



ANSWERS TO QUESTIONS POSED BY THE COMMISSION TO JOHN BRAITHWAITE, VALERIE BRAITHWAITE AND TONI MAKKAI

1. *Please provide an overview of your current role, any relevant past occupations, your qualifications, areas of expertise, research and other professional activities. In particular, please provide an overview of your research relating to regulation and aged care.*

1(a). John and Valerie Braithwaite and Toni Makkai are the authors of *Regulating Aged Care* (2007, Edward Elgar) and other publications on regulating aged care that can be found at <http://johnbraithwaite.com/empirical-regulatory-studies/nursing-homes/>. All three of us are semi-retired ANU academics and professors. Toni Makkai is a former Director of the Australian Institute of Criminology and Dean of the College of Arts and Social Sciences at ANU and John and Valerie Braithwaite were founders of the School of Regulation and Global Governance (RegNet). We intensively studied aged care from 1987 to 1997 and less intensively from 1997 to 2007. Since then we have not kept as up-to-date as we should have, and we have only had a limited number of days to try to become more up-to-date, so our apologies if there are some questions we cannot answer adequately. Some of the findings in our 2007 book, however, may be a basis for reflection on current challenges facing the sector.

Introduction

1 (b). While we have some strong criticisms of aged care regulatory outcomes we also have strong respect for so many outstanding regulators across all the generations of regulatory leaders with whom we have had strategic conversations across the past 33 years. During many of these years they have struggled courageously for better aged care while operating within a seriously under-funded regulatory regime and under-funded and complex aged care sector.¹ We believe the Royal Commission is a wonderful opportunity for the fine leaders among the current generation of regulatory custodians to make a significant new contribution to a better life for our older generation.

1 (c). Aged care regulation is an example of Michael Lipsky's "street-level bureaucracy".² This means that the most important governmental decisions are not made by the policy-makers at the top, but by the assessors, who we prefer to call inspectors, at street level. While we have a critical, even cynical, perspective on the limits of many policy innovations about which others are more enthusiastic, overall we think the evidence is encouraging that aged care regulation has made life much better for residents and can be improved to make it hugely better. This is largely an accomplishment of individual inspectors who diagnose a specific problem in an aged care service, make an issue of it, persuade a care team leader of the provider that this is indeed a problem, then together the inspector and the team leader become catalysts of culture change toward a more relational and regenerative caring culture.³ Learning circles and reflective professional practice then

¹ Aged care work is underfunded in most societies; Australia seems to be in the middle of the pack of developed economies in terms of care workers (per aged population), though a long way behind the leaders: Sweden, Norway and the United States (OECD Health Data 2012).

² Lipsky, Michael. (2010). *Street-level bureaucracy: Dilemmas of the individual in public service*. New York: Russell Sage Foundation.

³ This is about both self-efficacy of team leaders to lead and collective efficacy of teams to lead as teams: Jenkins, A. L. (1994). The role of managerial self-efficacy in corporate compliance with the law. *Law and Human Behavior*, 18(1), 71-88.

become important for both the care provider and the regulator. This does not happen every time an inspection team visits an aged care facility, but it happens often enough that regulation makes a real difference. This has been true under the current accreditation regime and the former standards monitoring regime and in our very extensive observation of aged care regulation in the UK and US, as well as Australia. None of this is to say, of course, that regulation is as important as the level of reflective professionalism, training, managerial competence and the relational culture of caring in the sector. This must be encouraged to grow organically through learning by providers with weaker cultures of care from the best providers.

1 (d). It follows that we have great respect for the noble reformers within the industry. This respect goes down to the lowest level of carers. They are a large piece of the Australian workforce and one of the most disadvantaged sectors of our workforce. A joy of aged care regulatory reform for us is that what makes life better for the disempowered elderly also makes life better for that disempowered workforce. For example, many care workers used to believe that tying up residents with restraints made life easier for the care workforce. Now we know this is not true. Restraint reduction replaced by focus on the underlying problems that motivated restraint, makes life better for both disadvantaged groups.

Role of regulation

2. *What is the role of regulation, particularly in the context of government-subsidised private service provision of essential services? What outcomes can or should it achieve?*

2 (a). We have tended to think that Australian standards have done, and are doing in their latest revisions, a reasonable job of defining the most important outcomes. The big issues are in realising those outcomes. What we have to say below about relational regulation does raise the question whether helping to maintain strong networks of relationships in their lives with loved ones, friends and carers should be more explicit as an outcome in the standards.

2 (b). We are pleased that in a legal sense Australia has maintained commitment to being outcome-oriented, even if in practice there have been constant slippages into ritualism, as discussed below. We know that there has been much well-intentioned pressure to put much more detail and specificity into the legal regime that risk it becoming one of hundreds of rules (even over a thousand, as in the United States). Resistance to this pressure has been good public policy and good legal policy.

2 (c). We are pleased that in recent times the work summarized in our 2007 book⁴ has seen this Australian policy experience with aged care to hold not only profound implications for the role of rules versus principles in all domains of regulatory law, but in the deeper structure of the law. Samet's (2018) British book, *Equity: Conscience Goes to Market*,⁵ supports our favoured approach of rules playing an important role, but deeper principles in the law trumping rules when they contradict. We developed this approach in more specificity in our collaboration with the Australian Taxation Office on tax law.⁶ Samit interprets this as the core of the relationship between rules in

⁴ Also in J. Braithwaite and V. Braithwaite (1995) '[The Politics of Legalism: Rules Versus Standards in Nursing-Home Regulation](#)' *Social and Legal Studies* 4, 307-341; J. Braithwaite (2002) '[Rules and Principles: A Theory of Legal Certainty](#)' *Australian Journal of Legal Philosophy* 27, 47-82.

⁵ Samet, Irit (2018) *Equity: Conscience Goes to Market*. Oxford: Oxford University Press.

⁶ Braithwaite, John (2005) *Markets in Vice, Markets in Virtue*, Sydney and New York, Federation Press and Oxford University Press; Braithwaite, John (2003) 'Making Tax Law More Certain: A Theory', *Australian Business Law Journal*, 31(2), 72-80.

common law and equity, where equity trumps common law or statutory rules if there is contradiction between them. 2 (d). One of Australia's most thoughtful judges, Justice Mark Lemming of the NSW Court of Appeal,⁷ advanced a similar analysis this year with respect to the role of rules and principles, rules and equity, in Australian law; more specifically, in the way the balance of deliberation works between lower courts which routinely follow common law rules in matters such as contract, and appellate courts that do the work of trumping those rules with principles such as unconscionability.

2 (e). Providers should be able to demonstrate how they are using 'big data' (in the case of aged care, Australia should be able to look at millions of data points on individuals as well as systemic analysis across different types of residents and providers) alongside AI and IT systems that are flexible and innovative, to inform better decision making for individuals, providers and policy-makers. This is not about 'more' data but actually effectively and efficiently using data that already exists in the systems of the best of nursing homes.

2 (f). New issues will become significant in the near future such as the regulation of AI for aged care robotics. We discuss below how some European countries are mandating active involvement of staff, residents' councils, advocates and relatives in developing quality improvement plans and then evaluating them. In our 2007 book we argued for the US version of this kind of standard. We still think this kind of addition to the standards has merit. Such a standard would make it a breach to fail to prepare a consultative quality improvement plan, to fail to implement it, and to fail to evaluate it. An evaluation that showed the attempt to fail would not result in non-compliance. The provider would then be expected to experiment with a better plan.

3. *What does "ritualistic regulation" mean in the context of aged care regulation?*

3 (a). Ritualism means obsession with means for attaining outcomes that are encouraged by regulators while losing sight of the outcomes themselves. Mostly it means focus on inputs rather than outcomes. For example, if a resident is asked to sign approval of her care plan without being able to read it and without being told what is in it, so that she enjoys no serious opportunity to have input, the signature is ritualistic regulation. Improving the care is what matters; improving the documentation should be a means to the end. But all too often attention shifts in regulatory encounters from getting good care to getting good paperwork.

3 (b). In the worst cases, less time is devoted to care because more time is put into documentation that does not improve care. Many good ideas in Australian aged care regulation, such as continuous improvement, have taken the path of ritualism, as argued in our book, and as argued in Dr. Lisa Trigg's testimony to the Commission.

4. *What does "risk based" regulatory approach mean?*

4 (a). The key meaning of "risk based" in the context of aged care is allocating regulatory resources to the cases and contexts where there is the highest risk of abuse, neglect or poor quality care. Some metrics, such as number and seriousness of complaints, or of falls, can give some indication of risk. Caution is needed with risk-based metrics in aged-care because of the small scale of caring organizations. If an outstanding nursing leader resigns or retires from a large hospital, this will have only a small impact on risk; whereas in a small aged care facility the departure of the one outstanding leader among the nursing staff can have a catastrophic effect on the quality of care in a short space of time.

4(b). We are therefore cautious about the value of long periods without inspections for aged care facilities based on risk metrics. A better approach is to allocate "low-risk" facilities to regular one-day visits by one inspector. If that inspector finds it is no longer true that the facility is low risk, the

⁷ Lemming, Mark (2019). The role of equity in 21st century commercial disputes: Meeting the needs of any sophisticated and successful legal systems. *Australian Bar Review*, 47, 137-58.

inspection can be extended to a second or third day, or more, with a second or third inspector. In many ways, field staff should call in for advice and back-up from supervisory staff more than they do in Australian regulation. This can help risk drive the intensity of regulatory scrutiny. But a low risk assessment should never result in a regulatory absence in aged care. Regulatory excellence requires more than being risk-based.⁸

5. *What would be important in a regulatory system that promotes quality and safety in aged care?*

5 (a). We also agree with Dr. Lisa Trigg's submission to the Commission that relational regulation and relational care is a key. We like aspects of the approach of the current British Chief-Inspector of Social Care. From our reading, her approach to training seems to create the right relational sensibility among regulatory staff, challenging them to test the service against the "mum test": would you be satisfied if your mum was getting this care? More formally, we like the questions British Care Quality Commission staff must ask in assessing fundamental standards, as drawn to our attention by Dr Trigg. It balances a drive for relational care and relational regulation with basics of safety, effectiveness and professionalization of leadership:

Key Questions for CQC Fundamental Standards

KEY QUESTION	DEFINITION
IS IT SAFE?	People are protected from abuse and avoidable harm.
IS IT EFFECTIVE?	People's care, treatment and support achieves good outcomes, promotes a good quality of life and is evidence-based where possible.
IS IT CARING?	Staff involve and treat people with compassion, kindness, dignity and respect.
IS IT RESPONSIVE?	Services are organised so that they meet people's needs.
IS IT WELL-LED?	The leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Source: *How CQC regulates. Residential adult social care services. Provider handbook* (CQC, 2016a)

5 (b). The consumer consultation by COTA (2018) *Measuring Quality and Consumer Choice in Aged Care* also definitely place relational concerns at the top of the concerns they revealed:

When asked in the survey how important specific quality of life measures were to consumers in choosing any aged care provider, they ranked them as: Being treated with respect and dignity (98.7%); Staff friendliness (98.1%); Feeling safe and secure (97.7%);

⁸ Braithwaite, John (2017) '[Responsive Excellence](#)' in C. Coglianese (ed) [Achieving Regulatory Excellence](#). Washington: Brookings Institution.

Being supported and encouraged to raise any concerns I have with the service (96.6%); Food satisfaction (96.4%); Their sense of independence (96.2%); Having control over their daily life (95.6%); Being supported to maintain social relationships and connections with the community (95.6%); Maintaining and supporting spiritual, cultural, sexual and religious identity (90%); How likely they would be to recommend the service to a family or friend (89.4%).⁹

5 (c). Likewise the systematic review of qualitative studies by Bradshaw et al¹⁰ found that relational caring, and more broadly “forming appropriate relationships with others”, was the essence of living well in care homes.

6. *What is the significance of data, information and transparency to a regulatory system, and how does it relate to regulatory aims?*

Is or should the role of or approach to regulation in aged care be different depending on:

- a. the type of the service (for example, residential care or home care)*
- b. the nature of the service (for example, clinical care, personal care, accommodation and quality of life).*

6 (a). We are social scientists, so we love data. On the other hand, we see so many regulatory regimes that distract care staff from providing care to fill out data sheets, and then we see no one using that data in government in any remotely strategic way. It would be a tragedy for Australia if we went the way of US aged care where all the best care staff, the most experienced and competent nurses, are removed from hands on care delivery and assigned to filling out and managing information systems. Sadly this sometimes involves learned creativity in massaging the data to create the best financial outcomes and the best image for the corporation in seeming on paper to deliver quality care. Beautiful data systems for evidence-based care can be quickly gamed into ugly practices, as our book demonstrates:

Down-coding of MDS [Minimum Data Set] outcomes is common. We also concluded earlier that down-coding of outcomes (or up-coding of risk categories to the same effect) is almost universal to avert MDS coding of the sentinel events of fecal impaction, dehydration and pressure sores on low-risk residents. While the evidence is encouraging that different appropriately trained nurses can come into a nursing home to run MDS codings with high inter-rater reliability (Mor et al. 2003b), appropriately trained nurses consistently code fecal impaction¹¹ and dehydration as something else. Even more sadly, as Schnelle et al. (2003a)

⁹ COTA (2018) *Measuring Quality and Consumer Choice in Aged Care*. Canberra: COTA, p. 7.

¹⁰ Bradshaw, S., E. Playford & A. Riazi (2012). Living well in care homes: a systematic review of qualitative studies'. *Age and Aging*, 41, 429-440.

¹¹ Fortunately Australia has rejected ‘fecal impaction’ as a Quality Indicator: ‘Fecal impaction’ MDS coding is another quality indicator sentinel event. ‘This is why there is always a zero return on them in the MDS, unless they have a new MDS nurse who is still learning the job’ (2005 Maryland interview), as one senior state regulator explained. The return is actually 0.1 per cent nationally for fecal impaction. Minimum Data Set nurses learn to code fecal impaction down to a diagnosis of severe/repeat constipation. Dehydration (the third sentinel event under US quality indicators) also rarely gets non-zero returns on the MDS, with the national MDS-reported dehydrations coming in at 0.0 per cent in all recent years (Centers for Medicare and Medicaid 2005: 69). Obviously the national data are false; as revealed by our own eyes, nursing home residents in the US do suffer

and other data discussed above suggest, MDS nurses have to deal with a great deal of fraudulently recorded information in resident records. Different MDS nurses often reliably code on the basis of information recorded by care staff that is systematically false. Even if MDS nurses were reliably coding valid data, which they are not, their codes would still be misleading. This is because of the sample size US nursing homes offer. In a small facility, one or two residents admitted with a pressure sore can move it from below average to above the seventy-fifth percentile. Obversely, if two residents with pressure sores have died in the months since the last MDS results were published, at the facility level MDS results quickly become an outdated trigger of concern. Health outcomes have large standard errors or bands around the true level. For example, Mor et al. report: '[I]f the true 3-month incidence of pressure ulcers is 5%, the 95% confidence interval around the estimate for any given facility would range from 1% to 11% in a facility with 100 residents in the denominator. Not until the number of observations exceeds 200 do the confidence intervals around the observed rate drop to less than twice the size of the point estimate' (Mor et al. 2003a: 39).¹²

6 (b). This research in our book was about understanding when is a pressure sore a pressure sore and when is a fall a fall (or a minor trip)? It was about showing that in some circumstances the commercial logic is to code up level-of-care reimbursement and in other circumstances it is to code down to avoid sanctions from a regulator. Australia is of course now committed to going down this path with the Quality Indicator Program. But there remain questions of how far down it will go in the record-keeping requirements that are mandated.

6 (c). As new Quality Indicators are introduced, evidenced-based practice would be to randomly assign pilot facilities to the introduction of this, versus that, versus no new Quality Indicator. Then the overall impact on quality of care, on staff time devoted to care versus paperwork, of introducing the extra Quality Indicator, could be evaluated. Furthermore, it could be ascertained which new Quality Indicators deliver better overall benefits.

6 (d). As we understand the regulatory literature, there is strong evidence that regulatory inspection works and that the right kind of policing works. We are not aware of studies showing that the introduction of a Quality Indicators program improves quality, though that might be because our knowledge of that literature is out of date. But if that is right, we have doubts about the benefits of shifting regulatory resources from inspection to a bigger and better Quality Indicators program. Also we doubt if it can work without a serious commitment of criminal justice resources to prosecuting fraudulent misreporting of Quality Indicators.

6 (e). There can be no one-time fix of data systems in a world where there are strong commercial incentives to game them. They must be ships with holes constantly repaired at sea. Because of game-playing, because of creative crafting of shelters that are safe havens from regulation, regulated aged care Quality Indicators risk becoming like tax law in that regard. Then the problem becomes that comparability from year to year is compromised when data systems must be adjusted each year to cope with the gaming.

6 (f). The bottom line is that governments must not place unrealistic hopes in sophisticated data systems measuring medical outcomes. And there is a need to be iteratively evidence-based about that policy choice and about how we are adjusting the policy to keep it in good repair. These problems are further compounded by the small size of aged care facilities. Hence, for example, bed shortages in a local hospital that pushes one or two patients with pressure sores into a local aged care facility might double the number of pressure sores in the facility. Statistical inference that this

dehydration. By prioritizing something as a sentinel event, the regulatory system renders it invisible and unmeasurable.' (p. 51, *Regulating Aged Care*).

¹² Braithwaite, John, Toni Makkai and Valerie Braithwaite (2007) *Regulating Aged Care*. Cheltenham: Edward Elgar, p. 250.

says anything meaningful, because of the small numbers, even putting aside shared responsibility for the continued existence of the pressure sores, risks being quite misguided. Medical outcome measurement that can be good policy for hospitals can be bad policy for aged care. The small size of aged care facilities reduces the usefulness of metrics for any comparative analysis. That said, facilities learn from their own monitoring of cases of bed sores, flu, and other outcomes that matter, and how they are dealing with the problem in real time.

6 (g). Our book argues that previous research gives little hope for consumers making good use and drawing balanced inferences from reading on My Aged Care that a particular facility has above average pressure sores or falls. When the consumer (or the inspector) asks providers about that result, management will have a narrative that says that they have more of them because of how sick our residents are in certain ways compared to other facilities, because we empower residents to chose to take risks that lead to falls more than other facilities that are less empowering of residents on freedom of movement, because two of our residents already had the beginnings of pressure sores when they arrived here, because the restraint standards forced us not to use bedrails when we believed we should have used them, and on and on.

6 (h). Some of these excuses may be right and some may be wrong. But they mean that neither successful litigation nor rich empowerment of consumers with information are likely. It continues to be the case that only a small minority of US consumers make evaluative use of the much superior quality of information in their Nursing Home Compare website.

6 (i). To date the transparency regime in Australian aged care has not worked well. It is not providing information of a kind that helps families to choose the best quality of care for their loved one. This is such a huge challenge that there is no chance that Australia will “get it right” in response to the Commission’s recommendations. Only that long journey of repairing the ship at sea can get it right.

6 (j). In principle data sets should be open to independent outside researchers in universities and other research institutes. Although there has been significant improvement since our study in the regular availability of data (in an easy and useable format) on descriptive characteristics of the aged care sector along with aggregated financial data via the AIHW and the Productivity Commission reports, this is not the case for the regulatory data. AIHW have recently linked individual records across data systems that enable more sophisticated ‘life-course’ analysis but linking this to the regulators’ reports in a meaningful, transparent and open way would enable scholars, journalists, and research groups to build a more nuanced account of the impact of regulation on outcomes over time. It also provides the capacity for ‘oversight’ that identifies emerging issues well before the system is in crisis.

6 (k). We think most of the standards can be quite comparable across different domains, with some variations. But home care is mostly much more difficult to regulate than an aged care facility. Our research was only on residential care. Sadly, the empirical research by others is also not very

instructive on what works in home care regulation.¹³ Inspectors can arrive at an aged care facility for a surprise inspection at any time of day or night and check some critical aspects of the provision of care. Inspectors who arrive without warning to visit a home care client are very unlikely to find a carer present.

6 (l). The best option may be telephone calls to the home care recipient and/or a nominated representative to check provider self-assessments. Too much reliance is currently placed on volunteered complaints. If the telephone questioning reveals serious concerns with the quality of care, or if complaints have been received, then the inspector can ask the client when the carer of concern will be visiting next and do a surprise inspection at that time.

6 (m). We want inspectors to have helping relationships with care providers, but we also want them to be detectives who sniff out poor quality care and do something about it. We have limited confidence in over-reliance on data filled out by the care providers themselves, as there will be gaming in the way they tick the boxes. Self-assessment that is not checked by inspectors “kicking the tyres” does not work. With site inspections more difficult in regulating home care, more emphasis probably should be placed on mandating improved training and inspecting that. The quality of VET training also needs attention.

6 (n). The important thing with home care is that “all eyes are on care”. Sometimes the pharmacist who supplies to the home care client and sometimes the next door neighbour will be the ones who detect neglect or abuse. The home care inspector must be a good enough detective to find that out and then to go and interview that pharmacist and that neighbour.

6 (o). One difference that goes the other way relates to termination of service as a regulatory sanction. It is usually the wrong thing for a regulator to close an aged care facility even if residents are all successfully moved to better quality facilities. This is because of the evidence that any forced move for the very frail aged increases mortality and morbidity.¹⁴ With home care, however, termination of service does not work that way. The carer is removed and replaced, but the frail aged person remains in place. Hence, while quality monitoring is more difficult with home care, tough enforcement is more feasible when there is evidence of endangerment.

7. *How could a regulatory regime be designed so that it is flexible enough to address quality and safety in different aspects of aged care services (for example, clinical care, personal care, accommodation and quality of life)?*

7 (a). Flexibility is important. We would be against the US aged care inspection practice of always having a trained nurse observe the administration of medications to calculate a med-pass error rate. Even though these med-pass observations reveal shockingly high rates of medication errors, we would still be against it. The observation must be done by a qualified nurse and is therefore expensive in terms of resources. We think those resources can prevent more harm by being deployed in other ways. This issue at the same time reveals why we want inspectors to be detectives. We want them to watch for evidence that medication management systems may be, for

¹³ Genet, N., Boerma, W. G., Kringos, D. S., Bouman, A., Francke, A. L., Fagerström, C., & Devillé, W. (2011). Home care in Europe: a systematic literature review. *BMC health services research*, 11(1), 207.

¹⁴ This was the state of the evidence at the time of our 2007 book. The need for caution in moving residents against their wishes is a reason that Australia needs in its regulatory pyramid the powers aged care regulators have in many countries to put new managers in charge of the home. Financial regulators in Australia have had this power with respect to banks since the Great Depression. It is a valuable power to have in matters of such importance even though it should be rarely used. It is quite infrequently used in the United States with aged care regulation.

example, well run when the Director of Nursing is on duty but a shambles when she is not. In this circumstance, bringing in a nurse inspector trained to do a surprise med-pass observation and calculation of a med-pass error rate at a time when the Director of Nursing is off duty is the way to go. If the med-pass error rate is then well above international norms, the combination of the evidence gathered by the detective work of the front-line inspector and the quantitative evidence of the med-pass nurse inspector should put the facility in serious trouble.

7 (b). Let us imagine the detected problem is that care staff are treating eye infections carelessly in ways that spread infection from the infected eye to a non-infected eye. Perhaps then either a deferred criminal prosecution or an enforceable undertaking is needed that requires the facility to retrain its staff in these matters. In addition, the undertaking could require recording the incidence of eye infections in the first instance to establish if they are above normal levels, coming up with a plan to manage eye infections and reduce them, and then keep counting the number of infections to evaluate the effectiveness of the intervention. The enforceable undertaking could also require them to pay for independent nurses to come into the home without warning to calculate further med-pass error rates for all types of medication errors (because different kinds of medication errors tend to cluster together) until the med-pass error rate comes down.

7 (c). Pain management in our view can be the most important care issue. Many of us worry less about a medical error that causes us to die earlier than an old age lived in unbearable pain. Sadly, however, our research from many years ago concluded the pain management standard was the least adequately monitored in Australia compared to the US and UK. It appears to still be relevant, perhaps with over-medication being added to the problem of ineffective medication.

7 (d). Again, we are inclined to see flexibility monitored by inspectors-as-detectives as holding the key. Relatives complaining about pain management during treatments is not decisive evidence. But it is a clue for the inspector-detective. What this clue might lead to is nurse inspectors observing all treatment of wounds during the inspection period and follow-up observations of wound treatments and their documentation as required.

7 (e). Real time observation of staff dealing with causes and consequences of pain provides evidence of how skilled the staff in the facility are in managing pain, at least in this example of wounds. This is a flexible escalation of the inspection process to focus on one important issue in a way that would not normally occur in such a big way.

7 (f). Quantitative indicators of participation in activities programs do not work very well because it is easy for staff to gather up residents sleeping in their chairs into the back of the activities room and count them as participating in the activity! What the flexible inspector-detective can do here is assess through a combination of interviews with residents and relatives and dropping in on activities at random that the activities program is not attracting a wide base of enthusiastic participation. Then there can be a discussion at the exit conference at the end of an accreditation visit on the need to send the Activities Director on a training course that will energise new ideas and commitment to that professional calling. This can then be earmarked as an issue for special scrutiny at the next scheduled inspection.

Complaints

8. *What is the role of complaints in quality and safety regulation?*

9. *What are the characteristics of an effective complaints system?*

8 (a). Complaints are critical for the detective part of the inspector role. Serious complaints should drive special unscheduled inspections. These complaint inspections averaged 29 inspector hours during our US research. So there is a big gap here to Australian practice and resources. Patterns of less serious complaints should shape risk-management judgements and which issues get special attention at the next scheduled accreditation visit. These patterns and concerns in the complaints should be discussed with management during the inspection.

10. *Regulating Aged Care: Ritualism and the New Pyramid (Regulating Aged Care)* refers to the role of residents' councils. *How important is the role of residents or their representatives in addressing government or service provider failures? Do you consider that residents' councils should be considered in the Australian context?*

10 (a). Yes they add some value, as can relatives councils or combined residents-relatives councils. Our book argues that it is no easy challenge to get them to work well, however. Community visitors can also attend these meetings and help organize and energize them. A meeting with the residents' council can be good; it is a standard part of the US inspection process. It can have a catalytic effect. For example, one or two residents at the meeting might suggest that they think that some particular thing is an issue the accreditation team should focus on at this facility. Other residents may say that they have no idea if this is a problem or not. Then the Chair of the residents' council might say I'll get around and ask other people who have not come to the meeting in confidence about this and report back to the inspectors.

10 (b). It is good practice to invite a representative of the residents' council and the relatives' council, if there is one, to attend the exit conference at the end of the inspection to discuss such issues and indeed all quality of care issues that come up. They can help push for quick action after the inspectors leave and complain to the inspectors if nothing is done about agreed reforms. Inspectors should normally read the minutes of residents' council meetings and then check that the grievances raised have been addressed.

10 (c). The most important form of resident and relative participation is probably exercising the right to attend a Care Planning Meeting of all the staff working on the care team for the resident. Australian aged care facilities can be quite backward in international terms in not having Care Planning Meetings. Professional conversations with peers to share learnings on how to improve care are important to professionalizing aged care. And they are further improved by input from residents and families or nominated friends of the resident who assist with their participation and speak up for them. In the United States, Care Planning Meetings are mandatory, and in many US states it is mandatory to invite residents and their nominated relative/friend in writing to attend each scheduled Care Planning Meeting.

10 (d). Effective empowerment of the aged is a gift of master practitioners of aged care and street-level regulators, or so we argue in our book. Therefore peer to peer learning of how to empower the aged is a key.

10 (e). That includes learning how to get more visitors, friends and loved ones, who will empower the aged, to feel more welcomed to visit. "More eyes on quality" and "more eyes on abuse" works. The large criminological literature on situational crime prevention through the eyes of guardians decisively demonstrates this. This is about ordinary visitors, especially in home care, as much as it is about community visitors, inspectors, advocates, complaints investigators and other more formal checks and balances.

Continuous improvement

11. How important is a culture of continuous improvement to a quality system, and why?

11 (a). Australians want excellence in aged care, not the bare minimum. In our book we therefore praised the 1997 shift to continuous improvement. We still do. That does not mean we think it has been well implemented. We would ask the Royal Commission to enquire how many facilities have experienced significant regulatory enforcement for failing to continuously improve. We would also ask for enquiries about the quality and integrity of the evidence for continuous improvement that is being cranked out.

11 (b). If the Accreditation Agency cannot extract credible answers from their records, with credible enforcement case studies as well, then that will mean we are right in our suspicion that continuous improvement ritualism may now be the norm.

11 (c). One of the most neglected aged care regulatory reforms is also the cheapest. This is that inspectors must be trained to offer informal praise when continuous improvement occurs on their watch. Our research showed quantitatively across 300 Australian aged care facilities that this significantly improved quality of care in the next two years.

11 (d). We continue to assess the evidence to be strong that succeeding in motivating the aged care workforce to get genuinely involved in initiatives to improve quality of care does improve it. What we do not have good evidence on is exactly how to achieve that genuine workforce motivation. The wrong kind of regulation, where staff believe that the more measurable drives out the more important can certainly reduce that motivation. An example would be where staff perceive that regulation to reduce physical restraint results in more debilitating forms of chemical restraint.

11 (e). On the negative side with continuous improvement during our Australian fieldwork, we saw the ritual of appearing to do something of writing a new page in a policy and procedures manual that made it a more complicated and less useful document. On the positive side was the idea of monitoring improvement in staff surveys that included items like 'I find the policy and procedures manual easy to read.' Other staff survey items that impressed us when they demonstrated marked rises or falls were:

I receive informal recognition by the organization that I am doing a good job.

I believe that my contribution to the organization is valued by the organization.

11 (f). Another positive thing we saw in our research in the move from inspection to detect breaches to inspection to assess continuous improvement was in the way it helped change the relational quality of the encounter:

‘Please blow your trumpet’, an inspector explains during an entrance meeting with the senior staff, ‘Bring forward the good things you have done.’ At another 2005 inspection, it was said: ‘We want to listen to all the good things you have done. Don’t be embarrassed to show off. Enjoy yourselves telling the story of what you have accomplished.’¹⁵

11 (g). On one sad day during the last decade we were told in an aged care home of the practice of gaming continuous improvement by ‘letting something slip so you can improve it later’. Here are two other stories of gaming continuous improvement from our research:

¹⁵ Braithwaite et al, *Regulating Aged Care*, p. 210.

One nursing home administrator who was in full flight listing continuous improvements from her CI log, pulled herself up during a support visit when she realized she had a full site audit in another six months: 'I'll have nothing left for next time if I'm not careful about all these CIs.' At the conclusion of another visit:

JB: Maureen [the director of nursing] has a list of continuous improvements in the front of her black book and another list in the back that she is saving up for the next visit.

Maureen: Gee you saw that.¹⁶

11 (h). We would like to see a research-led strengthening of the promise of the continuous improvement approach. This could be qualitative research that asks experienced assessors to describe the best examples of genuine and well-documented continuous improvement that they have seen. There are plenty of them out there and some could be turned into positive media stories when the research is published. Then they could be asked for the worst examples of gaming continuous improvement they have seen. Between those extremes they could ask for the most common ways of proving continuous improvement that are accepted by assessors. Another source of data is the continuous improvement plan that all providers are legally required to provide in writing. These data could be organized into a guidance note for assessors. The guidance note could say that certain really outstanding forms of proven continuous improvement in the lives of old people could count toward receipt of a 5-Star Rating. Other forms of evidence would be regarded as insufficient to prove any kind of continuous improvement, and so on with various degrees of persuasiveness in between.

11 (i). In sum, what we favour is for the Royal Commission to recommend and expect continuous improvement in the assessment of continuous improvement that is research-driven.

12. *What are regulatory mechanisms that can effectively incentivise or facilitate continuous improvement?*
13. *To what extent or in what ways do you think an accreditation system by reference to minimum quality standards can promote (or retard) continuous improvement of the quality and safety of aged care? If accreditation has a place in promoting continuous improvement, what should its essential characteristics be?*

12 (a). When a consultant is suspected of producing fabricated evidence of continuous improvement, the Commonwealth could retain the services of one or two of their competitors to do independent assessments of whether the improvement is real. Continuous improvement data and methodologies could/should be posted on a public website so that academic critics and competitors can critique and complain to the regulator about the rigor and integrity of continuous improvement data. Alternatively, the Accreditation Agency could have a Best Practice in Continuous Improvement Measurement Team recruited from doyens of that particular consultancy market (including from beyond aged care). When detective work indicated the whiff of continuous improvement fabrication or game-playing, the Team could come in to do an accurate assessment of continuous improvement. Standard compliance ratings would be modified accordingly and the provider would be counselled by the Team on how to improve their continuous improvement measurement in future.

12 (b). Continuous improvement requires facilities to know their weaknesses - that is the areas in which continuous improvement can make the biggest difference. Facilities, in the course of an accreditation visit or inspection, should be prepared to acknowledge their weaknesses – insufficient staff, underqualified staff, poor food quality. These are unlikely to be hidden from an inspector-as-detective who observes treatment practices, asks questions of residents and staff, sits down to have a

¹⁶ Braithwaite et al, *Regulating Aged Care*, p. 207.

meal with residents in a facility and observes activity programs. When the inspector-as-detective is the model for checking a facility, it is in the interests of the facility to acknowledge their weaknesses and set out their plans for addressing those weaknesses and improving quality of care.

14. *Regulating Aged Care describes the Standards Monitoring Regime that applied in the early 1990s. How does that regime differ from an accreditation model? What do you see as the comparative advantages or disadvantages of the two approaches?*

14 (a). We think it was a mistake to take the Accreditation Agency outside the Health Department and create a schism between the power to monitor and the power to enforce. These regulatory functions should have been integrated and we are pleased the government is now fixing this. We are pleased, as we recommended in our reports for the Commonwealth three decades ago, that in this integration Australia finally decided to suspend benefits for new admissions more frequently as a sanction. The courts are the appropriate agency to hold accreditation to account. As we said above, we think the move to continuous improvement was good in theory but disappointing in practice in some important respects. Part of the reason is likely to be poor accountability mechanisms and the way in which poor care practices have had no serious consequences for the facility.

Inspection / monitoring / safeguarding

15. *What should be the role of inspection / official visitor / ombudsman / safeguarding schemes in an aged care regulatory system?*

15 (a). If we make a complaint to a Health Department officer that our relative has been abused and the Department fails to act appropriately on this, we should complain to the police. We humbly request the Royal Commission to advise the police sternly that elder abuse is a criminal offence and they have an obligation to investigate in these circumstances. It is not acceptable for the police to say that this is a Health Department regulatory matter in circumstances when the complainant has not had a just Health Department response. The evidence is clear that police presence on the beat at hot-spots of crime works. Aged care facilities are hot-spots of crime and so it is good public policy for police to be seen more frequently in aged care facilities.

15 (b). If we make a complaint to a Health Department officer that our relative has been neglected and the Department fails to act appropriately, then the Commonwealth Ombudsman is probably the right port of call for Departmental unresponsiveness to elder neglect.

15 (c). It is good if residents and relatives can be better educated to complain through many lower-level pathways – direct to the care-giver, to their supervisor if they do not get satisfaction, to management, to the residents’ council, the community visitor, an advocacy organization, a visiting assessor, or the Complaints Hot Line if they do not get satisfaction there.

15 (d). Care Planning Meetings are also important places for concerns about quality of care to be raised by relatives and friends and corrective action taken before problems escalate in terms of quality of care or interpersonal conflict. This is an important function of regular Care Planning Meetings where relatives and friends are encouraged to attend and made to feel welcome.

15 (e). Exit Conferences after accreditation visits or inspections that are open to visitors, relatives, and friends also provide opportunity for complaints to be aired and fixed and for inspectors to develop contacts for follow-up to ensure the action plan is followed.

16. *What would be the characteristics of an inspection / official visitor scheme?*
17. *Are there best practice examples of inspections / official visitor / ombudsman schemes in other sectors or overseas?*

Comparisons

21. What can we learn from approaches to quality and safety regulation in other jurisdictions and in other sectors?

16 (a). We suspect there is much to learn from the best Northern European aged care regulators. Sadly we are behind the times and we cannot advise where in Europe would be best to research. More than a few years ago we saw impressive reports on planned reforms in the Republic of Ireland. It would be great to have a conference that tracks down and brings together the most innovative and evidence-based regulators from around the world.

16 (b). One interesting issue for comparative learning is the way many European states, including Germany, Spain, Slovenia, Austria and France, require the choice and implementation of a quality management system as one of the minimum regulatory standards. Generally they can opt for the system of their choice. Murakami and Colombo report that Total Quality Management and Balanced Score Care are the most frequently chosen under this mandate.¹⁷ We have no empirical experience of whether this is good regulatory policy or not. This study also reports that the paperwork burdens can be a challenge.¹⁸ It also reports that some European regulators have been pushing the quality management system E-Qalin, purportedly on the basis of some evidence of its effectiveness.¹⁹ E-Qalin is a self-assessment approach led by two process managers but with the interesting relational self-regulation feature of empowering a steering group with representatives of all major stakeholders that include the residents' council, advocates and friends. This could be worthwhile for the Commission to investigate, including with a view to whether it could be adapted to the challenge of stakeholder empowerment in regulation of home care.

Enforcement

18. *To what extent can weak or inconsistent enforcement of compliance with quality and safety requirements (including quality standards) have systemic effects on quality and safety issues? In particular, please comment on the context of aged care in Australia.*

19. *In what ways could enforcement in the aged care context be strengthened? What might be some appropriate enforcement mechanisms?*

18 (a). Regulatory science is helpful in providing answers to questions like: Is regulatory inspection effective and what kind of inspection is most effective? Is policing effective and what kind of policing is most effective? It is less helpful in answering questions like: Is policing effective in preventing theft from building industry sites? Is inspection effective in improving quality of care in Australian home care for the aged? Up to 2007 our research team in *Regulating Aged Care* and our various reports to the Australian government did the best job we could manage on how regulation of aged care can be more effective than its current moderate level of effectiveness.

18 (b). What the empirical evidence on regulatory effectiveness and our own Australian aged care research shows is *not* that compliance is driven by how tough sanctions are,²⁰ but by inspection that

¹⁷ Murakami, Yuki and Francesca Colombo. (2013). 'Regulation to improve quality in long-term care'. In *A Good Life in Old Age*. Paris: The Organization for Economic Co-Operation and Development and European Commission.

¹⁸ Ibid., p. 157

¹⁹ Ibid. p. 159.

²⁰ Makkai, Toni and John Braithwaite (1994) '[The Dialectics of Corporate Deterrence](#)' *Journal of Research in Crime and Delinquency* 31(4), 347-373; Braithwaite, John and Toni Makkai (1991) '[Testing an Expected Utility Model of Corporate Deterrence](#)' *Law and Society Review* 25(1), 7-40.

assures detection, and by the deployment and use of a varied mix of enforcement tools. The 2016 meta analysis by Schell-Busey et al is the best evidence we have on this.²¹

18 (c). It could help the quality of enforcement for the states and territories to refer their relevant regulatory powers to the Commonwealth so the Commonwealth can impose civil and criminal penalties of a variety of kinds. In every area of regulatory governance, even such fundamentally national and international ones like corporations and securities regulation, Australia has been slow to refer appropriate powers to the national level compared to other federations. Sometimes Australia needs a Royal commission to get this done. Then it might be possible for Australia to put a more potent and sophisticated regulatory pyramid in place.

18 (d). Enforceable undertakings or deferred prosecutions, as we have exemplified earlier, could be other options lower in the pyramid than actual prosecutions. Lower still on the pyramid is suspension of Commonwealth benefits for new admissions. This can do most of the grunt of enforcement work when persuasion and warning letters fail. It can accomplish that because at low enforcement cost to the regulator it can normally deliver quick compliance because the sooner compliance occurs, the sooner the provider can restore the revenue flow from new admissions.

18 (e). At the peak of the pyramid are temporary suspension and then permanent revocation of accreditation. Not far below that is negotiation of an enforceable undertaking that commits to dismissing irresponsible managers and replacing them with a new management team of a quality that is acceptable to the regulator. This is generally better than closure of the facility because it avoids the risk of putting residents on the street. It is also better than the American approach of a court order to dismiss managers and put in a court-ordered Administrator, which is such a high-profile humiliation for a professional manager that it tends to be robustly contested in the courts, and therefore regulators use it less frequently than they probably should.

18 (f). To a considerable extent, the industry plays games with some of the words in Questions 19 and 20. When it suits them to say that regulators are inflexible, they say that; when it suits to say regulators are inconsistent, they say that. It is hard to be flexible and consistent! What we actually want regulators to be is responsive in ways that follow principles that the industry commits to after participating in their formulation. A principles based approach necessarily will result in what on first blush looks like ‘inconsistency’; the key issue is the ability and willingness of service providers, the regulator and policy makers to move beyond a rules based enforcement approach to an outcome oriented responsive approach to achieve the best that is possible for residents. Then it is imperative to keep raising the bar on that best possible quality of care that is delivered by re-energizing the continuous improvement approach, and motivating innovation in care delivery.

18 (g). We look forward to the Royal Commission publishing data on how often different enforcement tools are used. But why cannot we as regulatory scholars give better answers to your questions 19-20 by going to Health Department Annual Reports to get the basic enforcement facts? We were able to do that with the ASIC annual reports when the Royal Commission on Banking asked us similar questions as regulatory scholars. Indeed, we were able to say to them between their Interim and Final reports that what they said in their Interim Report about ASIC enforcement patterns, compared to the more impressive enforcement record of the ACCC, was not in all ways fair to ASIC on our reading of those reports. We have not been able to do this with the Commonwealth Health Department.

18 (h). If you go to the ‘Outcome 6’ section of the 2017-18 Health Department Annual Report (from p. 115) it is surprising how uninformative it is. Is the Department of Health a regulatory authority or is it not? It is unheard of in our international experience for a major national regulatory agency not to provide any information about the nature of its enforcement actions in its Annual Report.

²¹ Schell-Busey, Natalie, Sally S. Simpson, Melissa Rorie, and Mariel Alper. 2016. What Works? A systematic review of corporate crime deterrence. *Criminology & Public Policy*, 15(2), 387-416.

18 (i). Nor does it provide evidence of how quality of care has or has not improved. There is no semblance of a summary of which outcomes have got better and which worse. This is unsatisfactory for a regulator that supposedly has a continuous improvement philosophy. If the Department of Health is the peak authority for safeguarding the health of elderly people, we would expect them to lead by example and provide annual reports on their enforcement actions to prevent harm to nursing home residents and how quality of care has improved, or not.

18 (j). Perhaps more disturbing in an era in which great importance is placed on having informed and active citizen consumers is the actual information provided in the Annual Report on performance of the Department of Health as a regulator of the quality of aged care. We draw the Commission's attention to a Table on p. 117, "Summary of results against performance criteria". It tells us that 4 out of 4 of the Aged Care and Quality targets were "Targets Met".

18 (k). Later we have a more detailed account of one of these targets: "Commonwealth Home Support Programme continues to assist older people to stay independent and live in their homes and communities for longer." Then the "Result: Services were provided through the CHSP: Met".

18 (l). We hope for more specific information when we get to p.126, 6.4 Aged Care Quality. We find this more specific aim: "Protect the safety, wellbeing, and interests of Commonwealth-subsidised care recipients through regulatory activities." Then "Result: Met". At least that reports on some outcomes, happily all "met".

18 (m). A "Target" here is: "Identify, respond to, and take appropriate action to address approved provider non-compliance under the Aged Care Act 1997 (the Act)". The "Result" here is also "Met" because: "The Department undertook appropriate action to address approved provider non-compliance. For each incidence of potential non-compliance received by the Department, a risk assessment has been undertaken to determine the appropriate action to address non-compliance. The Department's role in responding to non-compliance complements the complaints resolution function of the Complaints Commissioner and the accreditation assessment and monitoring function of the Quality Agency."

18 (n). The Department met the target because it says twice that it took "appropriate action" (of an unknown kind) based on a "risk assessment". We worry that the discourse of "risk assessment" might be a meaningless mumbo-jumbo of accountability evasion. But we would be pleased if the Health Department proved us wrong on this in its answers to you. And perhaps the 2018-19 Annual Report will appear soon with information on fraud prosecution cases sent to the DPP, cases where Commonwealth benefits have been suspended for new admissions or for all admissions, cases where accreditation has been suspended or revoked, referrals for professional disciplinary action, and so on.

18 (o). We might be able to provide answers to Questions 19-20 if the Health Department Annual Report was more like the ACCC 2017-18 Report. Page 32 of their report might be one helpful model. Its reporting is actually shorter but it provides more information. For the ASIC Annual Report 2017-18, see pages 5, 39-45, 66-68, 192-3 for the kind of information that should be available to the public. In earlier times the ACCC and ASIC Annual Reports would actually list all major enforcement cases, naming the companies concerned. The general trend is perhaps for the Commonwealth to talk transparency more but do it less. The Commonwealth Health Department, however, is acting out this philosophy in extreme ways. There is a responsibility of acting as a role model here. The reporting by the Department described above is at best ritualism of the kind observed among poor care providers.

18 (p). It should be noted that the Royal Commission should also look at the Department of Health document: Regulator Performance Framework Self-Assessment Report

[https://www.health.gov.au/internet/main/publishing.nsf/Content/C3B10A392B150004CA258090000BB537/\\$File/Aged-Care-Group-2016-17-Self-Assessment-Report-2016-17.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/C3B10A392B150004CA258090000BB537/$File/Aged-Care-Group-2016-17-Self-Assessment-Report-2016-17.pdf)

Regulator performance is assessed here in terms of reducing the costs of regulation to the industry and completely neglects improving the quality of regulation for the elderly.

18 (q). This is relevant to the way the Department thinks about and reports on “risk” and “continuous improvement”, for example. The concern prioritized is not continuous improvement in quality of care but continuous improvement that is captive to industry concerns. There is no mention of residents, families, staff or communities whose lives are affected by whether continuous improvements within frameworks for regulation and compliance work or not. Continuous improvement should apply to the quality of a resident’s and family’s lived experiences, not to abstract frameworks that may have meaning within the conversations between the Department of Health and the providers, but that are meaningless, if not harm-producing, beyond that.

KPI 6: Health actively contributes to the continuous improvement of aged care regulatory framework.

Measure 6.1: We establish cooperative and collaborative relationships with providers to promote trust and improve the efficiency and effectiveness of the regulatory framework.

Measure 6.2: We implement continuous improvement strategies across key compliance activities with providers.

18 (r). Finally, it should be said that if you go to the My Care website under Residential Care Sector Performance and then go down to “Accreditation Decisions” you do see that one decision was made not to accredit between July and December 2018 and one more is recorded for this year. These can also be found in Accreditation Agency Annual Reports, as can numbers for ‘Findings of Serious Risk’ (which is not really an enforcement measure).

18 (s). Our quantitative work from 410 Australian aged care organizations shows that inspections work best in improving quality of care when street-level inspectors aim to build trust with providers and are perceived by them as trustworthy.²² Regulation is effective when it enculturates trust and institutionalizes distrust;²³ ‘trust and verify’ as Reagan and Gorbachev used to say. Our research also shows that procedural fairness by the Australian government in regulatory encounters predicts improved quality of aged care;²⁴ while stigmatization of nursing home staff and management, as incompetent or crooked for example, makes quality of care deteriorate.²⁵ On the other side, aged care providers need to understand that they also do better out of regulatory encounters when they refuse to be game-players, when they are trustworthy, procedurally fair, and when they do not stigmatize regulators. Most importantly of all, it is commercially rational for aged care providers to be open and honest with inspectors.²⁶ Sadly, our data shows that both regulators and regulatees in Australia do not always understand these facts.

²²Braithwaite, John and Toni Makkai (1994) ‘Trust and Compliance’ *Policing and Society* 4(1), 1-12.

²³ Braithwaite, John (1998) [Institutionalizing Distrust, Enculturating Trust](#) in V. Braithwaite and M. Levi (eds) *Trust and Governance*, 343-375. New York: Russell Sage.

²⁴ Makkai, Toni and John Braithwaite (1996) ‘[Procedural Justice and Regulatory Compliance](#)’ *Law and Human Behavior* 20(1), 83-98.

²⁵ Makkai, Toni and John Braithwaite (1994) ‘[Reintegrative Shaming and Regulatory Compliance](#)’ *Criminology* 32, 361-385.

²⁶ Rickwood, Debra and John Braithwaite (1994) ‘[Why Openness With Health Inspectors Pays](#)’ *Australian Journal of Public Health* 18(2), 165-70.

Industry 'capture'

20. Describe the concept of industry capture, and explain what forms it might take in the aged care context.
21. What can be done to protect the system against industry capture?

20 (a). We have attempted to answer Question 21 in this paper:

T. Makkai and J. Braithwaite (1992) '[In and Out of the Revolving Door: Making Sense of Regulatory Capture](#)' *Journal of Public Policy* 12, 61-78.

20 (b). Note also our comments earlier about the Department of Health being accountable to the aged in its accountability documentation for improvement in the quality of aged care and not just accountable to industry concerns.

20 (c). It is our view that Accreditation teams have tended to be afraid to give providers negative reports on compliance with the standards. This is reflected in a long history of ratings of around 99% compliance with standards. If we as professors gave 99% High Distinctions in our marking, our Dean would chastise us for wanting to be popular with our students instead of giving them feedback on when they are doing well and when they should be doing better.

20 (d). A contrast is the US Star Rating System in Nursing Home Compare where, when we last looked a few years ago, nursing homes were approximately twice as likely to receive one-star ratings (23%) as five-star ratings (12%). The Australian quality of feedback is insufficient in both qualitative and quantitative terms in the current accreditation system.

20 (e). Our aged care research shows that praise by inspectors can also improve quality of care,²⁷ so that too is important. But the currency of praise can be devalued in a system where providers get accreditation reports with a perfect score when they are not perfect. Moreover, when the accreditation ratings for all the aged care facilities in our area are all perfect or near-perfect, they provide no help to consumers as to where they should place their loved one.

20 (f). The ethos of the 1997 establishment of the Accreditation Agency was to move away from the idea of government "inspectors" or "standards monitors". As we have said, the evidence from regulatory studies is that "inspection" works. So viewing inspection as a dirty word in a regulatory culture is not very healthy. Policing should also not be a dirty word in the way it currently is. That is why we have argued that with so much assault occurring in aged care facilities, we need more police engagement.

22. Do you consider that (a) the Australian policy reform processes in aged care and (b) administration of the Australian aged care system (in particular the regulatory system) are adequately safeguarded from the risk of industry capture?

22 (a). No. A huge mistake was removing the public funding for the Combined Pensioners and Superannuants Federation to be a third party monitor of regulatory capture on behalf of aged citizens. In earlier times we saw it play a wonderfully constructive role, indeed a formative one on aged care regulatory policy, that enjoyed respect from the aged care industry and the Department of Health and Aged Care of that time.

22 (b). In specific cases where residents' councils want support over a conflict with a provider, advocacy groups should be able to support them (for example at an Exit Conference at the end of an inspection). This is a common role for advocacy groups to support powerless aged consumers in other developed countries. In other words, Commonwealth funding support for advocacy should

²⁷ Makkai, Toni and John Braithwaite (1993) '[Praise, Pride and Corporate Compliance](#)' *International Journal of the Sociology of Law* 21, 73-91.

encourage support for residents' councils collectively in their campaigns in a particular facility and in the way they seek to connect up with campaigning for reform in other facilities and nationally, in addition to advocacy support for individuals.

22 (c). We have no doubt the Aged Care Advocacy Network does a great deal of wonderful work on behalf of thousands of consumers. We would say, however, that in the conditions of their original funding, as we understood them in the late 1990s, they were constrained against being critics of government policy. They were contractually constrained from being advocates in that sense. They were constrained to be individualized in their service provision to individual clients. Australia has not seen the kind of aggressive advocacy we see in other countries, where civil society groups target the consistently poor compliance record of a particular chain of aged care facilities and also targets the regulator for being weak and captured in their regulatory dealings with that powerful corporation.

22 (d). We were always worried that government policy on advocacy in Australia had sought to tame and privatize by contract. We do not pretend to be up to date on these issues and we do hope policy has changed. But we would ask the Royal Commission to look at the contractual constraints on advocacy organizations funded by the Commonwealth concerning what kinds of advocacy they cannot do.

23. Have you examined the role of pay for performance approaches to improving the quality of care, whereby, for example, government payment levels are adjusted for the relative quality of the service?

23 (a) We invested quite a lot of fieldwork time in observing regulation by government payment levels adjusted for the relative quality of the service, especially in the state of Illinois, which was the most admired program that won prestigious awards for this innovation. Years later Illinois abandoned it as cost-ineffective. In *Regulating Aged Care* we agreed with this judgement. So did all the other states that had less lauded programs in Michigan, Massachusetts and Florida. We also visited and checked out the experience of these states. The issues are discussed particularly in Chapter 8, entitled 'Market Ritualism', of *Regulating Aged Care*. As with so many other innovations, but even more so with this one, the incentives became incentives for gaming the funding system.