by restructuring the process to create consumers and customers who have market power.

The productivity Commission's Draft Report documents the vulnerability of seniors and their families. It recognises that most 85 year olds will want to reside close to families and as a consequence there will be little if any choice in where they can go. The logic of market theory dictates that steps should be taken to counteract this lack of choice by augmenting their market power and by increasing the leverage of those who act for and advise them. For this to happen these advisers must be given legitimacy and recognition. Giving community-based groups an important place in the structure of the system would do so.

If we must have a market in misfortune and decrepitude then we should be searching for a better way of controlling its propensity to go off the rails, and of not only restoring, but of justifying, the community's confidence in the system. Simply separating regulation from government does not do that. It must go much further.

5.5 Marketplace dishonesty and the customer

There is a glaring lack of integrity in the application of market principles in this Draft Report. In my view this amounts to intellectual dishonesty, although the Commissioners will not see it that way.

This dishonesty lies in the application of market theory to the providers but not to the consumer and the customer.

Providers, whose regulation is to be reduced are encouraged to offer "innovative" services to the "consumer". The consumer is given choice, but in aged care the consumer is not usually in a position to evaluate the offerings and so exert market power.

The term "consumer" is appropriate here because the real "customer" is the local community, whose social responsibility it is to care for their aged members. The care is being provided on their behalf and the social contract is with them. Yet they are not choosing and they do not have market power.

If competition is to be effective in maintaining standards (called "quality" in the report) then the consumer and the customer must have accurate information on standards of care and failures in care. They need much more information about the nursing homes available to them and about the staff there. They may then be in a better position to "choose".

Instead of reporting objective data and the failures in care that concern citizens we have a grading system that hides them and gives staff a deceptively rosy perception of their performance. The recommendations in this regard are vague and lack vigour. I have little confidence that there will be real change here.

The withholding of the report of the inquiry into the accreditation system at this time is a disgrace, and we can only fear the worst.

5.6 What do the consumer and the customer need to know?

No consumer or customer can be effective unless they have useful information and are in a position to generate market pressure by using it. Abundant evidence shows that the single most important pointer to the care provided in a nursing home is the number and skill distribution of the nursing staff, who care for the residents. This can be further quantified by calculating the hours of care received.

The lack of integrity in this Draft Report is glaringly apparent in its failure to require nursing homes to disclose the number and skills of the staff they employ and to educate potential users of the nursing homes of its importance.

This would be the single most effective tool to empower the customer and the consumer. This failure to empower the customer and consumer goes to the integrity of the Commission in their pursuit of marketplace reform.

It exposes a lack of intent in their recommendations that accreditation be made more objective, and that consumers be better informed. It is what they are informed about that is critical and that might make them better customers. This failure goes to the heart of the failure of this Draft Report.

Understandably many are demanding compulsory staff/resident ratios and the Commissioners know that hardly any nursing homes will be found to comply. This would expose what those at the coalface tell us has been happening and it may be that this Commission is not going to risk doing that.

5.7 A lack of market integrity in staffing

The Commissioner's suggestions in regard to improved staffing sound good but are not going to solve the serious staffing problems, to which the Commission does not give sufficient attention.

Once again there is intellectual dishonesty in the application of market theory. Nursing salaries are by far the largest cost of care and in a market context there are strong pressures driving providers to cut staff – or to capitalise on a convenient shortage of staff. There are no pressures encouraging them to recruit, train, employ, pay or provide pleasant working conditions, other than humanitarianism. This is not a quality we find in the banks and other private equity owners, nor, if the rumblings coming from the coalface are any indication, in an increasing number of other providers.

Were staffing levels closely linked to profitability, then there would be strong pressures to do all of these things. If staffing parameters were public and were consumers and their families educated in their importance then market forces would drive employers to attract staff. Success would depend on enticing qualified staff to the facility. Providers would recruit, train, support, encourage and create an environment in which staff could realise their mission of care.

As I indicated in my earlier submission this Draft Report cannot have any credibility if it does not insist on the disclosure of staffing in such a way that it becomes a key measure of performance and is used in making "choices".

Simply giving providers more money is not going to make them spend on staff - not when their owners are clamouring for the profits that drive their share prices up - and when doing so will reduce their competitiveness. The manner in which this report caters to providers' "demand" for more funds without requiring real transparency in how it is spent is a disgrace. This is our money they are spending.

5.8 The Complaints System and the market

Simply advising that the complaints system will be restructured along the lines suggested by Walton is far from adequate. Walton was recommending changes to a complaints system she was not restructuring the whole aged care system.

The Commissioners need to show how the recommendations suggested by Walton will be incorporated into this new more competitive system. It will still be possible to hedge the complaints system away from public view and hide it behind officially released figures.

In a marketplace people talk and tell each other, which shop's fruit is old or worm infested and which is fresh and tasty. If consumers and customers are to play a role in making this market work then they need to have free access, within the limits of patient confidentiality, to what is happening in the facilities and in regard to the services in their local communities.

They need to know the sort of complaints being made, and they need to know how these local nursing homes have responded. This will only happen if those handling complaints, and mediating solutions are local, accountable to the community and part of the group that advises consumers and the community.

Experience across our country tells us that while authorities promise and genuinely intend to provide transparency, this seldom happens when they control the information. The only way to ensure transparency is to include those who need to know in the collection of information.

5.9 The Draft Report and data: (fudging the issues)

3 December, 2010: *Retirement Living – Advertising Feature (North Shore Times)*

"... Campbell Meldrum, chief executive of Cranbrook Care, Lansdowne Gardens' parent company, said they were lifting the bar in aged care..."

26 February, 2011: *Aiming high in aged care (Australian Financial Review)*

"... Cranbrook Care chief executive Campbell Meldrum and co-founder Stephen Bauer are creating up-market aged-care facilities ..."

6 March, 2011: *Nurses sacked after horror games with patients revealed (The Sunday Telegraph):* *http://bit.ly/hgjeEp*

"... NURSES have been sacked from a nursing home for allegedly depriving a dying man of food and photographing residents' genitals in a game called the "Genital Friday Club ..."

6 March, 2011: Disgraceful treatment of our elderly
(Editorial, The Sunday Telegraph): *http://bit.ly/eNdowY*

"...Our investigations over the past year suggest these are not isolated incidents of abuse and neglect.

Don't let anyone tell you this is just an isolated case, that it wouldn't happen at a nursing home near you.

In the latest case, staff were made to sign confidentiality agreements to prevent the broader community being alerted to the outrage ..."

The approach would have succeeded if not for the bravery of a couple of whistleblowers and The Sunday Telegraph's determination to pursue this issue. The sad truth is, everyone cares about the treatment of our vulnerable citizens - but too few in public life seem intent on doing too much about it ..."

This Draft Report draws extensively on opinion from the submissions. It is sadly lacking in hard data and in fairness it recognises this. What is concerning is that this lack of data allows the Commissioners to discount arguments that they would prefer not to confront.

The quotes above go to the heart of the problem in markets, where selling is more important than providing, and to the heart of the failure of this Draft Report, where the presuppositions of the Commissioners are unable to confront the world out there.

The best example is the way the Commission deals with standards of care. The hard data we have shows that the number of trained nurses in aged care has fallen dramatically, that care is provided to sicker patients by fewer and fewer less well trained staff. Many speak English poorly. Nurses are ageing and not being replaced. Many studies show the close relationship between care and the number and skills of staff.

Submissions by many family members, nurses, ex-nurses, doctors and university academics from two of our universities to the Productivity Commission all document seriously inadequate care. People do not do this lightly.

There have been a succession of serious failures in care starting with the Riverside scandal in 2000. These have provided a focus around which those aware of problems in the system could focus their concerns. There have been a succession of newspaper reports and television programs documenting failures in care.

I have closely studied the many health and aged care scandals in the USA and in each case similar issues were taken up by the press, and the press continued to publish until action was taken. In each case the press was finally vindicated. It is not rational to argue that the Australian press is somehow less responsible and is simply scandal mongering.

Major failures in Australia have been exposed by individuals rather than authorities such as the accreditation agency. They have taken their evidence to authorities, or when that fails, or when they fear retribution, to the press.

The only "objective data" showing improvements in care come from the Aged Care Standards and Accreditation Agency (*The Standard, Special edition 2010*[1]) which claims that the percentage of homes meeting all 44 accreditation standards has increased from 63.5% in 2000 to 94.2% in 2009 - a dramatic improvement.

I find the fact that the Commissioners do not quote these Accreditation Agency figures in support of their claim fascinating. It indicates that they accept that this Agency's figures are rubbery and not reliable. Yet they recommend that this Agency continue to collect data on standards of care for the sector.

The unsupported assertion that standards of care are improving is simply not sustainable without objective data. Nurses and more and more families are saying otherwise. Experience elsewhere shows that there is seldom smoke without fire.

Many have risked their jobs and suffered financial hardship by speaking out. This Draft Report betrays them. It does nothing to protect whistle blowers. It devalues the efforts of all these people and the efforts they have made to document the parlous state of our aged care system.

Openness, with more accurate measures of what is happening in regard to staffing and failures in care would reduce the newsworthiness of detected failures and the need for concerned citizens to drive the issues vigorously through the press.

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[1] **November 2010 *Special Edition* 10 years of accreditation**:
Aged Care Standards and Accreditation Agency
http://www.accreditation.org.au/site/uploads/10%20years%20accreditation.pdf

5.10 How will the Accreditation Agency perform in the reformed system?

It is critically important to look at the way the accreditation agency understands what it is doing and how it handles data because the Draft Report recommends that the agency be ported over to the new regulator and become a part of it. There are a number of caveats about more objective data collection and greater transparency (eg. page LVI).

A multitude of inquiries have made recommendations like this over the last 13 years and nothing has happened. It is quite clear that nothing like this will happen while this agency continues to collect the information that is used to assess standards of care and which consumers and customers are expected to base their decisions on. The theoretical basis, the patterns of thought and the practices on which accreditation is based conflict with all of these expectations. They are simply not capable of it.

The agency itself does not inform the public by issuing press releases when they identify problems. It does not facilitate the market process by empowering customers.

The agency acts for the industry and not for the consumer and customer, who must exert market power if the market is to work. The agency accentuates the disparity in market power, and further tilts the already sloping playing field.

An external review of the agency in 2003 found that it did not collect objective data so its effectiveness could not be evaluated. The agency promised that it would collect objective data. But at a further accreditation friendly expert review in 2007, initiated by the agency, there was no objective data available to assess the agencies performance.

The best that these reviewers could do was to survey "stakeholders" and in a long and circuitous argument conclude that opinion showed that its activities were beneficial. This was not in dispute. The dispute was whether the agency measured real standards of care, whether it was an effective regulator, and whether the information it released was of any use to consumers. Nurse whistle blowers and advocates did not believe it was.

As concerning is the fact that the release of the review conducted by the Department of Health and Ageing in 2009[2] has been delayed for up to 18 months, at a time when its findings were critically important. This is far beyond any reasonable period. This can only be a deliberate attempt to frustrate the critical comment that the Commissioners would get.

The quality of the information released by the agency is well illustrated in the November 2010 special edition of its publication *The Standard*[3]. This purports to record the percentage of nursing homes that did not pass all 44 accreditation "standards". It is compared to previous years.

The only indication that this is not so is in the sentence "The data ***as at*** 31st December 2009". Yes that's right - these are only the homes that had failed to correct all of the standards they failed by the end of the year, a fraction of those who did not pass all the standards.

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2 **Review of the Accreditation Process for Residential Aged Care** (DOHA, 29 May 2009) Department of Health and Ageing - Office of Aged Care Quality and Compliance (OACQC) www.health.gov.au/internet/main/publishing.nsf/content/ageing-mailfax-2009-2905a.htm

3 **November 2010 *Special Edition* 10 years of accreditation**: Aged Care Standards and Accreditation Agency http://www.accreditation.org.au/site/uploads/10%20years%20accreditation.pdf

This way of misrepresenting data was only revealed when the Aged Care Crisis Centre collected a subset of 2007/8 accreditation reports and found that they had found more than twice as many as reported by the Minister to parliament[4]. The Minister was forced to admit the deception[5].

A regulator should be primarily concerned with those who fail standards, not those who pass them. To find out what they should be showing we must invert the figures published in *The Standard* and so get a better idea of what is happening.

This shows that 5.8% of all homes (ie. only those ***as at*** 31st December) had not yet put their house in order. The figures shows that, as one would expect, distance from major centres had a major impact on performance. The figures for failures were major cities 4.9%, inner regional 6.4%, outer regional 8.5%, remote 8.3% and very remote 4.5% (a small number only).

If we turn to the failures of providers we see that in order of best performance we have religious 4.4% (1.9%), private 5.2% (5%) charitable 5.5%(2.1%), community 7.8% (5.8%), and government 8.1% (6.1%).

In its 2008 assessment of facilities that had actually failed at least one standard, the Aged Care Crisis centre found similar figures except that the religious and charitable groups performed more than twice as well as the private group. It may be that the latter was more adept at addressing problems. These figures are given in brackets above.

But both these sets of figures are deceptive and distorted. The distribution of services across regions is very different. In 2008, 96% of private nursing homes operated in major cities and inner regions whereas all other groups are spread across the regions in different proportions.

When the aged care crisis centre restricted their analysis to the cities and inner regions so levelling the field, they found:

> The difference in the performance of the different not-for-profit groups now disappeared.
>
> The private-for-profit aged-care homes now had twice the number of homes failing one or more standard than the government operators, three times that of any of the not-for-profit operators and almost 4 times the religious based subgroup - the largest of these.
>
> (http://www.agedcarecrisis.com/aged-care-report-card)

Now, if the agencies figures do show that one group of providers was 4 times as likely to fail standards of care then that would be of considerable interest to those who must choose a nursing home. If we look at the figures given by *The Standard* then it is very likely that they would confirm the general thrust of the ACC findings - **if the data were properly analysed**.

If the agency were trying to make this market work for the consumers and customers to whom they should be accountable, then they would analyse and publish their figures properly.

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4 **Elliot's figures don't add up:** Report under attack (13 January 2009)
http://www.agedcarecrisis.com/news/3349-elliots-figures-dont-add-up-report-under-attack

5 **Minister in public aged-care fumble** (17 December 2009)
http://www.agedcarecrisis.com/news/3325-minister-in-public-aged-care-fumble

Now these actual figures are not really important because they are all based on smoke and mirrors so both may be deceptive. As I argued in my submission, the agency is not measuring anything real and its distorted scale of measurement does not allow a proper analysis.

What is important, and why I have described this in detail, is the way the data is presented and distorted.

I find it incongruous that the Draft Report fails to quote the Accreditation Agency's figures when claiming that care has been improving, yet its uses this same Accreditation Agency's oversight as an excuse for rejecting mandatory staffing ratios (page 365). One of the major criticisms of the agency is its accreditation of facilities that are then shown to have totally inadequate staffing, particularly at night.

The reason that I have examined these reports critically is that this is the Agency that the Commissioners recommend be ported over to their new regulatory body. There is no prospect whatever that we will gather useful data while this Agency, and the patterns of thinking that underpin its activities, continue to be responsible for oversight and for supplying information to consumers and customers.

5.11 Market principles are not applied to the accreditation process

> Regulation, of course, requires regulators. But if democratic accountability is a charade, if regulators are hopeless captives of "rent-seeking" interest groups, if public-mindedness cannot be cultivated, then the regulatory impulse is doomed. Yet because capitalism requires ground rules, it is wrong to insist that the best remedy is no regulation at all. The choice is between good regulation and bad regulation.
>
> *Robert Kuttner 1997**

The strong support for community care, and the establishment of an independent regulator are the two major contributions that this submission makes to the provision of care and these are welcomed. But simply porting existing processes across to this new regulator without restructuring them will defeat the objective.

While aiming to make the system more "market-like", the Draft Report fails to give the consumer and the local community, the real customer, the information and the power to create the balance on which the success of any market ultimately depends. This is bad regulation.

The regulation of standards of care is as important as the financial restructuring but in this Draft Report it lacks the same detail. The devil will be in the details. That the recommendations of the Walton review of the CIS are supported is welcomed, but the report would be much more convincing if these were itemised and specifically included in the productivity Commission report.

As I have indicated, the greatest concern is that the accreditation agency is simply to be ported to the new independent regulator. The withholding of the release of the report into accreditation and the Commissions silence on these issues suggests that this is all that will be done.

If we are to have the same faces, the same thinking, the same processes, the same 3 yearly assessments, and the same biased reporting of figures then no amount of "making the assessments more output based" is going to make them really useful.

If the industry finds accreditation a useful tool, one that impacts positively on care, then they should take this over and pay for it. As a community prepared to flex our muscles and exert our role as customers we need to know what is actually happening in our local nursing homes.

If accreditation is really valuable, and not just a marketing tool, then market forces will drive the providers to seek accreditation as a means of improving their performance. It will have commercial benefits.

If this market is to work then standards of care must actually drive the market process. This will only happen when consumer and customer have market power and can exert it effectively. Actual standards of care should replace accreditation in the minds of consumers.

5.12 Collecting information about care

Every business, keeps a record of its income and its expenditure as should every well run nursing home. Similarly every provider of care keeps a record of staff numbers, skill levels, failures in care and of the services actually provided. There can be no excuse for not doing so.

With the development of electronic records pressure sores, injuries, weight loss, contractures and other misadventures will be recorded and are easily flagged. All this is essential for the provider if they are to provide high quality care.

The burden in collecting information is offset by the benefits for the providers in conducting their business properly. That is the foundation for the process of reflection and continuous improvement on which the "quality cycle" depends.

There is no reason why the key objective data needed for financial and clinical performance control should not be agreed to by providers, regulator and community, be specifically flagged, and be reported out on a regular basis. If properly structured, and if it were done electronically the additional burden would be minor.

There are additional measurable parameters such as the time taken to respond to call lights. In the 21st century these should be flagged in the office and recorded. A caring provider would want to monitor this for their own purposes. It is easily collected electronically and is a pointer to what happens in a nursing home.

The electronic monitoring of drug administration, if it is practical, would be of interest to the genuine provider as well as to those considering spending their last days in a residential facility.

What consumers and customers want and need to know is, not only the strengths, but also the real incidence of failures in care, and it is critical for standards that a provider knows this too.

5.13 Integrity of data

It might be argued that much of this data can be easily fabricated by a provider intent on doing so. But financial documents are audited and the new regulator is to provide prudential oversight. Spot audits here can be effective. I note that prospective residents will be allowed to see the provider's most recent audited accounts. That right should be extended to visitors and advocacy groups.

Fabricating the process of measuring standards would be very difficult in a system that tracks and dates the entries, alterations and deletions made and where there is periodic sampling and verification by an outside monitor who visits regularly.

1. Doctors: In a medical facility, which high care is, serious events such as injury, pressure sores, weight loss, significant diarrhoea or general deterioration should always be drawn to the attention of the resident's doctor and receive their attention and supervision. Ultimately they are responsible for the patients care.

Any resident frail enough to require high care, should have a brief medical review, a check on their drugs, and their progress every 4 to 6 weeks, if not by their doctor then by the independent practice nurse. Provided doctors are not hamstrung by being commercially contracted to nursing homes they are in a position to check the entries made in the charts and to make additional notes. Discrepancies would be apparent. They should be able to exert leverage similar to that they have in hospitals.

2. Community: This Draft Report is remarkably vague in regard to the role to be played by "visitors", advocacy groups and volunteers. If this is to be a market that works then they are the eyes and the ears of the local community - the real customer. The report must empower them if the proposed reforms are to succeed

There are a multitude of parameters that cannot be readily assessed objectively or by infrequent accreditation visits. There are many that the accreditation process is blind to, because of its limited access at a time when everyone is on their best behaviour.

The parameters include:

- the atmosphere in the facility,
- the way in which staff, management, families and residents relate to one another,
- the quality of life experienced by the residents,
- the number and qualifications of the staff on the floor,
- whether staff registers are kept and are accurate,
- the stress among staff, as well as
- the presence of odours,
- the type and storage of food, the temperature of food, feeding practices,
- whether incontinent residents are promptly changed or left in excrement,
- limitations placed on diapers,
- timely administration of drugs with adherence to safe practices, and
- whether residents are encouraged to be physically active.

All of these would be readily apparent to regular visitors and advocates if they are given a modicum of training. These are what critics are concerned about, these are what brave whistle blowers tell us are deficient, and these are what every educated ageing citizen and their families are concerned about.

Trained visitors and advocates would soon gain an excellent grasp of the amenities, additional options (choices) offered by the facilities and be in a position to comment on their utility and market value.

5.14 Data and making the market work

> Governments should allocate risk to where it is best managed — most effectively and at lowest cost.
>
> As a guide, providers are best placed to manage operational risks and their own financial risks that, in turn, can pose risks to the quality and continuity of services to clients. But they need incentives to do so and **also active consumers who assess quality before entry and monitor quality in delivery. Government may have a role in providing the infrastructure to support consumers in this role, and remove constraints on consumers to play their role and for providers to respond.**
>
> *Aged care regulation Appendix E Draft Report*

If market principles are to be applied and if consumers and customers are to be given market power then these are the people who should be reporting to their local communities and advising consumers and their families,

They know what is happening locally and are in a position to place this in the content of the figures generated by the new regulator. An agent working for a central agency will not have the same access to the local facilities and is not going to do this effectively.

Providers will argue that much of this information is subjective and that isolated incidents may be given undue weight. That however is how every market works. People talk to one another and freely express their opinions and their abhorrence at some product or event. It may be unfair but that is how markets work and without it you cannot have a functioning market. We now have a market and we have to make it work.

5.15 Leverage

The Draft Report is also extremely vague in regard to

- how health professionals, visitors, advocates and the community at large will coordinate their roles and express their market power,
- their relationship with the new regulatory agency, and
- the way in which the insights from visitors and advocates who have experience with individual homes will be fed back into the community and to consumers.

If the market is to work then the people who enter the nursing homes regularly, should be the ones comparing the local facilities with the data collected by the new regulator, and then advising prospective residents and their families.

The transparent collection of objective measurable data is important but it is only a part of what needs to be done to empower consumers and customers so making this uncomfortable market work. This is why in my original submission I pressed for complaints, oversight and information to be locally based in the community but centrally coordinated.

Governments have a poor record for funding their critics. It might be better if this were at arms length and the new regulatory agency also recommend their funding.

5.16 Another system set in stone

The two great problems with the *Aged Care Act* of 1997 were the lack of data collection and the failure to create a balanced social context within which those interested could advance arguments and initiate change. As a consequence the system was set in stone. Critics met a brick wall and contrary information was ignored or discredited. I do not believe that this has changed.

I have had a life times personal experience (as both insider and outside observer) of the way in which practices and thinking become established and then blindly defended. Critics are labelled and discredited, evidence is ignored or given little credence. Whistle blowers become a threat. They are attacked and discredited. This is normal human behaviour and will occur in all human settings. Sociologists write books about it and theorists explore the reasons for it.

I am persuaded that short of a revolution the only way to address this problem and to institutionalise progressive change is to design a system in which all representative parties have "leverage".

By this I mean that there is a common imperative in making the system work, but all sides have the power to block the other. Those with fixed positions then have no choice but to critically confront the arguments and the logic of the other participants and accept evidence and logic.

5.16.1 Examples

- This occurred in South Africa when it was clear that the country would be crippled and everyone would suffer. The groups had to talk to one another. People had to work together and their futures depended on doing so. There had actually been extensive social dialogue between many in the workplace, long before de Klerk and Mandela finally made their move. It was not as many believe an isolated personal triumph but the leaders supplied the trigger.

  It was only accepted because sufficient numbers of the citizens had been compelled to confront the logic of the arguments of those they dealt with. All sides knew the consequences and they all had leverage. No one could go it alone any longer.

- This occurred in Australia when Mayne Health's cherry picking and other practices angered doctors who almost bankrupted the company by taking their patients elsewhere. They showed who was the real customer and that they had leverage. They have since been able to credibly argue the importance of their value systems in all hospitals. They cannot work without one another.

This is another cogent argument for structuring the relationships between visitors, advocates and community and for giving them a role in the regulatory structure, both centrally and peripherally. Their additional experience and perspectives can only enrich the march of change, and ensure that this occurs early rather than after years of battling and ignoring. This is what I advocated in my earlier submission.

The structure of the new regulatory body is still relatively poorly defined I urge the Commissioners to give it much closer attention and to closely examine the market theory they espouse so strongly to be sure that the aged care system is structured in a way that both logic and the theory indicates will work.

Both logic and theory support empowering consumers and customers in their relationship with providers. If innovative changes are to be discussed, tried, tested and then spread through the system then the leverage enjoyed by staff, community and providers should be balanced in each local setting and that balanced leverage should be replicated centrally.

5.17 The approved provider process:

While we focus on prevention and lifestyle in order to prevent disease and maintain function and activity as we age, we have gone in the opposite direction with regard to providers of aged care and make no effort to weed out unethical providers before and after they enter the aged care sector.

Probity requirements have been a core component of our health and aged care systems for many years. While they have not always been given the legal backing they need, they have nevertheless been effective in restricting access to and constraining operators with a track record for exploiting the vulnerable and defrauding the system.

As part of the liberalisation of aged care in 1997 the probity requirement that protected residents from known exploiters was removed. It was replaced by an approved provider process that concentrated on financial viability and did not have the power to act on the basis of an applicants ethical standards and its track record in criminal activity or in the exploitation of the vulnerable elsewhere. It addition it has no power to reappraise the approval of businesses owning nursing homes when they behave in an unsavoury manner and exploit the vulnerable - unless this is actually in the nursing homes that have been approved.

5.17.1 Examples

- The approval process was powerless when a giant multinational with a dreadful track record for exploiting the vulnerable bought a large section of our nursing home industry. State regulators had already restricted the health care operations of this group on probity grounds. This was in the much less vulnerable hospital sector
- When the alarming conduct of a nursing home operator in its other businesses and in its retirement village operations was drawn to the regulator's attention, they did not have the powers to examine this issue.

The approved provider process places elderly residents at increased risk. Simply moving it to an independent body will not change this. I urge the Commissioners to advise restructuring so that the approved provider process can assess and act on probity issues. If an approved operator subsequently shows a propensity to dangerous dysfunction in any of its operations the process should be able to respond appropriately.

Probity can be defined as the sort of entity that a community would trust to care for its seniors, if they were aware of all of the facts. Local communities are more likely to research the background of providers planning to operate in their region. They should have representation on the body granting approved provider status.

6 Additional points

(see Appendix A for details)

There are additional issues and dangers that I believe the Commissioners should consider carefully.

These include:

- the risk that resources and staff will be funnelled to profitable services and away from care
- the risk of cost shifting between accommodation charges and care
- the risk that the funding arrangements for paying for accommodation will be seen as a raid on family savings and that many will go out and spend it first
- the benefits of registering staff and the dangers in training unskilled staff, who do not have a proper grounding, to undertake services that require conceptual mastery
- how appointees to the new regulatory body will be selected.
- how consumers will direct the choices they want to be offered
- the risk that the choices made by a consumer will be thwarted by the market as facilities and the residents in them are traded between different sorts of operator.
- whether consumers making choices will be independently educated or be subjected to provider marketing
- how seniors can be confident that the advice they are receiving when they make choices is in their best interests.

References

Robert Kuttner: "The Limits of Markets" The American Prospect 1 March 1997: p 28-41
http://www.prospect.org/cs/articles?article=the_limits_of_markets_3197

Robert Kuttner was editor of the American Prospect. In 1996 he played a pivotal role in analysing the way market forces resulted in serious dysfunction by the US's largest and most credible aged care provider Columbia/HCA. In 1997 the FBI swept through the company's hospitals, the first step in the exposure of its $2.7 billion fraud. Kuttner subsequently analysed and wrote about the way market forces had eroded the mission of not for profit health care providers in the USA.

 # Building on Values: The Future of Health Care in Canada
Commission on the Future of Health Care in Canada: The Romanow Commission
http://dsp-psd.pwgsc.gc.ca/Collection/CP32-85-2002E.pdf

Romanow was charged with evaluating proposals to open the Canadian system to competitive corporate for profit providers. He invited the for profit sector to respond to the arguments and the evidence provided by critics to his Commission. They could not do so. In fact as Romanow indicated in his 2002 report when confronted by the evidence they did not even try.

7 Appendix A: Additional Points

7.1 The redistribution of staff:

One of the consequences of the decision to allow providers to offer any sort of innovative additional service is that these services will be more profitable than basic services. The competitiveness of the providers will depend on it.

There will be pressures to divert staff and resources to these extra services for the wealthy at the expense of the basic care that others should be receiving.

This is what happened in one of the examples I gave. Probably thousands died prematurely from neglect. The principal protagonist was a businessman who considered himself an authority on nursing homes and particularly on staffing. He was widely accepted as such. His dictums about staffing were music to politician's ears in the USA and Australia where he briefly entered the health care market. They continued to be applied long after he had been discredited and his empire had collapsed. They contributed to the alienation of staff and the shortages we have today.

7.2 Cost shifting:

The Draft Report advises the separation of the costs of accommodation and living expenses from those of care - then funding accommodation privately and care largely from the public purse. If we have no choice but to accept the inequity inherent in a market system then the concept has merit but I have reservations about the practicality. I suspect that there will be great difficulty in clearly delineating each. There will be considerable overlap. In that case cost shifting is inevitable. But this will not be a shifting of costs between different levels of government.

Profit hungry providers and providers under competitive pressure will shift services to the softest touch - in this case the elderly resident - while still claiming from government. This will happen at a local level where managers will be under pressure to increase their bottom lines.

Only an active and vocal local community with real power and the leverage to mediate forcefully would be able to contain this.

7.3 Raiding the family home:

While the intention seems reasonable to the Commissioners, older Australians feel that they have contributed to the wealthy Australia we have today and to the care of past generations. They have worked hard to do so but they are not among the wealthy. This wealth has been built on their effort. They have expected to be supported in the same way. They have been encouraged by successive governments to save, to own their own home and to leave enough to give their children a leg up. This measure is equivalent to putting a tax on savings, which the Commissioners do not support. (*page 138*).

Many workers will see this as a raid on their savings and a betrayal. Many are likely to sell their houses early and spend it enjoying the fruits of their labour before the providers can get their hands on it. This behaviour is economically sensible but this will be unfair to others and may cause the process to backfire.

The Commissioners are proposing a major impost on the life savings of many older Australians, in most cases, to cover only the last few months of life. The product of a life time of prudent saving will be taken away from them, and the financial status of a surviving spouse compromised at a very vulnerable time.

7.4 Licensing of aged care workers:

Registration creates a body that vets candidates and supervises the standard of training - a problem identified in the Draft Report (page 369). It leads on to the establishment of professional associations that develop values and ethical codes of conduct.

This creates a force that has the leverage to contribute to the melting pot and speak up for themselves and those who need support.

I urge the Commissioners to recommend this. Necessary checks on registrants probity can be conducted here and severe penalties imposed for a failure to disclose. This might replace mandatory police checks.

The argument that workers should not be licensed because some rural providers find it difficult to have them properly trained and that this would create labour shortages is fatuous and panders to the providers (*page 366-7*). If there are no trained staff then these providers have no choice but to use untrained staff. This is far from ideal and creates a problem. It needs to be documented and addressed. Covering it up for the benefit of the providers does not do so. Even our accreditation system shows that remote providers already perform less well.

The current practice of increasing the scope of practice of untrained workers and training them to do more (*page 369*) threatens care. One must first ascertaining whether they already have (schooling and basic science training) the basics needed to benefit from additional training, and then after that being certain that they are proficient.

Attempting to train staff who perform tasks that do not require conceptual mastery, to do tasks that do, is dangerous when they do not have the background needed to master the concepts.

7.5 Office Holders in the new regulatory body:

Critically important here is where the office holders of this new regulatory body, the seniors gateway and the national data clearinghouse will be drawn from. How will they see their role and what will their views be? How will they be selected? The Draft Report is opaque on this critical issue.

Unless these issues are addressed confidence in the system will not be restored.

7.6 Consumer directed:

The Draft Report recommends that aged care be consumer directed and this be accomplished by giving consumers choices. Choices may create an illusion of consumer direction, but consumer direction will only occur when consumers have the power to direct the choices they want to be offered.

This Draft Report does not offer them that power.

7.7 Change of operator:

The trading of nursing homes and retirement villages in the marketplace brings its own threats to residents. It exposes the illusionary nature of the choices the Draft Report promotes. They are powerless to do anything about it.

The days when an owner would look for a suitable buyer who would continue his mission of care when selling are long gone. It goes to the highest bidder.

Residents and retirees who have carefully evaluated the situation and taken great care to select an owner or operator, whom they trust and relate to, can find themselves sold to another owner within a short period. There have been several instances, particularly in retirement villages where owners have found themselves trapped by an operator from hell. It is almost impossible to escape from this.

When they have been wealthy enough some residents have spent the last 20 years of their lives fighting costly appeals through the courts. The Commissioners are remarkably reticent about this problem.

There are similar concerns about what has happened to care in nursing homes acquired by private equity or other large commercial conglomerates. Residents in not for profit nursing homes have been sold off to commercial entities that they might never have chosen.

The Draft Report simply ignores this betrayal of the trusting elderly.

7.8 Education versus advertising and marketing:

Many commercial operators in the health care sector have made no secret of the fact that their success depends on marketing. They have linked incentives to marketing activities and the success of marketing in selling their services.

They have accomplished this by blurring the distinction between marketing and education. Large numbers of patients have been misused as a result, agreeing to hospitalisation or unnecessary operations when there was no need (see examples in Appendix B). This is the reason advertising (but not education) has always been restricted by professional ethics - until this was forbidden by competition policy.

It is not at all clear whether the information consumers will get under this new officially sanctioned system with its information gateway will be marketed by the providers or be educational in nature, based on and provided by people with direct experience of the situation in the facilities on offer.

This distinction is critically important and goes to the heart of the integrity of the system. The report should make it clear exactly what it is recommending - marketing or education. Consumers and customers need to know where the information comes from so they can assess its trustworthiness.

7.9 Contracting of regional gateway services: *(page 241 and 256)*

As an octogenarian contemplating aged care services and examining residential care services I will be looking to find someone in my community who has been involved in assessing and evaluating the facilities and services - someone I relate to and feel I can trust - someone who will explain the public information available and interpret the audited accounts I will be entitled to see - someone who will follow up on the recommendations I accept, - and someone with the knowledge who will later be motivated to keep a watchful eye to see that I am cared for.

I am likely to have grave reservations about any group who are contracting with the Seniors Gateway Agency simply in order to capitalise on the commercial potential. I would worry that they might enter into other commercial and incentivised arrangements that would not have my care as their central focus. I would expect their interest in me to disappear as soon as they have fulfilled their contract by efficiently placing me.

This Draft Report should be up front about the sort of groups who will be contracted to do this. It would be better for the community to form groups that would be supported by the regulator. If consumers and customers are to have any market power then these advisers and coordinators are going to be pivotal in this. They will consequently become the focus of marketing and attempts at incentivisation (kickbacks). Their probity and their motives should be a major consideration. They must represent and act for the consumer and be totally independent in doing so.

8 Appendix B: Examples of Market Failure

8.1 The USA

This is only a small selection of examples from the USA. The vast majority of large corporations in hospital care, in rehabilitation, in aged care, in managed care, in renal care, in dialysis, in laboratory care and in most other sectors have a history of being involved in fraud, in unethical practices or in practices impacting on care, Health Care fraud easily dominates all other sectors, in both the number and the amount of money recovered by fraud investigators in the USA. It has done so for many years. Studies have shown higher mortality and complication rates in for-profit services.

- In the 1980s, in respond to a perceived "demand", psychiatric care for children in the USA was liberalised. Restrictions on the number of beds and restraints on trade were removed. This was on the basis that competition would increase services and ensure good care.

  Anxious but ignorant parents were sold vast quantities of hospital treatment, which was of no value to the children, most of whom did not need treatment. An anxious mother unable to cope with the temper tantrum of her toddler could phone a help line. A team would respond and cart the child off to hospital for treatment - sometimes for months.

  Many children and adolescents were imprisoned in psychiatric hospitals for long periods and harmed there. Incredibly, those involved in providing these services actually believed that what they were doing was providing care. They identified with these practices. Critics were discredited.

  Those who failed to indulge in these activities could not compete and were driven out of business – the very reverse of what competition was supposed to do. Ultimately almost every commercial provider of psychiatric care operated in this way.

  Accreditation, state oversight and scrutiny by insurers were all ineffective. It was a policeman who believed parents rather than the hospital who exposed what was happening.

- In aged care uncontrolled commercial pressures were fostered during the 1990s. Instead of caring for the aged, nursing numbers and skills were cut. Instead funds were diverted to therapists. They were employed to provide the much more profitable "post acute care". Once again there was extensive over-servicing of the healthy. Vast fortunes were made from the vulnerable and their insurers. The frail aged were neglected. Regulators were ineffective.

  The daughter of a nursing home resident looked around her and saw what was happening. She took out thousands of death certificates in her state and analysed them to show that the elderly were dying of neglect. She submitted her findings to federal politicians. Her findings were confirmed when clinical records were examined.

- In the 20th century many hundreds of patients who did not need surgery were subjected to unnecessary cardiac surgery in a drive to increase profits. They were enticed by advertised heart screening programs. Some died, others were harmed. Incredibly financial success was equated with legitimacy and the doctors were persuaded by their own success. It was not accreditation, state oversight, or insurers reviewing the bills who exposed what was happening. It was a priest!

8.2 Australia

There have also been examples of market failure in health and aged care in Australia:

- In 2000 a flagging Mayne Health, Australia's largest health care company, appointed an aggressive market focussed Mr Fixit to turn the company around. This he rapidly did by appointing the staff he had brought with him to senior positions and firing experienced management. He restructured the hospitals to run his way, which doctors considered compromised care. His plans to replace nurses with untrained assistants was thwarted by a public outcry. Mayne started cherry picking healthy patients with profitable conditions and turning sicker and frailer patients who needed costly nursing care away.

  Mr Fixit had not learned from the USA where doctors were bound to the hospitals by profitable contracts. Australian doctors had refused to sign similar contracts. They moved en masse to competing hospitals and Mayne Health almost went under. It sold all its hospitals and fired Mr Fixit.

- In aged care there have been a succession of scandals exposing failures in the market and failures in the accreditation system. The only credible information about what is happening has come from nurse whistle blowers and from journalists who have entered nursing homes incognito. The Commission does Australia a great disservice by discrediting these people, and disregarding their assertions as isolated incidents.

- The way the market manipulates every loophole, whether ethical or not, is well illustrated by what has happened in regard to bonds in aged care. We learn that the wealthy are pressed to pay up to 2.6 million in bonds to get into the nursing home of their choice. With practices like this it is probable that stories of kickbacks paid in return for referral of wealthy "consumers" have substance. There is no smoke without fire.

  The elderly have been cherry picked and then held to ransom while the less wealthy are deprived of places in nursing homes. Cherry picking and kickbacks have been unethical in the health sector for over 2000 years and health practitioners are barred from practising if found guilty of these practices. When negotiated in the market and when called "incentives" they become legal, even desirable and providers are open about it. This did not disturb the 2004 Hogan review.

  Regulators have turned a blind eye. While the Commissioners do address the issue, they fail to forcefully condemn these practices as unethical and name the offenders. They give legitimacy to those who breech society's ethical restraints when they can get away with it. Conduct is constrained by regulation rather than morality.