Submission to Royal Commission on Aged Care Quality and Safety

Gabrielle Meagher
Professor Emerita
School of Social Sciences
Faculty of Arts
Macquarie University

August 2020

Contents

Introduction .................................................................................................................................. 1
Attracting, training and retaining aged care workers in the context of COVID-19 .......... 1
A permanent ‘surge’ is required ................................................................................................. 2
Paid to train through a dedicated Jobseeker stream ................................................................. 4
Increasing pay and creating formal career structures in aged care ....................................... 6
Online platforms are risky business ......................................................................................... 7
Towards a responsive, navigable, equitable, high quality home care system ...................... 9
Problems exercising ‘choice’ under the current CDC model ............................................... 10
Integrating home care – no individualised funding for the CHSP ........................................ 16
Tying the threads together ...................................................................................................... 17
Introduction

The starting point of this submission is that any new policies and strategies for aged care must improve the accessibility and quality of services for older people. Rejecting ageism, services must recognise the dignity and rights of older people who need services and support because of disabilities. The clinical problems exposed in residential care by the COVID-19 pandemic should not be the sole driver of reforms going forward: aged care should enable older people to live lives as full as possible regardless of level of frailty and setting. Ensuring equitable access and improving service quality are the ‘prizes’ we must all keep our eyes on, in the face of competing claims for keeping costs down and reducing unemployment.

This submission addresses several connected aspects of the aged care system: workforce, program design and quality regulation. The main focus is home care, defined broadly to include the Commonwealth Home Support Program and the Home Care Packages Program. The submission proposes and supports reforms to the structure and funding of home care to give older people maximum opportunities to receive individualised care that meets their needs, while mitigating the significant risks of the current system of individualised funding for transactions in a weakly regulated competitive market of providers. Both workforce and system design issues are considered.

Attracting, training and retaining aged care workers in the context of COVID-19

The COVID-19 pandemic has exposed the vulnerability of aged care services arising from long-standing and long-recognised workforce-related problems, including inadequate staffing levels, poor employment and working conditions, and under-developed skills. The pandemic and recovery also present an unforeseen opportunity to address problems with the aged care workforce.

By taking the opportunity of the pandemic and recovery to grow the number and improve the quality of jobs in aged care, several social and economic problems can be solved simultaneously. Research has shown that job quality and care quality are inextricably linked, so improving job quality will help address the problems of service quality identified in the Interim Report. (Improving program design and regulation are also necessary, and addressed later in this submission.)


A permanent ‘surge’ is required

One important and well-known aged care workforce problem is that there are currently too few staff in both home care and residential care.³

- In home care, the Royal Commission has pointed to the persistent long queue for home care packages. The immediate cause of the queue is that the number of home care package ‘places’ is around 100,000 fewer than the number of older people assessed as eligible to receive one. While formally an undersupply of service places by the federal government, it is unclear whether enough appropriately skilled staff would be available to deliver services to the level needed, should 100,000 packages be rapidly released.

- In residential care, research conducted for the Royal Commission found that more than half of all residents (57.6%) live in facilities with unacceptably low levels of staffing.⁴

This submission does not include modelling of the number and type of aged care workers needed to meet current or future demand. However, existing research, including that carried out for the Royal Commission, gives a clear sense of the scale of demand for aged care workers, and the competition posed by growing demand for disability workers, who deliver a range of similar supports as aged care for people under 65 within the National Disability Insurance Scheme.

- In home care, available evidence shows that between 2012 and 2016 (the last year for which data are available), the equivalent full-time direct care workforce in home and community care for older people actually shrank, despite growth in the number of Home Care Packages and in total CHSP hours.⁵

- In residential care, to bring all aged care homes to a ‘good’ level of staffing would require an increase in total staffing of 37.2% nationwide. Allied health staffing would need to increase 175% from current levels.⁶

- In disability support in the NDIS, there is an estimated demand for a further 52,000 full-time equivalent disability support workers between 2019 and 2023. Taking turnover and typical part-time work hours into account, the estimated number of actual additional workers needed is 173,000.⁷

These figures are stark and behind them lays a more complex picture, because the quality of many jobs in aged care and disability support is often very poor. Significantly, underemployment is a known problem. Two fifths of home care workers would prefer to work

---

³ See page 15, paragraph 69, Royal Commission into Aged Care Quality And Safety Counsel Assisting’s Submissions on Workforce.
⁶ Eagar et al. (2019).
⁷ Department of Social Services (2020), Submission to the Joint Standing Committee on the National Disability Insurance Scheme Inquiry into implementation, performance and governance of the National Disability Insurance Scheme (NDIS): the NDIS Workforce.
longer hours, and half of these want around a day a week or more of work. Around one in six home care workers holds multiple jobs – more than three times the rate in the workforce overall. This suggests that there is some room to expand provision with the current workforce, which could provide a potentially quick and partial solution.

However, deploying even this underutilised care labour would also take major change in the ‘business-as-usual’ management practices of providers. **In general, addressing staffing deficits requires a permanent ‘surge’ in the aged care workforce and major improvements in the quality of aged care jobs.**

Attracting workers to aged care may be easier in the context of the pandemic and recovery because of poor general labour market conditions, but **growing the aged care workforce must not be pursued simply as an entry-level employment creation policy.** Service quality will not improve, and new workers will not be retained, if governments and providers treat aged care work as a last resort for people who do not have other employment options, and workers perceive and experience it as such.

In the same vein, **recruiting temporary migrants in a specific care work stream (or other temporary migrant program) should not be pursued as a solution to aged care workforce problems.** Research has found that migrant workers are more likely to work under poor employment conditions and this has a known, robust link with poorer service quality.

There are also broader ethical problems posed by recruiting migrants to fill ‘care deficits’ in aged care. Temporary migration programs typically involve family separation, which passes the ‘care deficit’ back to the developing countries from which migrants are often sourced, in addition to creating other economic and social problems in source countries.

Rather, to drive, achieve and sustain the necessary workforce growth will require **coordinated planning and investment across aged care, post-secondary education and workplace relations.** In other words, remedying the problem of too few aged care workers necessitates dealing with the full range of workforce issues documented in the Royal Commission’s Interim report – recruitment and retention, selection of suitable persons, education and training, improved employment and working conditions, better remuneration and career pathways. **Policy and practice needs to change at the sector wide level, as shaped by national policies on aged care funding and regulation, and in national industrial awards. Many providers also need to improve their employment practices and how they organise care work at the workplace level.**

---


9 See pages 87-88, Mavromaras et al. (2017).

10 See Charlesworth, S., & Isherwood, L. (2020). Migrant aged-care workers in Australia: do they have poorer-quality jobs than their locally born counterparts?. *Ageing & Society*, 1-21. [https://doi.org/10.1017/S0144686X20000525](https://doi.org/10.1017/S0144686X20000525)

11 For a comprehensive review, see Meagher et al. (2019).


Paid to train through a dedicated Jobseeker stream

The aged care workforce needs to grow, but the workforce also needs a more diversely and highly skilled staff. The lack of sufficient clinical expertise from infection control to clinical care in residential care has become headline news during the COVID-19 crisis. However, lack of appropriate skills in the aged care workforce was also well-documented long before the pandemic. The causes relate to the marketisation and deregulation of the aged care sector, both of which must be addressed by any reform package.14 Strategies to drive the necessary increase in the size of the aged care workforce must include arrangements to ensure that new workers are well-prepared and trained to deliver high quality services.15 This submission proposes some strategies to achieve this.

The context of the pandemic provides an opportunity to create a cohort of new VET-trained aged care workers by training them to enter aged care, paid through a dedicated stream in the income support program, Jobseeker. This measure would support the introduction of a mandatory minimum qualification of a Certificate III in Individual Support (Ageing) for entry into aged care work. Under the proposal, participants would receive Jobseeker with a substantial training bonus (eg $300 fortnightly) for the duration of their full-time training, up to a Certificate IV level qualification. Participants would be subject to no additional mutual obligation requirements beyond participation in this training. Pro-rata payment for part-time study should be considered.

The training itself should be free to participants and of demonstrated high quality. As foreshadowed in Counsel Assisting’s Submissions on Workforce (Recommendation 9), ensuring the quality of training will require careful selection from existing RTOs, given concerns about poor quality at present.16

Paid training for new entrants should comprise initial training in a Certificate III in Individual Support (Ageing). The training should be delivered largely in person, not online, and involve supervised work placements. These placements should be coordinated within the local strategies and networks discussed in the Counsel Assisting’s Submissions on program redesign,17 ideally within a new regional funding and governance structure for aged care along the lines proposed by Professor Kathy Eagar.18 High quality work placements are essential for ensuring new entrants are job-ready at the end of their training.

A range of occupations is required to ensure that aged care meets the diversity of older people’s needs, which encompass supports in activities of daily living as well as in

---

14 This is discussed in detail, albeit in different terms, on pages 30-32 of the Royal Commission into Aged Care Quality and Safety Counsel Assisting’s Submissions on Workforce (RCD.0012.0061.0002).
15 The government’s experiment with supplying a surge workforce via the platform Mable showed that growing the workforce without attention to training and recruitment does not work. See: Caisley, O. and Baxendale, R. (2020, August 18), Coronavirus: More than half of funds for aged surge workers unspent. The Australian.
16 These concerns have also been raised in previous inquiries. See, for example, the 2017 report by the Senate Standing Committee on Community Affairs, Future of Australia’s Aged Care Sector Workforce, https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareWorkforce45/Report
17 Page 5, paragraph 13 f. Royal Commission into Aged Care Quality and Safety Counsel Assisting’s Submissions on Program Redesign, RCD.0012.0062.0001.
18 Eagar, K. (2020) National Aged Care Program Streams and Funding Models, Australian Health Services Research Institute, University of Wollongong, AWF.660.00183.0001.
clinical, physical, psychological, social and emotional domains. Following decades of deskilling, the aged care system does not currently meet this diverse array of needs. The diversity of older people’s needs is an opportunity for attracting and training new aged care workers, retaining existing workers, and enabling enhanced career structures. Offering paid training to new aged care workers across a range of occupations gives these entrants opportunities to choose a domain of aged care work that best meets their preferences, existing skills and dispositions.

Accordingly, paid training should also include the option for additional more specialised training up to Certificate IV level across multiple specialised streams. Participants would need to successfully complete initial Cert III training and be screened for suitability for employment in aged care before continuing on to further paid study in their selected specialised stream, supported by ongoing Jobseeker payments. Specialised streams would increase the attractiveness of work in aged care, by offering diverse entrants a choice from a range of potential pathways to, for example, assistant or professional roles in nursing, allied health, dental care, social and leisure support, and dementia care. Specialised streams also spread the demand for training across existing courses and programs, increasing the ease of roll-out of training for the workforce surge.

Training for workers already employed in aged care should also be enhanced and made more available through paid study time. Existing workers holding a Certificate III in Individual Support (Ageing) should also have access to training across the specialised streams to open pathways for them to assistant or professional roles in nursing, allied health, dental care, social and leisure support, and dementia care. Professional care workers (nurses, allied health practitioners and others) should have paid time to develop advanced and/or further specialised skills.

Some care workers from non-English speaking backgrounds have the opportunity to use another language in their work to the benefit of older people who share that language. However, most care workers support older people from a variety of backgrounds, and a high level of English proficiency is needed to ensure care and support are safe, because of disabilities affecting speech and cognition among many older people receiving aged care. Further, some potential entrants into the aged care workforce may not be able to access training in aged care because they do not have sufficient English proficiency. Accordingly, support to study English, including some paid study time, should be offered to intending or existing aged care workers who do not have a high level of English proficiency. The government’s recent announcement of legislation that will increase funding for the Adult Migrant English Program and extend eligibility to citizens and residents who have been in Australia longer than 5 years is very welcome.

To attract degree-trained professionals in nursing, allied health, medical, dental and social professions into aged care, people with these qualifications should have their HECS-HELP higher education loans forgiven for any periods they work in aged care.

---

19 Eagar et al. (2019) documents deficits in clinical and allied health staffing; Meagher et al. (2019) addresses social and emotional needs. Dental and dietetic needs are also identified in Counsel Assisting’s Submissions on Workforce (RCD.0012.0061.0002).
In other words, applicable repayments would be permanently waived during periods they are employed in aged care.

This submission supports calls by others, not least Counsel Assisting’s Recommendation 9 in the Submissions on Workforce, for minimum qualifications and national registration for all aged care workers. Strong initial screening during training, followed by national registration for all trained aged care workers, should be established to ensure suitability for all roles involving interaction with older people. There is research support for background checks for all aged care workers who have contact with older people. A recent, large American study found that the National Background Check Program was associated with fewer quality deficiencies and higher star ratings for participating residential facilities. Employers have a responsibility to support existing workers to gain qualifications required for registration.

**Increasing pay and creating formal career structures in aged care**

Poor rates of pay and underdeveloped career structures for direct care workers in aged care are problems that the Royal Commission has recognised, along with the need to consider ‘mechanisms to develop and support career pathways in aged care, which could range from changes to classifications in awards, and to training opportunities to improved leadership in aged care organisations’.

In line with other submissions and evidence given to the Royal Commission, notably by Professor Sara Charlesworth, this submission supports revision of the classification scales and pay rates in relevant aged care awards. Classification structures can be used to map out career paths, by increasing the number of levels and steps in the aged care award and articulating the skills required at each step. **Moving up a revised and extended award classification structure must be linked to pay increments that meaningfully reward people gaining and exercising skills.** Professor Charlesworth also sets out a range of other measures to address other problematic working conditions that depress home care workers’ incomes, including fragmented working hours and lack of payment for travel time, pointing to lessons that can be learned from New Zealand. Also in relation to industrial instruments, pay parity must be established between workers undertaking similar roles in different settings, notably in aged care and health care.

Training and development opportunities for aged care workers need to go beyond acquisition of formal qualifications discussed in the previous section. Aged care workers should have access to regular, paid opportunities for professional support and development, including, for front-line home care workers, regular team meetings to enable sharing of skills and relevant information and concerns about clients.

---

20 See page Royal Commission into Aged Care Quality And Safety Counsel Assisting’s Submissions on Workforce.


22 See page 81, paragraph 359, Royal Commission into Aged Care Quality And Safety Counsel Assisting’s Submissions on Workforce.
While very important, formal structures in industrial instruments alone will not enable aged care workers to exercise higher skills in care or to develop along a career path. Research shows that factors under employer control, such as employment arrangements (casual or permanent; hours of work) and how employers organise and support care work are also extremely important. These aspects require providers to be committed to offering high quality care and high quality jobs, which are in turn underpinned by sufficient resources to the sector.

The home care program reforms discussed in a later section would provide a strong foundation for pursuing the kind of reforms required in employment relations and work organisation in the aged care workforce.

Online platforms are risky business

Online platforms mediating care work have emerged in recent years, as part of the digital transformation of the economy. Online platforms can work with different business models, and depending on the model, the implications for the quality of home care and the working conditions of home care workers also differs. Most platforms work with a brokerage business model that poses significant risks to quality of home care and the quality of home care work jobs.

The vast majority of platforms operate as brokerage agencies, based on an underlying business model similar to domestic placement agencies that have existed since the nineteenth century, and that offered similar services: the company screens workers and enables people needing care and support to find individuals available to offer paid care, support or domestic assistance. The main difference with traditional domestic placement agencies is that traditional agencies matched clients and workers, while platforms allow people seeking to buy and sell services find each other independently, through a proprietary online database, sometimes styled as an ‘online marketplace’. Platforms typically charge an administration fee to the employing care recipient per hour of service provided and often also charge the employed care worker a fee per hour worked. In addition to facilitating matching, many agency-type platforms provide administrative support – for example, households and the care workers they employ may be able to arrange work schedules and keep records of hours worked and payments through the platform. Brokerage platforms may also offer public liability insurance or facilitate other forms of insurance for workers by making an arrangement with an insurance company.

Importantly, platforms operating on the brokerage model do not employ any care workers, and may not set, monitor or enforce workers’ rates of pay or any other working and employment conditions. Indeed ‘flexibility’ for both parties in relation to all aspects of their transactions, and low cost to support recipients are a key selling points.

23 Meagher et al. (2019).
24 This section is based on review of several websites of online platforms, drawing on information they provide about their operating models.
25 For example, see https://www.findacarer.com.au/page/Support-Worker-Frequently-Asked-Questions ‘Find a Carer is an online marketplace (website) for self-employed Carers to promote their services and connect with clients who require in home or community care.’
workers are positioned as ‘independent contractors’, so that although the platforms typically manage billing, other responsibilities such as paying income tax and superannuation are left to individual workers.

**Brokerage platforms position older people needing care as customers and employers, responsible for overseeing the quality of care and of jobs.** While older people should be the key reference point in assessing the quality of care, the task of doing so should not be left to them.

Much less common are platforms that allow matching by care workers and people needing support, but that also take responsibility for formally employing care workers, and fulfil the statutory responsibilities of employers. This ‘labour hire’ business model is a hybrid of the brokerage model and traditional providers. It offers some benefits over the brokerage model to both care recipients (eg no employer responsibilities) and workers (eg more formal employment rights). However, employment contracts are typically casual, leaving workers without a range of the rights and supports research that shows underpin consistent, high-quality care.

**The business models underlying these online platforms is not compatible with creating the high quality jobs needed to achieve high quality care.** To deliver high quality care, home care workers need secure employment, in jobs with clear career pathways and remuneration that recognises the acquisition of deeper knowledge and more advanced and/or specialised skills. Delegating quality oversight to clients is also highly risky for the safety of older people.

In aged care, brokerage platforms are targeted in the first instance towards people who manage their own home care package or who seek private support outside the subsidised aged care system. However, the risks these platforms pose extend beyond their use by these client groups. Providers approved to deliver services under the Home Care Package program are allowed to subcontract to platform operators. **Occasional use of agency workers to manage unexpected staff shortfalls may need to be part of any provider’s repertoire of HR practices. However, it has no place as a normal business strategy,** because it is difficult to see how approved providers could monitor and assure the quality of care and the working arrangements and conditions of care workers under such arrangements.

In addition to platforms that broker services between older people and individual workers are other platforms that offer information about provider organisations. These market intermediary platforms function more or less as alternatives to the search function in myagedcare.gov.au. Providers typically pay to be listed, and can pay more to be displayed more prominently. Some offer user ratings, although not all listed organisations have ratings. The main problem with these platforms is probably that they create information ‘noise’ in the system.

---

27 Hireup, which offers disability support workers, operates on this model; see hireup.com.au.
29 Meagher et al. (2019).
30 In the NDIS, platforms are promoted as a means to find support workers in the core of the program.
Overall, online brokerage platforms where workers list themselves can at best fill a small niche in a well-functioning, high quality home care system. The benefits offered by these platforms, most notably self-matching with workers and flexibility in scheduling, could also be offered by providers who employ home care workers and offer high quality jobs and high quality services as part of the regulated home support and care system. The next section addresses broader issues of home care program design.

Towards a responsive, navigable, equitable, high quality home care system

*Despite all the rhetoric about ‘choice’ and ‘consumer-directed care’, the person needing aged care is far from being the central focus of the system.*

Interim Report of the Royal Commission into Aged Care Quality and Safety

The preliminary proposals for broad system redesign made in the submissions by Counsel Assisting the Royal Commission emphasise improving and expanding home care.31 In relation to system design, the submissions argue for the benefits of *consumer directed care*, while recognising some limitations. The submissions also advocate for the role of *care finders and case managers* to assist older people find appropriate supports. These positions suggest that there is a ‘gap’ between how governments have been implementing consumer-directed home care as a *competitive market* for aged care services and how older people’s needs for support and assistance can best be met. This gap can be bridged from both sides: by revising the model of consumer directed care, and by implementing the Counsel Assisting’s proposal of a new workforce of ‘care finders’ and case managers to support older people in the aged care system.

Research shows that older people’s conception of good quality home care is based in trusting relationships with care workers and support that is flexible and attentive to their fluctuating and changing needs in daily life. In other words, what consumers want to direct about their care occurs in on-going interactions with the people and organisations who support them. In turn, the capacity of those people and organisations to give person-centred support is affected by the institutional environment, including the regulatory and funding arrangements, that they work and operate in.32

It is not clear that the current system of consumer directed care is an equitable or well-designed way to achieve person-centred support. This submission argues that what older people are looking for in person-centred care would be much more likely to be offered in a strong local or regional home care system, in which older people can choose from a few high quality providers that offer good jobs to a skilled workforce, supporting case managers and direct care workers with time to exercise appropriate latitude in providing individualised care and support.

This submission reframes the concept of consumer directed care, to improve its alignment with what older people value in home care services, and to remedy the interlinked problems evident in the current CDC model, which include:

---

31 Pages 59-61, Royal Commission into Aged Care Quality and Safety Counsel Assisting’s Submissions on Program Redesign, RCD.0012.0062.0001.
32 Meagher et al. (2019).
difficulties for older people in navigating the choice of providers
- new inflexibilities in funding that affect the kinds of services available and providers’ capacity to manage fluctuating needs in their group of clients
- inadequate assessment of provider organisations entering the sector
- weakly developed quality regulation

The logic of the current CDC system is that older people’s choices of provider, including the choice to exit when not satisfied, are the main means of quality oversight and improvement. This submission holds that reliance on older people’s exit choices to drive quality should be reduced. Instead, a high floor on service quality for all older people should be set by regulation and supported by funding, system design and workforce reforms argued for herein.

The problems in the current CDC model can be remedied by having fewer, more rigorously selected providers, funded on a capitation model at the regional level, and held accountable to high quality standards. The personalisation of care needs to shift away from the ‘market level’ to the organisational and interpersonal level, with provider organisations working collaboratively with older people and care providers to meet individualised needs.

Accordingly, this submission supports Professor Kathy Eagar’s proposal for a new National Aged Care Program Streams and Funding Model, which does not include consumer-directed care of the individualised funding type for aged care services. (The Witness Statement by Professor Sara Charlesworth gives information about the ‘Alliancing Framework’ in New Zealand, which provides a similar and very helpful regional funding and provision model.) This means that this submission does not support the extension of the individual funding model of CDC to services currently offered under the Commonwealth Home Support Program.

**Problems exercising ‘choice’ under the current CDC model**

The Royal Commission’s Interim Report discussed a range of problems older people have in accessing and navigating the aged care system. About residential care, the Royal Commission writes:

> My Aged Care often does not provide helpful information about local services. Perhaps even more worryingly, there is no easily accessible public information about the quality of services or reliable information about whether the services deliver on their advertised promises.

There are related problems in information about home care. The focus in this section is some specific challenges facing older people in choosing a home care provider and arranging supports under the current CDC model, assuming that they have been assessed and found

---

33 Eagar, K. (2020, March), Australian Health Services Research Institute, University of Wollongong, National Aged Care Program Streams and Funding Models AWF.660.00183.0001.
34 Statement of Professor Sara Charlesworth, October 2019, EXHIBIT 11-52 - WIT.0381.0001.0001.
eligible for a Home Care Package, and have reached the top of the national prioritisation queue.

The problems identified here are not simply with the My Aged Care online system. Underlaying the issues presented here are basic problems of the current CDC market system, which generates complexity for consumer choice that economists and psychologists over many decades have shown to be unmanageable.37

The starting point of the analysis here is the ‘Find a Provider’ function in the My Aged Care website, which presents authoritative information about aged care providers. The analysis shows that there are too many providers to choose from, and there is no realistic way that they can be compared.

Table 1: Providers of Home Care Packages in two NSW localities

<table>
<thead>
<tr>
<th></th>
<th>Cowra, town in Central Western country NSW, popn. 10,000</th>
<th>Chatswood, middle ring Sydney suburb, popn. 25,000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total no. of providers</strong></td>
<td>33</td>
<td>105 (appear to be several duplicates)</td>
</tr>
<tr>
<td><strong>Providers with availability</strong></td>
<td>33</td>
<td>104</td>
</tr>
<tr>
<td><strong>Listed location of providers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cowra</td>
<td>4</td>
<td>10 Chatswood</td>
</tr>
<tr>
<td>elsewhere in NSW</td>
<td>11</td>
<td>81 elsewhere in Greater Sydney</td>
</tr>
<tr>
<td>Greater Sydney</td>
<td>11</td>
<td>4 elsewhere in NSW</td>
</tr>
<tr>
<td>Interstate</td>
<td>7</td>
<td>9 Interstate</td>
</tr>
</tbody>
</table>


The first step is a search for a provider for a Level 3 Home Care Package in two localities. Table 1 compares two searches, one for Cowra, a NSW country town, and the other for Chatswood, a middle ring suburb in Sydney. The search returns a large pool of providers for both localities – 33 for Cowra and 105 for Chatswood (including apparent but unmarked duplicates).38 All (Cowra) and almost all (Chatswood) providers were recorded as having availability to offer services. Adding specialisations, religious preferences and language requirements, which is designed to narrow the search, did not seem to reduce the number of available providers at all in either locality. In both localities, a small minority of providers are local. In Cowra, at least half are quite distant, in Sydney or interstate. Whether the providers are actually available, whether they have the skills and resources to deal with all specialisations and preferences, and how those providers without a base locally or nearby can provide personalised assistance and support their care workers is not clear.

The older person is then expected to select providers for comparison. It is difficult for anyone to know how to approach selection from such large numbers of providers, which incidentally are presented in a list in no obvious order.

---


38 The same search terms yielded 34 results for Tibooburra – a town with a population of 134 at the last Census.
On the My Aged Care webpage, a person can select three providers at a time for comparison. A table presents information about whether or not the provider has been sanctioned (an extremely rare occurrence in home care to date), any other information offered by the provider about cultural, religious and social specialisations (not all providers complete this part), and a long list of prices for common services (as required since July 2019).

How to select three from 33 (or 104) is a challenge, as is how to use the information in the comparative table. The table in My Aged Care simply presents this information; if an older person knew the mix of services they are looking for, that specific package must be priced, item by item.

Focusing on price information, to enable comparison for the purpose of this analysis, a ‘sample’ package was created. The government subsidy at the time of this analysis (November 2019) for a Level 3 HCP was $33,500 p.a. or $1,288.50 per fortnight. The sample package included 13 hours a fortnight, consisting of:

- 6 hours personal care, standard hours (4 visits)
- 2 hours personal care, Sundays (2 visits)
- 4 hours domestic assistance (cleaning, shopping), standard hours (2 visits)
- 1 hour nursing, standard hours (1 visit)

A selection of 13 of the 109 providers offering services in Haymarket, Sydney,39 were chosen, and their prices for each item in the sample package list were compared using Excel. This analysis reveals that average prices are much the same across all service types (see Table 2), which suggests there is not much difference between providers.

Table 2: Summary data on selected item prices for a sample of 13 HCP providers, 2019, dollars

<table>
<thead>
<tr>
<th></th>
<th>Personal care (standard hours)</th>
<th>Personal care (Sunday)</th>
<th>Nursing (standard hours)</th>
<th>Cleaning and household tasks (standard hours)</th>
<th>Management fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (all, n=13)</td>
<td>53.45</td>
<td>89.63</td>
<td>87.02</td>
<td>54.57</td>
<td>274.99</td>
</tr>
<tr>
<td>Mean (non-profit, n=7)</td>
<td>54.43</td>
<td>90.19</td>
<td>91.46</td>
<td>57.00</td>
<td>282.66</td>
</tr>
<tr>
<td>Mean (for-profit, n=6)</td>
<td>52.31</td>
<td>88.99</td>
<td>81.83</td>
<td>51.74</td>
<td>266.03</td>
</tr>
<tr>
<td><strong>Range</strong></td>
<td><strong>42.00 - 64.00</strong></td>
<td><strong>58.80 - 120.00</strong></td>
<td><strong>52.60 - 115.00</strong></td>
<td><strong>45.00 - 64.00</strong></td>
<td><strong>0 - 399.82</strong></td>
</tr>
</tbody>
</table>


However, the last row of the table shows that the range of prices for each ‘common service’ was very wide. The most expensive provider of cleaning and household services in this sample cost more than 40% more than the cheapest provider – and this was the smallest difference between the lowest and highest rate for a service. The most expensive hour of nursing was more than twice the price of the cheapest. This means price comparison is very complex. Most of us find comparing electricity or phone plans, with two or three variables priced differently, difficult. Comparing even a fairly simple package of care supports is much more so.

39 This exercise was completed at a different time, but the essential findings are relevant for any locality.
The next step was to price the ‘sample’ package. Figure 1 shows the results of comparing the total price and the major components of the price for the package across the 13 selected providers.

The government subsidy for the package is shown by the line across the chart ($1,288 per fortnight). This analysis shows that total package costs appears to vary widely between providers. The cheapest provider consumes from as little as two thirds of the subsidy, while the most expensive package cost slightly more than the total subsidy. About half the providers included here would consume almost the whole value of a Level 3 package for the sample package.

The cost of the specified bundle of services also varies widely, from $662 to $953 per fortnight. The most expensive provider, measured this way, does not charge any management fees, and the cheapest provider overall is a non-profit that charges a fairly modest management fee. Management fees vary from 0% to 31% of the total value of the public subsidy. Travel charges are mentioned only by a handful of these providers – it may not mean they do not have travel charges.

**Figure 1: Price total and breakdown for a sample Level 3 HCP, 2019, dollars**

The basic daily fee, which is set by government and which providers can choose to charge, was about $10.30 per day – so around $144 per fortnight. But it is not clear which providers actually charge this fee. The three providers that included the basic daily fee in their list of charges on My Aged Care were non-profits, which may actually be less likely to charge it. The for-profit provider that charged the second lowest total price for the bundle of services (fourth column from the left in the chart) mentioned the fee on its website as something everyone pays, but did not include it in its pricing information on My Aged Care.

Even if an older person made this kind of systematic comparison, it is not clear how it would assist them, even if they chose a package based on price. How price relates to
quality is one question. Another problem is that if a person were to change the mix of services following a change in their needs, the price ranking of providers might be significantly reordered, since the providers have different ways of pricing nursing relative to domestic assistance, services on weekends, and so on. For example, the price gap between an hour of personal care and an hour of nursing varied from $8.85 to $51.00 across the sample of providers.

Another challenge older people face is that it is difficult to get a clear idea about how much support is encompassed in the package they now have to manage. One can seek this information from providers, but this can be difficult to interpret and compare. For example, one for-profit provider that does not charge a management fee includes a table on their website indicating approximate fortnightly hours for a home care package at each level. For Level 3, the provider suggests 23 hours. Looking behind this suggestion, it becomes clear that, at the hourly rates the provider charges, a Level 3 subsidy would purchase 23 hours a fortnight if the older person received only the services sold at the cheapest rate – personal care or domestic assistance on weekdays. Another provider’s website states that a Level 3 package equates to approximately 9 hours of care per week. Again, looking behind this suggestion, at the hourly rates charged, a Level 3 subsidy would purchase 18 hours a fortnight only of the services sold at the cheapest rate – personal care or domestic assistance on weekdays – along with the provider’s $159 per week management fee. Another provider suggests a Level 3 package equates to 5-8 visits per week, with no indication of the length of the visits or of the kinds of services offered.

Under the current program structure with its large numbers of providers, who set their own prices, from which older people are expected to compare, select, negotiate and manage their services, the same basic issues would arise if an older person was supported by a local care finder / case manager. The amount of variable information for the large number of providers is both overwhelming and too little to support a good decision. It is difficult to see how a care finder in a locality could have good knowledge about, and collaborative relationships with, the dozens of, or, more likely in major urban areas, the more than one hundred providers that are apparently available in the current system. A smaller number of providers, with more clearly designated specialisations would be much more manageable from the perspective of older people seeking support and the care finders / case managers who support them.

The individualised funding model of CDC creates unforeseen problems in equitably delivering high quality home care. In relation to equitable outcomes for older people, a study examined the profile of home care package clients (n=4,132) of a large provider before and after the introduction of CDC. The researchers found that fewer people entered packages after the change, and those who did were more likely to have more social resources (younger, partnered) than the profile of clients before the change. The authors conclude:

Vulnerable older Australians may be experiencing greater difficulty accessing home care services under the new system, suggesting greater scrutiny of the reforms in achieving
policy objectives is required.40

This is not a surprising outcome, given the complexities of choosing a provider, and the expectation that having chosen one, the older person is then expected to make a service agreement and manage and monitor their services going forward.

The individualised funding model of CDC also generates new inflexibilities in funding which have unforeseen negative impacts on the quality of care and of jobs. From the providers’ perspective, CDC funding is both less predictable and more inflexible than the previous funding model. The unpredictability drives precarious employment for care workers, as providers change employment practices to manage the unpredictability in their funding. A study conducted for the Department of Health and Ageing found that 53% of providers surveyed had increased the use of casual employment, and 40% had increased sub-contracting following the introduction of CDC. Only 4% reporting having increased training for their staff.41

At the same time, funding is also more inflexible, as funds from a particular package can only be spent on the older person to whom it was allocated. Accordingly, providers lose any capacity for resource pooling to manage fluctuating needs across their group of clients.42 It is also difficult to fund group social supports such as day centres with individualised funding.

In addition to these inflexibilities, the CDC model also incurs significant costs in administration and invoicing, which would be freed up under a capitation funding model.43 Other costs that are ultimately met from public or older people’s resources include marketing to attract users. The current model also creates troubling cost-shifting and service gaps, as shown by anecdotal evidence about difficulties public hospital community nursing units have in discharging patients to HCP providers anxious to avoid the cost of nursing services.

The introduction of individualised funding has drawn many new providers into the system, the majority of them for-profit. Between 30 June 2015 and 30 June 2019, the number of HCP package providers increased from 504 to 928. Of the new entrants, nearly two thirds (64%) were for-profit companies.44 The rapid increase in the share of for-profit providers poses significant risks to the quality and safety of care. As Research Paper 9 prepared for the Royal Commission shows, average quality of care is lower in for-profit residential aged care facilities than those operated publicly and not-for-profit. These findings confirm those of most existing Australian and international research.45 Elsewhere, in the Council Assisting’s

---


42 For more detail, see Meagher et al. (2019, pp. 20-21); see also Eagar, K. (2020).

43 Eagar, K. (2020, March), Australian Health Services Research Institute, University of Wollongong, National Aged Care Program Streams and Funding Models AWF.660.00183.0001.

44 Calculations using data from Table 5.1 in Aged Care Financing Authority (2016), Fourth Report on Funding and Financing of the Aged Care Sector, ACFA and Table 5.2 in Aged Care Financing Authority (2020), Eighth report on the Funding and Financing of the Aged Care Sector.

Submissions on Workforce, one driver of lower quality is discussed – an incentive, absent regulation to prevent it, to maximize profits by deskilling the workforce. While there is relatively little research on the impact of ownership on the quality of home care services in Australia and internationally, available evidence suggests a higher incidence of opportunistic, profit-maximizing behaviour by for-profit providers, with for-profit providers having higher costs and lower quality than non-profits – leading the authors of one American study to:

raise concerns about whether for-profit agencies should continue to be eligible for Medicare payments and about the efficiency of Medicare’s market-oriented, risk-based home care payment system.

Problems of opportunistic behaviour are not restricted to aged care. These problems have emerged across all publicly-subsidised social services when the model of consumer choice and/or competitive market provision has been introduced – including centre-based childcare, family day care, employment services, vocational education and training and disability support. For-profit providers have entered without adequate oversight, and service users and tax payers have borne the costs of some major market failures.

Further, as the residential aged care sector shows, once for-profit providers are responsible for a significant proportion of services, they gain ‘institutional power’. This ‘institutional business power contributes to an asymmetrical dependence of the state on the continued commitment of private business actors’ and private actors are able to exercise this power to influence regulation in their own interests. Thus, there are good reasons to limit the growth of for-profit provision in home care.

Integrating home care – no individualised funding for the CHSP

One proposal for integrating the home care system is to extend the existing CDC model to ‘entry level support’ offered in the Commonwealth Home Support Program. As noted above, this submission does not support this proposal. However, the proposal for a single, unified assessment system is supported.

As the Royal Commission explains in its Interim Report, the aged care system is organised to provide a continuum of care, across and back which older people move in their unique ways. However, the report notes evidence from the AIHW that most people (76%) use the CHSP before any other aged care program.
One role played by trusted existing non-government providers of recurrent CHSP services, such as domestic assistance and personal care, is to keep an eye on the well-being and support needs of the older people they serve. This is an important role, given that nearly half the older people using CHSP services live alone. These providers potentially identify when an older person may need more services and assist them with the transition to a new program, such as a Home Care Package. Large organisations that offer services under both the CHSP and HCP may currently be able to offer staffing continuity to a person who moves from CHSP to a HCP, for example.

Any system reform should minimise, not increase, the hurdles older people face in moving along or back the continuum of care. Introducing individualised funding for this program risks introducing rigidities and exacerbating fragmentation in the home care system, as each change in a person’s needs would trigger a needs reassessment, and may require renegotiation of a service agreement, and potentially a change of provider that may disrupt valued aspects of continuity of care such as maintaining relationships with existing personnel. When a change of need is temporary, it seems particularly inefficient and wasteful to engage older people and organisations in these processes.

Further, if the home care system is further fragmented by introducing a market for CHSP services, in which yet further new providers enter to offer the different services singly or in uncoordinated combinations, the process of putting together the specific suite of supports a person needs may become increasingly complex. It is not clear how the gentle oversight of a trusted provider can be offered in a system organised by competition. Nor could this role realistically be taken by care finders / case managers. While such a new workforce of case managers would be a welcome development, if the program was appropriately staffed and resourced, the caseload of each worker is unlikely to enable them to have a sense of how their clients are going on a day-to-day level.

The shift from block-funding to individualised funding changes the incentives for providers, draws in new kinds of organisations (notably for-profit providers), and creates new risks. Block-funded, values-driven providers currently have incentives to spread CHSP funds to meet the needs of as many older people as possible and can reallocate resources between clients and to new clients temporarily to meet fluctuating needs. When supports are individually funded, and the market opened to private providers, incentives shift to driving up returns from existing consumers potentially via over-servicing or by cost-cutting.

Tying the threads together

This submission’s proposals aim to remedy the problems of the current home care system and to enable older people to have ‘choice and control’ over the aspects that matter to them in the care and supports they receive. These aims can be achieved by reforming the system to reduce the number of providers, hold those providers to higher standards, and move from individualised to capitation funding. These reforms complement and facilitate the workforce reforms proposals laid out earlier in this submission.
The system reforms support and reinforce one another (see also Table 3). The pillars of the system need to reinforce each other to ensure that the general quality of services is high, rather than relying on market forces (consumer choice) or regulation to drive out poor quality providers.

Table 3: How proposed system reforms remedy problems of the current CDC model

<table>
<thead>
<tr>
<th>Problem</th>
<th>Remedies</th>
</tr>
</thead>
</table>
| Difficulties for older people in navigating the choice of providers | – Fewer providers  
– Capitation based funding for providers  
– More effective and better resourced quality regulation |
| New inflexibilities in funding that affect the kinds of services available and providers’ capacity to manage fluctuating needs in their group of clients | – Capitation based funding for providers  
– Better integration of community health and aged care |
| Inadequate assessment of provider organisations entering the sector | – Fewer providers  
– Higher barriers to entry for providers |
| Weakly developed quality regulation                        | – More effective and better resourced quality regulation  
– Higher barriers to entry for providers  
– Well-screened, well-educated and well-supported workforce |

Older people will find it easier to choose from a smaller number of local or regionally based providers. Local care finders and case managers will better be able to have deep knowledge about the relative strengths of different providers to enable them to support older people in selecting the right one. Fewer providers can be more carefully and rigorously assessed before entering the system. If what Counsel Assisting calls ‘Robust quality assurance about the entities eligible to receive … funding’ are in place, the regulation of service quality can focus more on lifting the ceiling rather than struggling to hold up the floor. As Dr Bob Davidson puts it:

> There is a trade-off between *ex ante* and *ex post* transaction costs, such that the more scrutiny by a buyer before purchase results in less need for monitoring performance; conversely, the less ‘due diligence’ beforehand, the greater the costs of subsequent monitoring. Up-front control of entry does not preclude the need for ongoing monitoring but it can reduce the costs and risks.52

In the same vein, a well-screened, well-educated and well-supported workforce is much more likely to deliver high quality services.

Robust accountability for public funds and for older people’s own contributions and welfare is, of course, essential. However, reforms to quality regulation in home care should avoid the ‘regulatory trap’ of inappropriately detailed steering and specification of care, support and administrative practice. Research about the ‘regulatory trap’ in aged care has

---

51 Page 3, Royal Commission into Aged Care Quality and Safety Counsel Assisting’s Submissions on Program Redesign.
mainly been conducted on residential care, but the lessons are transferable. The problem of the regulatory trap arises in systems in countries, such as Australia, Canada, England and the United States, because of the high reliance on private providers and the relatively low public trust in those providers. Because the average quality of care offered by for-profit providers tends to be lower, and the incidence of serious deficiencies higher, public demand for regulation rises. This sets off a vicious cycle of scandal followed by investigation, leading to an accretion of increasingly detailed and complex, but evidently weakly effective, regulatory processes. As regulations proliferate, an empty, ceremonial approach to compliance emerges – sometimes called ‘tick and flick’.

**Increase the rigour of quality assurance as providers enter the system is an important way to avoid the regulatory trap.** Another is to pay careful attention to incentives, including potential unintended consequences, in the design of service process and payment systems. The New Zealand system of collaborative, regional commissioning for home care is a starting point. Drawing a wider pool of participants into policy consultations and into regulatory oversight could assist here. Currently provider organisations and a very small number of organisations representing older people dominate most of the government’s ongoing advisory bodies. There is a tendency for the same voices to be heard, and there is plenty of room for innovative design in policy consultation and service regulation.

One often-proposed solution to the problem of service quality is to increase the amount and quality of information about providers available to older people to inform their choices. The Royal Commission’s Interim Report recorded as an established problem in the aged care system:

> the absence of any rating or assessment system for providers that can give older people and their families accurate, or any, information about the services they are seeking to access

**However, improving information alone can have perverse consequences if quality in the system overall is not high.** In the market design of the aged care system, information is expected to drive the behaviour of both older people and aged care providers. Public reporting of information about the quality of providers is expected to enable older people to choose better over worse providers, and to push providers to respond by improving their services to maintain or grow their market share. Clearly, well-structured, published information that meaningfully captures the quality of services is desirable. However, research on the

---


55 Statement of Professor Sara Charlesworth, October 2019, EXHIBIT 11-52 - WIT.0381.0001.0001.

56 Page 68. See also the 2017 Carnell Review of National Aged Care Quality Regulatory Processes, which called for better public reporting of provider performance.


introduction of the star-rating system for residential care in the United States points to the policy reinforcing existing inequalities – essentially, people with more money and education gained even greater access to the higher rated homes more than poorer, less educated people. Further, there is robust evidence that some providers game the system to drive up their ratings and profits. Such providers focus on what is measured by the ratings system, such that areas of quality that are not targeted by the ratings system either stagnate or decline as targeted areas improve. For-profit providers are among those providers most prone to this ‘teaching to the test’. These findings are important for two reasons. First, they show that better information alone is not enough. All older people who need support have a right to high quality care, and their access should not depend on their capacity to navigate the market. Second, they reinforce the risks of for-profit provision, and the challenges of designing market regulation that does not have perverse unintended consequences.

It is essential that any redesigned system retains and meets the underlying goals of consumer directed or personalised care: to enable older people to affect the dimensions of care and support that are meaningful to them, at the everyday level. At the centre are who comes to assist them, at what time, and with what. These values can be realised through giving older people a voice in the organisation of their assistance by trusted, high quality providers. For example, providers could use software like that underpinning brokerage platforms to work with older people and care workers to collaboratively create rosters. Careful matching of workers with clients, including giving older people a role in deciding who will assist them, can also be integrated into provider practice. Both organisational and technological innovation must contribute to ensuring the high quality of care and of jobs in aged care.

Finally, implementing the proposals in this submission will require significant investment in the aged care system. Such investment presents an important opportunity for post-COVID economic recovery. This is a counterintuitive idea to many policy-makers who tend to view services such as aged care as a recurrent cost to be contained and constrained, rather than as a means to investment-led stimulus. However, two recent international studies have shown that the employment and fiscal returns from investing in care are higher than in investing the same amount in construction. Women – who have been particularly harmed by the economic impact of the pandemic gain most employment, but men also benefit more than if stimulus targets construction. If the gender wage gap is addressed – something that the workforce proposals in this submission would help achieve -- the positive benefits of investing in care are even greater.

---

