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Submission:

Towards an Aged Care Pricing Framework Consultation Paper

Aged Care Crisis Inc.

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Glossary

ACC	Aged Care Crisis Inc.
AN-ACC	**A**ustralian **N**ational **A**ged **C**are **C**lassification
ABF	**A**ctivity **B**ased **F**unding
IHPA	**I**ndependent **H**ealth **P**ricing **A**uthority
IHACPA	**I**ndependent **H**ealth and **A**ged **C**are **P**ricing **A**uthority
DRG	**D**iagnosis **R**elated **G**roups
FIRB	**F**oreign **I**nvestment **R**eview **B**oard
Dialogic	Talking, thinking about and evaluating different viewpoints at the same time
RACF	**R**esidential **A**ged **C**are **F**acility

1 Introduction

NOTE: The issues, the system failures and the relevant research summarised in this introduction are explored more fully in the Appendix at the end of the submission.

1.1 About us

Aged Care Crisis (ACC) is an independent community-based advocacy group that has closely examined the development of aged care policy over the years. It has seen and despaired about what has been happening on the ground to staff and residents. It was glaringly obvious yet it took a Royal Commission to reveal it. Its members were among the first in the community to warn that the policies adopted would not work - 23 years ago. ACC, and prior to its formation, its members have been collecting data and making submissions to aged care related inquiries for nearly two decades, urging real change.

We have been pressing for structural changes that would address the consequences of the damaging changes made in 1997. In particular, we have pressed for models of care and staffing that would address the dreadful conditions that are driving staff away from aged care and giving it a dreadful reputation. The system has been allowing profit-hungry providers to avoid employing more costly skilled staff or giving more work to part time staff even when they were available[1].

The changes made in 1997 created an unbalanced system where commercial interests and values became ascendant and the interests and values of communities and professional staff subservient. The large power imbalance that resulted has distorted the way the system operates and it has been failing as a result. Our submissions have advocated for restructuring, using models which restored that balance in favour of staff and residents.

Aged Care Crisis is interested in social systems that fail and particularly their impact on care. **A**ctivity **B**ased **F**unding (**ABF**) seems to be a new initiative in aged care. Our interest is in the contexts where ABF operates and in particular by looking at how it has fared in other systems, particularly those that have failed.

We are interested in how it will perform in Australian aged care, a system that has failed so badly - how it will address the issues there. The recent Royal Commission into Aged Care has not made any significant changes to the context within which aged care is provided. It remains a market-led system without an effective customer and so at continued risk for those seeking care, as well as impacting on those working at the coal face.

1.2 Relevant Global and National Developments

A new belief system, now called Neoliberalism developed in Europe after the Great Depression and World War II. It was essentially a libertarian movement which saw personal freedom as being expressed through free and uncontrolled markets. It was subsequently supported by other libertarian movements and they became aligned spreading across the world through 'think tanks' and managerial policies based on the belief.

[1] Generation Next - Helping Graduate Nurses and Midwives Find Jobs Health Times https://healthtimes.com.au/hub/nursing-careers/6/news/nc1/helping-graduate-nurses-and-midwives-find-jobs/1422/

Both saw society and societal movements (described as 'the collective') as a threat to personal freedom and so to markets. Regulation was seen to interfere with the way markets work and to prevent them from functioning well and correcting themselves.

In making these claims believers ignored history and existing knowledge about humans, their society and markets. This belief system became ascendant globally in the 1980s and has had a profound impact on government, society and the market.

Humans and their society are inextricably linked. They create and maintain one another in a 'dialogic' manner. This narrow belief has come to dominate western countries inhibiting 'dialogic' engagement. It has had a profoundly negative impact on society and its citizens, and on the value systems that hold us together and support the 'public good'.

As a consequences civil society has been pushed aside and has fragmented. The balance of forces, knowledge and influence that effective social systems depend on has been disrupted.

We argue that the many failures in vulnerable sectors of our society are a consequence of this lack of balance and that any reform that does not address the unbalanced system that we have by rebuilding and involving civil society will not be successful in the long term.

What has happened in health and aged care in the USA and Australia illustrates the problems faced by Activity Based Funding. We need to examine this.

1.3 ABF in the USA

In the Appendix we review the USA experience including:

- the story of health care and its progressive marketisation starting in the 1960s.
- the growth of free market neoliberal thinking over the years and its ascendance in the 1980s.
- the way the system became unbalanced in the 1980s when the medical profession were blamed for increased costs and their control over care was removed by forcing them to operate under contracts (managed care)
- the rapid increase in the cost of health care and the cascade of frauds that followed.
- the development and introduction of Diagnostic Related Groups (DRG) - an ABF system in the 1980s.
- the way big corporations responded to the restrictions on profitability created by DRG based funding by becoming more innovative and finding other ways of exploiting and harming even more patients in order to make themselves very rich.
- not all fraud was in response to DRG funding but this funding had very little impact on the extensive health care fraud that developed across the system including hospitals that were DRG funded.
- aged care in the USA was not funded by DRG's but behaved in a very similar way and the large scandals in health care were soon followed by widespread fraud and exploitation of residents in aged care.
- By the mid 2000s, these scandals and the widespread publicity reduced the number and extent of the major scandals. Companies became more careful and an equilibrium of sorts developed. But the US health and aged care systems remain problematic and dysfunctional. US health is still the costliest in the world, provides poor overall care and fraud settlements are common.

- In summary, ABF funding in the USA stimulated providers of care to find other venues where extensive exploitation and misuse of patients occurred. It did not prevent exploitation of patients in hospitals where it was used.

1.4 ABF in Australia

The story of health care in Australia

- Corporatisation and profiteering did not become a major issue in health care until the 1980s when two US hospital companies entered our system, several local companies were formed and an effort was made to make money through medical tourism.
- There were many problems and these companies did not prosper and only a few were left by the 1990s.
- Globalisation in the 1980s led to the loss of farming and manufacturing to Asian countries. Australia responded by building a human services economy and wanted health and aged care to corporatise and become money making businesses. The Productivity Commission took a brutally commercial approach to health care.
- In the early 1990s, a large US hospital company was welcomed into Australia by industry and governments. It had made huge profits but was in the early stages of a scandal in which large numbers of patients had been exploited and harmed.
- Those who saw what was happening, collected information and supplied it to state regulators. Regulators used it to resist strong pressure from industry and governments who were enthusiastically welcoming it. It took 5 years of activism before the company finally gave up and departed.
- A new government elected in 1996 was even more determined to marketise. It welcomed three more US multinationals. All had skeletons in their cupboards, which were soon exposed and none stayed for long.
- Doctors were now aware of what had happened in the USA and the consequences for them and their patients of the new government's plans. They united and won a bitter and very public dispute when the government tried to force them into the sort of contracts that removed the doctors market power and created an unbalanced system in the USA.
- When a large Australian company adopted US style practices, doctors used the market power they had fought to retain to put the company out of business. In doing so they establishing a balance of power within hospitals that has largely protected the system from US type problems.
- This does not mean that the government's policies did not have an adverse impact and relationships between the medical profession and government remain tense.
- In Australia ABF was introduced for funding public hospitals where perverse pressures did not exist.in the late 1990s. It was eventually taken over by the Commonwealth and the IHPA (which has become the IHACPA).
- There have not been any major failures but the advice given by the IHACPA, if followed, clearly failed to take account of the growth in population and increased need for hospitals by an ageing population. The system stagnated and failed to expand. It was stretched to its limits and problems were developing well before the COVID pandemic. It was ill prepared and struggled to cope with this crisis.

- **Responsibility:** ABF was not used to fund private hospitals but the IHACPA and ABF were used to recommend funding for public hospitals. They must accept responsibility for the underfunding and under-resourcing of the public system that developed over the years.

The story of aged care in Australia

Infective ideas: The remarkable thing about the USA is that the people who marketised the system and then exploited their patients for profit believed deeply in what they were doing. They and the cultures that developed in their hospitals and nursing homes were impervious to the consequences. They were very successful generating large profits and building big reputations. Australian politicians and businessmen admired this and it confirmed their faith in free markets. They were influenced and wanted this.

The beginning: In Australia politicians first allocated funding in order to encourage the private market to enter aged care in the 1960s. They thought competition would make it cheaper. Some were already advocating for free markets.

There was soon a huge increase in privately owned nursing homes and problems with over-servicing and poor care developed. The full extent of the problems in for-profit nursing homes and the care provided was finally exposed in the Giles report in 1985.

Reforms: Reforms by the Hawke government in 1986 prevented profits from being taken from nursing services and care. They also introduced close oversight by often on-site state regulators. The reforms were effective but there was strong opposition from industry and the changes directly contradicted the new free market belief system.

Reforms abandoned: The reforms stagnated in the 1990s and were then abandoned, when the Howard government elected in 1996, applied the new free market principles and restructured aged care along these lines in 1997. Marketisation, competition and minimal regulation were prescribed. Strong perverse pressures were introduced into the system and there were soon many problems and recurrent scandals.

Failures and recurrent scandals: The belief in free markets has remained dominant on both sides of parliament. The problems in the system increased steadily in spite of multiple reviews, inquiries, consultations and reforms that responded to scandals by tinkering with the market system. In 2018 there was so much publicity that a Royal Commission into Aged care was called.

The evidence now available showed that our regulatory system underperformed. It protected government's reputation and the industry rather than the elderly receiving care. Staffing skills and numbers deteriorated as unhappy nurses left the sector in droves. Facilities focused on reducing costs to compete successfully and nursing staff were the largest cost.

The sector was repeatedly accused of raping, abusing and neglecting the residents. Fraud became more and more common as competitive pressures were increased. We explore how and why this happened in the Appendix.

Wilful blindness: At the same time, it is clear that politicians and industry believed that we had one of the best aged care systems in the world. They justified this on the basis that the numbers getting perfect scores from the regulator had increased from 64% to 98% over the years. This was not what staff and families were seeing.

In many ways the pattern of behaviour, the belief, the exploitation, the harming of residents, the failures of the regulator and the blindness to what was happening closely resemble what happened in the US health and aged care systems.

Royal Commission: The Royal Commission discovered that there was widespread neglect in the system. It was a system we should be ashamed of. It was not 'world class'.

The Royal Commission's own research paper examined the large numbers of investigations and inquiries that had been done and asked why they had all failed. The paper did not answer that question and the Commissioners made no attempt to do so either.

The Commissioners' expertise were in marketplace law and in government regulation. They consulted widely with industry and business advisors and made many useful recommendations regarding the visible signs of failure like staffing and funding.

They did not ask ***why*** these failures had occurred or challenge government policy. They avoided evidence that challenged the belief in free markets.

Outcome: At the end of all this we still had a market led aged care system without an effective customer and with essentially the same regulator in place. The same people responsible for the failed system are still in the same of similar positions. Some still believe aged care had been world class! There was little, if any structural change and the perverse pressures in the system remain.

Compounding factors: Behind this and inhibiting real reform is the control that wealthy corporate political donors and lobbyists have over the political system. Electoral success is so dependent on funding from donors that it is suicidal for any political party to risk challenging their power by genuinely protecting the system from their predatory behaviour.

AN-ACC funding in aged care: This deeply flawed and dysfunctional system is where activity-based funding is to be introduced. The sector closely resembles the US health sector where ABF funding created more problems than it solved and did not prevent fraud and exploitation. We cannot see it working if introduced in the same way as the USA.

This may be compounded by the same factors that led to the underfunding and under-resourcing with a lack of adaptability and resilience in the public health system in Australia.

Among the benefits of block funding, controlled and managed locally, is that it rebuilds and re-empowers civil society by rebuilding value systems, volunteering and trust. as well as building capacity and engagement, and so restoring balance. It directly challenges market dominance and the neoliberal ideas adopted by both major parties.

If this is not practical, then we are interested in suggesting ways that AN-ACC funding might be organised and structured, to encourage and build the balance of power needed to address the unbalanced pressures responsible for system failure.

This will only occur when there are sectors in society with the power to insist that the interests of community and residents effectively balance and control those of the marketplace and their shareholders.

1.5 The IHACPA Consultation Paper

In examining the consultation paper, we were struck by the wording used, which is reminiscent of the many pro free-market and managerialist fiscally focussed documents generated by policy advisers and markets over the years. The focus has been on greater efficiency and lower costs and so less money for anything that cannot readily be quantified.

It does not address the nature of care or the cultures necessary for good care.

While the consultation is silent on who will do the assessments, information elsewhere suggests that this will be drawn from staff who would be far better employed providing the care that is so badly needed. There is overlap which must entail some inefficient duplication at the expense of care.

This is only necessary because we have a system that depends on distrust of the providers. They are primarily motivated by money and have clearly shown that they cannot be trusted. We would not need this level or duplication and oversight if we had a balanced system where trustworthiness was a requirement for participation and accountability was directly to the communities served.

The consultation makes much of transparency and accountability but omits the equally important information about who the IHACPA is accountable to, who will hold it to account and whether they have the capacity and motivation to do so.

1.6 Social Research

In the appendix we review three levels of research that throw a light on failed systems and indicate what needs to be done to address them. These are:

- the broad Macro and historical,
- social system analysis, and
- the personal and social

The pathology: Each of these analyses focuses on the rise of dominant unopposed controlling groups in society that disrupt the balance of people, ideas and power that have been the basis of well-functioning social systems over the centuries.

The dominant groups create unbalanced dysfunctional systems where the excesses of their particular interests and beliefs and their dominance are not checked by alternative balancing insights. They become harmful to other citizens and/or society itself. One study specifically identifies market control as a one of the major dominance problems.

Each study shows how resistant these systems are to change and how enduring they are as a result. They also show an important and sometimes critical relationship with the breakup of civil society and uncertainty for individuals – a situation called ‘anomie.

Stable balanced systems are more resistant to dominance. Recovery from these ‘cascades’ of social pathology created by domination occurs when citizens, society itself, seizes one of the periodic windows of opportunity that occur when massive failures weaken the grip of the dominant.

Citizen’s reform the systems by using the power of numbers to regroup and rebuild structures in society that end dominance and restore balance.

Immunity to this pathology as well as its cure lies within society. Opportunities arise when they can rise up and end the dominance if they unite and have the will. Too often the opportunity is lost and the window closes as the dominant regroup and take control again.

An examination of what has been happening shows that we have been dominated by markets and a free market belief since the 1980s. We have been in a state of anomie and this has inhibited action. Instead of exposing and addressing the problems, the Royal Commissions appointed by the dominant group have provided an opportunity and a mechanism for the dominant to regroup and reorganise. The window of opportunity created by the cascade of dramatic failures in the banks, the NDIS, the VET system and finally aged care is rapidly closing.

The state of anomie in our society is particularly problematic because neoliberal and other supporting libertarian belief systems were founded on a rejection of society and any sort of control by it. As a consequence, they are particularly suspicious of and resistant to efforts to rebuild society. Elements of neoliberal ideology have been embraced by many ordinary citizens who are reluctant to participate in social movements for reform.

In the Appendix we examine localism, regionalism and other efforts to involve communities and rebuild civil society including those targeting aged care.

1.7 The IHACPA and AN-ACC funding

We conclude that AN-ACC funding by itself will have little impact on the social pathology that afflicts aged care. Profit will remain the driving force and industry will search for innovative ways to avoid any restrictions the funding system imposes. Whether AN-ACC funding will be of any benefit remains to be seen.

One of the major advantages of block funding is that the allocation and oversight of funding can be delegated to local community organisations whose responsibility it would be to organise and manage the aged care services provided locally. This ensures that community are directly involved so know what is happening, are engaged and are in a position to act effectively. When they identify a need, they can respond to it. They are in a position to restore the balance in the system and make trust and trustworthiness a requirement for every provider.

Gerontologist Hal Kendig spent the last 20 years of his life pressing for local management of funding. The HACC and CHSP funding systems have both worked well in building community capacity and encouraging volunteering. In spite of this government still intends to abolish this block funding. The problem seems to be that block funding challenges belief and exposes just how badly the free-market solutions have failed and why.

We are not economists and if block funding of local government and community structures to manage aged care is not possible, then it might still be possible for the IHACPA to implement the AN-ACC funding by delegating the processes to community organisations. The IHACPA could then focus on training and supporting. This would build knowledge, capacity and motivation in communities. The IHACPA would then integrate and draw the findings together for government.

Doing this would make the community-based staff part of an oversight process that builds community involvement and empowers communities to insist on a greater role in holding providers to account and balancing the system. It would also give the IHACPA greater insight into the relationship, cultural and clinical factors in care so that allowances can be made to enable these difficult to quantify activities.

In the next section we make some suggestions as to where this might be possible.

2 The IHACPA and AN-ACC funding

Ultimately the adequacy of the funding must be based on whether it is providing an adequate standard of care to allow good relationships and good quality of life for those receiving it. Our recent experience with centralised regulation in aged care confirms assessments made in the 1970s and 1980s that this needs to be assessed and addressed by those who are involved and often on site talking to staff, residents and family. There should be an adequate funding buffer to enable the development of relationships, cater for surges and crises, and adapt promptly to change.

If the **A**ustralian **N**ational **A**ged **C**are **C**lassification (**AN-ACC**) funding has an advantage over simple block funding, which has worked well in home care, it will be in the collection of better data as well as the extent to which it helps to build community, trust, trustworthiness and trusting relationships and does not encourage providers to innovate and defraud the system as it did in the USA.

The extent to which the **I**ndependent **H**ealth and **A**ged **C**are **P**ricing **A**uthority (**IHACPA**) succeeds in addressing the real problems in aged care will depend on its success in engaging with and working through local communities. Its failure will be reflected in more centralised control and less community empowerment.

2.1 Our response to questions asked in the consultation paper

We do not have the economic expertise to comment on the details. Out interest is in the positive or negative impacts it will have in a deeply flawed system and how those can be addressed.

Appendix A: Consultation questions

Responses to personal questions regarding the consultation are provided in our covering email and in the '*About us'* section in this submission.

Submission permissions

We consent to making our submission publicly available. We are happy to be contacted for further clarification.

A new funding approach for aged care

Question 1: ***What, if any, may be the challenges in using the Australian National Aged Care Classification (AN-ACC) to support activity based funding (ABF) in residential aged care?***

The perverse unbalanced pressures in the current system which incentivise providers to find innovative ways of rorting any system. We do not think the way it is being set up addresses this.

Question 2: ***What, if any, concerns do you have about the ability of AN-ACC to support long term improvement in the delivery of residential aged care in Australia that is efficient, sustainable and safe?***

We have huge concerns because ABF funding using AN-ACC has not addressed the context within which it will operate. The focus on efficiency without a full understanding of the needs of professional services has seen the public hospital system stagnate and be weakened so that it could not cope well with COVID-19.

Question 3: ***What, if any, additional factors should be considered in determining the AN-ACC national weighted activity unit (NWAU) weightings for residents?***

The extent to which it can be set up to work within and with communities - the need for some redundancy, and for relationship building – its complexity.

Question 4: ***What should be considered in developing future refinements to the AN-ACC assessment and funding model?***

The principle of community delegation, entrusting communities and working through them.

Principles for activity based funding in aged care

Question 5: ***What, if any, changes do you suggest to the proposed principles to guide the development and operation of the Pricing Framework for Australian Aged Care Services?***

Focus on integration and supporting communities, enabling them to assess their needs and implement them.

Question 6: ***What, if any, additional principles should be included in the pricing principles for aged care services?***

As above.

Question 7: ***What, if any, issues do you see in defining the overarching, process and system design principles?***

A focus on rebuilding community and enabling it to take a lead in the provision of care.

Developing aged care pricing advice

Question 8: ***What, if any, concerns do you have about this definition of a residential care price?***

The focus on financial efficiency above cultural and personal motivational factors in aged care. A focus on fiscal efficiency as a primary goal led to cost cutting as well as cultural and role conflicts, the flight of nurses and the neglect of residents.

Question 9: ***What, if any, additional aspects should be covered by the residential aged care price?***

Allowance for cultural and social factors, relationship building and necessary redundancy

Question 10: ***What, if any, concerns do you have about the proposed pricing approach and level of the residential aged care price?***

Adequacy but we do not have the knowledge to determine this.

Question 11: How should 'cost-based' and 'best practice' pricing approaches be balanced in the short-term and longer-term development path of the Independent Health and Aged Care Pricing Authority's (IHACPA) residential aged care pricing advice?

Best practice is a term repeatedly used during the last 20 years when residents were being neglected. Empty token words should be abandoned. The best measure is provided by knowledgeable but critically inquisitive people who are regularly on site. Strangely residents and even families often overlook or miss system failure. This has been looked at and analysed.

Question 12: What should be considered in the development of an indexation methodology for the residential aged care price?

An adjustment for the factors that are not considered when assessing 'services'.

Question 13: What, if any, additional issues do you see in developing the recommended residential aged care price?

As above.

Adjustments to the recommended price

Question 14: What, if any, changes are required to the proposed approach to adjustments?

In a well-structured community-led service built on trust and trustworthiness local people would be in the best position to assess the funding needed.

Question 15: What, if any, additional adjustments may be needed to address higher costs of care related to resident characteristics?

Local variability which would be best addressed locally provided the expertise is available. Mentoring and guidance should be a key function of the IHACPA .

Question 16: What evidence can be provided to support any additional adjustments related to people receiving care?

Hard evidence can be difficult to find in some important aspects of caring - common sense, subjective insights and critical thinking may be needed.

Question 17: What should be considered in reviewing the adjustments based on facility location and remoteness?

We do not have experience but local experience and comparisons are obviously important.

Question 18: What evidence can be provided to support any additional adjustments for unavoidable facility factors?

COVID-19 shows how bad we have been particularly when looking at the impact of ownership.

Question 19: ***How should any adjustments for quality and safety issues be considered in the long-term development path of AN-ACC and the associated adjustments?***

The problem here is a system where stakeholders cannot be trusted. If this funding is to work then the system needs to be restructured along the lines that we have suggested to ensure that trust and trustworthiness are key considerations for the inclusion of individuals and corporate entities in the provision of aged care.

Priorities for future developments

Question 20: ***Should hotel costs be incorporated into the AN-ACC funding model and what should be considered in doing this?***

We think that the whole system is unnecessarily complicated and this is because it is fatally flawed and complex as a result of attempts to patch it instead of fixing it. In a functioning system block funding should provide a basic good service and local community should be responsible for apportioning it.. It has worked well in community managed and provided HACC and CHSP funded home care over the years. People who want more luxurious hotel services should be able to pay for them. AN-ACC may have an advantage in assessing how this plays out and works but it adds to the complexity.

Question 21: ***What should be considered in future refinements to the residential respite classification and funding model?***

That should be assessed on the extent to which it contributes to the development of a balanced system in which domination is contained and the perverse incentives are effectively contained and neutralised by the power of a revitalised community whose values restore the trust and trustworthiness essential for effective community services.

Question 22: ***What are the costs associated with transitioning a new permanent resident into residential aged care?***

This is so variable under the current structure we prefer not to comment.

Question 23: ***How might workforce challenges present in the implementation and refinement of AN-ACC for the aged care system?***

As we have indicated earlier, the department's web site suggests that highly trained staff that are already in short supply will be diverted to do the AN-ACC assessments duplicating the acquisition of much of the information already provided in developing care plans. This will impact negatively on care.

This sort of work will not inspire anyone who has come to care and may contribute to the exit of staff who are driven by an ethic of care rather than fiscal considerations. This is what is driving people who care away. Simply increasing remuneration without addressing the cultural problems created by the present system that are driving staff away, may encourage more of those simply seeking a job rather than those actually wanting to care.

Question 24: ***What areas should be included in the proposed five-year vision for IHACPA's aged care pricing advice?***

The creation of a balanced system where trust and trustworthiness, community values and a culture of care ensures that funding goes to where it is needed rather than to those who are seeking to benefit from it themselves.

Question 25: ***What would be considered markers of success in IHACPA's aged care costing and pricing work?***

Satisfied highly motivated staff working closely with an involved and supportive community.

2.2 Concluding comment

This submission deliberately takes a different approach because the evidence shows that we have a deeply flawed system which drives all participants to exploit any opportunity and expend all their ingenuity in following the money in order to be successful and prosper. In doing so it exploits, harms and neglects vulnerable citizens.

Simply adopting a funding system that limits this sort of conduct without changing the system, as happened in the USA, can stimulate greater ingenuity in order to exploit other areas where people are vulnerable and this can do even more harm to the vulnerable. That is not a solution.

Aged care cannot be compared with health care in Australia, which did not behave like the USA and where the focus was on public hospitals. Aged care has behaved the same way as health and aged care in the USA.

It is time that we focused all our attention on what is required to address the far more urgent problems in the system that make the market and our society behave like this. Whether the backgrounds of IHACPA leadership and membership will make considering alternative systems too challenging remains to be seen.

IHACPA narrow terms of reference and purely fiscal functions may limit what it can do. In that case we urge it to say so and warn the government and the public that more urgent structural changes are required.

Conflicting demands

Funding and sources are not unlimited and there are other as disturbing issues in society. Distinguished epidemiologists and Australian of the Year 2003, Fiona Stanley has spent her life studying the young.

She describes the plight of the young on whom the future of humankind depends and the huge stresses placed on them by neoliberalism and its impact on society[2]. This urgently needs new paradigms and structural change in our society and their interests must take precedence. Structural change that includes the re-engagement and rebuilding of civil society is required for both problems.

[2] Stanley F and Lycett K 'The health and wellbeing of future generations' in 'What Happens Next? Restructuring Australia after COVID-19 ed Dawson E and McCalman J. Melbourne Univ. Press 2020

Decisions on resourcing when funding is limited cannot be left to distant warring politicians and the vested interests who control them to resolve. These are civil society issues and are best resolved by sensible debate between groups of responsible on site engaged citizens who see where the need is greatest and then elect politicians who will act on their behalf.

This does not mean that the market cannot contribute but that contribution must be in the way the individual communities need and whose responsibility it is to decide. We should never forget that when those who come for the money find that they cannot get it, they will depart.

A responsible civil society community on the other hand always steps up, helps and does the best it can with what it has or can get.

Rationing in a market-led system creates a situation where care is rationed to maintain profit and viability. That has been a factor in our failed system.

In crisis situations like we now face, fancy economic models can be irrelevant.

3 APPENDIX: Examining failures of ABF in the US and Australian systems

3.1 Introduction

Activity Based Funding (ABF) in aged care seems to be a new initiative in Australia and a quick search did not reveal its use in other countries or in the Review of international systems done for the Royal Commission in January 2020.

Aged Care Crisis (ACC) is interested in systems that fail to function effectively, particularly human services, and within that health care and specifically aged care. We think this sort of analysis is critically important at this time because failures are so widespread and yet so little attention is paid to in-depth social analyses of the reasons for these widespread failures.

This wilful blindness is classic behaviour for social systems that are unbalanced. This is because these social systems are in the grip of, and dominated by believers in an ideology whose validity, underpinnings and failures would be challenged by this sort of analysis.

It is clear that the patterns of thinking that society has been using to develop policy have failed – and in aged care more than anywhere else. This is very challenging for the dominant in our society.

Our strong criticism is necessary but is not intended to blame or stigmatise those genuine people who seek to address failures and cannot conceive of alternatives to the present system. It is an attempt to persuade them that there are alternatives.

We examine the contexts within which systems have failed and how any proposals that are made have fared if tried in current or other contexts elsewhere.

If proposals like AN-ACC are valid and useful but they have failed because the context is dysfunctional then we try to advocate for a different context within which the benefits of the new proposals and their contributions can be assessed to see if they will be more successful there.

For example:

> Accreditation and governance are processes designed to improve the system. Both have clearly failed because they are no match for the unbalanced strong perverse pressures in our society. They might work well if adopted in a balanced system where these pressures are eliminated.

Absent from the IHACPA discussion paper is an examination of problems that have developed with activity based systems elsewhere and also an analysis of the context within which the new AN-ACC will need to operate. This is a serious omission, but it is the way in which reviews and consultations have been conducted over the last twenty five years.

An examination of the wording around the various ABF systems including the AN-ACC reveals that it is primarily intended as a market tool to collect data for analysis, to control funding and to enable motivated providers to manage effectively. It is designed to operate within a functioning market context. We need to consider how it will operate in one that is not functioning well and needs rethinking.

The importance of context

The issue that has been taboo, the elephant in the room at every consultation since 1997 is whether a market system, and more specifically the sort of one size fits all market system that has been applied across Australia to vulnerable human services is an effective and safe way of delivering those services. Is the context created congruent with the desired services and outcomes?

We will examine the contexts within which health and aged systems in the USA and Australia have been provided and the consequences for services. We will look at how ABF funding has fared in these systems to see whether it has been beneficial. How might ABF funding or the way it is implemented contribute to changing the context when this is the problem.

A reminder

We remind the IHACPA that in 1985, the Giles Review of aged care exposed a situation similar to that revealed by the Royal Commission in 2021. In responding in 1986, the Hawke government introduced a funding system that protected staffing and care from profit taking. It also introduced financial transparency and an effective regularly on-site state regulatory system to ensure that this was translated into care.

That was very unpopular among those providers whose primary interest in providing services in the sector was the profit that could be generated from these services. These restrictions were not compatible with the free market beliefs that were now ascendant.

The Hawke government reforms did not implement the recommendations for greater citizen and community involvement and oversight and in time citizens moved on and the opportunity to re-empower civil society and so rebalance the system was lost.

The Keating government wanted to follow these free-market policies and introduce a market management system into aged care. Economists Bob Gregory was engaged to review this issue. He warned that if the 1986 funding system was abandoned there was no other effective means of preventing market pressures from eroding staffing and care. Keating did not proceed.

When industry support and the appeal of free-market beliefs successfully brought the Howard government to power, the dominance of business views and free market beliefs became firmly entrenched. The aged care market was freed from what were seen as harmful restraints by repealing the restrictions on how money was spent, removing financial and staffing accountability, abolishing probity requirements for owners and replacing the effective regulator with a 'helpful' one.

Gregory's predictions soon came true and there have been numerous reviews, inquiries and consultations in response to the many failures over the years. Marketplace consultants advised on every issue and were even engaged to advise on clinical issues. The Royal Commission into Aged Care's own Background Paper 8, **'A History of Aged Care Reviews'** concluded that *"Despite all of these reviews, and all of the Government responses, the underlying problems remain. The overarching question that arises is why, after all these reviews, the aged care system still fails to support an appropriate quality life for the most frail and vulnerable members of our community".*

The reasons for these repeated failures, the warnings that predicted failure and the taboos that prevented the unthinkable from being discussed were glaringly obvious. The reviewers did not have the courage to answer their own questions and the Royal Commission made no attempt to do so either.

Since the early 1990s governments and their selected advisors have been unable to conceptualise of care as anything more than a market and those with wider horizons were not seen as credible.

In functioning democracies and societies criticism is welcomed. The rejection of criticism based on alternative insights is a feature of every ideology in power. This is readily apparent in the selection of reviewers, investigators and consultants over the years. Most of the criticism was coming from relatives, nurses and social scientists – a discipline that had studied situations like this before.

In 2018 the government once again selected Royal Commissioners with expertise in marketplace issues, who thought the same way they did. It avoided social scientists who understood how society worked. Many social scientists had been critical.

Aged Care Crisis had, in its submission about terms of reference to the then Minister for Aged Care, warned of the dangers of doing this again.

As a consequence, the Royal Commission did not address root causes or confront flawed policy. Instead, it tried to 'renovate' a deeply flawed system. Commissioner Pagone who replaced Commissioner Tracey after the Interim Report (titled 'Neglect') was released, had once studied social science.

Pagone wanted to 'rebuild' the system to decentralise it and make it more independent. He clashed with Commissioner Briggs. His separate recommendations which attempted to rebuild the aged care system by making the central integrating bodies independent of government and decentralising management, and so broaden critical input, were ignored.

Clues to the reasons for failure in aged care

The decline in care was not uniform and there were two periods of rapid deterioration. The first occurred after legislation passed in 2005. This followed the review conducted by economist Warren Hogan in 2004. This legislation encouraged hesitant commercial investors to enter the sector by making it easier to control their largest cost – nursing staff.

This occurred again in 2012 following a review by the Productivity Commission in 2011 which gave the market everything it wanted. Both these reviews were conducted by strong advocates for free market principles and the marketisation of human services in order to boost the nation's economy.

None of these reviews considered the unique requirements of human services, or the consequences of the ideology that underpinned the use of free markets for humanitarian services.

Clearly the question to be asked in considering AN-ACC funding is to what extent the IHACPA and this funding system will follow the Hogan and Productivity Commission and serve the interests of the government and the providers.

Will it serve the communities, who are ultimately responsible for ensuring that their fellow citizens are well cared for. They have been pushed aside by neoliberal policies and by Hogan and the Productivity Commission. They have been excluded and so unable to fulfil this role. To whom is the IHACPA really accountable and who will it serve? Will we get real change?

3.2 Relevant global developments

Neoliberalism

In the 1930s and 1940s Austrian economist Friedrich Hayek and his colleagues developed a new economic system based on a libertarian belief in personal freedom. This freedom was expressed through free unrestrained markets which were self-correcting if not interfered with (now called neoliberalism). He and his disciples, including Milton Friedman in the USA, formed the Mont Pelerin Society in Switzerland in 1947.

They saw any social movements or control of markets by society as socialist describing them derogatorily as 'the collective'. They simply ignored the essential and important contributions that civil society and civil society movements had made to democracy and to society itself over the centuries. Societies had rallied across the world to fight fascism and protect democracy.

Instead, the new theory focused narrowly on what had happened in the 1930s when society broke down and fractured so that a balance of ideas and power was lost in several countries in Europe. This allowed dictators to capture citizen's imaginations and gain power.

Hayek wrote[3]:

> "In theory Socialism may wish to enhance freedom, but in practice every kind of collectivism consistently carried thought must produce the characteristic features which Fascism, Nazism, and Communism have in common. Totalitarianism is nothing but consistent collectivism, the ruthless execution of the principle that 'the whole comes before the individual' and the direction of all members of society by a single will supposed to represent the 'whole'."

Libertarianism

Other libertarian movements became supporters, particularly those of the libertarian philosopher Ayn Rand[4]. Her philosophy called 'objectivism' disregarded everything we already knew about our humanity and our society. She promoted selfishness as a virtue and railed against 'the collective' describing collectivism[5] as *"the tribal premise of primordial savages"*.

Society and its values were seen as a threat to personal freedom rather than its protector. She condemned selflessness and referred to altruism as a disease imposed by society. These are the values that underpin cohesive functioning societies, professionalism and care. As critics[6] have indicated *"Hers is an ideology that denounces altruism, elevates individualism into a faith and gives a spurious moral licence to raw selfishness"*.

Think tanks

For both groups, free uncontrolled markets were seen as essential for personal freedom, as universally applicable and as always effective. Satellite think tanks were rapidly developed across the world to promote Hayek and Rand's beliefs. There are now over 500 Atlas think tanks[7] across the world including Australia promoting these ideas[8], training 'future leaders' and awarding scholarships for promising students to attend institutions in the USA that teach these philosophies.

Managerialism

Schools of management have embraced these ideas. Management strategies were developed that saw market style management as superior and humans as essentially self-interested. They used self-interest as a tool for obtaining objectives. These new management strategies have been adopted across government services and by community organisations.

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3 Friedrich Hayek https://en.wikipedia.org/wiki/Friedrich_Hayek

4 Ayn Rand https://en.wikipedia.org/wiki/Ayn_Rand

5 This is what happens when you take Ayn Rand seriously PBS Newshour 16 Feb2016 https://www.pbs.org/newshour/economy/column-this-is-what-happens-when-you-take-ayn-rand-seriously

6 Freedland J The new age of Ayn Rand: how she won over Trump and Silicon Valley The Guardian 11 Apr 2017 https://www.theguardian.com/books/2017/apr/10/new-age-ayn-rand-conquered-trump-white-house-silicon-valley

7 Atlas Network Wikipedia https://en.wikipedia.org/wiki/Atlas_Network
Atlas Network https://www.atlasnetwork.org/partners

8 Mannkal – Ron Manners AO https://www.mannkal.org/about/team/ron-manners/
Mannkal - About Us https://www.mannkal.org/about/

An Australian doctor compared this thinking with mad cow disease and claimed that it was being transfused into every vein of society[9]. When Social Scientists saw the consequences for society and our humanity, they did their best to warn us of what was happening[10]. They were ignored.

Civil society and balance

One of the major consequences of this philosophy has been the marginalising of society and its value systems. The balance between sectors of society that is so essential for effective social systems has been destroyed as markets and market thinking have become dominant. Communities are no longer in a position to fulfil their responsibility to others and ensure that their vulnerable members are well cared for.

The Keynesian system of economics that was introduced after the Great Depression regulated the market stepping in and taking action when it did not work well. Keynesian economics were also not prescriptive and different sorts of markets were permitted.

Businessmen and the companies they formed were expected to behave as responsible citizens and to be 'of good standing' or 'fit and proper'. This was especially so if they were to operate in sectors that were vulnerable. In these sectors probity regulations were created to ensure that those who did not measure up were excluded.

Community organisations embracing society's Samaritan traditions and values could cooperate as they worked together to fulfil their mission by providing services according to need while charging according to means – all without compromising their values.

Neoliberal thinking rejected Keynesian control of markets and imposed its own very different way of thinking about these issues.

Support for neoliberalism

Many businessmen were smarting under these restrictions and by the 1960s free market ideas were gaining traction even among some politicians. It was a one size fits all model. Any sort of control by community or their elected governments was rejected and labelled 'collectivist' and 'socialist'.

3.3 ABF in the USA

3.3.1 The triumph of markets

While always more commercial than other countries health care in the USA was once driven by the Samaritan traditions of society and the health professions. That soon changed. Problems developed in hospitals after the USA introduced Medicare funding for the aged and Medicaid funding for the poor in the 1960's. Free market ideas were already popular.

Businessmen saw the opportunities. Companies like Humana, National Medical Enterprises (NME) and Health Corporation of America (HCA) were formed and expanded rapidly. Payment was on an item of service basis and large profits were made.

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[9] Mad-cow thinking - how far has it spread by Stephen Leeder Australian Medicine 20 May 1996 page 6

[10] **In the USA:** The Limits of Markets Kuttner R The American Prospect first MARCH-APRIL 1997 then Dec 2001 http://prospect.org/article/limits-markets
In Australia: The Human Costs of Managerialism : Advocating the recovery of humanity edited by Stuart Rees and Rodley Pluto Press 1995 A Truly Civil Society Eva Cox Boyer Lectures 1995 http://ldb.org/evacox.htm

The companies grew rapidly and the USA soon had the most expensive health system in the world. We do not have details but we are aware that, like Australia there were problems in the aged care marketplace in the USA in the 1970s.

Keynesian economics was finally replaced by free market (neoliberal) economics at the end of the 1970s. The appealing new ideas were embraced by President Reagan in the USA and Prime Minister Thatcher in the UK. Together they made it the basis for globalisation. It was soon enthusiastically adopted by businessmen, economists and a large body of politicians in most western countries.

Doctors are not immune to societal belief and a fair number would have embraced the belief in markets in the USA. Some even formed companies (eg Health Care of America - HCA).

Businesses in the USA

The post war period had been characterised by collegialism and a more socially responsible Keynesian economics. Businesses took responsibility for the welfare of their employees and in the USA paid for their health insurance and that of their families. By the 1980s, the rising costs of health care was impacting on their profitability and on the competitiveness of US products.

Medical profession neutralised

Doctors controlled the treatment given to patients and they became the scapegoats. They were blamed for the increasing costs and attacked by industry leaders[11]. Government and Industry set out to control the way that doctors practiced medicine by taking control of their incomes and their careers. Doctors were required to enter into contracts with health maintenance organisations as well as with hospitals and other companies. (called 'managed care')

They were the only group with sufficient market power, if they had united, to have prevented what happened in the USA over the next 20 years.

Regulatory capitalism

The now dominant belief saw free and uncontrolled markets as an unchallengeable truth yet believers needed to confront its growing numbers of failures and excesses without being seen to be regulating or controlling. In fact, as criminologist John Braithwaite later explained this resulted in more regulation rather than less. He called it regulatory capitalism – the regulation you had when you were not regulating. The focus was primarily on self-regulation and steering the system with incentives. The word regulation was not used. What has happened suggests that self-regulation was no match for the perverse incentives in the system.

3.3.2 ABF and DRGs

ABF was developed at Yale University at the beginning of the 1980's using a case mix model called **D**iagnostic **R**elated **G**roups (**DRG**) to fund general hospitals. There can be little doubt that it was intended to contain the blowout in costs – perhaps to encourage hospitals to do so.

Industry response to ABF

It was clear to the big hospital companies that they could not make as much money as they had been from the payment per item system. As happens in every commercially competitive market, the providers followed the money whenever they saw an opportunity and turned to more profitable sectors. There were four good examples.

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[11] See. Wynne JM. Joseph Califano and the Market Revolution http://www.corpmedinfo.com/califano.html (a critique and quotes from Califano's 1986 book 'America's Health Care Revolution: Who lives? Who dies? Who pays?')

1. Specialty hospitals: DRG funding was not introduced into hospitals specialising in psychiatry, substance abuse and rehabilitation. Major hospital groups immediately focused on these sectors and started building specialty hospitals until there was an over-supply.

Because it also operated in Australia for several years **N**ational **M**edical **E**nterprises (**NME**) is a closely examined and good example of corporate behaviour and thinking. We use it as a case study of corporate behaviour. It led the way and established subsidiaries to operate in these sectors. Soon well over half of its hospitals were specialist and providing these services.

Its success came from filling its beds with insured patients, in keeping patients there for the full duration of their insurance and in providing as much care as could be squeezed in, most of which was not beneficial and did not require admission to hospital. Glib explanations justified these practices.

Financial performance targets were set, called plan and managers were offered huge incentives if they met or exceeded plan.

Every available strategy from scare marketing, hot lines, kick-backs and rewarding bounty hunters for each head on a bed was adopted to keep the beds filled. In the USA children who rarely need hospital admission were insured for 6 months instead of one. They were specifically targeted and were harmed by what happened to them during the long periods they spent in hospital.

Doctors who were team players' became wealthy, those who did not starved. The company developed a huge reputation and their programs of treatment were widely praised especially by market analysts.

These business practices were soon adopted by competitors who poached their trained managers so that the problems became systemic across these sectors as they all became successful.

These hospitals were all accredited by the US 'Joint Commission', as well as local specialty associations. They were regulated and visited yearly by the government's Center for Medicare and Medicaid Services (CMS). They were visited regularly by insurers to evaluate the claims they made. The company's own documents revealed what was happening as everything was planned, tracked and recorded. None of these oversight bodies detected any problems.

It was only in 1991 when a hospital kidnapped a profitable teenager, and a policeman believed his parents rather that the doctors at the hospital, that the widespread fraud was exposed. It was the press who realised what was happening and published but the evidence was there for everyone to see and government inquiries soon confirmed it[12].

NME pleaded guilty and in 1994 paid a record US $175 million fine as well as large settlements to the insurers it had defrauded and the children it had harmed. Other companies including HCA paid smaller fines and settlements. NME was required to sell its entire specialty division, set up an ethics committee and subject itself to close supervision by the department of justice for 5 years.

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[12] "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

The remarkable thing is that at no stage did the company have any doubts about the superiority or legitimacy of its practices and it was able to inspire probably thousands of employees to enthusiastically embrace unethical practices and exploit their patients. Even after it pleaded guilty some were still blaming the press publicity and not its policies. It renamed itself Tenet Healthcare boasting of its new ethical commitments.

The company was at the forefront of implementing government policies and was a large political donor. It immediately got support. A senior Democrat, who had been defeated by Bill Clinton as presidential candidate joined the board and there was a revolving door between government and the company.

2. International Expansion: Other countries paid on an item of service basis and travellers were covered by insurance. US companies seized the opportunity presented by globalisation to enter Asia where they targeted tourists. They also set up in Europe. Health Corporation of America (HCA) and American Medical International (AMI) entered Australia in the 1980s, but for many reasons were not successful and soon departed.

National Medical Enterprises also had a large international empire. Its international division's headquarters were in Singapore where it had two very profitable hospitals which were referral centres for surrounding countries.

One of us (JMW) experienced the hospital and became concerned. He started making enquiries and became even more concerned by what he heard but lacked hard evidence. He made some efforts to have issues addressed but with limited success.

NME entered Australia in 1991, by which time both major parties were welcoming and its economic prowess was legendary. Despite adverse findings by state probity regulators, whose advice was not followed and then a guilty plea in the USA in 1994, the company was welcomed by government and market.

It was only when evidence from Singapore implicating its Australian directors and CEO in unethical practices was received by the minister that restrictions were imposed that forced it to leave Australia.

When the World Medical Association received copies of all available documents it acted as a resource for all the other countries where it operated. Tenet Healthcare, the now renamed NME, sold its international hospitals and returned to the USA. Their international team were appointed to senior positions claiming that they were not tainted by what had happened in the USA.

3. Step down care: Rehabilitation in hospitals was covered by DRG payments but if provided in nursing homes it was paid per item of service. By discharging patients whose rehabilitation was covered by DRG payments, early from hospitals to nursing homes, hospitals saved money. Nursing homes were able to make a large profit by providing services and charging for each item provided. They were soon trolling the world to find enough therapists to meet this large 'need'.

NME had been one of the largest providers in aged care but spun off its aged care division under the same directors in 1989 before its frauds were exposed. Two of its trained managers had left and set up competing aged care companies. They knew how successful these practices could be and led the way. They were dramatically successful, growing rapidly. One of these Sun Healthcare came to Australia in 1997 so has been more closely studied. Many others copied these practices.

This was only one of many scams in aged care. The government's Centre for Medicare and Medicaid Services (CMS) was the only regulator. President Reagans plans to introduce accreditation into aged care in the 1980s were strongly opposed and rejected by congress. The CMS did collect data but did not act on it effectively.

The government finally acted and stopped the step down rorting. It also commenced fraud actions against multiple aged care companies most of whom had raised large loans which they could no longer service.

Several including Sun Healthcare were soon in Chapter 11 bankruptcy. The government was forced to reach token settlements to protect residents and allow the companies to trade out of bankruptcy. Sun fired its founder and chairman.

4. Defrauding DRG's: It is very difficult for any highly structured system to accurately cost the services provided. DRG payments did not adequately reimburse the costs of high risk patients at increased risk of complications when undergoing major surgery. Hospitals did not want to treat them and government responded by incentivising these patients.

It offered additional payments. Treating them became very profitable especially if the patients included were not high risk. Companies built new hospitals or special additions to care for more of these patients.

One again it was Tenet Healthcare (the renamed NME) who seized the opportunity. Oversight by the Department of Justice ceased in 1999 and Tenet rapidly became very profitable again – something the share market enthusiastically embraced.

Tenet's most profitable hospital was the Redding Hospital in California and the senior official in that area was the CEO who had been in change in Singapore and then in Australia. He took a close interest in the hospital and even participated in negotiating contracts with the cardiologist and cardiac surgeon for whom a brand new unit had been built.

In 2002 journalists in New York analysed DRG figures and saw the huge increase in numbers pointing to widespread 'upcoding' of low risk patients so that they got the high risk payment. At almost the same time the FBI raided the Redding hospital.

It was discovered that the hospital had performed somewhere between 700 and 800 major cardiac operations on patients who did not need surgery. Once again it was not the accreditation system, the CMS regulators or the insurers that took action'

It was a whistle blower, an ethicist and priest who realised what was happening when he was told he needed urgent surgery and instead got a second opinion. He went to the FBI. Even In healthy patients undergoing this sort of surgery there would have been some complications and deaths.

Doctors in the hospital had been very worried about what was happening and had tried to set up a quality assurance committee to investigate. Management accused them of being jealous and the previous CEO from Singapore and Australia refused to allow it. The press described what was happening and a book was written about it[13].

[13] "Coronary: A true story of medicine gone awry" by Stephen Klaidman Scribner New York 2007

Two other instances illustrate the pressures for profit and the way Tenet's managers protected their bonuses. In another hospital cardiac surgery was being done in theatres in an old building. Instead of closing the operating theatres when flying insects started breeding in the roof, managers installed fans in the theatres so that these profitable operations continued. Predictably there were a large number of surgical infections in these high risk patients and large sums were eventually extracted in law suits.

In another hospital management prohibited staff from telling surgeons that test strips showed that instruments had not been properly sterilised. They would have cancelled their operating lists.

The Chairman now in charge of the company was one of George Bush's largest donors and these big companies were driving government policies. Considering that it was a re-offender the company got off quite lightly with a smaller fine and it only had to sell the Redding hospital. The largest costs were the settlements and the doctors' insurers paid for some of that.

This time it was the president's brother who came to help the company – Jeb Bush, recently retired governor of Florida joined Tenet's board.

These are only the frauds and misconduct that are linked to DRG's, which while not directly responsible, certainly led to them by distorting the funding and encouraging companies to look elsewhere.

3.3.3 Widespread fraud in health and aged care

Fraud was widespread and recurrent not only in health care but in the banks and other Wall Street companies. Investors, many of whom were persuaded to invest their life's savings were defrauded.

Two prize winning journalists investigated and wrote a book exposing just how extensive it was in health care[14]. Their comments are worth considering:

> *Over the past few decades, American health care has radically changed. A system that was largely not-for profit has become a field where the profit motive and market forces affect every decision. Publicly held corporations answerable to stockholders decide which doctor you may see, how much medication you can take, whether you can be evaluated by a specialist, whether you qualify for a test, how long you stay in a hospital, how many therapy sessions - physical or psychiatric - you may attend. Patients wait months for appointments that once could be made in days. Their medical condition is evaluated by clerks with no medical training. Patients who are so sick that they meet the strict criteria for hospitalisation are discharged before they are well, despite the protests of their doctors. (Page 2)*
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>
> *Much of the turmoil is a direct result of a national policy to run health care like a business, a misguided notion promoted by Washington over the last two decades that the free market and for-profit health care would restrain costs and bring high-quality care to all. On both counts, the experiment has failed miserably. In the meantime tens of billions of dollars - money that could have gone into patient care - has been drained from consumers and corporate subscribers and transferred to investors, executives, and others who have a stake in perpetuating this myth. (Page 4)*

[14] Critical Condition: How Health Care in America Became Big Business & Bad Medicine by Bartlett & Steele (Doubleday Nov 2004).

The fraud occurred across every sector of the health system[15] and extended to general hospitals where Columbia/HCA[16] eventually paid $1.7 billion in settlement, renaming itself HCA. Patients were caught up in this and exploited. Once again it was exposed by whistle blowers and not regulators.

Perhaps one of the more disturbing practices adopted by the big companies was the large fees that they charged for uninsured patients who were admitted to their hospitals often as emergencies – much larger fees than insurers paid for the same services. HCA was estimated to have overcharged by over US $2 billion[17]. The patients were energetically pursued by debt recovery businesses and forced to sell their houses or other possessions to pay.

Fraud and exploitation in aged care

Aged care was not far behind and there were multiple large fraud settlements over the years. Poor staffing levels were a major problem causing failures of care, particularly in the for-profit sector[18].

The companies targeted states where the elderly retired. Groups of citizens in some states took matters into their own hands and worked with lawyers. Staff leaked internal documents to them and families were supported to take action. Judges were horrified and awarded huge punitive damages causing some companies to vacate those states. The companies united and used their influence to induce states to pass laws limiting the amount of damages that could be awarded.

The company 'Vencor' is illustrative of what happened across the sector[19]. It was accused of a US$3 billion fraud but paid much less. In aged care Medicare paid for one month of care and private payers paid for as long as their money lasted. Medicaid paid more poorly and when funding ran out the company had to accept Medicaid payments.

Vencor avoided Medicaid patients and when other funding ran out it simply discharged the residents back to their families. Staff were rewarded financially each time they successfully did this. The regulators accepted that the company was entitled to do this and refused to act. It was a whistle blower and a public outcry that eventually forced regulators to act.

Equilibrium

Health care during this period took up more of the FBI's time than any other sector. More money was recovered through fraud actions and whistle blower initiated Qui Tam actions than in any other sector. Health care in the USA was by far the most expensive in the world yet the World Health Organisation (WHO) found that the overall standard of care provided was one of the poorest in the developed world.

This could not go on like this and an uneasy equilibrium seems to have been established so that we no longer see such extremes of behaviour and major scandals are less common although they still occur. It is not a system that works well.

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[15] The Health Care Marketplace in the USA Corporate Medicine web pages http://www.corpmedinfo.com/corporate_overview.html

[16] Columbia and HCA merged to form Columbia/HCA in 1994. It dropped Columbia and became HCA again in 2000 when it settled fraud actions.

[17] Tenet Healthcare Price Gouging http://www.corpmedinfo.com/tenet_gouging.html
HCA 2004 to 2007 http://www.corpmedinfo.com/hca_2004_2007.html

[18] Woefully inadequate staffing is at the root of patient neglect St. Louis Post-Dispatch October 14, 2002

[19] VENCOR (renamed Kindred Healthcare) Corporate Medicine web pages 2003 http://www.corpmedinfo.com/access_vencor.html

A recent example was in Paediatric Cardiology[20] and in this instance it was the press and not regulators who discovered what was happening and pressed the issue until action was taken. They also tracked it back to the involvement of a wealthy investor whose actions led to these many unnecessary deaths in children.

Health care in the USA remains the most expensive in the world and it still provides one of the poorest services in the developed world. More money is recovered from Qui Tam fraud actions than any other sector.

Rich-country health care systems: global lessons Development Ian Anderson Policy Centre 31 Aug 2021

Figure 2: Health care system performance compared to spending from

https://devpolicy.org/rich-country-health-care-systems-global-lessons-20210831/

Aged care also reached an equilibrium. The establishment of minimum staffing levels, the publication of facility staffing levels and some public stigmatisation saw the levels of staffing improve even though only a small percentage of families actually used published data when making choices.

Problems have continued at a lower level[21]. In 2015 in Dallas, for example[22] *"More than 500 Dallas-area home health care agencies have been accused of sending people, some of them homeless, to Roy* (a physician) *for fraudulent treatments"*. In 2022 there was more fraud[23].

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[20] US Example Heart Surgery in children
Heartbroken. A Tampa Bay Times investigation https://projects.tampabay.com/projects/2018/investigations/heartbroken/
Report: Officials Missed Warning Signs About Hospital. Associated Press 10 Dec 2018
https://apnews.com/article/a752997ce0e34af8babdfae86ab761f5
Feds threaten to cut funds to Johns Hopkins All Children's Hospital. Florida News 4 Feb 2019
https://wusfnews.wusf.usf.edu/2019-02-04/feds-threaten-to-cut-funds-to-all-childrens-hospital
How we got the story on a surgery program where 'children were dying at a stunning rate' Center for Health Journalism 27 Feb 2019
https://bit.ly/3wzF8WE
All Children's Hospital Faces Huge Fine Over Heart Unit. Associated Press 8 Sept 2019
https://wusfnews.wusf.usf.edu/health-news-florida/2019-09-08/all-childrens-hospital-faces-huge-fine-over-heart-unit
Exclusive: Michael Bloomberg took control of Johns Hopkins with his billions. Then, death rates skyrocketed at a children's hospital. The Healthcare Channel 21 December 2019
https://thehcc.tv/2020/01/09/under-new-leadership-johns-hopkins-creates-a-disaster-at-tampa-childrens-hospital/

[21] Q&A: What to look for in a nursing home KPBS News 8 Sept 2022
https://www.kpbs.org/news/health/2022/09/08/what-to-look-for-in-a-nursing-home
Fourteen Indicted in Connection with Operation Home Alone 3 – Dept Justice Press release, 5 Jun 2014
https://www.justice.gov/usao-sdil/pr/home-alone-3

[22] Cedar Hill nurse admits role in $375M home health care fraud The Dallas Morning News 17 June 2015
https://www.dallasnews.com/news/2015/06/17/cedar-hill-nurse-admits-role-in-375m-home-health-care-fraud/

[23] Five Individuals and Two Nursing Facilities Indicted on Charges of Conspiracy to Defraud the United States and Health Care Fraud. Press Release US Dept Justice 9 Aug 2022
https://www.justice.gov/usao-wdpa/pr/five-individuals-and-two-nursing-facilities-indicted-charges-conspiracy-defraud-united

The extent of the problem

The most remarkable thing about all this is the commitment of the corporate market to these practices and their denial of fault – their blindness to what was happening under their noses and their seemingly deliberate ignorance.

This faith in uncontrolled markets goes right to the top. The extent to which it is entrenched in the US psyche is revealed by two of their presidents.

Examples

If we look at the praise that President George Bush Jr heaped on the economist 'Milton Friedman' in a speech[24] in 2002 we get some idea of how systemic this pathology was. He described Friedman as *"a hero of freedom"* and echoing his ideas said:

> In contrast to the free market's invisible hand, which improves the lives of people, the government's invisible foot tramples on people's hopes and destroys their dreams. - - a free market system's main justification is its moral strength - - you cannot reduce freedom in our economy without reducing freedom in our lives

Ten years earlier his father President George Bush Snr had awarded[25] Friedrich Hayek, one of the two architects of neoliberalism and Friedman's mentor, the Presidential Medal of Freedom, one of the two highest civilian awards in the United States for a "*lifetime of looking beyond the horizon*". Our world might have been a much better place today if he had looked at the real world around him more closely instead.

Understanding how this happens

There is a large social science literature going back into the early 20th century analysing this sort of human behaviour. It's not new but the extent to which it is now occurring has led many more to write books about the way we ignore what is in front of us as well as everything we already know[26] in the service of a belief that we have used to build our lives.

Our gut response is to protect the belief that is now so closely tied to our identity. We do so by discrediting and attacking the messenger. At ACC we consider this situation and this behaviour to be a social disease. This is explored further later.

Significance for ABF

The US experience glaringly exposes the failures of the free market competitive market and the way in which unconstrained competitive pressures in this unbalanced system must follow the money to survive. It shows how innovative humans can be in finding ways to follow the money regardless of the consequences when they must do so to prosper and survive. As a consequences innovation that improves care but increases costs seldom gets support.

It is clear that ABF had no positive effect on the US health care system and when it collected data and sought to control the excesses of the market it stimulated even greater innovation in finding ways around the limits it imposed, and encouraged rorting of the system. Instead of improving the system it was rorted and many more were harmed.

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[24] President Honors Milton Friedman for Lifetime Achievements 9 May 2002
https://georgewbush-whitehouse.archives.gov/news/releases/2002/05/20020509-1.html

[25] Remarks on Presenting the Presidential Medal of Freedom Awards George Bush 18 Nov 1991
https://www.presidency.ucsb.edu/documents/remarks-presenting-the-presidential-medal-freedom-awards

[26] See for example
Willful Blindness: Why We Ignore the Obvious at Our Peril by Margaret Heffernan 2013 and 2019
The Unknowers: How Strategic Ignorance Rules the World. by Lindsey McGoey 2019

The implication is clear

- An unbalanced free market competitive system stimulates the market to innovate in ways that will maximise their income. That will rarely be in the interests of those receiving care but will often be at the expense of the vulnerable recipients of care. It rations care in order to generate more profits.

  It is a system that destroys trust and trustworthiness so harming the society of which it is a part. Rees and Rodley described how it was destroying our humanity in their 1995 book. Twenty-five years of this system has torn our society apart. It creates role conflicts and dissonance as those who come to care must serve the market above care. It is not a place caring citizens want to work.

  It places a huge drain on human and financial resources as governments fund endless reviews and consultancies, as well as setting up expensive regulatory structures in attempts to control the damage that the system does.

- In contrast a community led and controlled system built on Samaritan traditions will focus on and innovate in order to improve care. It is balanced by the need to secure funding and justify the need for this. There are few perverse incentives. As a consequence, it maximises care within the limits of any funding system.

  Humans are existential beings. Their character, mode of operation and value systems are developed as they play out their role in the world and interact and work with one another cooperatively. They grow by being involved and doing things.

  Such a system exercises our value systems and our responsibilities to one another as citizens. It connects us to the world and the people who live in it so that we become empathic and socially responsible. It builds trust and trustworthiness. It creates a humane society in which regulation rests lightly and is seldom needed so preserving resources.

  Eva Cox described the benefits in her 1995 Boyer lectures. To maintain our humanity we need to be involved in caring for one another and that has been taken from us. Functioning communities build a system which attracts caring humans and creates an environment in which their welfare is also a consideration – a place where people want to work and find it rewarding.

3.4 ABF in Australia

ABF came to health care in Australia in the second half of the 1990s. Australia and many other countries were following the USA. We need to consider the context in health and aged care in Australia since the post war period.

3.4.1 Health Care in Australia

Health care seemed to remain a not-for-profit dominated sector serving the sick. Although Paul Ramsay bought a psychiatric hospital in 1964 and then several more it remained a professional and not-for-profit mission driven system. Ramsay maintained good relationships with doctors and avoided sectors where there was strong competition.

The development of universities and an influx of UK skills into its teaching and public hospitals in the post-war years saw a high level of care develop. It did not follow the USA.

The 1980s: This changed in the 1980s when free markets became ascendant[27]. US companies were making large profits and expanding. A number of doctors were among the first to see the opportunities. Enthusiasm for privatisation and markets grew. At the same time as for-profit aged care facilities were being exposed and regulated, the health care market was expanding.

Two US companies 'Hospital Corporations of America (HCA)' and 'American Medical International (AMI)' entered Australia. Local doctors like Geoffrey Edelsten and Ian McGoldrick formed companies like Consolidated Health Care (CHC), Health and Life Care (HLC), Superclinics and Supercare. Their questionable activities and the consequences for care received a lot of critical attention in the media.

Bigger companies like James Hardie, Leighton's, Mayne Nickless and others saw the opportunity and entered the sector. Public hospital managers also saw the opportunities and entered the sector. We had Health Care Corporation (HCC) and Australian Hospital Care (AHC). Malaysian groups invested and created 'Alpha Healthcare'. Ramsay Healthcare went in the opposite direction and purchased international subsidiaries in the USA.

For-profit companies were struggling in Australia and were doing far better in Asia which was booming. Doug Moran targeted this wealthy Asian market building Luxury Medical Parks on the Gold Coast. The policy of privatising public hospitals by contracting them to marketplace companies and of co-locating private and public hospitals was adopted at this time.

These companies did not prosper and there were many problems. Doctors were not impressed. With Medicare and good public hospital care, private insurance became unattractive particularly for the young. Moran's Medical Parks were not a success.

The US companies sold up as did many of the others. Only a few remained including Mayne Health, Ramsay and Healthscope but they were all struggling. Problems with privatisation and colocations soon developed but the ideas were so appealing to politicians and businessmen that they persisted into the next century[28].

The Productivity Commission was strongly supportive of the marketisation of human services and its economic potential in replacing farming and other business enterprises which could not compete with Asia in a globalised market[29]. In 1989 a review had been conducted into 'international trade in services' by the Productivity Commission's predecessor, the "Industries Assistance Commission".

The early 1990's: The brutally impersonal commercial approach to the commercialisation of human services including healthcare is reflected in the Productivity Commission's 1991 review 'Export of Health Services' where they considered the opportunities for providing health care to wealthy Asians as Moran planned. They indicated that *"The Commonwealth Government's agenda for microeconomic reform is being progressively extended to the services sector"*.

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[27] The American Influence HCA and AMI http://www.corpmedinfo.com/hca_ami_au.html
Ian McGoldrick & Companies http://www.corpmedinfo.com/mcgoldrick.html
James Hardie and Health Care Corporation http://www.corpmedinfo.com/hcc_hardie.html
Australian Hospital Care (AHC) http://www.corpmedinfo.com/austr_hosp_care.html
Moran Health Care Hospitals http://www.corpmedinfo.com/moran_hosps.html
Ramsay Healthcare Early Years http://www.corpmedinfo.com/ramsay_early.html

[28] Colocations and Privatisations in Australian States http://www.corpmedinfo.com/privat_aus_states.html

[29] From Industry Assistance To Productivity: 30 Years of 'The Commission'. Productivity Commission Web Page. https://www.pc.gov.au/about/history/thirty-years

It was tasked with addressing *"institutional, regulatory and other arrangements which impede the efficient export of health services"*. This removal of restrictions on markets is called 'liberalisation'.

A new US multinational: In contrast to Australia big corporations in the USA were flourishing during the 1980s and the most successful was National Medical Enterprises. Its very successful business practices were widely admired as was its reputation in the marketplace. When it bought into Australia in 1991 the local company, which operated in NSW and Western Australia agreed to pay $1 million annually for access to NME's business expertise and the services of one of its most successful hospital managers from its international division.

Some were already aware of the company's business practices in Singapore and the company's practices were already being investigated in Texas. But governments and investors ignored this and welcomed it enthusiastically. Information about its operations in Texas was rejected by state probity regulators in NSW as the source was considered to lack credibility.

But more information was soon available and in 1993 the NSW health department refused to proceed with the licensing of a new hospital it was building and put it on hold. The state government responded by appointing a recently retired judge to make the decision. He had retired when an investigation into his vulnerability to improper influence was commenced,

The judge ignored the departments advice to reject licenses and approved them, as did the West Australian government when its department advised that this be done.

In the meantime, the company had clearly expected to get licenses and had raised large loans to expand. These large investments were on condition that the services of the US company's CEO and access to the company's business practices were maintained. The role of these business practices in the frauds that made the company so successful were revealed in the evidence now available to the judge and state regulators. The judge granted licenses with conditions approving the business deal and made an exception of the CEO who would have been excluded by his conditions.

Queensland blocked the company and its investment did not go ahead. Victoria who had the same information, found the company lacked probity and barred it from operating there. In 1994 the company pleaded guilty in the USA and paid a huge fine. The federal government put a temporary ban on further growth.

When the federal minister for health care received documents that implicated the directors of the international division, who were also directors of the local company, the ban was made permanent and the company sold up and left.

The Howard led opposition was likely to win the 1996 election and it was far more committed to free market reform than any previous government. The medical profession was by now acutely aware of what had happened in the USA and of how their colleagues had been disempowered. Several warned of the consequences for health care[30]. Eva Cox as well as Rees and Rodley warned of the consequences for society.

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[30] Mad-cow thinking - how far has it spread by Stephen Leeder Australian Medicine 20 May 1996 page 6
Price competition, professional cooperation and standards Peter C Arnold in MJA Vol 165 p 272 2nd Sept 1996
The Impact Of Financial Pressures On Clinical Care Lessons From Corporate Medicine by Wynne JM in Access to surgery: A National Symposium on the Planning and Management of Health Care Programs under Medicare. Townsville, May 23-24, 1996, editors Prof. P.K. Donnelly and Assoc. Prof. L. Wadhwa, published by the University of Queensland Press. Pages 98-127 .
Copy at http://www.corpmedinfo.com/corpmed.html

New US companies in the late 1990s: Three new US companies were welcomed into Australia in 1997. The giant Columbia/HCA promised to invest $1 billion in private hospitals. A large amount of information was soon available about its practices and, when the FBI swept through its hospitals in the first stage of a US$1.7 billion fraud investigation, it abandoned its plans.

The rehabilitation giant HealthSouth had an impeccable record when it bought a hospital in Victoria. It was not long before its massive US$4 billion accounting fraud was uncovered in the USA. It did not expand and eventually sold up.

The aged care company, Sun Healthcare, which was already in trouble in the USA, bought into hospitals and planned to enter aged care. The FIRB (Foreign Investment Review Board), an advisory body, was given information and, in its report to government, it was very critical. The federal government waved it through. Sun Healthcare tried to buy in Victoria but failed a probity review. It was soon bankrupt in both countries.

Health care 'reform': The new government ignored the conflict of interest and put the CEO of Mayne Health, in charge of the Health Insurance Commission, the regulator of hospitals In 1998. Mayne was now the largest private hospital owner in Australia.

The minister, Mayne Health and National Mutual, an insurer owned by AXA, a French multinational, united in an attempt to force doctors to enter contracts similar to those in the USA.

A bitter public battle erupted between the minister and the Australian Medical Association (AMA) but the doctors stood firm and won. The Health Minister and the CEO of Mayne were soon involved in the *'Scan Scam'* scandal, which tarnished their reputations.

Mayne Health was not popular and not making money. It appointed a new Mr Fixit, who had been very successful in other sectors. He fired existing hospital managers replacing them with the team he had brought with him. They started reorganising the hospitals as businesses.

In 2002 when managers started giving patients who were profitable preference over patients who needed care more urgently (cherry picking), the doctors used the market power they had retained and took their patients to other hospitals. Mayne's profits plummeted and the Mr Fixit left. An effort was made to recover the situation and the hospitals were then sold.

The medical profession had now shown they had power. They continued to decide who should be admitted, what treatment they should get, and how long patients needed to stay in hospital. Managers needed to work with them collegially and consult them when making decisions. A balance of power had been established in the hospitals and it lasted for nearly 20 years.

An uneasy equilibrium with government persisted. Because of the damaging policies that were still being pressed by government it was tense and not conducive to useful engagement. The system was not well balanced as doctors were unable to influence politicians.

Dr David Weedon, AMA president welcoming The Minister for Health, Dr Michael Wooldridge to a 1996 meeting where the new minister was describing the governments new market policy for health. http://www.corpmedinfo.com/weedon.html

By the end of 2019 the AMA President was so concerned that he spoke out writing[31]:

> We are being politely engaged and listened to, but then essentially dismissed, deferred, delayed, obfuscated, and buried with multiple – yes, multiple indeed – stakeholder forums, round tables, requests for information, or submissions.
> ----------
> The question clearly is what next? What to do if the Government continues to create such administrative barriers and obstacles to consultation with the profession?

The views of the believers in free markets were probably best expressed by Terry Barnes an adviser to both Wooldridge and Tony Abbott, two of the strongest supporters of free markets, when they were health ministers. Barnes accused[32] the AMA of being an *"activist political organisation"* calling them *"getup in white coats"* and of not being representative of the profession. They were *"far more a hinderance than a help in coming up with a better health care system"*.

The government clearly has not been supporting the public hospital system[33]. The bed ratio of 2.53 per 1,000 population has *"remained static since 2014-15"*, a period during which the government pursued neoliberal policies particularly aggressively.

In spite of an ageing population suffering from more diseases, needing more care and more time in hospital, the number of public hospital beds per 1,000 population over the age of 65 had halved over the 30 years before the COVID pandemic.

By 2019 our public hospitals were overstretched, understaffed and under-resourced with long waiting lists. They had no reserves and were not equipped to deal with any sort of national crisis let alone the COVID pandemic. The deficiencies were already only too obvious.

The failure to increase bed numbers and resource the system may be partly a result of shorter stay care encouraged by the Casemix system and welcomed as an achievement by the IHACPA - but it has clearly gone much too far and weakened the system. This must raise concerns that the IHACPA was not watching what was happening and was serving the government and its agenda rather than Australian citizens.

3.4.1.1 Introducing ABF in health care

Early period: Casemix has been discussed and advocated in Australia since the 1970s. A presentation[34] by an actuary in 2004 describes its introduction into contracts with insurers in the private sector and then a trial in the public sector in 1993. Initial trials involved both[35] and it was soon used by the states for funding public hospitals.

The author is critical concluding that although it was *"supposed to put hospital funding above politics. ---- In reality (it) shifts political interference to new levels"* and that it *"just introduces new gaming rules for funders and hospitals!"*. Long term problems occur "*as funders and providers learn new gaming rules.*" That sounds like the USA.

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31 The Government has had long enough Statement AMA President 3 Dec 2019

32 AMA unrepresentative and dangerous politicon May 1 2020 https://politicom.com.au/ama-unrepresentative-dangerous/

33 PUBLIC HOSPITAL REPORT CARD 2021 AMA https://www.ama.com.au/sites/default/files/2021-11/AMA_Public_Hospital_Report_Card_2021_1.pdf

34 Casemix Funding In Australia Brent Walker IAAHS Dresden Conference April 2004 http://www.actuaries.org/iaahs/colloquia/dresden/walker%20presentation.pdf

35 Casemix funding for acute hospital inpatient services in Australia Stephen Duckett Med J Aust 1998; 169 (8): S17-S21. https://www.mja.com.au/journal/1998/169/8/casemix-funding-acute-hospital-inpatient-services-australia

Others like Stephen Duckett who helped to introduce it into public hospitals in Victoria in 1993 were converts. In 1998 private hospitals were required to report data to federal regulators for evaluation using DRGs and some doctors were concerned about government control[36]. Private hospital data is still reported to the federal department in this way[37].

The Casemix ABF system of funding for public hospitals was introduced across Australia in the late 1990s and has been in operation ever since. One of us was chairman of a hospital medical staff committee in 1996/7 and was wary of the proposal to introduce Casemix funding because of what had been happening in the USA. Aged Care Crisis has no direct experience with it in Australia.

It is not clear when public hospital funding by the federal government was converted to Casemix, but government legislation created IHPA to do so for hospitals in 2011 and that became IHACPA when aged care was added in 2022.

ABF funding: In Australia, ABF funding has only been used for public hospital funding and not for private hospital funding. This cannot be compared with its use in the US profit driven system or with Australia's profit driven and incentivised aged care system where it is now to be introduced. But clearly failure in the public system where these stresses are absent would be significant.

Our balanced health system that prioritised care, prevented the sort of things that happened in the USA from happening in Australia. There are no reasons why any reasonable and adequate funding system should in itself cause major problems in a functioning system. Block funding has been very successful in aged care community run services, that are not subject to abnormal perverse pressures.

But clearly if that ABF funding system has been underfunding the services and contributed to the decline in our public hospital system then we should be alarmed.

State governments have complained repeatedly about the government's failure to contribute more to the cost of public hospitals. Doctors have been complaining for years. This would not be the first time that eminent economists and data analysts and managers have been so absorbed in what they were doing that they have not seen what was happening on the ground and very obvious to those who live and work there.

The IHACPA and Casemix are largely responsible for underfunding hospitals: The wording[38] used '*national efficient price'* and *'national efficient cost'* and the strong focus on them suggests that the focus has been on restricting funding to the bare minimum needed and has made no allowance for the huge variability of care needs. Some redundancy is essential in human services, but particularly in health and aged care.

This strong focus on efficiency renders systems inflexible and so unable to adapt to changes and lacking in resilience. They are unable to respond to surges and crises. While no one would advise inefficiency, an unbalanced focus on efficiency can be very harmful in health care settings where services must meet needs that are often unpredictable. Those who study resilience are critical of forces that unbalance functioning social systems that need to adapt and be resilient[39].

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[36] Casemix perspectives for clinicians in the private sector C N Maxwell Med J Aust 1998; 169 (8): S48-S50. https://www.mja.com.au/journal/1998/169/8/casemix-perspectives-clinicians-private-sector

[37] Hospital Casemix Protocol (HCP) Dept Health & Aged Care 28 April 2022 https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-about-HCP

[38] FAQs IHACPA https://www.ihacpa.gov.au/about-ihacpa/faqs

[39] Resilience Thinking: Sustaining Ecosystems and People in a Changing World by Walker B and Salt D Island Press 2006

In a 2017 article Professor Leeder looks at some of the problems in health care[40]. He describes how some of the *"realities of clinical care can be overlooked by those of us advocating an evidence- based approach*". An ABF system might well overlook them as well and that might have applied to public hospitals.

That the IHACPA is directly, but perhaps unwittingly, culpable in this regard is revealed in the response to a FAQ question about government funding on its web site. The response says *"NEP is a major determinant of the level of Commonwealth Government funding for public hospital services"* and then *"The national efficient price determines only the Commonwealth contribution to public hospital funding"* and then indicates that *"States and territories can also choose to pay a price that is higher or lower - - - if they choose to".*

But the IHACPA is the authority on pricing and does the estimating. Government follows its advice. States do not have the same ability to raise money that the Commonwealth has. They should not have to duplicate the assessments made by a Commonwealth body that is funded to do these assessments and *"work out the funding for a public hospital activity".*

The erosion of public service and its commitment to the public good: The IHACPA as a socially responsible 'independent' organisation must take responsibility and cannot hide behind a government that prioritises efficiency to the extent that it is harmful, even when it is set up to do just that. It should speak out when its role is harmful and when its advice is not followed and the system is harmed.

We are aware of instances in the past where career public servants in government departments have stood their ground and resisted strong political pressures when it was in the public's best interests. They have even been open about it. We have not seen that happen for a long time. The replacement of career public servants by government and industry supporters over the last 20 to 30 years may have a lot to do with this.

We note that the Act[41] specifies that *"Each member of the Pricing Authority is to be appointed by the Minister by written instrument'* although there is consultation with the states through COAG. This certainly provides opportunities to *"shift political interference to new levels".*

As we indicated above governments appoint those, whom they see as credible because they share political beliefs and support their policies, to their 'independent' government funded bodies. As a result, these bodies may be independent in name but not in substance.

They are likely to share the ideology and the blindness to evidence and data that usually supports ideology. Critics who challenge ideology are usually discounted by these appointed bodies and the Royal Commission seems to have done that. The problem may not be in activity based funding itself but may lie in those responsible for implementing it.

We are for example aware that the strongly neoliberal Morrison government seemed unable to accept that its policies were responsible for the failures exposed. During its final months it was appointing those faithful believers who created the flawed system that failed so badly to positions where they would have control and could influence and frustrate progress.

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[40] Over-servicing in health, by Stephen Leeder, 19 Jan 2017: https://johnmenadue.com/stephen-leeder-over-servicing-in-health/

[41] *National Health Reform Act 2011* Latest 2022 version https://www.legislation.gov.au/Details/C2022C00237

This included members of the aged care sector committee who would have contributed to implementing the red tape reduction program, the aged care roadmap, and the policy of competitive consolidation that gutted regulation and then increased commercial pressures and drove the system into crisis.

They must have been determined to frustrate any attempt to dismantle all the work they had done. A decision to restructure aged care as a balanced system would prevent market dominance – a central tenet of neoliberal belief.

As Peter Shergold, the Aged Care Sector Committee's first chairman indicated after he had moved on[42] in 2015, the government's greatest fear was *"a public backlash from people who believe that aged care should be a community service and not motivated by profit".*

That was the sort of thing that neoliberalism's founder Friedrich Hayek feared when he formed the Mount Pelerin Society in 1947. That has clearly not changed and his ideas are still taught in hundreds of think tanks as well as leadership and management courses around the world. Australia is well represented in the Mont Pelerin Society and a past prime minister is a member.

3.4.1.2 A new threat in health care

Doctors and neoliberalism: At one time doctors were among those supporting and driving corporatisation in health care. Doctors are members of society and memories are short. Some members of the profession embrace most ideologies and patients are harmed because of it. Others have led the way in exposing the consequences and leading reform as happened in Australia in the 1990s and 2000s.

It was perhaps inevitable that neoliberalism would continue to affect some of them as it has the rest of society. Terri Barnes may be partly correct in that insights and resolve across the profession may have slipped over the last fifteen years.

Several doctors and medical groups have been tempted by the advantages for them and they have sold to large corporate owners and/or been enticed to work for them.

Medical ethics and competition policy: Governments have prohibited ethical structures previously in place because they did not comply with competition policy. These had prioritised collegialism above competition, controlled quackery by limiting advertising and so protected patients. Both were seen as anticompetitive.

To practice doctors now need to learn business skills that challenge their values. Younger doctors and the deliberately blind now see this as normal practice. There are periodic reports of ethical failures.

The most glaring of these is the doctors who advertised themselves as cosmetic surgeons, when they had not trained as surgeons. They promoted their wares on social media.

Trained surgeons, particularly plastic surgeons who had to pick up the pieces when problems developed, spoke out about this but the regulator failed to act until Four Corners recently exposed what was happening and described the many failures that occurred.

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[42] IPS Closed-Door Workshop on "Aged Care Service Models: Challenges, Trade-offs and Policy Responses" Workshop Report May 2016 https://lkyspp.nus.edu.sg/docs/default-source/ips/report_aged-care-service-models_1005161.pdf

We can only imagine the regulators talking about jealous doctors who were protecting their patch. That 'surgeons' who had never trained as surgeons were calling themselves surgeons and doing surgery they were not trained to do was clearly ignored.

New pressures: The Australian health system is once again under pressure and it should not surprise us if the Morrison government had once again turned to American companies to break the power of the medical profession and encourage market domination.

Cigna, a US managed care company that has faced serious allegations of fraud[43] in the USA over the last few years has joined with NIB insurance to form Honeysuckle in an attempt to establish control over the care provided in Australia.

At the same time KKR, one of the largest private equity groups active in healthcare made a bid for Ramsay Healthcare earlier in 2022, by far our largest hospital operator in Australia.

That deal seems to have fallen through although that is not yet clear. Perhaps it has something to do with a change of government. But the last time Labor was in power it actively encouraged market dominance in aged care.

We have seen the way that patients were exploited and harmed in the USA and in aged care in Australia. If Cigna and KKR are successful then the balance of power that has kept patients safe in Australia may be disrupted.

If we remain wilfully blind to the consequences of these policies and the ascendance of companies like this then private health care in Australia might well follow this path and no amount of costly regulation will fully contain it.

3.4.2 Aged care in Australia

Where did the beliefs that have gutted aged care come from?: We should start by looking at why our politicians tried so hard to introduce one size fits all free-market models into health care and then succeeded in aged care. We need to understand the power of belief in these practices in the USA and just how confident, charismatic, persuasive and credible the big businessmen were. It was not only Joseph Califano, and president Bush. The USA and its hugely profitable companies had become the role model for Australia.

US businessmen were totally convinced and the US press quoted the public statements they made[44].

> *The day has come when somebody has to do for the hospital business what McDonald's has done in the fast food business.* (Richard Rainwater co-founder Columbia Healthcare)
>
> *Do we have an obligation to provide health care for everybody? Where do we draw the line? Is any fast-food restaurant obliged to feed everyone who shows up*? (Richard Scott co-founder. CEO and president Columbia/HCA)

[43] DOJ sues Cigna, alleging $1.4B in Medicare Advantage fraud 6 Aug 2020
https://www.healthcaredive.com/news/doj-cigna-medicare-advantage-fraud-lawsuit/583023/
DOJ files suit against Cigna over allegations of Medicare Advantage fraud 5 Aug 2020
https://www.fiercehealthcare.com/payer/doj-files-suit-against-cigna-over-allegations-medicare-advantage-fraud

[44] Quoted in "The Patient as Profit Center : Hospital Inc. Comes to Town by Carl Ginsburg The Nation November 18, 1996

At the time one of us wrote about these business leaders, what they said, what was said about them and the disturbing cultures that developed in their companies as a result. In health care these included Columbia/HCA[45] and Tenet (previously NME) Healthcare[46]. Then there was Citigroup which was one of the big financial groups advising health and aged care companies like HealthSouth[47] (US $4 billion fraud). It was supporting financial companies who committed massive frauds like Enron and WorldCom. Citigroup was involved in massive frauds on Wall Street itself[48].

Aged care leaders and cultures were not far behind. Sun Healthcare and its founder[49] were used to illustrative the sort of thing that was happening across US aged care and try to explain why it was happening. Sun Healthcare was also welcomed into Australia where it failed a probity analysis. Its charismatic founder met with the cabinet and business groups in Australia. Their subsequent conduct and remarks mirror his views.

Beverley Enterprises was the largest and had a chequered record[50]. It's founder wanted to introduce franchising like Taco Bell, Kentucky Fried Chicken, etc. He appointed an expert to do this and this expert soon became president.

Then there were Vencor[51], Integrated Health Services[52], Genesis Health Ventures[53], Mariner Post Acute Network[54] and their leaders - all showing how market beliefs and personalities played out in different ways creating a market system that defrauded society and harmed those who needed care in order to do so. The Australian government was supplied with documents and warned in 1999 but they were totally committed to introducing the same system into Australia,

The web pages referred to above wrestle with the problem of blind belief in the face of damning evidence. These companies provide an insight into what happens. These people were so naive in their belief that they did not try to hide what they were doing.

This depth of information was much more difficult to find in Australia, perhaps because by then businessmen were aware of the large fraud payments in the USA and had become more circumspect. But what happened in government and to the regulators was much more obvious to anyone who looked.

3.4.2.1 The story of aged care in Australia

Early policy

Until the 1960's care of the vulnerable aged and destitute had been provided by government and charitable institutions as well as hospitals. As indicated in our introduction, the government in the 1960s felt that supporting competing for-profit providers would keep costs down and improve care.

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45 Richard Scott & Thomas Frist - Columbia/HCA Leaders and Culture http://www.corpmedinfo.com/columb_cult.html

46 National Medical Enterprises (now Tenet Healthcare) Founding Executives and Culture http://www.corpmedinfo.com/nme_founders.html

47 HealthSouth Context, Leadership, Culture and Community http://www.corpmedinfo.com/healthsouth_culture.html

48 Citigroup http://www.corpmedinfo.com/access_citi.html
Citigroup Culture and People http://www.corpmedinfo.com/citiculture.html

49 ANALYSIS OF CORPORATE CULTURE AND PRACTICE (Sun Healthcare as an example) Lessons for the Future http://www.corpmedinfo.com/corp_anal_aug00.html

50 David Banks, William Floyd and Corporate Culture Beverly Healthcare http://www.corpmedinfo.com/beverly_banks.html

51 VENCOR'S CARE, MORALITY AND ETHICS http://www.corpmedinfo.com/vencor_care.html
Bruce Lunsford and Vencor http://www.corpmedinfo.com/vencor_lunsford.html

52 Robert Elkins - Founder of Integrated Health Services http://www.corpmedinfo.com/ihs_elkins.html

53 Michael Walker Genesis Health Ventures http://www.corpmedinfo.com/genesis_walker.html

54 Mariner Post Acute Network Culture http://www.corpmedinfo.com/mariner_culture.html

They provided funding to encourage this. Investors saw nursing homes as *'low risk, high profit financial ventures'* and over the succeeding years there was a huge expansion of for-profit providers.

Early problems

Australia soon had one of the highest rates of nursing home occupancy in the world and many did not need to be there. The Whitlam government tried unsuccessfully to address this by funding the non-profits better and the Fraser government tried unsuccessfully to regionalise more and move responsibility to the states.

The Coleman 1975 and the McLeay 1982 reviews recognised the complexity of aged care and the difficulties of central management. Both focussed on community engagement. The McLeay committee recommended that *"Planning the organization and delivery of health and welfare services for the aged should be a matter for State and local government".*

The Giles report in 1985 was similar to the recent Royal Commission and it exposed widespread failures in care in the for-profit sector. It wanted greater local accountability and suggested that local communities be involved in addressing failures in care.

The first reforms 1986

The reform program commenced by the Hawke government in 1986 prevented profits from being taken from money allocated for staffing and care. A system of more effective close state oversight with regular visits was commenced. While this did not meet all of the regional and community recommendations, it resulted in considerable improvement. It did not build civil society engagement and so create a balanced system.

These changes were very unpopular with large sections of the industry who saw them as restrictive. They strongly resisted them but their challenge in the courts was unsuccessful. The changes directly challenged the new economic thinking about free markets that had been adopted in the UK and the USA. They were being pressed for in Australia by the business sector, advocated for by the Productivity Commission and were soon adopted by politicians in both major political parties. Without direct community involvement, interest waned and vested interests soon took control. The window of opportunity was missed.

The Keating government, elected in the early 1990s, did not support the new regulations and they languished. When his own economist (Professor Bob Gregory) warned of the consequences for staffing and care of introducing the market changes he proposed, Keating sat on his hands. The industry turned to the opposition and supported them.

The new Howard government elected in 1996, worked with industry leaders to repeal the previous restraints and radically restructure aged care as a competitive market in 1997. Since then both political parties have supported this model and worked closely with industry. Contrary views have been ignored.

3.4.2.2 Recent history

Gregory's warning that staffing and care could not be protected proved prophetic. The Riverside kerosene baths scandal in 2000 after only three years, was the first of many involving failures in care. Since then, there have been ongoing problems with recurrent scandals, followed by a multitude of reviews, inquiries and consultations. These were followed by reforms that claimed to have addressed the issues.

None have worked and some made the situation worse. Staffing and care have deteriorated progressively. This has accelerated over the last 10 years as the focus on reforming the market when it had problems led to more marketplace solutions that ignored past knowledge. Whistle blowers have been attacked, families disbelieved and those who persisted threatened with defamation. The press investigated and published.

Aged care is not the only market that has suffered from these problems and Australia is not the only country that has adopted these policies with similar results. In 2015 we wrote about and collected a long list of links to articles describing failed markets and then of failures in aged care in the UK, USA and Australia over the years[55]. By 2018 it was much worse and there were so many problems that Four Corners did a two-part exposure forcing the government to call a Royal Commission.

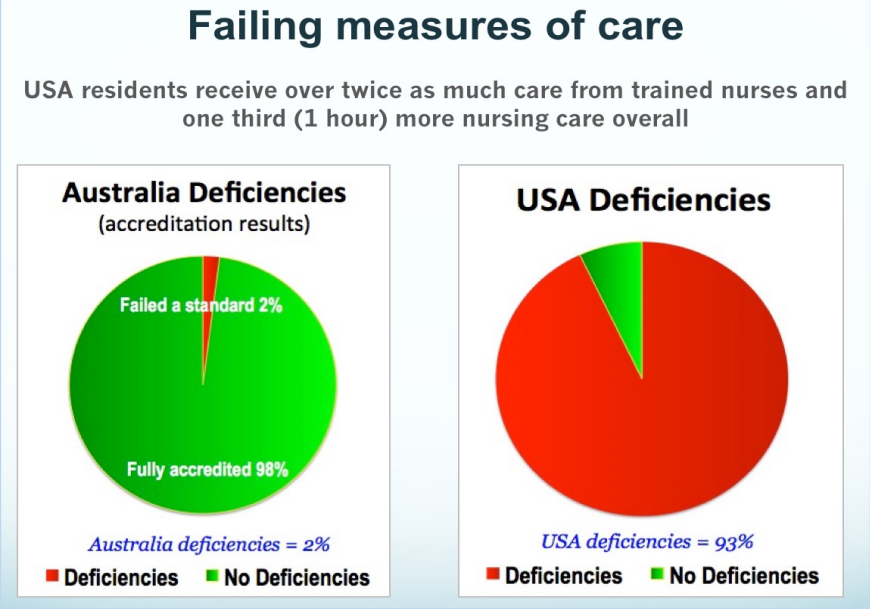
Aged care has not met anyone's expectations except the providers who entered the sector to make money and become wealthy.

In spite of this government ministers and industry have regularly boasted that Australia had a 'world class' system confirmed by a rigorous regulatory system, which showed that care was improving steadily.

During the last 23 years there have multiple 'reforms' instituted by the 'industry' and government working together. Each, like that in 2012, and those in 2014 and 2015, were promoted to the public in glowing terms, once again reaffirming that the system was world class. Yet each was followed by further more rapid deterioration and more scandals.

Some charts show what was happening.

Failing measures of care: By 2016, almost 98% of Residential Aged Care Facilities in Australia were getting perfect scores - something that should have been contrasted with the better staffed US system where only 7% got perfect scores and 20% had serious failures. This readily available information recorded over the years should have set red flags waving but it was not examined.

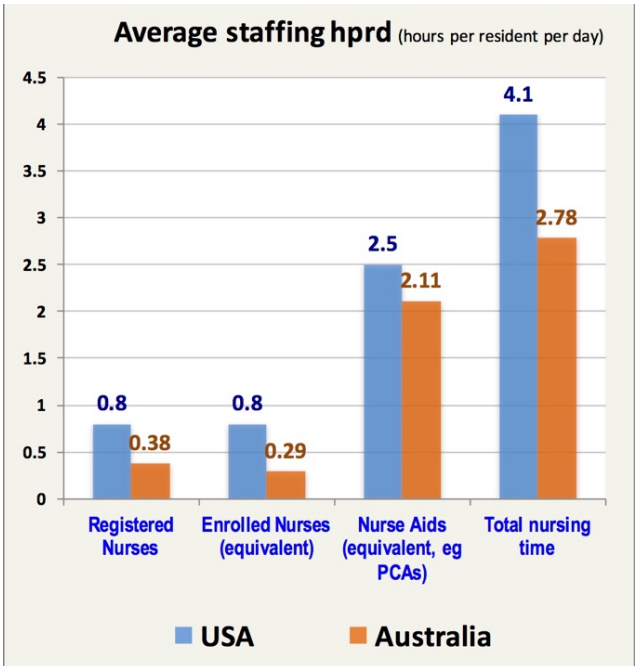


[55] Further Reading Aged Care Crisis 2015 https://agedcarecrisis.com/solving-aged-care/part-4/further-reading
Aged Care failures Inside Aged Care 2015 (updated 2018)
https://www.insideagedcare.com/aged-care-analysis/aged-care-marketplace/aged-care-failures
International aged care Aged Care Crisis 2015 https://agedcarecrisis.com/solving-aged-care/part-4/international-aged-care

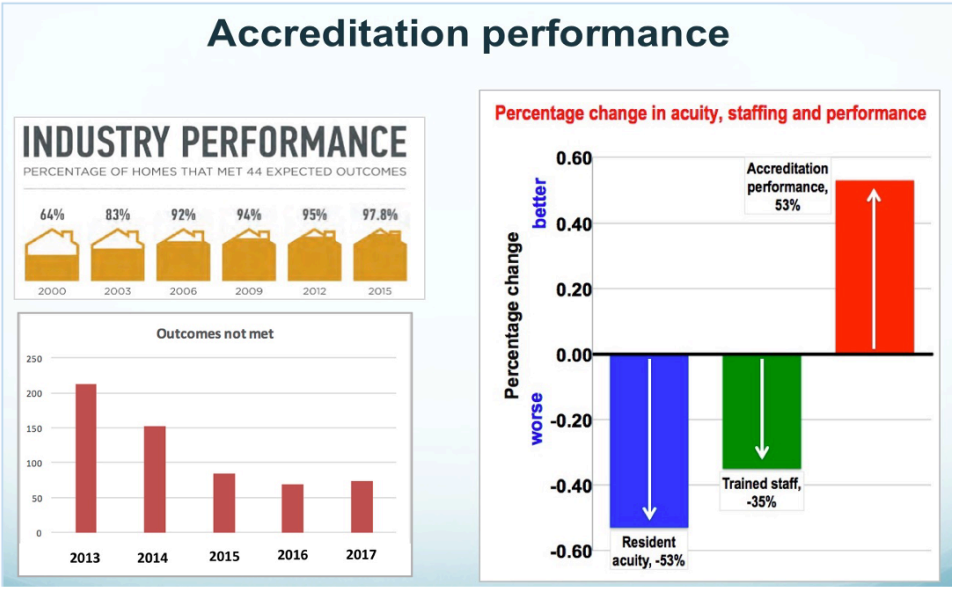
Average staffing hprd (hours per resident per day):
This success in meeting all the standards set was achieved even though residents in US nursing homes received more than twice the amount of care time from trained nurses and a third more care time overall than Australian residents. Comparisons were never made.

We are not suggesting that the US has a good or successful system. Its system has been flawed since the 1980s. It has had serious problems over the years. Their regulatory system has revealed them, and regulatory effort has contained them better than in Australia but the system remains suboptimal.

The argument is that systems that depend on regulation are dysfunctional and need restructuring if they are to work well.



Accreditation performance:
Even more remarkably, this success rate in Australia was achieved as the percentage of sicker and frailer residents (revealed by the number of high care residents) increased by over 50% and the percentage of trained nurses needed to care for them fell by 35%.



We now know that far from being world class, this was a system that had been neglecting residents and often harming them for years – one to be ashamed of.

It is now clear that whatever explanation is offered, the regulators that visited these facilities regularly were protecting the industry and the government from bad publicity instead of the frail elderly they were supposed to be protecting. We need to look at what was happening.

3.4.2.3 Regulatory failure

To understand how this developed we need to go back to an audit of accreditation by the Australian National Audit Office (ANAO) in May 2003. It focused on the failure of the agency and the industry to collect data to evaluate both the performance of facilities and of accreditation, a 'regulatory system' which was claimed to ensure good processes were in place[56]. At a hearing of the Joint Committee of Public Accounts and Audit later in 2003, the industry undertook to collect data and the Accreditation Agency indicated it was already happening[57].

We wonder what they found because there were no reports. Instead, the agency employed a consultant to review its accreditation performance in 2007. Interestingly these failures in care now became indicators and there was a *"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".*

This was the same year that Braithwaite and co-workers published **'Regulating Aged Care'**, the book in which he reported on his investigation and referred to *'over-whelming evidence of reckless neglect"* and noted that failures *"have to be bad for non-compliance to be recorded or strong criticisms to be made in an accreditation report."*

On multiple occasions over the years the accreditation agency insisted that it was not a regulator. It was there to assist the providers and its success was reflected in the number of providers who performed well. Braithwaite was told that the agency was not a regulator, the department did the regulating.

But this approach was also revealed in the department itself, when claims were made to ABC Four Corners in 2012 by nurses employed by the department to oversee payments for aged care services. They claimed that they had found widespread fraud where facilities were *"treating the residents like a cash cow".* Instead of addressing this they were *"told to look the other way, tick it all, let it go through."* and *"told many, many times it was not my money."*

It was also claimed that there were consultants who were advising nursing homes how to maximise their claims advertising that there were *"hidden goldmines"* which they could find. In giving evidence to a senate committee in 2013, the department referred to this as *"incorrect claiming"* rather than fraud. It was running workshops to deal with it – hardly a regulatory approach.

In 2014, a Capability Review of the federal Department of Health and Ageing[58] found that *"- - it is beset by a culture of 'inappropriate behaviour' including bullying and harassment, a command-and-control approach by top bosses and an environment where mistakes are not tolerated*". We can understand how conflicted it was.

The full extent of the problems in the regulator was revealed when in 2016 state regulators found appalling care and mistreatment of residents that had been going on for 10 years at the Oakden facility in South Australia. During that period, the Accreditation Agency had visited it several times and given it a perfect score. A government appointed inquiry and a senate review into regulation followed.

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[56] Managing Residential Aged Care Accreditation Auditor General by Aus Nat Audit Office (ANAO) 2003 http://www.corpmedinfo.com/agereport2003.html

[57] Joint Committee of Public Accounts and Audit - Review of Auditor-General's reports, fourth quarter 2002-03 - 18 August 2003 http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22committees%2Fcommjnt%2F6844%2F0003%22

[58] The federal Health Department: 80-hour weeks, bullying, command and control The Canberra Times 8 Dec 2014 http://bit.ly/2L8PPt6 Capability Review - Dept of Health (Oct 2014): http://bit.ly/2LbRZba

In 2018 a CEO of a not-for-profit who had worked for the health department for many years before resigning claimed[59] that aged care *"has become a smoke and mirrors game with the regulatory bodies either unable or unwilling to rid the sector of the poor performers"*.

3.4.2.4 Fraud in aged care

Meanwhile the pressures of competitive consolidation had caused the industry to innovate and it was soon far more successful at maximising profits. The CEO of Elders Rights Advocacy told the senate in 2013 of the excessively large amounts (up to 60%) taken from home care packages to cover administration and case management[60]. That has been ongoing and still happens today. It did not take long before the same sort of thing was happening with Consumer Directed Care[61].

The rorting of a dementia supplementary payment by nursing homes was so extensive that government had to abolish it[62] in 2014. Additional funding for high care residents was also a target and by the end of 2015 the minister was complaining of *"bogus claims for the high-level funding"* that had created *"a $150 million blowout"*. It had been going on for a long time. Large fines were promised[63].

There was extensive criticism of the funding model and particularly of the ever greater complexity for residents as changes were made to reduce rorting. The aged care payment system did not reflect the care needs of resident and in this market system they received the less effective treatment that was funded instead of the care they needed[64].

The funding system was blamed for creating perverse incentives and encouraging rorts[65]. Reports suggest that private equity owned and recently floated Estia Healthcare was particularly active in maximising funding[66] Before he joined Estia, its CEO, then with BUPA had been co-opted onto the committee that designed the funding system.

The new Turnbull government estimated there would be a budget blow out by a further $3.8 billion over the next four years and responded by cutting funding in 2016. This brought competitive consolidation to an end but companies had borrowed heavily and many were probably in debt.

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[59] LinkedIn: http://bit.ly/2BVYHww

[60] Community Affairs References Committee 16/12/2013 https://bit.ly/3DGsFEN

[61] Living with dementia: Catherine and John Clarke-Jones's story Lateline 29 Sep 2015
https://www.abc.net.au/lateline/living-with-dementia-catherine-and-john-clarke/6813966
In-home care recipients complain packages 'being fleeced' by not-for-profit providers charging high fees ABC News 1 Oct 2015
http://www.abc.net.au/news/2015-09-29/complaints-over-fees-after-in-home-aged-care-changes/6802312

[62] Govt documents shed light on dementia supplement claims Australian Ageing Agenda 26 Sept 2014
https://www.australianageingagenda.com.au/executive/govt-documents-shed-light-on-dementia-supplement-claims/
The Senate Questions without Notice Speech Senator Fawcett 1 Sept 2014 https://bit.ly/3LtVS7M

[63] MYEFO budget update: Big fines aim to stop fraud in aged care Sydney Morning Herald 15 Dec 2015
http://www.smh.com.au/federal-politics/political-news/myefo-budget-update-big-fines-aim-to-stop-fraud-in-aged-care-20151215-glo77u.html
Government clamps down on ACFI claims Australian Ageing Agenda 16 Dec 2015
http://www.australianageingagenda.com.au/2015/12/16/government-clamps-down-on-acfi-claims/

[64] Call for ACFI overhaul to cover exercise therapy for pain management Australian Ageing Agenda 1 June 2016
http://www.australianageingagenda.com.au/2016/06/01/call-for-acfi-overhaul-to-cover-exercise-therapy-for-pain-management/
Optimising aged care funding On Line Opinion 30 May 2016 https://www.onlineopinion.com.au/view.asp?article=18264

[65] ACFI Survey 2014 Australian Physiotherapy Association.
Call for an increased focus on wellness in ACFI Hammondcare 10 May 2016

[66] Health Department set to audit Estia over aged-care claims The Australian 7 June 2016
Aged care and fast money an unhealthy mix The Australian 11 June 2016

The pressures to find more money and reduce staffing and care increased and so did the failures in care[67].

The big companies looked for ways of charging residents more[68] and disputes ended in the courts[69]. Some charged extra service charges for services that were already covered under other fees and regulators blocked this[70]. Others including BUPA, which was fined, charged for services that it never provided[71]. The retirement village sector was even more predatory with headlines like *"Bleed them dry until they die"* describing some company policies[72]. An investigation that alleged tax avoidance by large for-profit aged care companies was followed by a Senate Inquiry[73]. The influence exerted by aged care corporate donations and lobbying has been a concern[74].

As illustrated in the USA and replicated in aged care the most alarming feature was the exaggerated claims of the believers in the industry and in politics who managed and regulated the system. This is contrasted with the experience of staff at the coalface as shown in the left column below. In the right column are the comments of those who went looking for data in what industry called the *"most robust quality system anywhere in the world"*.

The Royal Commission found a system characterised by Neglect, that Australia should be ashamed of. **What is so worrying is that in spite of this there are believers who still believe in 2022.**

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[67] Aged care providers seeking profit instead of residents' wellbeing The Age 27 May 2016. https://bit.ly/3Sh9l56
Aged care funding claims present massive challenge for new government Financial Review 6 Jul 2016 https://bit.ly/3UrNEB3

[68] Estia, Japara, Regis investors get a lesson on the impact of budget cuts Financial Review 6 Sept 2016
http://www.afr.com/news/politics/estia-japara-regis-investors-get-a-lesson-on-the-impact-of-budget-cuts-20160906-gra8l3

[69] What approved providers can and cannot charge under the Aged Care Act – Regis Aged Care Pty Limited v Secretary, Department of Health [2018] – Healthcare https://bit.ly/3foLNgE

[70] Regis Healthcare, Japara to repay extra fees taken from elderly clients The Australian 8 Mar 2018 https://bit.ly/3BISCkE

[71] Bupa Aged Care in Court for alleged misrepresentations about services ACCC 16 Apr 2019
https://www.accc.gov.au/media-release/bupa-aged-care-in-court-for-alleged-misrepresentations-about-services
Court orders $6m in penalties against Bupa and compensation for consumers ACCC Media Release 12 May 2020
https://www.accc.gov.au/media-release/court-orders-6m-in-penalties-against-bupa-and-compensation-for-consumers

[72] Bleed Them Dry ABC Four Corners 26 June 2017 https://www.abc.net.au/4corners/bleeding-them-dry-promo/8643348
The price of Freedom Sydney Morning Herald 2017 https://www.smh.com.au/interactive/2017/retirement-racket/the-price-of-freedom/

[73] Financial and tax practices of for-profit aged care providers Senate Economics Committee Nov 2018
https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Economics/Taxpractices-agedcare

[74] Lobby Groups and the Australian Aged Care Sector Lobbywatch 1 Oct 2019
https://medium.com/lobbywatch/lobby-groups-and-the-australian-aged-care-sector-ced7d9babf18
Are political donations protecting Bupa's aged care licence? Michael West 3 Feb 2020
https://www.michaelwest.com.au/are-political-donations-protecting-bupas-aged-care-licence/

Very Different views

Incompatible Views

A 'World Class' aged care system

Politicians - a very, very thorough accreditation system **(2000)**

Industry - the **most robust quality systems anywhere in the world (2012)**

The Austrade website - A global benchmark for best practice - strong government funding - robust framework for accreditation, quality and regulation **(2015)**

Federal minister Ken Wyatt says we have **a world-class system (2018)**

Industry - a good system - delivering high standards of care **(2018)**

A system to be ashamed of

Nurses - the tragedy of our nursing homes - **a huge indictment on our society**.- many acts of brutality and cruelty - care falls short by most facilities **(2005)**

Nurses - some mind boggling disgraceful care. - **open their eyes to the horror that exists** - It is a disgraceful situation **(2008-12)**

Nurses - Please, please change things. - **truly a hidden humanitarian crisis**. **(2016)**

Chairman AMA Council of General Practice - It's definitely worse now than it was 20 years ago (2018)

An absence of data

CEO Alzheimers Australia (2015):

"We still **don't have a single measure of quality** in aged care services, and this is critical - - one of the biggest challenges facing aged care.

Researcher (2015):

"very little, or none basically, - - -should have a much better system in place around the measurement of data.

Researcher (2018):

"(In Australia data is of) **insufficient rigour for use in research**

All of this data and more has been supplied to government and other reviews on several occasions since 2016. The more the situation deteriorated, the more ineffective centrally controlled regulatory reforms were introduced. The claims to excellence became more strident.

The striking difference in the ways those who were responsible for the system perceived it when compared with those on the ground was stressed to the inquiries and the well understood reasons for this explained. That has largely been ignored.

During this entire period citizens, staff and academics, who spoke out about what was happening were ridiculed and their credibility destroyed. Advocacy groups that spoke out and blamed the radical changes that were made in 1997 for the problems were marginalised and ignored.

Those who embraced the beliefs that gave these changes legitimacy, were welcomed and listened to. Logic, evidence, as well as the insights from social scientists over the last 200 years were ignored.

3.4.2.5 Failed reviews, investigations and consultancies

The Royal Commissions own Background Paper 8, '*History of aged care reviews*' in October 2019 described the large number of investigations and reviews done and commented that in spite of them *"the underlying problems remain"*. The final sentence was

> The overarching question that arises is why, after all these reviews, the aged care system still fails to support an appropriate quality life for the most frail and vulnerable members of our community.

Clearly these reviews and enquiries did little more than placate the community when they became alarmed at what had happened. Once community interest had waned, those in control tinkered with the system and went back to doing what they were doing before. A cynic might see this as a deliberate ploy of the self-interested but clearly it is more complex.

We can understand this more readily if we accept that our country is in the grip of another simplistic ideology. It is dominated and controlled by powerful believers that understand everything we do in free market terms and see citizens as driven purely by self-interest.

Alternative perspectives including past knowledge of markets and of the complexity of humans and their society have not been seen as credible. Those who thought differently were not considered when appointing inquiries. The system became unbalanced and services that did not fit this model were treated as if they did. Situations like this have been common in the past and are understood.

The late French 20th century philosopher, Michel Foucault explained how the powerful in society were able to control the way society thought and behaved - the discourse they used, and so 'govern' the thinking and behaviour of citizens. Importantly they also controlled what could not be said and what was unthinkable and not said. This makes what happened at these inquiries understandable. It explains Professor Leeder's warning that 'mad cow thinking' was being transfused into every vein in society.

Nurse academics have used Foucault's ideas to explain their observation of how modern management strategies based on neoliberal beliefs change the way in which nurses think about their role in hospitals and nursing homes and so how they behave.

We have explained that the free market discourse (patterns of thinking or paradigms) used by the ideology, and in the competitive marketplace, are very different to the discourse of care - the patterns of thinking used by functioning communities and professions in caring for one another over the centuries. We have repeatedly drawn attention to this 'paradigm conflict', the tensions created by the dominance of the market discourse and the consequences for care.

3.4.2.6 The Royal Commission into Aged Care Quality and Safety

Warning about the Royal Commission

Aged Care Crisis was well aware of all this. We had used Foucault's insights in some of our submissions. When The Royal Commission was announced, Aged Care Crisis issued a media release calling for structural changes and not patches[75] indicating that *"The failures in both care and staffing at the coalface and government regulation point to deep structural and conceptual problems within the sector"*. We stressed that this was a society wide problem. Aged care was not alone and *"These are matters that have been neglected by all previous inquiries"*.

[75] **Media release:** Structural Reform Needed - Not Patches. Aged Care Crisis, 26 Sept 2018 https://www.agedcarecrisis.com/news/426-media-release-structural-reform-needed-not-patches

In our submission to the then Minister for Health in 2018 after the announcement of the Royal Commission we warned him not to make the same mistake again. We pointed out that all too frequently *"Commissioners have been drawn from what were seen as credible candidates. This was because they came from an economic or other background that aligned with policy".*

In referring to those who would be contributing and making submissions we wrote *"Contributors need to be persuaded that the proposed commissioner is not biased by preconceptions that undervalue their contributions".*

We concluded *"It is essential that this Royal Commission explore the sector in the required depth and that a broad range of academic expertise with insight into our human condition and the nature of society be encouraged to contribute to the analysis".*

The government ignored this advice and instead appointed a long term government bureaucrat and supporter as well as judges whose expertise and careers were in industrial affairs and tax law. They clearly saw this as no more than a market problem – perhaps just an image problem.

The elephant in the room at the Royal Commission: Why?

Incredibly neither the Background Paper nor the Commissioners themselves tried to answer the question that asked about why so many reviews had failed, nor did they address these issues when they were raised in submissions.

This was so taboo that paradigm conflicts were carefully avoided and evidence that would have exposed this problem was not sought. They carefully ignored the extensive research into the large differences in both staffing levels and failures in care between facilities owned by government, non-profit, corporate structured entities, for-profit and private equity.

We suspect this taboo which prevented alternative discourses from intruding (at least publicly) may have been behind the unresolved dispute between the final two Commissioners. Justice Pagoni, who had once studied social sciences seemed to recognise the problem. Commissioner Briggs would not do so and resolutely insisted on 'renovating' a system that was fatally flawed.

Pagoni stood his ground and recommended that the system be rebuilt by distancing the central regulator from government and regionalising direct management and oversight. He was moving towards a more balanced system. But clearly a government wedded to an ideology would not follow this path when they had a choice.

In the end the Royal Commission behaved in exactly the same way as previous inquiries. It acted as a distraction until the attention of the community turned elsewhere, and the same people who are unable to change their thinking and have made such a mess are back tinkering with the system.

As Professor Eager and her team who designed the AN-ACC system indicated[76], the Royal Commission has only addressed the *"low-hanging fruit issues"* – or as we warned[77] the Royal Commission in Jan 2020, they were addressing *"the symptoms but not the cause"* of the social pathology.

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[76] 'Fundamental change' in aged care model needed Australian Financial Review 2 Mar 2021 https://www.afr.com/politics/federal/fundamental-change-in-aged-care-model-needed-20210302-p576yp

[77] ACC Submission re to Royal Commission re Program redesign 24 Jan 2022 'AWF.660.00070.0001': https://agedcare.royalcommission.gov.au/media/26733

They have not addressed the reasons for failure and as Eager and her co-workers indicated, they have not *"got to the core of what is a public aged care system"*. Instead *"they have handed the recalcitrant issues back to government"*.

While there has been a change of government, they have so far done little more than rubber stamp the previous government's program and the Royal Commission's recommendations. They have given no indication of any sort of willingness to restructuring it in ways that would restore balance to the system. The system needs balancing forces that neutralise the perverse pressures that undermine any attempt at reform. Instead, government are once again focusing on renewed efforts to regulate a deeply flawed system. In the meantime, little has been done to address the plight of the residents who are still malnourished[78] and neglected.

It was disappointing, but not surprising to see the response of researchers from the Faculty of Business and Economics at the University of Melbourne, when their research[79] revealed that *"Competition Isn't Improving The Aged Care Sector"* and they accepted that markets had clearly failed. Instead of fixing the problem, they wanted to make the system more transparent, with more competition to enhance choice and when that was not possible more regulation by government.

One wonders about academia when some are unable to challenge their beliefs and look for real alternatives that address issues rather than just try to regulate them – something that obviously has already failed on multiple occasions.

3.4.3 Introducing ABF to aged care

If we compare what has happened in aged care in Australia with what happened in health and aged care in the USA, we see the same blind beliefs, the same strategic ignorance and wilful blindness to knowledge, the same exploitation of vulnerable citizens, and the same regulatory ineptitude. Like the USA, the system in Australia pursues the money. The care that it should be providing is distorted and manipulated as innovative ways are found to maximise profitability.

ABF funding may have benefits but it may well suffer the same fate as in the USA. Its complex process and structured nature will simply challenge the innovative minds of those ambitious to succeed in the marketplace and they will find ways around funding constraints.

As Eager and her co-workers have indicated[80] the failure of the Royal Commission means that those who are looking for an *"elegant blueprint for how to fix aged care, they will not find it here"* and that *"the solution to the wicked problem of aged care will have to wait until next time."*

She points out that aged care has been treated as a competitive market rather than a public good.

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[78] Prime Minister: Aged care residents are still starving. Media Release Dietitians Australia 27 Sept 2022 https://dietitiansaustralia.org.au/about-us/media-centre/prime-minister-aged-care-residents-are-still-starving-media-release

[79] COMPETITION ISN'T IMPROVING THE AGED CARE SECTOR Melbourne Institute June 2021 https://pursuit.unimelb.edu.au/articles/competition-isn-t-improving-the-aged-care-sector

[80] Kathy Eagar and Anita Westera, Fundamental failure: Aged care a public good or competitive market? RC fails to address role of private providers, Pearls and Irritations 2 Mar 2021: https://bit.ly/3oBWc8W
Westera, A and Eagar, K, The Aged Care Royal Commission: the government responds with more money but the structural problems remain. Pearls and Irritations 18 May 2021 https://johnmenadue.com/the-aged-care-royal-commission-the-government-responds-and-we-all-move-on/

There has been a failure *"to address the underlying structural and ideological factors that have shaped the aged care system we have today".*

> *"... The three big strategic reforms that were required to really fix aged care were not addressed adequately by the ACRC and they have not been addressed in the government response. We cannot fix the aged care system until we recognise that aged care must be a public good and not just a competitive market".*

Eager is clearly not expecting the AN-ACC funding she designed to have any major impact on this.

Research shows that dominant ideologies and flawed systems based on them come in cascades which are very durable with only occasional windows of opportunity when they can be changed. The present crisis in our society and the change of government creates a window of opportunity but there is little to suggest that it will be taken. Next time may well be another 20 or 30 years away.

Major structural reforms are needed and AN-ACC funding itself should not be a priority until we have a system that will benefit from it – unless of course it can find a different route and become a catalyst for the innovative restructuring that is needed.

3.4.3.1 Donations and political paradigm paralysis

Both major political parties have adopted a market approach to their policies selling party policies and leaders to the electorate rather than engaging with and representing the views of their electorates. Electoral success has increasingly come to depend on successfully marketing personalities and catch phrases. That does not come cheaply and is paid for by large corporate or union donors. Being elected increasingly depends on large donations.

Kevin Rudd's demise

This was readily apparent when Rudd, sensing that the 2008 financial crisis was a tipping point mounted a savage attack[81] on neoliberalism in 2009. He called it the *"greatest regulatory failure in modern history"* and pressed for a financial system that *"balances private incentive with public responsibility"* in order to *"save capitalism from itself"*. He also announced plans to tax the large mining companies. Large donors clearly intended to stop donating and use their money to fund a campaign against Labor.

Rudd was soon replaced with Gillard. The Gillard government then did a policy U-turn and worked closely with industry in implementing the strongly pro-market recommendations of the Productivity Commission's 2011 report on aged care.

The Living Longer Living Better (LLLB) reforms were introduced in 2012 by COTA's Ian Yates in a speech[82], at the time aptly titled *"The aged care time bomb is ticking"*. COTA was the community body that strongly supported the policies that started the bomb ticking.

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[81] The global financial crisis The Monthly Feb 2009
https://www.themonthly.com.au/issue/2009/february/1319602475/kevin-rudd/global-financial-crisis#mtr

[82] The aged care time bomb is ticking National Press Club Address Forum on aged care 12 April 2012
https://flexiliving.org.au/wp-content/uploads/2021/01/Australians-deserve-to-age-well-the-time-bomb-it-ticking1.pdf

The system started deteriorating more rapidly. The strong pursuit of this competitive free market policy by the Abbott government elected in 2013 sent it spiralling[83] towards the Royal Commission.

Trapped by wealthy donors

Rob Oakeshott, one of the independents that kept Gillard in power later described the extensive access that the wealthiest businessmen had to politicians[84] and how the money they donated to political parties created *"the policy inertia of Australia today"*.

It allowed big business to influence the political agenda and send *"many necessary policy reforms to the doghouse"*. He described them as *"intimately involved with, and crawling all over, our democracy"*. He called it *"a sold out democracy bent to the will of big business"* as *"political parties took the money and ran"*. This peaked in 2011.

In 2018 a report from the Grattan Institute described what was happening[85] and a senate inquiry made recommendations[86] that were largely ignored. Donations from large donors were higher than ever during the 2019 election[87]. In spite of this both major parties joined forces to weaken the laws around donations[88]. Aged care companies are active there too[89].

The likelihood of either major political party introducing changes that challenge the dominance of big business is small unless the community rises up and exerts its power, and independent politicians come to hold the balance of power and use it.

The other hope is that the bureaucracy, particularly those who should be independent recovers its sense of social responsibility and places its responsibility to community above its loyalties to those politicians who appoint it. It's time for the token words 'fearless advice' to have some substance.

3.5 The IHACPA Consultation Paper

Groundhog days

We hope that the IHACPA will forgive us for being sceptical but we have read so many similar persuasive documents promising changes and benefits over the years. We see a government appointed body that is peppered with all the same words used by a system that failed us and allowed the marketplace to milk the system by neglecting our fellow citizens. Why should this be any different?

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[83] Exclusive: Aged-care sector at risk of collapse The Saturday Paper 5-11 Oct 2019
https://www.thesaturdaypaper.com.au/news/politics/2019/10/05/exclusive-aged-care-sector-risk-collapse/15701976008867

[84] Rob Oakeshott: How big business hijacked parliament The Saturday Paper 9-15 August 2014
https://www.thesaturdaypaper.com.au/topic/politics/2014/08/09/rob-oakeshott-how-big-business-hijacked-parliament/1407506400834

[85] Who's in the room? Access and influence in Australian politics Grattan Institute Report 23 Sept 2018
https://grattan.edu.au/report/whos-in-the-room/

[86] Political Influence of Donations Senate Report 2018
https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Political_Influence_of_Donations/PoliticalDonations/Report_1

[87] How big money influenced the 2019 federal election – and what we can do to fix the system The Conversation 4 Feb 2020
https://theconversation.com/how-big-money-influenced-the-2019-federal-election-and-what-we-can-do-to-fix-the-system-131141

[88] Federal parliament just weakened political donations laws while you weren't watching The Conversation 4 Nov 2020
https://theconversation.com/federal-parliament-just-weakened-political-donations-laws-while-you-werent-watching-149171
Push to reform political donations The Saturday Paper 6-12 Feb 2021
https://www.thesaturdaypaper.com.au/news/politics/2021/02/06/push-reform-political-donations/161253000011050

[89] Lobby Groups and the Australian Aged Care Sector Lobbywatch 1 Oct 2019
https://medium.com/lobbywatch/lobby-groups-and-the-australian-aged-care-sector-ced7d9babf18

This seems to be another complex remote system pulling levers in an attempt to steer the system to provide good empathic care. But good empathic care is only readily apparent to those who are often at the bedside and they are excluded from policy by its centralised structure, its complexity and their lack of involvement.

The words used in the consultation paper are the impersonal words of economists and the management system introduced by neoliberal free market thinking.

The nature of care

'**Nursing home**' accurately describes the facilities we are talking about because a 'home' is where people live with others who empathise and care for one another. Nurses are citizens who have selected a career of caring for the vulnerable because they empathise and care. They form caring and empathic relationships.

Instead, nursing homes have been commodified. They have become 'Residential Aged Care Facilities' (RACFs) where 'services' are provided and the focus is on doing them in a financially 'efficient' way. The commercial paradigms used create instrumental relationships when providing services. They are incompatible with truly caring relationships.

This is a very different sort of workplace and it cannot be treated in the same way as other workplaces.

The process described and the words used reveal where it comes from. Terms like *'national efficient price'* and *'national efficient cost*' make no allowance for the actual needs of the carers or the cared for. Efficiency has been pursued by government and providers for well over 20 years. In the pursuit of fiscal efficiency, staffing has been driven down to unsafe levels and residents who should have been embraced in caring relationships by their carers have been neglected and even abused.

The variability and complexity of care and the need to spend time building trusting relationships requires that there be redundancy in the system and in staff. This allows the system to adapt to changing needs. It is not to advocate for inefficiency but to stress that this is a system where measures that focus on financial efficiency are inadequate.

Professor Michael Fine has been writing about the nature of care for many years. He has looked at the adverse impact of marketisation and neoliberalism on culture and relationships[90]. In writing about cultures of care in 2015 he and his co-authors indicated[91] that cultures of care cannot be simply *"reduced to financial incentives and labour market opportunities – - traditional cultural values and 'care ideals' are deeply linked to a sense of personal identity".* A centralised system of assessment and funding cannot meet this need.

Incentives

We worry when we see reference to incentives because they are so harmful in these sectors. The use of incentives to obtain objectives in humans is based on experiments in rats in the early 20th century. They were first introduced into education in the 1960s.

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[90] Short summaries and comments on some papers by Professor Fine 1992 to 2015 can be found at https://www.insideagedcare.com/aged-care-analysis/theory-and-research/nature-of-care

[91] Cultures of Care by Fine, Michael (2015) in J. Twigg and W. Martin (eds) Routledge Handbook of Cultural Gerontology, Routledge: Abingdon UK: 269-276

They were very effective in stimulating learning to pass exams but they inhibited critical thinking and fostered selfishness so that children did not consider the consequences of what they were doing. Critics described this as turning children into rats.

If we look at the US health care system where huge incentives were offered for reaching goals, we see that it readily turns adults into rats too. Incentives played a critical role in leading to the frauds harming patients. Deliberate incentivisation changes the way people behave and we feel it should be avoided. Instead, people who have provided good caring services should be honoured and rewarded.

Who is going to do the assessments?

Information from the department of health web site[92] indicates that these will be independent *"trained, qualified and experienced aged care clinicians."*. They will have *"5 years' minimum experience as a registered nurse, physiotherapist or occupational therapist delivering clinical services in aged care settings"*. The AN-ACC assessments will be separate from care plans.

Separation of assessors and providers will ensure the integrity of the system and that residents' care needs come before funding decisions.

But where will all these trained clinical assessors with 5 years' experience come from if not from the providers of care? This is a sector desperately short of well trained staff. The sector does not need a competitor drawing trained staff away and so undermining care. If they are drawn from the sector they will be targeted if they do not deliver what the industry wants and they will not be welcomed if they want to work there again.

The claims to independent assessors sounds tenuous and the claim that *"providers will have more time to focus on understanding the resident's needs, goals and preferences"* and that *"This will contribute to better planning and quality care"* does not make any sense.

We are being promised independence which is unlikely to exist under the present system. But more than this, will a once off assessment by an independent assessor have the same validity as that of the regular staff caring for the residents on a day by day basis and making the care plans? The ground covered will be duplicated and that is not efficient!

The problem of trust

The problem here is that there is no trust and no trustworthiness in the system because it is deeply flawed and dysfunctional. In our society today it is the people who should be trustworthy and whom we have no choice but to trust who are exploiting every vulnerable person and every funding system they can find.

The banks, financial advisors, the VET system that trains staff, the disability sector and many more. Quite apart from the money defrauded and not recovered there are huge costly overheads in having to address this problem by regular checking and regulating.

The free market is claimed to be more efficient and so economical. If we look at the US health care system, it is by far the most costly system in the world yet it provides inferior service. This is quite apart from all the additional regulatory costs that are not included. It is far from efficient.

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92 AN-ACC assessment process and classification Dept Health 29 June 2022 https://www.health.gov.au/health-topics/aged-care/aged-care-reforms-and-reviews/residential-aged-care-funding-reform/an-acc-assessment-process-and-classification

Our argument is that the problems in aged care are those of our fractured, predatory and diseased society. The sensible thing would be to deal with the pathology in our society and create a system and a society in which trust and trustworthiness are valued and restored.

Accountability

The other important issue is accountability. To whom is the aged care system accountable to for providing care and to whom is IHACPA accountable to for the advice it gives. What balancing insights and forces are there to challenge IHACPA assessments and keep it on track.

Is it free to do its own thing, like the market we have. Is it accountable to the government that appoints it or the providers who need the money to provide care? Governments and the regulators that they appointed to watch over the system have both consistently denied accountability for failures and instead claimed that the providers are responsible. The providers are the people who have most to gain by not providing care. In a system where funding is rationed to ensure efficiency, their survival may depend on the money they save by doing so. It has not worked.

3.6 What does social research show?

What is happening in the world, in our society and in all of these many failing systems and how can we fix it? How might the IHACPA play a role in fixing this problem in aged care and more widely? How can we make them all accountable to the civil society they all serve and enable that civil society to hold them to account?

There is nothing new about this and similar problems have been studied over the last few hundred years. But because the failures are so pervasive and so widespread there has been considerable recent interest and several books have been written.

Studies that explain our failures and how to fix them

Humans and their societies are complex phenomena. As individuals and as societies we are a consequence of layers upon layers of evolutionary development over millions of years. Many have examined this complexity from many different points of view to give us insights into what we are like and how we operate. There are three useful threads, the Macro view, the social system analysis and the micro view of our behaviour that are particularly informative and helpful. They are not particularly difficult to understand. They show what needs to be done.

3.6.1 The Macro perspective – a broad view

Professor John Braithwaite, is an eminent criminologist and the founder of the international group REGNET. He and his international peers have spent many years studying human history to identify recurrent patterns of human misbehaviour and criminality. They have explored them to identify patterns that enable us to understand what is happening. He has brought this large volume of research together in a detailed in depth analysis in an extensively referenced book[93] *'Macro criminology and freedom'* published in February 2022.

The book explores the complex relationships between dominance of society by groups within it, anomie *(referring to societal breakdown and fragmentation often referred to as 'truth decay' or 'post-truth' today)*, the exploitation of citizens, criminal behaviour both by the powerful and the disempowered, and the association of these phenomena with warfare.

[93] Macrocriminology And Freedom By John Braithwaite ANU Press, Feb 2022

He finds that because of the way these developments influence one another, there are cascades of criminality and also cascades of virtue when society works well. Dominance is closely associated with exploitation and criminality. He writes at length about political and market dominance and criminality including when government and society are captured by the market.

Cascades of virtue are associated with a balanced society in which there is a balance of power within a well-structured civil society. Dominance is prevented by a strong civil society in which anomie has been replaced by a strong 'normative order'.

The balance of powers ensures that dominance and excesses by any group is checked by a network of others. Braithwaite says *"Criminalised states and criminalised markets evolve when there is no networked governance of their dominations".*

Cascades of criminality are eventually terminated and changed to cascades of virtue when citizens rise up and take back control of their societies, re-build a normative order and establish a balance of power. He writes about 'tipping points' when there are opportunities for society to interrupt the cascades.

Relevance

Braithwaite's insights seem to be particularly relevant to the USA, the UK and Australia today. The war in Ukraine by Russia and the aggressive behaviour of China are ominous.

The recent community backlash against major political parties and the dramatic success of the Teals and the Greens at the recent election reflects a strong desire for change within our society. This is a tipping point. It is an opportunity to rebuild and re-empower our civil society and re-establish a balance of power.

Additional Comment

At ACC we prefer to talk about social pathology rather than criminology because, too often, it is genuine people who believe that are responsible. The reasons why they so readily slide over into frank criminality are interesting, but as Braithwaite realises, regulatory effort and criminal penalties do not address the problems.

The outline of Braithwaite's book above does not do justice to the depth and length of his 600 page book. He advocates for a strong government, a strong market and strong civil society organisations so that there is a balance of power. That will certainly be necessary to reset the system and restore balance. But a balance of competing powers fighting for supremacy in our view, might, if that is all that is done, creates a number of waring states each fighting for supremacy until one gets an advantage.

That sort of balance where groups compete to get their way is not a good way to examine data, and use logic and real experience to follow the best path forward. In 1995 when she warned about what was happening and what was needed, Eva Cox wrote about a Truly Civil Society[94] in which people worked together, put power aside and rarely used it. In education, a constructivist approach which sets power aside and opens discussion to students also does that. Students come with fresh minds that challenge convention, widen horizons and build understanding.

[94] A Truly Civil Society Eva Cox Boyer Lectures 1995 http://ldb.org/evacox.htm

Instead of advocating and fighting for one's own solutions, we set them aside and engage with others collegially exploring their lives, their experiences and their views, and then when they are ready expose them to our knowledge and established views and see how they all stack up.

By sharing we bring many eyes to our problems and can reach an informed position. We also build critical thinking, a vitally important asset for a functioning civil society.

Braithwaite also writes about non-financial capital. This includes human capital, social capital, CHIME, bonding capital, recovery capital, restorative capital, restorative justice, societal capital. CHIME stands for Connectedness, Hope, Identity, Meaning and Empowerment. He is going there using many eyes. These are integral to building a truly collegial civil society of which the market and political system are a part - as well as a deliberative democracy which he supports.

This is the alternative to dominance and should surely be our ultimate objective. Power is held in reserve to check those who attempt to subvert this and use their power to dominate.

3.6.2 Exploring more closely- social systems

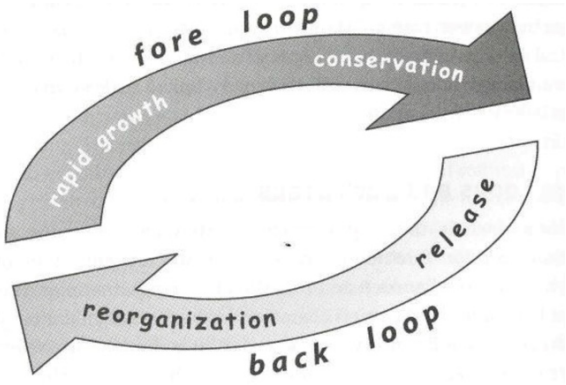
Social scientists, like Walker and Salt[95], studying the resilience of complex social systems have been particularly interested in the ecological consequences of failures in complex social systems and their resistance to reform. This approach is equally applicable to non-ecological complex social systems such as aged care.

They show how a broad range of balanced and empowered insights from different involved groups keeps complex social systems in check and prevent any one force from pushing the system out of balance. There is a good range within which the systems operate successfully and can respond and function well. When the system is pushed too far by one group others block it. These balanced systems respond effectively and adapt to change. They are flexible and are resilient to unexpected shocks.

When any particular pressure group becomes dominant and overcomes the others the whole system is pushed right out of the zone of effective operation. It becomes dysfunctional and damages the environment, citizens or society itself. This situation is very difficult to address.

The authors explain how when this happens and the failures are recognised and exposed, the system collapses (release phase). A program of reform is commenced (reorganisation) and at this stage there is a window of opportunity during which an actively involved community can take control and reform the system differently.

If they miss the opportunity, then the powerful vested interests take control again and 'reform' the system by centralising and tightly managing it making it more efficient (rapid growth) but less resilient and adaptable. It becomes very difficult to make any changes (conservation) until the next crisis of serious failures occur. Systems often go through recurrent cycles of failure before effective changes are made.



Reproduced from Walker and Salt 2006 pg 82

[95] Walker, B. & Salt, D. (2006) Resilience thinking: Sustaining Ecosystems and People in a Changing World. Island press

Successful reform is usually accomplished when the opportunity is seized by community groups to decentralise the system and manage it locally in collaboration with multiple different interested groups in society. Balance is created and stability restored.

Aged Care Crisis has analysed aged care using this model[96] showing how it became unbalanced during the 1970s and attempts to reform it and involve community in the late 1980s lost momentum. This allowed the powerful vested interests to take control again in 1996 and the opportunity was lost. A new cycle started as they centralised and managed. The ongoing failures were dramatically exposed again in 2017/18.

The community were angry again and wanted change, but they were distracted by other crises and attention waned. The long drawn out Royal Commission and its recommendations pacified them. The same powerful vested interests have once again taken control and the window of opportunity is rapidly disappearing.

This analysis meshes with Braithwaite's sweeping analysis of dominance. It explains the cascades of criminality, the potential tipping points and the importance of a strong and stable civil society with balanced power.

3.6.3 Going closer still. Examining human weaknesses

Our nature

Finally, we need to examine our own frailty and vulnerability as humans.

Developmentally the first individual forms of life were focussed only on survival and only the fittest survived. It was very inefficient. Those who cooperated and worked together became more successful and soon social networks and groups prospered. A balance between the deep selfish need to thrive and survive and our social responsibility to others and the group (social selves) was developed.

Humans thrived not only because they became intelligent and reflective, and learned to work together, but because their young were born so immature. Their genetic potential is modified and moulded by society in a process called socialisation. Our nature, our understandings, our behaviour and even our society are largely socially constructed. New strengths and new responses and behaviours are rapidly passed to succeeding generations making us very adaptable to changes and so successful. The development of language is critical.

The weakness in this process is that a fractured and anomic society will not do this well and the next generation might not be well socialised so that they are more focussed on self and less able to cope - perhaps even contributing to the cascades of criminality.

Our society

We live in a complex world which we all experience differently. We do not cope well with this complexity and have to build simpler patterns of ideas and ways of thinking (paradigms) that enable us to understand the bit of the world we live in and the society around us.

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[96] Attachment D: Analysis of aged care as a failed complex social system' (Jan 2021 updated 2022). Aged Care Crisis Submission to Productivity Commission inquiry into 'Aged Care Employment' April 2022 https://www.pc.gov.au/__data/assets/pdf_file/0010/339940/sub039-aged-care-employment-attachmentd.pdf

We do this by sharing experiences and ideas and building a world view and a normative order together. We also need to become active in this world and build lives there and for this we need to create meanings that motivate us and social values than build our societies.

As we build our lives in our societies, we create identities based on these paradigms, world views, meanings and values. They become a part of who we are.

Our problem is that we live in a changing world and change can happen quickly. We try to cling to the paradigm, world views and meanings that no longer apply. The world becomes unstable and we become disoriented and experience stress – also called anomie.

Our vulnerability

At times like this we are desperate for a new order and will create one for ourselves or embrace appealing ideas that others have developed. These are often not based on shared experience, on evidence or logic. Lives are created using them and they are incorporated into our identity. We defend them when they are challenged.

Imaginary ideas not based on the real world create problematic normative orders, world views and meaning systems, but they are vital and stabilising for those who embrace and believe in them.

Because they are not based on knowledge, logic or social values they can be harmful to others and to society.

When they fail and the beliefs are challenged, those involved assert these views strongly and defend them by attacking and discrediting their critics. They seek and often succeed in dominating society. We describe these as ideologies. They often become durable and long lasting. Understanding this adds another level of understanding to Braithwaite's cascades of criminality.

It may not be a coincidence that the USA, the UK and Australia almost at the same time elected populist leaders with flamboyant personalities who had little regard for society and its values.

There is an extensive volume of work describing the strategies used to ignore knowledge and logic in developing and maintaining ideologies and rationalising their legitimacy. There have been many studies of the psychological and social strategies we use to deceive ourselves, ignore the harm we are doing and discredit our critics. There has been renewed interest recently with McGoey[97] doing an in depth historical analysis of what she calls 'strategic ignorance' and Heffernan[98] writing about 'wilful blindness'.

Societies with an active well-structured and collegial civil society in which we are involved together, support one another and share experiences create balance and provide insulation from these problems. Change can become a welcome challenge to be met. Building new paradigms based on evidence and logic can become exciting and rewarding. We have the capacity to think critically and understand what is happening to us. We can respond intelligently in designing our future.

This aligns with Braithwaite's cascades of virtue and a society that challenges and stands up to vested interests so maintaining balanced social systems.

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97 Unknowers: How Strategic Ignorance Rules the World. by Lindsey McGoey 2019

98 Willful Blindness: Why We Ignore the Obvious at Our Peril by Margaret Heffernan 2013 and 2019

This is a only brief summary. These issues are explained more fully in an article *'Why our society and human services are in trouble'* on our web site[99] and in a root cause analysis[100] we wrote in January 2021.

3.6.3.1 Resolving the issues

The problems

We have an unbalanced system that is dominated by a narrow libertarian belief in free markets. We are in the grip of a cascade of criminality and our society has fractured and is behaving irrationally (anomie). This is the society that Rees and Rodley warned about[101] when they wrote *'The human costs of managerialism: Advocating the recovery of humanity'* in 1995.

Particularly alarming is the growing and increasingly violent crime rate, including domestic violence, and the increase in mental problems, suicide and gang violence in the more vulnerable young. These are the sort of things that are associated with the break-up of caring empathic and supportive relationships in anomic societies and the young growing up in this are particularly stressed.

Stanley and Lycett write about this[102] and attribute the poor performance of Australian children and young people *"on international wellbeing indicators"* to the impact of neoliberalism on society.

Solutions

As the research just quoted indicates the way out of this is to rebalance our society and our social systems by rebuilding our civil society. This problem is particularly acute during the current cascade of social pathology because civil society has been a specific target of neoliberal free-market ideology and the libertarian movements. Bizarrely they saw the society that formed and created every one of us, that has battled oppression and fought for democracy many times in the past as the main threat to our freedom.

Society has been pushed aside and disengaged from its affairs. The values on which our humanity is based and on which the stability and cohesion of effective society depends have atrophied from disuse leaving us with poorly developed social selves. This impacts on the socialisation of the young who are particularly vulnerable. All this makes it a difficult problem to address and it will take time.

Re-engaging Community: The solution to this is to re-engage civil society in managing its affairs and those of the nation at every opportunity. Across the world groups are advocating for regionalism, localism and deliberative democracy, all aimed at building greater community involvement.

So every time some central body takes on functions and activities that could be done by community it compounds the problems. Every time it engages with community and delegates responsibilities and duties to it, it rebuilds community. Human services, particularly those where citizens exercise their social values and build relationships will be critically important.

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[99] Why our society and human services are in trouble. Aged Care Crisis Dec 2021 https://www.agedcarecrisis.com/images/whysocietyandhumanservicesareintrouble.pdf

[100] Appendix 1: Root Cause Analysis of failures in Aged Care https://www.agedcarecrisis.com/images/pdf/root-cause-analysis.pdf

[101] The Human Costs of Managerialism : Advocating the recovery of humanity edited by Stuart Rees and Gordon Rodley Pluto Press 1995

[102] Stanley F and Lycett K 'The health and wellbeing of future generations' in 'What Happens Next? Restructuring Australia after COVID-19 ed Dawson E and McCalman J. Melbourne Univ. Press 2020

They are best placed to lead the way in rebuilding a society based on values and to serving the common good. Aged care occurs in our homes and in our communities. It is well placed to lead the way.

An alternative view: Looked at another way, we can also argue that everyone has elderly relatives and most of us today grow old. In a civilised and humane society, every citizen, every community and every society is responsible for its vulnerable members when they need help. Anyone or any organisation who provides that care is acting as their agent and doing it on their behalf. The people involved are directly accountable to the communities they serve when they provide caring services.

That is very different to 'community consultation' which in the current climate has been highly contrived and directed to securing approval for policies that have been harmful.

Instead, community has been pushed aside. They have been disempowered and denied the capacity to hold their agents to account. That situation must be addressed. Government and any other body making or implementing policy is also accountable to the community they serve and that pays for them.

Localism in aged care: The importance of local involvement and some control in aged care was recognised in several reviews between 1975 and 1989. Gerontologist Hal Kendig advocated for aged care to be regionally managed for the last 20 years of his life. Aged Care Crisis has been advocating for community involvement since 2008. Public advocates and public guardians have pressed for community oversight by an empowered visitor's scheme.

For the last 6 years Aged Care Crisis has been pressing for the 'industry-led' aged care system to be replaced with a community-led one. In this local communities will gradually assume direct responsibility for planning the services that are needed for their community and then for managing and overseeing them. After assessing their probity, capability and track record they would contract or licence providers to serve their communities and then work closely with them. If not satisfied they would replace them.

Central bodies and specialist services would adopt a reach down and support, train and mentor approach, and would assist when local services were unable to deliver. Staffing and care would be protected from profit taking but, unlike the 1986 reforms, selected providers would be well rewarded for their services.