

Submission to the Productivity Commission's Inquiry:

# Caring for Older Australians

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# 1 Summary

This submission examines what has gone wrong in the care of the vulnerable aged by looking at the social dynamics and belief patterns adopted by different participants in the system – particularly in nursing homes.

The *Aged Care Act* of 1997 established corporate competitive marketplace paradigms and commercial managerialism as dominant patterns of thought in aged care. These were prevailing political ideologies. As a consequence inappropriate patterns of thought became legitimate. There have been multiple consequences of this but a number stand out.

1. The exploitation and misuse of vulnerable senior citizens - wrinkle ranching
2. Alienation of the work force and groups in the community.
3. The detachment of the community from their responsibility to the elderly with consequent disengagement and disempowerment.
4. The creation of oversight processes that hid the sort of information that might have exposed the new system to criticism.

We cannot turn back the clock but we can reduce the adverse consequences of what has happened. This submission proposes two core solutions.

1. The proper collection and analysis of information about financing, staffing, care and quality of life.
2. Giving local communities leverage by involving them more closely in nursing home care, in the resolution of complaints, in oversight, and critically in the collection of financial information, staffing information and in measuring standards of care and quality of life.

It is suggested that care of the elderly is primarily a community responsibility and that the community should have a key role in the provision of aged cares services in each region.

It is suggested that the persons responsible for oversight, data collection, complaints resolution, and a number of other support and integrative responsibilities be sited locally in the communities where community and residential care are provided. These processes should be closely tied to the local community.

The employees and a community group would be structured as a local organization. The employees would work with and be jointly responsible to this group. The community group will be in a position to negotiate directly with the providers of care when there are issues they feel should be addressed and the employees would be in a position to monitor the outcome of this.

There would be a strong central representative and independent umbrella group. This would have important responsibilities and functions. Employees would be jointly responsible to this body. A central mentor and supervisor, to whom employees would report, would provide backup. Mentors would visit and supervise to be sure that oversight was appropriate and data collection uniform. The central organization would provide training. It would represent communities in negotiations with other large groups and with government.

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Employees would be supported by their mentors as well as by a local community member. They would work closely with this local person who would be in a position to promptly mediate any disputes that arise locally and support the employees in their work with providers.

The central organization would collect information, collate it and make it available. It would report directly to government, to the accreditation agency and back to the communities. It would have an important roll in recommending increased support by the accreditation agency, sanctions, or closure to government. It would represent the community in matters such as the approved provider status of organizations.

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# Section A: Outlining the context of the submission

The first section sets the context within which this submission is made. It sets out my qualification for criticising and making suggestions.

## 3 Preface

This submission specifically examines the history of aged care services in detail and through a particular frame. This is partly because it shows the consequences of a top down “democratic” system built around narrowly focused ideas, which are adopted centrally, packaged and sold, in plausible sound bites to a community that is not given the knowledge to evaluate them.

Policy is then implemented on the run and held together by band-aids. The underlying social dynamics seem to extend from the halls of power in Washington, through the corridors in Canberra to the hills and villages of Afghanistan.

The story of health and aged care illustrates the problems that develop very well.

The solutions proposed are directed at aged care but are also specifically sited within the concept of some sort of dynamic and ever changing, distributed, bottom up democracy. The agendas for debate and the issues are developed within real contexts in a distributed but networked community. Ideas and new beliefs are tested and debated within and against multiple situations and tested in each then funnelled, coordinated and centralised. The proposal explores and tries out an idea generated within the conceptual frame used - a community of interconnected interacting focus groups carrying out the business of society.

The proposal advocates a loss of central control and its replacement by trust. Leaders become facilitators, synthesizers and implementers. It changes the focus of education from training people for a job and then locking them into a working society where they feel powerless and disillusioned – controlled by experts. It moves education beyond training and into a life long system of engagement and ongoing growth in which citizens feel empowered and engaged, in which they interact, learn and explore as they engage in real situations, continuing to grow and contribute. The digital age opens up endless possibilities and the proposals seek to explore and capitalise on them. They seek to balance the growth in financial capital with a growth in social capital.

The proposal realises that playing with ideas is a little like playing with atomic energy and can have even more devastating consequences. Its dangerous and needs careful handling.

The Commission is examining the failures in the aged care system with a view to making changes. There are only a few of us who have given up enough time to collect information about problems and mishaps for the community, analyse what is happening and then press the problems on government and the public. In one sense we may be outsiders but in another we have a large constituency although they don't know it.

To help I have brought the issues together in summaries. The long section on accreditation is drawn together under the section “Major Accreditation Issues”. Then “Summarising all this” pulls it together after the analysis, “Summarising a way forward” comes after the solutions that I suggest. Weary commissioners might choose to read these sections first. There are links in the text to some definitions at the end where I define and explore the words and concepts I use.

## 4 Introduction

### 4.1 Experience

My qualification for analysing, commenting on and proposing solutions for aged care is a lifetime's personal experience of ideologies and conflicting paradigms (*Ref: [Paradigms](#)*) extending from fascism, socialism, apartheid and capitalism to professionalism and economic rationalism. I come from a medical family. I have lived and worked in health care in three different countries in three different contexts; private practice, government employee, and university.

A long term interest has been the way individuals and professional groups in health care respond to pressures introduced from outside including socialism, apartheid, (*Ref: [Ideology](#)*) commercial pressures, managerialism and more recently economic rationalism and competition policy.

Over the last 20 years I have closely examined the health and aged care systems in the USA and Australia with a particular interest in the responses to economic rationalism and the adverse consequences that have resulted. A web site tracks these developments<sup>1</sup>.

### 4.2 Frameworks

To explain what is happening I have borrowed a lexicon (*Ref: [Lexicon](#)*) from multiple sources. I have used and adapted concepts generated within the social sciences. I have applied and further developed insights into human nature and behaviour. These were first used while confronting apartheid and professional behaviour from within more than 30 years ago and have been modified since. This submission is framed within these concepts.

To assist in understanding what I am getting at I have included some definitions at the end of this submission. Hot text in the submission links to the definitions. The words and the concepts used are explained. The definitions show how the ideas are applied to the sector. They help throw a different light on what is happening.

### 4.3 Basis for criticism

While I have no personal experience of aged care I have examined available information from the USA between 1997 and 2001 and from Australia since 2006. I have looked at what has been said by members of the community, by staff who have spoken out, by "providers", and by politicians responding to allegations that vulnerable seniors were being misused and neglected. It is clear that similar forces are at work and that the same types of responses are occurring. An outside perspective can sometimes see what is happening very clearly. I realise that at other times it can misinterpret critical issues so must be carefully appraised.

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<sup>1</sup> Corporate Medicine Website: [www.corpmedinfo.com](http://www.corpmedinfo.com)

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I have examined a fair selection of reviews and reports<sup>2</sup> and have made four previous submissions to inquiries impacting on aged care. These related to private equity<sup>3</sup> (2007), the approved provider process<sup>4</sup> (2008), the complaints system<sup>5</sup> (2009) and the accreditation process<sup>6</sup> (2009). While I have modified and developed my thoughts on how to address these issues, these submissions can be considered as background and are readily assessed from the web page links in the reference section.

I have argued with the department and with politicians about the inadequacies of the approved provider process and the abandonment, in 1997, of probity as a key prerequisite<sup>7</sup>. As a consequence of this, I believe that many more groups whose ethos and manner of operation should have rendered them unsuitable have operated in the sector.

### 4.4 An Outsider's Point of View

An outside analysis of this type can provide insights that are not readily apparent to participants. While these may be valid and obvious to the outsider, they can be strongly rejected and even ridiculed by those in the system. This is because of the different and often inappropriate ways of understanding situations that develop in dysfunctional social systems. This is what happened when apartheid was examined and criticised from outside by people who had no experience. This was because they saw what was obvious more clearly. Those within the system saw their criticisms as uninformed and bizarre.

As the application of marketplace thinking to health and aged care illustrates so well, there are dangers to uncritically applying concepts developed in one context (*Ref: [Contexts](#)*) to another. The necessary conditions may not exist. In this submission the concepts used relate to the way in which individuals and groups behave when subjected to certain types of conflicting situations. They are not specific to the situations within which the conflicts actually occur. While they are more likely to provide insights they should be examined critically before being accepted.

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<sup>2</sup> *Oh no! Not another Aged Care Inquiry:* [www.corpmedinfo.com/agereport.html](http://www.corpmedinfo.com/agereport.html)

<sup>3</sup> Private equity investment in Australia - The Senate Standing Committee on Economics (August 2007): [www.corpmedinfo.com/agereport2007b.html](http://www.corpmedinfo.com/agereport2007b.html)

<sup>4</sup> Aged Care Amendment (2008 Measures No. 2) Bill 2008 [Provisions] - The Senate Standing Committee on Community Affairs (November 2008): [www.corpmedinfo.com/agereport2008.html](http://www.corpmedinfo.com/agereport2008.html)

<sup>5</sup> Review of the Aged Care Complaints Investigation Scheme - Assoc Prof Marilyn Walton (October 2009): [www.corpmedinfo.com/agereport2009b.html](http://www.corpmedinfo.com/agereport2009b.html)

<sup>6</sup> Review of the Residential Aged Care Accreditation Process for residential aged care homes - Department of Health and Ageing (DOHA) - **Report due June 2010** [www.corpmedinfo.com/agereport2009c.html](http://www.corpmedinfo.com/agereport2009c.html)

<sup>7</sup> Correspondence about Aged Care 1998/9: [www.corpmedinfo.com/agedcorresp\\_1999.html](http://www.corpmedinfo.com/agedcorresp_1999.html)

## Section B: How it happened

This section examines the history of thought patterns as they have impacted on health and aged care. It explores the impact of the 1997 aged care act as an ideological imposition on a sector where it was both in direct conflict with existing paradigms, inappropriate to the sector, and had adverse consequences for the system.

### 5 History

To understand the problems and develop solutions we need to understand how we got to where we are and where we went wrong. We will not get anywhere if we continue to deny the blunders that we have made.

#### 5.1 The early years

Health care, and later aged care as it developed, have been practised within paradigms developed by the community and the health professions over a period of almost 2500 years. These ways of understanding recognised the vulnerability of the sick and the frail, and the threat that personal financial and other interests (eg sexual) posed to their welfare.

Those providing care were required to be especially trustworthy (probity<sup>8</sup>) and to identify with and embrace a code of ethics. A system of apprenticeship entrenched the traditions. Health and aged care were deliberately shielded from the full force of market pressures. Health care professionals were expected to provide a form of social welfare by charging for services according to means but providing care according to need.

These traditions have been passed down into all western cultures. Until recently they were recognised by government and are still reflected in our probity requirements. They are apparent in the trust and high regard members of the community have had in providers and in systems of care.

On the other side there was strong social pressure on those providing care. They were motivated to define themselves and build lives as “trustworthy people”. I do not want to pretend that this always worked.

The point I want to make is that these ideas were considered by economic rationalists to be passé, even obsolete. In some sectors, the traditions have been lost or more commonly largely ignored. They are increasingly replaced by the need for a buyer beware mentality.

It is extremely difficult to provide the sort of empathic cooperative care that these sectors require, when those whom we seek to help think they are buying a product and are distrustful of what they are getting. The success of a market depends on their doing so. Carers give of themselves and in doing so define their lives. In this context they find it very difficult to do so and become disillusioned.

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<sup>8</sup> Some thoughts about Probity: [www.corpmedinfo.com/probity.html](http://www.corpmedinfo.com/probity.html)

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### 5.2 The 20th Century

Health and aged care professionals are part of the community and are affected by ideology. Health care has bent before the winds of ideological change including fascism, communism and apartheid, but it has recovered, sometimes leading the swing away from ideology.

Economic rationalism was little different. This pattern of thinking was increasingly sold to, and accepted by the community during the second half of the 20<sup>th</sup> century. Marketplace thinking gained traction in health and aged care. Business operators entered the sector. The not-for-profit sector dominated during this period. The businessmen who entered the sector were under pressure to embrace professional paradigms and usually did so.

In the USA the Samaritan traditions which underpinned their health and aged care system were undermined when corporations, entering the health and aged care sectors in the 1960s, became both enormously successful and at the same time gained control of doctors incomes and careers. Joseph Califano<sup>9</sup>, a powerful political figure saw doctors as the root cause of problems and sought to control them. Doctors lost their independence and failed to mount an effective response.

Patterns of thinking changed over the 1970s and 1980s years. The system for health and aged care that resulted in the USA 30 years later was highly dysfunctional<sup>10,11</sup>. It currently delivers what is both the most expensive and the poorest overall standard of care of all developed nations. Recurrent scandals involving the exploitation of the vulnerable are rivalled only by a massive problem with fraud.

Most of the examples I used come from health care, but aged care was little different with extensive commercialism, the exploitation or neglect of frail elderly, extensive fraud, and the distortion of humanitarian care in pursuit of profit.

This is extensively documented, on my Corporate Medicine web pages<sup>12</sup>, in companies like Sun Healthcare, Beverly Enterprises, Vencor, Integrated Health Care, Genesis Health Ventures, Mariner, Manor Care and Extendicare. Look at the aged care pages in the US section of the web site.

The internal documents and examples I have used in health care are at hand and organised better because these are the groups that entered Australia. Groups like Beverly and Vencor were even more dysfunctional than Sun Healthcare, which is the only US aged care company I have used to illustrate.

### 5.3 Changes in Australia

In Australia the critical change in health and aged care came from government not business. A government that had adopted economic rationalism as an ideology, when elected in 1996, imposed "National Competition Policy" on every sector of our society. Those whose successful operation depended on cooperation and trust were not excluded. They advocated microeconomic "reform" – the payment of money in return for complicity in securing what management desired. This practice was at the heart of the problems in the USA.

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<sup>9</sup> Joseph Califano and the Market Revolution: [www.corpmedinfo.com/califano.html](http://www.corpmedinfo.com/califano.html)

<sup>10</sup> "Critical Condition: How Health Care in America Became Big Business & Bad Medicine" by Barlett & Steele - November 2004, (DoubleDay) see: [www.corpmedinfo.com/financiers.html](http://www.corpmedinfo.com/financiers.html) for information and extracts

<sup>11</sup> The Health Care Marketplace in the USA [www.corpmedinfo.com/corporate\\_overview.html](http://www.corpmedinfo.com/corporate_overview.html)

<sup>12</sup> Corporate Medicine Website [www.corpmedinfo.com](http://www.corpmedinfo.com)

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Financial practices that would previously have been frowned on and regarded as the payment of kickbacks became, not only legitimate, but the accepted way of doing business, and of motivating people in the health/aged care sectors. Increasingly individuals have been conditioned to expect and to be motivated by kickbacks to the detriment of other motivations.

This is simply behaviourism (*Ref: [Behaviourism](#)*) under another guise. Behaviourism has always been effective in securing outcomes, both good and bad, but is dehumanising and alienating. It has long since been abandoned in other sectors. Two of the largest US health care groups gave managers massive bonuses or savage sanctions. In Tenet/NME<sup>13</sup> this was based on a cultural concept of “meeting plan” and in Columbia/HCA<sup>14</sup> on a similar system of “report cards”. Their great success in the marketplace was matched only by the profound adverse social consequences.

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<sup>13</sup> Tenet Healthcare & National Medical Enterprises (NME): [www.corpmedinfo.com/entry\\_to\\_Tenet.html](http://www.corpmedinfo.com/entry_to_Tenet.html)

<sup>14</sup> COLUMBIA/HCA: [www.corpmedinfo.com/access\\_columbia\\_hca.html](http://www.corpmedinfo.com/access_columbia_hca.html)

## 6 The 1997 Aged Care Act

### 6.1 Creating a paradigm conflict

The *Aged Care Act* of 1997 established economic rationalist thinking, not only as legitimate, but as the dominant pattern of thought and the way in which the “business” of providing care was conducted. “Competition” became a buzz word and was seen to be the way to make aged care “efficient”. The entire system was structured as a competitive marketplace.

Large corporate entities with management structures focussed on efficiently making a profit were welcomed in the belief that competition would keep prices down. Companies achieved their objectives and blunted the sensibilities of executives, to what they were doing, by offering incentives linked to profits. Mayne Nickless<sup>15</sup> had become Australia’s largest hospital group. Its senior health executive was offered a massive carrot.

The minister welcomed Mayne’s US like, vertically integrated, model and probably the massive bonuses linked to profitability. The lessons and experience of 2500 years were ignored and the patterns of thought turned upside down so making older and new thinking mutually exclusive.

(Ref: [Paradigm conflicts](#))

### 6.2 Establishing an identity

The community believed and expected that the traditional humanitarian focus and the ethos of the caring community and professions would be maintained. To achieve an acceptable identity, those in the system would have to operate and think within one pattern of thought while seeking an identity within a totally contradictory pattern of thinking. To feel and be genuine, and to build their lives they would have to embrace and believe that they were operating in one way while in practice operating in a very different way. Success depended on doing so. Complex but well recognised psychological strategies were called for. I have written about this elsewhere<sup>16</sup>. The social consequences can be profound.

### 6.3 The most likely to succeed

Those furthest from the coal face would find it easiest to employ these psychological strategies. They would be most readily adopted by isolated managers with closed minded or sociopathic traits, by the CEO’s of market listed entities, and by private equity owners who are even further from the coal face. The combination of “closed minded” (Ref: *Closed Mindedness*) traits, distance from the coal face and strong commercial pressures would be a witches brew.

Available evidence is supportive of this expectation. In the USA for-profit aged care operators have generally been found to have twice or three times as many failures in care.

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<sup>15</sup> [Access Page - Mayne Nickless and its subsidiary Health Care of Australia \(HCoA\) \(1886 to 2005\): www.corpmedinfo.com/mayne.html](http://www.corpmedinfo.com/mayne.html)

<sup>16</sup> [Belief versus Reality in Reforming Health Care J Michael Wynne Health Issues 2005, Number 83, pp. 9-13. www.corpmedinfo.com/jmwynne83.pdf](http://www.corpmedinfo.com/jmwynne83.pdf)

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A preliminary examination of a small sample of accreditation results in Australia has suggested that when controlled for differences between rural and urban results, for-profit entities had a four times increased likelihood that they would fail at least one of the accreditation standards when compared with religious and community not-for-profit homes<sup>17</sup>.

Our accreditation agency does not collect hard data. Its results have so little scale and sensitivity that no valid conclusions can be drawn from them.

Further support for this thesis is provided by evidence of serious problems in private equity aged care homes in the USA resulting in government enquiries and tightened legislation<sup>18</sup>. The Combined Pensioners and Superannuants Association of NSW have documented a multitude of failures in accreditation of nursing homes operated by Principal Health Care<sup>19</sup>. Principal is owned by AMP's private equity arm.

### 6.4 The least likely to succeed

Those closest to the coal face have to confront the consequences of applying company policy. Nurse managers responsible for enforcing policy would experience this most acutely. They would experience severe dissonance. A rapid turnover of nurse managers is a good pointer to serious problems. Ultimately those able to accomplish the mental gymnastics needed are appointed. They are likely to be the least suited to the post and to be at odds with the staff they need to motivate.

While some nurses may succeed in identifying with these new patterns of thinking and establish a new culture, others become disillusioned, alienated (*Ref: [Alienation](#)*) and unmotivated. Many leave. This has characterised aged care in Australia.

When management is successful in selling their ideas to staff they may succeed in building a culture in which staff identify enthusiastically with practices that an outside perspective would perceive as abhorrent and unconscionable. This is usually associated with incentives linked to management's objectives. In this situation innocent and trusting citizens can become profit bodies exploited and manipulated quite ruthlessly to milk their potential.

An impersonal culture strips them of their humanity. In this it is little different from both past and more recent ideologies.

This is well illustrated by the enthusiasm apparent in proceedings of meetings held by providers of psychiatric care in the USA at the end of the 1980s<sup>20a</sup>.

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<sup>17</sup> Aged Care Report Card: [www.agedcarecrisis.com/aged-care-report-card](http://www.agedcarecrisis.com/aged-care-report-card)

<sup>18</sup> More Profit and Less Nursing at Many Homes Sunday, 23 September 2007 10:00 *The New York Times*: Charles Duhigg: [www.agedcarecrisis.com/news/2264-more-profit-and-less-nursing-at-many-homes](http://www.agedcarecrisis.com/news/2264-more-profit-and-less-nursing-at-many-homes)

<sup>19</sup> Aged Care Disgrace: Combined Pensioners and Superannuants Association NSW: [www.cpsa.org.au/VOICE/article.php?id=516](http://www.cpsa.org.au/VOICE/article.php?id=516)

<sup>20</sup> "Profits of misery: How Inpatient Psychiatric Treatment Bilks the System and Betrays our trust" Hearing before the select committee on Children, youth and families, House of Representatives, Hearing Held in Washington, DC, April, 28, 1992 US Government Printing Office, Washington

- a. Outreach Programs that "Feed" inpatient programs - Program directors Conference June 1989. Internal National Medical Enterprise documents. Pages 362-395  
Administrator Driven Intake Systems Internal National Medical Enterprise documents. A few extracts only at pages 396-402
- b. Cross examination Executive Director of National Association of Private Psychiatric Hospitals pages 159-171

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The practices embraced were unconscionable. Also illustrative is a graphic description of the dedication with which managed care assessors denied care to those who needed it, simply to keep costs down. Dr Linda Peeno, who was one of these assessors described her experience to a US House of representatives subcommittee<sup>21</sup>.

### 6.5 The Logic

Like all ideologies this imposition of market thinking was based on flawed logic. The usual justification was that these practices had been very successful in other industries and that there was no reason why they would not work in health and aged care.

Many have pointed out that this is a classic category error. It would not pass even in an introductory logic course. Arrogantly confident advocates have simply ignored this criticism. The necessary conditions for a successful competitive market do not exist and cannot exist. I do not think that it is necessary for me to list the necessary conditions here.

### 6.6 Cultural diffusion

The extent to which this competitive market myth has permeated the sector and persists is reflected in some of the submissions to the commission from families and nurses, even in submissions from the churches.

### 6.7 Competition

With an excess of aged citizens, too few nursing home beds and too few staff there can be no real competition for seniors to put into beds – not yet anyway. There is simply a desperate need that we as a society should be struggling to meet.

The only competition that there can be is competition to make more profit from the system. Those who are more profitable succeed, grow, and become more credible in the eyes of government and the community. They gain status and become "believable", internalising this view of themselves. They gain ever more confidence in themselves and in what they are doing, and are increasingly blind to the consequences.

Profit and the funding of care come from the same limited pool of money. In general the more profit then the less care; or better care then less profit.

### 6.8 Nursing and Care

Nursing salaries comprise about 60-70% of the cost of running a nursing home. Multiple studies have shown that standards of care are closely allied to the number and skills of the nursing staff who provide care. This cannot be challenged and no one has tried to do so.

While hard objective data is difficult to obtain it is also universally recognised and no one disputes that the quality of life in nursing homes is closely tied to the nature and extent of the person to person communication between nurses and resident.

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<sup>21</sup>

Managed Care Ethics: The Close View - Prepared For U.S. House Of Representatives Committee On Commerce Subcommittee On Health And Environment - Michael Bilirakis, Chair By Linda Peeno, M.D. May 30, 1996  
[www.thenationalcoalition.org/DrPeenotestimony.html](http://www.thenationalcoalition.org/DrPeenotestimony.html)

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Communicating with elderly patients is a slow and time consuming process. The primary source of social interaction (involvement and combating isolation) in what has become their home is the staff who provide care there. Communicating with the elderly is a very inefficient business. Drives for ever increasing efficiency cannot but be at the cost of the quality of the life of residents. This is not an argument for planned inefficiency but for disseminated and individualised on site decisions about efficiency, made at the coal face – efficiencies designed to give carers more time with residents.

### 6.9 Incentives to reduce staff

Providers complain bitterly about a lack of staff but they have every incentive to capitalise on this shortage by either driving staff out of the system or at a minimum to do nothing about it. How many would be competitive in making more profit if they staffed fully?

### 6.10 The consequences of competition

The only possible competition then is about being more successful in developing strategies for taking more profit from available funding and squeezing care. The most effective way is by having fewer less skilled staff.

Nurses and families complain bitterly. There are allegations, that in many of the nursing homes owned by one of our major for-profit providers staff have been deliberately reduced and standards compromised<sup>22,23</sup>.

Speaking up like nurses have done takes great courage. Those who do so will be attacked and ridiculed. Their careers will often be compromised. There can be no doubt that they speak out because of real experience and great concern. Even our blunt and inadequate accreditation agency did not fail to detect the problems in these homes.

### 6.11 Political thinking and culture

Illustrative of the patterns of thought that have come to characterise both government and the market in decrepitude is the appointment of the acting Commissioner for Complaints. This was a lawyer with a long curriculum vitae and a distinguished and acclaimed career.

He was an outside director of the company targeted in the allegations above. His photo appeared on their web site alongside that of the owner who was criticised. Most might think that he was a key player working with the owner. He was also a consultant for a law firm advising aged care providers.

We don't know what role he played as a director of this company while management was by all accounts downgrading care but where was he?

When challenged<sup>24</sup> both the minister and new commissioner strongly asserted that because he had resigned from these positions there was no conflict of interest<sup>25</sup>. No doubt they genuinely believed this.

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<sup>22</sup> Aged Care Group Investigated For Poor Care: [www.nswnurses.asn.au/news/19343.html](http://www.nswnurses.asn.au/news/19343.html)

<sup>23</sup> Nursing home group investigated over care Sydney Morning Herald March 26, 2009  
[www.smh.com.au/national/nursing-home-group-investigated-over-care-20090325-9ai3.html?page=-1](http://www.smh.com.au/national/nursing-home-group-investigated-over-care-20090325-9ai3.html?page=-1)

<sup>24</sup> Conflict of interest: Aged Care Commissioner also a non-executive member of an aged care provider Joint Media Release – 15 June 2010: [www.agedcarecrisis.com/news/3981-media-release-conflict-of-interest](http://www.agedcarecrisis.com/news/3981-media-release-conflict-of-interest)

<sup>25</sup> No conflict of interest: Minister - Australian Ageing Agenda:  
[www.australianageingagenda.com.au/2010/06/16/article/No-conflict-of-interest-Minister/OWRPYZSEPH.html](http://www.australianageingagenda.com.au/2010/06/16/article/No-conflict-of-interest-Minister/OWRPYZSEPH.html)

## Section B: How it happened

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If we reflect for a moment on the nature of cultures, the patterns of belief that underpin them and the nexus between individuals, their culture and the context of their lives then the barrenness of this point of view is exposed.

I am not challenging Mr Kelly's distinguished career or his earnest belief that he can fulfil his role diligently. The issue is whether his background and past associations are likely to have equipped him with the patterns of thinking that would enable him to deal fairly with those from the opposite side of the divide.

The complaints system that he will monitor has been savagely criticised for being partisan with providers. A recent review by an independent outside appointee, Professor Walton, was very critical of the processes and advised major changes<sup>26</sup>. Evidence given by the previous commissioner to this investigation was critical of the department and of her inability to overrule them. She has publicly supported the findings and recommendations<sup>27</sup>.

Any sceptic familiar with the way the political system works must ask why the previous commissioner stepped aside before a successor was found and whether the new commissioner is likely to speak out as forcefully when this is required. Will he be any more effective than he was as a director?

Starting in 1997, a new lid has been screwed down tightly on the aged care cauldron each time competition for-profits have stoked the fire causing the cauldron to boil over<sup>28</sup>. Is this more of the same?

A point I want to make for this submission is that the way, in which the parties involved, interpreted and understood the situation is a reflection both of the malaise that pervades it, and of the suspicions that arise as the divide between community critics (*Ref: [A Divide in Perceptions](#)*) and the establishment that supports this system widens.

Many have therefore been encouraged by the recent independent complaints review and the prospect of another totally independent review of the whole system, one not coloured by the perspective that pervades the industry. They are worried that someone with a close association with the industry has been appointed, not by the commission itself, not as a resource person for the commission to consult, but by the minister, and as a commissioner who will make the recommendations.

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<sup>26</sup> Review of the Aged Care Complaints Investigation Scheme - Assoc Prof Merrilyn Walton - October 2009  
[www.corpmedinfo.com/agereport2009b.html](http://www.corpmedinfo.com/agereport2009b.html)

<sup>27</sup> Parker confident CIS review will still influence - Aged Care Insite Aug/Sept 2010:  
[www.agedcareinsite.com.au/pages/section/article.php?s=News&idArticle=17076](http://www.agedcareinsite.com.au/pages/section/article.php?s=News&idArticle=17076)

<sup>28</sup> Government and Nursing Homes – Australia: [www.corpmedinfo.com/nh\\_ausgov.html](http://www.corpmedinfo.com/nh_ausgov.html)

## Section C: The Consequences

This section closely examines the consequences. The most damaging of these was the closing off of every avenue that would allow important information to be collected - financial, staffing, and standards of care. Without this information no one knew what was happening and sensible decisions could not be made.

There were adverse consequences for funding, for staffing, for care, for quality of life, for those who had complaints, for not-for-profit operators, for the community who were disempowered, for medical services, for those going into retirement villages, for the rich who were rorted, and for the poor who lost their nursing home places to the rich.

## 7 Consequences and Developments

Within the frame I am using most of the major deficiencies in the current system are a consequence of what happened in 1997 as well as the subsequent refusal to acknowledge the failure of ideology and to confront what was wrong. Solutions were framed within the same patterns of belief that was responsible for the problems. They were then burdened with a complex and burdensome bureaucracy and by oversight processes that obscured what was happening. Band aids were applied to every crack in the system.

### 7.1 A lack of Information

The 1997 Aged Care act was introduced in consultation with the marketplace and was strongly criticised by the opposition<sup>29</sup>. It did not have the support of the public and was so unpopular that the government was forced to back down on several issues including bonds. The government was consequently very vulnerable to any failures in the system and the responses of the various ministers to the problems that soon followed reflect this. They were going out on a political limb.

It is not surprising that the system was set up in such a way that critics would not have access to the sort of information, which might bring down the government. This meant that no one had the sort of information needed to analyse or to criticise and suggest changes. This is why the current system has survived for so long.

The most serious problems in the system are the lack of useful information and an almost total lack of transparency<sup>30</sup> in regard to the information we do have. Whether this was a deliberate and deceitful process can be debated. I suspect it came about as the product of complex and confusing discussions as a multitude of interests generated arguments and rationalisations to justify and protect their positions.

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<sup>29</sup> Report On Funding Of Aged Care Institutions - Senate Community Affairs Committee - June 1997  
[www.corpmedinfo.com/agereport1997.html](http://www.corpmedinfo.com/agereport1997.html)

<sup>30</sup> Transparency, Accountability and Disclosure: [www.agedcarecrisis.com/transparency-accountability-disclosure](http://www.agedcarecrisis.com/transparency-accountability-disclosure)

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### 7.1.1 Financial Information

Prior to 1997 nursing homes were required to disclose how they had spent the money given to them by the taxpayer<sup>31</sup>. They complained bitterly about this claiming that it was too onerous and that it was inflexible. They claimed it limited innovation and creativity. The 1997 act abolished all economic accountability. The providers could be as secretive as they liked and take as much profit as they could provided they were able to meet a flawed and compromised oversight process. This was touted as rigorous in protecting the public, and the public were bombarded with a lexicon of "quality" words to claim that this was so.

A consequence of this is that the information needed to evaluate the economic performance and operation of the aged care system was lacking<sup>32</sup>.

#### 7.1.1.1 The Hogan Report

When the productivity commission was given the task of coming up with recommendations it found that the information needed to evaluate the system was lacking<sup>33</sup>.

Warren Hogan, the commissioner was forced to go cap in hand to the industry and ask them to voluntarily disclose financial information. He had to keep the details of the information secret and agreed not to disclose some information that critics of the system would have found useful. There are consequently gaps in his report.

Only 31% of the industry were prepared to supply information and the for-profit sector were underrepresented in the sample. Hogan had no means of confirming the accuracy of the data or that the 31% were representative. Hogan's report was going to advise on the financial future of the system. The financial viability and profitability of the operators would depend on his findings and whether they were implemented. Any sceptic looking at this must have grave doubts about the quality of the data. Hogan nevertheless set out the multiple linked variables that were seen to impact on the sector. Without some form of multivariate analysis little can be made of this.

Hogan then outsourced this data to other academic institutions asking them to perform a number of analyses and some complex modelling. We are not told whether they were asked to comment on the validity of the data or the manner in which it was collected. No doubt they were well paid.

Hogan recognised that the 1997 act had not turned aged care into a proper marketplace. His brief was framed in market terms and it is clear that he worked within the economic rationalist paradigm. He pressed for changes that would make the system more market-like and introduce market processes wherever this was practical. His primary goal was "efficiency".

Of necessity caring for elderly citizens is a very inefficient process. Crude and impersonal external pressures to increase efficiencies must seriously threaten both the care and quality of life of the elderly.

There was and still is no effective means of monitoring standards of care and quality of life in our nursing homes. Hogan may have had the best intentions but his conclusions and advice were fatally flawed and hazardous.

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<sup>31</sup> From socialist Labour to free market Coalition | - Doug Moran - Judi Moylan - Warwick Smith: 1985 to 1998 [www.corpmedinfo.com/nh\\_govchange\\_1996.html](http://www.corpmedinfo.com/nh_govchange_1996.html)

<sup>32</sup> **Navigate to** "What Are The Issues Now?" [www.corpmedinfo.com/agereportconclusion.html](http://www.corpmedinfo.com/agereportconclusion.html)

<sup>33</sup> Review Of Pricing Arrangements In Residential Aged Care - The Productivity Commission - WP Hogan 2004: [www.corpmedinfo.com/agereport2004.html](http://www.corpmedinfo.com/agereport2004.html)

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In the USA failures in health care were seen, not as a failure of ideology (this was unthinkable), but as a consequence of not applying market principals rigidly enough. As a consequence the marketplace responses to failures compounded the problems in that country.

Aged care in Australia has been no different. Each crisis is followed by the reaffirmation of market principles and more regulatory vigour. Well known US analyst and writer, Robert Kuttner cut to the core of the problem<sup>34</sup>. Kuttner has been an analyst and fierce external critic of the US health system. I paraphrase:

Kuttner asserts that "much of the economics profession, after an era of embracing a managed form of capitalism, has also reverted to a new fundamentalism about the virtues of markets. So there is today a stunning imbalance of ideology, conviction, and institutional armour between right and left."

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

### 7.1.1.2 Other inquiries

The absence of financial data has been the hidden elephant in the room at inquiries ever since. The managerialist term "stakeholders" with its associative meanings has become the catchphrase used in order to legitimise a reliance on self interested opinion and obscure the barrenness of the process. Input to inquiries has been dominated by submissions from providers who have the resources, the time, the motive, and more importantly the incentive to press their positions. Each has produced its own set of data.

The elephant finally appeared in the room at the Senate Standing Committee on Finance and Public Administration in 2009<sup>35</sup>. The inquiry degenerated into an unseemly barney between nursing home owners producing their set of figures claiming that the industry was in crisis and the department producing another set to show that the funding of aged care was in a healthy state.

The community did not have access to data, and were on the side lines. To their great credit the committee identified the problem and the absence of the community from the debate. They made some constructive recommendations.

### 7.1.1.3 Comment

This is not 1997. Every business keeps computerised financial records and information can be readily extracted using standard software. There can be no excuse for not disclosing information. The industry are crying poor. If they want the community to believe them they must give us access. Trust has broken down.

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<sup>34</sup> Kuttner R "The Limits of Markets" *The American Prospect* No 31 Mar-Apr 1997: p 28-41  
[www.prospect.org/cs/articles?articleId=4845](http://www.prospect.org/cs/articles?articleId=4845)

<sup>35</sup> Residential and Community Aged Care in Australia - The Senate Standing Committee on Finance and Public Administration April 2009: [www.corpmedinfo.com/agereport2009a.html](http://www.corpmedinfo.com/agereport2009a.html)

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It is clear from experience here and elsewhere that we should not rely on the industry to supply this information nor uncritically accept its accuracy. I will later make some suggestions as to how this can be accomplished with minimum disruption for the providers, with full transparency, and without strangling innovation with tedious bureaucracy.

The commissions report will lack credibility if it does not advance some method of reliably collecting financial information and making this public and fully transparent.

### 7.1.2 Clinical Information

My ability to comment and make suggestions is hampered by the failure of the minister to release the findings of the review of the accreditation process. I will want to make a supplementary submission when this is available.

#### 7.1.2.1 Nursing ratios

Prior to 1997 there were prescribed staffing levels. Nursing homes were required to disclose their staffing levels. Like financial accountability this was seen as interfering with the commercial rights of operators to conduct their wrinkle ranching in the most efficient way possible and be rewarded for this.

There is a close relationship between care and quality of life on the one hand and staffing levels and nursing skills on the other. Staffing parameters are consequently one of the key objective measurements that can be made. While not actually measuring care or quality of life, they provide an important red flag, which calls for closer scrutiny.

Having prescribed staffing ratios may well introduce an element of redundancy in order to protect residents. The principle of allowing some redundancy in order to give the interests of vulnerable citizens and communities some protection, by giving their interests priority over commercial rights, in certain contexts, was abandoned in 1997.

Economic rationalism was already distorting the human potential of globalisation. Advocates who considered globalisation as no more than a market process had a multitude of rationalisations to justify the removal of such restrictions. They had given it a catch phrase, "liberalisation", to dress it up and make it smell nice. The government had embraced globalisation and marketisation. It was going to fund aged care without raising taxes and so giving the opposition a stick to beat them with.

Local companies did not have the capital. Government went looking in the global marketplace and found the megacorps they needed. Naysayers like Ron Williams who had studied these megacorps had warned of the consequences<sup>36</sup>. They were derided.

Multinationals entering Australia including Tenet Healthcare<sup>37</sup>, Columbia/HCA<sup>38</sup> and aged care provider Sun Healthcare<sup>39,40</sup> had already stumbled when confronted by state probity requirements and the expectation of the Australian community that providers of care should not have a tarnished track record.

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<sup>36</sup> "Remission Impossible" Ron Williams (1992): [www.corpmedinfo.com/williams.html](http://www.corpmedinfo.com/williams.html)

<sup>37</sup> Tenet Healthcare & National Medical Enterprises (NME): [www.corpmedinfo.com/entry\\_to\\_Tenet.html](http://www.corpmedinfo.com/entry_to_Tenet.html)

<sup>38</sup> COLUMBIA/HCA: [www.corpmedinfo.com/access\\_columbia\\_hca.html](http://www.corpmedinfo.com/access_columbia_hca.html)

<sup>39</sup> SUN HEALTHCARE: [www.corpmedinfo.com/access\\_sun.html](http://www.corpmedinfo.com/access_sun.html)

<sup>40</sup> Analysis Of Corporate Culture And Practices (Sun Healthcare as an example) Lessons for the Future [www.corpmedinfo.com/corp\\_anal\\_aug00.html](http://www.corpmedinfo.com/corp_anal_aug00.html)

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In their eagerness to bring these multinationals into Australia governments conveniently ignored the furore they had created in their own countries, and the investigations that had started. To liberalise the sector in 1997 nursing levels went out of the window together with probity and financial accountability.

### 7.1.2.1.1 The might of markets vs. the protection of citizens

These legislative requirements, including nursing requirements, had acted as a preventive strategy, accepting some redundancy and inconvenience in order to minimise the number of failures and flag possible rogue elements. After these changes problems were only dealt with after the horse had bolted. The absence of an effective oversight process meant that, in nursing homes, it often took a serious mishap or someone with the courage to blow the whistle before any action was taken.

Sun Healthcare planned to enter the nursing home sector and was buying pathology businesses. Both fell under the federal department of health. The then minister for health excused himself from engaging with the inquiry initiated by the Foreign Investment and Review Board (FIRB) on the basis that Sun was buying hospitals, a state responsibility and he could not interfere. This was not only disingenious but dishonest and a breach of his duty to the public.

Sun's founder and chairman, Andrew Turner<sup>41</sup>, was a charismatic conman totally convinced by his own rationalisations. He presented himself as an authority and sprouted the sort of nonsense politicians wanted to hear. His most damaging, made from Sun's dominating and artistically decorated ivory tower in Albuquerque, was that you did not need nurses to look after the frail elderly, just someone able carry bed pans and wipe bottoms. Vast sums could be cut from costs. Politicians in the USA hung on his words and our minister was soon repeating them.

That Turner had a profound influence on our ministers and on policy is reflected by the health minister's announced plan to revolutionise our health system using step down care. This was soon after Sun was allowed into Australia by the assistant treasurer.

Step down care had been one of Turner's money making strategies. His company had used this as a means to double dip on Medicare payments and so to legally rot the system and mushroom his company. Purist market theorists who followed economic theorist, Milton Friedman, would argue that Turner had a fiduciary responsibility to do this, if it was legal, and if it would profit his shareholders.

The minister's plan and Sun's ambition to run nursing homes dropped off the political radar as Sun imploded in the USA and as evidence about its practices was presented to a probity review in Victoria. Turner's money making nonsense seems to have made a more lasting impression. Various ministers for aged care, without any nursing experience, continued to trot out similar nonsense over the years.

### 7.1.2.1.2 Comment

There is absolutely no reason why staffing and skill levels in nursing homes should not be made public and be continuously available. The community could not see the commission's report as credible if it did not recommend this. Publishing a recommended range of staffing levels based on the sort of services provided is sensible.

The 1997 act claimed to turn the sector into a market. A key market requirement – a necessary condition for it to work – is that the customer should not only have choice but be sufficiently informed that he or she can exercise that choice sensibly and not be taken for a ride.

Staffing levels would be a key consideration for any informed customer. If the government in 1997 genuinely believed in its policy of marketisation then the first thing it did was to betray it.

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<sup>41</sup> [Analysis of corporate culture and practices \(Sun Healthcare as an example\) Lessons for the Future www.corpmedinfo.com/corp\\_anal\\_aug00.html](http://www.corpmedinfo.com/corp_anal_aug00.html)

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The only conclusion we can draw is that the policy was written by for-profit entrepreneurs. Aged care entrepreneur, Doug Moran, subsequently claimed to have done so. These groups had funded the 1996 election campaign and then dictated their requirements to a government who gave them what they wanted.

Providers might try to make a reasoned argument against mandatory staffing levels, claiming that they create a rigid system, limit innovation and create redundancy in a stretched industry.

Without major changes to the present system, changes that include a method of actually monitoring what is happening, mandatory staffing levels are clearly essential. To do otherwise would be to endorse the policy of putting commercial rights ahead of the need to protect the vulnerable.

It would go back to closing the stable door after the horse had bolted. These should continue at least until they have been shown to be unnecessary and until trust in the provision of aged care is restored. Without them distrust will continue to fester.

I will later make some suggestions as to how the needed information can be collected in a manner that is reliable but not onerous for providers, and during which trust can be restored across the sector.

### 7.1.2.2 Oversight and clinical information – the accreditation process

#### 7.1.2.2.1 Waiting for the latest Review

The minister has not released the most recent review<sup>42</sup> of the accreditation agency so I have no choice but to write about this at some length as it is a major problem area. This review was by the Department of Health and Ageing, a department that worked closely with the accreditation agency so it is not a truly independent outside review. It is not making the submissions it receives public so there is little transparency.

This is the department that was heavily criticised by an independent outside review of the complaints system. Whatever it finds it will result in controversy and criticism. No one is expecting it to appear before the election. Hopefully the Commission will have access to an advance copy of this report but we do not. There are reasons for being wary of its findings.

#### 7.1.2.2.2 The Accreditation Idea

To return to the story. Well before 1997 the cycle of action, reflection, concept formation and then further more enlightened action was being promoted as a paradigm. Enthusiasts embraced it as a new way of managing dysfunctional practices and called it the "quality circle". This and the accreditation processes based on it were being enthusiastically embraced and promoted around the world as a means of improvement.

#### 7.1.2.2.3 What happened to the idea

I don't have a problem with the idea itself. It is no more than the recognition of an important way in which we learn and act effectively in the world. Nor do I have an issue with the basic accreditation idea. As one helpful way of improving standards for those motivated by a desire to do so it makes sense. As a means of monitoring and controlling failures in care or aberrant behaviour it makes no sense. I do not think it has worked. It was not designed for this.

As an outside observer I have a big problem with the way the idea has been applied. It has followed other ideological reforms in being applied to excess, to areas where it is inapplicable and to the exclusion of other processes that are more appropriate.

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<sup>42</sup> Review of the residential aged care accreditation process for residential aged care homes Department of Health and Ageing (DOHA): [www.corpmedinfo.com/agereport2009c.html](http://www.corpmedinfo.com/agereport2009c.html)

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In addition it developed a new lexicon of words to express its ideas and these came straight out of some corporate public relations department. They are designed to impress, persuade and to have unchallengeable validity. The word quality seems to be attached to almost every concept. Quality is a word so steeped in associative meanings that it sets my teeth on edge and sets red flags waving<sup>43</sup>. Almost all of these associations are positive. It really has little place in a rigorous scientific based activity, which this should be.

Health and Aged Care are not appropriate sites for evangelism and slick techniques of persuasion. It is harder to persuade people using denotative language because it invites and encourages analytical discussion and questions. If something is adopted it will be understood, its limitations recognised and it will be subjected to rigorous critical review. This has not happened. Instead we have a public relations fait accompli.

When I have challenged true believers on any real denotative meanings to these concepts I have been flooded with indignant explanations and figures to show that I was wrong. I did not have enough knowledge or understanding to evaluate them so had to nod and agree.

### 7.1.2.2.4 In practice

I must be fair. On the only occasion when I was part of a hospital that was accredited, management managed to create a great deal of enthusiasm (except for a few sceptics who looked after the patients whom those preparing for the visit now had no time for!). Changes which some of us had wanted for years suddenly happened (some only temporarily). Overall this was very beneficial and there were improvements. I am not convinced that this had anything to do with the actual accreditation process itself but it was an excellent catalyst for positive change.

### 7.1.2.2.5 Adopting Accreditation

Accreditation was seized on enthusiastically in the marketplace. There were perhaps two reasons for this. Firstly, it was largely controlled by industry and allowed self regulation. For businesses this was infinitely preferable to the outside regulatory oversight that was threatened. The second was that it concentrated on processes and not on measurable adverse events. These remained hidden and so failures were not as embarrassing. In addition to this accreditation status was a very successful way of marketing ones company.

### 7.1.2.2.6 Failures in the USA

The process was soon abused by some and was used simply as a marketing tool. A good example of this is the accreditation process set up by the psychiatric corporations in the USA in the 1980s. Not only did they not fail a single institution but it was alleged that they did not carry out any assessments. It was purely a marketing tool used to obscure the systematic abuse and misuse of psychiatric patients many of them children (*see footnote 20 b Page 8*).

The Joint Commission in the USA has been the strongest proponent of the accreditation process in the world. It has marketed itself across the world and promoted itself. It operates globally and others copy it. In true market form it fails to acknowledge its failures. It has failed on multiple occasions<sup>44,45</sup>.

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<sup>43</sup> Quality in the Health Care Marketplace: [www.corpmedinfo.com/quality.html](http://www.corpmedinfo.com/quality.html)

<sup>44</sup> Hospital Accreditation [www.corpmedinfo.com/hospital\\_accreditation.html](http://www.corpmedinfo.com/hospital_accreditation.html)

<sup>45</sup> Tenet Healthcare - Accreditation and oversight page [www.corpmedinfo.com/tenet\\_accredit.html](http://www.corpmedinfo.com/tenet_accredit.html)

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As far as I am aware the vast majority of the psychiatric hospitals (all of those in Texas) were fully accredited by the Joint Commission. It was only when a very ordinary policeman chose to believe the parents of a teenager, who had been kidnapped by a psychiatric hospital, rather than hospital authorities that what was happening was exposed.

Not only had the commission ignored information given them in confidence by psychiatrists but they had notified the hospitals, which promptly disciplined the doctors and destroyed their livelihood.

In the last 10 years there have been multiple further failures. I am aware that some 700 patients had unnecessary cardiac operations in one fully accredited hospital<sup>46,47</sup>. Oversight was ineffective when another hospital with an extremely high infection rate in its Cardiac Surgery operating theatre knew (as did the assessors) that this was because of a major problem in the structure of the cardiac theatre with an infestation of insects<sup>48</sup>. They refused to close the theatre because this would have reduced their profits. The Commission continued to accredit them. These are only the tip of the iceberg and only in one company that I studied.

The Commission has been strongly criticised by independent US politicians with an interest in health care. Congressman Pete Stark has struggled with the US health system most of his life. He tried to introduce legislation to reduce the control that the industry exerted over the Joint Commission and so make it more accountable to the public.

Following each set of public failures the Commission has made much of revising its processes, "putting this behind us" and "moving on". Failures are left behind and dropped from the corporate memory. This has been the accepted way of dealing with most corporate scandals. They are not analysed, the underlying issues are not explored, they are not used as illustrative examples so are ignored and forgotten. After a few years it happens again. The Commission promotes the quality cycle and continuous improvement but, like the corporations to whom it promotes this, it does not use it when it should.

Did accreditation improve standards of care – very probably yes. Was accreditation effective in detecting and stopping aberrant corporations and dysfunctional practices. Undeniably no, particularly if they were big and powerful.

### 7.1.2.2.7 Other regulators in the USA

In the USA state based oversight was retained. While these were far from adequate they did record and report on failures in care rather than processes. They form the basis of the figures on web sites used by the public so that there is a basis for informed choice. They provided a measurement based on outcomes that could be compared with the accreditation results. Where analyses have been done some glaring discrepancies have exposed accreditation failures.

### 7.1.2.2.8 The US nursing home industry and oversight

The US nursing home industry in the USA has been even more heavily criticised, by community groups, than the health system. Both state oversight and the accreditation agency have been blamed for failure to act.

The explanations given for their failure, the non-responsiveness to criticism and the evidence advanced was much the same as we are seeing in Australia today.

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<sup>46</sup> [Tenet Healthcare's Redding Hospital - Unnecessary Cardiac Procedures I  
www.corpmedinfo.com/tenet\\_redding.html](http://www.corpmedinfo.com/tenet_redding.html)

<sup>47</sup> "Coronary" by Stephen Klaidman Scribner New York 2007

<sup>48</sup> Unsafe Theatres - Dangerous Heart Surgery in Florida [www.corpmedinfo.com/tenet\\_palmbeachgdns.html](http://www.corpmedinfo.com/tenet_palmbeachgdns.html)

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Top of the list for state oversight failures were demonstrated close personal and financial associations between the politicians whose departments did the monitoring (and who hired and fired staff) and corporate nursing home owners and donors to campaigns.

Other criticisms include the large number of senior corporate managers on accreditation and other oversight boards, the employment of staff working in nursing homes as assessors and the revolving door between nursing home staff and assessors.

Assessors who knew the system soon got well paid corporate jobs. The network of friends and contacts ensured that unannounced visits were never unexpected and there was plenty of time to prepare.

There was reluctance to make adverse findings against very credible groups and pressure to fudge the findings. Put simply the system could be gamed and clearly was. The role of oversight and punishment came to dominate the educational role and undermined the process.

### 7.1.2.2.9 Accreditation in Australia

If we return to aged care in Australia we find that the accreditation idea was adopted far more radically than in the USA. This was in spite of the criticisms already being made in the USA. The agency has been the subject of multiple press reports that support the assertion that it has not worked<sup>49</sup>.

In 1997 the oversight carried out by Australian states was abolished and the accreditation process substituted. The accreditation agency looked at the response to adverse events but did not collect data about failures in care, nor about exemplary performance. As a consequence there was no way of evaluating its performance and no way of effectively criticising. It was shielded from evaluation.

### 7.1.2.2.10 An audit in 2003

As far as I am aware the agency was only once externally audited<sup>50</sup> – publicly anyway. This was in 2003. The agency had only been operating for a few years, had been very busy, and understandably the audit was kind.

The main thrust of the criticisms was the failure to collect useful data to assess whether accreditation had any impact on care, monitor its own performance, and measure quality of life. Concern was expressed about the conflicting roles of educator and supporter on the one hand and regulator on the other.

A process, that was designed to educate and facilitate improvement, was once again misapplied to a process for which it was not designed and to which it was not applicable, namely regulation. This is a key problem that has never been addressed.

It is acceptable and even desirable for directors from the sector being educated to be appointed to an education body. It is totally inappropriate that they be directors and be in a position to control their own regulator, yet this is what has happened.

### 7.1.2.2.11 A review in 2007

The agency promised its auditors in 2003 that it would collect the data needed to evaluate performance. It has never done so and this may be why it has never had another audit.

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<sup>49</sup> [The Accreditation and Complaint Processes - Australian Nursing Homes  
www.corpmedinfo.com/nh\\_accreditation%20.html](http://www.corpmedinfo.com/nh_accreditation%20.html)

<sup>50</sup> [Managing Residential Aged Care Accreditation  
www.corpmedinfo.com/agereport2003.html](http://www.corpmedinfo.com/agereport2003.html)

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The process and the department have been continuously criticised in the public arena and in parliamentary inquiries<sup>51</sup>. When the whole idea that accreditation was of any benefit was challenged an outside inquiry into this was arranged. This was safe.

The inquiry<sup>52</sup> was contracted out to two groups who were authorities on the accreditation process and totally on side with the ideas. There were no sceptics. The terms of the inquiry were very narrow. It reported in October 2007. This was not an inquiry into the operation of the department – only as to whether accreditation had a positive impact on “quality” care and quality of life. This is really a side issue, and as I have indicated previously it probably does.

Consider why the word quality, rather than standard was applied to the word "care" in this context but does not jar for "life"! In fairness it had been used in this way by the politicians. While it may sound pedantic the words used to introduce something do set the tone and the way a conversation proceeds. “Quality” has associations that set a context very differently to “standards”.

I found the report dense and filled with quality jargon. It did come up with some interesting observations.

First of all it found that there was no data, which could be used to assess whether accreditation worked or whether there had been any improvement in standards of care as a result. There were “*no measures available to consistently assess the level of quality outcomes*”.

What has the word “quality” got to do with measurable outcomes and why was it put there? To me its simply there to obscure and mislead or else to define a subset of observations that are made. This is not deliberate. It’s the way in which belief systems create impressive patterns of thinking to persuade but which obscure what true believers don’t want to now about. I have written about it in regard to the language used by big US health care companies.

What scientists would call facts or hard data like a hole in a patient’s bottom, loss of weight, delay in answering a residents bell are called “indicators” by the review. These are the real facts that scientists measure and record. Scientists then identify the factors operating to decide what was responsible in each case; whether the hole in a bottom (pressure ulcer) was a failure in care or a terminal event that could not be prevented. They are what would be evaluated together with other measures that might indicate good care.

### (a) *Revelations from the review*

The startling revelation from this review is their approval of the practice of not collecting information and measuring what was actually happening. This is an organization that promised its auditors that it would collect the information necessary to measure its performance. This is the information they promised to collect. This “quality” review sanctions their not doing so. The reality of course is that if they tried to do so many providers might not cooperate fully.

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<sup>51</sup> [Quality and equity in aged care - The senate Community Affairs References Committee June 2005  
www.corpmedinfo.com/agereport2005b.html#accred](http://www.corpmedinfo.com/agereport2005b.html#accred)

<sup>52</sup> [Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government subsidised residential aged care homes - 2007:  
www.corpmedinfo.com/agereport2007c.html](http://www.corpmedinfo.com/agereport2007c.html)

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The review does refer to these hard facts. It calls them “indicators”. This is what the review said.

The purpose of the indicators should be confirmed to the sector - the basis for the indicator development was **the clear understanding that they were being developed not to measure performance, but as tools to assist aged care homes to monitor and improve the quality of their care and services;** (*Page 99*)

Whatever the indicators used, they are only useful as far as they initiate and strengthen the continuous quality improvement process. (*Page 85*).

So for accreditation the importance is in the processes and not the failures.

They do go on to qualify this in various ways but the underlying patterns of thinking about this are inescapable.

Quality indicators are pointers, or flags, that indicate potential problem areas which need investigating and the starting point for a process of evaluating quality through careful investigation'. (CHSRA 2000) (*Page 84*).

You cannot escape the public relations approach. Why is the word “quality” put in front of indicator here. Why is the word “quality” used later in the sentence when the neutral words “standards” or the denotative term “failures” denotes exactly what is meant far more accurately without the associated baggage. It can only be to make it sound impressive and so legitimate. Using words in this way impresses government departments and politicians but to anyone familiar with this sort of thing its a worrying red flag. What is being hidden?

We also have a new obscuring word in the lexicon, “indicator”. In the real world in which I like to think I live the correct term would be “failure”. I hope I have made my point about the importance of language in determining the way we think about things and in setting the context of any debate.

A hole in the bottom (pressure ulcer) is usually due to someone being left to lie or sit in one place for hours on end and not being moved. It is preventable and in an ideal world it should be prevented. It's a failure in care and “indicator” simply obscures that. The incidence increases when there are insufficient staff and when they are not trained or motivated.

Pressure ulcers are serious and in this group of people can and often do cause death. There are situations in which a dying patient is kindly sedated and left in peace to die so is not turned regularly and that can be excused. When there are holes in bottoms or a cluster it's a red flag and someone has to go, look and ask why.

In fairness the review does say that the information about “indicators” is difficult to collect. When the oversight process resides in a major city and visits once every year then it is difficult to collect but only because those responsible will not report it honestly.

As I have indicated earlier this process was not designed to work. It was put in place by politicians to impress. It was not there to embarrass them by showing that what they were doing did not work. I hope to suggest changes to overcome these problems.

I must stress that it is not the people I am criticising but the ideas, practices and the way it was set up. They are expected to believe in it and they do. The king has no clothing and no one dare say so.

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It may be difficult to accept that politicians in 1997 were not being cynical and deliberately manipulative. If we look at the prevailing patterns of thought and the hyperboles and enthusiastic advocates (similar to Andrew Turner<sup>53</sup>) around at the time we can understand it. The weight of the rhetoric was irresistible. This happens all the time to people who are acting in good faith.

### *(b) Looking back nostalgically*

There was a time when patients sick or frail enough to be at risk would have had a personal doctor with a keen sense of responsibility for the patient. A red faced and angry doctor breathing fire and brimstone confronting senior nurses and looking for the culprit to tell them off in no uncertain terms was a bit crude but it was immediate and it worked. Replacement with a bureaucratised hospital complaint system that took months did not compare – and the doctor's anger festered and gave him an ulcer!.

In fairness in those days there were enough nurses and it would be very unfair in our nurse starved homes today.

The doctor would also have been informed of and taken a close interest in and supervised the treatment of any bed sore (as it was once called). Today there are few if any doctors in some nursing homes. Many of the allegations coming out of nursing homes suggest that the first time some patients see a doctor is when the relatives realise that they are dying and call an ambulance.

### *(c) Other findings*

There were a number of other observations. They found that the assessment system lacked sensitivity, the scale used was not adequate and they were not a rating of the "level of quality of care or of quality of life". This was what critics in the community had been saying for a long time. They looked at the processes on the web site and the reports did not mean anything to them. No real changes were made as a result of this review. I will return to this later.

They observed:

“...there are no measures available to consistently assess the level of quality outcomes – “  
*(Oh dear that redundant word again!)*

Without any information, the review resorted to going to the stakeholders who were involved with this process. They went through an elaborate process of focus groups in order to collect and evaluate their opinions. There was a long and complex discussion of the methodology used to support the validity of the process.

Finally they reached the conclusion that accreditation improved the quality of care. They also concluded that the disciplinary role encouraged nursing homes to embrace the process. They did not consider that this might encourage ritualisation.

The project found accreditation, together with the regulatory framework in which it is embedded, is an appropriate way to improve quality in residential aged care and has achieved an overall improvement in residents' quality of care and quality of life. **The project was not intended as an evaluation of the Aged Care Standards and Accreditation Agency (the Agency) or its processes.** However, the findings identified areas that could be addressed to improve the efficiency and effectiveness of the aged care accreditation system. *(Page v)*

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<sup>53</sup> Analysis Of Corporate Culture And Practices (Sun Healthcare as an example)  
Lessons for the Future: [www.corpmedinfo.com/corp\\_anal\\_aug00.html](http://www.corpmedinfo.com/corp_anal_aug00.html)

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How many would have read this dense document in detail. How many quick scanners would have missed the bolded words and perhaps by association thought that this was an evaluation of the agency.

Other opinions elicited are of interest.

This (*communication with staff*) was such an important element in stakeholders' views on quality that it emerged as a discrete domain of quality and was strongly aligned to quality of life. Interaction also emerged as a key driver of quality of care (for care staff and family carers) and quality of life (for care staff) in the CR&C Aged Care Survey key driver analysis. (*Page 71*)

The impact of care time and staff-resident interaction is particularly important in understanding quality of care and quality of life. Quality of life is particularly likely to depend upon adequate provision of staff time and this may at least in part explain why quality of life was not generally seen to have improved in the sector as a result of accreditation to the same degree as quality of care. (*Page 71*).

Apart from the jargon few would argue about this but how do we set this against the drive for efficiency and the efforts of managers distant from the coal face to meet Warren Hogan's objectives.

Another complaint that rears its head in every review is the burden of bureaucratic paperwork for staff and the time taken to complete it - time taken away from caring. It is interesting that 70% did not think accreditation had improved staff satisfaction. How motivating was it?

### *(d) Comment*

This is a dense word laden and very impressive looking report. How many would actually wade through it and understand its limitations. The simple question it was asked is a no-brainer but some interesting findings emerge.

#### 7.1.2.2.12 The 2009/10 Review of the Accreditation Agency:

This review<sup>54</sup> has not been released nor have the submissions been made public so I cannot comment on this. I did make a submission. What I can try to do is to list some of the concerns about the accreditation process and the department.

#### 7.1.2.2.13 Major Accreditation Issues

1. The mis-application of a process, designed to educate and assist genuinely motivated people to do better, as a means of regulating and sanctioning deviant behaviour and controlling those with very different priorities. This creates a paradigm conflict with consequences for the way the service is provided.
2. The measurement of process rather than outcomes. We simply do not know what is happening in our nursing home systems. Adopting a process does not mean that the problem is fixed. The agency measures and reports only what it is interested in and not what people want to know, and what academics can analyse and evaluate.

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<sup>54</sup> Review of the residential aged care accreditation process for residential aged care homes - Department of Health and Ageing (DOHA) - Report due June 2010 [www.corpmedinfo.com/agereport2009c.html](http://www.corpmedinfo.com/agereport2009c.html)

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3. The measurement itself is farcical. As indicated it lacks sensitivity and scale. A measure in which 95% of those evaluated obtain full marks (95% or 100%) is meaningless. How could Hogan possibly have considered translating this into a 5 star system. Everyone would have received 5 stars and what was actually being measured would have been hidden from them.

Any evaluation that contains a numeric scale can be plotted as a Bell's curve which fits comfortably somewhere away from the edge of the graph. It grades the measurements so that cut off points can be defined – such as good, safe, questionable and in need of remediation, or unsafe and unsuitable to continue. Having every result at one end of the graph indicates a test that does not discriminate.

4. **Lack of transparency:** Not only are the accreditation reports largely meaningless to the public and researchers but they spend only a very short period on the web site. If there are adverse findings then the assessment is removed and replaced by a new one as soon as the agency is satisfied that processes are in place. There is no way of tracking a homes performance history – something every informed “customer” should be looking at.

The department does not make any analyses of trends for individual homes, company performance, sector performance, or the multiple variables that apply. There are any number of spreadsheets and data bases that will generate graphs which update automatically to show these trends. The department needs this information to advise government and the public needs it so that it can debate rationally and effectively.

5. There are major deficiencies in the whole process.
  - a. Visits which occur once a year show only what is happening on one day and not the other 365. The findings are not made public.
  - b. The vast number of reports that appear on the agency web site are from formal planned audits and only a few from unannounced formal audits. I understand that most of the visits identifying problems (eg. from complaints or unannounced visits) are classified differently and so are not reported. In an analysis the Aged Care Crisis Centre found that between 10 and 22% of the visits made by the accreditation agency<sup>55</sup> are reported depending on when the three yearly expected audits come up. Only 5% of the information gathered from nursing homes by both DOHA and the agency is reported publicly<sup>56</sup>.
  - c. I believe that as in the USA the majority of unannounced visits are not unexpected.
6. **It is not possible to monitor and measure failures in care by occasional visits.** An onsite regular presence is required.
7. **Ritualisation:** Any bureaucratised process, but particularly one where there are paradigm conflicts is subject to “ritualisation”. The original objective of the accreditation process was to improve care. Increasingly the objective of participants shifts to the process itself and the intended benefit is lost. The focus shifts to ticking the boxes and not on improving care.

That the agency evaluates these processes and uses them as measures, and does not measure whether the outcomes have been attained ensures that this will happen. Past assessors set up businesses helping homes to succeed in accreditation – teaching how to tick the boxes – and dare I say it game the system.

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<sup>55</sup> Nursing home data - missing: [www.agedcarecrisis.com/transparency-accountability-disclosure/missing](http://www.agedcarecrisis.com/transparency-accountability-disclosure/missing)

<sup>56</sup> Transparency in aged care: [www.agedcarecrisis.com/transparency-accountability-disclosure/transparency-in-aged-care](http://www.agedcarecrisis.com/transparency-accountability-disclosure/transparency-in-aged-care)

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8. It is clear that the system can be easily gamed. Nurses who speak out describe how additional staff, fancy furnishings and other equipment kept for the occasion are brought out when a visit by the agency is expected.
9. The impact that having representatives of the sector on the board and in powerful positions in the agency – and the use of past, current or possibly prospective nursing home staff as assessors. I do appreciate the difficulties in finding assessors in the current system.
10. **Assessors:** No sensible assessor from one owner's nursing homes is going to produce negative findings on the homes of another large corporate provider whose executives are mates of their employer. Whistle blower's stories are a warning.

Past assessors have a number of lucrative employment opportunities because of their new skills. An assessor might be wary of compromising their future prospects. These problems arise because of the conflicting roles of the agency.

### 7.1.2.2.14 Comment

The situation is little different to that identified in the Complaints system by Professor Walton. The system is so structured and so restricted by inapplicable patterns of thinking that it does not work. I suspect that if Professor Walton were to review the agency she would find that they were motivated and tried hard. She would advise that oversight be placed elsewhere.

## 7.2 The Complaints System

This was another system set up in 1997. Instead of creating a separate independent agency, as it was advised to do, the government/industry machine chose to keep this under their control by getting the ministers department to do this.

As Professor Walton's review<sup>57</sup> found the systems was so structured and so restrained by bureaucratic and legal patterns of thinking that it could not work. I made a submission to this review and concur with her findings. I will not go into this in depth. I urge the commission to examine her report carefully and implement her recommendation to create an independent process.

A few years ago I was asked to come to a meeting between a community group assisting complainants, and the complaints section of the department of health and ageing in order to act as witness and balancing outsider. Staff from Canberra flew to Brisbane. We held several meetings. I found very genuine, motivated and likeable people. They were clearly upset by the negative publicity that the community group had generated and were keen to resolve the issues.

It soon became apparent to me that the complaints system simply could not work within the framework that had been set up. They were struggling against the impossible. Walton has confirmed that. Only some of the issues could be resolved.

I was also persuaded that investigators were listening to and embracing the views and thinking of the providers, and adopting their labelling strategies.

When the leader of the group supporting the complainants was speaking on the phone to one of the investigators who had been at a meeting with us she asked why some nurses who had witnessed the events, complained of, had not been interviewed. She was told that they had subsequently been fired by the nursing home and so were not credible.

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<sup>57</sup> [Review of the Aged Care Complaints Investigation Scheme - Assoc Prof Merrilyn Walton \(October 2009\): www.corpmedinfo.com/agereport2009b.html](http://www.corpmedinfo.com/agereport2009b.html)

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I was reminded of a particular glaring example of the assimilation of “market think” by a regulator in the USA. The regulator thought it perfectly legitimate for a company to adopt a policy to forcefully discharge poorly paying frail nursing home residents to their homes in order to admit other residents who were more profitable<sup>58</sup>. This was a business decision and they could not interfere. Families went to court. The judges agreed with them and fined the company.

### 7.2.1 Professor Walton's recommendations

Although I did not advocate for an independent investigation process quite separate to the department, I am persuaded by Walton that this is absolutely essential.

What I did advocate was the relocation of the main focus and of staffing to a local community level in order to facilitate resolution and when required rapid investigation.

Although Walton wrote about the benefits of resolving issues early and locally she made no suggestions as to how this could be done in an environment in which some worried and anxious family members are labelled as trouble makers and even barred from visiting their loved family member.

I have had to deal with unhappy patients and I do not believe that Walton fully understood the advantages in resolving and in investigating, by immediate collection of information and prompt action. Without this attitudes become hardened, and evidence is tarnished by rationalisations, justifications and pressure from others. Accounts are spontaneous and not constructed stories.

When complainants are directly involved with other parties, however distressed by their mistake, a level of sympathy and understanding develops which permits the error to be documented and a relationship of trust to remain. I urge the commission to look at this closely. An independent on site adjudicator trusted by both is the essential catalyst.

The previous Aged Care Commissioner has strongly backed Walton's Review and supported her recommendation to create an independent complaints system<sup>59</sup>.

## 7.3 Additional Problems

### 7.3.1 The Not-for-Profit sector

In the USA Robert Kuttner has described the way in which not-for-profits have progressively been inducted into market thinking and practices. The commercial marketplace and professional services to the vulnerable have had to find ways to accommodate and work together. This has, in the past, involved attention to the interface between them. A shielded form of competitive practices was adopted where this was necessary.

This is the first time that not-for-profits have had to actually adopt and identify with market practices in order to be successful. There is a critical paradigm conflict. To succeed they must behave like a market entity.

In the USA the process is more advanced. To survive church groups have entered into joint ventures with some of the most aggressive profit focussed companies in the country. While run as an aggressive profit focused market entity by the company the church continued to pretend it was primarily there to serve the community.

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<sup>58</sup> Vencor's Care, Morality And Ethics: [www.corpmedinfo.com/vencor\\_care.html](http://www.corpmedinfo.com/vencor_care.html)

<sup>59</sup> Parker confident CIS review will still influence - Aged Care Insite Aug/Sept 2010: [www.agedcareinsite.com.au/pages/section/article.php?s=News&idArticle=17076](http://www.agedcareinsite.com.au/pages/section/article.php?s=News&idArticle=17076)

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The for-profit group acquired the saintly halo attached to the hospital's name. Some of the not-for-profit operators have developed a fraud record approaching that of the for-profits. In others the not-for-profit status is no more than a convenient front.

I wrote about this in Australia in 2006<sup>60</sup> pointing out that when the paradigm conflict was too confronting some not-for-profits preferred to abandon their operations. In the aged care sector the Salvation Army did this. Others adapted.

This is readily apparent in the way not-for-profit church groups (eg. Catholic Health), which, while there might have been rivalry, essentially cooperated in their missions. They now advocate more "competition" in order to improve the system. They did not mention what they are competing about – specifying profit might have been too confronting.

The response to this adaptation seems to be a more assertive approach to caring in their public statements and a growth in mission statements. Is that because marketing is part of the new paradigm or could it be that the response to the paradigm conflict they have is to externalise their missions more strongly to persuade themselves rather than their customers. In a not-for-profit hospital I worked at I thought the marketing had more impact on staff than "customer" and worried that hype was replacing insight.

To be fair, Australian not-for-profits are not as aggressively commercial as their US counterparts - yet!

A good example in Australia is the UK not-for-profit BUPA<sup>61</sup>. It makes much of its not-for-profit status but has been aggressively commercial and focused on growth as much as service. Why would a not-for-profit founded to serve its community in one country want to enter an overseas market like Australia and grow by aggressive competitive buyouts? I can understand a willingness to cooperate and share expertise but aggressive competitive takeovers are out of character.

### 7.3.2 Disempowering, disenfranchising and sidelining the community

Traditionally the community have been at the centre of caring for their frail seniors. Family, friends and their church groups rallied around. They felt that they were responsible and there were strong social pressures to care and support.

As society changed so the need for Nursing homes became apparent and charitable church groups provided these. Others followed. Many preferred not to be recipients of charity or wanted more creature comforts. Churches supplemented their resources by offering more to some. More recently commercial operators have entered the sector. Governments also provided. As families became busier and employment increased, the care of elders was passed on to the experts in these institutions. Generally though the focus was still local and community were involved in their homes.

1997 was a significant watershed because aged care was now officially turned into a commodity and subjugated to an impersonal mechanism whose priorities were set against the humanitarian and empathic collegialism of the community. Care was turned into a commodity. Care packages were marketed to the public as a service to them. They were no longer a part of it. The community were pushed aside and disenfranchised. Dissatisfied members no longer went to their peers. They became disempowered supplicants to a distant arbitrary and out of touch complaints system

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<sup>60</sup> The Not-for-profit Dilemma [www.corpmedinfo.com/notforprof.html](http://www.corpmedinfo.com/notforprof.html)

<sup>61</sup> BUPA - The British United Provident Association [www.corpmedinfo.com/bupa.html](http://www.corpmedinfo.com/bupa.html)

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Nursing home residents are going to deteriorate and die. Some disillusionment is inevitable. The promised extravagant serene and pleasant life in this home is not going to last. Disillusionment is built into the system. This is a system whose new paradigm invites distrust and whose successful operation ultimately depends on distrust.

A core argument in this submission is that the values, norms and empathic collegialism on which the quality of life of the aged depends resides in the community and not in an impersonal mechanism which we tweak with incentives and disincentives in a crude attempt to make it do what we want it to.

Aged care is essentially a community activity. While we may delegate that activity we remain intimately involved and concerned. This is done for us. The community is the actual customer and any provider is responsible to them. If there are problems they should be monitored and mediated by a community with power - not by a distant agency restrained by rigid bureaucratic processes.

Community engagement is measured as social capital. This is the way in which this engagement allows a community to develop, build and hone values, norms and attitudes. Unless values are exercised they atrophy.

### 7.3.3 Doctors

This is another area in which belief develops a lexicon to hide reality. The word "medicalised" has been introduced and the word "patients" abandoned (admittedly it is tainted by past paternalism). Ageing is considered a normal process and not a medical condition. It should not be medicalised and by implication does not need doctors.

Well so is dying yet none of us suggests we do without palliative care. Ageing is due to the progressive failure of worn out systems not very different to failures from disease during younger years. We don't die of "old age". The vast majority of nursing home patients are there because their systems are failing. They all take medication which keeps them alive and functioning. There will be critical end of life decisions which are best made in consultation between family and a doctor who is caring for the "patient" and whom they know and trust.

Nursing home residents need a doctor more than any other members of society yet there are few doctors regularly visiting and active in nursing homes. Ideally there should be a team of doctors with an interest in aged care working under the supervision of a geriatrician. They should be responsible for the care received and would supervise and intercede when there were problems. They need somewhere to examine and treat patients. They need access to the digital world.

**The Australian Medical Association has been vocal about these deficiencies and I urge the commission to listen.**

### 7.3.4 Bureaucratisation

A bureaucratised managerial focus on efficiency and control has resulted in centralised management, centralised regulation and centralised interference. This is ill suited to a complex, individualised and scattered activity like health or aged care. Innovation is stifled and the system failures that result when local administrators respond to strong but inappropriate central pressures rather than local needs are well illustrated by the various investigations that have followed hospital scandals in Queensland – particularly the Bundaberg surgery scandal.

The folly of this is now being recognised. The AMA have argued strongly for the devolution of management of our public hospital system. They want local hospitals and staff to play a far greater role in the management of their hospitals. I believe that both major parties now realise that this is essential.

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I once worked in a 1000 bed specialist hospital with a patient load and occupancy rate that Australians could not imagine. The medical administrator running the hospital had only 2 or 3 staff. Heads of departments, including nursing, medical records, pharmacy etc. met with the administrator informally for an hour once a month over a sandwich lunch. Decisions were taken and we all went off and implemented them.

When government interfered inappropriately we took them on and they were forced to meet with us and confront our arguments. Incredibly it worked well. We won most times. We ran the hospital and had the power to confront bureaucracy and force it to debate and justify. While there were many problems inefficiency was not one of them. I am not recommending quite this level of informality!

Recent reviews of health, aged care, disabilities and other services in Australia reveal that people are falling between the cracks. It is simply not possible to bridge the gaps and coordinate these services from a central administration. The instrument is too blunt. There are multiple variables, and multiple factors operating in different regions across the country. This can only be done locally.

The focus on control and management leads to frustration and distrust in the community. On the other hand no one is more stressed than a manager who loses control of his department and what they do.

It requires courage and trust for politicians and government departments to hand control to the community. Managers have to stop managing and instead learn to facilitate, help, coordinate and advise. The need to collate and disseminate information and so draw it all together.

I am going to suggest the progressive devolution of complaints resolution, data collection, oversight and coordination of services to community based organizations. Will we have to sacrifice some efficiency? Maybe! but when we look at what happens now, maybe not much.

### 7.3.5 Risk, volunteers and life

Life is a risky business. We cannot lead a fulfilling life, partake in outdoor activities, play sport without risking injury and occasionally death. We can learn to be sensible and to take precautions but the quality of our life would be irreparably damaged if we were prohibited from taking any risks. But we do this to the elderly.

The aged are at greater risk but stopping them from taking those risks can and does impact on the quality of their lives. There are many common sense steps we take to protect them but when these impact on the quality of their lives there has to be compromise. The rising tide of litigation compounds this problem. Every facility is scared of this and the newspaper publicity that follows adverse events compounds the problem.

There is a real dilemma here. It impacts on volunteers and on the involvement of the community in nursing homes. While minimally skilled employees are covered by insurance and some legal protection, volunteers are not.

While many of them may have cared for frail elderly at home, and be skilled, they pose a legal risk to the owners of the home if anything goes wrong. Yet these people bring a level of empathy, and a collegiality into this nursing home community. They form a link to the wider community. They have time – a precious commodity. Many nursing homes feel threatened by the risks and try to discourage them.

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The following example illustrates the problems with top down management.

In a day care centre for people with dementia those attending were involved in activities with which they were familiar - things they had done all their lives. Men who no longer remembered what they had been doing a few minutes before would happily spend all day sweeping up leaves. The women enjoyed cooking and this was supervised by an occupational therapist.

Health and safety became alarmed by this. They considered that this created a risk of cross infection. Instructions coming down the system required all participants wear gloves. The activity immediately became artificial and unfamiliar so was abandoned. It seems staff could not be trusted to supervise hand washing before cooking and so reduce risk. It had to be regulated from on top.

Stephen Judd from Hammond Care has delivered a paper<sup>62</sup> that elegantly exposed the way in which the system we have has desensitised providers and depersonalised residents as they are handled by the bureaucratised system.

These are all problems that need to be confronted and sensible compromises reached – compromises that are mediated at the coal face not in distant offices.

The productivity commission can help by advising changes that empower those most involved.

### 7.3.6 Takeovers and Mergers

I did look briefly at some of the problems in retirement villages in 2006 but have not followed that up<sup>63</sup>. There were clearly many problems with contracts between management and residents. There were concerns that vulnerable people were sometimes exploited.

Residents in nursing homes, retirement villages and even those receiving care from a commercial entity face a number of risks.

Those who know the ropes advise every potential “customer” to seek expert legal advice and to insert additional clauses that will protect them<sup>64</sup>. Those who provide services can no longer be trusted.

The expectation that providers can be trusted, integral to the idea of probity, has gone out the window. Those who have been forced to protect themselves through regulators or the courts have found them resistant and lethargic in responding. Elderly people in retirement villages who have enough money to do so have had to abandon a fulfilling retirement in order to fight protracted court battles. Submission 89<sup>65</sup> describes one of these. Nursing home residents don't live long enough and families have to deal with the mess.

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<sup>62</sup> The Lost Citizens? The Erosion of Rights of Older Citizens:  
[www.agedcarecrisis.com/news/3995-aged-care-residents-voiceless-citizens](http://www.agedcarecrisis.com/news/3995-aged-care-residents-voiceless-citizens) and  
Full speech:  [www.agedcarecrisis.com/images/stories/Citizenship\\_Erosion\\_of\\_Rights\\_2010.pdf](http://www.agedcarecrisis.com/images/stories/Citizenship_Erosion_of_Rights_2010.pdf)

<sup>63</sup> Retirement Villages in Australia [www.corpmedinfo.com/retirevillages.html](http://www.corpmedinfo.com/retirevillages.html)

<sup>64</sup> Residential care agreements [www.elderlaw.com.au/articles/52-residential-care-agreements](http://www.elderlaw.com.au/articles/52-residential-care-agreements)

<sup>65</sup> Submission 89: Mr Neville Carnegie  [www.pc.gov.au/\\_data/assets/pdf\\_file/0013/100372/sub089.pdf](http://www.pc.gov.au/_data/assets/pdf_file/0013/100372/sub089.pdf)

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These risks confront even those who have been diligent in searching out a provider who actually cared and could be trusted. They have taken every precaution. Financial pressures, personal circumstances or lucrative offers may cause this trusted provider to put the nursing home on the market. The new owner can be a very different kettle of fish.

Typical is a retirement village<sup>66</sup> where very diligent 60 and 70 year olds carefully vetted the owner and settled in happily. Only a few years later the retirement village was acquired by a commercially aggressive corporate entity – one who had very different ambitions for the property. The next 20 years were spent fighting through tribunals and the courts. Now in their 90's they have finally been successful in getting some justice and their money refunded. Few would have the financial resources or the longevity to accomplish this. This must happen far more often than we think.

Community processes, and social control are far more sensitive, cheaper, and more effective than blunderbuss regulations and the courts. In a civil society<sup>67</sup> issues are resolved and the courts infrequently needed.

If the real partner and the customer in this endeavour had been the community and not the individuals, and if that community had real power – leverage – (*Ref: [Leverage](#)*) then it is likely that this organization would have been sanctioned and pressured to bring it into line years ago. Instead the retirement group that tried to support them was powerless and when they published they were threatened with a defamation suit.

### 7.3.7 Private Equity

As I indicated earlier the primary focus of market listed entities is profitability. This is the only reason that they enter the retirement or nursing home sectors – why they are there.

Private equity groups are even more aggressively focused on short term profitability. They are motivated to squeeze the system for profits so that they can sell at a profit and walk away.

In both situations money managers distant from the coal face make top-down financial decisions with little understanding of the consequences for the patients or residents that the sector is supposed to serve.

I have been critical and have opposed the involvement of these groups for some 15 years and have had some success in limiting the activities in Australia of some of the worst multinationals by working through state probity regulations. This has had no impact on government policy or practices.

It is clear that our politicians only a few weeks ago were going to turn a blind eye and allow a giant but recurrently deviant multinational, that we had already ejected once to return and dominate our hospital system. The reaction of sections of the community and the press so close to the election may have contributed to their withdrawal. Instead a massive multinational private equity group bought Healthscope, Australia's second largest health care company.

There can be little doubt that if the Australian community were well informed and actually engaged the issue, few would approve of this purchase.

We have a top down form of democracy in which the community has no power to influence individual issues – unless they can persuade some politician or media mogul to beat it up into a political issue.

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<sup>66</sup> Milstern Health Care - Retirement Villages [www.corpmedinfo.com/nh\\_milstern.html#Retirement%20villages](http://www.corpmedinfo.com/nh_milstern.html#Retirement%20villages)

<sup>67</sup> "A Truly Civil Society" by Eva Cox – ABC Boyer Lectures 1995

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We have to accept a political package of different policies, not someone we can mediate different decisions with. There is not much incentive to get involved. Citizens feel disillusioned and disempowered. Many don't want to vote and certainly not for the major parties.

Two submissions, one mine, were made to the Inquiry into Private Equity<sup>68</sup> in 2007, seeking some sort of restriction on the activities of private equity in health and aged care. Our concerns were discounted.

Within weeks the New York Times published an expose<sup>69</sup> of the behaviour of private equity groups in the nursing home sector. In Australia the NSW Pensioners and Superannuants Association has recently drawn attention to the disturbing cluster of AMP owned nursing homes that have failed even Australia's accreditation system<sup>70</sup>.

These large groups have the resources to have a unit of trained people who can move around and spruce up a nursing home before the creditors arrive. Is this gaming the system or legitimate staff training?

Private equity groups now own a majority of private for-profit nursing homes in Australia<sup>71</sup>. What happens in the homes depends very much on the financial decisions they make and pass down the system. It is a top down process. The horse has bolted and it is too late to keep them out. We must devise some other strategy to contain the consequences. This submission is interested in that.

### 7.3.8 Approved provider status

To understand and address this issue we need to start again by looking at where we have come from. We have come from a system that had certain expectations of providers – we called it probity.

#### 7.3.8.1 Probity legislation

In the health and aged care sector the primary and most important ethic is that the carer puts the interests and welfare of the patient/resident first. Every member of the community expects this.

We can define probity<sup>72</sup> as the opinion of a reasonable person, in possession of the facts, that the applicant, whether person or company, can be expected to behave responsibly - as that is understood by the community to be served.

In this instance whether they can be trusted to put the interests of the sick or frail person ahead of their own financial interest. The idea is applied in situations where citizens are so vulnerable that their protection takes precedence over rights that the applicant would otherwise have. Probity legislation was the legislative endorsement of 2500 years of professional and community experience.

Every market listed entity and its employees have a fiduciary duty to put the interests of its shareholders first. Big corporations make assertions that suggest otherwise but even a cursory examination comparing their advertisements and public statements with the information given and promises made to shareholders shows that this is not so.

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<sup>68</sup> Private equity investment in Australia - The Senate Standing Committee on Economics (August 2007): [www.corpmedinfo.com/agereport2007b.html](http://www.corpmedinfo.com/agereport2007b.html)

<sup>69</sup> More Profit and Less Nursing at Many Homes Sunday, 23 September 2007 10:00 *The New York Times*: Charles Duhigg: [www.agedcarecrisis.com/news/2264-more-profit-and-less-nursing-at-many-homes](http://www.agedcarecrisis.com/news/2264-more-profit-and-less-nursing-at-many-homes)

<sup>70</sup> Aged Care Disgrace NSW Pensioners and Superannuants Association: [www.cpsa.org.au/VOICE/article.php?id=516](http://www.cpsa.org.au/VOICE/article.php?id=516)

<sup>71</sup> Private Equity - Banks, Trusts and Financiers invest in Australian Aged Care: [www.corpmedinfo.com/austrbanks.html](http://www.corpmedinfo.com/austrbanks.html)

<sup>72</sup> Some thoughts about Probity: [www.corpmedinfo.com/probity.html](http://www.corpmedinfo.com/probity.html)

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The responsibilities and pressures on staff to put profitability first are even stronger in private equity groups. This is well illustrated by comments made by the manager of one of the biggest private equity groups in Australia, CVC Asia Pacific, a Citigroup subsidiary. It has bought up, made profitable and then sold hospitals and nursing homes in Australia. How does it make nursing homes so profitable that they can be sold at a massive profit?

I quote from the Sydney Morning Herald:

Mackenzie (CVC Asia Pacific CEO) flogged them to the British health giant BUPA for \$1.225 billion, or a 67 per cent return in 12 months. We're told CVC is "delighted" with the price it extracted from being so attentive to the needs of the oldies in God's waiting room.<sup>73</sup>

Strictly speaking then neither market listed companies nor private equity could be considered to be "fit and proper" for the sector. Neither can be trusted to put patients first. In the early part of the 20<sup>th</sup> century they would not have been considered suitable. Community distaste as much as regulation would have kept them out.

### 7.3.8.2 Probity and economic rationalists

This poses a great difficulty for a country and a government determined to fund its health care system from the marketplace. As with every ideological process contradictory evidence and thinking was buried and not discussed. The process was driven by political rhetoric and spin – not informed debate.

State probity regulations were not designed to deal with multinationals and with the exception of Victoria are almost impossible to enforce. Only Victoria has used the legislation to bar first Tenet in 1994 and then Sun Healthcare in 1998.

The legislation, particularly in NSW, has nevertheless provided a focus to bring the companies to the table and make them confront their practices. NSW was able to inconveniently sit on license applications and procrastinate. Both Tenet (at the time operating as NME) in 1993 and Citigroup in 2003/4 had to accept additional conditions to their hospital licenses<sup>74,75</sup>. Despite the problems our probity requirements have been a barrier to some of the largest, most ruthless and fraud prone multinationals in the world.

The importance of corporate culture as revealed by past conduct and business practices were recognised in probity determinations. A critical factor in deciding whether to grant licences to operate was the issue of control as reflected in the shareholding. Both Tenet/NME and Sun Healthcare had too large a controlling share holding and were barred in Victoria. NSW imposed conditions on Tenet/NME that included limiting its control so that Australian shareholders could always block any decision. This made the point even though there was no prospect of this, given the local company's indebtedness to Tenet.

While the expectation enshrined in probity regulations remains strong in the community, the government of the day has to express allegiance to them. To fund its system it must encourage and support massive groups whose primary commitment, quite explicitly stated, is to profit.

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<sup>73</sup> "Love splits, right down the middle" Sydney Morning Herald October 4, 2007

<sup>74</sup> **Navigate to:** Section 6 "Australia's Response to NME": [www.corpmedinfo.com/corpmed.html](http://www.corpmedinfo.com/corpmed.html)

<sup>75</sup> Affinity Health Hospital Licenses: [www.corpmedinfo.com/affinity\\_hlth\\_licenses.html](http://www.corpmedinfo.com/affinity_hlth_licenses.html)

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This is the paradigm conflict that lies at the heart of health and aged care policy. The one thing ideologists will not do is to confront this and argue it with the community. They will do anything but.

### 7.3.8.3 Abolishing Probity

The federal government resolved its dilemma in aged care in 1997 by removing the probity requirement, and it did so without telling the public. The opposition turned a blind eye. I only discovered this in 1999 when I attempted to use it to bar the US nursing home deviant Sun Healthcare from entering aged care. We had already been successful in Victoria so their lack of probity was established.

I challenged the government on this at the time and we corresponded<sup>76</sup>. I eventually received a definitive assurance that the new approved provider process was designed, and would ensure, that only companies that were "suitable" would be allowed to provide care.

### 7.3.8.4 The approved provider legislation

I only discovered in 2007 that this was blatantly dishonest in the first place and secondly that the definition of suitable in the department was unique. I had lodged an objection to the purchase by a Citigroup subsidiary, whose probity had already been found questionable in NSW, of Amity one of our largest nursing home chains. I challenged its suitability on the basis of the group's well documented culture. This had encouraged the exploitation of thousands it was pledged to serve.

It seems that suitability had more to do with financial stability so that the government would not be plunged into an expensive rescue exercise. It had little to do with conduct. Provided they undertook to tick the accreditation boxes they were in. Accreditation was the only control exerted.

I did not get even an acknowledgement for months – until it was all over. The lie was exposed. The department was forced to acknowledge that Citigroup had never applied for approved provider status. It did not have to. The approved provider status was attached to the group that was being purchased and went with the sale. This was even though Citigroup had total control. Any corporate miscreant, anywhere in the world could buy some nursing homes even though the seller might rack up the price a bit. Approval status was now a commodity that could be sold.

I took this issue up with politicians across the country and secured a promise from both the ministers for health and for ageing to address the issue. They lost the 2007 election and the new labor minister sat on her hands and avoided the issue.

The new minister produced a bill in late 2008 that she claimed would address deficiencies in evaluating the suitability of owners. I did not think that the legislation would do so adequately and I made a submission to the senate review of the legislation<sup>77</sup>. The bill was passed.

As far as I can ascertain the bill does require that the managers, actually managing the operating company, do not have a criminal history. It does not seem to consider corporate culture nor the track record of the holding company and its executives. The changes are minor and big private equity groups can still buy their approved provider status with the nursing homes to which they are attached.

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<sup>76</sup> Correspondence about Aged Care 1998/9: [www.corpmedinfo.com/agedcorresp\\_1999.html](http://www.corpmedinfo.com/agedcorresp_1999.html)

<sup>77</sup> Aged Care Amendment (2008 Measures No. 2) Bill 2008 [Provisions] - The Senate Standing Committee on Community Affairs (November 2008): [www.corpmedinfo.com/agereport2008.html](http://www.corpmedinfo.com/agereport2008.html)

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A related issue I raised in my submission was the conduct of companies with multiple businesses. Companies that behave appallingly in one of their businesses (eg. retirement villages) can continue to operate nursing homes in spite of past failures, provided that they have currently ticked all of the accreditation boxes.

I tested this issue by lodging an objection to an operator of nursing homes asking for an investigation of multiple reports and documents relating to its conduct in a closely related sector. The department responded by indicating that it did not have the power to investigate and that I should use other channels.

### 7.3.8.5 Comment

This rather long winded saga does illustrate very well the regulatory morass that develops when paradigm conflicts are created. I ask the commission to examine the issues to see if it can find a way through that will actually protect us from rogue operators. Given the established paradigms dominating globalisation, and the lobbying power of the market, I do not see any political will developing for a long time.

As indicated I would like to see a form of bottom up democracy in which society generates the sort of social pressures that make regulatory intervention only a last resort. At present that is not possible.

### 7.3.9 Bonds

Means tested accommodation bonds were introduced for all nursing homes by the government in 1997 but there was such a large public backlash that they quickly modified this and only low care residents were made to pay these. The industry have lobbied and politicians have wanted to reintroduce them for high care ever since but have not had the courage to do so.

#### 7.3.9.1 Distorting access

I have a number of concerns about these bonds and the way they operate. As I understand it from Hogan's report this is done by bargaining – a market principle. I don't see a level field here and I see the potential for gullible or confused oldies, who have not heard about "buyer beware" being misused. None of us know what goes on until we get there.

Submission 58<sup>78</sup> to the commission elegantly describes the issues in regard to bonds. This submission describing how one facility operates is insightful and representative of many accounts. It elegantly complements what I am saying and what Stephen Judd said in his Sydney Morning Herald article<sup>79</sup> "When I'm old I'll still want soft poached eggs" on 10th July 2010. This lady was wealthy. Most would be less fortunate and their families could not make the points as elegantly.

What I do see and understand is occurring is cherry picking. From what I infer from his report Hogan seemed to either know that it was occurring or knew that it would. It did not seem to bother him. Cherry picking means that people who have money are sought out and given the places of those who don't have money. These are the people who through no fault of their own have not benefited from our financial boom. In March 2008 the Senate Standing Committee on Community Affairs inquiry, "A decent quality of life", found that there were a large number of citizens needing help.

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<sup>78</sup> Submission 58: Name withheld  [www.pc.gov.au/data/assets/pdf\\_file/0009/100134/sub058.pdf](http://www.pc.gov.au/data/assets/pdf_file/0009/100134/sub058.pdf)

<sup>79</sup> When I'm old I'll still want soft poached eggs - Sydney Morning Herald July 10, 2010: [www.smh.com.au/opinion/society-and-culture/when-im-old-ill-still-want-soft-poached-eggs-20100709-103xk.html](http://www.smh.com.au/opinion/society-and-culture/when-im-old-ill-still-want-soft-poached-eggs-20100709-103xk.html)

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In addition, reports have documented that not-for-profit groups operating in rural or poorer communities suffer financially because they get very little income from bonds. The for-profit groups that operate primarily in wealthy sectors get the money to expand and increasingly dominate. The poor who need it don't get help from the system.

Cherry Picking is anathema in the health care sector. It was one of the reasons why doctors took their patients and walked away from Mayne Health in 2003 almost bankrupting the company and forcing it to sell its hospitals<sup>80</sup>.

The next step in this sort of competitive marketing is for nursing homes to pay assessors a commission for referring a resident able to pay a big bond to their home. This is perfectly legal in Australia if you are not a doctor. Most financial advisers make their money by doing this. It is responsible for many of the financial scandals that have rorted thousands of Australians. Many lost their life savings so wont be able to pay bonds and be rorted again.

I strongly suspect but I cannot be certain that this is already happening in aged care in Australia. I would be surprised if it were not.

The final step in this marketing process is for bounty hunters to emerge. These groups will go through the community identifying seniors able to pay big bonds. They will persuade them and their families to opt for nursing home care rather than community care at home. This is probably illegal but is difficult to detect.

It may become a problem when the age care curve passes its peak and there are empty beds. This happened in psychiatry across the USA and multiple groups participated.

### 7.3.9.2 The impact on families

The second problem I have is with the impact on families. Families or equivalent relationships are the closely knit units that form the core component of any community. They work to together and form financial arrangements to help one another. When one member of a family has to go into a nursing home the requirement to produce a large bond can seriously disrupt the lives of multiple people.

I do not have an issue with those who can afford it paying whatever rent is required to cover costs and to pay for expanding the sector. There is no issue about means testing with the government picking up some of the rent when here will be hardship.

With bonds families are asked to find a large sum to give to groups they have every reason to distrust. There can be a serious disruption of long term family arrangements or businesses. If we are realistic, that family member is likely to have a short stay in high care, so the benefit to providers is limited, yet the family can be dislocated.

This breaches the fundamental principle that we pay for what we get and that it is transparent. We don't pay for something we may or may not want. There are perfectly good rental arrangements that we all enter into regularly. Why can't we pay – even pay well for what we are getting. Its up to the family to decide whether they will pay out of income, gradually reduce assets, or borrow against them to meet the payments.

At the very least we should all be allowed to choose. If the government wants providers to spend more of that income on new facilities then it must require them to do so.

Bonds distort the way the sector operates. If possible we should do without them. I urge the commission to try to find a way of doing so.

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<sup>80</sup> Mayne Crashes 2002 and 2003: [www.corpmedinfo.com/maynecrashes.html](http://www.corpmedinfo.com/maynecrashes.html)

## 8 Summarising all this

There is widespread agreement that there are serious problems in aged care in Australia. I have examined the system exploring the reasons for this.

I have traced the development of a system that, with the best of intentions, has been subjected to an ideology that ignored over 2000 years of experience. The thinking directly contradicted and challenged that best suited to the sector and expected by the community. This created a paradigm conflict. The consequences were

1. Individuals were challenged and pressured. Because of this the least suited people and those furthest from the coal face become managers. Those who could not do what was asked of them went elsewhere. Staff at the coalface became alienated and lost motivation. Many left and fewer entered so aggravating staff shortages and depleting skills. This is something that suited some providers to the extent that some encouraged it. There was a strong disincentive for managers to go looking for more staff.
2. The collection of information that might be used to challenge what was being done was frustrated. Providers were no longer required to disclose what they did with taxpayers money and be accountable to taxpayers and their representatives.

Nursing ratios, a key pointer to failures in care, were kept secret.

A system of oversight, regulation and sanction that measured what was actually happening was abolished. This was replaced by a process designed to help those who were motivated to improve care but it did not measure failures in care so did not know if it did so.

This was misapplied as a means of oversight, regulation and sanction. It was not designed for this or to detect those who wanted to game the system. It measured processes and not results and this was done on rare and well announced occasions. The information it collected was largely meaningless to anyone else. Almost every home got full marks and no analysis could be performed using the information.

Nurses aptly described it as a farce and there are multiple instances when homes recently awarded full marks were found to be providing totally unacceptable care.

As a consequence of the lack of information few meaningful conclusions could, or have, been drawn about the sectors financial performance or the standards of care provided. This has not stopped some from doing so.

3. There is a complaints system that does not work.
4. The not-for-profit system which arose in the community and embodied its values was forced to operate in an environment and manner that challenged and contradicted them.
5. The community, which initiated and was once the backbone of aged care has been disempowered, disenfranchised and sidelined. Instead they are sold care packages.
6. As those in nursing homes have become older and sicker, needing more care they have been demedicalised and treated by fewer nurses and by assistants with very limited training. Doctors are in very short supply and few visit patients in nursing homes.

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7. Increasing bureaucratisation has created a top down system where one size fits all regulations frustrate everyone and interfere with the quality of life. A growing fear of litigation and an obsession with risk avoidance have skewed the system to the extent that directives intrude into the quality of life of residents and drive volunteers away.
8. The commercial nature of the sector and the encouragement of acquisitive entrepreneurs places retirees and residents at risk. After carefully selecting a provider they like and can trust some find themselves in the hands of a rogue operator who turns the rest of their lives into a nightmare.
9. Politicians have encouraged market listed and private equity groups to fund our aged care system. Their reason for agreeing is the opportunity to squeeze profit from the money provided for care. In the USA both have been found to provide inferior care. In Australia there are pointers to indicate that this is so but the absence of any useful information makes it impossible to tell.
10. The 2000 year old practice of protecting the vulnerable by monitoring probity (trustworthiness) has been abolished and replaced by a system that permits rogue operators to enter the system and remain there provided they can tick accreditation boxes.
11. A system of bonds replaced payment for services. This encourages cherry picking, kickbacks and ultimately bounty hunting. These distort the system and undermine our commitment to equity. In the health care context this is unethical and dysfunctional. The extent to which this has happened is not known.
12. There has been a growing divergence in the views of many. Management and politicians have positive views. Many of those at the coal face, those families who have had problems and those who have studied the system and sought information have become increasingly disenchanted. They have negative views. The trust and trustworthiness on which a system like this depends has broken down.
13. There have been a succession of aged care scandals over the years. In each instance self interested parties have forcefully asserted that we have one of the best systems in the world and that these are rare isolated events.

The likelihood that these are really red flags pointing to a wider malaise is strongly denied but is supported by accounts from nurses at the coal face and by newspaper reporters who have gone under cover into the nursing homes of some of our biggest and most credible operators.

In spite of millions of dollars spent over the years we don't have the information to tell us what is really happening - a telling indictment of a system whose ideological position is justified by claims of constant re-evaluation and ever increasing efficiency.

I have described a system that, with the best of intentions, has been designed not to work. It is fatally flawed. Every means of getting the sort of information from it that might give an indication of how well it is doing or how badly it has failed has been closed off. It is clear that there have been a significant number of serious failures, many of which have first been exposed by a dramatic event, by staff or a resident's family speaking out. The accreditation agency has been slow to detect problems.

I have looked at the aged care system through the lens of a set of ideas in order to highlight some fundamental issues which others are unlikely to do. This provides only a limited insight and there are other explanations and other factors operating that are also important. They all go to make a whole. Others will undoubtedly put these perspectives to the committee. I have not for example dealt with the poor pay, the disparity in nurses salary and their working conditions. These are very important practical issues and there are many more. Others will canvas them.

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My description suggests that our system should be a disaster and the public in uproar. I am not advocating determinism (*Ref: [Determinism](#)*). I leave that to the behaviourists. People are reflective beings. They can and often do behave very differently and for a variety of reasons.

In fact many nursing homes must provide good care and clearly large sections of the population are satisfied. Whether this is because they do not have the knowledge and are trusting, or whether care is adequate is not known. Even today many still trust the expert and believe what they are told.

**The real tragedy of our system is that this is all speculation. We simply don't know because we do not look. The public do not have access to information, nor are they able to collect and analyse it. Even those who put this system in place are unable to do so, but that is to be expected as this was created so that they would never know.**

That good care is still provided should not surprise us. In discussing professionalism elsewhere I have pointed out that I am not the first to describe the way that the medical profession, members of the affected society, have repeatedly bent before a succession of ideological pressures; often with sad consequences for their patients. In spite of this most at the coalface have continued to do the best they could in the face of obstacles. As each ideology passed on, and was replaced with another, ethical structures were re-established and reaffirmed.

Community values, empathy, and in Australia mateship are such basic community values that they are enduring and resilient. While rogue organizations and sociopathic individuals are much more likely to flourish and cause serious problems when there are paradigm conflicts, a large number of individuals, including managers will respond to the needs of others and do the best they can even in the face of monumental difficulties. The families of residents in some of the worst and most understaffed facilities describe how nurses have stayed on and struggled to do the best they could under very difficult circumstances.

I will use the view through my lens to propose changes that are based on the insights they provide. These are not the only insights. I would like them to be criticised from multiple other points of view, added to, subtracted from, combined with, set against and ultimately become part of a way forward that stands up or at least is a reasonable compromise.

There are no grounds for complacency but we do need careful and considered changes and not slick quick fixes. The most important priority is the establishment of a reliable means of collecting real information. Next we need to find some way to restore trust and create shared understandings. We should have a clear idea of what the core problems are, rather than the symptoms. We need an idea of the sort of system we want. We need to move steadily in that direction step by step, trying each, evaluating carefully and then either trying something else or moving to the next step. The last thing we need is more catch phrases, more grandstanding and a grand reform plan built around some simplistic logo.

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In order to address the problems identified, I have suggested a community focused structure which takes important functions from bureaucracy and places them in the ambit of local communities with access to nursing homes and so empowers them.

An open, bottom up structure replaces an essentially dysfunctional, secretive, top down system that has not worked. I suspect that like democracy itself this is an ideal that we will struggle to approach and always fall slightly short of. Like democracy I would expect it to be much better than the "totalitarian" equivalent which it would replace.

## 9 Steps to change

### 9.1 A starting point

Making change requires a realistic assessment of where we are today. We cannot return to an idealised past or turn the clock back to old practices and solutions. But we must learn from them.

We currently have an aged care system where private equity and other corporate groups comprise a very large slice of the sector. They entered because they were promised a profit and if they don't get it they will walk away. This will be a disaster. They are a powerful lobby group with enormous leverage over politicians. They have already started promoting their grand plan<sup>81</sup> and putting pressure on government. We have seen that the mining lobby was able to bring down a government. These groups could too. In a very real sense they have the minister on a leash. They can and do get her to do what they want.

Like it or not, providers need to be persuaded that what the community wants does not threaten their future profitability. But this is a market. Leverage and not logical argument are required. They want more money but in return they must give Australian citizens what they want – the right and the power to argue with them and get their way when they are correct.

At this time the providers are not making the profit they think that they should. If they want more money they must tell us exactly what they are doing with our money and account for it fully. Not a small self selected proportion of homes offering up some unverifiable financial accounts behind closed doors - but a full public disclosure. This is not like every other market. The rules are different. We as a democratic community set the rules. They need to make their case to us.

Like it or not, and I have opposed it for years, we now have a market system of sorts and I must accept that you cannot go back. We have to live with it, identify its weaknesses and actually deal with them.

In truth we have always had a market system of sorts but it has been subservient to the community and its ethics. It has been modified and controlled. The people who could operate there were limited. But that option has gone.

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<sup>81</sup> The Grand Plan: [www.thegrandplan.com.au](http://www.thegrandplan.com.au)

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### 9.2 A model to emulate already exists in Australia

We actually have a very good example of how to limit the adverse consequences of a market for vulnerable citizens. We can compare our own health system and contrast this with that in the USA. I am going to look at this carefully.

#### 9.2.1 What happened in the USA

Joseph Califano a health care adviser to President Ronald Reagan in the 1980s believed that the doctors were the root cause of all their problems and the rising cost of health care<sup>82</sup>. While he was at best only partly correct in this, he correctly realised that if you controlled doctors incomes and their careers - the future well being of their families - you could make them do what you wanted them to. He wrote a book about it. Doctors were trapped into managed care contracts. Big companies entered into contracts that rewarded those doctors who complied and sanctioned those who did not.

In some instances companies actually took control of the assessment and admission of patients to hospital. They drummed up admissions running scare campaigns, offering free health assessments and encouraging bounty hunters to bring in patients. After filtering out the uninsured poor and sending them home, the patients were allocated to those doctors who did what was expected of them. They were to order vast amounts of expensive treatment given by the hospital and to keep the patients in hospital as long as the patients medical insurance kept paying. Similar things happened in multiple companies and in multiple US states<sup>83</sup>.

Some doctors capitalised on this and became wealthy, others wisely lay low, and those who few who were foolish and conscientious spoke out. They became poor, destroyed their careers and were so vilified that they were powerless.

Not only did this actually happen but management and large numbers of staff - even doctors - came to believe in what they were doing, that this was the best way to provide care and that they were doing well. They were proud of their companies and boasted. They were incredible and disbelieving when the public revolted. They could not believe it. They were so convinced that what they were doing was the right way to go that, even after criminal convictions, they did it all over again 10 years later. The conceptual lens I have used helps to understand how this happened.

#### 9.2.2 What happened in the Australia

I went to the USA in 1993 where I met with many of those involved and met with investigators. I saw large numbers of internal documents and brought many back. I subsequently spoke at meetings with specialists using the documents so they understood.

At the same time doctors had visited the USA and spoken to colleagues so knew what had happened and the plight they found themselves in. Those who played the game were very wealthy. Those whose consciences would not allow this starved.

I was told that the minister and his advisers had Califano's book and were promoting Califano's views. The doctors had obtained a copy and lent it to me.

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<sup>82</sup> Joseph Califano and the Market Revolution [www.corpmedinfo.com/califano.html](http://www.corpmedinfo.com/califano.html)

<sup>83</sup> "Profits of misery: How Inpatient Psychiatric Treatment Bilks the System and Betrays our trust" Hearing before the select committee on Children, youth and families, House of Representatives, Hearing Held in Washington, DC, April, 28, 1992 US Government Printing Office, Washington

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In the late 1990s, the minister for health, Michael Wooldridge joined with AXA and Mayne Health, a company that had adopted similar thinking to the still very credible US giant Columbia/HCA and advocated a similar slick “one stop” commercial model of care. (How odd that the current aged care minister is now offering aged care a “one stop” system!) Columbia/HCA was about to enter Australia but its credibility and ambitions collapsed as a \$US 1.7 billion fraud was exposed.

Wooldridge, AXA and Mayne now attempted to induce doctors to enter into contracts with Mayne and AXA. The doctors rallied behind the slogan of “No managed care” and stood firm. They were vilified and attacked in a media campaign. Their public image was damaged. Wooldridge threatened legislation to force them but the doctors legal opinion was that this breached our constitution. Relations between government and the Medical Association broke down and Wooldridge destroyed his political career. Government policy did not change.

### 9.2.3 The consequences

What Wooldridge, AXA and Mayne had done was to create an integrated, powerful and hostile block of professionals who had rallied behind and so reinvigorated professional values and the professional paradigm. They had looked closely at where policy was going and did not like it.

Incredibly Mayne now brought in a Mr Fixit and he tried to impose Mayne's planned commercial strategies on doctors unilaterally. Some of these were blatantly unethical in the medical sphere. Others compromised care and interfered with the way doctors ran their practices. Doctors simply walked away and took their patients to other hospitals. Mayne collapsed, sold all its hospitals and broke up.

### 9.2.4 The model that eventuated

What the doctors had established was that they had economic leverage and that they were prepared to use it. But at the same time the specialists and the business managers were inseparably locked into a shared project. They had to confront the paradigm conflicts and neither could rationalise or justify without good reason. They had to talk and argue.

Any planned changes had to be negotiated by every manager in every hospital with every doctor. Every decision had to be argued about, justified and either rejected or modified. Professional thinking and logic had to be recognised but at the same time doctors had to allow hospitals to generate a profit. A bottom up management system had been established, not by design, but by default. Unlike the USA professional values were reinforced and remained credible.

As important is the fact that managers and doctors lived together in the same community, worked together, had to get to know each other, and had to learn to trust each other and be trusted.

I do not want to paint doctors as altruistic heroes. Their careers, their incomes, the well being of their families and the values they espoused were all threatened. That their position was in the interests of their patients and of the system made them feel altruistic about it and identify more strongly with professional altruistic values. My focus is social process. Wooldridge, AXA and Mayne were unbelievably stupid.

I do not believe that what we have is a good solution. It is a compromise. We would be better without this paradigm conflict but what we have is probably the best we could have hoped for.

We are paying a certain amount of money for what we get. I do not understand why providing a system through market mechanisms provides more care for the buck. I know this is what market moguls believe but as a simple person looking at where the money goes I remain unconvinced.

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All the information I see shows that, when you strip the silly words away, you get less for your buck. That is what I would expect. Commissioner Romanow in Canada asked the market to back up their claims and show that they could do it better. They were unable to do so and Romanow accepted the evidence advanced by analysts and critics.<sup>84</sup>

### 9.3 Applying the lesson to aged care

The purpose of this long description is to suggest that this is the best that we can hope for in aged care, at least for the foreseeable future. It is really the only option that acknowledges the problems I have identified and addresses rather than ignores them.

If we can create a powerful group who identify with our community's Samaritan values, give them real leverage, make them partners in every nursing home, turn them (not the frail elderly) into the real customers and then do this in every nursing home and every community care system then we may, if we are lucky, have a system where every decision has to be justified within both perspectives. We will have forced and established a bottoms up management system.

At first glance this may not appear to be as efficient and it challenges current managerialism's thinking. Central management have to facilitate and guide rather than decide. They have to argue with local people and persuade. If we compare it with totalitarianism and democracy we see that one is efficient and very effective in accomplishing objectives but it is dangerous and goes off the rails with awful consequences. The other seems to be inefficient, takes time, can be wasteful, and can follow winding paths, but ultimately it is the safest and best system we have. In the long run it is probably more efficient.

Technology has opened up enormous opportunities for a bottoms up consultative form of democracy and we have hardly touched its potential.

There are many difficulties to consider. There are few doctors out in the nursing homes and they do not have any leverage so we cannot look to them. We want them to be part of it but we have to turn to the community, get them into the nursing homes by giving them something important to do there, and then somehow give them the power to obstruct if they don't like what they see. We want a not-for-profit organization built around community values working in the aged care sector, and in nursing homes.

Not the least of the problems is that there is not a lot out in the community to build on – but there is a legacy. There are a number of volunteer visitor systems but we hear little from them. So either a whole new community group of interested people will have to form, have to be trained and organised, have to be motivated. Else existing groups will have to adopt new members and new areas of interest and influence. This will have to be a bottoms up movement and not a top down public relations effort. Lets look at what we have in the community.

### 9.4 The forces driving us to a decentralised system

All governments are focussing on providing more care at home and keeping people out of nursing homes. It's a wonderful idea. There are very few of us who do not want this when we get old. But it's a lot to ask.

Central planners are not confronting the changes in society that resulted in the move to institutionalisation in the first place. These have not gone away. They have grown. Families have children and both parents work.

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<sup>84</sup> "Building on Values: The Future of Health Care in Canada" Wynne & Armstrong in Health issues Journal March 2003:  [www.corpmedinfo.com/wynneandarmstrong.pdf](http://www.corpmedinfo.com/wynneandarmstrong.pdf)

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Caring for frail aged at home is going to require far more change than government envisages. It is going to require much more than glib words. It will need a level of engagement and empowerment of the community that no one has seriously addressed – and changes to the way we live.

Assistance at home, day care of all sorts, community activities where families and friends meet up and involve the elderly, sharing responsibilities with others as they do with children, and of course job sharing so that married couples can continue to work part time by sharing work and care responsibilities.

Life revolves around doing things and doing things together, and life continues to have meaning and to be worth living while we are able to do that. The pressures and rush of our capitalist world brings enormous benefits and we do define ourselves through it but it also engulfs us and restricts us.

Part of our caring is going to involve releasing people for longer periods from the whirl of the marketplace. Politicians want us to work longer and harder, but it is the younger retirees who will often offer this new time they have to the community and will seek an extended identity there.

All of this requires a coordinated and integrated but diffuse, ever varying community organization that can respond continuously to an ever changing situation. Government can facilitate and assist but it does not have the flexibility to do this itself. It really has no choice but to let go and trust. There are big risks for politicians but they have to hand it over.

Such a bottom-up (as contrasted with top-down) organization should have central representation and structure so that people with experience and knowledge become representatives, are credible, and can advise and negotiate from a position of knowledge and strength. They do need to walk the corridors of power and join with other community groups that do that.

If the productivity commission was able to find some way in which politicians in our political system can be persuaded to risk losing control over the agenda, this would be a monumental change. Democracy has been going backwards and this would be a step forward at last! Tentative steps along this path by some politicians show some willingness, but they have been ridiculed and attacked by other political opportunists.

## 9.5 Practical Suggestions

To keep it simple I am going to propose and argue for one model but it is simply representative. I will be concentrating on nursing homes but this is equally applicable to community care and I envisaging it extending to that. There needs to be a critical mass of activities in order to involve people, give a critical mass and to give stability and coherence to the community/professional paradigm we want them to use.

If they are too few and too fragmented they are likely to adopt the providers point of view and simply become a rubber stamp. It will need a core of paid staff to hold it together as well as a phalanx of volunteers and occasional expert advisors (eg doctors, nurses, social workers)

Professor Walton has recommended that complaints handling be given to an independent organization and there can be little argument about this. She has also indicated that complaints are much better managed locally and promptly.

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There can be no logical argument for keeping accreditation and oversight together. Oversight must be separated. The Retired Teachers Association submission<sup>85</sup> has placed this at the head of their submission.

I do not see how anyone can argue that someone visiting very occasionally can make a better assessment of what is happening in a nursing home than someone who is independent but actively involved in the home and visits regularly talking to residents and staff. The 2007 accreditation assessment rightly identified the difficulties in collecting data when you are not there. We are not going to get accurate data collected from an office in capital cities.

The collection of information by management is likely to be distorted by their priorities and even the assessors can have a distorted view of what is reasonable. The most accurate information will come when they negotiate and argue discrepancies. There are strong reasons for doing this locally where both have immediate access.

I do not think that there are major paradigm conflicts between complaints management, oversight and data collection. A single independent organization could embrace each of these and have staff devoted to the various activities.

### 9.5.1 Step 1 - A central guiding group

Establish an independent not-for-profit entity with directors and carefully selected managers. It will require funding. This will become the umbrella organization. It will organise, facilitate, train, and collect/analyse information. As community groups become established they will increasingly be represented centrally until community representatives from across the country control it and it becomes the forum for them to press aged care issues. They would negotiate at a corporate and government level when required.

### 9.5.2 Step 2 – Moving the focus into the community

The initiators would select a representative but manageable number of areas and contact local organizations and ask them to find and appoint interested members to a local board. They need not belong to or represent the organization appointing them. They are likely to include some active retirees. Their first task will be to find at least two but preferably more potential employees to be trained for their roles. I envisage that most will be part time, that at least one would have nurse training and that families who have had relatives in a nursing home might be interested as might younger retirees.

I would also suggest that aged care assessors deciding who qualifies for support also be local and also work closely within this group. Members of the community will know those receiving care and be able to help.

The community group would be the glue linking and smoothing the initiation and continued development of the program. As the group enlarges it will elect its own office bearers.

While they were training, these groups could start drawing together sections of the community. Pulling in volunteer groups, interested seniors, older citizens, family of current and previous residents and those who have received community care. Older people with disability have to be included and their families might participate.

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<sup>85</sup>

The Retired Teachers Association – Submission 84:

 [www.pc.gov.au/data/assets/pdf\\_file/0017/100367/sub084.pdf](http://www.pc.gov.au/data/assets/pdf_file/0017/100367/sub084.pdf)

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As well as their defined roles these people are going to organise community activities and involve seniors in them bringing nursing home or home care residents to activities or taking the activities to them. Things as diverse as retired groups doing university courses might be encouraged. They will want to maintain and foster friendships.

They are creating a community to which many aged will belong and progress from helper through to recipient as they age. Family and children will participate. It should have a broad focus and a broad brief that flows with the community.

The form and structure of any group would be determined by local needs and local thinking but it would have core functions.

The functions of the group and its employed members would extend from the community into nursing homes, hospitals and disability services with shared representation. It should be the glue coordinating and oiling the wheels so that people do not fall through the cracks.

It is important that there should be real benefits for the nursing homes and for community services. They should benefit too. I do not know enough about community services to suggest ways to fit in.

What would they do?

### 9.5.2.1 Collecting and collating financial information

A member of the group with bookkeeping and computer experience would assist the home by helping to collect record and collate information. They might need training by the owner and/or by the community group's central management. An accountant might be prepared to provide oversight. The group would be in a position to remonstrate if funds were not being directed to care services or if staffing was being underfunded. The group should recognise the need for a reasonable profit and the need for finances to grow the sector. They would be in a position to mediate with the central manager on the local managers behalf and lobby government for more funding. Financial data would be lodged and collated centrally so that the financial condition and practices would be transparent.

### 9.5.2.2 Patient Care Data Collection

The trained staff would work with staff helping them and teaching them to collect information and record it - supervising the use of technology. They would get to know the staff, the residents, and the families and would earn their trust. They would act to lubricate relationships. If staff or families have issues but fear reprisals they would be in a position to press the issues without disclosing the source. They would be in a position to protect both from reprisals. These staff would have full access to medical and nursing records checking that they are properly maintained.

The sort of information collected would not be restricted but would include a basic list.

#### 9.5.2.2.1 Objective data

With access to residents, staff and notes they would be able to collect objective data like pressure ulcers, weight loss and contractures. They would be able to look at the circumstances, decide about causes and give early feedback.

#### 9.5.2.2.2 Subjective assessment

Subjective data based on isolated observations can be very misleading. But there are many cues to what is going on when someone perceptive is there regularly. They can assess the relationships between staff, between staff and management, and with residents. What happens at meal times, at night and during activities. Are the resident's families happy and do they get on with staff and management? What is the general atmosphere like?

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The 2007 review of accreditation noted the difficulty in measuring quality of life. An astute observer meeting and talking to residents on a regular basis soon gets a very good idea of their quality of life. Its not rocket science. Its assessable.

### 9.5.2.2.3 Processes

An on site person is well placed to assess what happens when there is a failure in care. Whether the processes are in place and more importantly whether they are used and whether they work.

### 9.5.2.2.4 Handling data

As this is a cooperative effort there needs to be discussion about the data collected. There are going to be disagreements and this is why more than one person needs to be assessing and why the chairman or other manager of the local group should mediate.

### 9.5.2.2.5 Access to medical records

Clearly the employed evaluators and perhaps the chairman or an officer should have access to medical records. In disability services state voluntary visitors already have these powers legislated. A medical expert or someone from the central office may need to mediate. Other data should be de-identified.

### 9.5.2.3 Use of data

All data should be reported centrally, where it would be coordinated and analysed before being returned to the local group, and sent to the accreditation agency. Because the data is being collected continuously and is subjective as well as objective, developing problems would be flagged early and the local group would consult with the home and central supervisors with a view to calling in the accreditation agency to help. If sanctioning is to be considered this will be initiated centrally and through the department and the minister.

I am not a great fan of league tables but I am aware that others will demand this. I am passionate about collecting and displaying data so that everyone can see and watch outliers and watch to see that action is taken to bring them back. Groups and individual companies should certainly be analysed and named. Track records are essential for each nursing home and company. The community should get the information it wants and needs<sup>86</sup>.

### 9.5.2.4 Complaints Resolution and investigation

One of the important roles of the groups and the employed staff would be dealing with complaints. They would know and be trusted on all sides and they would intervene in any dispute. They will act and help residents and staff bringing them together whenever possible. They will promptly collect information, sort out what has happened and record valid complaints. The vast majority of issues should be resolved and only when this was not done would it be referred centrally. There would always be a right of appeal.

## 9.5.3 An Information Resource and advocacy

A key responsibility of the not-for-profit community group would be mentoring and assistance for prospective residents including helping them with bonds. Instead of a one stop shop there would be friendly locals known to the family. They would know what services were available. They would have all the data about local operators at their finger tips and national figures for comparison. They would be in a position to give expert local support and advice. They would provide the glue to coordinate hospital, disability services, nursing home and community.

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<sup>86</sup> "My Nursing Home": [www.agedcarecrisis.com/yoursay/3868-my-nursing-home](http://www.agedcarecrisis.com/yoursay/3868-my-nursing-home)

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An active and involved community would intervene in the situation described by Submission 58<sup>87</sup> and the chairperson would mediate.

### 9.5.4 Technology

Health and aged care have been poor cousins in the spread of technology. They have languished behind. Doctors are still required to type in notes, a system that makes it difficult to collect and analyse information.

We live in an era of WIFI, liquid paper, touch screens, buttons and sliders. There are screens you can write on in long hand. Everyone has buttons. Most nurses have digital phones with buttons to press. They text each other fluently?

Every activity and pill given can be recorded by touching a button, a value by using a slider and any qualifying comments can be written in long hand and attached. A time code ensures an accurate record and changes will also be time coded. Record keeping becomes accurate and collection and analysis can be done automatically. It might add about \$500 to the cost of each room but would save more in nurse time.

Simple call lights can send on and off signals to a computer and be logged. This is one of the most sensitive measures of care, particularly when set against the tap on the screen recording what was done in response. Its simple to do.

This is all information that any nurse manager would want to help organise staff and supervise care. It is the sort of information that any oversight body would require. Not once a year random observations but a day by day record of what is happening, collected, correlated and reported.

None of this is rocket science. It is here now, affordable and practical. It simply needs to be developed and applied.

I note with interest that the aged care sector is contracting with NEC to do all of the computing for them - outsourcing this. Lets embrace their intent with interest. I have some old fashioned reservations about the way they are approaching it and prefer a disseminated peripherally located system.

I would like to see a tablet computer next to the bed, connected by WIFI to the local desktop and then by broadband to the centre. Each separate, each doing its job, each modifiable, adjustable or replaceable without depending on the other and bringing everything down. Once again the critical component is trust. Letting it go.

## 9.6 Cost and personnel

How much will it cost and how many staff will be needed? How big should each group be? This is impossible to predict until a pilot study is done. Each will be different. They may amalgamate or separate.

I suspect that it will be relatively intense centrally and initially in each new area but would settle down with less frequent visits as time went by. Good homes will require little attention. Problem homes will be intense. It will fluctuate with staff changes, new management and new owners. As technology is adopted the load will decrease as the information will all be there. Because the group covers and coordinates all the services in the sector they can adjust to meet needs.

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<sup>87</sup> Submission 58: Name withheld  [www.pc.gov.au/data/assets/pdf\\_file/0009/100134/sub058.pdf](http://www.pc.gov.au/data/assets/pdf_file/0009/100134/sub058.pdf)

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### 9.7 The Central bodies role

**Training of local staff would be a central responsibility. Supervision and periodic visits would be very important. These would be to meet with the group, meet the managers, look at what the staff are doing and see that the same sort of assessments and ratings are conducted across the sector. Assessing how it was working and making suggestions.**

Each local assessor would have a central supervisor so would be able to consult and be supported by this person, by the chairperson of the local group and by various medical and other experts in the community.

### 9.8 Comment on the model

I have outlined an idealised system to illustrate an idea. I would not expect that we would get that all the time. What I have described is a credible and sizeable local not-for-profit group which is credible and motivated. It has influence and performs useful and important functions. It collects the data that will be used to praise, condemn or sanction. It discusses this with prospective residents and families so has the same control over admissions as doctors have. It has leverage. The group can meet with peripheral management to discuss proposed changes. If they want a good owner to continue operating they will have to allow it reasonable profit and also lobby on its behalf. We have an informed customer involved in the business and this customer has real leverage. They are interdependent and must work together.

### 9.9 But take a deep breath

It would be important to sow the seed and then let it grow returning periodically to water it and see its progress, perhaps some fertiliser every now and again. It has to be handled very carefully. It needs to be watched and nurtured. Constant but unobtrusive evaluation. A rework may be necessary with some pruning and weeding. It won't be plain sailing.

The first step would be a trial in a number of areas. Then, evaluation and some adjustment. Finally gradual expansion of the activity and a downgrading of the current system. If you implement a defined plan it will frustrate the people. It must grow locally with local input and design responding to local needs, and each will differ. Local leaders must emerge. Some will work much better than others. There will be some areas that need constant support. Occasionally the centre will have to take over and employ outside staff to do the job.

## 10 Addressing Other Issues

### 10.1 Doctors

**There is a desperate need to bring General Practitioners, geriatricians, palliative care experts, and other providers of care back into aged care. I urge the commission to work with the AMA on this issue. Families need discussions with those in the best position to make sensible decisions about practical and sensible end of life care. They need experts to fall back on.**

### 10.2 Private Equity, Mergers and Takeovers

I urge the committee to look critically and realistically at the consequence of private equity investment and of the consequences of the cycle of mergers, acquisitions and sale on the staff, the residents, the culture, and the stability of nursing homes faced by a succession of different management styles and priorities. These fly in the face, not only of 2500 years of knowledge but of everything we know about the need for stability in caring for the aged.

We cannot put the bird back into the cage, but can we put the community back in charge? Might there be some process whereby the community via the structures I have suggested be given a role in addressing these issues.

A first step would be a potted history of each owner or prospective owner describing the way it conducted its businesses elsewhere in Australia and in the world, and any legal settlements it had made. Government authorities never ever (and I **really mean never ever** because I have been watching) open their browser and put a few words into their search engines. Citizens do this all the time. A group of interested citizens would soon learn where to go and what to search for.

Not only should these issues be discussed with prospective resident's families but those monitoring the nursing homes need to be sensitised to the possibility that the homes might be at risk. We want to know a lot about the politician we make prime minister. They could take us to war and our sons be killed. The people we trust with the care of our loved ones will have a much greater impact on their lives. We need to know all about them. They also need to confront their own pasts and show us they have changed.

### 10.3 Approved Provider status

Once again the probity bird has flown. Because applicants for approved provider status are not disclosed to the public those who have information have no opportunity to supply it.

I urge the commissioners to look very closely at this. I suggest that.

1. Every party involved in management as well as any owner with more than a 20% stake should be required to seek approved provider status.
2. The names and details of every applicant should be supplied immediately to the central body of the community group. They will inform their constituency perhaps via a newsletter. A subcommittee of interested people will research the company and its officers, managers etc. It will receive any information from their branch members. Families of nursing homes will be strongly motivated to check up on prospective owners.

## Section D: Addressing the problems

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An outline of the findings and any reservations will be on the community's web site. The community group might elect to ask the company for elucidation. It will report to the government department and discussion may take place.

3. Where the committee has expressed concerns these will be put on their web site with the company profile together with the government agency's reason for granting the licence (eg. Do not have the power to refuse it)
4. The track record of any company outside aged care, whether an applicant or an established provider will be available on the web site, so that families can decide whether to trust them.

Prospective residents and their families will be in a position to look at this and discuss issues with the community advisers. The nursing home is going to be on notice to demonstrate its trustworthiness.

### 10.4 Sanctions

The community organization will be collecting and submitting results of its findings to government, and will be commenting critically on failures in care. It should have a right to make recommendations and comment in regard to sanctions or proposed sanctions, and to comment on any sanctions imposed. The government will have the right to a reply stating its reasons. Both will appear on that company and nursing home's profile on the web site.

### 10.5 The Accreditation Agency

Unless it is shown to be of no value the accreditation agency, but now supported and largely directed and funded by the industry, will continue to train and accredit nursing homes. It will ask for information from community staff who monitor homes, as well as work with and cooperate with them so taking the burden off staff. The agency will be kept in the loop and have access to all information. They should have input into decisions about sanctions as it is very likely that they may have been involved in attempted remediation.

### 10.6 Bonds

I am not in a position to make any suggestions but I urge the commission to find other ways of funding, and if there is no other way then, at a minimum provide optional alternatives, or at least find some way of making sure that unethical practices like cherry picking, legal kickbacks and bounty hunting are not profitable. Simply legislating against it has not worked elsewhere.

## 11 Summarising a way forward

I have suggested a way forward that removes

- the collection of data,
- the oversight of services,
- the handling of complaints,
- the integration of services,
- the education (advising) and support of citizens in the community, and
- perhaps the assessment of citizens eligibility for care

from centralised bureaucratic structures. I suggest that they be relocated to a community organization that operates locally but is centrally represented so able to press the issues identified at the community level. It would concentrate on integrating and serving both community and residential aged care but will link to other local services and has the potential to embrace them.

What I have suggested is based on a frame of understanding that uses the conflict between patterns of thought to analyse dysfunction. The proposal aims to create a context within which these conflicts are mediated, and in which new ideas will be critically confronted and evaluated.

It is intended to resolve many of the burdens that have plagued the industry. It should provide a venue where those who have struggled with the legalised bureaucratic wall of resistance can mediate their concerns and if they are supported drive them centrally with some hope of success. It is designed to respond to local concerns but also to mediate and promote general issues.

Such a system if it worked would resolve many of the problems we have but there would be other problems and it needs to be approached with care. If it is considered to be viable I would urge the commission to advise the government to commence a pilot project at the earliest opportunity and to evaluate it carefully in a step by step manner.

Other issues that I have addressed include:

- The urgent need and the great potential offered by technology.
- The need for a medical presence and medical supervision in the homes.
- The impact of private equity, and the consequences of takeovers
- Deficiencies in the approved provider system, and the abandonment of probity.
- The adverse societal and professional effects of bonds

## 12 Response to the Issues paper

In my criticisms I have addressed many of the matters referred to in the issues paper. Its applicability to others is obvious. It has a wider applicability in that, while not addressing all the issues it provides a forum from within which they can be addressed in an ongoing manner in the future.

The direction for aged care that I have proposed is intended to address the reasons why the system is so deficient as well as proposing a practical structure within which the services can be provided. Critically it does not see aged care as static. It supports diversity and allows innovation and change. It is a process which escapes top down centralised bureaucratic rigidity and control. It replaces it with bottom up pressures to meet changing situations. It creates a state of continuous development and renewal. Committed providers have access to assistance in managing many of their activities.

# 13 Definitions

In this submission I have used a number of analytical concepts. The defined words have the following meanings in this submission and in most of the references given. The definitions explain the relationships and the likely implications and consequences.

## **Paradigms (Thought patterns)**

The patterns of interlinked ideas we all use to give meaning to situations and conduct. They motivate people. They are underpinned by real or imagined preconceptions. These may be based on an understanding of some facet of the real world or be based on an imagined or “believed” reality.

They are the means by which we simplify, grasp and understand the complexities of the real world so that we can handle them and respond efficiently. They are also the means by which we escape reality and create the sort of “unconscious civilisation” Canadian John Ralston Saul describes<sup>88</sup>.

Typical broad examples include religions, communism, fascism, capitalism, apartheid, economic rationalism, professionalism, managerialism. Small groups and individuals adopt or develop more personal paradigms based on their own backgrounds and life experiences.

In an ideal multifaceted and stable world we would use multiple paradigms to constructively appraise each situation and evaluate the strengths and weakness of each, developing new paradigms to meet new situations. We would tolerate and confront dissonance.

In an unstable world where we are under pressure we tend to be responsive and identify with simplified paradigms. We limit dissonance by ignoring contradictions.

## **Ideology**

Many paradigms are based on experience within particular contexts. They provide a means of grasping the issues and defining ones life within that context. In this submission a paradigm becomes an ideology when it is seen to have universal relevance and to be broadly applicable to all the contexts of our lives, regardless of their suitability.

An ideology is consequently often applied as the dominant pattern of thinking in contexts in which it is inapplicable. In doing so there are logical inconsistencies and criticisms that true believers must handle. There are recognised social (eg labelling) and psychological (eg. compartmentalisation) strategies that are used to do this and to neutralise criticisms.

Individuals frequently define their lives within particular ideological patterns of thinking which become critical to their identities – who they are. They strongly defend them and promote them. An attack on the ideology is experienced as an attack on the self. Most of the paradigms listed in the previous box have become ideologies.

## **Lexicon**

The pattern of words with denotative (real logical) or associative (emotional or non logical links) meanings that each paradigm uses to describe and handle the contexts within which it operates.

Where a paradigm is applicable to a particular context the lexicon is likely to include words that have denotative meanings and which accurately reflect the situation.

Where the dominant paradigm is unsuited to the context or conflicts with another paradigm the lexicon will seek to obscure and hide the conflicts and the real situation. The lexicon is likely to be based on associative meanings and terms borrowed or adapted from other contexts.

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<sup>88</sup> “An Unconscious Civilisation” by John Ralston Saul CBC Massey Lectures 1995

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It is difficult to criticise a dysfunctional paradigm from within its own lexicon. When a dysfunctional paradigm is adopted critics lack the words and the understandings needed to confront and expose the deficiencies. It may take many years to develop these.

## Paradigm conflicts

This occurs when two or more paradigms give conflicting meanings and call for different actions that are mutually exclusive and when a paradigm requires action that is inappropriate for the context or will result in adverse outcomes. Humans can find it difficult and destabilising when they must confront insights from more than one paradigm<sup>89</sup> or do something that they should know is not what is required.

When the pressures on individuals to build their lives within one of these paradigms is strong then strategies are likely to be adopted that allow them to identify with the dominant paradigm and then ignore the insights from the conflicting paradigm as well as the consequences of their actions.

In this situation people can become desensitised. Those of us who can rationalise come to the fore. Vulnerable citizens can be exploited and fraud is more likely. Health care in the USA and the succession of Wall Street scandals are good examples.

I argue<sup>90</sup> that systems work best and people feel motivated and perform best when the paradigms are congruent and well suited to the contexts in which they are applied. In this submission I argue that when conflicting paradigms occur then the adverse consequences can be mitigated when the relative power structure of the two paradigms are balanced.

This submission argues that the introduction of and dominance of competitive corporate marketplace and managerial paradigms in aged care has created paradigm conflicts and that these lie at the root of a dysfunctional system.

## Leverage

This is the power or influence that the advocates of each paradigm bring to the table in every day activities, in discussions and in negotiations; whether this influence be economic, political or social. Strong leverage can and often does override logical argument and alternate points of view. For leverage to be effective in confronting inapplicable paradigms the groups need to be interdependent.

Because they are interdependent each group is constrained because it is forced to confront and justify their actions to the other. Excesses are prevented. A good example is hospital care in Australia where specialists maintained independence and leverage, contrasted with the USA where corporate entities gained control over doctors income and careers. They lost leverage to the corporations.

## Open Mindedness

An individual state of mind characterised by reflectiveness, and a constructive ability to handle multiple paradigms and deal with conflicts between them. Intelligence is used to identify and explore conflicts.

## Closed Mindedness

An individual state of mind characterised by responsiveness, identifying with single or limited paradigms. Intelligence is used to hide, obscure, rationalise or compartmentalise paradigm conflicts. I have used the term sociopathy to indicate the sort of extreme closed mindedness that results in serious harm to others and illustrated the consequences with examples from the health and aged care sectors.<sup>91</sup>

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Open and Closed mindedness can be both individual and group characteristics. Most of us lie along a spectrum between the two extremes. While individuals may be characterised by a position on this spectrum

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<sup>89</sup> "Reframing the debate on health care reform by replacing our metaphors" by Annas G. J. - N Engl J Med 1995; 332:744

<sup>90</sup> Understanding the Corporatisation of Health Care [www.corpmedinfo.com/understanding.html](http://www.corpmedinfo.com/understanding.html)

<sup>91</sup> Introduction to Sociopathy [www.corpmedinfo.com/sociopathy.html](http://www.corpmedinfo.com/sociopathy.html)

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they also move freely along it displaying different characteristics in different contexts and at different times. Multiple factors impact on this. Dissonance usually but not always pushes us towards closed mindedness.

### Dissonance:

This is the mental discomfort felt when paradigm conflicts are faced and/or when a paradigm is unsuited to the context and inappropriate actions result.

### Alienation

This describes the inability of individuals to identify with what they are doing. It embraces the anger, frustration, depression and despair individuals experience when they are forced to act within a dominant paradigm that is unsuited to the context. This is especially so when there are negative consequences and outcomes, readily understood within alternative paradigms.

### Contexts

The situations in which individuals find themselves and in which they must build their lives and create meaning. They act and justify their actions using the paradigms they bring with them. They may develop new paradigms in these contexts.

Success in each context will be defined by the dominant paradigm. Where an ill suited paradigm is dominant then there will be tensions and participants will experience dissonance. Those who most readily manage this dissonance and can do whatever it takes with complete conviction are likely to be successful.

Closed minded people generally accomplish this most successfully. Individuals and groups move towards the closed minded end of the spectrum. They are likely to be poorly suited to operate in this context and dysfunction is likely.

Contexts used in this submission include the marketplace, health and aged care, the community, hospitals, nursing homes etc. Each may be understood using multiple patterns of interlinked unique, related or conflicting paradigms.

### A Divide in Perceptions

I have argued that when a paradigm conflict exists and when one paradigm dominates and the other has no leverage then positions become polarised<sup>92</sup>. Each defends itself against the other. They respond by labelling and dehumanising the other. Ways are sought to neutralise those with views that challenge the prevailing paradigm.

Proponents of the dominant paradigm often isolate themselves from their critics and develop an arrogant certainty. They have no doubts. They express themselves so forcefully that dissent is difficult and no one dare speak up. This is apparent in the statements made by some aged care providers and the discourse between them. (eg. Submission 76<sup>93</sup>) Strategies are developed to "handle" the other.

Typically doctors who resist in the USA become "disruptive doctors". They are marginalised and neutralised. This is legitimised at corporate meetings in the USA where they even have sessions on the topic. In aged care relatives who become angry about the care their relatives receive in nursing homes are similarly labelled, are ignored by the complaints system, and may even be barred from visiting their relative.

Because the dominant paradigm has credibility, and is promoted with such certainty, many of those in less intimate contact with the system may pay service to both paradigms ignoring the dissonance. In aged care members of the community, relatives and workers identify with community and professional paradigms. Many may also adopt the dominant market paradigm and believe that the two are congruent and that the one will lead to the other. As a consequence the community paradigm is argued without as much conviction, and often within the frame and more "credible" lexicon of the dominant paradigm. It is difficult to argue logically in this way.

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<sup>92</sup> THE GREAT DIVIDE IN PERCEPTIONS about the CORPORATE MARKETPLACE  
[www.corpmedinfo.com/divide.html](http://www.corpmedinfo.com/divide.html)

<sup>93</sup> Lend Lease Primelife:  [www.pc.gov.au/data/assets/pdf\\_file/0010/100360/sub076.pdf](http://www.pc.gov.au/data/assets/pdf_file/0010/100360/sub076.pdf)

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Proponents of the dominant paradigm may exploit this in order to enlist the support of the community in selling themselves or in political lobbying. A typical example of this is The Grand Plan<sup>94</sup> – an attempt to enlist the community to lobby on behalf of aged care providers.

It is only when workers, relatives or sections of the community come into some sort of conflict with the system and confront the adverse consequences of the dominant paradigm that the issues are confronted.

They look more critically and realise that their experiences are representative and not unique. When the problem is an ideology that is so dominant that both sides subscribe to it, then critics are likely to make their criticisms within this paradigm and so promote solutions that either do not address the problem or make it worse. This is what has happened in health care in the USA. The quote from Kuttner that I used earlier describes this. Other critics group, and develop a base from which to criticise and confront.

In Australia the Aged Care Crisis Centre<sup>95</sup> has played a pivotal role in examining what has been happening. They have gathered scattered information together<sup>96</sup> so that it can be critically examined. They have published articles from the coal face<sup>97</sup> and created a forum<sup>98</sup> where participants can tell of their experiences and comment critically. They have driven debate and focused the attention of the public on the issues.

## Determinism

The concepts defined here recognise that humans are not slaves to social forces (Determinism). They have a unique ability to look critically and transcend the situations in which they find themselves. What I have described here are patterns of probable or likely responses to situations. Individuals and groups can and will on occasion behave very differently.

## Behaviourism

A psychological theory originating in the first half of the 20th century. It seeks to control individuals and secure desired objectives by a system of rewards and punishment called positive and negative feedback.

It was popular in education in the 1960's but was soon abandoned. It lingered on in computer based education into the 1990s. It obstructed the successful use of technology in education.

Microeconomic reform has been its most successful, and arguably its most socially destructive manifestation.

Behaviourism contrasts with systems of thinking and learning that seek to secure objectives by motivating people using values and cognitive processes - understanding.

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<sup>94</sup> The Grand Plan: [www.thegrandplan.com.au](http://www.thegrandplan.com.au)

<sup>95</sup> Aged Care Crisis Centre: [www.agedcarecrisis.com](http://www.agedcarecrisis.com)

<sup>96</sup> The Column: [www.agedcarecrisis.com/thecolumn](http://www.agedcarecrisis.com/thecolumn)

<sup>97</sup> Your Stories: [www.agedcarecrisis.com/your-articles](http://www.agedcarecrisis.com/your-articles)

<sup>98</sup> Letters: [www.agedcarecrisis.com/yoursay](http://www.agedcarecrisis.com/yoursay)