**TITLE: Marketisation of community aged care services in Australia. Insights into how rural managers and consumers navigate this context**

**Suzanne Hodgkin** (PhD)

Associate Professor,

John Richards Centre for Rural Ageing Research, La Trobe Rural Health School

La Trobe University.

PO Box 821 Wodonga VIC 3689 Australia

**T:** +61260249814 **F**: +61260249737

**E**: [s.hodgkin@latrobe.edu.au](mailto:s.hodgkin@latrobe.edu.au)

**Pauline Savy** (PhD)

Research Officer

John Richards Centre for Rural Ageing Research, La Trobe Rural Health School

La Trobe University.

PO Box 821 Wodonga VIC 3689 Australia

**T:** 0419230699 **F**: +61260249737

**E**: [p.savy@latrobe.edu.au](mailto:p.savy@latrobe.edu.au)

**Samantha Clune** (PhD)

Research Officer

John Richards Centre for Rural Ageing Research, La Trobe Rural Health School

La Trobe University.

PO Box 821 Wodonga VIC 3689 Australia

**T**: 02 6024 9720 | F: 02 6024 9737

**E**: [s.clune@latrobe.edu.au](mailto:s.clune@latrobe.edu.au)

**Anne-Marie Mahoney** (PhD)

Lecturer in Nursing

Rural Department Nursing & Midwifery

College of Science, Health and Engineering

La Trobe University Wodonga 3690

**T**: 02 60249725 I **F**: 02 60249737

**E**: [a.mahoney@latrobe.edu.au](mailto:a.mahoney@latrobe.edu.au)

**Abstract**

Across several OECD countries, aged care policy has been influenced by neo-liberal, free market philosophies. This is illustrated in the introduction of variations of cash for care schemes in community care services. Australia provides a recent case example with the introduction of a Consumer Directed Care (CDC) program. This marketised model with its clear definition of community-based care recipients as consumers, and care as a commodity, has effectively re-located the publicly funded aged-care system into the private, commercial sphere. In this environment providers market their services and procure and broker other services. As a consequence, Australian aged care services operate in a maze-like competitive environment. This paper draws from a qualitative study conducted in rural Australia, examining the introduction of CDC and seeks to examine how consumers and managers navigate this context. The equivocal outcomes illustrate the challenges associated with providing and accessing services in limited rural markets.

**Key words**

Consumer directed care, marketization, aged care policy, rural

**Introduction**

Rising costs in public expenditure in aged care have induced several OECD countries to turn to the market and market mechanisms to deliver services. The influence of neo-liberalism and the proclaimed superiority of the market in providing choice, has increased the for-profit sector’s stake in the ownership and management of residential care (Kaine and Green, 2013). More recently, several countries have introduced market- oriented reforms in the community aged care sector (Theobald et al., 2018). Contained in policy approaches such as New Public Management and couched in the language of consumer rights, variations of consumer directed care (CDC) programs have been introduced in countries such as England, Japan, Germany and Sweden. Often termed ‘cash for care’ schemes, their purpose has been to facilitate choice in the purchase of home-based services.

In Australia, the market tenets of neo-liberalism have also significantly influenced policy reform (Kaine and Green, 2013). Historically, Australia’s federal government has traditionally been a funder rather than a provider of aged care services (Brennan et al., 2012) with the delivery of aged care services predominantly the domain of not-for-profit organizations (charitable and community organisations) and local governments. Prior to a significant period of policy reform, services were provided through typically paternalistic welfare approaches. More recently, the introduction of a suite of aged care reforms has enabled the rise of the for-profit sector and seen the withdrawal of local government in the provision of domiciliary care. As a consequence, Australian aged care services operate in a maze-like competitive environment. In this context, not-for profit and for profit providers bid for subsidies based on the assessed needs of older people living in residential care facilities and those living independently.

The introduction of a CDC schemes established competition across a range of for-profit and not-for profit organisations, and consumer choice in selecting care items and providers (Yeandle and Ungerson, 2007). In Australia, the range of community-based programs are necessarily wide and include the provision of government-funded packages for personal care, nursing care, domestic assistance, respite care, meals, home maintenance and case management. Two schemes exist for community care funding: the Commonwealth Home Support Program (CHSP) designed to provide a modest amount of single service care and the Home Care Packages (HCP) program, a tiered system which provides greater levels of support according to individual care needs.

In 2017, all new and existing home care packages were assigned to consumers, rather than to aged care providers. This marketised model with its clear definition of community-based care recipients as consumers, and care as a commodity, has effectively re-located the publicly funded aged-care system into the private, commercial sphere. This shift, underpinned by the concept of CDC, has changed the landscape of community care delivery through the introduction of a competitive environment in which service providers market their own services and procure and broker other services. Regardless of whether or not provider organisations are profit-oriented, their operational framework must be business- and customer-focussed in order to remain competitive and attract consumer choice and uptake of their services.

Conceptually, CDC advances the philosophy of Person-Centred Care (PCC) which aims to individualise and improve care quality and outcomes for older adults (Australian Commission on Safety and Quality in Healthcare, 2007, 2012). Such approaches represent a fundamental shift from traditional, medical or paternalistic practices that limit input from the person receiving care (Delaney, 2018). As a central element of the marketised system, CDC upholds the agency and wisdom of older care recipients. For their part, community-based care providers must foster consumers’ agency, respect their decisions, and work to ensure that services achieve quality outcomes and customer satisfaction (Rathert et al., 2012).

What these broad reaching changes mean for service delivery and the ability of older people to age comfortably in their homes is the subject of international discussion (Bulamu et al., 2017, Kaambwa et al., 2015, Ottmann et al., 2013). This international literature on various cash for care schemes, focuses on the experiences of older people relative to accessing and receiving various services (Bulamu et al., 2017, Cardona et al., 2017, Ratcliffe et al., 2014, Sciegaj et al., 2004). One systematic review found older people report varying preferences for CDCwith some demonstrating limited interest (Ottmann et al., 2013). In other research, older people reported experiencing higher levels of control and choice in relation to their funding packages (Cardona et al., 2017, Gill et al., 2018). At the same time, similar results offered by Bulamu (2107) show that while older participants in receipt of funds express satisfaction with their quality of life, actual improvement in quality of life could not be demonstrated. This distinction has led some to argue that the perception of choice as a marker of program success is overly simplistic and fails to appreciate the inherent complexity of ageing in place (FitzGerald Murphy and Kelly, 2018, Ginsburg, 2006). Indeed, variables such as choice and quality outcomes and their interplay with the circumstances that constitute the health and care worlds of older people are inherently complex.

Locality and service availability, for example, play a major part in the exercise and outcome of consumer choice. Rural communities experience marked differences in terms of access to services and supports when compared to their metropolitan counterparts (Australian Institute of Health and Welfare, 2018 ). On the face of it, however, the reformed system offers rural consumers the opportunity to purchase care from local or distantly-based providers; in this sense, consumer choice appears to be equitable across all parts of Australia. For their part, providers operating in regional and rural parts of Australia will experience the marketised and maze-like service environment differently from their metropolitan counterparts. In regional, rural and remote communities, choices are constrained by the lack of aged care services operating outside of metropolitan and major regional locations (Baldwin et al., 2015). This relative lack results in often complex and innovative diverse service delivery arrangements. Equally, the charge to observe the principles of CDC poses location specific challenges; consumer choices for service provision may not realistically reflect geographical and resource limitations.

In this paper we draw from a qualitative study recently conducted in partnership with a consortium of aged care providers who operate within a largely rural region of Victoria, a South-Eastern state of Australia. The area under study is geographically diverse. It includes major regional centres, rural, and semi-remote communities. The findings presented here are drawn from a larger case study which set out to identify and examine the characteristics of community aged care provision within an area defined by its mostly rural and semi-remote location. In particular, this study aimed to explore the ways that the providers and consumers experienced the policy reforms as outlined above, and to identify workforce, skills and training needs pertinent to this region and to compare these with national statistics.

The study extends the authors’ previous research on service provision and workforce sustainability conducted in other rural parts of New South Wales and Victoria (Savy et al., 2017). The findings are significant in that they describe the limits to care provision as these are imposed by geography as well as the opportunities for maximising resources that arise from local service and inter-service characteristics and relationships. The findings are also significant in that they address a gap in the Australian aged-care literature. Little aged-care research in this country focusses on regional, rural and communities. The impact of the recent, major reforms in the aged care sector needs further focussed study to assess the implications of CDC and the challenges providers face as they navigate policy changes, stay afloat and provide quality care (Jorgensen and Haddock, 2018).

**Methodology**

The case study employed a mixed method approach including a survey of direct-care workers, semi-structured interviews with managers and consumers, and focus groups with case managers and workers. This approach allowed for a range of views on and experiences with the current arrangements for care delivery across diverse localities and provided insights into the worlds of service acquisition, provision and receipt. In addition, service information relevant to workforce and consumer profiles was obtained from the managers to contextualise the findings.

The managers’ interviews (n=8) aimed to gather information specific to the operations of the different services and their relationships with other, relevant services. These interviews were guided by a schedule of questions that pursued information about the organisations’ operations, the range of services they provide, the localities they serve, policy implications, and their staffing and consumer profiles. In addition, the schedule allowed for exploration of the managers’ capacity to achieve consumer care ideals relative to ageing in place and consumer directed care. The managers provided informed consent and the interviews were audio-recorded, lasted approximately 30 minutes to 1 hour, and were conducted at each manager’s workplace. This interview data provided sound representation of the five organisations, the communities they service in the larger and smaller towns, the scope of their service, and insights into the challenges of providing quality care within the current marketised environment.

The consumer interviews were conducted with 20 participants, including 18 women, from across the North East Hume region of Victoria between September 2018 and January 2019. The interviews were conducted either in participants’ homes or over the telephone to facilitate the older person’s availability. Each interview took between 30-60 minutes and a range of questions was asked to explore the participants’ experiences of accessing community aged-care funding and receiving assistance. The data from the consumers’ interviews provides first-hand narratives of infirmity and need for support, and of their exercise of agency as they navigated the formal assessment systems and interacted with local providers. This data complements that derived from the managers’ interviews in that it locates the receipt of care within the subjective, interactional world of consumers and highlights the role of relationships in realising agency.

Following transcription, the interview data were analysed by two research members who identified themes and patterns as these were framed by the interview schedules (Miles and Huberman, 1994). Termed peer debriefing, this approach ensured that the process of data reduction was guided by the experience of the researchers who had prior knowledge of and had worked in the aged care sector. For the purposes of this paper, a secondary analysis of the managers’ and consumers’ interview data was conducted to inductively formulate themes relevant to the impacts of the reformed service provision structure and process, and its emphasis on CDC.

Ethics approval for the conduct of this project was provided in 2018 by both La Trobe University Human Ethics Committee HEC18261 (managers and staff) and HEC 18327 (older consumers).

**Findings**

The findings are organised within the following themes: Marketised Care and CDC; Service Provision and Rurality; Sustaining Care.

*Marketised Care and CDC*

The current arrangements for the public funding of community aged care situates consumer agency as the main driver. That is, consumers or their representatives must initiate assessment via a newly established website termed *My Aged Care* to secure entitlement and funding. This shift assumes consumer competence and a capacity to understand the processes of assessment, eligibility and purchase of their selected care items. Entitlement to funding support via the current programs (CHPS and HCP) rests on meeting the assessment criteria. Once eligibility has been established, the older person must then nominate and engage a service provider.

The participants were asked to explain how they accessed information and funding and if they had received help in doing so. Most participants were given information about the process by an existing care provider, a healthcare professional during a hospitalisation or by family and friends.

I was in hospital - see, I had two hips and a knee done and you had the social workers come and talk to you and all that. I think somebody suggested that they'd put in for it. (2)

[named friend]…and she used to come around…I was saying how hard it was to do the vacuuming…she said…see the home care people in [named local provider]. So, that's how it started. (7)

Once engaged in the funding process, the participants experienced difficulty in accessing information related to the details of their package and their entitlements. In particular, they referred to the requirement of accessing information from government websites.

…a huge website, I don't think appeals to people. It will be quite all right when the current 30, 40, 50 year olds are accessing them. Because they are much more computer literate than we are… …it was just torturous in the beginning. (5)

Actually my daughter did it all because at one stage I wasn't very efficient, and she seemed to think I needed it, and organised it all. (11)

While the participants understood the general purpose of their packages, they reported being unsure about what they were entitled to under their funding agreement.

So it's pretty well anything that'll help me stay at home. [named community care worker] driving me out to Tallangatta next week, so I might ask her then, when we're driving along. (2)

Each level of the funding process involves wait periods, often lengthy gaps between application, confirmed eligibility, funding allocation and service availability. In some cases, because of Commonwealth funding shortfall, receipt higher levels receipt of the higher levels may be delayed for many months:

I sent the papers away May last year, not this year and I didn't get it until after Christmas [this year]. (2)

…I've been approved for a Level 3, but they're not available so it'll be a Level 2 and wait for a Level 3, but there's still another year - I rang the other day to say how long because we're in financial difficulties…he said oh nine to 12 months and I said oh, since application? No, from now. (17)

For consumers already ‘in the system’, advice from their local provider can help them to deal with the problem of a long wait for a higher level of care. The managers provided sound reasons why consumers should not accept a level of funding lower than their assessed level of need:

Clients get really concerned that they're going to miss out [so] they accept a level 2.. If they accept level 2, there's not enough money to provide the services...because everything has to go through the package. (T)

This kind of advice is integral to the managers’ role given the perceived and actual hurdles that aged persons may encounter as they exercise choice: it supports rather that overrides consumer agency. The managers recognise and advise on potential problems and traps that consumers may not readily perceive. For example, consumers may not understand the cost recovery arrangements which require them to pay administrative costs to their provider. Different fee structures apply across the funding levels and providers may figure these with some discretion.

…the provider takes off nearly fifty per cent for the administration…plus what he charges for the cleaning…(2)

One consumer described how she had to cancel an existing service to be able to manage to pay such costs to a new provider:

I was getting Meals on Wheels and it's cheap enough, I'm not complaining about that, but my bank was getting lower and lower. I thought well, it's $118 a month, so I stopped it. (6)

The managers held different views about their role in advising consumers within the concept of CDC. Two managers, saw that the imperative for CDC conflicts with their long-held goal of working actively *for* consumers to maintain their independence:

…the active service approach [has] gone out the window…[It’s] very hard…to say, hey I’m going to work with you to keep you independent in your home under a consumer directed care model…the forces are diametrically opposed. (A)

…[consumers’] goals may not be our goals as providers…their goals may be to go shopping once a week…not be to have somebody come in and clean their kitchen that might have mice or rats in it…that's an extreme example and that's the challenge for service providers. (C)

However, other managers saw CDC as a positive framework in which consumers and providers can work cooperatively to ensure that informed care choices are made for their mutual benefit:

…[CDC] makes goal-directed care planning easy because…they’re able to tell you what they want, what they value, what they prioritise…it gives people a sense of control…its flexible, it’s a discussion…more of a co-designed kind of approach, and empowering for the client. (W2)

The exercise of consumer agency within the marketised, competitive environment is not straightforward. Consumers may be tempted to make poor choices from the array of providers and differently costed items. They may select a remotely located provider on the basis of cheaper care items. Poor choices that do not directly support consumers’ capacity for independent living may impact on care outcomes. Even when remote providers broker local services to deliver the chosen items, they lack the immediate capacity to oversee care and respond to changing care needs:

[named service provider] is in Melbourne and also put some office in Shepparton and Wangaratta but not in locally. [It’s] very bad service, because if I ring up with the phone number if I want something, ring up Melbourne, Melbourne ring up Wangaratta, Wangaratta ring up…the lady who look after the carer […] Sometimes I ring three, four times and even never got a answer. (2)

Unlike the Services in this study, remotely located providers are not positioned to collaborate with the local community of professionals and Services to ensure continuous and responsive care. Local service providers are well-placed to provide advice and to augment package shortfalls:

…nobody will be disadvantaged because of finances. It's in our policies at [named service]so we will look at fee waivers, we will look at what we can do to keep these people at home and give them services. (B2)

For providers, the diverse mix of programs, funding and regulations complicate care delivery and impact on consumer choice and equity. For example, the Commonwealth Home Support Program (CHSP) funding provides entry level services for domestic tasks, personal care, shopping assistance, respite, home and garden maintenance, and transport. Funding and standards for identical tasks are set differently according to the government program through which they are delivered. One manager illustrated the impact of this inconsistency, using the example of a ‘shower’ as it is regulated and funded across various programs:

…it could come under five separate sets of standards…a Home Care Package it’s one set of things to comply with, if it’s Commonwealth Home Support Program [CHSP] it’ll be something else, if it’s Veteran Affairs - another set…if it’s NDIS another set of standards and if it’s Home and Community Care it’s another set..same shower, five sets of standards…and five sets of prices too. (A)

For the managers, this complex division of program funding and standards must be clarified to provide task guidelines for their direct care workers. Older people too may need explanation to help them to understand why their care items and procedures differ from those of their peers in terms of cost and procedure.

Our data indicates that consumers are likely to be confused about the process of assessment and choice of providers and care items. For those already receiving care from local providers, the decision was made to remain with their current provider. This decision meant that their range of choice was limited to those items offered by this provider. However, the benefits associated with local and rurally-based care delivery offset any narrowing of choice.

*Service Provision and Rurality*

The service providers operate out of a variety of settings. Multiple service sites include in-patient, day care, community and residential services. The services delivered by a single provider are necessarily wide ranging, for example:

…home care, personal care, respite care, planned activity groups, meals on wheels, other food services, social and individual support…district nursing… We deliver services under Commonwealth Home Support funding and under Home and Community Care (under 65). We've also got the contract for Veterans' Home Care for here and Corryong. We also provide services to consumers who hold packages levels 1-4…we don't actually hold the packages here [but] the organisation holding the packages will come to us and request the services

We've got the full range of allied health services; podiatry, physiotherapy, OT, dietetics, speech therapy, allied heath assistant, OT, health promotion… we provide services to residential aged care, to the acute and TCP beds… and also to the community -mainly outpatients but we do some home visiting. (B1)

This broad set of services delivered across a large rural location means that the health and functionality of consumers may be observed by different health care workers:

Where we're lucky here is that we have got a lot of services being delivered from Tallangatta Health Service. So you very quickly identify if there's an issue with the client. Because we've got different staff going in…they will sometimes pick up if something is going on in that house...feedback can come back to me quickly. (T)

In rural communities, the close relationship between co-located and other, local health services means that consumers are serviced within a local care spectrum and may be well known to care coordinators and workers, and to related health service professionals such as pharmacists, GPs, occupational therapists, podiatrists, physiotherapists and district nurses.

One of the things our…complex care coordinator, has put in place is a shared care meeting with the home care providers…the local surgery, the local surgery, the pharmacy, and allied health and community nursing. So any clients that are flagged as struggling or not coping, [their case] can be brought by anyone to that meeting, and then they're reviewed and…strategies are put in place [to] support them. They have started inviting the clients to that meeting too. (B1)

…the relationship between the allied health and community nurses with the surgery, is very good…we've got that ability, even with the nurses down at the surgery. (B2)

Typically, rurally located services cover a wide territory to reach consumers who live outside town boundaries and on distant properties. For example, the Corryong service extends across a 70 km radius. Similarly, services are delivered from Tallangatta to towns up to 75 km away. These distances mean that round trips to deliver services may total 100km or more and that travel costs are added to the cost of delivering a consumer’s package. In one example, a manager reported that *a one hour, $44 service became $204 for us* (W1)*.* To contain costs, care delivery to outlying consumers is generally organised around the home towns of both consumers and care workers.

Transport and rural distance factors are significant in light of the lack of adjustable funding to accommodate additional travel costs for rural older people within the CHSP or HCP packages. Distance and transport costs impact on consumer’s access to and uptake of services. In the case of acute services consumer entitlement to funding is determined formulaically by kilometres per week: Many participants also reported that, despite minimal expectations of their care entitlement, they had been pleasantly surprised with the breadth of options, once on a plan. They reported satisfaction with the service delivered by their local provider, and in particular with the easy relationship that they were able to develop with managers and case managers, and regular direct care workers:

…we've become quite friends with the people at Tallangatta, so when I ring up I'll say, hi, […] because they're local people, they know where we live and our situation. (4)

I've got to know them really well...the woman who comes here regularly, she sits down and we have a cup of tea and we go through issues, just like my phone's not working properly…she's been in the job for 11 years, so she's got a good understanding of how the organisation works…I could always call on her for any information for the future. She would also be watching. (12)

The participants linked their regular care services with their ability to anticipate and plan for changing care needs and to anticipate being able to continue to live at home even as their dependency increased:

Because of my kidney condition…my health will deteriorate…it's good to have it all in place ready so that we can have the services that we need. (4)

Our data indicates that local, rurally-based providers are well placed to support CDC and its realisation within the market environment. In particular, consumers who already receive care from local providers are advantaged by cooperative relationships in which funding and care decisions are made to achieve mutual goals. However, the sustainability of local services is in question given the circumstances of rural location, populations, and workforce availability.

*Service Sustainability*

Data obtained from the managers show that the majority of community-based services they deliver is via the CHPS program. This program provides for some 2,000 of their consumers who, on average, receive up to 1.5 hours service per week. In stark contrast, the number of consumers on higher level HCP packages totalled 159. Thus, at the time of study, the vast majority of the providers’ community-based consumers were receiving level entry services. This data is significant in the context of changing future circumstances. Demographic predictions concerning increasing aged populations in the areas under study imply that more services and higher levels of care will be required: growth of this cohort across the rural areas under study is project to occur at rates between 22 and 30%.

This may be considered good news for providers operating within the marketised model – higher demands may be linked to viability. However, the growing demand for service will occur along with a predicted decline in available direct-care workers. Our data shows that the current workforce is predominantly female and on average, workers are aged 50.5 years. Given the imminent retirement of many of these workers and the small workforce pools relative to metropolitan areas, the managers are facing critical recruitment and retention challenges. In particular, recruitment of younger workers is hampered by the negative image of aged care work, the low pay rates and the insecure hours of work:

*[we can only offer] insecure and random working hours…shifts are based on clients. Our staff have regular clients most of the time, but it only takes one, two or three of those clients to be in hospital, to be sick, to be away…then they won't do as many clients. It’s not too hard for me to give most of them 20 hours a fortnight but giving them 40…or 80 is impossible…there’s no way I can afford to pay them more than $22.70 an hour, even if I wanted to…(A)*

Other barriers include the difficulty inherent in attracting newly graduated and younger workers to a role more usually associated with mature and middle-aged women. The managers noted their need for a cross-section of age, experience and aptitudes to meet consumers’ needs:

*... with the younger worker…they've got the enthusiasm. They're physically able. They've got the fresh eyes. But sometimes they don't have some of the life experiences…of the… older workers -that can be anything from 40, 50, 60 - who can deal with situations that are thrown at them. Some [younger workers] can adapt really quickly, and others just might be thrown a whammy by it.* (C1)

The managers linked the retention of newly graduated workers to their preparedness for the role and capacity to adapt to working solo in consumers’ homes.

*…in the last three months we’ve had four staff that we have put through induction and training, kitted them out with uniforms,and then they’ve gone out one day on the job and said ‘no, I’m sorry, I can’t do this’.* (W1)

Community care work presents immediate challenges for new workers. Although they are usually ‘buddied’ with experienced workers for their first few shifts, thereafter they are rostered to work solo. Disappointment may ensue when new graduates anticipate a more clinical role. Although many consumers are quite frail and in need of personal care, observation and monitoring, the regular work is described as consisting of mostly domestic duties:

*…domestic assistance – shopping, meal prep, respite and some personal care thrown in. (W2)*

New workers may be daunted, even deterred, by the domestic environments that constitute their workplaces. Here, they may encounter cluttering, hoarding, carer stress, family tensions and abuse along with the consumer’s decline, poor hygiene, loneliness and despair. Workers may need support in the form of ongoing training as they learn how to manage and cope with the kinds of tasks they perform and the interpersonal challenges that accompany these:

*Workers need support to…to develop interpersonal skills to build a rapport with people who might not come from the same social background as they do. (W2)*

*It can be a bit of a shock to…go into someone’s home and assist them to shower and deal with their bedding…the bathroom and toilet that hasn’t been cleaned for a week or two…it’s pretty yucky work really* (W1)

Currently, the Services enjoy relative workforce adequacy and stability. The managers’ descriptions suggest that once newly employed workers ‘survive’ the initial challenges, they are likely to stay on. It also suggests that support in terms of mentoring, assisted skill acquisition and consolidation is essential if workers new to the field are to be retained. As more consumers receive funding for higher levels of care, the skill base of the available workforce becomes significant. While the current dimensions of direct care work involve mostly domestic assistance, shopping, respite and personal care, the scope of practice for these workers will need to expand; it is well noted that future cohorts of community-based consumers will require direct care and observation relative to conditions such as dementia and chronic diseases.

Regional opportunities for training are adequate at present. Entry level skills for the role are taught within locally provided vocational education courses such as the Certificate III (Individual Support). The managers reported that they enjoyed an effective relationship with training providers based in the nearest regional centre:

*We work with them quite closely…we will speak to them directly if we think something is being missed (T).*

Two of the more remotely situated managers have addressed training needs by providing courses at their own Service. The more distant Service has designed and runs its own approved training course. Such innovations maximise local recruitment potential, provide local employment and further the achievement of care goals through a sense of community care for community elders.

**Discussion**

The findings offer perspectives from two rurally based groups – consumers and service managers – who are key participants in the marketised environment of community aged care. Their experiences and views provide insights into the implications of this sector’s new directions within a defined rural area of Australia. The findings are limited by the relatively small number of consumers who participated in the study. Still, the findings are significant in terms of timeliness given:

* Mounting public concern in Australia about the standards of aged care across the sectors and the subsequent, current conduct of a Royal Commission into Aged Care;
* The growing demand for community-based aged care services;
* The lack of research into community aged care services within particular and rural localities; and
* The need for research into the impact of neo-liberal policies that have located community aged care within a marketised environment.

In Australia, public awareness of aged care services and the need for measures to ensure service adequacy and quality, has been heightened by recent, scandalous media reports and the current investigations undertaken within the Royal Commission into Aged Care. The issues raised imply failure to ensure appropriate levels of staffing and care, particularly within residential care settings. Concerns regarding the outcomes of community aged care arrangements as these relate to access to services, competition and consumer directed care have equally been expressed (Jorgensen and Haddock, 2018). Studies and discussion papers to date focus on community aged care service provision in remote parts of Australia and on consumers with special needs such as indigenous groups and members of the LGBTI community (Jorgensen and Haddock, 2018). Our findings highlight the need for a similar focus on rurally-based providers and consumers.

The shift to a marketised model for delivering community aged care has re-set the traditional, more paternalistic relationship between providers and consumers. Our findings reveal that the philosophy of CDC resonated positively with most of the managers, who viewed positively the loosening of traditional ideas about ‘what is best’ for the consumer. They also accepted that CDC broadened the role and responsibilities of workers and managers as they work with consumers to guide choices and tailor services. At the same time, the managers highlighted that an unreserved enactment of CDC was impeded by several factors. Their cautious views coincide with studies that suggest that many consumers may not have the capacity to determine care needs and buy appropriate services. The process of working through online information and bureaucratic processes may prove too difficult for many elders. Data collected by the Australian National Seniors showed that only 54% of over 800 people who had used My Aged Care were satisfied with the information they received (McCallum and Rees, 2017). Our results support the conclusion that the task of navigating the website and understanding the process and package entitlement is a barrier to enacting choice. This finding coincides with data that showed that 50% of Australians over the age of 65 do not regularly use the internet and 42 % over the age of 80 have never done so (Australian Communications and Media Authority, 2016). Furthermore, consumers who have a cognitive impairment are hampered in their efforts to comprehend and navigate the system and make the best choices for their care. Without assistance, potential consumers may give up on the process. Those who do so add to possible estimates of unmet demand (Department of Health, 2017).

Our findings indicate that consumers need and appreciate assistance to understand their choices and to exercise agency. From their position and experience, the managers saw the necessity to act as guides and advocates to ensure that consumers spend their funding on care items that support their capacity to live independently. Consumers are presented with an array of providers and costings and may be tempted to select lower cost items offered by remote providers. Poor and unguided choices may not squarely meet needs and support ongoing independent living. Poor choices may prioritise social support over more physical and clinical services. While it is recognised that social forms of care contribute to physical health, these may be unsuitable choices for some consumers: indeed, social support items are more likely to be chosen by consumers in funding systems such as CDC (Simons et al., 2016). Misguided choices are likely to hold negative consequences for the consumer as well to add to demands for institutional forms of health care when consumers’ health deteriorates.

Some costs and charges may not be apparent to consumers. As the consumers in this study pointed out, administrative costs may be higher than they anticipated. Their accounts resonate with other findings that suggest that, on average, administrative expenses passed on to consumers account for 40% of package expenditure (Belardi, 2017). Formal complaints regarding high administrative charges and other matters including lack of consultation and communication have risen in recent years (Aged Care Complaints Commissioner, 2017). In Australia, providers are not required to disclose their administrative fees on My Aged Care, and data enabling fee comparison between providers are not available (Jorgensen and Haddock, 2018). This opacity emphasises the need for consumer advocacy and guidance as they make choices about care provision.

For providers, administrative costs have increased along with the introduction of CDC (KPMG, 2015). This means that service provision and charges to consumers must be tailored to meet the ‘bottom line’ of individual organisations. In rural areas, the costs of delivering services grow as distance to consumers increases. Travel costs are therefore greater in rural areas but it seems from our data that this expense is offset by the advantages of choosing a local provider who is well-placed to provide ongoing assessment, clear communication, and familiar relationships with direct care workers. Notably, as the managers in this study describe, local providers draw from necessary interservice networks and collaboration to maximise resources and their capacity to care comprehensively for their consumers. Correspondingly, the consumers in our study reported high levels of satisfaction with the advice and care they received from their local providers.

A major cause of dissatisfaction for consumers and providers arises from the wait time for higher level packages to be activated. Consumers are placed in a queue, sometimes for a year or more. Our data coincides with statistics that reveal that some 27% of consumers in the queue were approved for home care packages more than 12 months previously (Department of Health, 2019). Interim services are likely to be inadequate for consumers’ needs unless their existing providers and other local services can top these up. At the end of 2017, 82,000 consumers were on the waiting list in this country (Department of Health, 2019). The implications of this wait time extend beyond consumers’ individual and local circumstances. Insufficient supportive services over a lengthy duration may reduce consumer’s capacity to stay at home: care demands will be re-directed to informal carers, acute health services and residential care (Jorgensen and Haddock, 2018).

A key aim of the market-based system of care provision is to enhance the quality and innovation of service delivery (Department of Social Services, 2015). However, national data indicate an increase in consumer complaints concerning lack of consultation by and communication with providers (Aged Care Complaints Commissioner, 2017). Available data relating to quality indicators and care outcomes are limited (Jorgensen and Haddock, 2018). Hence, consumers lack crucial information to guide their choice of provider and care items. This lack may be rectified once quality standards are imposed on providers in 2019 (Jorgensen and Haddock, 2018).

The need to monitor outcomes relates to quality in terms of workforce maintenance and the capacity of workers to service both the consumer and the concept of care itself. As the consumers in this study note, this element of care delivery, particularly as it is achieved via valued relationships with direct care workers, is central to satisfaction and perceptions of quality care (Day et al., 2017). However, sustaining this sector’s workforce is seen as a huge challenge as recruitment to direct care roles has diminished while care demands have increased over several decades. In this study, the consumers across the various rural localities are mostly in receipt of entry level, (CHSP) care packages. Some, of course, are queued awaiting higher level packages. All will need more and complex care as time goes on. Indeed, many of these consumers on low level packages are currently in need of more services than their present allocation provides (Leading Age Services Australia, 2017). The present and changing situation poses problems for the managers in this study who must redouble efforts to recruit and train new and committed direct care workers if they are to continue to provide quality care, compete with remote providers, and meet budget imperatives.

The achievement of a suitably skilled, sustainable workforce looms as one of the major challenges for rural areas. Australian rural towns are populated by increasing numbers of baby-boomers relative to younger cohorts. This demographic trend, along with the generally held view of aged care work as poorly remunerated, dead-end and gendered work, hold particular implications for recruitment and retention in rural areas. It also holds implications for the capacity of the sector to achieve policy aims for supporting elders to age in place and to reduce demands on tertiary health care services.

**Conclusion**

The findings presented here illustrate the challenges associated with accessing and providing care services in a rural and semi-remote part of Australia. Policy reforms that situate community aged care within a market-based, competitive environment have achieved equivocal outcomes in terms of the realisation of consumer choice and the receipt of timely, quality services. Indeed, given the complexity, wait times and lack of information around provider standards, this new environment, holds the potential to exacerbate inequalities for those who do not have the necessary knowledge, skills and abilities to navigate the process (Jorgensen and Haddock, 2018, Brennan et al., 2012). More broadly, when these difficulties result in lack of appropriate levels of service, demands on tertiary health services are likely to increase. For their part, service managers are required to adjust to a customer focus, set and achieve standards for quality care while meeting ‘bottom line’ imperatives and maintaining a suitably skilled workforce.

In this study, the issues associated with shrinking workforce pools and distance appear to be offset by the Services’ capacity to provide a wide range of services. The data from the managers’ interviews indicate that there exists a strong interface and working relationship with acute and primary care providers, and that this relationship functions to enable a holistic approach to care planning and to assist consumers to get the most out of their packages. This finding implies that rurally-based services, because of their location and necessary networks, are well-placed to achieve the ideals of care.

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