Regulating nursing homes: The challenge of regulating care for older people in Australia

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The crisis of care

From worldwide accounts in the media of the abuse and neglect of frail elderly people both in nursing homes and in community care it seems that Western governments and civil society are doing badly at meeting the challenges of caring for older people. Although horror stories provide evidence that the quantity and quality of services for frail elderly people need to improve, when they are put into historical perspective, the care of elderly people is a success story for both welfare and regulation. However, it is also one of failure for the neo-liberal policies of privatised care. (Neo-liberal policies seek to shift what were functions of the state to the private sector and the individual.) Australia provides a good example of this (box).

Before the welfare state existed in the West, families who were financially comfortable cared for their older relatives at home, often with love and with the responsive support of the family doctor; there was, however, often a cost to women who bore the burden of care. In some cases there was domestic neglect and abuse. Elderly people who were destitute were systematically neglected and abused during their incarceration in asylums. In Australia, poor elderly people were often cared for in buildings constructed to house convicts, although overcrowding in convict colonies was less serious than overcrowding among elderly people: convicts were sent into the community to work when there was a shortage of beds. In contrast, 19th century poorhouses burst at the seams, and their regimes became more totalitarian in response. The Melbourne Benevolent Asylum housed 1337 residents in 1891 and this grew to 3436 in 1897, and "the overspill population were incarcerated in Pentridge prison."[1]

Care of frail elderly people in Australia

1788-1888—The convict state: poor elderly people are incarcerated in asylums

1888-1988—Rise of the welfare state: institutional care for elderly people becomes less prison-like

1950-1988—Rise of the regulatory state: state government increases its role in inspecting nursing homes and setting standards

1988-1996—Takeover of the regulatory state: Commonwealth government takes over and standards shift towards evaluating outcomes for residents; there is also a shift towards providing care at home and in the community

1996-2000—Deregulation: experiments in deregulation and privatisation of care of elderly people

Summary points

In Australia, privatisation of the nursing home industry occurred at the same time as deregulation

This has caused a crisis in the quality of care and a crisis of political confidence

Depending on market mechanisms to regulate care in nursing homes is inappropriate because older people often cannot exercise their rights as consumers by leaving or complaining

All nursing homes should be inspected regularly, and sometimes without notice, and the results should be available to the public

A regulatory process that empowers residents and focuses on them will repay public investment many times over

The same phenomenon occurs today in many Western countries where policies aimed at moving people with mental illness out of institutions have had the unintended effect of turning prisons into the institutions that care for the largest number of people with mental illness. McCallum and Geiselhart considered that what changed this situation of care for poor older people in mid-20th century Australia was that "At some point in the development of countries, modern, high-quality aged care services emerge from these sometimes depressing beginnings. The key factor distinguishing the new from the old is the emergence of public funding for and public regulation of the aged care industry."[1]

The regulatory state

It was the growth of both the welfare state and the regulatory state that moved Australia from those depressing beginnings to public regulation and funding. The idea and reality of welfare and regulation slowly grew together from beginnings in the Victorian era. The Keynesian period (from the 1950s to the 1970s) was the high water mark of the welfare state. From the 1980s, starting with Margaret Thatcher in the United Kingdom and spreading to other developed countries there is a decline of the welfare state and a growth of privatisation. While a great deal of neo-liberal deregulation also occurred during this period, privatisation did not cause a retrenchment of regulation in the way it did welfare. Indeed many scholars have detected the rise of a new, reinvigorated

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WILL BURGESS/REUTERS

Reacting to the welfare state: Australian pensioners demonstrated in March in a bid for increased pensions

regulatory state. This new state is about steering, or regulating, rather than rowing—that is, the state providing welfare directly.[2] So even as Margaret Thatcher privatised telecommunications she created a new regulatory agency, Oftel, and a plethora of other new or expanded offices to regulate the newly privatised industries.

In Australia, as in most nations, nursing homes have had to react to both the growth of the welfare state and the regulatory state. Attempts to diminish either have been temporary setbacks. At moments when Western governments made concerted efforts to cut back either welfare or regulation, they tended to strengthen the other. In the United States, as the Reagan administration cut back on welfare it came under enormous pressure from the healthcare industry to deregulate nursing homes by dismantling inspection in favour of implementing accreditation schemes administered by the Joint Commission on Accreditation of Healthcare Organizations. Accreditation would have replaced public inspection with a form of privatised peer review or self regulation. As tempted as the Reagan administration was by deregulation, public outcry ultimately persuaded them that it would be a mistake.[3]

Deregulation in Australia

The current Australian government, led by Prime Minister John Howard, is the only example of a simultaneous attempt to cut welfare, encourage rapid growth of private care by large corporate organisations, and deregulate nursing homes. In 2000, 55% of the new beds in nursing homes that were funded by the government were in the private sector compared with 27% historically. About 12% of the new funding for beds went to one provider, the Health Care Group which is owned by Doug Moran, a prominent member of John Howard's Liberal Party.[4] The result has been a disaster both politically and in terms of policy.

In the lead up to the 1996 election the Liberal Party promised the politically active nursing home industry that it would seek to make the provision of care in nursing homes more competitive and also increase the industry's income by introducing means testing and new admission fees. Additionally, then candidate Howard promised that he would shut down the state run standards monitoring process and replace it with an industry controlled accreditation scheme. Once in government, he also ended public funding of the Australian Pensioners' and Superannuants' Federation, which had been the leading advocacy group for improving standards in nursing homes, and cut funding to other non-governmental organisations in the belief that this would silence criticism of the accreditation scheme.

Prime Minister Howard's aspirations for trimming the welfare state and deregulating a private market are now in tatters. The government has been forced to backtrack by public opposition to means testing and paying fees in advance. Commonwealth funding for nursing homes increased by $A1.4bn (£505m; $715m) to $3.9bn between 1996 and 2000. The accreditation regime is still in place (now known as the Aged Care Standards and Accreditation Agency), but the government has been forced to double the amount initially allocated to support it, eliminating nearly all the savings made from abolishing the inspectorate. The government has maintained the integrity of the old standards monitoring process by continuing to make accreditation reports on nursing homes available to the public. However, when critics complained about the weak enforcement of standards and about nursing homes that were providing poor care the Aged Care Standards and Accreditation Agency removed its accreditation reports from its website so as "not to put undue pressure on homes" (in the words of the minister).[5] This was another political disaster: a rogue website posted the worst accreditation reports. The secrecy of self regulation, which had led the United States to reject accreditation and self regulation, had become reality in the supposedly superior Australian accreditation system.

Privatisation and quality

The government's neo-liberal policies certainly have given impetus to multinational companies that run nursing homes to expand into the Australian market. These companies provide a more institutional, less home-like, form of care than the care provided by the nurses who own smaller homes and the homes run by churches and charities that are subsidised by the state.[5] The multinational companies tend to have superior risk management systems and better formal quality assurance programmes however.

Jenkins and Braithwaite used multiple regression to analyse the quality of care as assessed by the 31 outcomes standards in force in 1999 in 410 Australian nursing homes.[6] Their survey had good validity and reliability, as measured by independent ratings made by two simultaneous inspections of the same homes.[7] They found that the quality of care was significantly lower in profit making nursing homes than in non-profit nursing homes.[8] One reason was that in profit making homes there was significantly greater pressure on directors of nursing to reach financial goals by cutting corners on quality. Data from the United States support the finding that profit making nursing homes have lower care standards.[5]

Deregulation and quality

The evidence is convincing that the Australian standards monitoring process introduced in 1988 was effective in improving the quality of care.[7] The reasons for this included the fact that the process was more outcome oriented and resident centred than other regulatory regimes. It was an example of conversational regulation (box)[9]—where even very ill residents participated in effective conversations[10]—rather than regulation based on an audit of documents.

The broadness and vagueness of the 31 outcome standards meant that they could be rated with impressive reliability and validity.[8] The research by Jenkins and Braithwaite showed that the old Australian standards were rated much more consistently (by different inspectors rating the same home at the same time) than the US standards, which are much more precise and numerous. If an inspection team is rating a 1000 standards, team members cannot have a conversation with one another or with stakeholders about each of the standards. Instead, regulation proceeds by recording violations of the standards.

The Aged Care Standards and Accreditation Agency did learn from some of the weaknesses of the standards monitoring process. The old process had failed to make the category of "continuous improvement" central to its regulatory practice. In the new agency's ratings, however, one of the items that distinguishes a "commendable" rating from a "satisfactory" one is "demonstrating a continuous improvement cycle." Under the standards monitoring process informal praise by inspectors was important in improving quality but this praise was often lacking from the ritual of an exit conference.[11] A positive feature of accreditation has been to ensure that inspectors do not shy away from offering praise at exit conferences because they fear that it might compromise future enforcement. Additionally, accreditation teams have been trained to offer informal praise as they move about the facility, and this has also been helpful.

Other deficiencies in the standards monitoring process, however, worsened after the introduction of accreditation. Spot checks of nursing homes made without notice, which had been rare, ceased. In response to criticism the minister for aged care introduced some spot checks with notice. Enforcement of regulations, which had been inadequate under the standards monitoring process, has been weakened further. The government withdrew funding from one home out of 3000 in the first three years of accreditation.

Conversational regulation and empowerment

How do you empower a resident who is unable to speak? Good inspectors notice when a resident shows pain, for instance, or leaves all her peas on the plate. Knowing that she cannot reply, the inspector asks: "Don't you like the peas?" Her roommate speaks up and says that she always refuses the peas; she hates peas. The inspector confirms this with the resident who nods agreement. The resident shakes her head when asked if she is offered a substitute. Although this resident cannot speak, she has been empowered by conversational regulation

What makes regulation effective? Lessons from Australia[12]

Regulation is effective when

- Outcome standards are few enough to be regulated conversationally
- Standards empower residents
- Records are audited locally
- There are occasional inspections without notice
- A graduated hierarchy of sanctions exists to deter negligent care without punishing residents
- Praise is offered; this allows best practice to be disseminated by honouring innovations in providing quality care
- There is transparency, and reports are available and are discussed with committees of residents and their relatives
- Continuous improvement is used as a measure of outcome

Additionally, there is no credible hierarchy of sanctions. An effective regulatory regime requires the capacity to move up a pyramid of enforcement sanctions. Draconian sanctions, such as the revocation of a licence, are so hard to impose in practice that they are rarely used. More graduated sanctions that reflect the severity of a problem are needed. For example, suspending government payments for new residents until a problem is solved can be used before suspending payments for all residents (box).

The biggest worry in Australia is that accreditation teams, which mostly consist of two people, one of whom can be nominated by the facility, are not conducting rigorous inspections before giving facilities a clean bill of health for three years. In October 1999, the Aged Care Standards and Accreditation Agency quoted the director of nursing in a private home in its newsletter as saying of her accreditation visit: "They gave a lot of positive feedback to the staff [and] they did not make excessive demands!"[13]

Another worry is that accreditation is a manifestation of "the audit society"[14]: a triumph of methods from the discipline of accounting over those of other fields that have superior evaluation methods. Auditors tend to check outputs, such as financial or medical records, rather than outcomes, such as health and welfare. Audit is a "ritual of verification" designed to give shareholders "comfort"[14]; audit is actually no more useful in evaluating the quality of investments than it is in assessing the quality of nursing homes. The first stage of accreditation by the Aged Care Standards and Accreditation Agency shows some elements of an "audit mentality." The first stage is called a "desk audit." The agency's assessors from the private sector can be registered to audit providers by attending a four day course given by organisations like the Australasian Auditing and Certification Services.

Neo-liberalism and rationality

As a model for improving the quality of care in nursing homes, relying on fees and consumer choice is naive. Residents are too sick to vote with

Irrationality, the market, and quality of care

Consider the irrationality of a person who pays extra so as not to share a hotel room with a colleague while on a business trip. He does this because he values privacy but he also scoffs at taking out long term care insurance to guarantee a private room in a nursing home. Why is he willing to risk sharing a room for the rest of his life with a person he does not like? This common irrationality is often masked by rationalisations such as "I would rather die than have to live in a nursing home." Yet we know that when the time comes most prefer the limited pleasures of life in a nursing home to suicide

their feet. There are even more fundamental reasons why depending on the rationality of the market will never work well for quality of care (box). Sensible policy for providing nursing home care requires a larger welfare state, a larger regulatory state, and encouragement of public, non-profit providers. Australia's recent experience shows that to head in the opposite direction is medically, economically, and politically irrational.

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Statistics Notes

Concealing treatment allocation in randomised trials

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We have previously explained why random allocation of treatments is a required design feature of controlled trials[1] and explained how to generate a random allocation sequence.[2] Here we consider the importance of concealing the treatment allocation until the patient is entered into the trial.

Regardless of how the allocation sequence has been generated—such as by simple or stratified randomisation[2]—there will be a prespecified sequence of treatment allocations. In principle, therefore, it is possible to know what treatment the next patient will get at the time when a decision is taken to consider the patient for entry into the trial.

The strength of the randomised trial is based on aspects of design which eliminate various types of bias. Randomisation of patients to treatment groups eliminates bias by making the characteristics of the patients in two (or more) groups the same on average, and stratification with blocking may help to reduce chance imbalance in a particular trial.[2] All this good work can be undone if a poor procedure is adopted to implement the allocation sequence. In any trial one or more people must determine whether each patient is eligible for the trial, decide whether to invite the patient to participate, explain the aims of the trial and the details of the treatments, and, if the patient agrees to participate, determine what treatment he or she will receive.

Suppose it is clear which treatment a patient will receive if he or she enters the trial (perhaps because there is a typed list showing the allocation sequence). Each of the above steps may then be compromised because of conscious or subconscious bias. Even when the sequence is not easily available, there is strong anecdotal evidence of frequent attempts to discover the sequence through a combination of a misplaced belief that this will be beneficial to patients and lack of understanding of the rationale of randomisation.[3]

How can the allocation sequence be concealed? Firstly, the person who generates the allocation sequence should not be the person who determines eligibility and entry of patients. Secondly, if possible the mechanism for treatment allocation should use people not involved in the trial. A common procedure, especially in larger trials, is to use a central telephone randomisation system. Here patient details are supplied, eligibility confirmed, and the patient entered into the trial before the treatment allocation is divulged (and it may still be blinded[4]). Another excellent allocation concealment mechanism, common in drug trials, is to get the allocation done by a pharmacy. The interventions are sealed in serially numbered containers (usually bottles) of equal appearance and weight according to the allocation sequence.

If external help is not available the only other system that provides a plausible defence against allocation bias is to enclose assignments in serially numbered, opaque, sealed envelopes. Apart from neglecting to mention opacity, this is the method used in the famous 1948 streptomycin trial (see box). This