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Community aged care providers in a competitive environment: Past, present and future

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In Australia, as in many other nations, the ageing of the population, coupled with other social and demographic changes, has underpinned significant growth in aged care in recent years, a development that is projected to continue during the first half of the 21st century.¹ At the same time, there has been an increasing recognition by government and aged care service providers that most older people wish to remain within their own home and remain independent as much and for as

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1 In 1970, 8.3 percent of the Australian population was 65 years and older, while 0.5 percent was 85 years and older. By 2010, this had risen to 13.5 percent and 1.8 percent respectively; by 2030 it is projected to be 19.3 percent and 2.7 percent, and by 2050 to be 22.7 percent and 5.1 percent (Treasury 2010, p. 10). The growth in aged care, however, arises from a range of factors other than simply more people needing care, including greater participation of women in the workforce with its effects on the number of informal (unpaid) carers, and the greater wealth and political activity of older people relative to past generations. In Australia, the growth of the aged care industry may accelerate after the announcement in April 2012 that the number of funded aged care places will be significantly increased over the next decade (Australian Government 2012).

long as possible (ageing-in-place), rather than go into residential care (such as a nursing home).² This has led in recent years to significant ‘de-institutionalisation’ of older people needing care (AIHW 2001, pp. 96–139). In this context, community aged care, which provides care services to people in their own home and community³ has experienced particularly high growth and is destined to become a major human services growth industry in future years (Productivity Commission 2008, 2011).

Alongside these developments, the growing political dominance of neoliberalism (Davidson 2012; Stilwell 2005; Nevile 1998) has led to provision of most human services becoming increasingly marketised over the last two decades. This is reflected in the use of a wide range of market mechanisms to distribute government funding and determine who will provide funded services; a greater emphasis on the right of service users (as ‘consumers’) to choose their services and providers; an increasing obligation on users to make a financial contribution to the cost of services; a greater focus on efficiency in the production of services; and the delivery of many government-funded services by non-government (or ‘third party’) providers, both non-profit organisations (NPOs) and privately owned ‘for-profit’ organisations (FPOs). Another aspect of neoliberalism during this period has been the increased pressure on governments to limit public expenditure, a factor with added salience in aged care given the need to ensure that services will be financially sustainable as the population ages in the coming decades. These themes, reflected in contributions to this volume, are all relevant to community aged care in Australia.

As the marketisation of human services has continued apace, a major issue in many sectors has been its impact on the supply side of services, both at the level of individual providers and at a systemic level. One important aspect of this has been a focus on the *types* of organisations that have emerged as providers, and whether different types of

2 The term ‘ageing-in-place’ is also used where someone remains in the same retirement village or nursing home as they age and their care needs increase.

3 In Australia, these services have been known as community care, but other names are used elsewhere, such as domiciliary care or home care. In the United Kingdom ‘community care’ is used to refer to both domiciliary care and residential care.

providers differ in their capacity to achieve the core objectives of the services, namely that the services are high quality and responsive to user needs (effectiveness), accessible to all people who need them (equity), and make the best use of available resources (efficiency). Within this context there is concern that trends such as the increasing presence of FPOs, the effect of 'new public management' on government agencies (MacDermott 2008), the 'corporatisation' of many NPOs, the ever-growing presence of large providers, and the pressures on all providers to compete to remain viable, will lead to an excessive focus by providers on efficiency, growth and profits, rather than on the individual needs of each service user and ensuring the best services and outcome for all users.

This chapter examines how these processes have played out in terms of who provides paid community aged care services in Australia, and is thus a case study of how the structure of one human services sector has evolved under marketisation. After giving a brief overview of the current structure (the present) (based on Davidson, 2011), it examines *why* that structure has emerged (the past) and how it may change (the future). This account points to some distinctive features of this industry that illustrate important aspects of the impact of marketisation more generally in relation to how and why certain kinds of organisations may become prominent in the provision of human services and the potential implications of this for service users.

These questions are examined from the perspective of service providers, drawing on an economic framework that is based on industrial organisation theory,⁴ but which also takes account of the special features of human services and the major political and social forces that have shaped the industry in the past and are likely to shape it in the future. Much of the discussion here is framed in terms of understanding how the 'markets' for community aged care function, but it is important to note that there are more fundamental questions about the validity of using markets in the organisation and delivery of aged care, given,

4 Industrial organisation is 'the broad field within microeconomics that focuses on business behaviour and its implications both for market structures and processes, and for public policies toward them' (Schmalensee & Willig 1989, p. xi), or 'the study of the structure of firms and markets and their interactions' (Carlton & Perloff 2005, p. 782).

for example, the dangers in the 'commodification of care' (Himmelweit 2008; Ungerson & Yeandle 2007) whereby personal and relationship values are replaced by 'care' as a tradeable product.

The chapter draws in part on my own current research into the community aged care industry in New South Wales (NSW) as a case study of the impact of contestability on human services providers.⁵ In particular it draws on my analysis of funding data for one of the major funding programs (the Commonwealth government's community care packages⁶) and on 43 interviews with senior representatives of funding agencies, industry bodies, and providers between October 2009 and March 2011. These interviews included 30 with CEOs, owners or senior managers of 22 providers in NSW, including eight of the nine major providers that together receive over 40 percent of the funds for community aged care in the state. While much of the data used here is from NSW, and there are some differences between states in the structure and functioning of the industry, this state in many respects reflects the situation in other states. Moreover, given that it is the most populous Australian state and has around one-third of national community aged care funding and clients (SCRGSP 2011), it is a major part of the overall national picture.

Community aged care in Australia is currently in a state of flux following major changes to funding programs announced since 2011. The research reported here was largely conducted before 2011, but the industry structures and processes described remain fundamentally in place. As the chapter shows, however, much of that is likely to change in the next few years.

The community aged care industry (the present)

Community aged care is now a substantial industry in Australia, the value of which was around \$4 billion in 2010, including at least \$3.2 billion from government funding (SCRGSP 2011). The industry is very

5 Ethics approval for the research was obtained from the University of New South Wales.

6 The funding data is in Excel format by individual provider for each of service outlet in Australia for each year from 2002–3 to 2010–11 (DoHA 2003, 2010a).

diverse, in terms of the sources of demand, the range of service types, and the types of services providers.

The demand for community aged care – who needs care and who pays?

The majority of care provided to older people living at home is unpaid care ('informal care') from relatives and friends (ABS 2010). However, paid care may be needed to supplement informal care or where there is no informal carer,⁷ and at least one-third of the 2.1 million people in Australia who are aged 70 years or older receive paid care (SCRGSP 2011, pp. 13, 28). There is a wide diversity among older people in both their need for paid community care (for example in terms of the level of need and personal agency arising from frailty or disability, the types of services they require, the need for other services, availability of informal care, and cultural and language background) and their financial capacity to pay for or contribute to the cost of services.

From an economic perspective, the 'demand' for any service is a function of 'need' backed by 'purchasing power' (or money to pay for the service). With community aged care, as with human services more broadly, many people needing care are not able to pay for it and much of the purchasing power must come from government.⁸ Over time, in re-

7 Note that the term 'carers' is used for those who give informal care, while 'care-workers' refers to paid staff.

8 Within the context of purchaser-provider models, which underpin the marketisation of human services, the level of government funding determines the *demand* for services. In this context, there may be 'unmet need' either because of 'unmet demand' (arising from input or organisational constraints on supply, such as a shortage of staff, even though there are funds available to pay for services) and/or because of inadequate funds to meet all the needs of older people (demand constraints). In recent debates on aged care, limits on government funding are commonly described as 'controls on supply', but this overlooks the nature – and intent – of a purchaser-provider model, a distinction that is important in analysing the role of government in a managed market. In fact, industry-wide, there currently appears to be no major supply constraints in community aged care, given that the main 'input' is staff time and the current workforce is under-utilised (Martin & King 2008; Productivity Commission 2011; Mears 2012) with 'workers wanting ... more hours far outnumber[ing] those wishing to work fewer hours' (Howe et al. 2012, p. 87). There are, of course, long-term and some localised concerns about the availability of sufficient care-workers.

response to the diversity of need, Commonwealth and state governments in Australia have introduced an extensive array of government-funded community aged care programs. In addition, a range of other non-government sources of funding have emerged. This has led, from the perspective of service providers, to the development of a number of market segments. Table 6.1 shows these segments, which fall into two main 'arenas' of competition.

The *first arena* consists of an array of government-funded programs where a government agency plays at least some part in choosing the possible provider(s) for a designated group of users. The core of the industry is based on two of these programs, the Home and Community Care program (HACC, \$1.9 billion in 2009–10), and the Commonwealth government's community care 'packages' (\$0.8 billion) (SCRGSP 2011, p. 13, 16) which together provide over 80 percent of government funding and over two-thirds of the total revenue of all providers in the industry. HACC, which was established in 1985 and caters for a lower level of need, funds a multiplicity of block grants for different types of services in each local area, with providers essentially determining the eligibility of users on the basis of common guidelines. The community care packages, which were introduced in 1992 and cater for people with a higher level of need equivalent to those in residential care, operate via a two-part process whereby an independent Aged Care Assessment Team (ACAT) determines the eligibility of an older person and the level of assistance he/she can receive; and (by a totally separate process), a limited number of providers in each region are allocated a maximum number of users at each level that they can assist.⁹

The *second arena* includes an array of situations in which service users (or an agent on their behalf) select their own provider using their own funds or funds that have been previously allocated to them from another (government or non-government) source. This includes a subcontracting segment whereby some funded providers sub-contract care-workers from other providers. It also includes an unsubsidised

9 The term 'community care packages' collectively describes the Community Aged Care Packages (CACP), Extended Aged Care in the Home (EACH) and EACH Dementia (EACH D). CACPs are for people whose needs are assessed as equivalent to low-level residential care, while EACH and EACH D are for people with needs equivalent to high-level residential care.

(fee-for-service) segment where people buy services without any government subsidy, either because they are not eligible for a government program; or because they are eligible but on a waiting list, or wanting more hours, or wanting to avoid government.

It is important to note that community aged care is unusual amongst human services in the range of sources of revenue for providers for the core service, both in terms of the number of separate government programs and the existence of services that operate with no government funding.¹⁰ As discussed later, this diversity of revenue sources underpins a number of the distinctive features of this industry. Market mechanisms are used to allocate the available funds for each of the government programs, and thus all operate as *managed markets* (quasi-markets).¹¹ In this context, three forms of managed market are relevant, namely (i) where government chooses a monopoly provider for each type of service or group of users in a given area, generally via competitive tendering and contracting (CTC); (ii) a quasi-voucher licensing (QVL) system, where users themselves can choose from any licensed provider, with the cost largely subsidised by government, and which is more akin to a conventional market;¹² and (iii) a hybrid of the CTC and QVL systems, with licensed providers having to go through a CTC process that limits the number of providers from which users can choose and where the funding agency (at least to some extent) determines the market share of providers. Historically, CTC systems were

10 For example, with government funding, in Australia there is only one source for residential aged care, child care is funded via two linked levels of contributions to parents, and the core funding for schooling comes from one state and one federal agency. Virtually all these services have some level of government funding or subsidy.

11 Davidson (2012) sets out a framework of possible market regimes in which human services are delivered, encompassing both conventional markets where users pay for their own services, and managed markets, where government is the major source of purchasing power for services. A discussion of the differences between the various types of managed markets can be found in Davidson (2008, 2009, 2011).

12 QVL systems encompass what are commonly called 'consumer choice' or 'demand-side-funding' models, and include 'cash-for-care' (Ungerson & Yeandle 2007) and 'individual budgets' (Wilberforce et al. 2011). In QVL systems, the government subsidy may be paid by cash vouchers, tax deductions or reimbursement of the provider (Davidson 2008).

Markets, Rights and Power in Australian Social Policy

Table 6.1: Sources of demand for community aged care in Australia: arenas of competition and market segments. For sources and notes, see appendix at the end of the chapter

Arena and market segment	Examples of program / buyer	
<i>Arena A – Government-funded CTC and hybrid programs</i>		
1	<p>HACC – funding and administration by Commonwealth – prior to 2012, funding was jointly by states and the Commonwealth, with administration by states (ADHC in NSW)</p>	<p>HACC – (Home and Community Care program)</p>
2	<p>Community care packages – funding and administration by Commonwealth</p>	<p>CACP (Community Aged Care Package) EACH (Extended Care at Home) EACH Dementia (EACH D)</p>
3	<p>Other Commonwealth community care programs</p>	<p>NCRP (National Carers Respite Program) Commonwealth Respite Centres Assistance with Care and Housing for the Aged</p>
4	<p>Dept Veterans Affairs (DVA) – programs for war veterans</p>	<p>Veterans’ Home Care Veterans’ Home Nursing</p>
5	<p>Mixed Delivery Programs – funded by Commonwealth and state – in NSW, delivered by NSW Health</p>	<p>Multi-Purpose Services (integrated residential and community care services in rural areas (Commonwealth)) Transition Packages (Commonwealth) and Compacks (NSW) – short-term care for people leaving acute health care</p>

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	Arena and market segment	Examples of program / buyer
<i>Arena B – Individual Selection of Providers</i> ^(a)		
6	Quasi-voucher licensing (QVL) models ^(b) – government funding/ user choice of provider	Attendant care (currently mainly disability) Productivity Commission (2011) proposal
7	Sub-contracting from government-funded services (also known as ‘brokering’)	Providers that have been funded under programs in Segments 1–5
8	Guardianship and insurance (compensable) arrangements ^(c)	NSW Office of Protective Commissioner (OPC) NSW Long Term Care Support Agency (LCSTA) Other insurance and compensation payments
9	Funded by non-government bodies (NPOs and FPOs)	NPOs (additional to government funding) FPOs (e.g. for employees with aged parents) ^(d) Paid through NPOs (e.g. Claims Convention) ^(e)
10	Unsubsidised individuals	People approved for Segments 1–5, but either on a waiting list or wanting more ‘top-up’ hours People not approved for Segment 1–5

most likely to be used in the early years of marketisation, but with the greater emphasis in recent years on the need for users to have choice and some power over their services, QVL and hybrid systems are increasingly being used (Davidson 2012).

In the Australian aged care system there are virtually none of the QVL (‘choice’) models, although such a system was recommended by the Productivity Commission (2011). HACCC uses CTC or hybrid systems to determine who receives the block grants, although ‘direct allocation’ by the department without any formal competitive process

is often used in NSW to minimise the transaction costs of tendering where there is no obvious competitor for an existing provider; the community care packages use a hybrid system, and most other programs use a CTC or hybrid system, to appoint a single provider or panel of approved providers in each region. With all of the government programs, a user's eligibility is based on his/her level of frailty or disability, and there is no financial means test for basic eligibility, although an income test is applied to determine the level of financial contribution by the user. However, funding is significantly less than demand, with more people approved for assistance than there are places, leading to waiting lists ('queues') for places in most programs in most areas. For example, the Productivity Commission (2011 Appendix E, p. 20) estimated that the unmet need for packages in 2011 was 49 percent of current places.

In principle, with the Commonwealth community care packages and some of the other programs, users can choose from the providers in their region that have been allocated places, but with long waiting lists, users must often take whatever they can get and thus the potential for users to exercise choice is severely limited. In practice, a government agency determines the total market share of each provider of packages based primarily on an annual tendering round for places or funds. Moreover, for both HACC and the packages, only growth funding is contestable. Subject to a provider meeting its contractual and regulatory requirements, the places and dollars it has been allocated in earlier years are never re-tendered, so that allocations received by a provider in past years are effectively locked in as recurrent funding indefinitely (Davidson 2012).

A major focus in the following sections is on the packages segment for a number of reasons. First, it is the main object of the ambitions, if not activity, of many community aged care providers. This is largely because, while the total funds from HACC are much larger, the packages have much higher per user funding, with payments in 2009–10 ranging from \$15,000 to \$49,000 annually compared to the mean cost of just over \$2000 for each HACC recipient (Productivity Commission 2011, Appendix E, p. 3). The packages also support people with higher needs and are thus of most interest to providers for whom social objectives are paramount. Second, it is a good case study of how an industry has developed under marketisation. The current hybrid system of allocating places has operated since the inception of packages in 1992, and despite

the strong limits on contestability for funding, the segment is considered by most providers to be very competitive. Third, the packages have been administered by the Commonwealth funding agency (the Department of Social Services) that is now taking over HACC programs for older people, and which will be increasingly responsible for community aged care in the future.¹³ Fourth, it allows a comparison with another related type of service (residential aged care) for which funding is also allocated by DSS using the same basic system, and for which similar data is available.

The supply of community aged care – who are the providers?

On the supply side there is a wide range of providers and types of providers that differ, in organisational terms, in the form of ownership (whether government, NPO, or FPO), scale (size), the scope of services they provide, the geographical spread of their operations and the time for which they have operated. There are several major groupings of providers:

- *Government*: There are three main types of government providers, namely (i) state government specialist home care agencies, although only in NSW is such an agency still significant;¹⁴ (ii) local government, which has a larger role in some states (such as Victoria) and in non-metropolitan areas; and (iii) state health departments, which are becoming increasingly involved as healthcare transition programs are expanded.
- *Non-profits (NPOs)*: As a group, the *religious and charitable NPOs* receive the most government funds, both nationally and in NSW. These are mostly longstanding bodies with wide geographic cov-

13 The department has been called the Department of Social Services (DSS) since September 2013, following the election of the Abbott Coalition Government. Before that, it was called the Department of Health and Ageing (2001–03).

14 The NSW government's Home Care Services (HCS) is the largest single provider in NSW with an annual budget of over \$200 million based solely on community care (both aged and disability). HCS works primarily in HACC where it is a dominant presence. It received 30 percent of the \$552 million of HACC funds in NSW in 2009–10, including 81 percent of the \$179 million for HACC personal care and domestic assistance services (NSW DHS 2010).

erage that provide a range of services, both in aged care and in other fields. A number are now large enterprises, run along corporate lines, but their size and scope also enable them to develop more sophisticated models of care (Davidson 2011). The largest number of providers, however, are the *community-based NPOs*, which are mostly small and medium-size organisations limited to one area, controlled and managed by local groups. These bodies, many of which originated in the 1970s and 1980s, service either the broader community, or a sub-group within the population, (such as Aboriginal and ethnic groups, and, more recently, GLBT [gay, lesbian, bisexual and transsexual] groups). In general, they have a distinct ethos, support base, and modus operandi from the larger religious and charitable bodies (Lyons 2001).

- The *for-profit organisations (FPOs)* in the sector are almost entirely small to medium-size organisations that are specialists in community aged care. Virtually no publicly listed multi-service FPOs are present¹⁵ – unlike residential aged care, health care, and child care where they have become increasingly involved in recent years – although some large companies have entered and left the sector in the last decade. For example, Ramsay Health Care took over a small FPO in 2004, reselling it in 2006 to a religious NPO.

Each of the market segments shown in Table 6.1 has a distinctive profile in terms of these various types of providers, although most providers operate in more than one segment and it is common for users to access services from more than one segment, both at any one time and over time as their needs change. The providers in the five segments in the first arena (as shown in Table 6.1) are mainly NPOs, although NSW Home Care Service (HCS) is the major provider of HACC services in NSW. In both these major programs, especially HACC, there is a multiplicity of local community-based NPOs that only operate in one geographic area. The providers in the five segments of the second arena are mainly FPOs, although some NPOs operate in these segments. The two arenas are bridged by the extensive use of subcontracting by

15 As of June 2011, there were only two publicly listed FPOs providing packages in Australia (both in Queensland), receiving a total of only \$1.2 million (0.1 percent of the \$872 million allocated for packages nationally).

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government-funded providers, with the effect that staff employed by FPOs provide services for at least 20 percent of all users.

Table 6.2 shows the proportion of place provided by government, NPO, and FPO providers in each state and Australia overall for the Commonwealth community care packages in 2009–10.

Tables 6.3 and 6.4 show the allocation of funds for the packages in NSW in 2003 and 2010¹⁶ in terms of ownership and how this changed in recent years in this segment, which providers consider the most attractive and competitive, and which has a profile of providers that is most likely to be the pattern for the industry in the intermediate term.¹⁷ The major features to note are the substantial market share and continuing growth of large religious and charitable NPOs, the larger number of small local community-based NPOs, the limited role of government providers, and the low share of government funds that is allocated directly to FPOs.

In a number of respects, the profile of providers in the industry differs from that in community aged care in other nations and in a number of other human services in Australia that have been marketised. In particular, for a service directed at the broader population (as distinct from services whose target group is based on socioeconomic disadvantage, such as homelessness), FPOs have a low market share of funded programs with virtually no large corporate FPOs. Why, does the industry differ in this respect from community (domiciliary) care in other nations (Brennan et al. 2012) when the service everywhere has a similar basic production function? Why does it differ from residential aged care in Australia (Table 6.4), when the same government agency, processes and people are used to determine funding allocations as for the community care packages? And why does it differ from child care in Australia (Brennan et al. 2012), given that both sectors were substantially reliant on community-based NPO providers two decades ago?

16 As at 30 June each year (DoHA 2003, 2010a).

17 An analysis of the major implications of these tables can be found in Davidson (2011).

Table 6.2: Community aged care package places by state and ownership of provider, Australia, 2009–10, percent. For sources and notes, see appendix at the end of the chapter

State/territory	Non-profit organisations			For-profit organisations			Government			TOTAL	
	Religious	Charitable	Community	Total	State	Local	Total	%	Places	%	Places
NSW	35.2	32.5	20.9	88.6	5.3	2.3	3.8	6.1	100	16,724	
Vic	39.8	22.0	13.6	75.4	3.1	12.4	9.2	21.6	100	12,517	
Qld.	46.1	24.5	19.2	89.8	6.2	1.4	2.5	3.9	100	9,381	
WA	31.3	43.4	4.5	79.2	13.5	1.8	5.6	7.4	100	5,112	
SA	26.8	48.1	11.9	86.8	3.4	7.3	2.5	9.8	100	4,158	
Tas.	37.1	22.6	26.1	85.7	6.9	5.3	2.0	7.3	100	1,339	
ACT	20.6	62.1	11.6	94.4	5.6	0.0	0.0	0.0	100	800	
NT	30.7	9.4	18.5	58.6	15.3	0.0	26.1	26.1	100	773	
Total	37.0	30.7	16.3	84.0	5.8	5.0	5.2	10.2	100	50,804	

Table 6.3: Funding for community care packages (CACP, EACH, EACH D) and residential aged care, NSW, 2003, by ownership of provider. For sources and notes, see appendix at the end of the chapter

Type of provider	Community care packages				Residential care					
	No	%	\$M	%	Mean per provider (\$M)	No	%	\$M	%	Mean per provider (\$M)
NPO										
Charitable	10	7.9	17.1	16.9	1.71	37	9.9	151.7	9.8	4.10
Religious	28	22.0	47.2	46.6	1.69	61	16.2	512.0	33.6	8.40
Community – general	38	29.9	15.4	15.1	0.40	120	31.9	200.3	13.1	1.67
Community – group	29	22.8	10.4	10.2	0.36	11	2.9	32.7	2.1	2.97
<i>Sub-total NPO</i>	105	82.6	90.1	88.8	0.86	229	60.9	897.3	58.8	3.92
FPO										
Publicly listed										
Private Incorporated	5	3.9	2.7	2.7	0.54	121	32.2	568.9	37.3	4.70
Private non-incorporated						5	1.3	11.2	0.7	2.24
<i>Sub-total FPO</i>	5	3.9	2.7	2.7	0.54	126	33.5	580.1	38.0	4.60
GOV										
Local Government	15	11.8	5.2	5.1	0.35	20	5.3	15.1	1.0	0.76
State government	2	1.6	3.5	3.4	1.74	1	0.3	33.0	2.2	32.98
<i>Sub-total government</i>	17	13.4	8.7	8.5	0.51	21	5.6	48.1	3.2	2.79
TOTAL	127	100	101.4	100	0.80	376	100	1525.6	100	4.06

Table 6.4: Funding for community care packages (CACP, EACH, EACH D) and residential aged care, NSW, 2010, by ownership of provider. For sources and notes, see appendix at the end of the chapter

Type of provider	Community care packages				Residential care					
	No	%	\$M	%	Mean per provider (\$M)	No	%	\$M	%	Mean per provider (\$M)
NPO										
Charitable	17	12.0	44.9	16.3	2.64	38	11.7	298.3	12.4	7.85
Religious	33	23.2	147.3	53.3	4.47	46	14.2	870.6	36.1	18.93
Community – general	33	23.2	33.3	12.1	1.01	92	28.4	285.1	11.8	3.10
Community – group	25	17.6	17.9	6.5	0.72	12	3.7	32.0	1.3	2.67
<i>Sub-total NPO</i>	108	76.1	243.4	88.1	2.25	184	58.0	1,486.0	61.6	7.80
FPO										
Publicly listed						2	0.6	57.4	2.4	28.68
Private incorporated	17	12.0	19.9	7.2	1.17	114	35.2	811.6	33.6	7.12
Private non-incorporated						2	0.6	5.0	0.2	2.49
<i>Sub-total FPO</i>	17	12.0	19.9	7.2	1.17	118	36.4	873.9	36.2	7.41
GOV										
Local government	15	10.6	9.1	3.3	0.61	17	5.2	20.1	0.8	1.18
State government	2	1.4	3.8	1.4	1.89	1	0.3	32.4	1.3	32.36
<i>Sub-total government</i>	17	12.0	12.9	4.7	0.76	18	5.6	52.5	2.2	2.92
TOTAL	142	100	276.2	100	1.95	324	100	2,412.4	100	7.45

The origins of the current profile of providers (the past)

The establishment of HACC in 1985¹⁸ was a major watershed in the development of the community aged care industry. HACC consolidated and extended a number of state and national funding programs, and brought more systematic planning and coordination of services, replacing a process of uncoordinated grant submissions by a planned allocation of funding across each region (House of Representatives 1982, 1994, pp. 7–9). At that time, the mix of providers was not dissimilar to today, except that the religious and charitable NPOs had only relatively small-scale community care operations. However, HACC operated essentially through a joint planning model between government and providers, with FPOs initially excluded from applying for funds for HACC services, and it was not until the introduction of the packages in 1992, which used competitive tendering, that a more marketised approach was used in the sector. This section seeks to explain how the industry has moved from there to the current profile of service providers.

Economic theory from the field of industrial organisation, modified to take account of the reality where a human service is the ‘product’, can help explain how and why the current profile has emerged. Two broad groupings of factors are relevant in determining the incentives for, and barriers to, entry of providers in any human services industry. First, there are factors intrinsic to the type of service, stemming from the nature of demand (the characteristics and needs of users) and the production function (the resources and processes needed to produce and distribute the product). Second, there are ‘location’ factors, notably the geographical, historical, social, demographic, institutional, and political factors, along with key individuals, that may have an influence from the national to local level and shape the industry, markets, and service system in each place.¹⁹ The policies and actions of national and state governments in relation to regulation and funding systems for the

18 A bipartisan House of Representatives (1982) report had recommended a more ordered approach to government support for home care. The Hawke Labor government, elected in March 1983, established HACC drawing substantially on the recommendations of that report.

industry are especially important. In turn, the operation of the industry, markets, and providers that have derived from these two sets of factors, constantly feeds back to influence future developments.

Path dependency and government funding

The history of a sector, especially where path dependency is strong,²⁰ constrains and shapes its development; and where a sector is substantially dependent on government funding, the form and extent of the funding is obviously a critical determinant of the structure of the sector.

These two factors combine powerfully to form a critical parameter for the profile of providers in the community aged care industry in Australia. It was earlier noted that with both HACC and the packages, generally only growth funding is contestable – and this has been the case since both programs were established. Thus the large bulk of funding each year derives from the accumulation of decisions made in previous years going back over for two decades or more.²¹ For example, in the allocations for the three main types of packages (CACP, EACH and EACH D) in NSW in 2009–10, 87 percent of funding derived from decisions made in earlier years. This is a substantial barrier to entry for new providers, but it also facilitates stability in the service system.

19 For example, a service system may be shaped at a national level by political and cultural traditions (Esping-Anderson 1990), and at a local level by the distance of a community from a major city. With globalisation, the distinctive impact of international forces on each 'location' is also important.

20 'Path-dependency' (Liebowitz & Margolis 1990, 1995; Bessant et al. 2006, p. 46, 82; Travers 2005, p. 89) refers to the power of established institutions and past policies to shape and limit future policies and events. This goes beyond merely that 'history matters' and refers to past decisions and events that determine and limit future options.

21 Some other government programs in the first arena have a provision for regular re-tendering every few years, but this often does not occur and existing funding and contracts are 'rolled over'; or where there has been re-re-tendering, it has led to little change in who are the providers. For example, the National Carers Respite Program (NCRP) uses a hybrid system with competitive tendering to be held every three years in each region. In practice, the funding for NCRP has generally been rolled over with no re-tendering, and the one time there was re-tendering (2005) is remembered by providers as being very disruptive and costly, with very little change resulting.

6 Community aged care providers in a competitive environment

In this context, it is inevitable that many existing providers in the funded programs will be longstanding and that the entry of new ones will be limited. This leaves three questions to consider regarding the current profile of funded providers, namely (i) what factors in the early years of marketisation set the foundation for the current profile; (ii) what has determined new entry and growth of providers in the funded programs since then; and (iii) how is the growth of FPOs explained, given the small share of government funding that they receive?

Earlier history

The stability of funding systems

The limits on changes in providers over time noted above are part of a broader stability and continuity in the funding and administration of government community aged care programs over the last quarter century, especially when compared to the major changes imposed in that period on some other human services in Australia, such as child care and employment assistance. Since the establishment of HACC in 1985, there has been a gradual evolution in the services and programs that are available and the way in which they have been run, but currently HACC remains a cornerstone of the industry as the largest government program in terms of funding and client numbers, and in broad terms it operates as it has since 1985.

Nevertheless, there has been an increasing, but gradual, marketisation of the sector since 1985. Competitive tendering was introduced with the packages in 1992 and then extended to HACC in the wake of the Hilmer Report (1993) on competition policy; FPOs were able to tender for packages, at least on a pilot basis, from the early years and for HACC from 1998;²² funding agencies have continued to refine and extend tendering processes; and there has been some movement towards various 'consumer-directed care' options.²³ These changes, however, have been introduced as a continuity with the past, and most programs

22 The actual date varied between states. The Amending Agreement between the Commonwealth and New South Wales, which introduced this change, was signed on 1 July 1998.

now work in a similar way in regard to critical aspects in the operation of 'the market'. Thus, in general, a government agency chooses the providers; competitive tendering (and sometimes direct allocation) is used rather than QVL systems; and funds are paid to providers and administered by them effectively as block grants, with cross-subsidisation across clients a normal practice accepted by the funding agencies.

The 'original' providers

Given this stability and the lack of contestability for previously allocated funding, the early days of HACC and the packages are particularly important in explaining the current profile of providers in the industry. The current position of the major providers is based on their early start in the industry, the continuing accretion of places in the annual funding round each year, and the consolidation of smaller providers within the large NPOs.

Three points are particularly important from the period in which HACC and the packages were established. First, HACC was established before the marketisation of the industry,²⁴ and many of today's providers, including virtually all the major ones, were operating even before HACC began. Further, Australia has a long tradition of NPO and voluntary provision of human services at a higher level than most other nations (Davidson 2008; Lyons 2001), a tradition reinforced by various government initiatives during the 1970s to support the development of community-based NPOs. Thus when governments sought to move out of direct provision, to 'steer rather than row' (Osborne & Gaebler 1993), it was much more likely that NPOs would play a key role. In Sweden and the United Kingdom, marketisation began in a context where community aged care services had been wholly provided by lo-

23 'Consumer-directed care' is aimed at giving service users greater control over the services they receive. In part this stems from long-standing human rights objectives of social movements (Yeatman 1990), but it also has been driven from another direction by the notion of consumer sovereignty that is central to neo-classical economics.

24 While neo-liberalism began to impact from the mid-1970s, it did not substantially affect human services in a number of nations including Australia (MacDermott 2008) and the United Kingdom (Le Grand & Bartlett 1993) until the late 1980s.

cal government, and thus FPOs have subsequently taken a much bigger share of government funding (Brennan et al. 2012; Meagher & Szebehely 2013).

Second, FPOs were formally excluded from providing HACC-funded services until 1998, (although some, such as Kincare, established NPO arms that enabled them to move into HACC earlier than that (Kincare 2007)). While they were able to apply for packages from the early years (1992), FPOs had less opportunity to demonstrate their capability in a field in which trust and reputation are critical.

The history of FPO access to this sector is indicative of some important broader processes in human services that remain relevant to the present day. On the one hand, as outlined by Hansmann (1980, 1987) in his theory of 'contract failure', where there are strong asymmetries of information, buyers are more likely to rely on trust, and they are more likely to trust NPOs because of their 'non-distribution constraint' (such that financial surpluses are not distributed to individual shareholders).²⁵ In human services there are major asymmetries of information arising from the limits on the personal agency and financial capacity of many users, and on the measurability and observability of the actual services (Blank 2000; Davidson 2012). Thus there is scope for opportunist providers that are profit maximisers rather than social maximisers to reduce the quality and equity of services in order to lower costs, and concern about this possibility in large part explains the continuing concern about FPOs working in human services.

On the other hand, the history of FPO access illustrates the changed environment and expectations created by neoliberalism and marketisation. In 1985, the exclusion of FPOs appears to have been considered largely unexceptional as 'it was the culture then' (interview with government official) following the strong growth of, and government support for, NPOs, especially community-based ones, in the 1970s; problems with FPO nursing homes that had led to government measures to encourage NPOs in aged care (Lyons 1995); and the fact that publicly funded community care providers at the time of the establishment of HACC were government or NPOs. Then, after over a decade of neoliberal dominance, the decision in 1998 to allow FPOs

25 See Davidson (2009) for a discussion of the limits to contract failure theory.

into HACC was similarly considered unexceptional within government. More specifically, there had been the Hilmer Report (1993) on competition policy; a number of years during which FPOs had access to the packages with few apparent problems; and the increasing acceptance of FPOs to deliver government programs in a range of fields. The election of the conservative Howard government may have given some impetus to admitting FPOs, but it was a bipartisan decision supported by state Labor governments.²⁶

Third, until the 21st century, community care was very much the 'poor cousin' of residential care. For some of the larger NPOs and FPOs, residential care was their only interest, and they did not look to compete seriously for the new stream of funding from packages until later. Those who initially saw the opportunities gained a first-mover advantage (Lieberman & Montgomery 1988), although even some of those were initially persuaded primarily by the argument that it would assist future residential business. The stability and form of the funding system has undercut any second or late mover advantage.

The result of the above processes is that the NPOs have had time to grow and consolidate without competition from aggressively marketing FPOs. In particular, the religious and charitable NPOs that operate across a wide geographic area have had space to develop as large and efficient operators now able to successfully compete in a more robust competitive environment if required, while smaller community-based NPOs have at least been able to retain their earlier funding, and, to varying extents, have experienced some growth. This contrasts with child care in Australia where there were few large NPOs when a QVL system was introduced in the early 1990s (via both tax deductions and benefits paid directly to parents) and FPOs subsequently took a majority of the market (Brennan et al. 2012).

26 Interviewees for this study who had been government officials who were part of the process at the time recalled that allowing FPOs in was not considered a major issue amid other more significant changes to mechanisms in HACC for planning, decision-making, and accountability.

Entry and growth of providers in the funded programs

While funding from previous years is not contestable, new or 'growth' funding is continually made available, usually within annual funding rounds for packages and HACC. Over time, there has been substantial potential for new entrants and for existing ones to grow, with the real value of funding more than doubling in the last decade (Davidson 2011).

Who has received this growth funding? And what factors explain the types of organisations that have received the funding? While the allocations are the result of decisions made about tenders each year, these largely flow from the broad framework and principles that underpin the design and management of the regulatory and funding systems for the programs. This section briefly examines the change in the allocation of total funding for packages in NSW between 2003 and 2010, and whether there were factors in play that may have favoured certain types of organisations.

Outcomes of the tendering process

The packages segment is considered by providers to be 'very competitive', with the total number of new places in some regions each year being less than 10 percent of the total number being sought by providers in their tenders. There are no formal barriers to *entry* for any provider in terms of ownership or size, although each one must be of sufficient size such that it has the capability to meet the requirements to become an approved provider. There has been both new entry and exit of providers between 2003 and 2010. In 2010, 13 organisations from the 2003 list no longer provide services or have been absorbed into another body, while there were 28 new ones. The main increases have been in the number of FPOs. However the market share of the 114 providers in 2003 who remained in 2010 remained constant at 93 percent.

The major interest, however, relates to the *growth* of existing organisations, and the change in the market share of different types of providers. The funding data reveals a number of features. First, while the largest percentage increase went to FPOs, this was from a very small base. The number of FPO providers has trebled in the period. After eleven years of the packages, there were 6 FPOs with 2.7 per cent of to-

tal funds (2003); seven years later, there were 18 with 7.1 per cent of funds. Second, the providers receiving the largest absolute increase in funds (and a percentage increase above the overall rate of growth) were the religious and charitable NPOs. Third, the general community NPOs have also grown substantially, but less than the overall rate of growth. The lowest growth was for group-based community NPOs, a fact reflected in their common concern expressed in interviews that in recent years, they have had difficulty in winning places but are then asked by the larger providers to assist in working with their group. Fourth (not shown in the tables), some individual community-based NPOs have had major increases, reflecting their growth-oriented strategies and innovative approaches. In summary, the major growth has been directed to the large NPOs, FPOs have made substantial gains, and some community-based NPOs have flourished, but the share of funding going to the smaller community-based NPOs has declined.

The reasons

A number of factors explain the above. First is the importance of *incumbency*. In any industry, incumbency is a critical advantage for a supplier and an important factor in explaining the structure of the industry. An incumbent firm, especially one with longevity, has an established infrastructure and networks for the production and distribution of its products, a reputation and trust through demonstrated performance over time, access to better information than new entrants (Demsetz 1982) and brand loyalty. Its position will be further buttressed if buyers are risk-averse. Incumbency has some powerful additional benefits in community aged care, given the importance of trust.²⁷ Governments, generally being risk-averse, will tend to stay with proven performers even if there may be some reservations. For individual users, changing care providers is a major emotional and logistical disruption, and they cannot be sure that a new one will be better than their current one; this is not the same as changing toothpaste for a week's trial. Finally, the value of incumbency is further reinforced in the Aus-

²⁷ However, trust and reputation may also be transferable from work in related fields, where a long-standing NPO wishes to move into a sector, as is currently occurring in community aged care.

tralian community aged care industry given the long-term stability of the funding systems.

A second issue is whether there is *government support for certain types of providers*. In some jurisdictions, government or the funding agency has an objective (possibly explicit, but often unspoken) to encourage the entry and growth of certain types of providers in terms of ownership or size. In Australia, FPOs were excluded from HACC before 1998, and in Sweden in recent years, there has been a strong and deliberate push to increase the presence of FPOs in aged care (Meagher & Szebehely 2013). However, for HACC since 1998 and for all of the other current community aged care programs in Australia from their beginning, there appears to have been no explicit policy to promote certain types of providers, other than the aim of some agencies 'to keep a mix of large and small'. Nevertheless, it was clear from statements in a number of interviews that some providers consider there are various unspoken agendas in funding decisions and that, at least informally, decisions unduly favour NPOs and large providers; ironically, others felt that decisions are often aimed at 'giving everyone something'.

Third, a *high level of regulation* generally favours larger and more established providers, given the administrative and resource requirements it entails, while the limitations on profits that regulation implies also reduces the incentives for some FPOs to enter. Arising from concerns about both protecting vulnerable people and ensuring the best use of government funds, the aged care industry has been subject to increasing regulation, especially over the last 15 years from the *Aged Care Act* (1997) on, while different requirements for each program impose extra costs. In contrast, there is no industry-specific regulation on providers in the unsubsidised segment of the industry (part of the second arena in Table 6.1), nor in 2010 were there any specific requirements set by funding agencies regarding bodies that are subcontracted other than that the funded provider must ensure they meet the requirements of their contract (Davidson 2011).

Fourth, the *processes* by which funding is determined will affect the type of providers.²⁸ Because of the resources it requires, tendering favours larger and more established providers, and this is exacerbated

28 Clearly there are strong arguments that regulation and the information required in tenders are a necessary cost in ensuring quality in a marketised system.

where separate tenders are required for each program in each region. The larger providers have the resources to support market research, professional tender writers, and promotional activities to build a positive image – and thus trust – amongst the funding agencies. The process of direct allocations commonly used in HACC in NSW partly avoids these transaction costs and facilitates the growth of smaller community-based providers, but it further reinforces the position of established providers.

Fifth, the *criteria* by which tenders are decided affect the types of providers chosen. There is much documentation setting out the formal criteria, but my interviews with a range of stakeholders sought to identify what they believed to be the crucial factors in practice.²⁹ A generally positive picture emerged with the major focus in the packages on the (i) quality of care, as reflected in the capability of staff, well-established models of care, and systems to monitor quality; (ii) the scope of services to ensure a better integrated experience for users; (iii) local appropriateness, in terms of a knowledge of local needs and services, established networks, and senior staff with local experience; (iv) the financial and logistic viability of the organisation; and (v) the capacity to begin the service quickly. While the scale of a provider's operation may not be a criterion per se, many of the factors are substantially dependent on scale, thus favouring larger providers. There is no direct price competition, with a fixed amount for each type of package set by the department. Further, departmental staff explicitly rejected the idea of some indirect price competition whereby a tenderer could gain an advantage simply by offering more places than what it was funded for, and were insistent that any proposal had to be justified in terms of its effect on the quality of care. (Providers could, of course, cut costs and reduce quality once they have received allocations in order to increase their fi-

However, the aim here is not to debate that issue, but simply point out the implications for the type of providers that emerge in the industry.

²⁹ Providers can attend feedback sessions as to why they were unsuccessful in tendering for packages. While providers had widely differing views on how useful these sessions were, they are an insight into what was significant in funding decisions. One common comment from providers was that high priority criteria varied from year to year.

financial 'surplus' (or profit), but there are no obvious incentives to do this to win funding).

In these ways, the system would appear to work towards selecting social maximisers rather than profit maximisers, although there also appeared to be limited focus on equity and discouraging cream-skimming³⁰ or on protecting the conditions for the low paid care-workers. While most providers generally accepted that the outcome of the process was a set of providers that gave quality care, they commonly complained about the process that success mainly depended on how well the tender was written ('an essay-writing competition') and very little on actual first-hand knowledge of the quality of a provider's current care, and that it was rarely clear why the successful providers were chosen over other good ones.

Taken together, the above factors suggest that established providers, providers with size and scope, and NPOs are most likely to succeed with tenders. However, through the emphasis on localisation and demonstrated capability, the system also gives significant opportunities to existing smaller local bodies, many of which have been able to keep winning growth dollars; indeed, 74 percent of package providers in NSW in 2010 operated in only one region. It also enables small and medium-size FPOs that are not profit maximisers, who have been in the sector for a number of years and developed a good reputation, to win funding. On the other hand, the lack of price competition, high profits and the opportunity to quickly get scale, reduces the incentive for some FPOs to enter the sector, especially the larger corporates.

For-profit organisations in the industry

There are three significant features about the involvement of FPOs in the community aged care industry in Australia – their low share of direct funding from government programs; their prevalence in those markets segments in the second arena of competition where providers are chosen by or for individual users; and the fact that they are all small

30 Whereby providers avoid more difficult and resource-intensive users or favour more affluent users who can pay a higher co-payment or buy extra services.

and medium-sized enterprises, with no large corporate FPO presence at this stage.

The low share of direct funding for FPOs from government programs is substantially explained above. The combined effect of the strength of NPOs, concerns about FPOs giving priority to profits rather than good services (as embodied in contract failure theory), low profitability, and formal exclusion of FPOs from HACC for over a decade were particularly powerful in the early years of marketisation in the sector, and the first three of these factors remain important today. Moreover, NPOs have shown limited interest in the segments in the second arena, given that the segments in the first arena have the large majority of revenue and cater for people with the highest need which is consonant with the overall mission of most NPOs. Some NPOs provide unsubsidised services, but this is usually limited to clients who are on a waiting list or who want more hours and/or different services above their government-funded entitlements. Some have gone a step further and sought to develop a business that can subsidise their other services, but some of these say that they 'burnt their fingers', finding that they faced tighter margins which forced a mode of operation that did not allow them to assist clients as fully as they wanted. On the other hand, FPOs, with little direct access to government funds, have been able to use these segments to give themselves a good platform of business, especially through subcontracting.

The fact that currently most FPOs in the industry in NSW are small and medium enterprises is explained by a number of factors. The owners of many of these providers are ex-nurses or other people with a human service background who want to work independently of large bureaucratic organisations (whether government or NPO), and thus are examples of the 'dwarves of capitalism', motivated primarily by a desire for independence and good service rather than profit (Davidson 2009, p. 57; Marceau 1990). Some of these FPOs go back decades, others are very recent, and new ones are always being established. Many of today's FPOs have emerged from this sort of beginning, including some now very substantial ones that were begun by nurses on a part-time basis with one or two clients. (Of course, a number of the FPOs are profit maximisers and/or operated by people with no human service background, while no industry-specific regulation of providers for un-

subsidised services leaves the way open for more opportunist providers to enter or emerge.)

The fact that people with limited capital have been able to start their own business in this industry in a way that would not be possible in many other human services is a result of the *production function* of community aged care. At the most basic level, the provider of care for an older person living at home needs no physical equipment, financial outlay, or specialised skills to begin. There can be few industries with so few barriers to initial entry. Allied with this is the fact that the basic service involves short periods of assistance (one to two hours) where care-workers do things that most people do for themselves, and thus staff with limited skills and training can be engaged at the margin as additional hours are needed. These features of the production function also facilitate the use of subcontracting and the development of franchises. Clearly, if a provider wishes to grow and ensure consistent high quality service for large numbers of users, it needs more substantial infrastructure, better training and conditions for staff, and economies of scale and scope, but the ease of entry at a basic level of operation has been a powerful reason for the past and continuing establishment of small FPOs in the industry.

However, even a large-scale provider of community care does not need property or the substantial initial capital that is necessary, for example, with a nursing home or childcare centre (Access Economics 2009; Brennan & Newberry 2010). This critical feature of the production function also helps explain the limited interest of large corporate FPOs, whose interest in other human service sectors is based substantially on the role of property, both as a source of profits and as a security against operational and other risks, rather than the actual provision of care.³¹ As well, there are other limits on the incentives for larger FPOs to seek to enter this industry, given that the nature of the target group

31 Thus, for example, a nursing home can be seen as an investment in rental property where there is a guaranteed high level of occupancy, rents are underpinned by secure government funding and where there is an asset that can be sold if the return is no longer considered satisfactory or the risk becomes too high. On the other hand, property also involves costs, and currently the regulations and cost structure in residential care makes that sector less attractive for providers (Access Economics 2009), and make 'community care more profitable' (Stewart Brown Business Solutions 2009).

means there are limited profits to be made relative to other industries, while under the current funding system (with previous allocations not contestable) they cannot get scale. Notwithstanding that, the profitability of community care is sufficient to attract smaller FPOs and retain large NPOs, with packages estimated in 2009–10 to return at least seven percent (profit as a proportion of total costs), and potentially 20 percent for some providers (Stewart Brown Business Solutions 2009, 2010).

Possible changes

In addition to the substantial growth arising from the ageing of the population and the increasing emphasis on ageing-in-place, the community aged care industry faces major change over the next decade arising from two sets of government decisions. One is the transfer of full responsibility for HACC services for older people (65 and over) to the Commonwealth. The other is the decisions arising from the report by the Productivity Commission (2011) of its inquiry, *Caring for older Australians*. This section considers some possible impacts of these two sets of decisions, which are likely to have profound effects on the structure and operation of providers in the industry.

Transfer of HACC for older people to the Commonwealth

In 2010, Council of Australian Governments (COAG) decided that the Commonwealth would have full funding and administrative responsibility for HACC for older people and the states would have similar responsibility for HACC for people under 65 with a disability.³² This was to be phased in, with the Commonwealth taking policy responsibility from July 2011 and funding responsibility from July 2012, with an agreement that there would be no significant change to the program before 2015. The key principle behind this change is that services should

32 The Council of Australian Governments is the meeting of heads of the Commonwealth, six states and two territory governments in Australia. Since 1985, the Commonwealth and states have jointly funded HACC and the states have administered the programs.

be client-centred and making one level of government responsible for each of aged care and disability programs will facilitate integration of the planning and delivery of services for each group.

One set of effects on providers will flow simply from the fact that aged care will be the responsibility of only one level of government. This will lead to changes aimed at achieving greater consistency between the states and closer linkages between the different forms of aged care, while any further change will be much easier to achieve without the need for negotiation and agreement with the states. Further, it has already led to a different approach to allocating HACC funds than the states currently use. State agencies have relied strongly on the input of regional and local staff in deciding the allocation of funds, but the Commonwealth currently does not have a presence in this field outside the capital cities and historically has been far more dependent on formal tender processes (which, as noted earlier, tend to favour larger providers).

Some major changes to HACC, both in the short term and ones to apply after 2015, have now been announced (Australian Government 2012). The personal care services are to become a basic level of packages and administered along those lines. The other elements of HACC will be amalgamated with a number of other aged care programs to form a new Home Support Program. These changes, along with the more general effects noted above, are likely to substantially impact on the role that small NPOs play in the operation of HACC.

One significant change in NSW that in part has been driven by the transfer of HACC to the Commonwealth has been the decision by the Liberal government, elected in 2011, to privatise NSW Home Care Service (HCS) during 2015. HCS is currently the largest provider of HACC services in NSW, with total revenue of \$200 million from all sources.

Government response to the Productivity Commission Report

The Productivity Commission Report (2011) and the initial government response (Australian Government 2012) were very wide-ranging and it is not possible here to trace through all the possible implications for the profile of providers in the community aged care industry.³³ Two key issues are considered below.

The Productivity Commission (2011) recommended that sufficient funding be made available to ensure that there is a place for all older people eligible for assistance. The then government decided to phase this in over the next decade by gradually increasing the number of aged care places from 113 per 1,000 people aged 70 and over to 125 places by 2021–22. Alongside this, the major theme of the government response was the importance of supporting people to remain at home as long as possible and thus a higher proportion of these places will go to community rather than residential care. Given the current parameters (in terms of population, levels of need and eligibility requirements) these changes will go a long way to meeting, by 2022, the Productivity Commission's recommendation for sufficient places for all eligible people. They will also lead to significant growth for providers, including those in the subcontracting segment. It will also mean that, with fewer waiting lists, users will have greater choice, and thus may lead to providers having to do more to attract and retain clients.

The then government decided to defer a change that has the potential to have a major impact on providers. The Productivity Commission (2011) proposed to replace the current hybrid system of funding packages with a QVL system, whereby all approved providers could freely compete for clients on an ongoing basis. Both the former and current governments have indicated support for this approach in the long-term, but will conduct further analysis. There are no plans to implement such a scheme in the short-term.

Such a system would give service users more apparent options, but (as set out in Davidson 2012), it has a number of major dangers, both in terms of ensuring the quality and efficiency of individual providers, and ensuring stability, equity, efficiency, and quality at a systemic level. Such problems have beset child care over the last decade, largely as a result of this form of funding (Brennan & Newberry 2010; Press & Woodrow 2009).

In terms of the profile of providers, it would be likely to lead to more FPOs and a greater market share for FPOs, which would be able to compete directly for clients eligible for government assistance. It may also increase the presence of large corporate FPOs, since they will be

33 The federal Labor government lost office in September 2013. The incoming Coalition government has largely endorsed earlier decisions.

able to obtain larger scale more quickly and can use their marketing experience to achieve this. It may also lead to either an excessive number of providers, or conversely, if regulation is reduced, to greater concentration of ownership.³⁴ At the same time, however, it may also allow the growth and survival of small specialist providers able to meet a niche, either for groups or to provide a specialist service which can be purchased by larger providers for their clients.

Nevertheless, the large NPOs are likely to remain dominant. They have had the time to develop as strong corporate enterprises and should be able to compete strongly in the marketplace that emerges. This has been the case in Job Network, where the NPOs that had scale in similar programs at the time of the introduction of Job Network have continued to grow. It contrasts with child care, where there were few large NPOs when a QVL system was introduced and FPOs quickly took a major share of the market, although those NPOs that did exist (such as Kindergarten Union) have continued to flourish.

Conclusion

Community aged care in Australia is a diverse and complex industry, and provides a useful study in how the structure of one human services sector has evolved under marketisation, and the impact of marketisation on the profile of providers. In community aged care in other nations and in other human service sectors in Australia, there are numerous examples of how marketisation has led to the extensive growth of FPOs, the reduction of the role of NPOs and the end of the substantial involvement of government providers. That this has not happened here in this case is a result of a number of factors, notably the situation two decades ago at the time that marketisation took hold; the subsequent relative stability of the funding system; limited incentives for the entry of larger FPOs in terms of potential profits; the fact that only growth funding has been contestable in the two major programs;

34 Previously, the Productivity Commission (2002, p. 11.5) has noted that the introduction of such a system for funding employment assistance for disadvantaged people under the then Job Network program would be likely to lead to some 'consolidation in the industry'.

and the maintenance of close government control over the entry and growth of providers via a tendering system where a major focus has been on ensuring the quality of care.

Much of this may change, however, in the light of government decisions both taken and still to come, especially if these lead to the introduction of a QVL funding system for the major programs where the users choose their providers and *all* funding is continuously contestable. In this context, the large NPOs are likely to retain their prominent position, but there is likely to be an increase in the number of FPOs, a greater concentration of market share, the appearance of large FPOs, and a reduced market share and uncertain future for small community-based NPOs.

The experience of community aged care in Australia has some broader implications for human services. First, where there is long-term stability of funding, history becomes more significant and the first-mover advantage is especially significant. Second, the limits on the entry and growth of FPOs in the early years of marketisation of this service enabled NPOs to develop a strong presence and the capacity to be successful in a robust competitive environment. Third, it shows that tight government control of entry and contestability aimed at ensuring quality services can co-exist with a system that maintains incentives to improve quality and efficiency alongside strong competition between providers. Fourth, it also shows the benefits of a process that closely controls the entry of new providers so as to minimise the potential problems arising from marketisation.

Change is going to happen in this industry in Australia. It is to be hoped that this does not go too far down the marketisation track in ways that remove some of the strong incentives and requirements for quality in the current system. Whatever the change is, however, it will be interesting as an experiment on the impact of government policy and funding systems on different types of human service providers and on the structure of human service industries – and the effects of this on the quality of services and outcomes for users.

Appendix

Sources and notes to Table 6.1.

(a) This includes services *funded* by government either indirectly (Sub-contracting) or by QVL systems; and services *organised* by government (Guardianship and Insurance Arrangements).

(b) The consumer-directed packages pilots started in 2011 are not included here, but under the Commonwealth community care packages, because the department selects providers to manage the packages, albeit under more direction by users.

(c) In these cases, government agencies assist people to obtain care that is often paid for from their own funds. OPC supports both younger people with a disability and older people. LCSTA is for people who have received compensation payments for a road accident injury, and is mainly used by people under 65 years old.

(d) This can include payments by companies to employees who have aged parents. I have not identified any such schemes in Australia, but they do operate in Europe (Snell, Fernandez & Bennetts 2007). (e) This funding is compensation to survivors of the Nazi Holocaust paid by various European governments, coordinated by the USA-based Claims Conference, and distributed through Jewish Care in Australia. In 2012, Australia received \$3.8 million (\$1.5 million in NSW), most of which was for community aged care.

Sources to Table 6.2.

Derived from DoHA (2010b p. 29 Tables 9–11). Note that the relatively high proportion and number of places held by state government providers in Victoria and South Australia are primarily state health department agencies.

Sources to Table 6.3.

Derived from DoHA (2003). Note: The data cover only CACP, EACH, EACH D packages. Some more recent minor specialised packages for which there is a single provider. (For example, NSW Health has 100 percent of Transitional Health packages are not included).

Sources to Table 6.4.

Derived from DoHA (2010a). Note: The data cover only CACP, EACH, EACH D packages. Some more recent minor specialised packages for which there is a single provider are not included (For example, NSW Health has 100 percent of Transitional Health packages).

References

- Access Economics 2009, Economic evaluation of capital financing of high care, Access Economics, March.
- ABS (Australian Bureau of Statistics) 2010, *Disability, ageing and carers, Australia: Summary of findings of 2009 survey*, Cat. no. 4430. 0, ABS, Canberra.
- AIHW (Australian Institute of Health and Welfare) 2001, *Australia's Welfare 2001*, Canberra, Australian Institute of Health and Welfare.
- Australian Government 2012, *Living longer, living better: Aged care reform package*, April. <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-factsheet-7.htm>
- Bessant, J., Watts, R., Dalton, T. & Smyth, P. 2006, *Talking policy: How social policy is made*, Allen & Unwin, Crows Nest, NSW.
- Blank, R. 2000, 'When can public policy makers rely on private markets? The effective provision of social services', *The Economic Journal*, vol. 110, no. 462, pp. 34–49.
- Brennan, D., Cass, B., Himmelweit, S. & Szebehely, M. 2012, 'The marketisation of care: Rationales and consequences in Nordic and liberal care regimes', *Journal of European Social Policy*, vol. 22, no. 4, pp. 377–91.
- Brennan, D. & Newberry, S. 2010, Indirect policy tools: Demand-side funding and lessons to be learned: early childhood education and care, paper presented to the Asia-Pacific Interdisciplinary Research in Accounting (APIRA) Conference, Sydney, July.
- Carlton, D. W. & Perloff, J. M. 2005, *Modern industrial organisation*, Pearson-Addison-Wesley, Boston.
- Davidson, B. 2008, Non-profit organisations in the human services marketplace: The impact of quasi voucher-licensing systems, paper presented to the 37th Annual Conference of the Association for Research on Nonprofit Organisations and Voluntary Action (ARNOVA), Philadelphia, 20 November.
- Davidson, B. 2009, 'For-profit organisations in managed markets for human services', in *Paid care in Australia: Profits, purpose and practices*, eds G. Meagher & D. King, Sydney University Press, Sydney, pp. 43–79.

6 Community aged care providers in a competitive environment

- Davidson, B. 2011, The community aged care industry, paper presented to the 10th Annual Conference of the Society for Heterodox Economists, Sydney, December.
- Davidson, B. 2012, 'Contestability in human services markets', *Journal of Australian Political Economy*, vol. 68, pp. 213–39.
- Demsetz, H. 1982, 'Barriers to entry', *The American Economic Review*, vol. 72, no. 1, pp. 47–57.
- DoHA (Department of Health and Ageing) 2003, Data on approved service providers and aged care places as at 30 June, Excel spreadsheets, provided to author by DoHA.
- DoHA (Department of Health and Ageing) 2010a, Data on approved service providers and aged care places as at 30 June, Excel spreadsheets.
<http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-servlist-download.htm>
- DoHA (Department of Health and Ageing) 2010b, *Report on the Operation of the Aged Care Act 1997 – 1 July 2009 to 30 June 2010*, Department of Health and Ageing, Canberra.
- Esping-Andersen, G. 1990, *The three worlds of welfare capitalism*, Polity Press, Cambridge.
- Hansmann, H. B. 1980, 'The role of nonprofit enterprise', *The Yale Law Journal*, vol. 89, no. 5, pp. 835–901.
- Hansmann, H. B. 1987, 'Economic theories of nonprofit organisations', in *The nonprofit handbook*, ed. W. W. Powell, Yale University Press, New Haven, pp. 27–42.
- Hilmer, F. G. 1993, *National competition policy*, Report by the Independent Committee of Inquiry, Australia Government Publishing Service, August.
- Himmelweit, S. 2008, Rethinking care, gender inequality and policies, paper presented to the United Nations Expert Group Meeting on 'Equal sharing of responsibilities between women and men, including care-giving in the context of HIV/AIDS', Geneva, 6–9 October. <http://www.un.org/womenwatch/daw/egm/equalsharing/EGM-ESOR-2008-EP-7%20Susan%20Himmelweit.pdf>
- House of Representatives Standing Committee on Public Expenditure 1982, *In a home or at home*, Report, Australia Government Publishing Service, Canberra, October.
- House of Representatives Standing Committee on Community Affairs 1994, *Home, but not alone: A report on the Home and Community Care program*, Australia Government Publishing Service, Canberra, July.
- Howe, A., King, D., Ellis, J., Wells, Y., Wei, Z. & Teshuva, K. 2012, 'Stabilising the aged care workforce: An analysis of worker retention and intention', *Australian Health Review*, vol. 36, no. 1, pp. 83–91.

Markets, Rights and Power in Australian Social Policy

- Kincare 2007, Kincare website, <http://www.kincare.com.au>
- Le Grand, J. & Bartlett, W. (eds) 1993, *Quasi markets and social policy*, Macmillan, London.
- Lieberman, M. B. & Montgomery, D. B. 1988, 'First-mover advantages', *Strategic Management Journal*, vol. 9, no. S1, pp. 41–58.
- Liebowitz, S. J. & Margolis, S. E. 1990, 'The fable of the keys', *Journal of Law and Economics*, vol. 33, no. 1, pp. 1–25.
- Liebowitz, S. J. & Margolis, S. E. 1995, 'Path dependence, lock-in, and history', *Journal of Law, Economics & Organization*, vol. 11, no. 1, pp. 205–26.
- Lyons, M. 1995, 'The development of quasi-vouchers in Australia's community services', *Policy and Politics*, vol. 23, no. 2, pp. 127–139.
- Lyons, M. 2001, *Third sector: The contribution of nonprofit and cooperative enterprise in Australia*, Allen & Unwin, Sydney.
- MacDermott, K. 2008, *Whatever happened to frank and fearless? The impact of new public management on the Australian public service*, ANU E Press, Canberra. http://epress.anu.edu.au/frank_fearless_citation.html
- Marceau, J. 1990, 'The dwarves of capitalism: the structure of production and the economic culture of the small manufacturing firm', in *Capitalism in contracting cultures*, eds G. Redding & S. Clegg, de Gruyter, Berlin, pp. 198–212.
- Martin, B. & King, D. 2008, *Who cares for older Australians? A picture of the residential and community based aged care workforce, 2007*, National Institute of Labour Studies, Flinders University, Adelaide, October.
- Meagher, G. & Szebehely, M. 2013, 'Long-term care in Sweden: Trends, actors, and consequences', in *Reforms in long term care policies in Europe: Investigating institutional change and social impacts*, eds C. Ranci & E. Pavolini, Springer, New York.
- Mears, J. 2012, *The world of care work: Care workers and care managers working in community aged care*, PhD Research Thesis, The University of Sydney.
- Neville, J. 1998, 'Economic rationalism: Social philosophy masquerading as economic science', in *Contesting the Australian way*, eds P. Smyth & B. Cass, Cambridge University Press, Melbourne, pp. 169–79.
- NSW DHS (NSW Department of Human Services) 2010, *Annual Report, 2009–10*.
- Osborne, D. & Gaebler, T. 1993, *How the entrepreneurial spirit is transforming the public sector*, Plume, New York.
- Press, F. & Woodrow, C. 2009, 'The giant in the playground: The reach and implications of the corporatisation of child care provision', in *Paid care in Australia: Profits, purpose and practices*, eds G. Meagher & D. King, Sydney University Press, Sydney, pp. 231–52.
- Productivity Commission 2002, *Independent review of the job network: Inquiry report, Report No. 21*, Productivity Commission, Canberra.

6 Community aged care providers in a competitive environment

- Productivity Commission 2008, *Trends in aged care services: Some implications*, Productivity Commission, Canberra, September.
- Productivity Commission 2011, *Caring for older Australians, Inquiry Report*, Productivity Commission, Canberra, August.
- Schmalensee, R. & Willig, R. 1989, *Handbook of industrial organisation*, Elsevier, Amsterdam.
- Snell, T., Fernandez, J. & Bennetts, R. 2007, Tax exemptions on care vouchers for working carers: An economic analysis, Personal Social Services Research Unit (PSSRU), London School of Economics.
- SCRGSP (Steering Committee for the Review of Government Service Provision) 2011, *Report on government services 2011*, prepared by the Productivity Commission, Canberra. <http://www.pc.gov.au/research/recurring/report-on-government-services/2011/2011/rogs-2011-volume2.pdf>
- Stewart Brown Business Solutions 2009, Aged care financial performance survey for year ended 30 June 2009. <http://www.sbsolutions.com.au>
- Stewart Brown Business Solutions 2010, Aged care financial performance survey for the 9 months ended 31 March 2010. <http://www.sbsolutions.com.au>
- Stilwell, F. 2005, *Political economy: The contest of economic ideas*, Oxford University Press, South Melbourne.
- Travers, P. 2005, 'Rights and responsibilities: Welfare and citizenship', in *Social science and public policy in Australia*, eds P. Saunders & J. Walter, UNSW Press, Sydney, pp. 85–102.
- Treasury 2010, *The 2010 Intergenerational report: Australia to 2050 – future challenges*, Australian Government Treasury, Canberra, January.
- Ungerson, C. & Yeandle, S. 2007, *Cash for care in developed welfare states*, Palgrave Macmillan, Basingstoke.
- Wilberforce, M., Glendinning, C., Challis, D., Fernandez, J., Jacobs, S., Jones, K., Knapp, M., Manthorpe, J., Moran, N., Netten, A. & Stevens, M. 2011, 'Implementing consumer choice in long-term care: The impact of individual budgets on social care providers in England', *Social Policy & Administration*, vol. 45, no. 5, pp. 593–612.
- Yeatman, A. 1990, 'The right of redress', *Australian Journal on Ageing*, vol. 9, no. 3, pp. 27–31.