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

9 November, 2008

Committee Secretary
Community Affairs Committee
Department of the Senate
PO Box 6100
Parliament House
Canberra ACT 2600, Australia
Email: community.affairs.sen@aph.gov.au

Dear Sir/Madam,

Submission to the Senate Community Affairs Committee

Re: Aged Care Amendment (2008 Measures No. 2) Bill 2008

I thank you for granting me an extension and so allowing me to give this bill the attention it deserves. It addresses matters that have concerned me for some time.

One of the advantages of a delayed submission is that one sees the other submissions before posting ones own. These reflect and illustrate the paradigm differences about which I write. The market paradigm is readily seen in the submissions from the corporate for-profit operators (one third of the sector) and these generally oppose the bill. The not-for profit sector (two thirds of operators) is generally supportive but has reservations. It makes constructive criticism. The submissions from the growing number of community groups critical of the system focus more on the failures of the system and press for greater change.

The submissions from the two thirds not-for-profit sector suggest to me a willingness to change direction and develop a sensible system which addresses the nature and particular peculiarities of the aged care sector; one that does not force it into a one size fits all commercial pressure cooker. The Catholic Health Submission is particularly constructive. While this bill needs adjustment it offers real hope for a considered and careful move in the right direction.

I hope that the committee will find these comments and my submission constructive and useful.

Yours sincerely,

J Michael Wynne

Contents:

1 Summary

This submission welcomes the proposed bill and the important change in direction proposed. It takes issue with the explanations offered by the minister particularly the historical account. A failure to properly understand what has happened and why real change is needed can leave this bill isolated, and in purposeless limbo. We will not build on its potential. It is not clear from the explanation where this first small but important step is headed.

To understand what has happened and how we can fix aged care we need to clearly understand what has happened, where we have gone wrong, how bad the situation is and the personal and social processes that have made it so bad.

There are many obvious and readily identified matters impacting on care. While these are the focus of discontent, complaints and submissions, they are not unique to aged care. They do not adequately explain the malaise in the system, or the widening polarisation and differences in perspective between the different groups interested in the sector.

My assessment is that there are key underlying problems in the way the service is structured. While these are more complex and not always easy to understand, they are critical. If we do not confront them we will do no more than once again patch the system and get a temporary reprieve.

In this submission I have:

1. **Given a very different and I feel more accurate account** of the developments in aged care since 1997. We can not go forward unless we properly understand where we have come from. The minister's explanation may placate the providers but it is not accurate. One cannot base action on it.
2. **Summarised a series of concepts** that explain what the core underlying problem is and what we must try to do to correct it.
3. **Made a more realistic assessment** of where we are today and the possibility of moving to something better without disrupting the system we have and harming residents.
4. **Looked at the changes proposed to the approved provider process** and at what they might accomplish. My impression is that the bill falls short of the promises suggested in the minister's press release.
5. **Illustrated some of the difficulties and the approved provider issues** that should be addressed using actual Australian examples. If my reading of the explanation is correct, the bill falls well short of what is required.
6. **Expressed concern** at the failure to properly address the un-sustainability and recurrent failures in accreditation, and in resolving complaints.
7. **Noted the failure to deliver on the governments promise of real transparency** and the need to address this in the future
8. **Expressed disappointment at the failure to adequately address** the critical problem of adequate staffing ratios

This bill is potentially an important first step in addressing the major paradigm conflicts that sap the system and undermine it. I was not persuaded that it did so adequately. It will not do so on its own. I have suggested changes that will build on this first step and which I feel might work. The bill should point the way to innovative changes like those I suggest. These include:

1. Introducing real transparency to the system.
2. Greater involvement and influence by the medical and nursing professions.
3. Major changes in the accreditation process moving it close to the nursing homes.
4. Involving the local community directly in ongoing oversight, accreditation, complaints resolution and other matters in the nursing homes so making the homes accountable to them

Because of the breadth of the issues and the complexity of some of them I have been prescriptive and dictatorial in writing this. The issues are explored in greater depth on the web page links I have supplied.

The bill is long and complex and I do not have the skills to properly assess and suggest detailed changes. This submission therefore supports the Bill (**Option B**) but addresses key matters that I feel need to be expressed through the legislation. I could find no reference to many of them in the explanation. Some of the changes that I believe are desirable have not been included in this bill. I believe the bill should be designed to accommodate their subsequent inclusion, as well as some suggested innovative changes should further research validate their efficacy..

My gut impression is that the Bill still protects the interests of the providers more than the residents. I note that the providers (called stakeholders) were extensively consulted and get the impression that changes could not be made without their approval. There is no reference to discussion with critical community groups. Having watched the US and Australian systems over the years it concerns me that the increasing dependence on the marketplace has given these operators so much leverage over policy that little can be done without their approval – however eager the minister is to make changes. This is not the first time this has happened in either country.

2 Background

2.1 Personal background

Over the last 20 years I have studied and collected information from the USA and Australia. This traces the transformation of health and aged care from a compassionate humanitarian community endeavour, focussed primarily on altruistic service, to a corporate marketplace focussed primarily on maximising profit for investors.

My particular interest has been the adverse impact this has had on the organization of medical services, on care and on the incidence of fraud. I have made this information publicly available on a web site (http://www.corpmedinfo.com/). I have used it to pressure politicians. I have assisted state regulators assessing whether applicants for state hospital licences met their probity requirements. I have persuaded them to initiate probity reviews. I have tried to prevent Australia from following the US path.

The problems I describe are clearly intrinsic to the US system. Although we have performed better, we are not significantly different. I have tried to explain why the marketplace ethic has been dysfunctional in the health and aged care sectors. To do so I have built on an understanding of human behaviour developed during many years of personal contact with individuals living in communities that had

embraced dysfunctional ideologies. During this time I had some personal experience of dysfunctional doctors and of practices that did not serve the community.

Since 1999 I have corresponded with Ministers and with the Department of Health and Ageing in regard to the inadequacy of the *Aged Care Act 1997*; particularly the abandonment of probity requirements in assessing approved providers. The recent correspondence has focussed on the failure to assess the owners whose focus on, and control of, nursing home finances makes them a threat to care. These efforts are documented at http://www.corpmedinfo.com/dca_sale.html and http://www.corpmedinfo.com/bupa_approval.html.

The AGED CARE AMENDMENT BILL 2008 is the first concerted attempt to address these issues and the Minister is to be congratulated on her efforts. This is a major and important first step in addressing some of the deficiencies.

2.2 Historical background

It will be helpful for the Committee to look at what has happened from a different perspective to that advanced by the Minister. Her historical explanation attempts to gloss over past failures and the reasons for them. This is unhelpful and will lead to complacency and a bill that is ineffective.

2.2.1 The wider context

The problems in aged care should be understood from within the wider context of social processes at the time when legislation was passed. Change should be informed by a realistic analysis of how we came to where we are and why we should not be here at all.

There is little dispute today that sensible capitalism has provided an environment within which most citizens' wellbeing improved and within which most could lead fulfilling lives. However during the last 20-30 years an extreme form of economic ideology has dominated capitalist thinking in the USA and Australia. Rigid market principles were seen to be applicable to every sector of our complex society. The full market process was seen to be universally applicable and self-correcting. Regulation was counter productive. As with all extreme ideologies common sense and evidence were ignored. Irrational explanations were offered for failures. All too often the response was to apply market principles even more rigidly so compounding the problems (Kuttner 1997). Market objectives largely replaced broad societal objectives as the goals of our social system.

Economic managerialism saw market style management as a generic skill equally applicable to every sector and activity (Rees and Rodley 1995). Detailed knowledge of the sector managed was not required. Outcomes were measured in economic rather than social terms. For many these economic outcomes became an end in themselves, rather than a means to an end. The ultimate goal of a sensible capitalist system supporting a society which functioned for all of its members was almost lost.

The recent economic collapse has prompted a rethink even by such diehard economic managers as Alan Greenspan. Many believe that the pendulum will now swing back to a more balanced form of capitalism. If this happens then there is hope that the health and aged care systems can be progressively modified so that their special needs and unique problems are accommodated.

2.2.2 The consequences of the *Aged Care Act 1997*

At the time of the 1996 election the not for profit sector was not functioning effectively. The private for profit sector was fragmented and under resourced. Regulations were overly onerous and ineffective. Many in the public system were disillusioned. The freedom and promise of better funding in the marketplace had great appeal. A number of medical entrepreneurs had established companies and some were market listed. Aged care was following. The financial success of corporations in the USA and the resources they were able to harness were persuasive. They gave the market ethic legitimacy.

Reform and consolidation were needed. At the time economic extremism was unchallenged. It is not surprising that the entrepreneurs had the ear of the new government. State probity requirements had already frustrated the ambitions of large multinationals whose entry into Australia had been supported by the market and by politicians from both major parties. Economic ideology saw the future of health and aged care as lying with giant multinationals. The governments of the day supported this (Williams1992).

The *Aged Care Act 1997* reformed aged care turning it into a competitive corporate friendly free market. Most restrictions on the way the nursing homes operated and spent their government funding were removed. Staffing requirements were abolished. Probity requirements, which focussed on the degree of control by owners were replaced by an approved provider process which ignored the control exerted by local and multinational owners. It concentrated instead on the individuals they appointed as managers and controlled.

Control of any adverse outcomes was vested in a provider friendly accreditation process established in cooperation with the industry. That similar oversight processes had already failed repeatedly in the USA was ignored.

Although only 25% of nursing homes were for profit, these new changes established the market ethic as the driving force in aged care. It forced all providers to operate as competitive market entities and to identify with market processes.

These changes were illogical and ill considered. They lie at the root of the unsatisfactory state of our aged care system. They failed to grasp the fundamentally different nature of health and aged care.

Ideologists had conveniently ignored the fact that a successful market depends on distrustful and informed customers in a position to form objective assessments and sufficiently in control to act effectively to penalise unsatisfactory service. Aged care is not the only sector where these requirements are absent and where serious problems have developed as a consequence. In such sectors trusting citizens have been misused and exploited for profit.

Not unexpectedly the story of aged care since 1997 has been the story of successive scandals and regulatory failure. This has been compounded by a succession of well intentioned ministers locked into the ideology of the times and as a consequence blind to the problems in the sector. They have been glaringly inept, ignored the real issues and resorted to ever more draconian but ineffective oversight and monitoring processes. These have been onerous and demeaning for staff, discouraging many from entering the sector.

Successive ministers have deluded themselves by maintaining that these scandals were not red flags to systemic problems in the sector but isolated exceptions in a world class system. The bizarre claims made by the prime minister and the minister for ageing after the rape scandals of early 2006 are good examples. For more detail see http://www.corpmedinfo.com/nh_ausgov.html

That the 1997 reforms were inappropriate and placed the system at risk is now readily apparent. Many reports describe failures in nursing homes across the country but particularly in Victoria and Queensland.

The level of nursing discontent, the number of whistle blowers and the problems they experience are pointers to a system in crisis. All sectors, state run, community, church, private for profit, market listed and private equity owned seem to be affected. These failures have been collected and collated by the Aged Care Crisis Centre on their web site (http://www.agedcarecrisis.com).

It is clear that the system is not working. The lack of transparency in our system makes it difficult to collect meaningful data, compare different services and engage in constructive debate. This lack of data permits wishful delusions about the true situation.

One of the benefits of corporatisation has been the formation of larger groups able to harness resources and set up teams to address problems. It would be in their interests to identify issues related to accreditation and also to respond to accreditation failures by bringing in teams to make homes compliant. Whether this results in better care in the total meaning of that word or simply in more compliant processes is not clear.

2.2.3 The relevance of our health care experience

When compared with the USA, the adverse impact of a marketplace in health care in Australia (not including aged care) has been less dysfunctional. We have not seen similar extreme examples of fraud and exploitation. A number of factors have contributed to this including

- By 1996 most of the deviant entrepreneurs had been weeded out.
- The community's expectations were given legitimacy by state probity regulations. A number of widely reported probity investigations showed companies that they were expected to conform.
- Unlike the USA most of the medical profession maintained their independence from corporate entities and were able to develop their professional careers without interference. They retained economic leverage and acted as effective customers. They used this leverage very effectively to protect their patients. When Mayne Health adopted policies which were considered unethical and to compromise care doctors took their patients elsewhere forcing Mayne to sell its hospitals. Other corporations took note.
- There are now so few competitors that aggressive competition is not required. Corporate survival is not at risk. The pressures are less intense.
- The largest operators in hospitals and pathology have been dominated by individuals who have behaved acceptably

None of this has happened in aged care which has followed the USA into dysfunction. There are lessons to be learned from our hospital sector.

(Note that in spite of probity requirements the West Australian Government has contracted dialysis services for public patients to two multinationals who have quite recently reached massive fraud settlements in the USA. - http://www.corpmedinfo.com/dialysis.html)

2.2.4 The focus

I would like to make it clear that this is not an attack on the many genuine businessmen, politicians, regulators and accreditors who have enthusiastically embraced market beliefs and the system it gave rise to. They have tried to make it work. It is a critical analysis of system failure and the way we humans have behaved.

The failures in the USA and Australia are because we have not properly analysed or learned the lessons of 20th century history and applied them to aged care. To move forward we need a realistic grasp of what has and is happening.

3 Explanation

3.1 The human factor

Human beings build and embrace patterns of ideas (paradigms, beliefs). They use them to understand the complex world in which we live and to guide their actions there as they build their lives and identities. They give our lives stability. We embrace these paradigms and promote them. When they are criticised we find this destabilising and resist it. We not infrequently embrace aberrant patterns of thinking that have been important to us. They become durable and resistant to change. When we see them as having universal relevance and universal applicability, they become ideologies.

At the heart of the problem in health and aged care is a requirement that participants embrace and utilise two conflicting and incompatible paradigms simultaneously and apply them to the same activities. These paradigms are the traditional cooperative community/professional health care paradigm based on service to others, and the newer competitive market paradigm based on personal financial reward and self advancement. A system built around human empathy and values is asked to accommodate and serve an essentially impersonal process.

Career prospects, status and rewards now reside within a dominant market paradigm that insists it be served before other paradigms. The pressures are intense. A company's public face and the personal identity of staff must reside within the community paradigm. The community expects aged care providers to embrace it. This situation creates dissonance (mental stress) for those involved.

Humanity responds to situations like this using a variety of strategies. The most common is compartmentalisation. In this strategy the two paradigms are mentally separated and conflicts are either ignored or rationalised away. It is only necessary to look at corporate reports from the health and aged care sector and compare them with the public statements made about care by these same corporate leaders. Look too at company advertisements.

The consequences of this are that those who compartmentalise most successfully can meet the demands of the market, while ignoring the consequences for aged care. They succeed and are promoted. The system therefore selects individuals with qualities that are poorly suited for the sector. It promotes them to positions of power and influence. Success reinforces their egos and dulls the dissonance.

These strategies are more difficult to adopt for those at the coalface. They must directly confront the consequences for those being served. Altruism and dedication, qualities highly valued by the community paradigm, are undermined and undervalued. A major consequence is a high turnover of often dysfunctional nurse managers and alienation of the work force. Lack of motivation, apathy and disinterest plague the sector. There is a flight of staff and a falloff in new recruits.

Market managers make much of the recognition of "conflicts of interest" and their management. Experience across the board is that this does not work consistently or effectively and that these conflict situations are best avoided if at all possible.

I have explored the way in which paradigm conflicts operate in greater depth in a published paper "*Belief versus Reality in Reforming Health Care*" (Wynne 2005- http://www.corpmedinfo.com/jmwynne83.pdf). The consequences are explored on several linked web pages (http://www.corpmedinfo.com/grips_health.html).

There are of course multiple other factors influencing staff morale and working conditions. These include poor remuneration, under-funding, understaffing, lack of interest in and support by the community, and more attractive employment opportunities elsewhere. They are not unique to health care and do not fully explain the malaise in the system. The nurses themselves do not articulate their unhappiness theoretically. They focus their discontent through these bread and butter issues.

My thesis is that while addressing these bread and butter issues is important they will not solve the problems in the industry. We live and operate in a world of ideas and we must address these too. If people can live out their altruism and be recognized for this, they will be more tolerant of the limitations a stressed society may have to impose.

What I am saying can be illustrated by multiple examples. Two striking examples will suffice. One is in the financial sector and the other in health care. Similar paradigm conflicts occur in both.

> **Citigroup** (http://www.corpmedinfo.com/access_citi.html)
> Following the great depression, legislation was passed in the USA to prevent companies from operating businesses where there were serious conflicts of interest. By the 1990s this became ideologically unfashionable. The market was thought to be self correcting. In 1998 these laws were repealed in order to permit the merger of Citicorp and Travellers to form Citigroup.
>
> By the early 21st century Citigroup was a Wall Street leader in widespread dysfunctional practices. Analysts and brokers distorted their market predictions and advice in order to bolster the profitability of the new banking sections of the company with whom they now worked closely. Rationalisations were developed to justify this. Citigroup's leading analyst Jack Grubman (http://www.corpmedinfo.com/citianalysts.html) promoted the glib rationalisation that "What used to be a conflict is now a synergy" to encourage others. He made vast profits for Citigroup. Competitors followed the example. Grubman was richly rewarded and admired. He and his competing colleagues in other companies were largely responsible for the dotcom bubble in which millions lost their life savings. Colleagues had to follow his lead in order to remain competitive. Those who did so became wealthy celebrities.
>
> … [second example omitted]

The glib explanation that these and so many other companies were criminal organizations run by evil and corrupt men simply does not hold up. The problems involved thousands of individuals and in both instances extended across multiple companies. Close study does not support this "evil empire" explanation. Similar problems have brought the US health system to its knees (Barlett & Steele 2004).

The two doctors were not evil conspirators preying on unsuspecting patients but self deluded incompetent misfits with oversized egos – ordinary misfits who had not prospered in the profession. The company fed their delusions and turned them into leading unchallengeable authorities by marketing them to the public and the profession. They internalised this new status. They felt they were invincible and saw pathology when there was none. They rejected all criticism.

It is certainly true that many involved in these scandals could not have been unaware of what they were doing and this seems incongruous. We will not come to grips with these problems until we realise that many of us are capable of compartmentalising this knowledge and still identifying with and doing the illogical and unthinkable. This is how we survive the pressure cooker of a confusing and conflicting world. This is why so many of us continue to serve illogical ideologies.

We can only understand what happens by looking both at the way individuals behave when cognitively stressed, and at the way social situations and processes intersect with these individuals to generate dysfunctional beliefs and practices. I have tried to develop concepts that will provide insights and allow us to move forward.

There is a striking similarity between what has happened in health and aged care, and the patterns of behaviour seen in the 20th century ideologies that have buffeted the world. The beginning of the 21st century is littered with the ideological debris of the 20th. We are still plagued by them and there is as yet no sign that any of our leaders have developed much insight into what is happening.

3.2 Sustainability

An unregulated competitive corporate marketplace is the most expensive and possibly the most inefficient system for providing care (Barlett & Steele 2004). Money needed for care is diverted to profit. Professor Arnold Relman (2007) has argued that the US system is economically unsustainable and that a move away from markets is ultimately inevitable. I am not in a position to comment on this.

In my view a competitive market in human misery is socially untenable and ultimately unsustainable. A trade in human misfortune and frailty for the benefit of distant shareholders with no interest in their welfare cannot be tolerated by any reasonable functioning human society. The idea of "wrinkle ranching" carries with it a big yuk factor.

Health and aged care systems ultimately depend on participants embracing the community/professional paradigm and ensuring that it dominates and takes precedence over the market paradigm. If a market is to work in aged care then it must be very different to the one we have today.

4 The predicament

4.1 Limited options

We are now confronted by a dysfunctional system that is largely dependant on market processes – processes which lie at the heart of its dysfunctional state. We have an economic downturn and a rapidly increasing demand for more services as the baby boomers age.

We have lost the opportunity to develop integrated and cooperative community structures to deal with humanitarian services. Society is conditioned to delegating its responsibilities first to government agencies and then to the market as ideologies chopped and changed. It has become self absorbed and has little interest in these issues.

I have not addressed the adverse consequences of these developments for society nor the benefits of integrating these services into the social milieu. I will not do so here. Suffice it to say that society is not in a state to assume full responsibility for its members and that any dramatic moves in this direction are likely to compound the problems we have.

4.2 Community slowly mobilising

As in the USA, nurses, family members and concerned citizens who have experience or knowledge of the consequences of the system are gradually grouping together to assist others and help them lodge complaints. They advocate for change. I am aware of groups in the three major state capitals in the east but there are probably more.

They have found that the complaints system does not meet their needs and does not work. With the best intentions accreditation and complaints systems are not capable of meeting the community's expectations. There is a divide between the way these community groups perceive the situation and the way providers and regulators see it. This is likely to widen. Experience suggests that the perceptions of these groups and of the nurses at the coalface will ultimately prove to be accurate.

This has led to a critical confrontation between community and nursing groups, on one side, and with both providers and government agencies on the other. In the USA similar community groups have found that the only way to force change has been to encourage and assist family members in bringing actions against corporations. Horrified juries have awarded massive punitive damages. This is likely to happen here.

All of this is undesirable. It is enormously costly, a waste of resources and extremely stressful for those who seek reform by this means. A community service like aged care cannot operate effectively in this milieu. We must try to break the flow of events and bring the community into the process of reform.

In summary we have a market in ageing and even if we abhor a market in misery our best course is to strive to improve the system by modifying that market to make it function as well as possible. That the adverse consequences can be markedly reduced is illustrated by the way the adverse consequences of a market in health care have been constrained in Australia.

5 Reforming the market in wrinklies

I am not going to deal in any depth with the issues of pay, recruitment, staffing etc. I am addressing the issue of who and how care is provided – not how it is paid for. This is not to suggest that these issues are not important. I am going to concentrate on the core issue of conflicting paradigms and the modifications to this market that I believe are needed to ensure that the community paradigm is embraced and used – and to ensure that those who do not do so are outed.

5.1 The approved provider process

There are two key functions of this process. The most important is that it sets out the community's expectations to the applying provider and forces it to confront them. The second is that it functions as a filter to exclude unsuitable individuals and companies from the sector. Experience suggests that legislative processes are not very good at this second function. Nevertheless the fact that applicants go through a process, which can and may sometimes exclude a provider is important in forcing the entities to confront their own conduct and set it against what is expected. When they do this their rationalisations come unstuck.

5.2 Setting out expectations

To be effective any reform process must reverse the dominance of the market paradigm over the community/professional paradigm. Regardless of how it is structured or paid for, the provision of services to the frail aged is a service provided by the community to its vulnerable members. Government agencies, community groups, churches, individuals and corporate entities are providing those services as agents of, and on behalf of the community of which they are a part. The bill should emphasise this.

The community expects providers of aged care to adopt and serve the community paradigm as a prime focus of their activities. This also should be made absolutely clear.

These providers are not villains. Most do respond to the expectations of the community when status in that community depends on this. Since 1997 these expectations have been muddled and confused. The removal of the probity requirements and the exclusion of controlling owners from the assessment process sent a totally different message. We should not blame the providers.

The proposed legislation is therefore critically important in setting out our expectations and indicating how we expect providers to behave. The inclusion of owners who exert economic control is doubly important. My concern is that the bill may not send a clear message. The department's powers of investigation and the scope of investigations seem to be too restrictive.

Parliament has the opportunity to indicate clearly and unequivocally what is expected. These expectations will be reinforced during the actual assessment process. The wording of the bill should ensure this. It may be too much to hope that parliament will restore "probity" as a key concept and use that word? The word "probity" sends a clear message.

As I read the explanation the Bill as it is presently planned would send a tepid message. If it is to send a clear message its scope would need to be extended considerably. The department should be free to do its job properly.

The need for providers and owners to respond to issues about inappropriate conduct in all their operations drives home the critically different expectations in the aged care sector when compared with the wider marketplace. Applicants must realise that this is a very different sort of marketplace and that what is expected of them will be different.

It has worked in the health sector :- Probity requirements in state hospital licensing regulations have been difficult to enforce and frequently have not been. In spite of this the very fact that probity is expected and that an applicant's conduct will be evaluated against this standard has been very effective both in keeping dysfunctional multinationals out of our hospitals, in making expectations clear, and in supporting the community paradigm.

5.3 Filtering out dysfunctional entities

In June I sent an email to all members of the senate and to all in the house of representatives drawing attention to the problems in the current approved provider process. I understand that Aged Care Crisis has included a copy of that letter in their submission and it is available on their web site (http://www.agedcarecrisis.com/nursinghomes/open-letter-to-govt). I will not repeat its contents here. Suffice it to say that owners control the finances. They appoint and control those who make the decisions and manage the company. If these appointees don't do what the owners require they are replaced. The assessment of owners is more important than the assessment of managers and directors.

In his November 15, 2007 submission to the hearing "Nursing home transparency and improvement" before the special committee on aging, United States Senate, Professor David Zimmerman (Zimmerman 2007 http://aging.senate.gov/events/hr183dz.pdf) stressed the importance of total transparency in corporate and nursing home ownership. He insisted that ownership in all its complexity be disclosed and carefully vetted. He emphasized the importance of owners (landlords) and the need to include them in any assessments. He recognized the difficulties in this. I urge the committee to read this short but important submission. It deals with important issues. I will return to the issue of transparency later.

5.4 The scope of the legislation

The proposed attention to potential problems following a change in a company contracted to manage homes for an owner that does not have the skills to do so is welcomed. Equally important is a change in an owner with significant financial control. The purchase of a struggling provider by a "turnaround" (cost cutting) specialist without experience in the sector could have disastrous consequences. Even more worrying would be the purchase by the sort of "vulture" private equity group that takes its profit by stripping a company of its assets and then selling off what's left. The bill should protect residents from these risks**.**

Takeovers and mergers should be conditional on the new party being approved by the department as "suitable". This does not seem to be required by the bill. Unscrambling a business transaction after it has occurred is a daunting task and is unlikely to occur. Without this there would be a gaping hole in the bill.

Owners may be individuals or corporate entities. The legislation clearly covers individual owners but the explanation is vague as to how they would be assessed. My reading of the explanation is that assessment would be restricted to prior nursing home operations. Other business operations and personal conduct suggesting unsuitability would be ignored.

Many unsuitable operators may be entering the sector for the first time. That the legislation may not empower the investigators to evaluate every aspect of the applicants conduct is concerning. I will consider some real examples. I have bolded the issues each example raises.

Example 1:

The entity (not named here) was owned and operated by a very successful individual business person who operated hotels as well as retirement villages and nursing homes. She was aggressive in her business strategies and was involved in some bitter and acrimonious disputes in relation to the hotels. There were some critical comments in the press and she threatened the newspapers with litigation. Some might see the characteristics she displayed as unsuitable for a nursing home operator.

Q: **Had the company applied for approved provider status before it entered the nursing home sector, would this conduct be evaluated under the proposed legislation?**

I suspect not. While any identified unsuitable conduct in another area might not totally preclude this person from becoming an owner or operator, its inclusion in the assessment and a request for an explanation would send a clear message.

This company also owned a retirement village where there was a dispute with residents. The village was described by a residents' representative association as "The Worst Village". In a related dispute the Commercial and Consumer Tribunal found that the manager of this village had made an implied threat to residents. In another retirement village there was a dispute with residents in which politicians became involved in order to help residents. The owner unsuccessfully appealed a decision supporting the residents. Relationships between the company and the residents it served were clearly strained.

Q: **Would all this have been assessed under the new bill and would unsuitable conduct in the retirement sector have precluded the owner, or her company, from owning or operating nursing homes?**

I suspect not.

As I read the explanation supplied with the bill, it is also not clear **what action would be taken under this legislation when an existing owner of nursing homes displays unsuitable behavior either in the nursing homes or outside it**.

I suspect that none would be taken.

In the example above the company already owned nursing homes when these events occurred.

Q: **What action would be taken under the new legislation to re-evaluate the company's suitability to continue operating these nursing homes if questionable conduct occurred in either unrelated or in other aged care related businesses?**

I suspect none.

During this period there were concerns expressed in the press about standards at a large nursing home. The home was threatened with sanctions because of accreditation findings. Accreditation assessors were concerned about an unpleasant work environment and an environment of harassment. There were complaints of verbal abuse. Over half the staff at this large nursing home lodged a complaint expressing lack of faith in the operator/owner.

A second nursing home was reported in the press as a problem for many years. It was described in a press report as among the 25 worst. There were recurrent problems with accreditation with damning reports. The home was never sanctioned or closed.

Representative extracts from the numerous press reports about this company and its owner were placed on a web site. Potential customers could inform themselves of the company's track record and make decisions.

The owner attempted to have the page taken down by aggressively threatening the university where the web pages were located with a defamation action. An invitation to respond to and explain why the allegations made in the reports were false was rejected. The page was not taken down and no action was taken against the university.

A more recent press report records that the daughter of a resident who died was a witness at an inquest into her fathers death. She claimed that she was intimidated by the owner who said "This is your fault we're having this inquest. He was old and going to die. You've got pro-bono lawyers. You're not going to get any money - he was worth nothing. He was old and sick anyway." The report also suggests that the daughter who held a part time job at the nursing home was told not to come back. The judge barred the owner from the inquest.

In this case there were two issues. Firstly problems in care and with accreditation that did not quite reach the level requiring sanctions. Secondly, aggressive and inappropriate behavior by the owner inside and outside the nursing homes, behavior which might have raised the issue of suitability to operate in this sector but not of accreditation.

Q: **Would unsuitable behavior either in or outside the nursing homes be matters of concern under this legislation and if so what action could be taken?**

I suspect the answer is none.

In this instance there are multiple reports quite separate from the accreditation problem. These extend over a long period of time and in multiple business sectors. They suggest personality characteristics totally unsuited to the provision of nursing home care. Under the previous legislation no action could be taken.

Q: **Would the new laws change this and would such reports be investigated? Would the combination of unsuitable characteristics and accreditation problems be sufficient to prompt action?**

I suspect not.

In this instance the available reports point to an aggressive owner with an inability to work with people. She has a history of aggressive confrontation in every business venture she engages in. That there have been serious problems in some of the nursing homes is hardly surprising.

There have been multiple examples of unsuitable people continuing to operate in the sector. Regulators have been powerless to do anything about this. The courts are required to apply the same standards in this sector as they do in the wider marketplace. The special problems in this sector do not have legislative support.

Q: **Will this new bill provide that support and enable regulators to deal with these difficult problems?**

I suspect not.

I have not named the owner or the company in Example 1 but can supply the committee with the web link.

As I read the explanation I am confused as to whether companies will now also be considered to be "persons" and their suitability to be owners or operators will be assessed before giving approval. State hospital regulations do this. This is clearly essential.

The explanation uses the term **entities** and I am not at all clear what sort of owners or operators are included or what sort of assessment they will undergo. The explanation harps on about "key personnel" but a company with a deviant culture and dangerous business strategies need only move any unsuitable persons aside or into another venture to subvert the process.

Corporate culture is the group equivalent of character. It can be as durable and resistant to change but may not be tied to any specific individual.

Corporate entities should be assessed. If the bill actually does so then my interest relates to the sectors that will be assessed and what characteristics will be examined.

Q: **Will the company's corporate culture as revealed by its past conduct in all business sectors and in its public statements be examined?**

I suspect not.

Example 2:
is CVC Asia Pacific, a private equity division of Citigroup operating in Australia. It purchased DCA's nursing home operations in 2006. Under the existing legislation the approval status was held by DCA's subsidiary Amity. Approval came with the purchase. CVC did not have to seek approval status in its own right. As I read the explanation the new bill would require them to do so. It is essential that this be so.

At this time CVC's controlling entity, Citigroup, had reached massive settlements following disturbing allegations in the financial sector in the USA. Its business practices and culture were appalling. Millions were affected adversely and many lost their life savings. Prior to this neither CVC nor Citigroup had operated hospitals or nursing homes. These issues were sufficient for the NSW Health department to impose conditions on licenses for hospitals.

Q: **Would conduct in another business sector and/or in another country by a controlling owner be evaluated under the new legislation? Would the aged care approval process now examine Citigroup's conduct as occurred earlier in NSW?**

Shortly before the purchase of DCA's nursing homes a newspaper reported some worrying remarks made by the chairman of CVC Asia Pacific. This indicated a policy and a culture which focused narrowly and aggressively on profitability and disregarded other issues. Similar attitudes had been displayed by Citigroup prior to the dotcom scandal. Such an attitude would have posed a threat to care and been unsuited to the provision of nursing home care to the frail elderly.

Q: **Will the public statements and corporate releases made by corporations and their officers be examined for evidence of conduct and corporate attitudes (corporate culture) unsuited to age care and potentially threatening for standards of care?**

I suspect not.

5.4.1 Summary: Reforming

In Summary the key issue I am raising here is whether the legislation actually gives regulators and assessors the freedom to examine the totality of an individual or a corporation's actions and statements, in order to do their job effectively?

Will the same rigor be applied to entities who display unsuitable characteristics after they have been granted approved provider status and how will residents be protected? My interpretation of the information given about the bill is that it falls far short of what is required.

I realize that these are not easy issues but they are important if the changes are to actually filter out unsuitable entities. It seems to fall far short of what is required and is unlikely to be effective. I ask the committee to press the government to properly address these matters in the bill.

5.5 Transparency and submissions from the community

I have made many submissions to state hospital regulators, sometimes after they have already granted licenses. It is apparent that the investigation of applicant's suitability in most instances is cursory in the extreme. Claims made in applications are usually accepted at face value. Rationalisations are accepted without question. Assessors don't even do a simple internet search. Applicants are not penalised for failing to disclose relevant information.

Departments are simply not staffed or resourced to do the vast amount of work required to thoroughly vet each applicant and this would be very onerous.

Experience in the hospital sector shows that success in filtering out unsuitable operators is almost entirely dependent on concerned citizens who are aware of problems. They collect the information and lodge objections. State departments seldom commence probity reviews until this occurs.

As far as I am aware there is no public disclosure of those applying for approval status in aged care. The community are not encouraged or given the opportunity to object or supply information. I found no reference to the public listing of the names of applicants for approval and their owners in the explanation accompanying the bill.

This legislation will not work to filter out unsuitable operators unless the public is given the opportunity to assist the process by collecting and supplying information for the department to evaluate. It is therefore essential that there be total transparency in regard to owners and operators and that both be made readily available to the public in a timely fashion by placing it on a web site. There are now active aged care advocacy groups in each state. They would welcome the opportunity to assist assessors and to argue a case against questionable operators and owners.

5.6 Summary

There are issues in this bill regarding the adequate assessment of personal and corporate owners and operators. There are also issues about what will be assessed and what domains of business activity and public statements inside and outside the aged care sector will be relevant. The legislation seems to restrict the freedom of the department to assess the totality of an entity's suitability, and if so then it is protecting the providers and not the residents.

The issues are complex and a thorough investigation of every applicant's suitability would be daunting and onerous. Success is likely to depend on interest in the community and the willingness of community groups to research applicants and supply information. The new bill does not facilitate or encourage this process.

6 Changes to the accreditation process

I find the planned changes to the accreditation and complaints processes disappointing. Despite all the dedication and effort by staff these processes have not worked and there are many reasons for this (http://www.corpmedinfo.com/nh_accreditation.html). Simply increasing its rigor is not going to change that. These processes are based in distant offices and depend on occasional visits. In a system based on a paradigm which places continuous pressure on care this is unlikely to be effective. Later in this submission I will suggest an accreditation and complaints strategy which is local, continuous and ongoing. It might work and should be tried.

7 Other changes in the Bill

I am supportive of some of the other changes in the Bill including the further protection of accommodation bonds. The collapse of ABC Learning is a critical pointer to the risks created by a corporate marketplace.

It is only a matter of time before a large aged care provider follows ABC Learning into bankruptcy. The consequences will be far worse in this sector and the government will be faced with an organization and financial crisis at a time when they are ill equipped and financed to do so.

8 Issues not addressed in the Bill

8.1 Transparency

One of the major reason's why our aged care system is in disarray and why community groups, industry and regulators have such very different perceptions of the performance of the system is the lack of information, the lack of transparency, and the lack of accountability to the local community served.

The current limited system of late release and early removal of adverse reports from the aged care web site is unsatisfactory. The Rudd government has promised greater transparency but there is little evidence of that in this bill. The US senate held a hearing into the issue of transparency in nursing homes in November 2007. I referred to the submission by Dr Zimmerman (2007) earlier. It deals with this issue – including the importance of ongoing disclosure of staffing ratios by nursing homes.

One of the reasons for this secrecy is that aged care is seen as a market just like any other. Companies are entitled to secrecy lest competitors be given an unfair advantage. What is required is a paradigm shift so that the providers of care are seen as acting for and on behalf of the community and within the paradigm that they use. This paradigm and its need for transparency must take precedence over such "commercial rights".

The care of the frail aged, a humanitarian service, differs from the sale of soap, an inanimate product. It cannot be managed within the same framework of ideas. It is essentially a compassionate service provided by a caring community to its members. It is a reflection of our social development. Whoever provides this service is doing it on behalf of the community, is acting for them, and is responsible to them. There can be no commercial in confidence restrictions or denial of access to information about clinical or economic management. If this data is not being collected then it should be and it should be available to citizens and to researchers.

If the accreditation agency and government departments are doing their job then they are collating the material and graphing it. They are using it to compare sectors and modes of operation. They are using this to inform their activities and to formulate policy. This is still a market and if it is to work then customers (and it is the community as much as the resident and family that is the real customer) must have useable information about the companies and the nursing homes they run. If the community is to function effectively and exert its democratic right to debate policy and practice, to lobby and to vote, then they should have access to all this information.

Any business manages its finances and maintains records of its transactions. It allocates its resources. Each nursing home does this in one way or another. Clinical services are or should also be managed and monitored. A nursing home cannot operate effectively if it is not tracking the weight of its residents, the incidence of pressure sores and multiple other markers of care.

If the operator is giving the community paradigm pride of place then it will divert resources to its clinical management and the data base on which it is based. This will be resourced as well as or better than its financial management. It will correlate them to ensure that they are integrated and that limited resources are stretched for maximum benefit. The community should expect the operator providing this service on their behalf to show that they are doing so and to make this information available to them.

One of the most remarkable and inexplicable things about the accreditation process is the total absence of any real data from the nursing homes. The agency does not expect the facility to disclose its incidence of pressure sores, contractures. weight loss etc. Nor do they verify its accuracy and report it.

This absence of information makes citizens fear the worst. It fuels distrust. A service like aged care cannot operate effectively if the community does not trust it. Trust has been eroded.

8.2 Nursing requirements

There is no attempt to set out optimum and desired staffing requirements or to mandate minimum staff and skill ratios. This is very disappointing. Employees at the coal face in the USA and Australia have been lobbying for this for years.

If we are to have a marketplace then customers and potential customers need to know on a continual basis both the number and the skills of the staff available to care for them. This should be one of the most important considerations when selecting a nursing home. At a minimum the bill should require this disclosure. It is the only way to stop providers from using the nurse shortage as a convenient cover for cost cutting.

9 Giving the community paradigm more weight

This Bill is important but even if it is changed to do what its claims it will do (protect residents) , its impact will be limited unless it is followed by further change. Hopefully in its final form it will set out what is expected and signal a shift in emphasis. If its final form addresses the issues I have covered then it will be an important and critical first step but it is only a first step. It must be followed by increased transparency, increased debate, increased engagement of the community and the trial of new and innovative strategies – strategies which if successful can be generalised and added to legislation. The bill should accommodate and encourage this and build a framework for innovation.

9.1 The medical and nursing profession

As I described earlier, the presence of the medical profession as the providers of the service in hospitals, their independence and their economic leverage has kept corporate excesses in check and ensured that hospital operators recognised and paid service to the community/professional ethic. That the doctors' careers and their financial rewards were aligned with the interests of patients rather than the hospitals' owners was a bonus that facilitated their effectiveness.

One of the startling aged care revelations for me has been the absence to any information about the role of doctors when adverse events are reported in nursing homes (eg Infective diarrhoea outbreaks). When a person becomes ill in the community the first person called upon is a doctor. When a patient's condition in hospital changes the doctor is notified. The doctor is responsible for what happens to the patients.

This does not seem to happen in nursing homes and doctors are never seen to have been accountable for adverse events there. Where are they? Are managers and nurses, who do not have clinical training acting as doctors? The AMA has complained about the lack of medical services in nursing homes and the absence of sufficient remuneration to attract them.

Doctors should be brought back into the nursing homes and given an independent role there. They have the credibility, the knowledge and the authority to act decisively when things are not as they should be. They bring with them a focus on the community paradigm.

Another group that embraces the community/professional paradigm is the nurses. A major cause of alienation is their inability to live out and realise their careers within this paradigm. If they were given greater independence and control in the homes and less dependence on the owners they might be able to do for aged care what the doctors did in hospitals. I do not know how this could be structured or made to work.

9.2 Accreditation and the community

I would like to suggest that much of the accreditation and complaints processes be progressively moved into the local community and into the nursing homes. The current accreditation and complaints bodies should act as coordinators, supervisors, trainers, overseers and collators of information ensuring that it is working properly. There may be different ways of doing this.

Since first drafting this section I have been told that a not dissimilar proposal giving the local community influence was planned for the original *Aged Care Act* when introduced by the Hawke government. It was emasculated before the act was passed and little came of it. I have also learned that a very similar community process has already been introduced by the Office of the Public Advocate in Victoria (see reference) and that it has been effective. I would like to suggest that this is an idea whose time has come.

Such a system should be progressive and be tried and tested in aged care in different ways in local areas before being generalised. We do not want to repeat the ideological debacle that occurred in 1997. We cannot afford more big mistakes. This does not mean that formal accreditation visits should not continue but their frequency might be reduced. Such an arrangement would give the agency access to information about the day to day situation in the homes, something that is lacking at present..

Example:-

There are many nurses, retired doctors, social workers and relatives who have had experience in aged care or related areas. They are well qualified to assume a friendly oversight and supervisory role in nursing homes. Many full time mothers would welcome some outside community interest that can be carried out in their own time.

What I am suggesting is the formation of partly voluntary groups/committees of informed people for each nursing home or region. These groups would take an interest in the nursing home. Appointed officers would be known to the home and have access to the home and its documentation.

The accreditation agency would in cooperation with these groups appoint and train a local officer to carry out surveillance of the home in an ongoing but not intrusive manner. They would be in a far better position to monitor some of the processes. The group would be responsible for checking the accuracy of data collected by staff, of collating it and forwarding it to the agency.

At least one person, nurse or doctor would need confidential access to clinical records and some arrangement would need to be made to ensure that residents knew and agreed to this. Such a group would be in a far better position to act as an early warning system and notify the agency when problems were developing.

Such a community group would have continuous informal contact with management, nurses, doctors, residents and family as well as occasional formal meetings. They would be in a position to monitor the way in which staff interact with residents and the extent to which they listen, motivate, question and give meaning to residents' lives. They would assist and facilitate this. In other words they would ensure that the residents received actual care rather than an impersonal nursing process.

This group would be the local arm of the accreditation and complaints agencies. When deficiencies were identified they would play an important oversight role in their correction. They would supply feedback on the way management operated and its suitability. They would also represent the community and be accountable to them.

The group or its members would act as mediators, facilitators and conflict resolvers between residents, family members, nurses and managers. Nurses could bring issues to their attention confidentially and not risk victimisation. If required the group could act for them in dealing with management. Patients' complaints could be resolved locally and would only be taken to the complaints resolution body when this was required or family members were unhappy.

The group would meet periodically to report back, discuss and plan its activities. Hopefully at least one person would be rostered to visit the home informally each week and be able to report back. They would have talked to staff, and, if they were qualified to do so, even helped them.

Someone from the complaints unit and the accreditation agency would visit periodically to look at the way the complaints and accreditation processes were being handled and when possible local meetings would coincide with this. An annual national congress would help to coordinate and reduce fragmentation.

Because these groups would be the local arm of the central agencies and influence accreditation and approved provider status they would have considerable leverage. They would ensure that their community/professional paradigm was given precedence over the market paradigm. Because they would meet with management they would be in a position to gently challenge rationalisations used by management to justify actions not in the interests of residents. By doing so they will bring change.

It is likely that the agency would need to appoint at least one person part time and pay them, provide a computer, and possibly supply some secretarial support.

What I am suggesting is that a combination of real transparency, and the direct involvement of the community in the way nursing homes operate would go a long way to entrenching the community paradigm and in reversing the polarising of positions between politicians, providers, government agencies, nurses and community. We all need to work together towards a common goal moving carefully and systematically. To do so we need to be sure we all have the same objectives and at the moment this is not so.

Its not going to be easy to persuade Macquarie bank that serving the community, by ensuring the wellbeing and quality of life of the frail elderly, far outweighs the importance of their profits and bonuses. Finding common ground on which to build and from which to move forward will not be easy. Shareholders need to understand that investing in health and ageing is a service to their community, and that they can expect a reasonable return for their efforts, but this is not where they come to make a killing. Analysts need to become socially responsible and temper their enthusiasm for vast profits by applauding those who provide worthwhile community services and encourage investors to support them.

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