

27 October 2016

Human Services inquiry

Productivity Commission
Locked Bag 2, Collins Street East
Melbourne Vic 8003

Re: Response to preliminary findings report

A public inquiry into the increased application of competition, contestability and informed user choice to human services (<http://www.pc.gov.au/inquiries/current/human-services/identifying-reform/preliminary-findings>)

We thank the Productivity Commission for the opportunity to submit a response to the preliminary findings report.

We are encouraged that the preliminary report recognises the wide disparity and complexity of human services and does not attempt to create a one size fits all solution. This is a significant step as this was a major flaw in previous reviews.

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In Summary

This comment on the draft report is particularly concerned about the way in which the patterns of belief that we adopt impact of how words and concepts are understood in different sectors.

Competition, efficiency, contestability, choice and even the handling of information can be very different when seen through different eyes - especially Human Services.

This response to the draft report:

1. Acknowledges that there is awareness of the risks, but does not feel they are fully understood.
2. Points out that government is incapable of and has repeatedly failed to protect the vulnerable. It argues that government needs the support of a more powerful and effective regulator – the socialisation and social sanctioning of a functioning community and effective customers.
3. Addresses the dangers of incentives and disincentives.
4. Warns that the complexity and process driven structures that usually accompany the proposed changes compromise our humanity and this impacts on humanitarian services.
5. Is particularly concerned about the difficulty in collecting and evaluating data, whose importance the draft report recognises. The problems of confirmation bias extend beyond the collection of data into the threat that they pose to politicians and the powerful in the industry. The report does not adequately address these issues and those who receive it will not recognise it themselves or acknowledge its importance.

Previous reviews have repeatedly called for reliable data but its absence has not stopped them making recommendations or been heeded when introducing the changes they advise.

6. Points out that the report uncritically accepts statements and assertions that come from the industry and are not only unsupported by data, but in some instances refuted by abundant data. Of particular concern are the adverse consequences of the 2011 PC report “*Caring for older Australians*”. This ignored key considerations, which the inquiry was asked to address. The recommendations were then interpreted and applied by government in close cooperation with the providers so that the real needs of the vulnerable were sacrificed to the demands of the marketplace and neoliberal policy.
7. Without any experience in some of the sectors selected for reform, we suggest that there may be much better ways of restructuring and improving these sectors than lumbering them excessively with some of these proposed reforms.

Introduction

The usage and meaning of words is closely tied to the paradigms of society and in particular to those of the more powerful sections of society. The associated meanings they have can vary in different sectors of society. In the interactions they have, the more powerful will usually set the paradigms within which the discussion takes place, which words are used and the associative meanings they will have. They use their dominance to determine what is legitimate and reasonable and how data is interpreted and the meaning it has. Currently the discourse in our society is dominated by neoliberal and free market thinking, so that words and even data will be interpreted and implemented within market and managerial paradigms.

1.1 A human services paradigm

In human services competition has taken the form of rivalry to do better. Efficiency is delivering more by stretching available resources to provide more, contestability is about the rights and responsibilities to the person being served. Choice is to meet need and to improve care. Information is closely tied to the everyday services and experiences of those administering care and those receiving it. Individuals obtain identity and worth by service so developing identities based on social selves. People who do this prosper and have control.

1.2 Currently dominant paradigm

In our wider society, in management, and in politics competition is to make more money, to grow and to become more powerful. Efficiency is about extracting more money from the services provided in order to do that. Contestability is closely tied to power and the paradigms and words used rest with the powerful. It becomes more about protecting the interests and the reputations of the powerful than the human dignity, rights and care of those being served. “Choice” becomes an opportunity to make more money. An excess of choice is confusing particularly for the impaired and diffuses experience in the community to the extent that options are no longer evaluable. Increasingly, choices are based on marketing and this leads to exploitation.

Information and the way it is interpreted is tied to the interests of the powerful. Individuals obtain identity and worth through financial rewards and by status gained by serving the interests of the employer – selfish selves rather than social selves. A very different sort of person prospers and does well.

1.3 The risks

The way in which power operates is well illustrated by the way organisations that operated within the first set of paradigms lost their funding and influence after 1996 and the way that those individuals who had contributed to the design of human services lost influence and were no longer consulted. The more powerful set the frames of discussion and decided what was legitimate to talk about.

It was because the things that were not legitimate topics for discussion were ignored that we have so many problems today. These changes infused themselves through every pore of our society even to the bedside of those dying in our nursing homes. The adverse outcomes are not identified, not confronted and denied because the paradigms brought to the collection and the assessment of information are those of the dominant paradigm.

The imposition of competition and its bedfellows on human services by government, market or even our current communities is likely to bring with it all of the understandings that now dominate in our society and that is the problem. People who embrace these interpretations will prosper. Not only will the

intended beneficial outcomes be compromised, but the culture and mode of operation are likely to be adversely impacted. The services may be harmed rather than benefited.

2. General comments

1.4 The risks associated with free markets

We are reassured that the review does not press for increased marketisation or a system that is driven by competition for profit, as experience shows that care is frequently compromised in vulnerable sectors when competition for profit becomes a driving force. We were interested to learn that government *“recognises that markets, as price and quality-setting forums, often struggle to deliver an appropriate level or distribution of these services across the community”*.

This is the first acknowledgement of any problems in marketisation that we have seen, but we also believe that this change in policy is precarious and at risk. We worry that we may once again find ourselves governed by politicians who will use any recommendations for competition, contestability and efficiency as an excuse for greater marketisation of sectors that are ill suited to this.

1.5 Government stewardship

While governments acknowledge their stewardship role and responsibility for protecting the vulnerable, they have a very limited capacity to do so and have failed to successfully implement *“appropriate consumer safeguards”* on multiple occasions. ACC argues that responsibility for each other is a core responsibility for any civil society and that this stewardship should be a partnership with government.

Civil society is responsible for the socialisation of its members so that they behave in a socially responsible manner. Social pressures impact on identity and so inhibit unacceptable behaviour. This is a powerful form of social control. Free market ideology’s rejection of social responsibility has undermined this and distorted society’s value systems. Regulation and sanctions should be the fall-back option for when socialisation fails and not the primary method of control.

1.6 Quality of life

1.6.1 The impact of incentives and disincentives

Humans are not puppets on a string and the idea that we can make them do what we want by pulling strings to encourage or discourage them is risky. These strategies build selfish selves by switching the focus of their activities to the achievement of personal gain or status. The outcomes are often unpredictable and harmful.

This is particularly so in those sectors which depend on our responsibility as citizens, on engaging our humanity or on developing motivation based on our ability to identify with the lives of others. They diminish our sense of social responsibility and inhibit the development of social selves. They often do have short measurable benefits but the long-term social consequences are more difficult to measure.

Rather than incentives, people should be praised and rewarded for their achievements in providing services and criticised for selfishness and a lack of attention to the human needs of others. This builds social selves, creates role models and increases motivation in others.

Those who were involved in battling the introduction of behaviorism into education and discrediting it in the 1960s and 1970s cynically described this approach as turning people into rats.

If we look at what happened in health care in the USA or the banks in Australia, this seems to be exactly what the widespread introduction of incentives has done. In medicine, the use of incentives (usually called kickbacks) has been criminalised (eg. Stark laws in the USA), but the pressure of competition has seen the creation of multiple exceptions or ways around these laws.

The majority of the giant US healthcare frauds have included charges of illegal kickbacks and would not have been possible without them.

We remain concerned that the suggestions for increasing competition in some of the sectors mentioned in the draft report will introduce perverse incentives. They may well have an adverse impact.

1.6.2 Neoliberal policies

Competition (rivalry), efficiency, contestability and choice are all a normal part of our complex activities but so are cooperation, inefficiency (social interaction) and a multitude of other factors. The latter are important in the creation of the social contexts within which we develop our social selves and lead fulfilling and satisfying lives.

While the former may increase productivity, their dominance in any sector can be at the cost of the quality of our lives and the social milieu within which we live. The impacts of this are greater in humanitarian services because unhappy people disengage and lose motivation.

1.6.3 Management structure

Complex hierarchical systems that rely heavily on processes may lead to a focus on tasks rather than people and a failure to detect developing problems. This too, impacts on our ability to imagine the life of the other and so develop empathy, humanity and the motivation needed in human services. This problem is peripheral to the commissioner's brief but nevertheless impacts on it.

In such systems staff, particularly those who become critical because of failures generally have little control over their working lives and are unable to contribute in any meaningful way to addressing this. This makes for an unhappy environment and dysfunctional cultures readily develop.

In this regard, Everald Compton, chair of the Longevity Forum has complained about "*great hierarchies of administration had been created within major aged care providers*" of home care. He found it "*repugnant that a third of a package goes towards the administration of the service*". The matter has been raised in media^{1 2} and parliament³, including various inquiries over the years⁴.

- **Compton calls for review of 'repugnant' home care admin fees**
(20 Oct 2016, Australian Ageing Agenda)

<http://www.australianageingagenda.com.au/2016/10/20/compton-calls-review-repugnant-home-care-admin-fees/>

¹ In-home care recipients complain packages 'being fleeced' by not-for-profit providers charging high fees (ABC Lateline, 1 Oct 2015)
<http://www.abc.net.au/news/2015-09-29/complaints-over-fees-after-in-home-aged-care-changes/6802312>

² So much for client control (The Senior, 1 Mar 2016): <https://www.thesenior.com.au/news/so-much-for-client-control/>

³ A statement on rorting in the aged care sector - Andrew Wilkie - 14 Sep 2016,
<http://andrewwilkie.org/a-statement-on-rorting-in-the-aged-care-sector/>

⁴ Care and management of younger and older Australians living with dementia and behavioural and psychiatric symptoms of dementia - Community Affairs References Committee - 16 Dec 2013 - <http://bit.ly/1uAc4Xi>

1.7 Data

Collecting data: We are impressed with the emphasis that the Commission places on the collection of data and its proper evaluation. In this regard we would like to emphasise the following points:

Government: The very poor record of government and market in the collection and proper evaluation of data. Data collection should not be constrained and impeded by excessive process or based on a narrow single-focus *approach* (eg. *A legalistic approach in the Aged Care Complaints system prior to the Walton Review and a focus on unsupported local resolution since then*).

Complexity: The complexity of data in many sectors and the adverse conclusions that can be drawn by the examination of subsets or otherwise incomplete data (eg. Examination of financial data in the absence of data about outcomes as occurs in aged care).

Subjectivity: The subjectivity of assessments of data in many human services and the inaccuracy of periodic external assessments as well as the strong confirmation bias that is created by self-assessment approaches. What is happening can be obvious to an outsider who visits regularly but difficult to document objectively.

Management structure: Hierarchical management systems in which staff are unable to contribute are at particular risk of bias. Highly motivated staff with the time and willingness to interact with recipients of care and their supporters in the community reduce the risk of confirmation bias provided they are free to express their views and these are accepted. This does not happen in hierarchical systems.

Bias: Confirmation bias is readily apparent in the facility with which offenders in failed markets continue to see what has happened within their own paradigms and in doing so reject criticism and alternate points of view. Instead they become defensive and attack the messenger. This is readily apparent in the conduct of the Commonwealth Bank and in the dispute that arose between 7-Eleven management and Professor Fels after 7-Eleven appointed him to assess their liability to compensate the employees whose vulnerability they had exploited.

It is readily apparent in the aged care industry's denials and the ferocity with which some in the aged care industry have responded to studies by academics showing deficiencies in care. These academics were simply fulfilling their responsibilities as citizens by speaking out.

1.7.1 Examples of confirmation bias

1.7.1.1 Example: Finance

The Aged Care Financing Authority (ACFA) commissioned RSM Bird Cameron and PricewaterhouseCoopers to conduct a "comprehensive analysis" of the 2012-13 financial performance of providers. It was released in June 2015. It divided the performance of providers into quartiles based on their OEBITDA, a measure of profitability. The top quartile was good and the bottom quartile was bad and they saw no reason why they could not improve.

The figures (average key operating metrics per resident per annum) were interesting. The Operating Revenue in bad group 4 was \$76,909 compared with \$93,875 in the good group 1. Despite charging government and residents less, the poor group 4 spent all of their money and more \$78,909 on providing services making a small loss. The good group which made more money spent only \$68,144 ie. \$10,765 (13.5%) less.

In fairness, the report acknowledged that many providers operated differently and were not focused on profit. But in the absence of data about care, it would be reasonable to conclude that these groups were probably employing more staff and providing better care. This is what all the data available actually shows, but which neither industry nor government will admit.

One would have thought that, for citizens and the government representing them, providers that were able to charge less and devote more to providing the care they were being paid to provide would be good. Giving us more for less should be very good! That government departments and politicians would accept this as bad seems to be a good example of the extent to which politics has become interest driven and governments come to think like those whose interests they represent - those who helped them gain power rather than those they are there to serve.

As the report indicated, the government were about to pour more money into the sector in 2014. We can see what was about to happen and how that would be wasted.

The figures seem to confirm everything that ACC and other advocates have been saying for years, what nurses are complaining about and what the numerous recent press reports that the industry is denying are describing. In essence, it is telling us what is wrong with the industry.

1.7.1.2 Example: Standards of care

International studies overwhelmingly show a close relationship between profitability and both staffing and failures in care. Market listed and particularly private equity owned facilities had fewer staff and far more failures in care. In Australia a study has shown that for-profit facilities are sanctioned for failures in care more than twice as often as not-for-profit facilities.

In Australia, the only data collected is by the government and industry operated and deeply flawed accreditation system. It deceptively under-reports failures as the numbers of facilities that have not corrected identified failures on a particular date rather than the number that have failed over a one year period - multiple times the figure reported.

When Aged Care Crisis challenged the figures released by the minister, she admitted this publicly and gave the real figures. In spite of this the agency has continued to report its figures in this way but has been careful to add a footnote explaining how the figure was obtained. By doing this, the agency is able to promote a positive image of the industry and of its own performance that is not supported by the real figures.

The agency's analysis of the figures document the increased number of failures in rural aged care facilities when compared with urban ones. **It then reports equal performance of for-profit and not-for-profit facilities by disregarding the variable of location.**

There are hardly any for-profit owned facilities in rural areas and to generate these results, not-for-profits must be performing several times better than for-profits in urban areas.

When like is compared with like, the finding of international studies is confirmed. Aged Care Crisis own study in 2008⁵ revealed exactly this.

In spite of this, the Quality Agency has continued to evaluate its data in this way and to loudly proclaim in its reports, in its public addresses to the industry and in correspondence with residents families, that there is no difference in performance between the two sectors. When challenged with their own data and asked to revise their claims, the Quality Agency refused to engage in the debate and did not respond to the issue⁶.

The data clearly challenges government policy and current practice, yet government and industry resolutely choose to ignore this issue. It challenges the assumptions that underpin their policies.

“ ... When challenged with their own data and asked to revise their claims, the Quality Agency refused to engage in the debate and did not respond to the issue ... ”

⁵ Aged Care Report Card: <http://www.agedcarecrisis.com/news/research/108-aged-care-report-card>

⁶ Quality Agency rejects ownership factor on accreditation (Aust. Ageing Agency, 25 Mar, 2016): <http://www.australianageingagenda.com.au/2015/03/25/quality-agency-rejects-ownership-factor-on-accreditation/#comment-5069>

As is revealed here, it is likely that the power structures behind the dominant paradigm will cause government, industry and even society to develop and design data structures and analyse data in ways that support policy rather than inform it.

1.7.2 References

1.7.2.1 Example: The type of data collected

The difficulty in human services is their nature and the difficulty in identifying data sets that accurately represent the standard of care and that by their selection do not distort the care given. Currently the focus of data collection is on processes, the recording of tightly specified objective data and a tick boxes approach checking that desired processes and practices are in place. This sort of data does not accurately measure care. A focus on a small number of items as in the use of Quality Indicators is likely to distort care rather than improve it, particularly in a competitive market context.

Another academic has warned of 'perverse incentives', where international evidence has shown that published quality indicators can lead to the '*cherry picking of clients or providers diverting resources to areas being measured*'⁷.

If we go back to pre-1996 pre-neoliberal studies like that undertaken by Braithwaite and Braithwaite in 1995 we find that an investigative approach within broadly defined areas, careful attention to subjective assessments and more regular on site visits yielded more accurate data about the sort of care that was being provided. Aged Care Crisis' (ACC) assessment is that the current approach is failing citizens. The sort of approach advocated by these researchers is central to our proposal to move the collection of information, oversight and regulation (including social control through regular on site discourse) to local communities and to the bedside.

- **The Politics Of Legalism: Rules Versus Standards In Nursing-Home Regulation** Braithwaite J and Braithwaite V Australian National University (Social & Legal Studies (Sage, London, Thousand Oaks, CA and New Delhi), Vol. 4 (1995), 307-341
http://www.anu.edu.au/fellows/jbraithwaite/_documents/Articles/politicsoflegalism_95.pdf

Proposal for change: Aged Care Crisis is advocating for a flexible local partnership between community and government to replace the current structure. This would play an active role in the provision and oversight of care. They would work closely with staff in the collection of objective and subjective data in order to eliminate confirmation bias as much as possible. Their investigation of failures in care would illuminate underlying problems and identify causes. They would support motivated staff and work with them.

Participants would be drawn from those in the community with some knowledge and their expertise would grow. We feel that this is the best way to maintain objectivity and reduce bias. Care would become a joint venture between government, community and provider rather than a packaged product.

Our proposal would give the community the insights needed to develop a language and paradigms that adequately reflect the reality of care at the point of delivery and assess information from that perspective. The success and commercial prospects of providers would lie in the palms of customers and community. This would ensure that they rather than providers set the paradigms and parameters within which the discourse of aged care is conducted first on site and then centrally. Power is important and in a democracy should be in the hands of citizens. It makes socialisation and social sanction legitimate.

⁷ Special report: Quality indicators program rolls out, but debate continues (AAA, 20 Jan 2016):
<http://www.australianageingagenda.com.au/2016/01/20/37547/>

Formal regulation and sanctions would only be necessary when normal social processes fail – a last resort and not the first and only constraint on social deviance and irresponsibility. What matters is having the power to force change but rarely if ever having to use that formally and forcefully.

The draft report: While the preliminary report is strong on data, it does not address the great difficulties in collecting the sort of data needed and evaluating it properly.

The threat posed by data: Accurate data can be costly. It poses a threat to providers and threatens to embarrass politicians. There is consequently little incentive for government to fund effective data collection and experience has shown that they seldom do so. Confirmation bias is endemic in both political and market sectors and the response to criticism is to attack the messenger.

The handling of major adverse events in aged care has suffered particularly when these have occurred during an election. In our view the inadequacy of regulation and data handling in aged care is in part a consequence of the precarious political position of the new government in 1997 and the strong community and political opposition to government policy at that time. Accurate data was a threat then and still is.

Data as the first step: We urge the commission to strongly recommend that adequate data collection and analysis is the first step in any planned changes. We should establish a solid base from which to evaluate changes. Any recommendations that introduce new pressures into the system should be tied to a well-structured and planned system of data collection and evaluation by a process that is independent of market and provider and whose officers are not appointed by government.

Choice and data: Many elderly and many families simply do not have the training or the skill to assess data adequately and good data is not always simple or easy to understand. Decisions are often based on emotion, impressions, the sales skill of the provider or intuitively without logical assessments. In many instances it is the feeling of control that choice gives that is beneficial and satisfying. So choice is very important in our wellbeing but because of its risks in the marketplace it needs to be guided and assisted. Our comments are not about abolishing choice but about making it as safe as possible.

Ultimately it is the presence of someone with knowledge who understands the potential recipients needs and guides them towards the wiser choices that is important. Even people who have done their homework can benefit from some guidance and help.

Choice as an ideological cure-all is likely to expose many to predatory businesses. There are many examples where they have been exploited. The hollowness of choice as a slogan is revealed when after carefully selecting an aged care provider the recipient is sold off with the provider to a private equity group then after care has been squeezed to boost profitability traded on the share-market. Changing providers is not an option for many elderly residents.

1.8 Questionable matters

Logical errors: The draft report claims that *“one of the clearest benefits of markets — the emphasis on putting power into the hands of individual service recipients through choice”*. This was the argument made by big corporations that went on to exploit their patients. This is clearly true when the necessary conditions (eg. effective customer) for a market to work are present, but in most human services there are large numbers who have neither the power nor the capacity to make informed choices. The generalisation of this statement is a logical category error.

The major cause of market failure in vulnerable sectors is the ability of providers of services to influence the choices that recipients make and so exploit them. This is what pre-Friedman market theory (eg. Adam Smith) indicated was likely to happen. It has happened in health care in the USA and more recently in financial services in Australia.

Why GP's? It is interesting that the draft report uses GP services as an example of competition, contestability and user choice. While there is and always has been competition and choice of GP, competition has never been a driving force as it has been in the USA where it has had adverse effects. Choice is largely based on hearsay and the way in which the GPs relates to patients. There is less prospect of making choices based on competence.

Even well informed patients need guidance and no GP will hopefully agree to provide treatment when it is not beneficial so choice is limited. It is the GP's skills, ethics, integrity and trustworthiness in guiding the patient to the best treatment or to see an appropriate specialist rather than enter into a kickback arrangement with a surgeon to do a lucrative operation that makes this work.

While the patient can contest the advice given he is disadvantaged in doing so by a lack of knowledge and judgement. Inappropriate incentives and some types of contracts create situations where doctors succumb to pressures and take advantage of their power over their patients. This has been a major problem in the USA but it is not limited to that country.

The GP's competence is monitored by professional structures and their effectiveness can ultimately be more important for the patient than choice or competition.

The point here is that competition, contestability and user choice are part of the way in which the profession deals with the public and ensures the user has rights but they are modulated and controlled so are part of a whole. Much of the benefit comes from the perception of control rather than the actual choosing because choices are based on advice and the supply of information within the context of that advice. Any attempt to make these the driving forces in the provision of GP services would not only be impractical but would probably do more harm than good. More benefit might come from restructuring services so that they better meet the needs of the community, greater transparency about performance and in improved training and GP support.

Type of provider: The commissions view about the provision of human services not depending on "*adoption of one type of model or favoring one type of service provider*" is not supported by evidence. There is clear evidence from many international studies and also from local data that those aged care groups that are most driven by profit compromise on staffing and have a larger number of failures in care.

In spite of all the regulatory efforts, that has not changed since the first study in 1994. Providers and governments in Australia have simply ignored the evidence and the Australian Aged Care Quality Agency (renamed from Accreditation Agency), has perpetuated that myth by refusing to take confounding variables into account when reporting their data. ACC drew this to their attention in 2008 and again in 2015, but no changes were made and they are still making this claim.

It is likely that a similar situation exists in other sectors. In both the recent Vocational Education and the Jobs scandals it has been the for-profit sector that has dominated and led the way although not-for-profits were drawn into the Jobs racket to a lesser degree.

Canadian researchers have documented higher morbidity and mortality in for-profit than not-for-profit services in some services such as renal care.

Kuttner in 1997 noted that not-for-profit hospitals were increasingly operating like for-profits and experiencing the same problems. In the past, most of the problems encountered by ACC seemed to be in for-profit owned facilities.

ACC is now encountering increasing unhappiness from staff in not-for-profit facilities. They complain about the way in which the focus on profits is impacting on staffing and on care.

It seems likely that the changes that followed the *Living Longer Living Better* reforms are forcing not-for-profit to embrace marketplace paradigms and that in time the difference in performance between the two groups will diminish.

The for-profit sector was once constrained by the values of the dominant not-for-profit sector. The 1997 changes reversed that process and the for-profit ethic and its accompanying value systems have become legitimate. The abolition of probity, staffing requirements and accountability for funding at that time sent a very clear message.

Aged care: The report suggests that “*There is considerable scope to improve outcomes by promoting competition, contestability and user choice in the provision of residential aged care services*”. As indicated in ACC’s previous submission, the introduction of these practices as part of the marketisation of aged care has been very damaging. The evidence coming from staff and families is that this has resulted in serious and ongoing problems in care.

“*... The abolition of probity, staffing requirements and accountability for funding at that time sent a very clear message ...*”

Contrary to the claims in regard to choice of residential aged care services on page 46 of the draft report, the reforms recommended by the Productivity Commission in 2011 led to the *Living Longer Living Better* “reforms”. Far from enabling choice, these further disempowered users by making choice far more complicated and far more risky. The reforms created an unstable market where frequent trading of facilities resulted in any choice made often being superseded by the facility being traded in the marketplace, greater financial pressure on services, increased charges and repeated changes in policy that were destabilising for residents and confusing for staff who became disillusioned. Care suffered. These consequences were predictable because they have been a problem in the USA since the 1990s.

The consequences of these changes have been the diversion of funding away from care creating staffing problems and growing unhappiness in the system because of failures in care. Money has been squandered on activities that harm rather than improve care. The lofty objectives are not being met and staff describe the process as “all show and no go”. Accounts coming from the UK suggest that Consumer Directed Care introduced in a similar way to that occurring in Australia is not working. Choices to be offered by a competitive market pose particular risks here.

Funding intended for care has been rorted and instead of going to care has fuelled an unstable private equity led competition to grow the size of the companies. There has been a high risk feeding frenzy. Large debts have been incurred in order to buy overpriced aged care facilities incapable of generating the income needed to service those loans. To meet these objectives there was cost cutting and additional charges to residents. Bond money that should have been securely invested was used to buy facilities.

In October 2016 when the government stopped the rorting of federal funding and prohibited the extra charges to residents, the market collapsed. The market-listed companies are in dire trouble with loans they struggle to service and bonds that are no longer secured by the value of the nursing homes they purchased. Large numbers of residents and families are trapped in this. The investors knowingly took these risks but the profit parcels (residents) in the nursing homes were given no choice.

The extent to which other aged care companies have been trapped by this loss of value is not known. Large sums of money intended for care have simply evaporated – some of it went with the private equity and company founders who were shrewd enough to get out when trouble developed and before the market collapsed. Government is likely to have no choice but to restore the funding and so protect residents by bailing out the companies. This has already happened twice in the USA.

Other services: The introduction of strong competition, contestability or user choice into disability services, mental health services and vocational education and training without some form of support for the vulnerable recipients and their families is likely to have adverse outcomes. Vocational training is already a failed market. Mental health and disability services are at risk of the same sort of exploitation that occurred widely in psychiatry, in substance abuse and in rehabilitation services in the USA.

Living Longer Living Better reforms: Note that the implementation of the 2011 reforms recommended by the Productivity Commission was largely driven by industry. Paul Gregersen, long term CEO from BUPA was appointed by cabinet as an independent expert for the Aged Care Financing Authority in 2012 and *“as the inaugural chair of The Aged Care Guild, Paul advised the Australian Government on the Living Longer Living Better aged care reforms”*.

BUPA is a strongly profit focused company that has a very poor international record for care. There have been reports of serious failures in Australia. Like all profit driven corporations, it looks for profitable sectors and attempts to vacate those that are less profitable.

Economic conditions and government policies are compromising profitability in the UK. BUPA has sold off its home care division and it is rumoured to be selling off many of its care homes⁸. Unlike not-for-profit facilities, these companies are not there for the long haul and readily abandon their responsibilities as citizens. This puts key services at risk.

In 2014, Gregersen became CEO of the private equity driven company Estia when it listed on the share market. This company was a major player in “maximising” profits from loopholes in the ACFA that Gregersen had helped restructure, in increasing profitability by adding extra charges to residents fees, reducing costs by spending less on services and to leading the excess financialising that resulted in the current crash and the loss of huge sums of money intended for care.

In May 2016 after allegations of industry “rotting” were first made, the private equity group Quadrant that had floated the company in 2014, sold all of its remaining shares. When the impact of the restriction on maximising for Estia became obvious, its original founder, Peter Arvanitis sold his entire stock and resigned as director leaving remaining shareholders “ropeable” (according to the *Financial Review*). Gregersen resigned two weeks later.

- UBS sells balance of Quadrant's stake in Estia Health - *Australian Financial Review (AFR)* (9 May 2016) <http://www.afr.com/street-talk/ubs-sells-balance-of-quadrants-stake-in-estia-health-20160509-gopvq6>
- Estia Health gets a not so fond farewell from Peter Arvanitis - *AFR* (31 Aug 2016) <http://www.afr.com/brand/chanticleer/estia-health-gets-a-not-so-fond-farewell-from-peter-arvanitis-20160831-gr5uth>
- Estia Health CEO Paul Gregersen departs after shares lose 50pc in nine months - *AFR* (16 Sep 2016) <http://www.afr.com/real-estate/estia-health-ceo-paul-gregersen-departs-after-shares-lose-50pc-in-nine-months-20160915-grhjt6>

As a group representing the interests of the community, ACC considers the close links, when developing policy for vulnerable sectors, between governments and senior executives from big corporations, to be unhealthy. Their primary objectives are not aligned with those of the sector or the community so they are not there for the long haul. They are not in the best long-term interests of the sector or the community and readily abandon both.

Prospective residents and their families are easily persuaded by glossy brochures and impressive looking websites. The government is selling them “choice” and giving these company's their stamp of approval by listing all their facilities and their services for families to choose from on the MyAgedCare website. Trusting families see them as approved and therefore, safe. They readily choose these facilities and place their trust in these businesses. But these businesses may not be there for them when the going gets tough.

We can understand why this “reform” has become so problematic. The *Living Longer Living Better* reforms in aged care are something that the Commissioner should be using as an example of the pitfalls of these processes and not holding it out as an example of success.

“
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⁸ BUPA readies sale of 200 UK care homes (Financial Times, 9 Oct 2015): <https://www.ft.com/content/9eca70fa-6cdc-11e5-aca9-d87542bf8673>

1.9 Items selected for change using greater competition, contestability and user choice

With the exception of health care we do not have experience of the following sectors selected as suitable for these changes. These comments are therefore very general and tentative.

1.9.1 Social housing

We have little knowledge of the sector but if what is said is correct then the service clearly needs restructuring to make it work and it should serve users who should have choice and be empowered. It is not clear to us how competition would add anything to this and it might simply create more problems.

1.9.2 Health care generally

The breakdown of relationships between government and the profession at the end of the 1990s when attempts were made to marketise the sector and adopt the failed US system has continued to fester as governments have continued on this path. While Australian health care has escaped the worst of this process this distrust has inhibited progress in developing the system.

The system is currently structured to meet the government and markets administration and financing needs rather than the service needs of the community and the profession. The system might for instance, be better served by structuring and funding it along clinical service divisions - each division responsible for working with communities and hospitals across the nation in organising and providing services to those regions. This would enable the divisions to address issues of data collection, distribution of skills and standards of care by providing mentoring, supervision and retraining where there were deficiencies. This would be facilitated by proper data collection and transparency.

It is difficult to understand why 30 years after computing power made this possible we still do not have a workable digital medical record keeping system.

Nor do we have the software to continuously scan the records, collect data, monitor and report on performance and detect outliers. We are not adequately scanning for potential preventable errors nor flagging matters for review in a timely manner. Many doctors work in relative isolation and variability in performance is potentiated by this omission.

Instead of imposing disruptive market and managerial solutions from the outside, efforts might be better directed to this sort of reform. This is not to suggest that competition, contestability and choice have no place and cannot be useful but in this sector their role in improving services is minor and only supportive.

1.9.3 Public hospitals

Transparent data collection is always necessary. In practice choice of hospital is made in cooperation with the General Practitioner and locality is usually important. Although there is no guarantee about which doctor will provide care, unless things have changed in the last few years, GP's have been able to book patients to the public hospital outpatient department of a doctor of their choice and many find it convenient to attend a specialist with a hospital appointment privately and then be admitted under him or her in the public system.

Training requires that therapy and surgery be carried out by trainees under supervision. Provided supervision is adequate this does not compromise care. Allowing patients to insist that consultants provide the service personally might have long term consequences for training standards.

Hopefully no one is planning to resurrect the privatisation of public hospitals. This failed in the 1990s.

1.10 Palliative care and gerontology

The problems here seem to be the lack of facilities and staffing for providing good care particularly in nursing homes. Because of this the work environment in both may not be attracting new members and offering a rewarding career path. Professor Maddocks proposed a structure for providing medical services in aged care - including gerontology and palliative care. This received little support. ACC supported Maddocks proposal and we have built on it in our proposals. This would be far more productive than making it more competitive.

The problems in these two sectors might be best addressed by establishing service divisions as suggested above to work with communities in organising and providing palliative care and gerontology services in their regions and mentoring others who do so. The community would pressure nursing homes for the facilities and staffing needed to provide these services. Properly informing patients and families about their prognosis (a complaint in the draft report) should not be a problem for palliative care or gerontology specialists. Both would be well placed to train and support others in doing this.

1.11 Public dental services

Our understanding is that this service has been underfunded, under resourced and understaffed so has lagged behind other services. This seems to be the primary problem.

1.12 Remote communities

We have little knowledge of these services. It sounds as if the real problem is that no one is enthusiastic about providing these services because of distance and lack of facilities. Would competition deter potential providers rather than help? We agree with the draft report that local community involvement is the key to successful community services. Experience in Aboriginal health care and in providing services to indigenous peoples internationally suggests that the local community need to be given a controlling and organisational role in these services. It might be wise to integrate some of the services first so that the number of people they have to work with is reduced. Alternately if they were in control they might do this themselves.