



Real Choice for Ageing Australians: Achieving the Benefits of the Consumer-Directed Aged Care Reforms in the New Economy

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Executive Summary

One of the most important sets of reforms to the human services sector in a generation came into full effect on 27 February, 2017. On that date, all 'Home Care Packages' — the federal government subsidy that gives elderly Australians access to home-based care and support services — became fully portable. Care recipients have for the first time been empowered with the freedom to choose the type and mix of care and support services they wish to receive, and have been given the freedom to choose the service provider they prefer.

Full portability completed the funding reforms implemented on 1 July, 2015, which converted all funding for home care packages into 'Consumer-Directed Care' (CDC) packages. Under the new demand-driven system, ageing Australians requiring home care can now access individualised funding budgets (according to their assessed levels of need) to purchase the care they require based on personal choice.

CDC packages have replaced the long-established system of block funding of 'Approved Providers' who were contracted by competitive tender to deliver a set quantity of packages within specific geographic regions. Under this highly-regimented supply-driven regime, the consumer's choice was limited to the kind of one-size-fits-all service model the provider chose to deliver. Historically, the provider market has been dominated by faith-based charitable organisations that mostly offer similar standardised sets of services to consumers forced

to accept what they are given with no alternatives.

Traditional providers' rigid models of care invariably involve centralised rostering by head office managers of care workers who rotate in and out of homes and perform set tasks in a set timeframe. This 'institutionalised' style of care is replete with paternalistic and ageist assumptions about knowing what's best for passive and vulnerable elderly care recipients. It does not allow for the personalising of services according to the diverse needs, expectations and preferences of today's more demanding consumers, especially among the ageing baby boomer demographic who are assisting ageing parents receiving care, or in the early stages of accessing care themselves.

As well as being inflexible and unresponsive to the needs of consumers, traditional home care services also incur large administrative overheads that absorb a significant proportion of funding. Complying with government red tape and regulation of standards has also increased the cost and reduced the level of frontline services delivered locally in care recipients' homes.

A Level 4 Home Care Package offers substantial government support of \$48,906 per annum. Yet it is common for an individual in receipt of a Level 4 package typically to receive just 10–12 hours of care per week. Historically, providers charge between 35%–50% of funding (and sometimes more) for core administration and case management services. The amount of care and

support received by people assessed as having Level 4 needs is unlikely to be sufficient for them to remain living in their own homes.

A key objective of the CDC reforms is to ensure that elderly Australians have greater control over what, how, and when they receive the kind of services that best allow them to 'age in place' for as long as possible in their own homes, and delay the need to move to higher cost (for both government and consumers) residential aged-care facilities. Hence, the introduction of greater choice and competition into the new market-based CDC system is designed to encourage providers to tailor the range of services offered to care recipients' individual needs in order to win the custom of consumers who are free to take their business elsewhere. The need to compete successfully will also spur providers to discover operational efficiencies and other innovations to increase the amount and/or mix of services that can be delivered out of the funding package.

The 'value' locked up in inefficient and ineffective provider-centric models of care can now easily and conveniently be released by consumers thanks to CDC funding allowing new and technologically innovative players to enter the market. The 'Uber'-style, peer-to-peer (P2P) online platforms now available to connect consumers directly with self-employed care workers can potentially double the amount of flexible and personalised care and support consumers receive.

Consumer-focused P2P platforms that are not burdened by traditional provider overheads have found that consumers are able to access 20 plus hours of care per week — 8 hours of additional support — out of the same Level 4 funding package. The additional care and support delivered (in place of paying for head office positions) will materially improve the quality of life of elderly care recipients and promote active ageing, wellness and social connection. P2P platforms — which cut out the middle management in service delivery — will provide local jobs for care workers in local communities, particularly in rural and remote areas with the greatest need.

The CDC reforms are of great significance given that Australian governments are generally struggling to achieve consumer-focused, market-based and sustainable reform in other areas of large public spending in government services facing similar policy, cost and service delivery challenges. Given the tight budgetary situation confronting both state and federal governments, the major lesson to be drawn from the CDC reforms is how better value and better performance — more and higher quality government-funded services with minimal additional public cost, plus greater private investment in service delivery — can be achieved without resort to the so called 'solution' of simply spending more taxpayer's money.

The CDC changes are an important opportunity to showcase the benefits of market-based reforms to often sceptical and change-averse members of the public. Given the broader implications, this report warns that the CDC reforms could fall short of their promise and fail to optimise the potential outcomes due to a lack of follow up and follow through reforms.

If the full benefits of choice and competition are to be realised for consumers, care workers and tax-payers, further government action is needed to remove other regulatory barriers. This report encourages the federal government to implement the following 'to do' list of additional reforms to promote real choice and greater improvements in the efficiency and effectiveness of consumer-driven aged care in the new economy:

- Establish a minimum standards framework for home care services to ensure excessive regulation does not restrict provider competition — and therefore customer choice — in the new consumer-focused market, and doesn't burden the sector with excessive cost.
- Ensure consumers do not face significant switching costs, by foreshadowing the application of Australian consumer law to the charging of hefty exit fees should traditional providers fail to cease a practice that is contrary to the spirit and intent of the CDC reforms.
- Review the duty of care provisions of the *Aged Care Act* to prevent traditional providers citing statutory obligations as an excuse to deny consumers the right to choose alternative providers. This will help stimulate the unbundling of one-size-fits-all care packages into separate services (spanning fund holding, administration, case management, care coordination, advocacy and service delivery) that can be purchased discretely from specialised organisations offering different parts of the bundle.
- Revisit mandatory qualification requirements for care workers to make it easier for those without industry experience to seek employment in the sector, while trusting consumers to judge workers' suitability based on the quality of service received and assume a level of risk consistent with independent ageing and dignity of life.
- Examine how employment laws might be applied to an individual engaging another individual to provide personal care and domestic service, to clarify the status of care workers as independent contractors hired directly by consumers. This will encourage the growth of innovative online marketplaces for care and support services that can offer better value and superior quality home care.
- Undertake a public information education campaign to foster awareness among ageing Australians and care recipients of their right to choose under the CDC system, and promote knowledge of the full range of options now available, including online platforms.

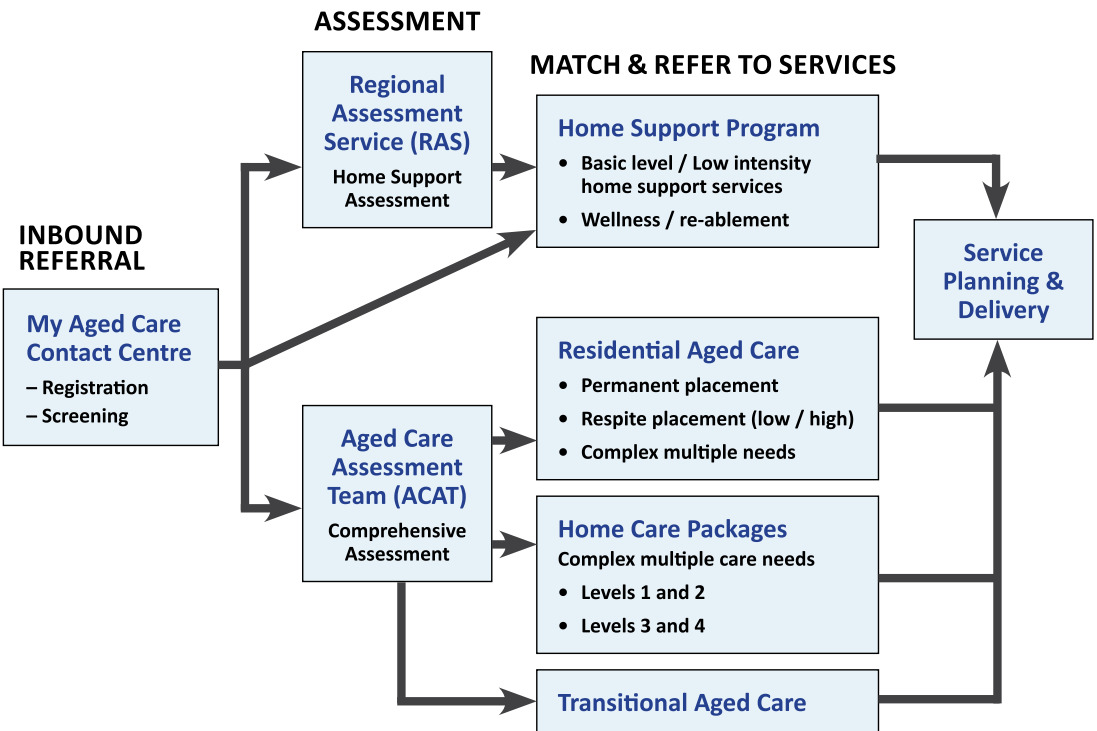


Introduction: a New Era for Aged Care Services

One of the most important sets of reforms to Australia’s human services sector in a generation came into full effect on 27 February, 2017. On that date, all ‘Home Care Packages’ started to follow consumers and became completely portable. Home care packages are the taxpayer-funded subsidy provided by the federal government to give people assessed as having complex and multiple ageing-related needs access to home-based care and support services to enable them to live safely and well in their own homes. Home-based aged care services include the Commonwealth Home Support Program that provides entry-level support

(including assistance with cleaning and meals); home care packages, now Consumer Directed Care (CDC) packages, are designed to provide access to more intensive care and support for people with needs ranging from basic to high needs. (Figure 1) The introduction of fully portable home care packages means ageing Australians have for the first time been empowered with the freedom to choose the type and mix of home-based age care services they wish to receive, and have been given the freedom to choose the service provider they prefer.

Figure 1: Aged Care in Australia

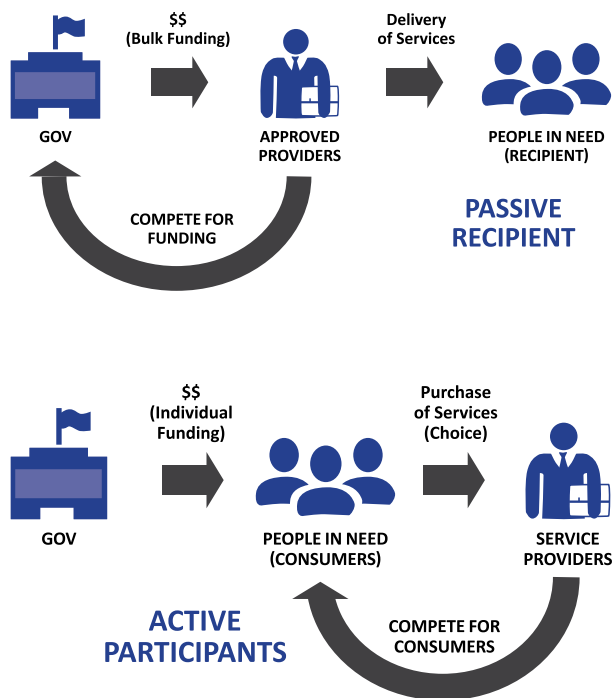


The implementation of full portability has completed the funding reforms implemented on 1 July, 2015. From that date, all funding for home care packages was converted into CDC packages that replaced the long-established system of bulk funding of 'Approved Providers' who — having undergone a competitive vetting process to be eligible to provide care — were contracted by public tender to deliver a set quantity of packages within specific geographic regions for which they received per package payments from the federal government. In place of this highly-regimented 'supply-driven' (and ultimately provider-captured) regime, the new demand-driven system allows ageing Australians requiring home care to access individualised funding budgets to purchase the care they require based on personal choice. (Figure 2)

The amount of CDC funding an individual receives is tiered across four increments according to level of need. The level is assessed by the Aged Care Assessment Team (ACAT), the federal government agency that employs health and medical professionals to determine eligibility for subsidised aged care services. A means test (effective from 1 July 2014) was also introduced as part of the CDC reforms, and takes the form of mandatory income-related 'co-payments' that are paid out-of-pocket by individuals.¹ (Figure 3)

In the transition phase from the old to the new system, consumer choice was constrained by continuing government regulation. Consumers still had to accept packages that were available and 'held' (won by tender) by approved providers. On 27 February, the legacy restrictions on choice were abolished, and consumers holding a CDC package are now free to choose their provider. Approved providers will continue (for

Figure 2: From Supply-Driven to Consumer-Driven



administrative purposes) to hold and manage funding on behalf of, and at the direction, of consumers. But instead of having to receive a full service from the approved provider, consumers are now free to choose an alternative provider, and determine the kind of care and support they want from their preferred provider.

Figure 3: Home Care Packages

Levels of Home Care Package	Home Care Subsidy Rates		Maximum Daily Contribution based on Income		
	Per annum	Per day	Income <\$25,792.00 p.a.	Income \$25,792.00 to \$49,873.20 p.a.	Income >\$49,873.20 p.a.
Level 1	\$8,044.60	\$22.04	\$9.97	\$24.27*	\$38.58**
Level 2	\$14,632.85	\$40.09	\$9.97	\$24.27*	\$38.58**
Level 3	\$32,171.10	\$88.14	\$9.97	\$24.27*	\$38.58**
Level 4	\$48,906.35	\$133.99	\$9.97	\$24.27*	\$38.58**

* Annual cap of \$5,208.20 per year for part pensioners, **Annual cap of \$10,416.42 per year for self-funded retirees

Lifetime Cap of \$62,498.66 for all income-tested care fees, including residential care fees

Note: Amounts increase on 20 March & 20 September each year in line with aged pension increases.

Source: Australian Government Department of Health, accessed February 2017.

* Note: supply of aged care was regulated to ration services based on severity of need and control the financial risk to government. This was achieved by use of population-based service provision target ratios for designated regions. Under the CDC system, supply caps remain in place, but the ratio is being increased from 113 residential and home-based aged care places per 1,000 people aged over 70 to 125 places by 2021-22, with the proportion of home-based places increasing over the period from 27 to 45. A long term benefit of the reforms may be that supply will ultimately be uncapped by government. This will perhaps be contingent on achieving efficient supply of services, so a truly consumer-driven system is affordable given available funding.



Why Choice and Competition?

The CDC reforms are designed to give consumers greater control over the design and delivery of their care by transforming their role from passive recipients into empowered, active purchasers of home care services. The old funding system essentially allowed providers to 'capture' the system and dictate the overall cost and service delivery outcomes achieved. Under the old system, the consumer's choice of type and mix of services was limited to the kind of one-size-fits-all service model the provider chose to deliver. Under the new system, consumers will no longer depend on traditional providers or be obliged to 'take what they are given'.

Hence, a key objective of the CDC reforms is to ensure that elderly Australians have choice and control over what, how, and when they receive the kinds of services that best allow them to 'age in place' for as long as possible in their own homes, and delay the need to move to higher cost (for both governments and consumers) residential aged care facilities.² The introduction into the home care sector of consumer choice and provider competition is intended to drive improvements in the quality and cost of care. Providers seeking to win the custom of those who are free to take their business elsewhere will now have to be aware of the needs of customers in order to compete successfully. In the new dynamic market-based environment, the benefits of choice and competition are expected to include tailoring or personalising the range of services offered to care recipients' individual needs and preferences, and spur

providers to discover operational efficiencies and other innovations that will increase the amount and/or mix of services that can be delivered from the funding package. The aim of the CDC model is to put consumers (instead of providers) at the centre of the system, generate better value for current and future taxpayers' money by promoting efficient service delivery, and ensure elderly Australians in need receive more — and higher quality — services for the available funding.

The CDC reforms are of great significance given that Australian governments are generally struggling to achieve consumer-focused, market-based and sustainable reform in other areas of large public spending across the human services sectors. Aged care (along with disability services) is one of the few human services sectors in which the principles and recommendations of the 2015 Harper Competition Policy Review have started to be implemented. The Harper Review highlighted the need for governments to undertake reforms that place consumer choice at the centre of service delivery, combined with regulatory changes that maximise choice and competition, encourage diversity in provision, foster innovation in service delivery and drive improvements in efficiency.³

At a time of considerable pessimism in the Australian community about the ability of governments to achieve structural reforms in important areas of the national economy, it is worth examining a positive story of policy

change and pondering the lessons. Understanding 'how' the CDC reforms were implemented is thus as important as 'why' they were implemented. This is crucial in terms of trying to emulate similar reforms in other government service sectors facing similar policy, cost and service delivery challenges, including the health sector. For example, Medicare (Australia's taxpayer-funded 'free and universal' health care scheme) is essentially a provider-captured payment system, which locks consumers into traditional GP-led or hospital-based healthcare delivery systems and prevents the development of innovative, more cost-effective alternative models of care.⁴

With regard to the broader challenges of structural reform, and given the tight budgetary situation confronting both federal and state governments, a major lesson to be drawn from the CDC reforms is how better performance — more and better quality government-funded services plus greater private investment in service delivery⁵ — can be achieved by ensuring that government funding is spent in the most efficient and effective ways. The imperative to limit the call on public resources and maximise the outcomes achieved for the funding expended — without resort to the so-called 'solution' of simply spending more taxpayers' money —

is especially vital in a fiscally sensitive area such as aged care, where demand and expenditure will grow rapidly in line with the ageing of the population.⁶ The need for the CDC reforms to generate better value for limited funding was reinforced by the cuts to aged care funding announced as part of the 2016 federal budget.⁷

Given the broader implications of the CDC reforms, this report seeks to identify the potential barriers to their success. The point stressed is that the CDC system could fall short of its promise — as measured by failing to optimise the potential outcomes for consumers, care workers, governments and taxpayers — due to lack of follow-up and follow-through reforms. This is to say that consumer-directed aged care could prove less successful than hoped, not because the reforms 'go too far' but because they don't go far enough to yield the full benefits for the recipients, providers and funders of home-based aged care. The policy recommendations of this report encourage the federal government to implement a range of additional reforms to promote real choice and greater improvements in the efficiency and effectiveness of consumer-driven aged care.



Background: Consumer-Focused, Bi-Partisan Reform

In April 2010, the Rudd Government instructed the Productivity Commission to inquire into Australia's aged care sector.⁸ The inquiry was sparked in part by the Government's recent commitment to take over full funding and policy responsibility for the disability and aged care sector (as part of the establishment of the NDIS — the National Disability Insurance Scheme). However, the inquiry — as was ultimately reflected in the findings and recommendations of the Productivity Commission's final report — was also prompted by mounting concerns and frustrations expressed by consumers, families and advocacy groups about the inability of the existing, largely inflexible and high-cost aged care system to respond to significant shifts in the type of aged care being demanded by increasing numbers of elderly Australians who preferred independent living arrangements and to live in their own homes. Policymakers were also motivated by an awareness that the current system was ill-equipped to meet the increasing demand for services in a rapidly ageing Australia, and that among the most important challenges was the need to expand the size (and improve the wages and conditions) of the aged care workforce.

A month later, in May 2010, the Henry tax review (*Australia's Future Tax System Review*)⁹ was released and made specific recommendations relating to aged care services. The review recommended less regulation of the sector and found there was "considerable scope to align aged care assistance with the principles of user-directed funding to provide assistance in line with

recipients' needs." The report advised the Productivity Commission to consider recommending reforms along these lines, together with appropriate regulatory changes.¹⁰

In August 2011, the Productivity Commission released its final report, *Caring for Older Australians*.¹¹ The report found the sector struggled with a number of weaknesses, including: consumers having limited choice, receiving limited services and limited coverage of needs; difficulties accessing information and navigating complex assessment and funding arrangements; uneven quality of care; and inconsistent or inequitable pricing and subsidies. The Commission proposed an "integrated package of reforms" to tackle the major structural challenges facing the sector, and made the following recommendations:

- Establish a new regulatory agency, the Australian Aged Care Commission, to ensure independent governance and regulation of standards.
- Create a single, simplified online gateway to access aged care services and information.
- Establish a means test for co-contributions and a lifetime limit of co-contributions.
- Replace the current care package regime with a single system of integrated and flexible care provision to increase consumer choice, access and financial sustainability.

In April 2012, in response to the Productivity Commission report, the Gillard Government unveiled the *Living Longer, Living Better* aged care reform package.¹² The proposed reforms were welcomed and garnered initial support across the sector. Due to support and lobbying by consumer advocacy groups such as COTA Australia, the *Living Longer, Living Better* package enjoyed bipartisan support in Parliament. Following extensive consultation with the community, there was broad-based political acknowledgement of the need for change, and both the government and the opposition saw the merit of putting the care of older Australians and the needs of consumers, their families and taxpayers ahead of the “business imperatives” of traditional providers with vested interests in the status quo.¹³

The legislation implementing the Aged Care Reform Package passed in June 2013, and introduced the following changes:

- Established the Aged Care Pricing Commission, Aged Care Quality Agency, and Aged Care Financing Authority.
- Created a new, simplified gateway, the My Aged Care website, with easily accessible information, screening and needs assessments.
- Increased residential care places by 29,500, and home care packages by 40,000 over 5 years.
- Introduced fairer and more transparent, means-tested thresholds and tiers for co-contributions, including the introduction of a \$60,000 lifetime limit on co-contributions.
- Replaced bulk funding of home care packages with individualised CDC funding packages.

The fundamental reforms announced by the Gillard Government were largely based on the Productivity Commission’s recommendations, and were set to be implemented progressively over three years to allow for a smooth transition. The reforms aimed, in the first instance, to reorganise the governance of the system and to increase the amount of recurrent government investment in aged care by expanding the number of packages available. The ratio of home care to residential care funding packages was increased, and funding for home care packages was also substantially increased. However, the additional ‘investment’ in the sector was a canny one in concert with the introduction of the CDC system. Rather than simply add additional funding ‘inputs’, the overall objective was to increase ‘outputs’: the quantity and range of services delivered from available funding by putting consumers in charge of their care and spurring competition, innovation and efficiency among providers.

Reorienting the system around consumers began with the establishment of the My Aged Care gateway to provide consumers with better and more easily accessible information about their rights and options available, as is standard policy when governments undertake market-based reforms. But the major step in the consumer-focused direction was, of course, the move to CDC packages, with the aim being to wrest control of service design and delivery away from traditional providers by empowering consumers with the right to choose their own levels of support and services.



Objectives: More Care, Better Quality

Under the old, supply-driven funding system, the federal government purchased home care services in bulk from providers who determined the model of care — the type and mix of services provided. The paternalistic relationship established between providers and consumers probably derives from the ‘charitable’ status of the Not-For Profit, usually faith-based organisations that dominate the sector, among the over 2000 aged care service providers in Australia supplying both residential and home-based services.¹⁴

From colonial times, Australian governments have subsidised the work of voluntary organisations providing assistance to the poor and vulnerable. The work of these charitable bodies, which were mostly controlled by churches, included the provision of homes (“asylums”) for the aged.¹⁵ These institutions were the forerunners of today’s ‘nursing homes.’** The inflexible, one-size-fits-all, impersonal nature of the home-based services delivered by many traditional providers resembles an ‘institutionalised’ model of care — but without the walls. This model of care is underpinned by well-intentioned assumptions about providers knowing what is best for ‘vulnerable’ elderly care recipients — assumptions that can ultimately feel patronising and ageist because they fail to take into account and reflect the capacity of many elderly people to make informed decisions about their care needs and service requirements. As the Aged Care Reform Implementation Council chair Peter Shergold observed, “the problem is that even with good intentions... [at] every forum I’ve attended in which consumers have had a voice, they excoriate providers who are perceived to patronise them.”¹⁶ This issue — and hence the need to empower consumers with greater choice and control — was highlighted by the Productivity Commission’s *Caring for Older Australians* report, which recommended a more reasonable and balanced approach to choice and risk be applied across the sector as a part of the CDC reforms (see ‘Risk’ below).

Whatever its historical roots, provider-driven home care has impeded the development of responsive and innovative service delivery. The service provider market has historically been dominated by Approved Providers that are mostly similar organisations offering similar standardised sets of services and service delivery terms to consumers denied any real alternatives. The rigidities within the traditional care model also stem from operational considerations pertaining to centralised rostering of the care worker workforce by head office

managers. Rotating rostered staff in and out of homes to undertake set tasks in a set time frame — in effect delivering an ‘institutionalised’-style service — does not allow for the personalising of services according to the diverse needs, expectations and preferences of today’s more demanding consumers. Nor does it allow for consumers to have the basic right of privacy and to control who comes into their homes.

The historic, hierarchical structure of traditional home care services also reinforces perceptions of care and support workers being a low-skilled, poorly-paid profession, thereby exacerbating retention and recruitment challenges. This rigid structure also inhibits the human dimensions of care — the development of a personal relationship between care worker and consumer that is vital to worker morale and the recipient’s experience of quality services. In addition to feeling under-valued and under-paid, workers are further denied the personal reward that initially attracted many to the sector — the opportunity to make a difference in the lives of other people. The inherent inflexibility of this model is further compounded by the need for providers to meet government-determined mandatory ‘quality assurance’ standards and training frameworks, which are enforced through monitoring, audits and complaints procedures. Being obliged to fulfil report and compliance red tape requirements under the terms of government contracts has added to large head office overheads and administration fees charged by traditional providers, which absorb a significant proportion of funding; and have both increased the cost and reduced the level of frontline service delivered locally in care recipients’ homes.

A Level 4 Home Care Package offers \$48,906 in government support per annum — a substantial sum. Yet it is common for an individual in receipt of a Level 4 package typically to receive just 10–12 hours of care per week, which is unlikely to be sufficient to care and support people assessed as having Level 4 needs and allow them to remain living in their own homes. As spelled out in monthly statements (and to the chagrin of many dissatisfied care recipients and their families), traditional provider organisations can charge between 35%–50% of funding (and sometimes more) for core administration and case management services, leaving just 65% or \$31,789 available for frontline service delivery. Of the remaining funds available, service delivery is then typically charged at \$45–\$50 per hour

** The growth of the modern aged care system after World War II was also stimulated by state support: this took the form of Commonwealth grants to subsidise the capital cost of building “suitable homes for aged persons” by eligible charitable organisations, which was introduced by the Menzies Government in 1954. See Kewley, 316.

during the week, the bulk of which represents the provider’s margin, given that care workers are often paid \$20–\$27 per hour.¹⁷ (See Figure 4)

When a Level 4 package consumer receives 10–12 hours of care per week, this means the effective cost of care is in the range of \$80–\$85 per hour. The deadweight loss in fewer hours of care and additional support that could be delivered from the same funding could materially improve quality of life and promote active ageing, wellness and social connection. The problem of excessive overheads is well known; a telling and typical example was documented in the federal Parliament by Andrew Wilkie MP. Citing one of the “many complaints from older Australians and their families about the ridiculous cost of home care packages”, Wilkie gave the example of a “client who was effectively being charged \$165 an hour ... when all the administrative expenses were included.”¹⁸

The CDC reforms are the first, crucial step towards making the home care sector more transparent. The ‘value’ locked up in provider-centric models of care can now easily and conveniently be released by consumers, thanks to the introduction of CDC funding allowing new and technologically innovative players to enter the market. More efficient use of funding for service delivery not only means more hours of support for carers, but also more local jobs for care workers. (See ‘Alternative Models’ below.)

The Uber-style, peer-to-peer (P2P) online platforms now available to connect consumers and self-employed care workers can potentially double the amount of care received. The introduction of choice and competition has already revealed that non-traditional, for-profit online platforms can allow consumers to access services far more efficiently and receive many more hours of care: innovative entrants into the market that are not burdened by traditional provider organisational overheads have found consumers can access 20-plus hours care per week — 8 hours of additional support — out of the same Level 4 funding package.¹⁹

This is consistent with the promising results of an Australian-first trial of consumer-directed aged care conducted in Western Australia. Under a pilot involving the Regional Assessment Service (RAS) and two home care providers, funding for the Home and Community Care program was converted into individualised, needs-

based funding. Due to the attitudes of two forward-thinking partner organisation Avivo and MercyCare, the 103 participating clients were encouraged to exercise choice and control over the services and support they purchased. The traditional ‘provider’ role was transformed from fully controlling, managing and coordinating service delivery to offering information and advice about engaging their care workers directly as independent contractors. The reported (as anticipated) benefits of consumers having greater say in directing their care included savings in administration charges, higher pay for care workers, better matching of clients with workers and, in general, the ability to use funding flexibly and creatively to maximise service and support — such as by having the autonomy to purchase equipment or choose taxis over HACC transport.²⁰

The financial significance for government of the innovative service delivery options now available needs underlining. Inefficient use of available government funding adversely affects the availability of packages overall. The more efficient the delivery of services, the longer recipients can remain on lower-level funding packages, and the more packages that can be funded from the available pool. But if the benefits of choice, competition and the new economy are to be realised across the sector, the CDC reforms are insufficient by themselves to achieve the desired outcome.

The broader aged care regulatory environment, including employment law, threatens to prevent innovators from helping consumers to enjoy the full benefits of the CDC reforms. For example, if governments continue to regulate quality through rigid mandatory standards and dictate how care is delivered from the top down, this could hobble the market for consumer-focused care. A focus on compliance with overarching standards and regulations threatens to limit the opportunities for real choice and competition to raise quality from the bottom up, preventing providers from discovering how best to deliver the type and mix of services that consumers want to purchase. The additional regulatory reforms suggested in this report would promote the development of “a diverse ecology of aged care providers [that] is the best guarantee of a diversity of service options for consumers”, as recommended by the peak lobby organisation, the Aged Care Industry Association.²¹

Figure 4: Funding Breakdown

Level 4 Home Care Package	Administration Fee (e.g. 20%)	\$9,781	}	Administration & Case Management Fees
	Case Management Fee (e.g. 15%)	\$7,336		
\$48,906	Funds Available for Service (e.g. 65%)	\$17,484	}	Provider’s Margin on Services Delivered
Total Funds Available		\$14,305	}	Amount Paid to Worker for Service



Optimising Outcomes

Regulation

Under the historic bulk funding system, quality was regulated by requiring approved providers to comply with audited home care standards and mandatory training of care workers to enforce the development of a skilled and knowledgeable workforce.²² Under this regulatory regime, the federal government effectively paid providers not just to deliver services, but also to manage the risks involved in caring for the elderly in their own homes. This is understandable, given the vulnerable circumstances of some care recipients. Yet this tick box, micro-management approach of requiring providers to meet a handful of easy-to-measure standards and employ qualified care workers with the requisite training certificates was no guarantee of a quality care experience for consumers. The further unintended but predictable consequence is the administrative burden and compliance costs associated with government regulation, which compromised the efficiency and effectiveness of the system. This also encouraged the 'institutional-style' control exercised by provider organisations over what the care workers did and when they did it — a model of care necessitated (or at least justified) on the grounds of reducing potential liability and fulfilling the providers' statutorily-imposed duty of care.

In terms of delivering quality care, it is possible both government and providers have been more focused on avoiding adverse events by meeting basic standards, and less focused on maximising outcomes and quality of life for consumers. Perpetuating the excessively risk-averse regulatory environment embedded in the culture of the sector will undermine the objectives of the CDC reforms. There is an appropriate regulatory role for government to establish minimum quality standards for providers such as police and reference checks, and insurance and basic training requirements. This is the model of regulating core safeguards favoured as best

practice by the Harper competition review,²³ with the rationale being that regulation must be light, and the temptation to over-regulate must be resisted, if choice and competition are to become the major drivers of quality.

A move in this direction has been foreshadowed in the 2016 *Aged Care Roadmap* developed by the Aged Care Sector Committee at the request of federal Government. Recognising the need for a "more proportionate regulatory framework that gives providers freedom to be innovative", the *Roadmap* envisages the creation of a single provider registration scheme, which will also encompass the development of a single set of "core standards based on their registration category and scope of practice."²⁴ The *Roadmap* also envisages simplified criteria and a streamlined approval process, recognising that the current application process is marred by "unnecessary red tape which creates barriers to entry", limiting the choice available to consumers by limiting the participation of new, suitable providers offering innovative models of care. A commitment to establish "a single quality framework for all aged care services" was announced by the Turnbull Government as part of the 2015–16 Budget.²⁵

However, deregulation may need to go further and extend to revisiting the regulation of care workers. Requiring mandatory qualifications for care workers is an example of over-regulation, which exacerbates the well-documented workforce challenges in the sector (including the additional demand and competition for care workers created by the NDIS rollout). According to the 2015 'stocktake' prepared for the federal Department of Social Services, the aged care workforce will be required to nearly triple from 352,145 people to 827,100 people by 2050.²⁶

Just because care workers have attended and completed a training course does not guarantee they will practise what they have learned, nor ensure that consumers

will be guaranteed a quality experience. Quality of care is a personal experience that rests on the nature of the relationship between the consumer and the care worker, and is largely dependent on what the consumer perceives about the attitude and motivation of the care worker.

Given the 'institutionalised' style of 'rote caring' that proliferated under the old system, often involving limited personal connection between care workers and recipients, it is not surprising that consumers may prefer to hire people without industry experience and mandatory qualifications. The freedom to engage care workers without industry experience requires governments to trust consumers to make choices in their own interests, and to acknowledge that care recipients are best placed to judge the suitability of care workers based on the quality of services delivered. This would also help to address the national care worker shortage and increase the size of the care worker pool to meet the growing demand for care.²⁷

Risk

Governments are likely to be wary of a minimum standards regulatory framework — and are being encouraged to do so by traditional providers who warn that the emergence of online disrupters will lead to low-paid workers delivering "second-rate" services and support.²⁸ However, the current array of complex and burdensome regulatory safeguards has often originated (in the words of the Productivity Commission) as an "over-reaction to specific incidents" of poor quality care or maltreatment of the elderly.²⁹

In other words, regulation also serves to protect the Minister and the department when things go wrong. When media stories about incidents of poor quality aged care appear, the amount of regulation imposed can easily be cited to claim that government has done everything possible to maintain standards. Nevertheless, widely publicised failures have occurred despite the highly regulated nature of the aged care system. As Professor Ian Harper has warned, continuation of excessive and high-cost regulation will defeat the purpose of the CDC reforms by entrenching the position of incumbent providers whose business model is more or less purpose-designed to meet standards dictated under regulation, and by acting as a barrier to entry for new players that can otherwise offer consumers real choice of services based on their own assessment of quality.³⁰ Regulations that increase overheads will raise costs at the expense of consumers receiving less care and support, and at the expense of the wages of care workers.

Minimum standards would also address the paternalistic hangover from the old system by adopting a more dignified attitude towards the elderly and to managing risk within the system. As the Productivity Commission argued, aged care services for older people should be "delivered in ways that respect their dignity and independence."³¹ The notion that providers know what's best assumes the elderly are incapable of making choices — and that they must be protected by regulation against making bad choices. This is 'institutional-style' thinking,

when the point of home-based aged care is that people are capable of independent living with appropriate supports. Independence includes the capacity to live a meaningful and dignified life, which entails making decisions to improve quality of life and take responsibility for the reasonable risks those decisions entail. Or as the Productivity Commission puts it: "people should be able to make their own life choices, even if it means they accept a higher level of risk."³²

Allowing consumers to exercise real choice in a competitive service market will enhance, not obviate, duty of care. Yet the emphasis of the CDC reforms on consumers being best able to judge and drive quality through exercising choice is not adequately reflected in the current federal legislation. Under the new system, the role of some approved providers will change: they will no longer provide services but will continue to hold the individualised funding for consumers (see 'Unbundling' below). However, under the *Aged Care Act 1997*, approved providers remain responsible for packages and compliance with regulations, and ultimately for service provision. Revision of the Act to resolve these tensions in line with the principles, objectives and practicalities of the consumer-directed environment is needed. The legislation should clarify that, under CDC, approved provider organisations that offer fund holding services are not responsible for the quality of services independently purchased by consumers.³³

Amendment of the Aged Care Act along these lines is especially important to avoid the current legislation being exploited by traditional providers, for example, by citing statutory obligations to fulfil standards and protect quality of care (based on internal assessments of risk and potential liability) as an excuse to deny consumers the right to choose — and remain in charge of delivering — the entire package. Terminological change is needed to reflect the CDC realities within the sector. The term 'approved provider' is redundant and reflects the norms of the old bulk-funded system. The *Aged Care Roadmap* suggests that the term 'registered provider' or 'recognised provider' will gain official currency, and notes the need for reconsideration of provider responsibilities and new compliance pathways and monitoring of standards consistent with the changed role of providers in a consumer-driven system.³⁴

While the proposed new terminology will somewhat reflect the change of status under the CDC system, the use of 'provider' still implies that organisations whose exclusive and primary functions may now be limited to fund holding are in fact providers of services. Establishing new and accurate terminology — 'Registered CDC Fund-Holder' comes to mind — will help foster consumer awareness of individualised funding and the right to choose.

Independent Contractors

A core or minimum standards regulatory framework will also help break down workplace rigidities and amplify the flexibility and responsiveness of consumer-directed care. An expanded care workforce would not necessarily need to be employed and rostered by provider

organisations, but could be self-employed — literally cutting out middle management in service delivery—and be hired as independent contractors by empowered consumers. The rigid model of 'rote care by roster' would become a thing of the past, starting with consumers being free to access services when they want and need them, such as in the evening and on the weekend. Independent contracting would make employment as a care worker more desirable and rewarding by addressing the hierarchical structures and low pay and low status that deter people from pursuing a career in the sector. Allowing consumers to contract directly with their care workers, and be able to set and negotiate agreed fees — which is an inherently more professional, client-based employment relationship — would apply to aged care the same principles of choice and contestability that consumers are familiar with in other human services sectors, including GP services, allied healthcare and dental care. Compensation for self-employment and the loss of traditional employee benefits includes not only much greater work flexibility but also the opportunity for workers to invest in their own knowledge and skills, develop niche specialised services, and build their own businesses as independent care contractors.³⁵

The introduction of individualised funding for disability services under the NDIS has increased demand for self-employed support and care workers.³⁶ This is consistent with the world-wide trend towards self-employment across a range of industries, as noted by the 2015 Committee for the Economic Development (CEDA) report, Australia's Future Workforce.³⁷ Independent contracting of home care workers is possible under the CDC system, and due to the emergence of alternative, non-traditional online platforms that allow care workers to be engaged independently by multiple (demanding) consumers to provide personalised services. Because these online platforms — as noted above — release funding tied up in the excessive administration charges of traditional providers, they allow care workers to be paid more to deliver more care, while giving care and support workers the opportunity to take responsibility for the quality of care by responding to consumer need and developing the personal relationship and connection with care recipients in ways that make a substantial difference to quality of life.

To nurture the growth of the new economy in home care services, government action is needed concerning workplace legislation. Potential confusion arises under current employment laws as to whether the consumer is employing or contracting the care worker. To enable real choice, consumers need clarity around employing and contracting workers for personal services and domestic services so that local consumers and care workers can negotiate flexible and mutually beneficial arrangements.³⁸ A consumer who directly engages a care worker — when the intent of both parties is a flexible contracting arrangement — could also potentially be interpreted under existing laws to be creating an employment relationship subject to existing industry award conditions — a line of argument that could be advanced by unions (and some traditional providers intent on preserving control over both fund holding and service delivery) in proceedings before the Fair Work

Commission. This is a common problem across disruptive industries, and determining the status of workers as either an employee or independent contractor is being worked out on a case by case basis.³⁹ One way to provide certainty for consumers and care workers would be for independent contracting for home care services to be carved out from existing laws and extended legislative relief from sham contracting provisions.⁴⁰

Unbundling

The success of the CDC system relies on changing the cultural and social assumptions about the elderly that have surrounded aged care services. Many elderly people have the capacity to control their own lives by making choices about their care and support services based on self-assessed needs and preferences. Some elderly consumers will need to make these choices in consultation with family and advocates. And some (including those with dementia and other cognitive defects or limited language skills) may need to have their choices guided and have their care case-managed by providers, ideally in concert with independent advocates or other proxy decision makers.⁴¹ However, the current situation, where all consumers are effectively denied choice by having their care case-managed by traditional providers, is unnecessary and inconsistent with the goal of consumer-directed care.

Traditional providers bundle case management into their one-size-fits-all care package, along with fund holding, administration, care coordination, advocacy and service delivery. A full package may be appropriate for some consumers, including perhaps the most vulnerable elderly. However, vulnerable and disadvantaged people should still have access to impartial advice to help guide their choices as recommended by the Harper Review.⁴² If consumers are to exercise real choice, unbundling of traditional packages is required to enable people to pick and choose the mix of services that is right for them. Unbundling could proceed through the emergence of specialised organisations offering different parts of the bundle and components of care that can each be purchased discretely. Advocacy services are currently offered free of charge through the My Aged Care website.⁴³ However, to ensure consumers are properly informed about their care needs, specialist organisations could emerge offering independent advocacy and impartial, easy-to-understand advice and case management without offering services.⁴⁴

Unbundling could involve consumers receiving a personalised care plan, while retaining the freedom to purchase services independently. This could include choosing an individual independent contractor care worker ahead of an approved provider, whose role in delivering unbundled packages would change to offering only to host and administer the funding at the direction of consumers. Unbundling makes possible real choice of services and service providers by enabling consumers to access the innovative technological solutions that are now available — the P2P online platforms that offer real-time brokerage services for consumers without the excessive overheads of traditional bundled care packages.



Alternative Models

P2P Platforms

Despite the advent of consumer-directed care, many traditional provider organisations fear the consequences for their businesses of transparent competition on cost and quality of services. Some, in defence of their generous margins, are therefore keen to limit consumers' right to exercise choice, denying them the opportunity to seek better outcomes. This may succeed in part due to many care recipients being unaware of their rights under the new system — an information gap government could remedy through an appropriate education and awareness campaign.

However, there are also reports of providers having scrambled — ahead of the introduction of full portability on 27 February — to introduce barriers to choice in the form of charging exit fees for consumers wishing to choose a different service provider.⁴⁵ This is on top of other concerns about “the high barriers to change including the time it may take [up to 10 weeks] to transfer unspent home care amounts.”⁴⁶ Imposing large switching costs creates an unlevel playing field contrary to the spirit and intent of the CDC reforms.⁴⁷

The federal government has allowed providers to charge exit amounts (and retrospectively include such charges in home care agreements) on the questionable grounds of allowing them to “recover administrative costs associated with determining and making payment of unspent home care amounts.”⁴⁸ Nevertheless, the

government should signal its strong disapproval of the charging of hefty exit fees by traditional providers keen to lock consumers into existing contracts. To encourage providers to cease this practice, it may be sufficient for the government to foreshadow the application of Australian consumer law, which according to the Combined Pensioners and Superannuants Association “states that a person has the right to cancel a service without incurring fees if that service was...unfit for the purpose you asked for”.⁴⁹

For real choice to occur, consumers also need to be aware of the innovative options that are now available alongside traditional providers. Across a variety of sectors of the economy — from taxis and travel to retail, music and education — disruptive technology is empowering consumers, connecting people in new transparent and efficient markets, and raising the quality and lowering the cost of services. The rise of a tech-enabled new economy in aged care is the solution that can deliver real choice for increasing numbers of elderly consumers needing care and support to live independently in their own homes cared for by an increasingly large number of care workers required to provide care and support locally.

These innovative solutions are already operating today. Consumer-directed funding has enabled new providers to enter the Australian aged care (and disability support) sector offering online P2P marketplaces for care and

support services. P2P organisations support the right to choose by enabling access to an online platform — a website or app — which allows care recipients (or their family members, advocates or case managers) quickly and conveniently to purchase the kind of services desired. Consumer-focused P2P platforms expand the available choices by allowing consumers to access the services of competing provider organisations or individual care workers (operating as independent contractors).

P2P organisations can afford to charge much lower administrative fees — in the vicinity of 15% of the cost of care — with care workers paying a fee of 10% of their hourly agreed rate and consumers a 5% fee on top of the agreed rate. Lower overheads compared to traditional providers release additional funding to allow consumers to purchase more services — approximately 70% more care and support per week out of a CDC package as noted above — and improve care worker remuneration to help draw workers to the industry. This is especially the case in regional, rural and remote regions with greatest need and limited access to services: low-cost online platforms connect local consumers and care workers in these areas where traditional high-cost providers cannot afford to operate — creating local jobs in local communities instead of head offices. P2P marketplaces can therefore help solve workforce challenges and drive job creation in both urban and rural locations by offering more flexible and attractive opportunities for care workers operating as independent contractors.⁵⁰

P2P market places also permit aged care provision to occur in a minimum standards regulatory framework, and are the key to resolving the conflict between the vision of a flexible consumer-driven, independent contractor-based system, and the existing regulation of home care standards. P2P organisations ensure care workers meet basic checks, policies and procedures but quality would be community-regulated. P2P market places ensure accountability through transparent feedback from consumers on their experience — by the ratings and comments made on provider sites that inform the choices of other consumers. Choice and competition become the ultimate safeguard of standards, since care workers who fail to provide high quality care and satisfy customers' needs and expectations will not be able to function on the platform — as is the case in any industry subject to disruptive technology.

Public Information Campaign

Ensuring consumers can exercise real choice also depends, in the first instance, on fostering greater awareness of the fact that consumers now have the

right to choose. As analysts of the sector have rightly warned, “consumers might not be able to find the right aged care provider if their choices are limited by lack of information.”⁵¹ According to a survey by researchers at the University of SA, University of Adelaide and Torrens University: “Only 11 per cent of respondents to our survey had heard of CDC, and only 22 per cent of those who were aware of CDC (2 per cent of the population of older people) had a sound understanding of its entirety.”⁵²

A government-funded public information campaign is needed to complement and complete the final stage of the CDC rollout — full portability from 27 February, 2017. This would be similar to the public education campaign conducted by the NSW Government to inform people with a disability about the NDIS.⁵³

Education for consumers about the CDC changes should include information about how to switch providers, and personal stories of consumers making choices and achieving better outcomes by switching (as is the case with the NSW NDIS campaign). It should also include information about individualised budgets and provider charges, and about accessing impartial and independent advice.

The biggest service a government-funded public information campaign might render would be to challenge the established culture of the sector regarding the key issues of choice and risk. Education of providers and consumers alike is needed around the concept of duty of care — which should be redefined to a more reasonable and balanced definition that encompasses people's right to choose, as opposed to providers inhibiting choice on the basis that they have to manage risk.

Fostering greater awareness of innovative online options should also be a key objective, regardless of the objections of traditional providers whose interests are threatened by greater choice and transparency. Fear of upsetting key stakeholders with vested interests (and ready access to media prepared to run “embarrassing” anti-private sector, pro-‘charity’ stories) may explain why the federal government is running relatively quietly on the full introduction of the CDC system — at the expense of leaving consumers in the dark about the new private sector care options now available, and thereby jeopardising the success of the key reforms. Consumers have a right to be informed about the full range of government-funded services available if they are to exercise real choice, and should not be denied knowledge of the innovative models that can deliver better value and quality.



Conclusion: Reforms Must Go Far Enough to Achieve Real Choice

The shift to the consumer-directed aged care system presents an important opportunity to showcase the benefits of market-based reforms to sceptical and change-averse members of the public. However, optimising the outcomes achieved for consumers, care workers and taxpayers depends on government willingness to pursue additional regulatory reforms in order to maximise the provision, value and quality of aged care services at minimal additional cost.

Legislative clarification of providers' role and duty of care and clarification of employment laws to confirm the status of independent contractor care workers are required to facilitate real consumer choice and competition. Enabling innovative and efficient online platforms to challenge the dominance of traditional providers will help to connect consumers directly with the kind of care they want, when they want it, from the care worker they want to deliver those services. By improving the quality of services received, a competitive and transparent market for aged care will improve the quality of life enjoyed by many ageing Australians.

The federal government's role as market steward in nurturing the success of consumer-directed care should include ensuring consumers do not face significant switching costs by foreshadowing the application of Australian consumer law to the charging of hefty exit fees. This is indicative of the wider educative role the federal government should play to maximise awareness of the new CDC system through a public information campaign that makes consumers aware of their right to choose and the choices available including innovative online P2P market places. Encouraging consumers to exercise greater choice would be money well spent, given the potential benefits for care recipients accessing more support and services, for care workers afforded new employment opportunities in local communities, and for taxpayers funding more efficient and financially sustainable home care packages.

Real consumer choice means diversity of provision. P2P platforms allow individual consumers and individual workers (independent contractors) to strike highly

personalised and mutually beneficial agreements without the added cost of traditional providers in the middle. Workers who value independence and control over their employment, who are motivated by making a difference to the quality of lives of their elderly clients in a commercially accountable environment, will be attracted to the sector by the new employment opportunities created by disruptive technology. The flexibility, fulfilment and superior financial rewards on offer will help solve the workforce challenges facing the sector, especially in non-metropolitan Australia where service shortages are chronic.

P2P care workers will deliver the kind of care consumers want to receive, not the kind of care providers want to deliver. The demanding and informed baby boomer demographic that will be exercising their right to choose in coming decades will not accept the status quo of 'institutionalised' care in their own home, particularly when many will be contributing to the means-tested cost of their care. Traditional provider models (and the corresponding regulatory framework), whether those organisations like it or not, are out of date and must adapt and innovate — or perish. This reality is already dawning on established service providers in the disability services sector in the wake of the rollout of the \$22 billion NDIS, which has finally empowered consumers dissatisfied with traditional providers to take their business to the "number of new, more innovative, cost-efficient and consumer-responsive startups, multinational for-profits, and sole-traders entering this market."⁵⁴

Aged care services, too, must join the modern world and the new economy, and continuing reforms must go as far as necessary to achieve the optimal, desired outcomes. Further action by government to nurture the aged care market is needed to give consumers real choice and control over the services they want to receive. The regulatory barriers that will otherwise restrict consumer choice and limit genuine competition among traditional providers and innovators must be removed to give ageing Australians greater access to efficient and effective consumer-focused aged care services.

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