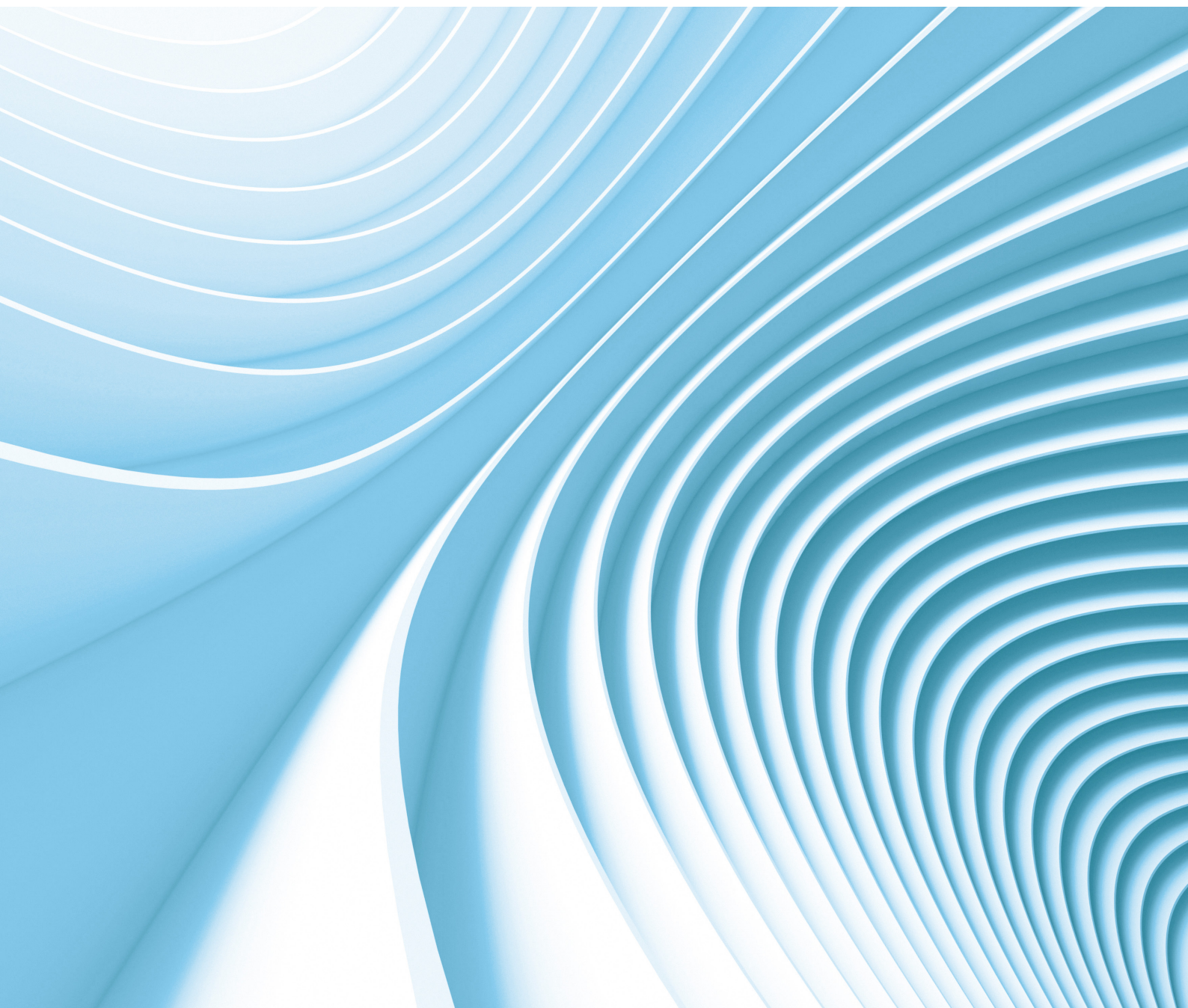




# **Aged care employment**

## Study report



**The Productivity Commission acknowledges the Traditional Owners of Country throughout Australia and their continuing connection to land, waters and community. We pay our respects to their Cultures, Country and Elders past and present.**

## **The Productivity Commission**

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The Commission's independence is underpinned by an Act of Parliament. Its processes and outputs are open to public scrutiny and are driven by concern for the wellbeing of the community as a whole.

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ISBN 978-1-74037-751-5 (online)

ISBN 978-1-74037-750-8 (print)

An appropriate reference for this publication is:

Productivity Commission, *Aged care employment*, Study Report, Canberra

Publication enquiries:

Media, Publications and Web | phone 03 9653 2244 | email [publications@pc.gov.au](mailto:publications@pc.gov.au)

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## Foreword

The aged care sector is at a critical juncture. The broad suite of reforms in train for the sector have the potential to make a meaningful difference to the quality of life of older Australians. Reforms that are related to addressing workforce challenges are an integral part of being able to deliver on this goal.

It is within this context that the Productivity Commission was asked to examine the relative merits of a policy that would require aged care providers to preference the 'direct' employment of aged care workers. This study examines the implications of such a policy for aged care consumers, workers and providers respectively.

In undertaking this study, the Commission has benefited from strong engagement from a wide range of stakeholders including consumer groups, aged care workers and their representatives, and aged care providers and other businesses involved in the sector. We particularly thank those who took the time to meet with us, provided written submissions and gave us access to unpublished data.

This study would not have been possible without the assistance of the Department of Health and Aged Care and the Aged Care Quality and Safety Commission.

We would also like to express our appreciation to Jane Melanie, who led the study, and the team: Meredith Baker, Peter Bon, Rachel Burgess, Angela Le, Shaun McMahon, Vivikth Narayanan, Anthony Shomos, George Steel and Danielle Venn; and to Jenny Price, Sarah Crawford and Karen Godfrey for administrative support.

Catherine de Fontenay  
Commissioner

Martin Stokie  
Commissioner

Paul Lindwall  
Commissioner

October 2022



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## Terms of reference

I, the Hon Josh Frydenberg MP, Treasurer, pursuant to Parts 2 and 4 of the *Productivity Commission Act 1998*, hereby request that the Productivity Commission (the Commission) undertake a Study to examine:

- employment models in aged care, and the effects that policies and procedures to preference the direct employment of aged care workers would have on the sector.

### Background

The Royal Commission into Aged Care Quality and Safety (the Royal Commission) was established on 8 October 2018 and the *Final Report: Care, Dignity and Respect* was released on 1 March 2021.

The Australian aged care system provides subsidised care and support to older people. It is a large and complex system that includes a range of programs and policies. In response to the Royal Commission there will be significant reform to the aged care system. These reforms will be underpinned by a new Aged Care Act, which is intended to commence from 1 July 2023, subject to parliamentary processes.

The Royal Commission noted a trend in recent years has been the increased use of ‘independent contractors’ in aged care.

The Royal Commission’s Final Report noted numerous submissions over the course of the Royal Commission inquiry had made the claim that quality care was more likely to be delivered by direct employees than by contractors. However, some stakeholders consider these subcontracting models deliver better consumer choice and flexibility, which is also desired by the sector.

### Scope of the inquiry

The Commission will undertake a study to examine employment models in aged care, and the effects that policies and procedures to preference the direct employment of aged care workers would have on the sector.

When examining these issues, the Commission should also consider recommendation 87, as well as submissions and evidence provided to, the Royal Commission.

In undertaking this Study, the Commission should:

- examine the extent of the aged care personal care and nursing workforce who are not directly employed by aged care providers
- taking into account the wide scope of duties within the aged care sector, ranging from low level care such as grocery shopping and gardening through to high level personal and medical care, examine how different employment arrangements might impact on:
  - quality of care
  - consumer choice
  - job creation and availability of workforce
  - employment conditions for the workforce
  - worker preferences

- flexible and innovative models of care
- accountability of aged care providers for care delivered on their behalf
- costs of providing care
- viability of aged care providers
- explore any preconditions in personal care and nursing workforce supply that would be required prior to any potential policies and procedures to preference direct employment
- consider whether new policies and procedures would impact other care sectors, such as disability and childcare.

The Commission should support analysis with modelling using quantitative and qualitative data.

## Process

The Commission should undertake broad consultation with consumers, the aged care workforce, unions and aged care providers.

The Commission could release a draft report in June 2022, and provide a final report to the Australian Government in September 2022.

**The Hon Josh Frydenberg MP**

Treasurer

[Received 23 February 2022]

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# Overview

## Key points

- \* **It is widely recognised that there are major problems in the quality of aged care, especially in residential aged care. There are many reasons for this, but there is little persuasive evidence that a policy to preference direct employment would improve outcomes. It could indeed worsen outcomes.**
- \* **Direct employment is already by far the most common mode of employment in the aged care sector.**
  - Agency workers and independent contractors account for less than 4 per cent of the care workforce (personal care workers, nurses and allied health workers).
  - The scope for any gains from a policy to preference direct employment therefore needs to be kept in perspective.
- \* **In the context of the chronic staff shortages facing the sector, a policy to restrict agency work is not a realistic option.**
  - Where agency workers are used by approved providers of residential and home care, it is typically as a last resort for filling short-term staffing gaps or vacancies that cannot be filled otherwise, particularly in remote areas where workforce pressures are most acute.
  - Independent contractors in residential care are used mainly for accessing specialist skills.
- \* **The use of independent contractors in home care — often through digital care platforms that connect workers directly with consumers — is growing from a very small base as more older Australians express a preference to self-manage their government-funded care package.**
  - This attests to the benefits derived by individual consumers (and their families) and individual workers who are choosing this form of work over more traditional employment.
- \* **Many older Australians highly value the choice and agency that this model provides, as well as the bespoke nature of the service offerings from platforms that cater for diverse needs.**
  - In many cases this is allowing them to fulfil an aspiration to stay in their own home for as long as possible.
- \* **Equally, many platform workers highly value the flexibility, autonomy and the potential for higher pay associated with independent contracting — all of which add to their job satisfaction and help keep them in the sector.**
- \* **Given these benefits, there is a role for platforms as part of the solution for the future of work in aged care.**
  - This model works particularly well for the delivery of lower-risk care services to older Australians who have the requisite abilities and support to exercise choice and control over their care.
- \* **Instead of focusing on employment models per se, the Government should expedite the suite of reforms to increase safety and quality that are currently planned or underway.**
  - These are likely to be more effective at managing the risks inherent in the delivery of aged care services, irrespective of employment models.
- \* **Issues that go beyond aged care, such as the protection of workers in the gig economy, are best addressed through an economy-wide lens.**

## 1. About this study

Quality aged care is critical to the wellbeing of older Australians, their families, and their communities. It is widely acknowledged that a quality aged care experience cannot be separated from the people who deliver that care.

The aged care workforce comprises close to 435 000 workers — mostly personal care workers and nurses. This workforce is already under significant pressure, with the COVID-19 pandemic imposing unprecedented costs and absences on the sector.

Many recent reviews have diagnosed a plethora of issues that have made the sector a comparatively unattractive and difficult place to work. The sector has struggled to attract and retain enough staff to keep pace with the demand for care and support services as the number of Australians aged over 65 years has continued to grow. The past few years have seen the expansion of home care in particular, as more older Australians choose to live at home for as long as feasible.

Based on the current trajectory, various projections point to an increase in this shortfall of care workers over the coming decades. This is a reflection of Australia's ageing population as well as reinforcing factors including changes in policy settings (such as increases in staffing ratios), increasing competition for workers in other care sectors (such as disability and mental health), and the declining propensity to provide informal care.<sup>1</sup> These forces may be compounded by constraints on funding by governments.

This study's main task is to *examine employment models in aged care, and the effects that policies and procedures to preference the direct employment of aged care workers would have on the sector*. The study stems from recommendation 87 of the Royal Commission into Aged Care Quality and Safety (the Royal Commission) that approved providers be required to preference direct employment of workers engaged to provide *personal care* and *nursing services*. The recommendation appears intended to assuage concerns that indirect employment could erode the quality of care, accountability for the care provided, and pay and conditions for workers.

In responding to the Royal Commission's final report in 2021, the previous Government determined that this recommendation required further examination.

While recommendation 87 referred explicitly to 'direct employment', this term (or 'indirect employment') is not used or defined in the *Fair Work Act 2009 (Cth)*. For the purposes of this study, the Productivity Commission has interpreted the term 'direct employment' to apply only to employees directly employed by aged care providers on a permanent, fixed term or casual basis. Under this definition, labour hire, independent contracting and platform work are all categorised as 'indirect employment'.

Likewise, what it means to have a policy 'to preference' direct employment is not specified. In practical terms, it could entail a mandated upper limit on the share of indirect employment for approved providers and other businesses operating in the sector.

In undertaking this study, the Commission has taken into account the broad suite of reforms to Australia's aged care system that are currently planned or underway. Of note is the planned Aged Care Act, which will establish the purpose of government-funded aged care as: ensuring that older Australians have a universal right to high-quality, safe and timely care and support.




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<sup>1</sup> In addition to this study, the Commission has been tasked with an inquiry to examine support for informal carers of older Australians.

Within this broader context, the study has sought to identify the main pros and cons of indirect employment, importantly from the perspectives of older Australians, but also from the perspectives of aged care workers and businesses (figure 1 summarises the key issues considered in the report).

In doing so, the Commission has strived to go beyond anecdotal evidence. However, data limitations have made it difficult to undertake a systematic examination of the relationship between employment models and outcomes in aged care. This has led the Commission to consult widely and place a large onus on stakeholders to demonstrate the feasibility and relative merits of a policy to preference direct employment.

**Figure 1 – Preferring direct employment: key considerations**

Consumers	Workers	Businesses
 <p><i>Recipients of government-subsidised residential or home care</i></p> <p>Key dimensions of impact on consumers:</p> <ul style="list-style-type: none"> <li>• quality and continuity of care</li> <li>• cost of care</li> <li>• choice of providers and services</li> <li>• control over delivery of care</li> <li>• accountability and oversight over care.</li> </ul>	 <p><i>Nurses and personal care workers, including employees and independent contractors</i></p> <p>Key dimensions of impact on workers:</p> <ul style="list-style-type: none"> <li>• job security, flexibility and autonomy</li> <li>• wages and working conditions</li> <li>• payment of superannuation, tax and workers compensation</li> <li>• training and skill development</li> <li>• workplace health and safety.</li> </ul>	 <p><i>Approved providers of residential and home care, labour hire agencies and platforms</i></p> <p>Key dimensions of impact on businesses:</p> <ul style="list-style-type: none"> <li>• costs of engaging workers</li> <li>• flexibility in sourcing workers</li> <li>• ability to cover absences or short-term staffing needs</li> <li>• ability to meet consumer demand</li> <li>• accountability and oversight for care, and workplace health and safety.</li> </ul>

## 2. Indirect employment in aged care

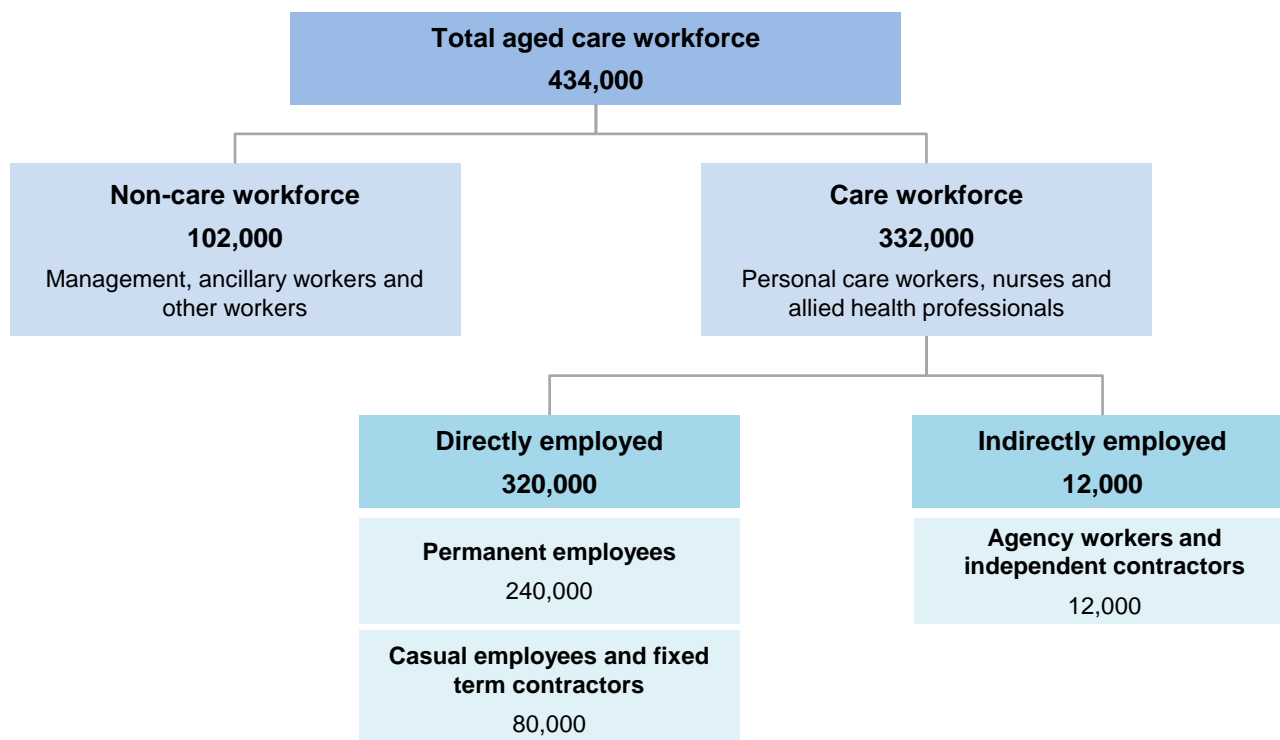
The data available to the Commission suggest that, by and large, aged care providers and workers already have a preference for direct employment, with over 96 per cent of the care workforce (personal care workers, nurses and allied health workers) directly engaged as permanent employees (mostly part-time), casual employees or fixed term contractors (figure 2a). It is therefore hard to see how further preferencing direct employment will improve care outcomes for older Australians or the employment outcomes for this significant cohort of the care workforce. It also implies that, for such a policy to be binding, it would essentially need to involve a prohibition on the use of indirect employment.

Agency workers and independent contractors — about 4 per cent of the care workforce — mainly work in residential care, and most are allied health workers with specialist skills (such as physiotherapists and dental hygienists) (figure 2b).

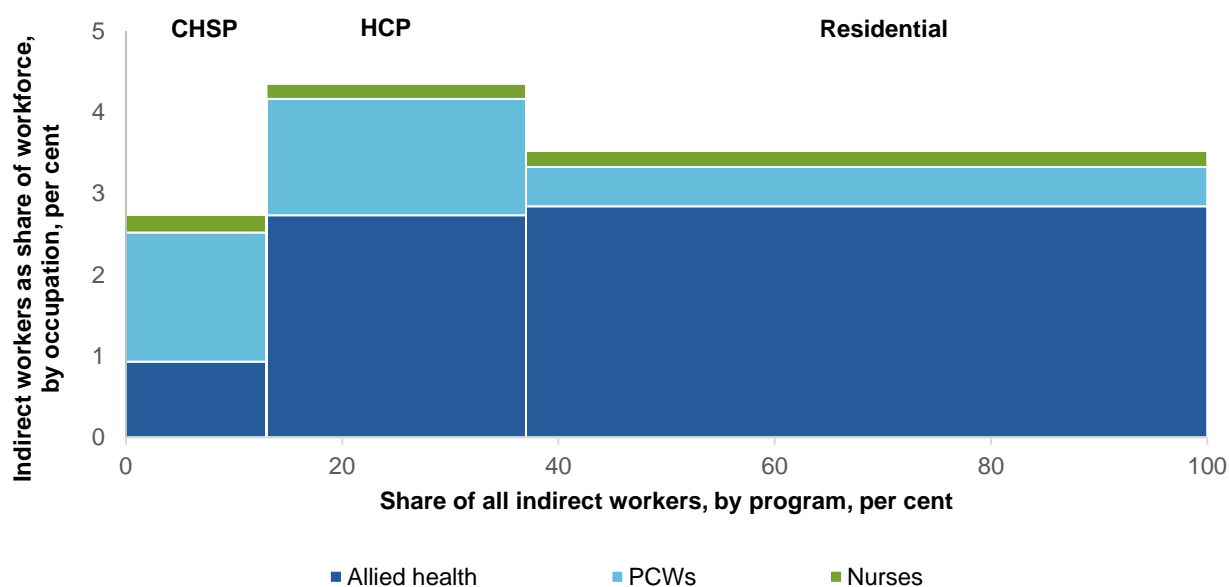
Even though agency workers and independent contractors make up a small share of the workforce, they play a well-established and important role in the delivery of aged care services. Agency workers are often used to cover short-term staff absences and fill vacancies, particularly in residential care. The view that aged care facilities cannot operate without the flexibility afforded by agency work is widely held amongst stakeholders.

**Figure 2 – The share of indirect employment is small<sup>a</sup>**

a) Number of workers in the aged care sector, by worker and employment type, 2020



b) Composition of indirectly employed care workers by occupation and program, 2020



a. CHSP is the Commonwealth Home Support Program and HCP is the Home Care Packages Program. PCW stands for personal care worker.

Agency workers are also particularly beneficial in regional and remote areas where the demand for care services is dispersed and workers may be difficult to source locally.

Given that it is not feasible to proscribe the use of agency workers and independent contractors in residential care, this study has focused primarily on independent contractors in home care. Of the 1.4 million people receiving government-subsidised aged care, the majority (76 per cent) live at home and receive either entry-level care through the Commonwealth Home Support Program (CHSP) or structured home care through the Home Care Packages (HCP) Program.

Various data sources suggest that the use of agency staff and independent contractors in home care is similarly small and relatively more common in the provision of non-care services, such as gardening, home maintenance and cooking.

Building on the approach in the disability services sector, the advent of self-managed home care has encouraged the entry of digital care platforms. While the exact number of platforms currently operating in aged care is not clear, these platforms make their services available to the 6 per cent of HCP consumers that self-manage.<sup>2</sup> Platforms can also service aged care providers, though this is less common.

There is partial evidence to suggest that platforms for care services are becoming more popular, attesting to their value to consumers. One high-profile platform in the disability and aged care sector has reported an increasing worker base. In aged care, these platforms are particularly appealing to older Australians living at home and choosing to self-manage their care needs. While platforms currently make up a small share of the market, their coverage is likely to grow with greater consumer awareness and a growing demand for home care.

### **3. Consumer perspectives**

A policy to preference direct employment would reduce the care options for older Australians who are seeking to self-manage their care needs at home. Independent contracting through platforms works particularly well for older people with lower care needs and good cognitive abilities, some level of digital literacy, and ideally some family or community support.

With growing demand for aged care services, greater diversity among care recipients, and a greater aspiration for independent living and individualised care, the delivery of home care is not and should not be one-size-fits-all. Consumer groups expressed a strong preference for an aged care system that offers older Australians choice and control over their care. They saw individual agency as a critical dimension of care quality and wellbeing, particularly when safeguarded by proportionate quality assurance.

While there is broad consensus that relationships and continuity of care matter in aged care, there is less agreement that these can only be achieved through direct employment, at least in home care. Indirect employment, such as work facilitated via platforms, has a lot to offer to consumers who choose to self-manage their home care.

Continuity of care can be achieved through long-lasting relationships built on rapport between the care recipient and the care worker, as well as through access to a more diverse workforce that is better able to meet the needs and preferences of people with different life experiences, personal characteristics and identities. Meeting these diverse needs is more challenging with prescriptive models of service provision.

It can also be achieved through community-led solutions that draw on local residents as independent contractors, particularly in regional and remote settings where traditional home care providers may not have the scale to be viable.

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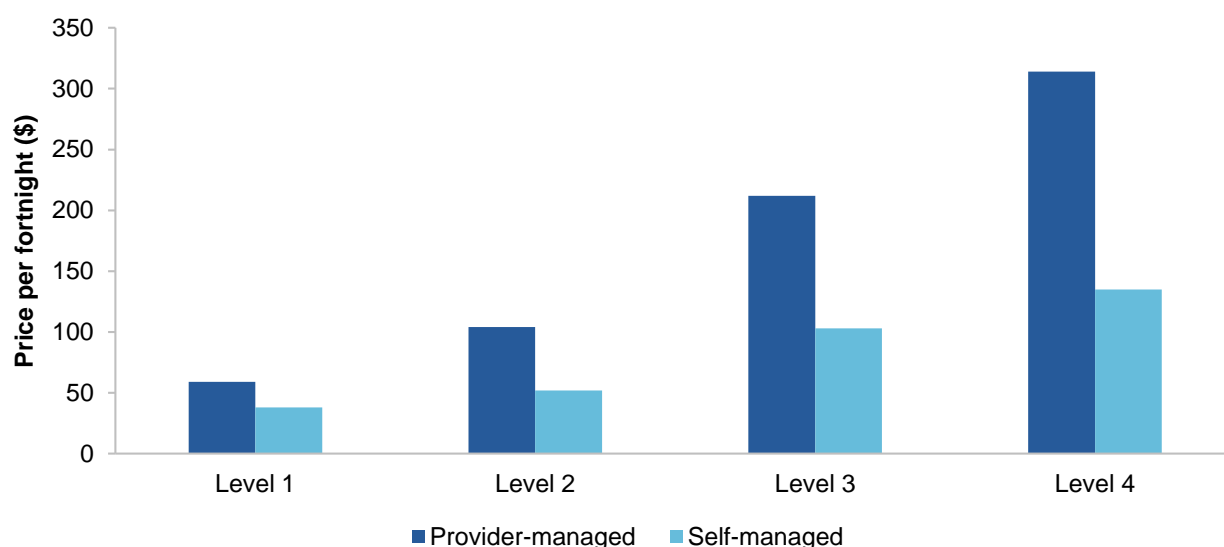
<sup>2</sup> The Commission is aware of at least six platforms engaged in the subsidised home care market: Care.com, Careseekers, Findacarer.com, Five Good Friends, Like Family and Mable.

Maintaining connections with the community more generally is important to many older Australians who value a sense of belonging. These include Aboriginal and Torres Strait Islander people with strong ties to their community and for whom quality care is one that also needs to be culturally appropriate. It is also relevant to other cohorts of older Australians with specific needs such as those who identify with a particular LGBTI status or have a culturally and linguistically diverse background.

Another motivation leading consumers to self-manage their home care and engage workers directly through platforms is to get more care hours out of their care budget. Across all home care package levels, the median fortnightly price of care management is significantly higher in fully provider-managed packages relative to self-managed arrangements (figure 3). This means that a fixed home care budget can go further in terms of obtaining more hours of care. As such, any policy that makes self-management harder would come at a cost to those seeking to get the most out of their limited care budget while being able to make decisions about their own care.

**Figure 3 – Self-managing a Home Care Package costs less<sup>a</sup>**

**Price per fortnight for care management at each HCP level, 30 June 2022**



a. Providers are responsible for care coordination services, and typically charge care management fees for this service to consumers. Where a consumer chooses to self-manage, the provider is still responsible for the oversight of any services delivered and continues to undertake a range of activities to meet this responsibility. As such, care management fees are still charged to self-managing consumers, albeit at a lower level compared with provider-managed consumers.

## 4. Worker perspectives

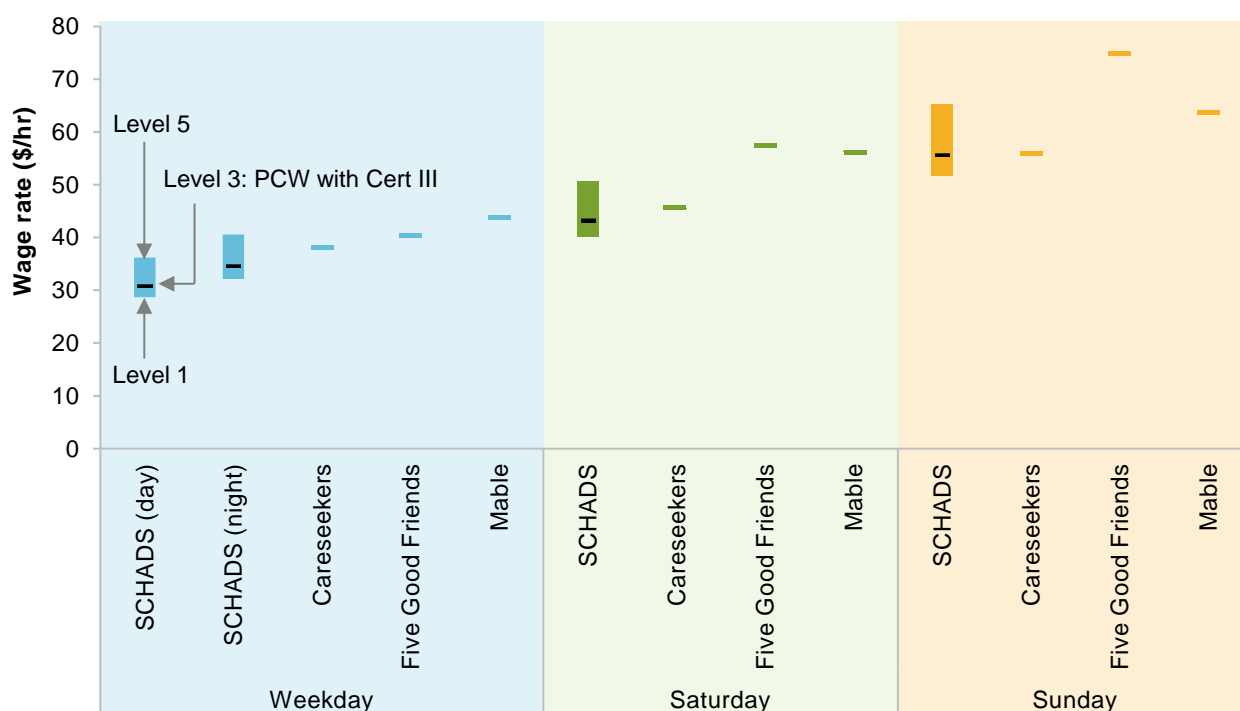
Only a small fraction of workers in aged care choose to work as independent contractors. A policy to preference or effectively mandate direct employment would most likely have negative implications for these workers. It might reduce the income earned by these workers, and even cause some to leave the sector.

There are many conjectures about the relative pay rates of directly employed staff and independent contractors. Data made available to the Commission suggest that the average rates paid to workers are typically higher than award minimum rates, at least for weekday and Saturday work (figure 4).

This pattern is also evident in the distribution of wage rates across all workers. For example, data from Mable (a major platform servicing both the aged care and disability sectors) reveal that the bulk of independent

contractors using its platform received levels of remuneration above the minimum SCHADS (Social, Community, Home Care and Disability Services) Industry Award rate for a casual employee (\$28.68 per hour, or \$31.69 inclusive of superannuation). In July 2022, 98 per cent of personal care workers who operate via the Mable platform received \$30 or more per hour net of platform fees, and 74 per cent received \$40 or more per hour net of platform fees during the week.

**Figure 4 – Most independent contractors are paid above the minimum award wage rate<sup>a,b</sup>**  
**Hourly pay rates for home care workers, July 2022**



**a.** Rates of pay under the SCHADS Award for casual employees, adjusted for penalty rates for shift and weekend work. Caution should be used when comparing actual pay rates (platforms) versus the SCHADS Award, as some employees might get paid more than the Award rate. The SCHADS Award pay rates also do not include allowances, or the 10.5 per cent employer superannuation contribution, which all adult casual employees are entitled to. SCHADS range is for home care workers from level 1 (entry level) to level 5 (care manager). Level 3 (black lines) represents the rate for personal care workers with Certificate III. **b.** All platform wage rates are net of fees. Platform rates are not comparable with each other. Mable rates are for 'personal care workers' in aged care and disability support who have at least a Certificate III or two years demonstrable work experience. Careseekers rate is for aged care workers only. The Five Good Friends rate is their *recommended* default rate for aged and disability care workers. Default rates might be different to actual average pay rates.

Moreover, given the shortages of workers in aged care, any independent contractor could choose to work as a direct employee. The fact that they do not suggests that their wages or some non-pecuniary benefits are important factors in their employment choices. In relation to the latter, work flexibility to fit around family commitments and lifestyle, independence and task diversity have been found to be important determinants of job satisfaction among aged care workers generally, and crucial for attracting and retaining workers in the sector. For many independent contractors engaged on digital care platforms, the ability to choose the customers they work for also adds to a sense of purpose and job satisfaction.

A policy to preference direct employment would make independent contractors who work in aged care worse off. It is therefore likely that such a policy would lead some workers to seek opportunities elsewhere, for instance in the disability support sector where there is no policy to preference direct employment.



There is indeed some evidence that independent contracting appeals to a group of workers who might otherwise not work in the sector. A recent survey of workers operating through the Mable platform found that 50 per cent were new to the care sector while 21 per cent indicated that they would not continue providing care and support services if they had to do so as an employee of a care organisation.

In a sector where worker attrition is already relatively high — with 75 per cent considering leaving the aged care sector within five years according to a recent survey — a policy to preference direct employment can be expected to exacerbate this situation. Such a policy would also not necessarily prove fruitful in improving conditions for aged care workers, whether directly employed or not, as it may simply lead to some workers leaving the sector, thus exacerbating staff shortages and the associated stress for all workers.

## 5. Business perspectives

As highlighted earlier, aged care providers generally prefer to keep service delivery in-house by directly employing most of their personal care workers and nurses. Akin to other service delivery areas, residential care providers use labour hire agencies sparingly, essentially to backfill staffing gaps (although staffing gaps have grown during the COVID-19 pandemic). Home care providers also use personal care workers and nurses who operate as independent contractors to supplement their workforce. While it is generally more costly for providers to use independent contractors than their own staff, contractors may be more cost-effective for care involving non-standard hours, substantial travel time and home visits of a short duration.

Digital care platforms provide one way for both providers and self-managed home care recipients to source independent contractors. Most platforms currently servicing the aged care sector fall into the 'indirect employment' category. They operate as intermediaries that solely facilitate the matching of independent contractors with providers or self-managed consumers.

A policy to preference direct employment would not only reduce the available labour pool in the sector, it would reduce the flexibility that providers have to manage intermittent and variable demand for care on a day-to-day basis.

Care needs can change quickly resulting in a sudden need for more intensive care or the transition of a client with very high care needs into residential care. In addition to using part-time and casual staff, independent contractors can give providers a flexible and cost-effective way to temporarily boost their capacity to address these fluctuations in service demand.

Access to independent contractors allows providers to meet bespoke service needs. Older people have diverse and evolving care needs. In many cases it is not viable for providers to directly employ workers with the full range of skills and backgrounds that consumers may require at different points in time and in different locations. An important justification for using independent contractors is to be able to source workers with specialised skills that are only needed for a small number of service hours across a consumer base – a case in point is that 37 per cent of allied health workers in the aged care sector are agency workers/independent contractors. This is applicable not only in regional and remote areas with fewer and/or more widely dispersed consumers, but also in metropolitan areas where access to specialists is costly.

In a similar vein, independent contractors allow providers to service markets where they do not have an established presence. There is at least one example of a registered provider, Country Home Services, which relies exclusively on independent contractors to service its consumer bases in regional and remote South Australia. The case study of the town of Bell is another example. Residents of the small Queensland town had little access to home care services as significant travel time limited the ability of non-local providers to service the town with their own staff. By partnering with the digital care platform Mable, Trilogy Care was able to engage local residents as independent contractors and support them in delivering home care services to the town.

In these contexts, a policy to preference direct employment could result in providers ceasing to service certain consumers and/or locations.

There is no doubt that the presence of independent contractors creates greater contestability for service quality and value. The platform model is challenging the status quo by giving older Australians more options in terms of care worker engagement, service offerings and pricing. In a sector that has traditionally underinvested in innovation and productivity-enhancing measures, the emergence of new business models has the potential to spur new approaches and incentivise improved service quality and value.

There is scope to do more in terms of enabling technology. The Commission heard from several providers about their investment in solutions to provide the service delivery flexibility that consumers increasingly expect (such as Montefiore's recent implementation of a digital workforce management system to automate rostering), but the use of technology across the sector as a whole is inconsistent and fragmented.

## **6. The way forward**

Having taken into account stakeholder views and considered the available evidence, the Commission's overall assessment is that adopting a policy to further preference direct employment would be adverse to the interests of older Australians, workers and providers, particularly under current tight labour market conditions.

A focus on indirect employment also comes with a high risk of distracting from the more important challenges facing the sector.

Rather than mandating a preference for direct employment, the Government should expedite the broader aged care reform agenda, including those reforms that will attract and retain workers to the sector, better screen aged care workers, promote choice of home care options for older Australians, allow for improved oversight of home care services and workers, and ensure better protections and support for all workers including independent contractors in aged care.

These reforms are better targeted at managing the risks inherent in the delivery of aged care services regardless of the employment model.

The reforms range from a new Aged Care Act to a fundamental re-think of the regulatory framework to better align regulation with the proportionality of risk and better-quality indicators to measure performance and help inform consumers.

Given that the quality and safety of care essentially comes down to the care provided by an individual personal care worker or nurse, a risk-based approach to regulation should encompass individual workers, as well as providers. The new code of conduct for aged care workers, which came into effect in August 2022, will extend regulatory oversight to the individual worker (including independent contractors), as well as to the aged care provider. Further, the planned worker registration system can also be expected to provide additional reinforcement to the protection of aged care consumers.

Ultimately, confidence in the effectiveness of regulation is contingent on the effectiveness of the regulator. A sufficiently empowered and resourced regulator should be the central party responsible for evaluating and managing risk. The reforms recommended, planned or underway to improve the Aged Care Quality and Safety Commission (ACQSC) are among the most important to safeguard aged care quality and safety. The Government has recently announced a capability review of the ACQSC, which will inform the design of a new 'revitalised' regulator.

Done well, these reforms would provide the necessary safeguards without undermining the ability of older Australians to take reasonably controlled risks to maximise their quality of life.

## Findings and recommendation

### The use of indirect employment in aged care is already limited



#### Finding 2.1

**Most aged care consumers live at home and mainly receive domestic assistance and social support**

Of the approximately 1.4 million older Australians who receive some form of government-subsidised aged care, more than 75 per cent live at home and receive either entry-level care through the Commonwealth Home Support Program (CHSP) or structured home-based care through the Home Care Packages (HCP) Program. The bulk of home care service hours provided to consumers are for domestic assistance and social support. Clinical (allied health and nursing) and personal care services account for a fifth of CHSP hours and less than a third of HCP hours.



#### Finding 2.2

**Part-time employment is the norm for most care workers**

Although about three quarters of care workers are permanently employed, there are higher than average rates of part-time work (often with minimal guaranteed hours) in aged care compared with the overall health care and social assistance industry and the broader economy. The rate of casual employment is also higher than the average across the health care and social assistance industry and the broader economy.



#### Finding 2.3

**Notwithstanding data limitations, the share of indirect employment in aged care is estimated to be small**

Indirect employment through agency workers and independent contractors makes up a small share of the care workforce — less than 4 per cent. This share has remained relatively unchanged over the past five years. Most agency workers and independent contractors work in residential care, and most are allied health professionals.



#### **Finding 2.4**

#### **Providers rely on the flexibility, specialised skills and additional capacity that agency workers and independent contractors provide**

The use of labour hire agencies is a well-established practice in aged care. Agency workers are commonly used to address short-term absences and labour shortages, particularly in residential care. Aged care providers use independent contractors most frequently to obtain specialist skills. Some aged care facilities could not operate viably without the flexibility afforded by agency work and independent contractors.



#### **Finding 2.5**

#### **Digital care platforms are likely to grow with the rise in home care**

While digital care platforms in Australia are more established in the disability sector, these are also emerging in aged care primarily to service older Australians living at home and choosing to self-manage their care needs. Notwithstanding some variation across business models, platforms essentially connect consumers in need of care directly with personal care workers and nurses. While platforms currently make up a small share of the market, their coverage is likely to grow.

## **Restricting indirect employment would be a retrograde step for older Australians**



#### **Finding 3**

#### **A policy that preferences direct employment would leave self-managing consumers worse off**

Indirect employment models (such as those used by digital care platforms) offer several benefits to self-managing consumers, and these models work particularly well for older people with good cognitive abilities, lower support needs and some level of digital literacy and family/community support.

There appears to be a perceived lack of understanding or awareness by consumers that engage independent contractors that the provider (rather than the platform) is accountable for the safety and quality of care. However, robust complaints management policies, combined with ratings and reviews systems, help mitigate risks to consumers and provide an incentive for platform workers to deliver quality care.

A policy preferencing direct employment would lead to worse outcomes for those consumers who value choice and control over how their care is delivered. While the proportion of consumers engaging independent contractors is currently small, for them, such a restriction would:

- restrict consumer choice, autonomy, and control
- reduce access to personal care workers and nurses, particularly in regional and remote areas, and during worker shortages
- reduce access to a pool of workers who are better able to meet the diverse needs of consumers
- increase the cost of care and result in fewer hours of care for a given budget
- dampen the development of innovative services tailored to diverse consumer needs.

## Aged care workers value the option to work as independent contractors



### Finding 4

**Independent contractors can earn more than the award wage and preferencing direct employment would reduce workers' options**

Independent contracting offers workers a degree of autonomy and control over when, where and how they work. There is no evidence that workers are being 'forced' to engage as independent contractors in nursing and personal care jobs.

Independent contractors trade off sick leave, superannuation, training and insurance. However, most contractors engaged by consumers via digital platforms have rates of remuneration that are higher than award rates of pay and, in some cases, by a considerable margin. With widespread vacancies in the sector, independent contractors who are not satisfied with their earnings or conditions are likely to be able to find alternative work through more traditional employment arrangements.

From a worker perspective, preferencing direct employment would:

- reduce options and opportunities for some workers to engage in work that suits them
- limit opportunities for workers on low wages and/or hours to supplement their income.

In the current tight labour market, restricting indirect employment would also exacerbate labour shortages.

## Providers need the flexibility that indirect employment provides



### Finding 5

**A policy to preference direct employment could undermine the provision of consumer directed care**

Nurses and personal care workers who operate as independent contractors are a small but important part of the home care market. It is generally more cost effective for providers to employ their personal care and nursing staff. However, independent contractors may provide a lower cost labour source to deliver care that involves non-standard hours, substantial travel time and/or a short visit.

While providers are responsible for the quality and safety of care delivered on their behalf, there is concern that some have inadequate oversight of independent contractors, particularly where they are engaged by self-managed consumers. However, it is not evident that preferencing direct employment would improve this. Overall, restricting the use of independent contractors would:

- constrain providers' flexibility to manage day-to-day fluctuations in demand and service diverse consumer needs
- reduce the size and capability of the workforce
- weaken market incentives to improve service quality and value.

## The focus should be on expediting the broad reform agenda



### Finding 6

#### A risk-based approach to regulation

Older Australians highly value the ability to make decisions about how their care needs are met. The principles underpinning the proposed new regulatory framework for aged care (released by the Department of Health in February 2022) are promising because they focus attention on addressing risks, in a proportionate way, while not unduly restricting older Australians' options for care.



### Recommendation

#### A policy to preference direct employment would be detrimental

The Australian Government should not introduce a policy to preference direct employment in aged care as it would reduce choice and options for care for older Australians, and at the same time, limit the options for care workers who value self-employment and flexible work arrangements. Worse, it could — given the current tight labour market — lead to a smaller aged care workforce, to the detriment of care outcomes.

The Australian Government should instead expedite the broad reform agenda for aged care to enhance quality and manage any specific risks from indirect employment through a risk-proportionate regulatory framework. In doing so, it should ensure that the development of quality standards and indicators for home care are not unduly delayed.

# 1. About this study

## 1.1 Background to the study

Aged care services are vital to the quality of life of many older Australians. Community and home care services help older Australians to maintain their independence and stay in their homes, while residential services provide ongoing support and care to those with higher needs.

Demand for aged care services is expected to continue to increase as Australia's population ages. The 2021 Intergenerational Report forecasts that, by 2060-61, over one in five (23 per cent) of the population will be aged 65 years and over, with one in 20 (5 per cent) aged 85 years and over (Treasury 2021, p. 29). Australians are also living longer, which increases the complexity of the care that they need.

Meeting the care needs of older people requires a large and skilled workforce. In 2021, 1.4 million Australians received some form of government-funded aged care from 434 000 aged care workers. While the aged care workforce has grown rapidly in recent years, it has been unable to keep pace with demand. This has resulted in providers struggling to find staff and long waiting times for some services. As of 2020, there were an estimated 22 000 vacancies for caring roles across the sector, including for personal care workers, nurses and allied health professionals (DoH 2021a, p. 7). Shortages are particularly acute in regional and remote areas (Australian Association of Gerontology and Regional, Rural and Remote Special Interest Group 2019, p. 3). The Grattan Institute estimates that, by 2024-25, an additional 58 000 home care staff will be required to meet the planned growth in Home Care Packages alone (Duckett and Swerissen 2021, p. 3).

Attracting and retaining enough workers with the right skills in the locations where they are needed is a critical challenge for the sector. Recent reviews have highlighted a range of issues that make aged care a comparatively unattractive and difficult sector to work in (Aged Care Workforce Strategy Taskforce 2018; DoH 2021a; Senate Community Affairs References Committee 2017). These include poor working conditions such as low pay and inconsistent working hours, as well as a lack of opportunities for skill development and career progression. These factors have contributed to low job satisfaction, high turnover and unfavourable perceptions of the sector. The COVID-19 pandemic exacerbated these issues by placing additional pressures on existing workers and cutting off the supply of migrant workers (CEDA 2022, pp. 5, 10).

At the same time, a significant share of approved providers who deliver government-funded aged care services are financially stressed. Sutton et. al (2022, p. 9) reported that in the first-half of 2021-22 more than 60 per cent of residential aged care providers recorded an operating loss, while average home care operating margins had declined from a relatively low base.

By and large, approved providers prefer to deliver care services by using workers who they directly employ. But providers also engage workers through intermediaries such as labour hire agencies, or as independent contractors. Given widespread staff shortages, these 'indirect' workers are usually contracted to backfill staff absences and vacancies but also undertake more specialised roles. More recently, the entry of digital platform-based businesses has provided a way for home care consumers to find and engage their own care workers. This has opened a new avenue for care workers to be engaged as independent contractors.

## The Royal Commission and recommendation 87

The Royal Commission into Aged Care Quality and Safety (the Royal Commission) was established in October 2018 to investigate problems in the aged care system and the quality of residential and in-home care services. Its final report concluded there were ‘fundamental systemic flaws with the way the Australian aged care system is designed and governed’ and made a raft of recommendations to reform the sector.

The aged care workforce was a principal area of focus throughout the inquiry. The Commissioners characterised the workforce as undervalued, and argued that ‘inadequate staffing levels, skill mix and training are principal causes of substandard care in the current system’ (Royal Commission into Aged Care Quality and Safety 2021a, p. 76). The Royal Commission’s final report contained several recommendations intended to improve the sector’s workforce capability (box 1.1).

### Box 1.1 – Recommendations of the Royal Commission about the aged care system

The Royal Commission into Aged Care Quality and Safety was established in October 2018 amidst concerns triggered by reports of abuse and substandard care affecting older people in aged care homes.

In its February 2021 final report, the Royal Commission made 148 recommendations for reform across the sector. While many of the recommendations were jointly agreed, Commissioners Pagone and Briggs made a range of separate recommendations or parts of recommendations.

Some of these major recommendations included:

- a new Aged Care Act that provides a new definition of aged care and outlines the rights of older people to receive support that puts their needs and preferences first
- new governance arrangements for the aged care system (though the two Commissioners proposed different models to achieve this)
- replacing multiple existing aged care programs with a new program with common national settings that aims to simplify the complexity of the current system
- a variety of funding measures, including a new funding model that provides an entitlement to care at home via government subsidies.

Specific recommendations to address issues with the aged care workforce included:

- a National Registration Scheme for personal care workers that features ongoing training requirements and English language proficiency requirements for the personal care workforce (recommendation 77)
- making a Certificate III the minimum qualification required for personal care workers performing paid work in aged care (recommendation 78)
- dementia and palliative care training for workers (recommendation 80)
- increases in award wages and improved remuneration for aged care employees (recommendations 84 and 85)
- three mandatory minimum staff time standards for residential care (recommendation 86).

The Royal Commission also recommended that the proposed new Aged Care Act include a non-delegable duty that providers of subsidised aged care services provide safe and high-quality services and that their personal care and nursing staff have the experience, qualifications, skills and training to perform the work that they are being asked to perform (recommendation 14).



### Box 1.1 – Recommendations of the Royal Commission about the aged care system

In May 2021, the previous Australian Government accepted, or accepted-in-principle, 126 of the 148 recommendations. It also committed to a five-year aged care reform plan, with a new Aged Care Act intended to commence on 1 July 2023.

Sources: DoH (2021c); Royal Commission into Aged Care Quality and Safety (2021c).

This study is focused on one of these recommendations (recommendation 87), which called for approved aged care providers to be required to preference the direct employment of nurses and personal care workers (box 1.2). Recommendation 87 (made by Commissioner Briggs alone) was intended to address a reported increase in the use of independent contractors and workers sourced through digital platforms. The Royal Commission was concerned that such alternative modes of employment were inconsistent with the objectives of developing a skilled and sustainable workforce and ensuring high-quality care. Specifically, it identified that *indirect employment* could:

- *Impede the quality of care* by inhibiting continuity and care coordination and limiting investment in training and skill-development. Views expressed in submissions and hearings also suggested that ‘monitoring and checking the quality of care ... is far simpler when employing staff directly’ (Royal Commission into Aged Care Quality and Safety 2021c, p. 428).
- *Obscure employment-related accountabilities*. As most platforms act only as intermediaries between care workers operating as independent contractors and consumers who engage them, there is potential for uncertainty regarding who holds primary responsibility for occupational safety. It was observed that some models of worker engagement might place employment-related responsibilities on an older person (Royal Commission into Aged Care Quality and Safety 2021c, p. 431).
- *Erode pay and conditions*. Independent contractors bear the cost of covering leave, tax and superannuation contributions, and are not entitled to the other benefits and protections typically granted under Australian employment regulation. Some witnesses suggested that a move to greater reliance on independent contractors in aged care could erode pay and working conditions in the sector (Royal Commission into Aged Care Quality and Safety 2021c, pp. 429–430).

Overall, Commissioner Briggs regarded ‘direct employment’ as the best model to achieve the wider workforce reforms proposed and avoid a ‘fractured, disparate and ill-supported workforce’ (Royal Commission into Aged Care Quality and Safety 2021c, p. 432). Commissioner Pagone was sympathetic to this view, although he believed that high-quality care could best be enforced through a statutory non-delegable general duty included in the proposed new Aged Care Act that would apply to approved care providers regardless of their mode of engagement (recommendation 14).

To reach its findings on the risks of different modes of employment, the Royal Commission drew on a volume of written submissions and expert testimony. However, there was a lack of granular data on the prevalence of indirect employment in the aged care sector and limited evidence establishing a clear causal link between indirect employment and the concerns identified.

The previous Government responded to the Royal Commission’s final report in 2021 and accepted most of the workforce recommendations, excluding those proposing increases in award wages and mandatory minimum qualifications. It determined that recommendation 87 required further examination.

### **Box 1.2 – Recommendation 87 of the Royal Commission**

#### **Recommendation 87: Employment status and related labour standards as enforceable standards**

1. By 1 January 2022, the Australian Government should require as an ongoing condition of holding an approval to provide aged care services that:
  - a) approved providers: have policies and procedures that preference the direct employment of workers engaged to provide personal care and nursing services on their behalf
  - b) where personal care or nursing work is contracted to another entity, that entity has policies and procedures that preference direct employment of workers for work performed under that contract.
2. From 1 January 2022, quality reviews conducted by the Quality Regulator must include assessing compliance with those policies and procedures and record the extent of use of independent contractors.

Source: Royal Commission into Aged Care Quality and Safety (2021c, p. 265).

## **1.2 What has the Commission been asked to do?**

Against this backdrop, the Productivity Commission has been asked to undertake a study to examine employment models in aged care, and the effects that policies and procedures to preference the direct employment of aged care workers would have on the sector.

Specifically, the terms of reference for this study ask the Commission to:

- examine the extent of the aged care personal care and nursing workforce who are not directly employed by aged care providers
- examine how different employment arrangements might impact on:
  - quality of care
  - consumer choice
  - job creation and availability of the workforce
  - employment conditions for the workforce
  - worker preferences
  - flexible and innovative models of care
  - accountability of aged care providers for care delivered on their behalf.
- explore any preconditions in personal care and nursing workforce supply that would be required prior to any potential policies and procedures to preference direct employment
- consider whether new policies and procedures would impact other care sectors, such as disability and childcare.

The full terms of reference are available at the front of this report.

### **Employment arrangements in aged care**

Recommendation 87 refers explicitly to 'direct employment'. However, this term is not used or defined in the *Fair Work Act 2009* (Cth) (FWA) and is not commonly used in industrial relations discussions in Australia (box 1.3). Workers in the aged care sector are engaged through a variety of employment arrangements (figure 1.1).

In this study, direct employment is defined as arrangements where a worker is employed by an approved aged care provider as a permanent employee (either full-time or part-time), or on a casual or fixed-term contract. Approved providers must comply with the *Aged Care Act 1997* (Cth) and its associated Aged Care Principles, and are regulated by the Aged Care Quality and Safety Commission.

### Box 1.3 – Common types of employment in Australia

The *Fair Work Act 2009* (Cth) (FWA) and the Fair Work Regulations 2009 govern employee and employer relationships in Australia. The FWA maintains a clear division between employees and self-employed independent contractors.

Employees work for an employer, who pays their wages, salary and other benefits and withholds tax on their behalf. Employers can direct employees when, what and how to do their work. There are a range of contract types for employees.<sup>a</sup>

- **Permanent employees** are employed on an ongoing basis. They can be employed on a full-time (typically for 38 hours per week) or part-time basis (with a regular pattern of work typically averaging less than 38 hours per week). Permanent employees can have their employment terminated in certain circumstances, including for poor performance, misconduct or redundancy. In the case of redundancy, they are entitled to a notice period and redundancy pay.
- **Fixed-term employees** are employed for a specific period or to complete a specific task. They can work full-time or part-time hours. They are generally entitled to the same wages and conditions of work as permanent employees, except that they have no expectation of ongoing work beyond the end of their contracted period.
- **Casual employees** do not have firm advance commitment of ongoing work or an agreed pattern of work (although many casual employees work similar hours each week). Most casual employees do not receive paid leave but are typically paid a casual loading on top of their hourly rate. Casual employees can work full-time or part-time hours. Casual employees are not typically entitled to notice of termination or to redundancy pay.

**Labour hire workers** (also known as on-hire or agency workers) are employed by an agency and outsourced to a host employer for a fixed period or to complete a specific task. Workers are paid by the agency, and the host employer pays the agency a fee for the services provided. Labour hire workers can be engaged as employees or independent contractors of the agency.

**Independent contractors** (also known as contractors or subcontractors) provide an agreed service to another person or business and do not have an expectation of ongoing work. They usually negotiate their own working arrangements and fees with the person or business. Independent contractors usually:

- have an Australian Business Number and submit invoices for payment to the employer
- can work for more than one employer at the same time
- use their own tools or equipment
- can choose to perform the work themselves or subcontract it to someone else
- have a high level of control over when, where and how they perform work
- bear the financial risk for making a profit or loss for each contract, as well as the costs of covering leave, tax and superannuation.

### Box 1.3 – Common types of employment in Australia

Under the FWA, employees are covered by the National Employment Standards, which set out 11 minimum entitlements including maximum weekly hours, flexible working arrangements, annual leave and other forms of leave, termination notices and redundancy pay. The standards apply to all employees, including those covered by an award, enterprise agreement or employment contract as well as casual employees for certain entitlements.

The *Independent Contractors Act 2006* (Cth) establishes the right of contractors to enter into and set the terms of service agreements. Independent contractors are not covered by the National Employment Standards, however the FWA does provide protection from adverse action, coercion and abuse of freedom of association. It provides some limited protection against ‘unfair’ contracts (chapter 5).

It is illegal for employers to engage in ‘sham contracting’, where workers who are really employees are told they are independent contractors and not given their full entitlements. Courts have considered a range of factors (including those listed above) when deciding whether workers are employees or independent contractors.

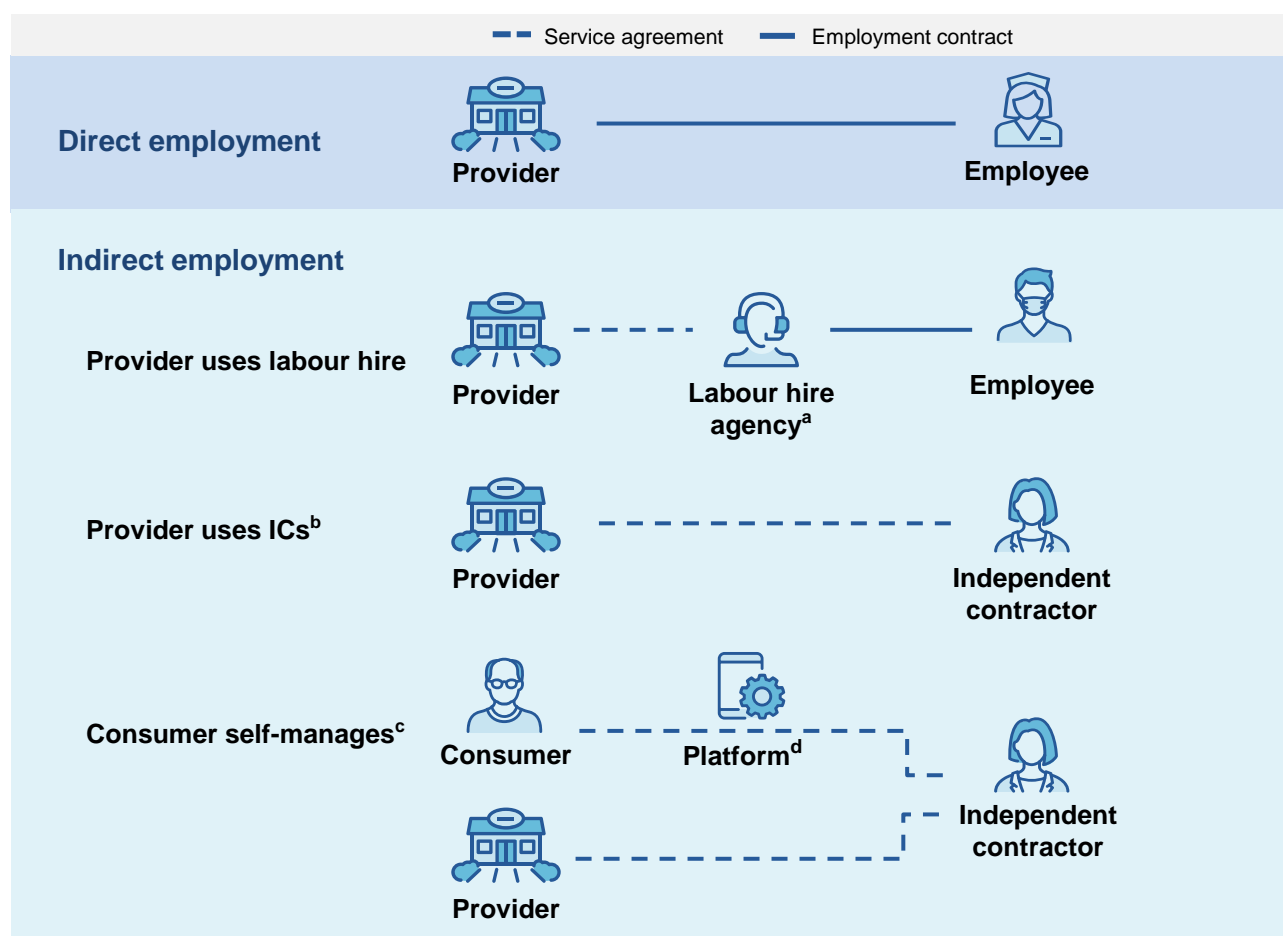
a. Other less common contract types apply to employees employed as apprentices, trainees, daily or weekly hire workers (in the building, construction and plumbing industries) and outworkers.

Sources: Australian Government (2021b); Fair Work Ombudsman (FWO 2021).

A standard form of indirect employment is for labour hire agencies to employ workers who are then hired out to aged care providers. Workers can also be engaged as independent contractors, either by aged care providers or labour hire agencies or by individual consumers who are self-managing their home care services. As described above, digital platforms that operate as intermediaries provide one way for workers to connect with consumers (and in some cases to home care providers).<sup>3</sup> But under current funding arrangements, a provider is still required to oversee and approve payment from a self-managed consumer’s government allocated funding for services delivered by platform workers (unless a platform is itself an approved provider).

These different forms of employment arrangements have important implications for the rights and protections afforded to workers and the responsibilities borne by the worker and employer. Under the FWA, employees are guaranteed minimum entitlements and are covered by awards that specify employment conditions such as minimum hourly pay, allowances and hours of work. In contrast, independent contractors negotiate their own rates of pay and working arrangements and are not guaranteed award rates or entitlements such as paid leave and superannuation. Independent contractors must also maintain their own public liability and personal accident insurance, which are typically less generous than the worker compensation schemes that cover direct employees.

<sup>3</sup> Rather than acting as an intermediary, some platforms employ workers as casual employees, however, there are no known examples of this model in the aged care sector.

**Figure 1.1 – Aged care workers can be employed through a variety of arrangements**

**a.** Labour hire agencies can also engage workers as independent contractors instead of employees, but this is uncommon. **b.** Providers may also source independent contractors through platforms and broker workers from other providers. **c.** Refers to consumers who self-manage their allocated Home Care Package. Self-managed consumers can also engage independent contractors by themselves. **d.** Platforms may also directly employ workers, however there are no known examples that service self-managed aged care consumers.

### The focus of this study

This study broadly considers the indirect employment arrangements of approved providers of residential and home-based aged care, the labour hire agencies that service them and where consumers engage their own care workers. Consistent with recommendation 87, this study focuses on the employment of personal care workers and nurses in aged care. However, other types of workers can also be indirectly employed, including allied health professionals and ancillary workers (such as cooks, cleaners, and transport and maintenance workers).

The scope of this study encompasses the workforce that delivers the subset of aged care services that are subsidised and regulated by government. It excludes privately funded services that are accessed by older people (and the workers who provide them).

The primary task of this study is to examine the extent and impacts of indirect employment in aged care. The terms of reference also ask the Commission to explore any necessary preconditions to requiring employers to preference direct employment. The Commission has interpreted this consideration as contingent on first establishing that a policy to preference direct employment is warranted and desirable.

## Intersections with broader aged care reforms and other cross-cutting issues

This study takes place as a host of significant reforms are being planned and enacted across the aged care sector — to increase staffing ratios, expand training requirements, improve pre-employment screening, and require nurses to be onsite in residential care at all times. These changes alone will involve a significant structural adjustment to the workforce and are due to be implemented within the next three years.

Other reforms have the potential to increase the use of independent contractors. A new aged care program and funding model will expand access to home care and give consumers greater capacity and flexibility to self-manage their care. This includes allowing consumers to engage multiple service providers (box 1.4). To support this approach, the Department of Health and Aged Care is designing a new regulatory framework based on a risk-proportionate model that would allow individuals to register as providers (DoH 2022b).

### Box 1.4 – Support at Home: a new home care program

The Support at Home Program is proposed to commence in July 2024 to replace the existing Commonwealth Home Support Program, Home Care Packages Program and Short-Term Restorative Care Program.

While the details of the program have not been finalised, the Department of Health (2022e) released a proposed design in January 2022. Key elements of the proposed program include:

- Consumers would receive individual support plans that specify the services they are eligible for and the frequency and duration they can receive them. The plans will be based on an independent assessment of a recipient's care needs and personal circumstances.
- Funding would be allocated according to individual support plans. This is a change from the existing system which groups consumers with different care needs into discrete funding tiers
- A service list detailing the providers that supply each service and a price schedule would determine the price of each service. The Independent Hospital and Aged Care Pricing Authority would set prices to reflect the efficient cost of delivering services.
- Consumers would receive access to funding as needed for assessed goods, equipment, assistive technologies, and home modifications, rather than needing to save up package funds or apply for grant funding.
- There would be greater support for older Australians to self-manage their care, including the ability to use multiple aged care providers and a new payments platform to pay for services at the point of delivery.

Following consultation with key stakeholders, the Department of Health and Aged Care (formerly the Department of Health) is refining the proposed model in response to key areas of feedback, including:

- the need for more flexibility to address the changing needs of older Australians
- consideration of supplementary grants funding to support services with high overhead costs (such as community transport and cottage respite)
- the need for a more responsive care management model.

Funding for the existing Home Care Package Program is limited by a population-based quota system. While the proposed design for the Support at Home Program does not rule out a cap, the previous government accepted-in-principle the Royal Commission's recommendation 41 to provide for 'demand-driven' access to aged care in accordance with assessed needs.

### **Box 1.4 – Support at Home: a new home care program**

Overall, the new program aims to help older Australians to preserve and restore capacity for independent living, stay at home for as long as possible before transitioning to residential care and enable consumer choice through increased self-management of home care funding.

Sources: DHAC (pers. comm., 19 September 2022); DoH (2021c); DoH (2022e).

The operation of digital platforms and independent contractors is also a live issue in other care sectors and workplace relations policy more broadly. In disability care, a high take-up of self-managed plans and the ability of National Disability Insurance Scheme participants to engage unregistered providers has allowed platforms to become quickly established but also raised questions about the potential risks to workers and participants (appendix B). There have been a number of recent reviews and reports examining on-demand platform work (IRV 2020; Senate Select Committee on Job Security 2021a). Workplace relations issues relating to the 'gig' economy are also being considered by the Commission's Productivity inquiry (PC 2022a). These issues were also discussed at the Jobs and Skills Summit in September 2022 (Australian Government 2022, p. 6) and are expected to be addressed in a forthcoming employment white paper (Treasury 2022, pp. 4–5).

It is not within the scope of this study to make policy recommendations on the status of platform workers. However, the regulation of employment arrangements involving platforms in aged care could have knock-on effects in other industries. As such, an understanding of the current concerns and ambiguities provides important context.

In addition to this study, the Commission has been tasked with undertaking an inquiry in response to the Royal Commission's recommendations to improve support for informal (unpaid) carers of older Australians. The Carer Leave inquiry will examine the potential impacts of amending the National Employment Standards to provide informal carers with an entitlement to extended unpaid leave (PC 2022b). As well as concern for the wellbeing of carers, the Royal Commission suggested that this policy could help further support older people to remain at home and relieve some of the burden on the formal workforce.

## **1.3 The Commission's approach**

### **What is the role of government?**

A standard to preference direct employment in aged care is a specific policy measure intended to broadly support high-quality care and a strong workforce. As a starting point, it is useful to clarify the possible rationales for this form of government intervention.

A principal reason for government involvement in aged care is to ensure equitable access to affordable aged care services at a standard that is in line with community expectations (PC 2011, p. 75). The Royal Commission considered that the purpose of the government-funded aged care system is to ensure that older Australians have a universal right to high-quality, safe and timely care and support (Royal Commission into Aged Care Quality and Safety 2021a, p. 2). Furthermore, it said the government should administer the system according to two fundamental principles:

- to ensure the safety, health and wellbeing of people receiving aged care; and
- to put older people first so that their preferences and needs drive the delivery of care. (Royal Commission into Aged Care Quality and Safety 2021a, p. 33)



The Productivity Commission outlined a similar sentiment in its *Caring for Older Australians* inquiry: the aged care system should seek to ensure that all older Australians needing care and support have timely access to appropriate person-centred services that can change as their needs change (PC 2011, p. 80).

In an ideal scenario, older Australians would be able to make well-informed choices to access the services they need from a range of providers with competing offerings. In reality, left to itself the aged care sector is unlikely to produce such an efficient outcome. There are several inherent features of aged care that can require intervention:

- *Information gaps.* Older Australians and their families may not be well-placed to assess the quality of the services they are engaging. An older person may not have the expertise to know whether a practitioner is following clinical guidelines or if a provider is adhering to its advertised model of care. Moreover, it may be difficult to gauge the relational quality of care prior to commencing with a service and whether the service meets an older person's personal preferences and needs.
- *Search and switching costs.* Imperfect information may deter older people from exiting a service they are dissatisfied with if they're not confident an alternative will be better. Finding another provider takes time and resources and may be particularly difficult for older people who do not have family and friends or other informal carers to assist them. People may also delay or be dissuaded from changing providers if it has the potential to disrupt their care, particularly if there are long wait lists.
- *Thin markets.* Aged care providers may struggle to operate profitably in areas with low demand, such as regional and remote locations. Similarly, providers may find it too costly to provide services that cater for older people with high or specific needs. In these instances, consumers are likely to have no or few providers to choose between, dampening market incentives. Moreover, the failure of a sole provider in a thin market could put the welfare of the older people who use its services at risk.
- *Risk of harm and exploitation.* Regrettably, as highlighted by the Royal Commission, substandard care and abuse is not uncommon in aged care. Those who are socially isolated or have cognitive impairments that prevent them from expressing their wishes can be particularly vulnerable. While older people should have the right to direct their care, this must be supported by regulatory approach with appropriate safeguards. (PC 2011, pp. 75–76).

There may also be a role for government in regulating aspects of the labour market. In general, labour market policies aim to balance adequate protections for workers against efficient matching and allocation to jobs.

Labour markets can be characterised by information asymmetries and power imbalances. Workers are not always well informed about the nature of the different employment arrangements they enter into and can be misled by employers (box 1.3). In contexts where employers command significant market power, employees may feel compelled to accept unfavourable arrangements.

But regulating the types of employment models that businesses can use could also have negative effects. Individuals have different preferences for work arrangements; some will value the certainty of minimum conditions and award wages while others will prefer the control over their schedule offered by contract work. Importantly, a diversity of arrangements may allow people to participate in the workforce whose needs or circumstances may not otherwise be accommodated by traditional forms of employment (PC 2016). Similarly, non-traditional employment arrangements can give employers the flexibility to adapt their business models to operate in small/niche markets or better meet the needs of consumers. Where they help to reduce labour costs the benefits may also be passed on to consumers through lower prices.




Another potential concern is that labour market regulations in one industry can have effects that spill over into others. And while the short-term effects of an intervention on certain groups may be evident, its long-term effects can be larger, more dispersed, and difficult to quantify.



## The Commission's framework

As required by its Act, the Commission's approach to this study has been to examine how the regulation of employment standards in aged care might affect the welfare of the community overall. Accordingly, this study considers the substantive pros and cons of a policy to preference direct employment (figure 1.2) and how it would affect the relative interests of consumers receiving government-funded aged care services, workers and businesses that service the sector.

**Figure 1.2 – Preferring direct employment: key considerations**

Consumers	Workers	Businesses
 <p><i>Recipients of government-subsidised residential or home care</i></p> <p>Key dimensions of impact on consumers:</p> <ul style="list-style-type: none"> <li>• quality and continuity of care</li> <li>• cost of care</li> <li>• choice of providers and services</li> <li>• control over delivery of care</li> <li>• accountability and oversight over care.</li> </ul>	 <p><i>Nurses and personal care workers, including employees and independent contractors</i></p> <p>Key dimensions of impact on workers:</p> <ul style="list-style-type: none"> <li>• job security, flexibility and autonomy</li> <li>• wages and working conditions</li> <li>• payment of superannuation, tax and workers compensation</li> <li>• training and skill development</li> <li>• workplace health and safety.</li> </ul>	 <p><i>Approved providers of residential and home care, labour hire agencies and platforms</i></p> <p>Key dimensions of impact on businesses:</p> <ul style="list-style-type: none"> <li>• costs of engaging workers</li> <li>• flexibility in sourcing workers</li> <li>• ability to cover absences or short-term staffing needs</li> <li>• ability to meet consumer demand</li> <li>• accountability and oversight for care, and workplace health and safety.</li> </ul>

In the context of the substantive reforms that are currently underway or planned, the study has considered the extent to which this specific policy would:

- improve care quality
- improve conditions for workers
- affect the ability of the aged care sector to accommodate the diverse needs and preferences of consumers and workers, and different market conditions
- affect the performance of aged care providers and businesses operating in the sector
- have any negative unintended consequences
- have implications for the ongoing wider reforms to the aged care system
- have implications for the care economy more generally.

In light of significant data limitations (see below), judgements in assessing and balancing the pros and cons for each interest group have been informed by extensive input from workplace relations experts, regulators and wide consultations with representative stakeholders.

Consistent with the Commission's previous work (PC 2011), this study upholds that older Australians should have choice and control over the services they engage and that individual agency is a critical dimension of care quality and wellbeing. At the same time, the aged care system must provide adequate protection from the risks of mistreatment and substandard and/or inadequate care. This is reflected by the risk-proportionate approach proposed for the new regulatory model for the system (DoH 2022b).

Accordingly, this study considers the various contexts where indirect employment arrangements are used in aged care and focuses on where its potential risks are highest. Employment arrangements involving labour hire agencies are not a key focus. This reflects feedback from study participants that agency work is a well-established and necessary part of service delivery in residential care settings (given current circumstances). A similar approach applies to independent contractors engaged by residential care providers who are by and large allied health professionals (as distinct from personal care workers and nurses – the focus of the terms of reference). Instead, this study concentrates on examining the use of independent contractors in home care, particularly where they are engaged directly by consumers through digital care platforms.

As well as weighing up the effectiveness of preferencing direct employment, this study considers how else the risks associated with indirect employment could be mitigated either as part of, or in addition to, the broader reforms that are currently underway.

### **Data availability**

A paucity of data and high-quality evidence has made it difficult to estimate the extent and nature of indirect employment in the aged care sector.

The National Aged Care Workforce Census provides the most comprehensive source of information. The census is conducted every four years by the Department of Health and Aged Care, with the most recent undertaken in 2020. While the census provides a snapshot of the overall rate of indirect employment, it does not disaggregate labour hire workers from independent contractors by different types of roles. Moreover, the COVID-19 pandemic impacted data collection for the 2020 census affecting its reliability and comparability to previous years (appendix C).

Given these limitations, the Commission has drawn on alternative data sources, including the ABS Characteristics of Employment Survey and bespoke datasets provided by the commercial accounting firm StewartBrown and the Aged Care Quality and Safety Commission.

Despite significant effort, the Productivity Commission has been unable to source or compile the data needed to conduct a robust quantitative analysis of the effects of indirect employment on relevant outcome measures. Furthermore, the Commission is not aware of any studies that establish a causal relationship between the use of independent contractors and quality of care in an Australian setting (chapter 3).

### **Conduct of this study**

The Commission received the terms of reference for this study on 23 February 2022. An issues paper outlining the scope of the study and the key matters and questions the Commission was seeking information on was released on 22 March 2022.

The Commission received 50 written submissions and 37 brief comments from a range of interested parties, including: older Australians and their representative organisations, approved providers and industry peak bodies, digital platforms, unions, self-employed workers, health and aged care professionals and researchers. To further inform its understanding, the Commission also met virtually with a broad cross-section of interested parties, including relevant government agencies and the Aged Care Quality and Safety Commission.

To seek guidance and feedback on its interim findings, the Commission held three roundtables between 26 and 28 July 2022, with stakeholders representing aged care employers and digital platforms, workers and consumers.

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The Commission appreciates and wishes to thank the individuals and organisations who have contributed to this study (appendix A). Each submission was carefully considered, and the information provided by all participants has greatly benefited this study.

## **A guide to this report**

The remainder of this report proceeds as follows.

Chapter 2 provides a brief overview of the use and delivery of government-funded aged care services and examines the extent to which they are delivered using indirect employment arrangements.

Chapter 3 assesses the pros and cons of indirect employment from the perspective of consumers and considers the available evidence on the relationship between employment models and quality of care.

Chapter 4 considers the effects of indirect employment on workers, including employees and independent contractors. It analyses whether workers voluntarily enter indirect employment arrangements and assesses the pros and cons of doing so.

Chapter 5 examines the pros and cons of engaging independent contractors for businesses operating in the aged care sector, with a focus on home care providers and digital platforms.

Chapter 6 concludes by weighing the findings of the preceding chapters to come to the Commission's recommendation and discusses a way forward to managing the key risks for consumers and workers.



## 2. Setting the scene

### Key points

- \* About 1.4 million people receive government-subsidised aged care. The majority live at home and receive either entry-level care through the Commonwealth Home Support Program (825 000 persons) or structured home care through the Home Care Packages Program (237 000 persons). A significant proportion receive care in residential facilities (311 000).
  - These services are primarily delivered through approved providers, who are bound by the *Aged Care Act 1997 (Cth)* and the Aged Care Quality Standards.
- \* There were about 434 000 aged care workers in 2020 delivering residential care, the Home Care Packages and Commonwealth Home Support Program. Three quarters of this workforce provide care services, including personal care workers (58 per cent), nurses (14 per cent) and allied health workers (5 per cent).
- \* Only a small share of personal care workers, nurses and allied health workers are indirectly employed as independent contractors or agency staff — estimated at 3.5 per cent.
  - The majority of these indirectly employed care workers work in residential care (63 per cent) and most are allied health professionals (70 per cent).
- \* Agency workers play an important and well-established role in the aged care workforce, particularly for residential care providers. They help to cover short-term absences and fill vacancies.
- \* Independent contractors are most commonly used by providers to source specialist skills. However, they are also engaged by home care providers to increase their capacity and flexibility to respond to consumer needs.
- \* Digital care platforms have entered the aged care sector in response to the introduction of consumer self-managed Home Care Packages. Most operate as intermediaries that allow consumers to find and engage care workers directly.

This chapter examines the extent of indirect employment in the delivery of aged care services. Section 2.1 provides an overview of the government-funded aged care services used by older Australians, the providers that deliver these services, and the composition of the aged care workforce. Section 2.2 examines the use of indirect employment by residential and home care providers and considers the different roles of labour hire agencies and independent contractors. Section 2.3 concludes with a brief description of digital care platforms and their operation in the aged care sector.

## 2.1 A snapshot of the aged care sector

### Consumers of government-subsidised aged care

Of the 4.3 million Australians aged over 65 years, about 1.4 million<sup>4</sup> receive some form of government-subsidised aged care (SCRGSP 2022).<sup>5</sup> These ‘consumers’ of aged care services have a diversity of preferences and care needs that are shaped by their individual life experiences and personal characteristics (chapter 3). Their needs also evolve over time and tend to become more complex with age (SCRGSP 2022).

The evolution of care needs is broadly reflected in the structure of government-funded aged care services (box 2.1). Generally, residential care is offered to people with the highest care needs, and home care services for people with relatively less complex needs.

#### Box 2.1 – Government-funded aged care programs

There are currently three main government-funded aged care programs: residential care, the Home Care Packages (HCP) program and the Commonwealth Home Support Program (CHSP). Other government-funded aged care programs include the Veterans’ Home Care program, flexible care programs and dementia support programs.

To access government-funded aged care programs, a consumer typically first checks their eligibility with My Aged Care (the Government’s entry point to all aged care services), which will then direct them to a suitable needs assessment service.

**Residential care** is for older people who are unable to live independently at home and have higher level care needs than can be provided at home. Residential care includes accommodation, personal care 24-hours a day and access to nursing and general health services. Residential care is provided on a permanent or temporary (respite) basis.

**Home Care Packages** are intended to help older people live independently and safely at home by providing a coordinated mix of ongoing services. These services are delivered through a care plan that a HCP provider develops and agrees to with an older person. There are four levels of HCPs that are assigned according to an individual’s needs and provide different amounts of funding ranging from around \$9000 per year for basic care (level 1) to \$53 000 per year for high care needs (level 4). A package budget consists of contributions from the Government (subsidies and supplements, if eligible) and the recipient’s contributions (fees that they may be asked to pay which vary between providers). Care plans must be reviewed by the provider at least once a year.

Like the HCP Program, the **Commonwealth Home Support Program** helps older people live at home. It is an entry-level program; services offered are similar to those that can be accessed through the HCP Program, though the CHSP offers less flexibility as recipients can only choose from a set catalogue of services. The CHSP is designed for people with less complex care needs who only require one or two

<sup>4</sup> This number is based on the sum of consumers in permanent and respite residential care, levels 1-2 and levels 3-4 Home Care Packages, the Commonwealth Home Support Program and Transition Care over the 2020-21 financial year. Refer to appendix C for more detail.

<sup>5</sup> Most, but not all, consumers of aged care services are aged over 65 years. Aboriginal and Torres Strait Islander people are eligible for government funded aged care services from age 50.

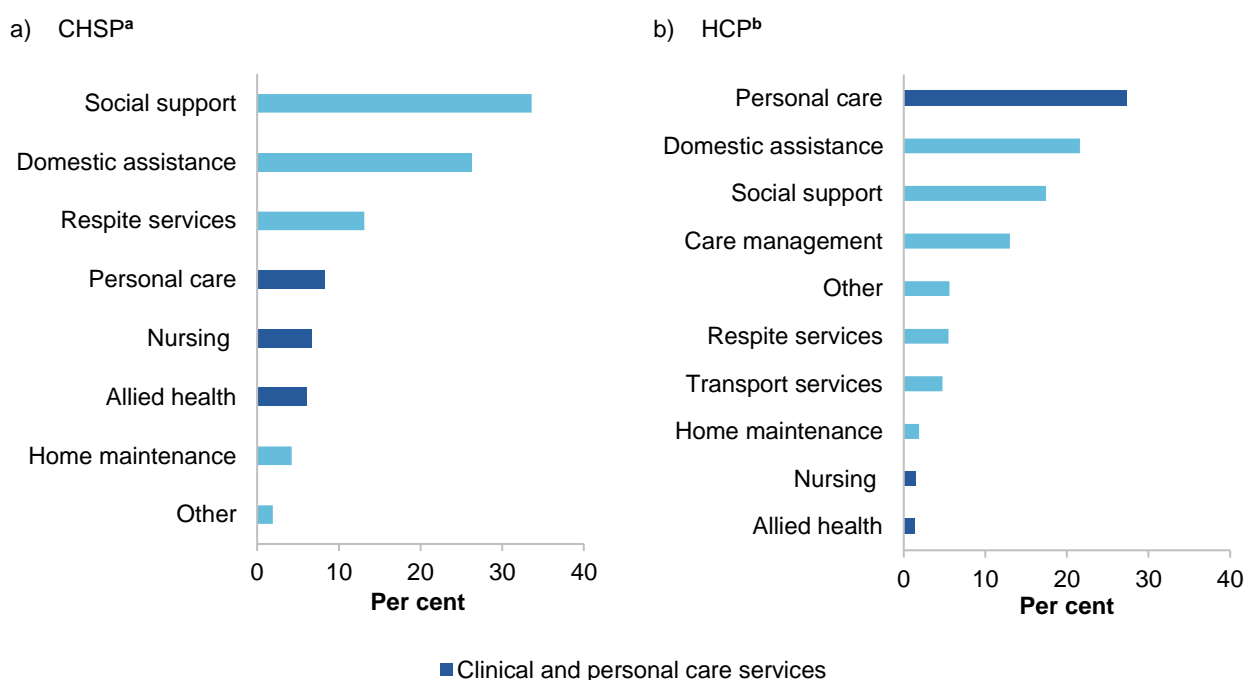
### Box 2.1 – Government-funded aged care programs

services. Similar to the HCP Program, CHSP services are subsidised, and consumers are required to have a support plan (though this is developed with a trained assessor from My Aged Care rather than the CHSP provider). CHSP providers are required to review clients' services at least once a year. Unlike the HCP Program, CHSP consumers can choose multiple CHSP providers for different services. However, this is dependent on service availability in particular areas.

Sources: DoH (2021e, 2022a).

Home care services include the provision of clinical (nursing and allied health) and personal care services, and other support services (such as social support and home maintenance). Reflecting their higher care needs, Home Care Packages (HCP) consumers receive higher levels of clinical and personal care services than Commonwealth Home Support Program (CHSP) consumers. In 2018-19, clinical and personal care services accounted for an estimated 30 per cent of HCP service hours but only 21 per cent of CHSP service hours (figure 2.1).

**Figure 2.1 – HCP consumers use more personal care services than CHSP consumers**  
**Estimated share of total hours delivered, by service, 2018–2019**



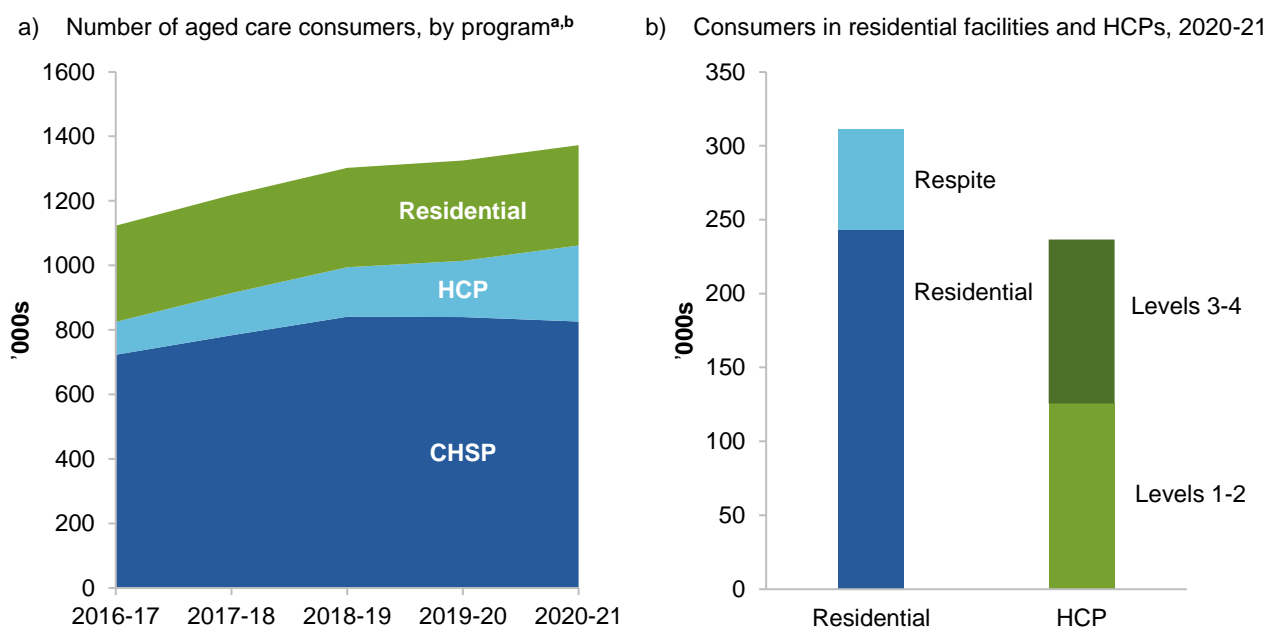
**a.** Based on analysis from Deloitte Access Economics of the number of hours delivered across the entire CHSP in the 2018-19 financial year. Service categories have been aggregated and/or renamed for comparability. 'Social support' refers to group and individual social support. 'Allied health' includes therapy services. 'Other' refers to assistance with care and housing, other food services and specialised support services. **b.** Based on a survey of 416 HCP providers, and the number of hours delivered per package per fortnight, averaged across all HCP levels. Service categories have been aggregated and/or renamed for comparability. 'Nursing' refers to enrolled, registered and other licensed nursing services. 'Home maintenance' refers to light gardening. 'Social support' includes shopping services and community access. 'Domestic assistance' refers to cleaning and household tasks.

Sources: Deloitte Access Economics (2020, p. 23); DoH (DoH 2020c, p. 43).

The CHSP is the largest of the three services by number of consumers (figure 2.2a). In 2020-21, there were more than 825 000 CHSP recipients, with the average consumer in 2020-21 receiving \$3000 worth of services.<sup>6</sup> By comparison, over that same period there were 237 000 HCP consumers, with an average service value of about \$23 500 per consumer. Packages for people with intermediate and high care needs (levels 3 and 4) (box 2.1) accounted for nearly half of all HCPs (figure 2.2b). There were nearly 311 000 residents in residential care (permanent and respite) with an average service value of about \$118 200 per resident in 2020-21 (DHAC, pers. comm., 20 September 2022).

The total number of aged care consumers (in these three aged care programs) grew at an average compound rate of 5 per cent each year between 2016-17 and 2020-21, outpacing the population growth of older Australians over the same period. Although it remains the smallest of the three services, this growth was primarily driven by the HCP Program. Between 2016-17 and 2020-21, the number of HCP consumers more than doubled (from 102 000 to 237 000) increasing its share of aged care consumers from 9 per cent to 17 per cent. Over that same period, the number of residential care recipients remained steady while the number of CHSP consumers grew by 14 per cent.<sup>7</sup>

**Figure 2.2 – Recent growth in aged care has been driven by the HCP Program**



**a.** Residential estimates include clients in permanent and respite residential care over the financial year. HCP estimates are the sum of clients in levels 1-2 HCPs and levels 3-4 HCPs. These estimates may overstate the number of unique consumers, where consumers have moved from respite care into permanent care, or to a higher-level HCP within a financial year **b.** Excludes consumers in other aged care services, such as flexible care programs and Commonwealth-Home and Community Care (Commonwealth-HACC) consumers for 2016-17 and 2017-18.

Sources: SCRGSP (2018, 2019, 2020, 2021, 2022).

However, the supply of HCPs has not kept up with demand. As at 31 March 2022, there were over 58 000 people who were waiting to be allocated a HCP at their approved level (although this is a reduction in the size of the waiting list compared with previous years) (DHAC 2022d, p. 30). In 2020-21, the median

<sup>6</sup> For the HCP Program and residential care, 'average service value' is based on a provider's expenditure per consumer per day.

<sup>7</sup> Part of the growth in consumers in the CHSP is due to the transition of Western Australian consumers on the Commonwealth-HACC program to the CHSP in 2018.

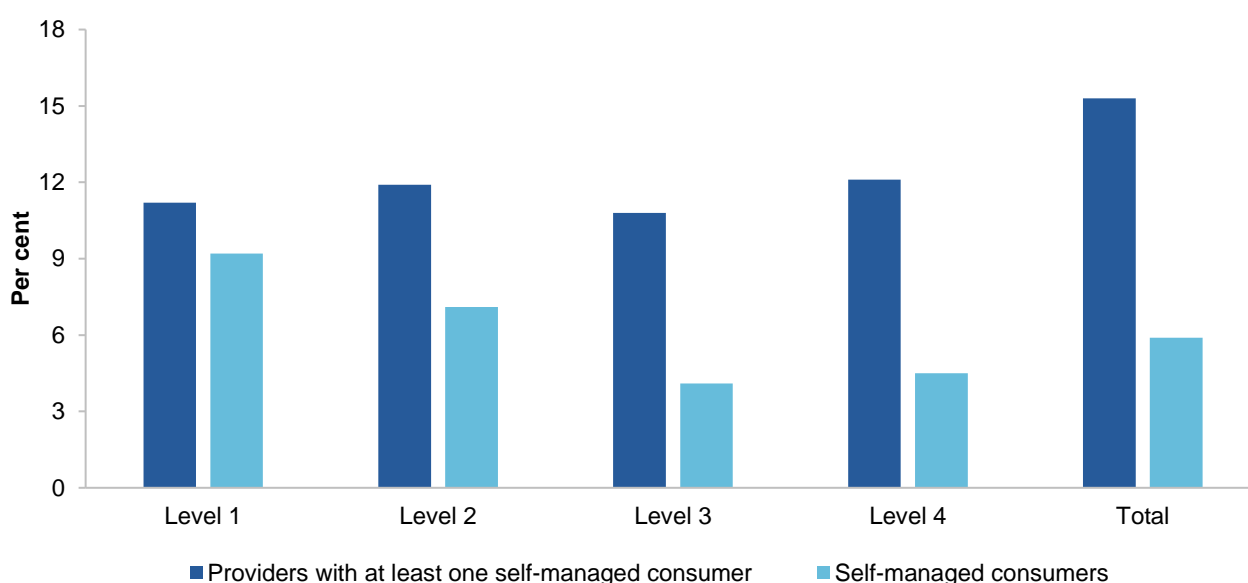


elapsed time between approval for a HCP to receiving a HCP ranged from 6 months for a level 1 package to 15 months for a level 3 package (SCRGSP 2022).

The growth in home care has coincided with a policy shift towards consumer-directed care that began in 2009 (Moore 2021). As part of these ongoing reforms, since 2017 HCP funds have been allocated directly to consumers rather than providers. Alongside this change, a self-managed HCP model was developed and introduced between 2017 and 2019. Self-management gives consumers more control and authority to determine how their HCP is spent, such as by being able to choose their preferred support workers and manage their care schedule. However, consumers must still nominate an approved provider who maintains responsibility for overseeing their package budget and care plan.

The share of HCP consumers who currently self-manage is small: in June 2021 only 6 per cent of all HCP recipients were self-managed, ranging from 9 per cent for level 1 care recipients to 4 per cent for level 3 (figure 2.3). Overall, only 15 per cent of providers had at least one self-managed consumer in June 2021. The proposed model for the new Support at Home program could lead to an increase in the uptake of self-management by allowing consumers to engage multiple providers (box 1.4).

**Figure 2.3 – There are relatively more self-managed consumers in level 1 HCPs<sup>a</sup>**  
**Share of self-managed consumers by HCP level, June 2021**



a. Based on a stocktake where 39 per cent of HCP providers responded, who had at least one care recipient and were operational at the time of the survey (326 of 828 providers) and 39 per cent (69 451) of HCP consumers.

Source: DHAC (pers. comm., 24 May 2022).

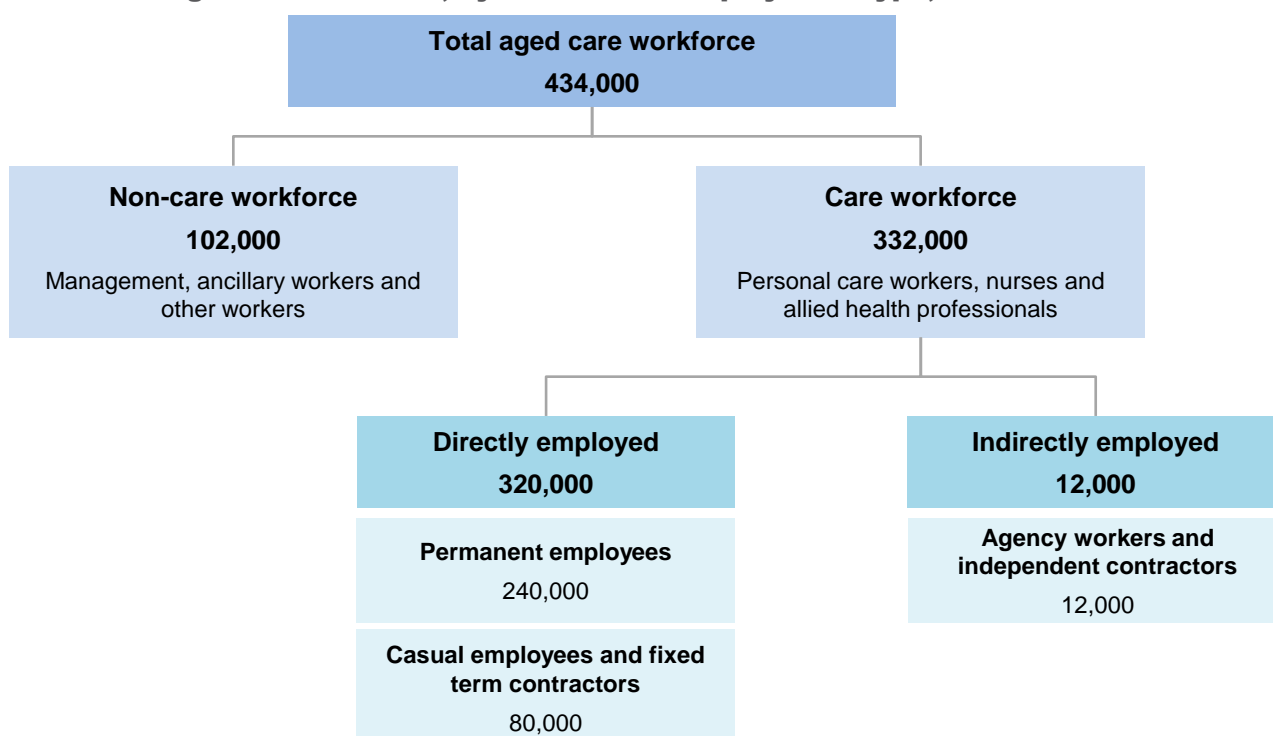
**Finding 2.1****Most aged care consumers live at home and mainly receive domestic assistance and social support**

Of the approximately 1.4 million older Australians who receive some form of government-subsidised aged care, more than 75 per cent live at home and receive either entry-level care through the Commonwealth Home Support Program (CHSP) or structured home-based care through the Home Care Packages (HCP) Program. The bulk of home care service hours provided to consumers are for domestic assistance and social support. Clinical (allied health and nursing) and personal care services account for a fifth of CHSP hours and less than a third of HCP hours.

## The workforce

There were 434 000 aged care workers in 2020 (DoH 2021a).<sup>8</sup> The workforce is comprised of a diversity of job types and skillsets, which include some of the fastest growing and most in-demand occupations in the Australian labour market (National Skills Commission 2021, p. 5, 2022a). Three-quarters of the workforce are *care workers*, including personal care workers (58 per cent), nurses (14 per cent) and allied health workers (5 per cent) (figure 2.4; box 2.2). Residential providers employ almost two-thirds of the workforce, although personal care workers are more evenly distributed across residential and home care (including the HCP Program and CHSP) (figure 2.5a).

**Figure 2.4 – Three quarters of the aged care workforce are in roles that provide care**  
**Number of aged care workers, by worker and employment type, 2020**



Source: DoH (2021a).

<sup>8</sup> Based on the 2020 National Aged Care Workforce Census. Includes workers employed by residential care, HCP and CHSP providers. See appendix C for more detail.

According to the 2016 National Aged Care Workforce Census, the care workforce is predominantly female (nearly 90 per cent) and slightly older than the broader Australian workforce (median age of 48 years).<sup>9</sup> Nearly 29 per cent of care workers were born overseas (Mavromaras et al. 2017, pp. xvi, 12, 69). Though there is no formal qualification requirement for personal care workers, the majority (66 per cent in 2020) have a Certificate III or higher (DoH 2021a, pp. 8, 24, 38).

The total number of care workers grew from about 268 000 to 332 000 (about 5 per cent compound average annual growth) between 2016 and 2020. Most of this growth is attributable to an increase in personal care workers, with the total number of workers in other occupations, such as nurses, relatively stable (figure 2.5b).

## Box 2.2 – Types of jobs in aged care

There are many types of jobs in residential and home care, with different duties and responsibilities. The 2020 National Aged Care Workforce Census defines *direct care workers* as including personal care workers, nurses and allied health workers (collectively referred to as care workers in this study).

- **Personal care workers** provide domestic assistance and basic healthcare in an individual's home or residential care facility. Duties vary from straightforward and low-risk tasks such as housekeeping and grocery shopping, to personal and clinical care tasks such as managing medication and assisting with showering.
- **Nurses** manage an individual's general healthcare. Nurses have different responsibilities depending on their experience and qualifications. The different types of nurses include registered nurses, nurse practitioners, enrolled nurses and specialist nurses.
- **Allied health workers** represent a broad range of health professionals. They are often employed to help an individual recover following an injury or to manage chronic conditions. Examples include physiotherapists, dietitians, audiologists and podiatrists.
- **Ancillary workers** provide non-care services to older people at home or in residential care facilities. Examples include gardeners, cleaners and cooks.
- **Management and administrative workers** oversee the operations of a residential care facility and provide administrative support. This may include supervising staff and ensuring compliance with quality standards. In home care, responsibilities may include developing care plans with, and advocating on behalf of, a consumer.

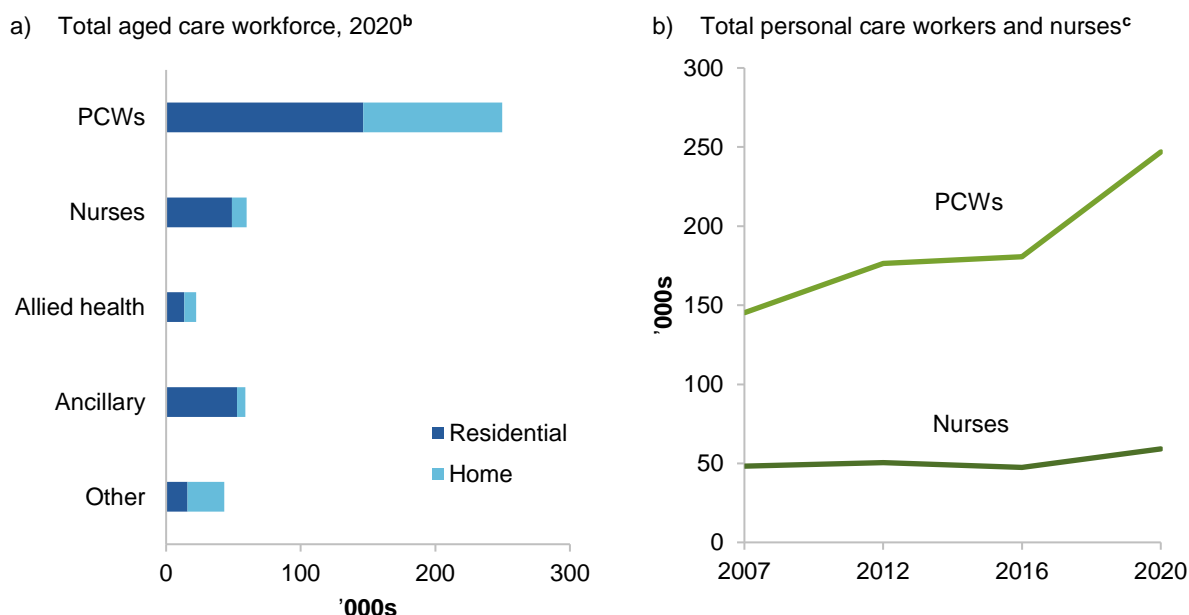
Sources: Aged Care Guide (2020); DoH (2021a).

Part-time employment in aged care is widespread — 92 per cent of permanent (i.e. full-time and part-time) care workers are employed on a part-time basis. This is substantially higher than the share of part-time workers in the health care and social assistance industry as a whole (41 per cent of permanent workers) and the nation-wide share of part-time workers (21 per cent of permanent workers) (ABS 2021). Amongst permanent care workers, personal care workers have the highest rate of part-time employment with 96 per cent of permanent personal care workers working part-time. The Senate Select Committee on Job Security heard that zero- or low-hours part-time employment contracts are commonplace in aged care. Some unions have described these contracts that guarantee workers no or very few hours as a way for providers to operate a pseudo on-demand workforce (Senate Select Committee on Job Security 2021b, p. 46).

<sup>9</sup> Figures only include directly employed care workers.

The share of workers employed on a casual basis in the aged care sector (24 per cent according to the 2020 National Aged Care Workforce Census) is also higher than the average across the health care and social assistance industry (16 per cent) and the broader economy (17 per cent) (ABS 2021; DoH 2021a).

**Figure 2.5 – A snapshot of the aged care workforce<sup>a</sup>**



**a.** For 2020, PCWs combines the 'personal care workers' and 'personal care worker (formal traineeship)' categories from the 2020 census. **b.** 'Other' includes management, administration and pastoral care and education workers. **c.** Only includes pay-as-you-go workers.

Sources: DoH (2021a); Mavromaras et al. (2017).



### Finding 2.2

#### Part-time employment is the norm for most care workers

Although about three quarters of care workers are permanently employed, there are higher than average rates of part-time work (often with minimal guaranteed hours) in aged care compared with the overall health care and social assistance industry and the broader economy. The rate of casual employment is also higher than the average across the health care and social assistance industry and the broader economy.

## Aged care providers

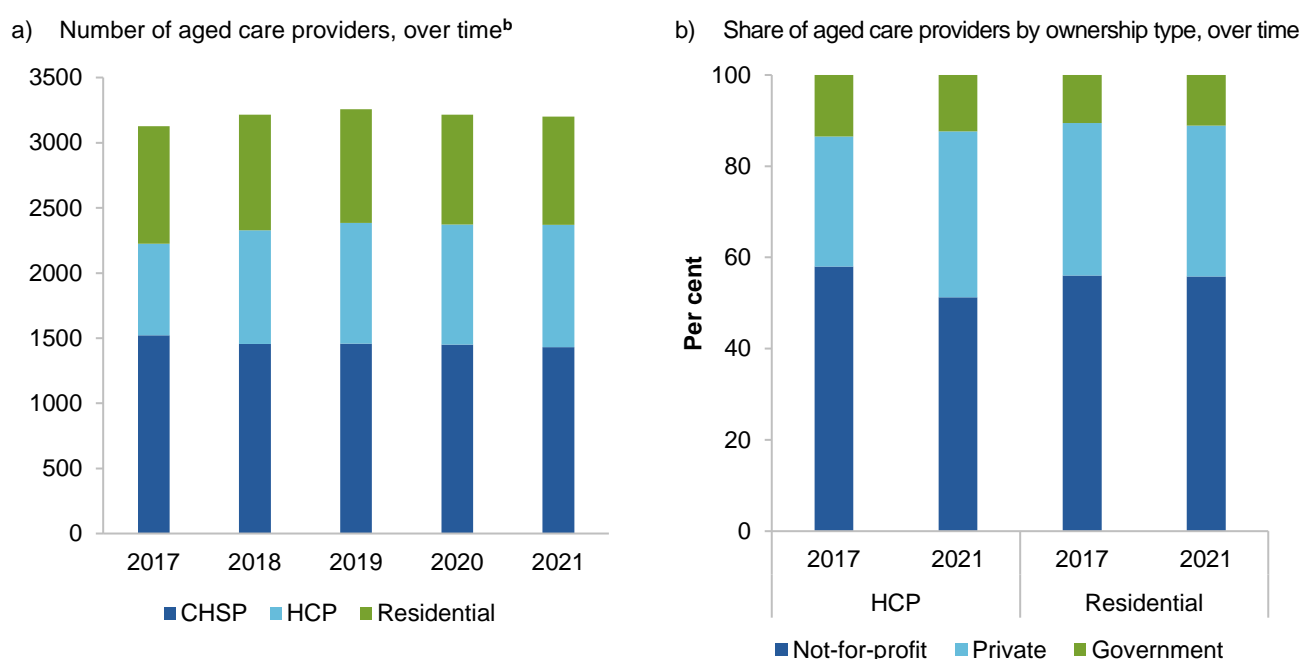
To receive government funding, an aged care provider must be approved under the *Aged Care Act 1997 (Cth)*. Approved providers (hereafter providers) must comply with the Aged Care Act and its associated Aged Care Principles. Together they set out a provider's obligations and responsibilities, including compliance with the eight Aged Care Quality Standards that cover the provision of care and support, as well as organisation management and governance (Royal Commission into Aged Care Quality and Safety 2021a, p. 65).

As at 30 June 2021 (or during the 2020-21 financial year for the CHSP), there were 830 residential care providers, 939 HCP providers, and 1432 CHSP providers (DoH 2021b). Some providers operate in both the residential and home care sectors (about 17 per cent) and a small subset are part of larger health-focussed

businesses. Consistent with the growing need and demand for home care, the number of HCP providers has increased in recent years, while the number of residential providers has slowly declined (figure 2.6a).

Aged care providers range from small bespoke businesses to large multi-service national providers (Royal Commission into Aged Care Quality and Safety 2019, p. 25). The majority of aged care providers are 'not-for-profits' owned by community, charity or religious organisations, though the share of private (for-profit) providers of the HCP Program has increased since 2017 (figure 2.6b). There has also been a recent shift towards the largest providers accounting for a greater share of aged care services, particularly in residential care (Royal Commission into Aged Care Quality and Safety 2021b, p. 31).

**Figure 2.6 – HCP providers are growing, and most aged care workers are directly employed<sup>a</sup>**



**a.** Provider counts taken at 30 June for HCP and residential care and over the financial year for the CHSP. **b.** CHSP provider counts for 2017 and 2018 exclude Commonwealth-HACC providers in Western Australia.

Sources: AIHW (2017, 2021); DoH (2017, 2018, 2019, 2020a, 2021b).

There are longstanding concerns about the financial sustainability and viability of aged care providers. Based on data from a survey conducted by accounting firm StewartBrown, Sutton et al. (2022, p. 28) found that more than 60 per cent of residential care providers recorded an operating loss in the first half of 2021-22. This share has increased from 41 per cent in 2017. Average operating margins of home care providers had also declined to an average of \$3.82 per client per day (2022, p. 57). The report also found that residential providers based in regional and rural and remote locations were more likely to report operating losses (2022, p. 40).

## 2.2 Indirect employment in aged care

By and large, providers operate business models that preference direct employment to deliver their care services — arrangements where a worker is employed as a full-time, part-time or casual employee or on a fixed term (pay-as-you-go) contract. As described in chapter 1, aged care workers can also be indirectly employed through a range of different arrangements. This includes the use of labour hire agencies, subcontracting / brokering, digital care platforms and independent contractors.

Labour hire agencies also typically preference direct employment and employ their workers as casual staff who they hire out to providers. The Recruitment, Consulting and Staffing Association (the peak body for the recruitment and staffing industry in Australia and New Zealand) said that labour hire agencies rarely engage their workers as independent contractors (sub. 23, p. 3). In contrast, most of the platforms that service the aged care sector operate as intermediaries that match independent contractors with self-managed HCP consumers and/or providers (section 2.3).

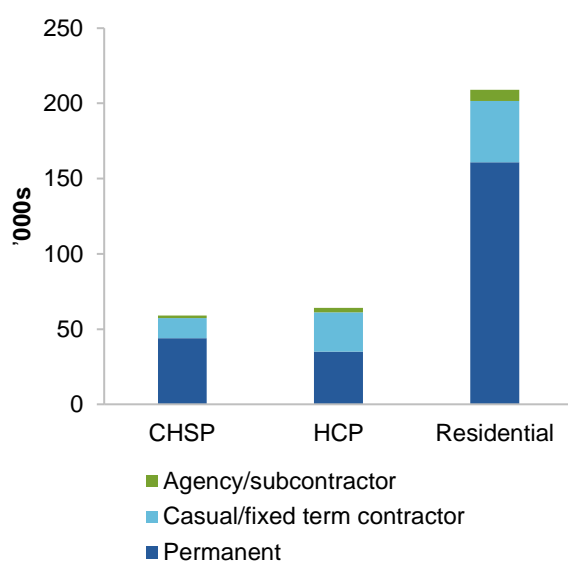
## Indirect employment is a small share of the workforce

The 2020 census surveyed residential care, HCP and CHSP providers about their employment arrangements. For workers in caring roles (personal care workers, nurses and allied health workers) it estimated that (figure 2.7a):

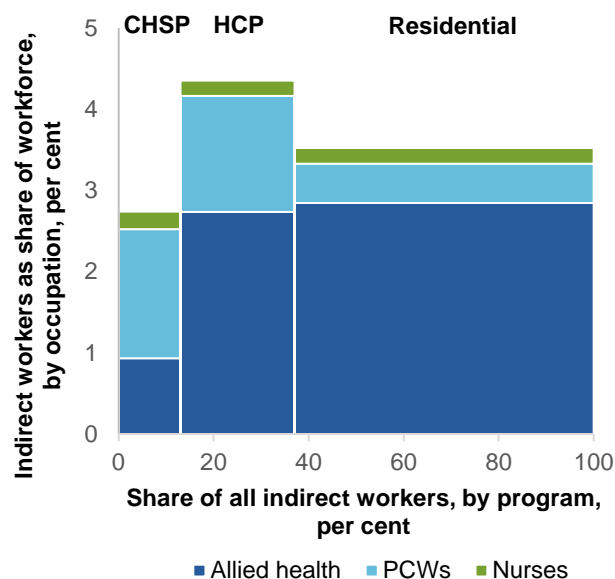
- 72.3 per cent were permanently employed
- 24.2 per cent were employed as casual or fixed term contractors (on the payroll of the provider)
- only 3.5 per cent were indirectly employed as agency workers or independent contractors.

**Figure 2.7 –Most indirectly employed workers are in residential care and are allied health professionals**

a) Number of care workers, by employment type and program, 2020



b) Composition of indirectly employed care workers by occupation and program, 2020



a. Includes personal care workers, nurses and allied health workers. The full definition of the casual/fixed term contractor and agency/subcontractor categories are in appendix C.

Source: DoH (2021a).

Agency workers and independent contractors are most likely to be allied health professionals (70 per cent), while 24 per cent are personal care workers and 6 per cent are nurses. Overall, 63 per cent (nearly 7400 workers) work in residential care (where they account for 3.5 per cent of the residential care workforce), 24 per cent (nearly 3000) for HCP providers (4.4 per cent of HCP care workers) and 14 per cent (about 1600) work for CHSP providers (2.7 per cent of CHSP care workers) (figure 2.7b).

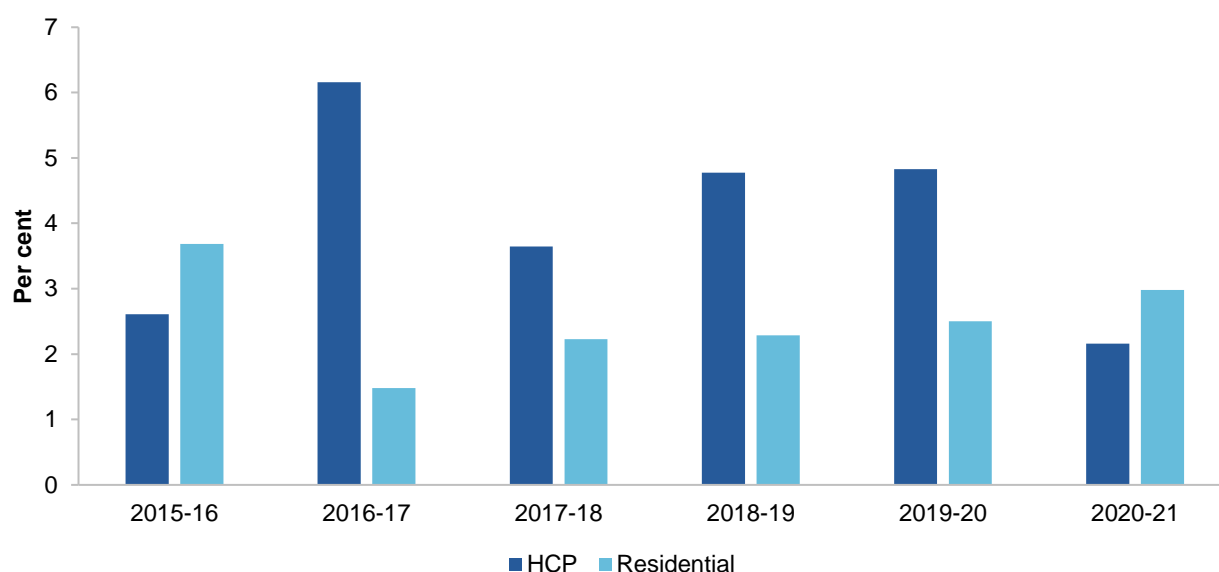
While the 2020 census is the most recent and comprehensive source of data, its reliability as an estimate of the extent of indirect employment in the aged care sector is affected by several known issues (appendix C).

Notably, it only surveyed approved providers of residential, HCP and CHSP services and as such it may exclude independent contractors sourced by self-managed HCP consumers. Moreover, while the survey normally collects data from individual aged care workers, due to the COVID-19 pandemic in 2020 providers completed worker demographic questions on their behalf, affecting the comparability to responses in previous years. Further, some worker demographic questions were not asked in 2020.

However, the estimates of the extent of indirect employment from the census are broadly consistent with other available data sources. Accounting firm StewartBrown collects data on the share of hours completed by agency workers from a non-random sample of providers.<sup>10</sup> The data show that in 2020-21, 3 per cent of the total hours worked by nurses and personal care workers in residential care were undertaken by agency workers, while 2 per cent of service hours<sup>11</sup> in the HCP Program were worked by agency workers. Historical data from StewartBrown show that agency hours as a share of total care hours rose slightly from 2017 to 2021 in residential care, though it remains very small. In home care, the share of service hours worked by agency workers has fluctuated between 2 to 6 per cent between 2015-16 to 2020-21 (figure 2.8).

**Figure 2.8 – The share of agency hours has remained low over time**

**Share of agency hours of total care hours, over time**



Source: StewartBrown (unpublished data from audits of 126 to 233 residential providers and 46 to 90 HCP providers).

The ABS Characteristics of Employment survey also suggests that the aged care sector does not stand out as having a high share of independent contractors relative to the broader health care and social assistance industry.<sup>12</sup> In 2021, independent contractors made up 5.6 per cent of workers in the health care and social assistance industry (which includes aged care) (ABS 2021).

Within the broader home care and social assistance industry, independent contractors made up 0.8 per cent of the 'residential care services' workforce, which includes residential aged care as well as children's, crisis accommodation, and other types of residential care. In comparison, independent contractors accounted for

<sup>10</sup> StewartBrown's 2020-21 data are based on a sample of 233 residential providers (out of 830 as at June 2021) and 90 HCP providers (out of 939 as at June 2021). An estimate based on the share of workers rather than hours could give different results. Residential agency hours are a mix of hours reported by a residential facility, and hours imputed by StewartBrown. See appendix C.

<sup>11</sup> Includes domestic care, clinical care and any other client-related care services.

<sup>12</sup> Appendix C has more detail on the sub-divisions of the health care and social assistance industry.

7.2 per cent of the 'other social assistance services' workforce, which includes home-based aged care and disability services, as well as a range of other welfare and counselling services (ABS 2021).

### Subcontracting is more common for non-care services

In addition to engaging individual independent contractors, providers can also subcontract and/or broker services to other businesses and providers. While the vast majority of care services are delivered using directly employed staff, it is relatively more common for providers to use third-parties to deliver non-care services, such as gardening, maintenance, and cooking.

Consistent with the 2020 census, a survey of HCP providers in 2019 found that a very small proportion of personal care services were subcontracted (0 to 5 per cent across all HCP levels) (DoH 2020c, p. 56).<sup>13</sup> Subcontracting was more common for specialised nursing services (ranging from 10 per cent for level 1 enrolled nursing care to 47 per cent of level 4 registered nurse services), however these services comprised 1 per cent of total HCP hours. In comparison, across the four package levels subcontractors provided 48 to 59 per cent of gardening and home maintenance services and 10 to 21 per cent of meal preparation services.



#### Finding 2.3

**Notwithstanding data limitations, the share of indirect employment in aged care is estimated to be small**

Indirect employment through agency workers and independent contractors makes up a small share of the care workforce — less than 4 per cent. This share has remained relatively unchanged over the past five years. Most agency workers and independent contractors work in residential care, and most are allied health professionals.

### Indirect employment provides critical buffer capacity and flexibility

While only a small share of personal care workers and nurses are indirectly employed, they play a well-established and important role in the delivery of aged care services.

According to the 2016 census, agency workers are most likely to be used to cover short-term absences of staff, such as sick leave or other types of unplanned absences (table 2.1). More than 87 per cent of residential care providers and nearly 66 per cent of home care outlets who had contracted agency staff did so to cover short-term absences (table 2.1). In comparison, independent contractors appear to be drawn on less regularly to fill short-term absences. Both agency workers and independent contractors are less likely to be used to cover maternity or annual leave, which is typically planned and longer in duration.

Providers also draw on agency workers to respond to temporary staff shortages. Several providers who participated in this study said that they have established relationships with labour hire agencies to source nurses and personal care workers to manage absences and skill gaps in their workforces (Anglicare, sub. 17, p. 5; BallyCara Limited, sub. 22, p. 4; Regis Aged Care, sub. 37; p. 3; Resthaven, sub. 26, p. 3). Agency staff may be preferred over independent contractors as agencies have processes to conduct quality and safety checks on the workers they place and have an understanding of the provider's needs (Recruitment, Consulting and Staffing Association, sub. 23, pp. 3–4).

<sup>13</sup> The survey was conducted by the Department of Health (now Department of Health and Aged Care). There were 485 respondents to the survey, of which 19 voluntarily provided responses on the proportion of services provided by subcontractors.



**Table 2.1 – Reasons for using agency and self-employed workers<sup>a,b</sup>**  
**As a percentage of providers that report using each type of workers, 2016**

	Residential facilities		Home care outlets	
	Agency workers	Self-employed	Agency workers	Self-employed
Matching staff to peaks in demand	14.2	6.2	36.1	33.1
Covering short-term absences	87.2	9.6	65.9	6.6
Covering maternity or annual leave	18.6	5.6	12.3	2.2
Unable to fill vacancies	51.1	5.6	38.4	8.8
Obtain specialist skills	4.3	75.3	18.3	44.9
Freeze on permanent staff numbers	1.9	1.7	3.2	6.6
Other reason	1.3	6.2	7.2	12.5

a. Multiple responses allowed; columns do not sum to 100 per cent. b. Self-employed workers are equivalent to independent contractors.

Source: Mavromaras et al. (2017), tables 4.20 and 6.23.

Providers can also use casual and part-time employees to maintain some flexible workforce capacity in-house (BallyCara Limited, sub. 22, p. 7; Regis Aged Care, sub. 37, pp. 2–3). Directly employed staff provide the benefit of being trained in-house and as direct employees, they are familiar with a provider's specific operating procedures and policies (Anglicare, sub. 17, p. 4). Similarly, large and/or integrated providers may have capacity to temporarily reallocate staff between their residential and home care services or across their different locations to respond to localised staff shortages.

However, in the context of a sector-wide workforce shortage, most providers have a limited capacity to responsively flex their directly employed workforce. This is particularly the case when faced with a major disruption, such as COVID-19 outbreaks (Recruitment, Consulting and Staffing Association, sub. 23, pp. 4–5). In its submission, BallyCara Limited (sub. 22, p. 7) highlighted the difficulties of maintaining its casual pool in the midst and aftermath of the COVID-19 pandemic.

### Agency workers also help with chronic labour shortages and thin markets

According to the 2016 census, the second most common reason providers contract labour hire agencies is to fill vacant positions (Mavromaras et al. 2017, pp. 64, 129). More than half of residential providers and almost 40 per cent of home care providers reported they used agency workers because they were unable to fill vacancies (table 2.1). A study using the 2012 National Aged Care Workforce census found that, after controlling for other characteristics, for each additional full-time equivalent vacancy reported by residential care providers, the likelihood of using agency workers increased by 1.4 per cent for personal care workers and 6.2 per cent for nurses (Knight and Wei 2015, p. 226).

Throughout this study the Commission heard that agency staff are particularly necessary in regional and remote areas, and that service delivery would be jeopardised or cease in some remote locations without access to agency staff or independent contractors (Aged Care Workforce Remote Accord, sub. 15, p. 3). Providers in regional and remote communities face significant challenges in recruiting and retaining local staff and must compete against better-served population hubs.

While agency staff form a necessary component of the workforce, most study participants agreed that they are not a perfect substitute for directly employed staff. The Aged Care Remote Accord said that agency staff are more costly and can lack the skills and knowledge required to provide culturally appropriate care:

Agency staff in remote areas are overwhelmingly not from remote areas and are not embedded in the culture of an organisation. As such they may not share the same commitment to organisation values as other staff. Agency staff also often have limited understanding of the particular cultural contexts of remote and very remote services and their communities, where cultural care and safety is paramount. Additionally, agency staff generally have very high turnover rates and are very expensive for service providers. (sub. 15, p. 2)

There is also some evidence that increases in the use of agency staff are correlated with increases in various measures of poor-quality care (chapter 3). However, this does not imply causality and there are a range of factors that may jointly explain both greater agency use and lower quality care (box 3.3).

While using agency staff may be sub-optimal, several providers submitted that regulating or restricting the use of agency workers would, at least in the short-term, impede their ability to operate (Aged Care Workforce Remote Accord, sub. 15, p. 3; Anglicare, sub. 17, p. 5; BallyCara Limited, sub. 22, p. 7). Current workforce shortfalls are expected to persist, particularly as Australia's skilled migration program takes time to restart (noting only registered nurses, and not personal care workers, are currently eligible for skilled migration visas).<sup>14</sup> A further expansion of the workforce will be needed to meet growing demand for aged care and adjust to policy changes (such as increases in staffing ratios) (chapter 1). In this environment many providers will need to continue to rely on agency workers to temporarily backfill vacancies.

### **Residential care providers use independent contractors to source specialist skills**

While this study is focused on the personal care and nursing workforce, independent contractors also play an important role in the delivery of specialised care, particularly in residential care settings. About 37 per cent of allied health workers in the aged care sector are agency workers or independent contractors, and the majority of them work in residential care (DoH 2021a).

This is also supported by the 2016 census, which found that obtaining specialist skills was by far the most common reason residential providers engaged independent contractors (more than 75 per cent, table 2.1). Residential providers also broker specialist staff from other businesses/providers but very few use labour hire agencies for this purpose. Obtaining specialist skills was also the main reason home care providers reported using independent contractors.

### **Independent contractors are also increasingly supporting consumer-directed home care**

The introduction of self-managed Home Care Packages has led to some consumers sourcing and selecting their own care workers. Although these care workers may be employed by an approved provider (as chosen by the consumer), they are more typically engaged as independent contractors, often through digital care platforms. Independent contractors can also give home care providers greater flexibility to meet consumer needs. In 2016, about one-third of home care providers used independent contractors to help match staff to peaks in demand.

### **Focus for this study**

Agency workers are an established part of the aged care workforce, particularly for residential providers. They are typically directly employed by labour hire agencies as casual employees. In the context of a chronic shortage of nurses and personal care workers, providers rely on labour hire agencies to cover staff absences and fill vacant positions.

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<sup>14</sup> The Royal Commission noted the aged care sector's reliance on migrants is precarious. Most permanent skilled immigrants initially entered and worked in Australia as temporary immigrants on working holiday, student visas, or with a family member.

Independent contractors have traditionally been used by providers to source specialised skills that may only be required for a small number of service hours. In residential care settings, independent contractors predominantly work as allied health professionals. Residential providers are relatively less likely to engage personal care workers as independent contractors and instead prefer the reliability of having established relationships with labour hire agencies.

This provides the basis for this study to focus on the use independent contractors in the home care sector. As a relatively new form of indirect employment, this study will give particular consideration to digital care platforms and their growing use by self-managed consumers to source their own care workers.



#### **Finding 2.4**

#### **Providers rely on the flexibility, specialised skills and additional capacity that agency workers and independent contractors provide**

The use of labour hire agencies is a well-established practice in aged care. Agency workers are commonly used to address short-term absences and labour shortages, particularly in residential care. Aged care providers use independent contractors most frequently to obtain specialist skills. Some aged care facilities could not operate viably without the flexibility afforded by agency work and independent contractors.

## **2.3 The emergence of platforms**

Labour platforms allow consumers to find on-demand workers, often to complete a task or perform a 'gig' (IRV 2020, p. 4). They have emerged in recent years across many industries, including aged care, using a range of different operating models (box 2.3).

A 2019 survey of 14 000 adult Australian internet users found that about 7 per cent of respondents had engaged in some form of platform work in the past 12 months (McDonald et al. 2019, p. 31).<sup>15</sup> Among respondents who were currently working through a platform, 7 per cent reported that they provided care work (including aged, disability, child and pet care) through the main platform they used (McDonald et al. 2019, p. 40).

In response to the introduction of the National Disability Insurance Scheme (NDIS) (appendix B), a number of digital care platforms have entered the market (box 2.4). These platforms serve individuals who are self-funded or receive funding from the NDIS, and many are NDIS-registered providers. Similarly, the advent of self-managed HCPs has also facilitated the entry of platform-based businesses into the aged care sector. The Commission is aware of at least seven platforms who service the aged care sector, most of which also service the disability sector.

Nonetheless, platforms currently account for only a small share of service delivery in the aged care sector. While some platforms service aged care providers (such as Careseekers and Sidekicker), most service the 6 per cent of HCP consumers who self-manage their packages (although not all these consumers would use platforms). Mable, who are one of the more well-established platforms indicated that they currently service between 20 to 25 per cent of self-managed HCP consumers and 1.5 per cent of the overall HCP market (Mable, pers. comm., 8 June 2022).

<sup>15</sup> Respondents were recruited by an online research panel provider and the sample was constructed to be nationally representative.

### Box 2.3 – Categorisations of platforms

There are many types of platform-based businesses.

Care platforms fall under the category of **platforms for labour services** such as Sidekicker, which typically match end users with workers. There are also **platforms for selling goods** such as eBay and Gumtree where merchants can sell their wares to end users and **platforms for renting out assets**, such as clothing and rooms. Examples of platforms for renting out assets include Rent the Runway and Airbnb.

Labour platforms can be categorised based on whether the end user or the platform determines which worker will carry out the task. A **crowd-work system** is where workers apply or bid competitively for tasks, such as on Airtasker. A **work-on demand system** is where the platform assigns tasks to workers, such as Deliveroo.

Labour platforms can also be categorised based on the relationship between workers and end users. **Horizontal platforms** merely facilitate transactions between workers and end users and have little control over how the work is performed. An example of this is Freelancer, which allows end users to post jobs that workers can bid to complete. On the other hand, **vertical platforms** such as Uber offer end users a service and supply the labour necessary to achieve that. They may also dictate the terms of the service, such as by setting prices. There is some ambiguity over whether vertical platforms should be considered as employing their workers.

Based on these typologies, most care platforms would be categorised as horizontal platforms for labour services.

Sources: Industrial Relations Victoria (2020); Manyika et al. (2016); Stewart (2020).

### Box 2.4 – Platforms for care services

Care platforms essentially provide a matching service between consumers and workers, but they can operate with a variety of different business models (refer to table below).

Typically, care platforms have a digital interface — such as an app or website — that consumers use to find potential care workers. Consumers (and in some cases, providers) source workers by posting a job and selecting workers based on their profile, which typically outlines the worker's skills, rates and availability. The actual terms of a job are negotiated between the consumer and worker. Services can include personal care, nursing and allied health support, meal preparation, transport, companionship and domestic assistance. Most platforms have scheduling and communication features on their portals and apps, and some have systems that allow consumers to rate and review worker performance.

Most platform operators perform basic worker screening including through police clearance, identification and references. Depending on the platform and job, additional qualifications may be required. Nearly all platforms provide insurance, typically public liability insurance. While most platform workers are engaged directly by consumers as independent contractors, at least two platforms offering care services (Hireup and Sidekicker) engage workers as casual employees.

To the Commission's knowledge, only one digital care platform providing aged care services (Five Good Friends) is currently an approved aged care provider.

### Box 2.4 – Platforms for care services

Most platforms charge a fee to the consumer and worker — usually a percentage of the agreed hourly rate. This is typically 5 per cent for the consumer and between 10 and 25 per cent for the worker. Digital platforms typically generate and issue invoices on the worker's behalf following a job.

#### Not all platforms are the same

	Workers are independent contractors <sup>a</sup>	Workers are directly employed	Approved aged care provider	Registered NDIS provider	Consumer / worker set price
<b>Aged and disability care</b>					
Care.com	?		?	?	✓
Careseekers	✓			✓	✓
Findacarers.com	?				✓
Five Good Friends	✓		✓	✓	✓
Hireup <sup>b</sup>		✓		✓	
Like Family	✓			✓	
Mable	✓				✓
Sidekicker <sup>c</sup>		✓			
<b>Other markets</b>					
Airtasker	✓				✓
Deliveroo	✓		na	na	
Didi	✓		na	na	

**a.** 'Workers' refers to nurses and personal care workers. **b.** Hireup only operates in disability care. **c.** Sidekicker operates in residential care and disability care, as well as non-care industries. **na** Not applicable.

Sources: Airtasker (2021, 2022); Care.com (2022a, 2022b); Careseekers (2022a, 2022c, 2022e); Deliveroo (2022); Didi (nd); Find a Carer (2017); Five Good Friends (2021a, 2021b, 2022b); Hireup (2022a); Industrial Relations Victoria (2020); Like Family (2022, nd); Mable (sub. 30); Macdonald (2021); Sidekicker (2022).

There is some evidence to suggest that platforms for care services are becoming more popular. Mable, which operates in the disability and aged care sectors, reported that there were over 10 000 active workers using its platform in 2022, up from 5600 in 2020 (Mable 2022, p. 8; Redrup 2020). Between 2019-20 and 2020-21, disability care platform Hireup reported that its customer base grew from approximately 15 000 to 22 000 customers (Hireup 2021, 2022b).

There have been policy developments that are likely to encourage the use of independent contractors, and by extension, digital platforms. These include changes to the Social, Community, Home Care and Disability Services Award that have introduced a minimum engagement period (i.e., minimum shift length) of two hours, up from one hour. This may draw consumers who may not need or cannot afford longer shifts to engage independent contractors on platforms. A new home care program (Support at Home) proposed to be

introduced in 2024 will potentially support greater uptake of HCP self-management, though the details are yet to be finalised (chapter 1).



#### **Finding 2.5**

#### **Digital care platforms are likely to grow with the rise in home care**

While digital care platforms in Australia are more established in the disability sector, these are also emerging in aged care primarily to service older Australians living at home and choosing to self-manage their care needs. Notwithstanding some variation across business models, platforms essentially connect consumers in need of care directly with personal care workers and nurses. While platforms currently make up a small share of the market, their coverage is likely to grow.

### 3. Consumer perspectives

#### Key points

- ✳ **Quality in aged care has several dimensions. Prima facie, there is no clear case for employment models to be a key driver of quality in aged care. And there is no evidence base to allow for a reliable test of the causal relationship between employment models and outcomes in aged care.**
  - The Royal Commission highlighted many examples of poor quality care across all employment models.
- ✳ **Many consumer groups have a strong desire for an aged care system that prioritises the ability of home care recipients to exercise greater autonomy, choice, and control over how they receive care, with appropriate quality assurance and safeguarding mechanisms in place.**
  - To the extent that greater choice and control lead to better matches with workers, older people will be able to remain at home for longer, and it will contribute to their quality of life and connection with their community.
- ✳ **Indirect employment models (such as those offered through digital care platforms) offer several benefits to consumers. Benefits include enhanced choice and control, the potential for better care outcomes through more individualised services, community-led solutions, and a lower care management bill, leading to more hours of care for a given budget.**
  - These models work particularly well for older people with good cognitive abilities, lower support needs and some level of digital literacy and family/community support.
  - This is likely to apply to many consumers who receive entry-level home care.
- ✳ **While self-management requires consumers to take on some of the screening costs associated with engaging personal care workers and nurses, similar screening costs apply when searching for a home care provider.**
  - Digital care platforms help reduce time and effort required for this activity and may increase transparency for consumers through ratings and reviews.
- ✳ **There may be a lack of understanding or awareness by consumers that, under current policy settings, the approved provider (rather than the platform) is accountable for the safety and quality of care delivered (and is paid for this responsibility), even when consumers engage personal care workers or nurses themselves.**
- ✳ **Most risks to consumers in home care settings relate to the nature of receiving care in the home environment, rather than the employment model per se. Restricting the use of indirect employment would not address these risks and may leave self-managing consumers worse off.**

This chapter focuses on the link between care quality and employment (section 3.1), discusses the advantages and disadvantages of indirect employment models from the perspectives of consumers (sections 3.2 and 3.3), and makes conclusions on whether there is a justification to restrict indirect employment (section 3.4).

## **3.1 The link between care quality and employment**

### **What is quality in aged care?**

One of the key underlying factors for a focus on employment models is the purported link between forms of employment and quality of aged care. The Australian Government's Aged Care Quality Standards seek to conceptualise quality through a range of indicators. The Aged Care Quality and Safety Commission (ACQSC), established in 2019, accredits, assesses (box 3.1), and monitors subsidised aged care services, conducts investigations of providers, and determines provider compliance including whether any requirements or sanctions need to be imposed. It also resolves complaints about services. There are eight categories of standards that approved providers must comply with, including:

1. consumer dignity and choice
2. ongoing assessment and planning with consumers
3. personal and clinical care
4. services and supports for daily living
5. provider's service environment
6. feedback and complaints
7. human resources
8. organisational governance.

All approved providers are expected to deliver care and services that are inclusive and safe. Within the first category — considered to be a foundation standard — important concepts regarding consumers' needs are to be considered by the provider, including their choice, dignity of risk, and cultural identity, among others. The standards make clear that respecting the identity, culture and diversity of a consumer means understanding their needs and preferences.

Organisations are expected to provide care and services that reflect a consumer's social, cultural, language, religious, spiritual, psychological and medical needs. Services are to be delivered in a culturally safe way which is responsive, inclusive and sensitive to consumers who identify as Aboriginal and Torres Strait Islander, come from culturally and linguistically diverse (CALD) backgrounds, and those who identify as lesbian, gay, bisexual, transgender and intersex (LGBTI).

While there are benefits and a clear rationale for defining standards in aged care, it is also important to consider other ways in which quality can be viewed, particularly from a consumer perspective. Meagher et al. (2019, p. 24) stated that:

Despite the different ways they [various studies] are framed, and the various countries in which they have been conducted, their findings are remarkably consistent: older people's assessments of residential care quality emphasise the social and emotional dimensions of life and of care, including good relationships with care staff, staff having time to care, feeling at home and feeling valued.



### **Box 3.1 – How is quality in aged care assessed?**

All government-funded, approved providers must comply with Aged Care Quality Standards that outline a range of requirements about the level of care and services the community expects from providers. For each of the requirements, quality assessors expect the provider and its workforce to demonstrate it understands the requirement; applies the requirement, and this is clear in the way it provides care and services; monitors how it is applying the requirement and the outcomes achieved; and reviews outcomes and adjusts practices based on these reviews for continuous improvement.

Residential care providers are assessed against these standards through monitoring visits, reviews, and feedback from those receiving care and services. From July 2020, information on providers' performance against the standards has been published on the My Aged Care website. Consumers can search by provider to review their compliance ratings and any current or archived notices of non-compliance.

From July 2021, residential care providers have also been required to report to the Department of Health and Aged Care (formerly the Department of Health) on a quarterly basis under the National Aged Care Mandatory Quality Indicator Program. Providers are required to report on the proportion of residents who have experienced or been subject to: pressure injuries; physical restraint; unplanned weight loss; falls and major injury; and medication management, including polypharmacy and anti-psychotics.

Currently, home care providers do not have comparable reporting requirements. The Royal Commission into Aged Care Quality and Safety recommended that the expanded Australian Commission on Safety and Quality in Health and Aged Care be tasked with reviewing the current standards and setting quality indicators for all aged care services, including home care. This recommendation (22) was accepted in principle by the Australian Government, and responsibility for its implementation sits with the Department of Health and Aged Care.

Sources: Australian Government (2021a); ACQSC (2021b); Department of Health (2021c).

Throughout this study, the Commission consistently heard that how somebody views whether a quality service has been provided to them can vary from one person to another. While there are some common themes across submissions (consumers want strong relationships with their personal care workers and nurses), the observed diversity among consumers implies that their needs, and what is considered most important to them in both residential and home care environments, will differ.

COTA Australia (sub. 40, p. 3) noted from its research and engagement with older people that consumers think of quality and care outcomes through a 'customer experience' lens to inform their choice of provider. Choices are based on 'their own experience and the experience of their peers', whereas much of the current policy focus is on clinical and other health performance indicators. The *Caring for Older Australians* report (PC 2011, p. 77) presented a framework which conceptualised quality in aged care through the perspective of maintaining living standards (including in terms of care and personal needs and access to healthcare) and maintaining quality of life (including independence, choice and control, social and family contact and being treated with respect and dignity). These concepts have remained important since that report was published.

### **Is there a causal link between employment type and care quality?**

Given the positions put forward in the Royal Commission, this study tackles a fundamental question regarding the employment models used in the aged care sector and seeks to understand whether there is any causal link between the form of employment and care quality. Prior to the commencement of this study,

there was already a range of evidence and opinions that sought to provide answers to this question, and these are briefly outlined below. Sections 3.2 and 3.3 focus more deeply on how participants in this study have tackled this question and the evidence to support their claims.

### What the Royal Commission heard

The Royal Commission heard that continuity of care is a key indicator for high quality care, which is universally agreed within the sector. Commissioner Briggs ultimately formed a view that direct employment created continuity of care and improved other dimensions of quality (skill acquisition, job satisfaction), with many submissions to the Royal Commission also supporting this view (box 3.2). However, at times the Royal Commission put a greater focus on how casualisation impacted continuity of care, as distinct from indirect employment models. Specifically, Commissioner Briggs stated:

Older people get the best care from regular workers they know, who respect them and offer continuity of care as well as insights into their changing care needs and health requirements. That is why I have recommended that aged care providers preference the direct employment of workers, rather than use casuals who may be unable to provide continuity of care and form ongoing relationships with older people. (Royal Commission into Aged Care Quality and Safety 2021a, p. 42)

Many submissions to the Royal Commission also spoke to improved employment conditions leading to improved continuity of care, which in turn drives higher quality of care for consumers (box 3.2). These submissions focused on the importance of having a valued workforce and how this may have flow-on impacts to higher quality outcomes. However, they generally referred to care provided in residential care rather than at home, which is the focus of this study.

#### **Box 3.2 – Selected views on workforce and continuity of care from submissions to the Royal Commission**

Retention of staff promotes continuity of care, a key indicator of quality. The retention of aged care staff is also important when considering education and upskilling. When care workers are engaged, empowered and offered variety in their role, it increases the likelihood that they will desire and be physically able to remain in their role for longer. In turn, reducing staff turnover will lessen the demand for basic education and certification — notwithstanding the need for periodic, ongoing education — and improve care and relationships for clients and residents. (HammondCare 2019, p. 9)

The provision of safe and quality care cannot be separated from the people who deliver that care. It is therefore essential to address a range of areas — from entry to the sector through to maintaining a career that is satisfying, appropriately rewarded, secure and comparable to working in the public health sector. (ANMF 2020, p. 31)

Continuity of care is particularly important for people living with dementia. Multiple staff changes can be confusing and distressing, and exacerbate symptoms of dementia. It is important that people with dementia are able to develop rapport and relationships with those who care for them. The use of casual and agency staff is therefore problematic. (Dementia Australia 2019, p. 15)

Despite these views put forward at the time, the evidence presented to the Royal Commission did not draw a clear causal link between the use of indirectly employed workers (such as independent contractors and agency staff) and poor quality outcomes. The Royal Commission did, however, hear many examples of poor quality care, including abuse and neglect, from all types of workers (full-time, part-time, casual, contractor). Given that indirect employment represents about 3.5 per cent of the care workforce (chapter 2), there is an inherent difficulty in drawing strong conclusions about the links between employment type and care quality.

### What the academic literature says

There are some academic studies that broadly support a link between employment type and continuity of care in a residential care context. For example, Meagher et al. (2019, p. 3) noted that:

High quality, person-centred care depends on high quality jobs in care work. Research shows that the quality of care and the quality of jobs in aged care are inextricably linked. This research points to the need for policies and practices to drive a 'virtuous circle', in which good organisation of care work, good employment and working conditions, supportive management and an empowering work culture, collaborative teams, high quality, relevant education and training, and high job satisfaction among care workers underpin high quality, person-centred care.

The 2021 Senate Select Committee on Job Security noted that workforce characteristics — including total staffing, staff mix, casualisation and clinical governance — were among several factors that determined the quality of care in residential care. It cited international evidence which suggested that the degree of casualisation of the workforce is linked with a higher rate of adverse events and poor quality of care (Senate Select Committee on Job Security 2021b, p. 57). Further, Per Capita (2022, pp. 26–28) cited a number of references that purported to show these linkages and emphasised the benefit of a well supported, directly employed workforce in delivering better care outcomes through consistency and continuity of care.

However, these associations point to a link between the way in which direct employment arrangements are configured (for example, full-time, part-time or casual) and care outcomes, often in residential care settings or nursing homes in the case of international examples. These studies do not consider the option of self-employment, even though many allied health professionals in residential care are independent contractors. Many of the studies highlight the importance of having a consistent set of workers to ensure quality care is delivered; and some consumers report that engaging personal care workers and nurses as independent contractors has facilitated this consistency (brief comments: C20, C21, C34). Box 3.3 discusses the link between quality of care and agency staffing in Australian residential care settings.

#### **Box 3.3 – Evidence of a link between quality and agency staff in residential care**

A recent paper by Ma et al. provides a useful exploratory analysis of agency staff use in Australian residential care facilities, and identifies that increases in agency use are positively and significantly correlated with increases in various measures of low quality care, including complaints, missing persons, reportable assaults, hospitalisations and accreditation flags.

The paper notes that despite this association, there are limitations to the research. Causal direction is difficult to establish without controlling for other factors that independently affect quality, such as poor management of a residential care facility. A change in management that led to staff dissatisfaction and high staff turnover could simultaneously lower care quality and require agency staff to fill vacant positions. In that instance, higher agency staffing may proxy poor management or reflect local shortages

**Box 3.3 – Evidence of a link between quality and agency staff in residential care**

in the personal care workforce, but not be an independent cause of quality problems. Indeed, as noted by Ma et al., removing the capacity to hire agency staff when there are shortages could lower quality and create operational difficulties.

This finding is broadly consistent with a study undertaken in the United States. Research into American nursing homes showed that high agency use in nurses and nurse aides (above 5 per cent of total staffing) is also correlated with lower quality of care metrics. Like Ma et al., the researchers note that causal direction cannot be inferred, and provide further analysis to show how turnover rates also affect both agency use and care quality, raising some questions about the causal link.

Notwithstanding this limitation, the Commission has heard from both providers and worker representatives that using agency staff is less desirable than using directly employed staff, given their lack of familiarity with aged care recipients and the facility. That said, staff turnover of employees is very high on average, and would appear to be a more significant source of low continuity of care. It is also recognised that agency staff offer much needed flexibility to providers (chapter 2) and that agency staff are better than no staff. Further, results from other studies suggest that nurses hired from an agency might bring greater expertise and experience to a facility, improving care quality overall.

While the Ma et al. paper is a useful first attempt at examining any link between agency workers and care quality in an Australian context, better datasets would help address the considerable uncertainty about causality and effect sizes. Controlling for staff turnover and measures of management capability would help isolate the effect, if any, of agency workers on quality. Further, the datasets used draw on providers' self-reported information to StewartBrown (appendix C) and result in a sample primarily of larger providers, based in major cities and run for-profit. Including smaller providers, those operating in regional, remote and metropolitan areas, and not-for-profit might alter the results. While not a deficiency per se, Ma et al.'s model suggests that reportable assaults aside, about 95 per cent of the variation in quality of care outcomes have an unknown origin — which points to the need to assess other determinants of quality. Finally, to the extent that agency workers do affect quality of residential care (either positively or negatively), understanding why and for what types of agency workers (who fulfill many roles in aged care) would aid policymakers.

Given the uncertainties about causality and the potential for unintended outcomes, it would be premature to impose any strict restrictions on agency employment in residential aged care. Even greater caution should be applied when considering employment policies for home care. The correlations described above only refer to residential care, and cannot be translated into home care (which is a varied and complex service offering, with different consumer needs) and other primary forms of indirect employment, such as independent contractors.

Sources: Ma et al. (2022); Castle and Engberg (2007, 2008); Department of Health (2021a).

There are no Australian studies examining the effect of independent contractors on quality of care in home care, which is not unexpected given the relatively new policy of consumer-directed care and low up-take of self management. Whilst the ACQSC seeks and uses data on individual provider use of independent contracting and holds information that can be proxies for low quality care (for example, complaints and non-compliance notices), these data are not robust enough to meaningfully test whether indirect employment had any causal relationship with quality of care outcomes, in a systemic way for the entire sector.

## What other factors affect quality in aged care?

While the Royal Commission naturally focused on understanding the link between employment and care quality, some submissions pointed to the role of government funding as one of the underlying drivers of consumer outcomes. Those submissions argued that increased funding in packages would flow through to the workforce and in turn improve the quality of care provided to recipients. For example:

Inadequate government funding is at the core of all workforce issues across the aged care sector. Poor workforce outcomes can be directly linked to inadequate and outdated funding mechanisms. High workloads, no time to care, short shifts, inadequate hours, and high rates of part time or casual employment are all symptoms of a poorly funded system. (UWU 2019, p. 8)

These views have been echoed by many participants in this study, who have argued that, while providers already preference direct employment to achieve their own objectives and deliver on their particular care models (chapter 5), there needs to be a sufficient level of funding to drive this model across the whole sector. It has also been put forward that the use of independent contractors is a result of these funding constraints and the desire for consumers to get the most out of their package.

## 3.2 Indirect employment — advantages for consumers

Consumer groups have a strong desire for an aged care system that prioritises the enablement of older Australians to exercise greater autonomy, choice, and control over how their government-allocated funds are spent, with appropriate quality assurance and safeguarding mechanisms in place. To the extent that greater choice and control lead to better matches with workers, older people will be able to remain at home for longer, and it will contribute to their quality of life and connection with their community. This is relevant for all older Australians, and particularly those with strong ties to their community such as Aboriginal and Torres Strait Islander people who seek care that is culturally safe and appropriate.

Various submissions spoke to the benefits for consumers of indirect employment, which was generally supported by peak consumer groups such as COTA Australia (sub. 40) and the Older Persons Advocacy Network (OPAN, sub. 41), and some platforms and providers (Mable sub. 30; Country Home Services sub. 5). Other consumer groups (such as Dementia Australia, sub. 6) were agnostic about the role of the employment method in determining quality, noting there are benefits and costs of each approach.

Stakeholders in this study highlighted some common benefits such as:

- the opportunity to improve choice and control over the type of care received (COTA Australia, sub. 40; Dr Carmel Laragy, sub. 16; Carers Australia, sub. 34)
- more care hours for a given budget (name withheld, sub. 3; Mable, sub. 30)
- flexibility for providers in filling staff gaps and ensuring basic care needs are met (Name withheld, sub. 20; Palliative Care Australia, sub. 2; Karyn and Enid Cullen, sub. 14; Carers Australia, sub 34).

These views and other benefits for consumers associated with indirect employment are expanded on below.

## Potential to improve care outcomes for some consumers

The Commission heard that self-management and the use of platforms to engage care workers has the potential to improve outcomes for some consumers. During consultations, several consumer groups argued that consumers (or their informal carers and family members) were best placed to judge the quality of care provided to them. They also noted that suitable matches between consumers and personal care workers or nurses could lead to longstanding relationships and better continuity of care — a key quality indicator.

## Better care outcomes through self-management and relationship building

Consumer-directed care, and self-management of home care packages (HCP), has allowed consumers to have greater choice and control over the services and people they wish to enter their homes, leading to improvements to a number of care outcomes. A trial by COTA Australia showed small improvements in quality of care with participants' first experience of self-management compared with their previous provider-managed arrangements (box 3.4). Based on the results of this trial, Laragy (sub. 16, p. 2) stated:

The findings ... clearly show that older people who self-managed or had a family member manage their aged care package on their behalf, had a higher quality of care compared to previous experiences with aged care service providers.

### Box 3.4 – COTA Australia's self-management trial

In 2018, COTA Australia worked with RMIT University to undertake a 9-month study trialling and evaluating self-management for HCP recipients. The study recruited 103 older people who had existing HCPs with one of seven participating providers, and allowed them to self-manage, or have a representative manage their HCP. Funds were held by their provider who had oversight on spending to ensure payments were in keeping with care plans.

The aim of the study was to evaluate the requirements, benefits, and challenges of self-management in comparison to provider-managed home care. Participants were surveyed pre- and post-trial to measure changes in their satisfaction with their current service model, motivations for self-managing and perceptions of associated risks. Both quantitative and qualitative questions were posed to participants to allow for both aggregate statistical analysis and personal feedback.

The findings of this study were largely positive. Following self-management, participants reported:

- improvements in perceived physical wellbeing (but no statistically significant improvements in other quality of life measures)
- slight improvements in satisfaction with the quality of support from care workers
- greater choice and control
- less perceived risk than expected.

In qualitative responses, participants particularly enjoyed the autonomy self-management gave them as well as the ability to remain at home, select staff and spend their money in economical and flexible ways. The qualitative data highlighted some issues that a small number of participants experienced, including finding self-management burdensome, confusing or time consuming, while a few saw no benefit in participating. While the sample is too small to be definitive, the COTA Australia trial suggests that self-management offers benefits for some consumers with minimal risks for many types of recipients.

Sources: COTA Australia (2019); Laragy and Vasiliadis (2021).

A submission from a 69 year old woman who is a full-time informal carer for her husband who has Parkinson's disease and receives support through a level 3 HCP (name withheld, sub. 3), further illustrates the benefits of self-management. She documented her experiences working with traditional home care providers, and the benefits of switching to self-managing her husband's HCP and contracting personal care workers and nurses through platforms. In particular, she found that self-management allowed her the freedom to build a support team, maximise the benefits of their HCP funding, and develop strong

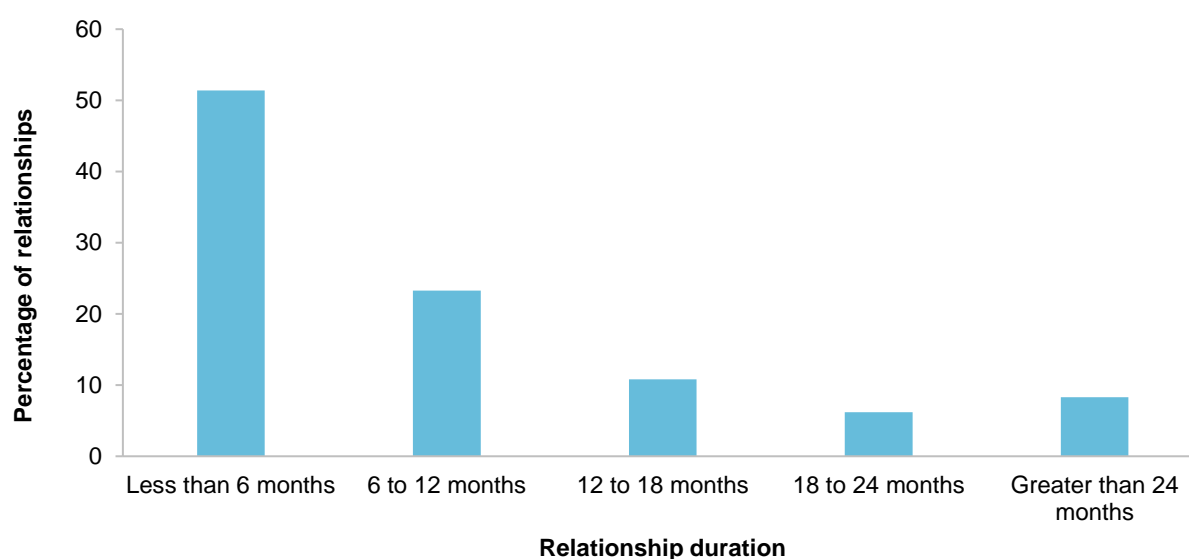


relationships with their workers who are all from the local community. In turn, she described experiencing better continuity of care with an adaptable team that works to cover care needs during any interruptions.

Mable (sub. 30, pp. 22–23) stated it had evidence that its marketplace model ‘is facilitating quality care and quality of life outcomes, with appropriate safeguards’ and pointed to a range of evidence to support this claim. Of note was reference to a 2019 survey of Mable’s customers comparing their experience using Mable to engage support versus prior experience. The results showed a high proportion of respondents (48 per cent) describing their prior experience with traditional providers as quite poor or very poor, compared with 89 per cent who rated their experience with Mable as very good or quite good. However, it is expected that consumers who are unhappy with Mable are unlikely to keep sourcing workers through that platform and hence the survey is likely to over-represent consumers who prefer platforms.

Mable also provided the Commission with data that shows the relationship duration between personal care workers and consumers using the platform over a 12 month period from 1 October 2020 to 30 September 2021 (figure 3.1). Noting that matured relationships are considered those that have reached a minimum of six months, these data show that during that period about 40 per cent of relationships had a duration of 6 to 24 months. Further, over 8 per cent of relationships had a duration of greater than two years, indicating the potential for long lasting relationships between independent contractors and consumers, which achieve the desired outcomes that many in the sector aim for — namely, consistency of worker and continuity of care.

**Figure 3.1 – Personal care workers on Mable have long relationships with consumers**  
Length of relationships between 1 October 2020 to 30 September 2021<sup>a</sup>



a. As the data represents the duration between an initial and most recent engagement (which may not be final) between a consumer and their care worker, many of these relationships are ongoing and not considered to be fully matured.

Source: Mable (pers. comm., 16 September 2022).

It is also worth contrasting the experience of self-managed care with the experience of consumers who rely on providers to select and roster their workers. Carers Australia (sub. 34, p. 2) noted there can also be difficulties establishing continuity of care through a home care provider:

When a home care provider supplies a nurse or aged care worker who the consumer is not comfortable with, which is especially important to consider from a cultural safety perspective as well as basic dignity, it may be difficult to organise an alternate paid care worker. Conversely, if

the care is provided by someone with whom the consumer is compatible, there is no guarantee they will not be reassigned by the provider to other clients.

Various submissions expanded on the importance of relationships in delivering good care outcomes. Mable (sub. 30, p. 23) argued that quality of care is linked to the 'understanding of the person providing support and the relationship and connection that forms between people ... [which] ... can be equally delivered by someone employed or someone self employed'. Cullen and Cullen (sub. 14, p. 2) further reiterated the role of relationships. They noted that they 'do not consider the differentiation in impact to be between direct and indirect forms of employment ... because it is the nature, passion and approach of the people that makes for good quality care'. Dementia Australia (sub. 6, p. 6) was equally agnostic to the employment model in delivering better care outcomes, but also pointed to the importance of relationships:

... workforce continuity and competency underpins the quality of aged care service delivery. Regardless of whether they are employed directly or indirectly, in home or residential care, if aged care workers at all levels are employed on a regular basis, know their care recipients well, understand their individual needs and preferences and adopt a genuinely person-centred approach to their care, this will make the most significant contribution to ensuring the provision of high-quality dementia care.

There is potential for self-management to allow consumers to be better matched to workers with characteristics they prefer, given the greater diversity in the pool of workers on platforms (figure 4.3). This might lead to more long-lasting care relationships. Carers Australia (sub. 34, p. 2) gave the example of providers not having employees proficient in a consumer's language and acknowledged that 'advertising on digital platforms may produce better results'.

Dementia Australia (sub. 6) noted the importance of having the appropriate training in dementia care to provide high quality care for consumers with dementia. In some circumstances, self-management may allow matching with workers that have the appropriate dementia training and, in turn, forming a lasting care relationship and better care outcomes. However, training is not provided to independent contractors in the same way employers deliver training to their staff, so independent contractors may have to source and pay for this themselves (chapter 4), although training costs will be tax deductible. Alternatively, these benefits may be realised if experienced personal care workers and nurses with specialised training move to platforms later in their careers, or take up platform work alongside their employment, and therefore offer the appropriate skills and experience to provide dementia care to self-managing consumers who require this.

## **Servicing regional and remote Australia**

Platforms also offer the potential to match personal care workers and nurses with older people in regional and remote settings where the establishment of a home care provider that directly employs local workers is not feasible.

In such circumstances, platforms may be able to provide community-led solutions (box 3.5), however they may need to operate through other channels where internet access in remote areas is poor. The ability to better service these markets through an independent contracting-based approach was noted by Carers Australia (sub. 34, p. 2), OPAN (sub. 41, p. 4) and Mable (box 3.5).

Carers Australia (sub. 34, p. 2) also noted that engaging workers through platforms can assist in markets where home care providers are unable to meet demand, and where the reliance on family and friend carers (or a premature move to residential care) may be the only option. The Commission heard through consultations that this scenario is common for older Aboriginal and Torres Strait Islander people, who may be forced to move off country. Indirect employment methods were considered to be one way to maintain care



services to regional, remote and very remote areas, and to provide care that is culturally safe for Aboriginal and Torres Strait Islander communities.

### **Box 3.5 – Case Study — Mable in Bell, Queensland**

Mable (sub. 30, pp. 27–28) outlined a community-led solution to identify and engage an aged care workforce in Bell in Queensland where no home care providers previously existed. Mable stated:

Bell, a small town with 500 people, three hours west of the Sunshine Coast in Queensland, had no Approved Home Care Providers in town and older residents had to rely on Providers delivering support by driving from towns several hours away.

Travel time eats into home care package funds, meaning fewer hours of support and less reliability and consistency for older residents who want to age in their home. As a result older town residents were without support and at risk of having to leave their community and move into residential aged care facilities in towns that were 2 to 3 hours away [ ... ]

Mable was contacted by a concerned local resident. Together, we identified the potential for a new workforce from within the local community, where older residents could get support from people they know and trust.

Partnering Mable's ... platform with an Approved Home Care provider, for package and care management, and starting with one Home Care Package, Mable has been able to help the community build this solution, whereby there are now 20 older town residents with home care packages, being supported by ten residents earning income providing care and support as independent contractors.

This means more of the Government home care funding stays in the town, lower overheads enable consumers to get more hours of support and a new workforce offers economic opportunities for locals.

## **Catering to diverse needs**

Meeting the needs of a diverse cohort of older Australians is a key aspect of the consumer dignity and choice aged care standard. OPAN recognises that every older person has different needs based on their life experiences, personal characteristics and identities, such as cultural and ethnic background, religion, sexuality or military service, and views diversity in aged care through twelve key groups (figure 3.2).

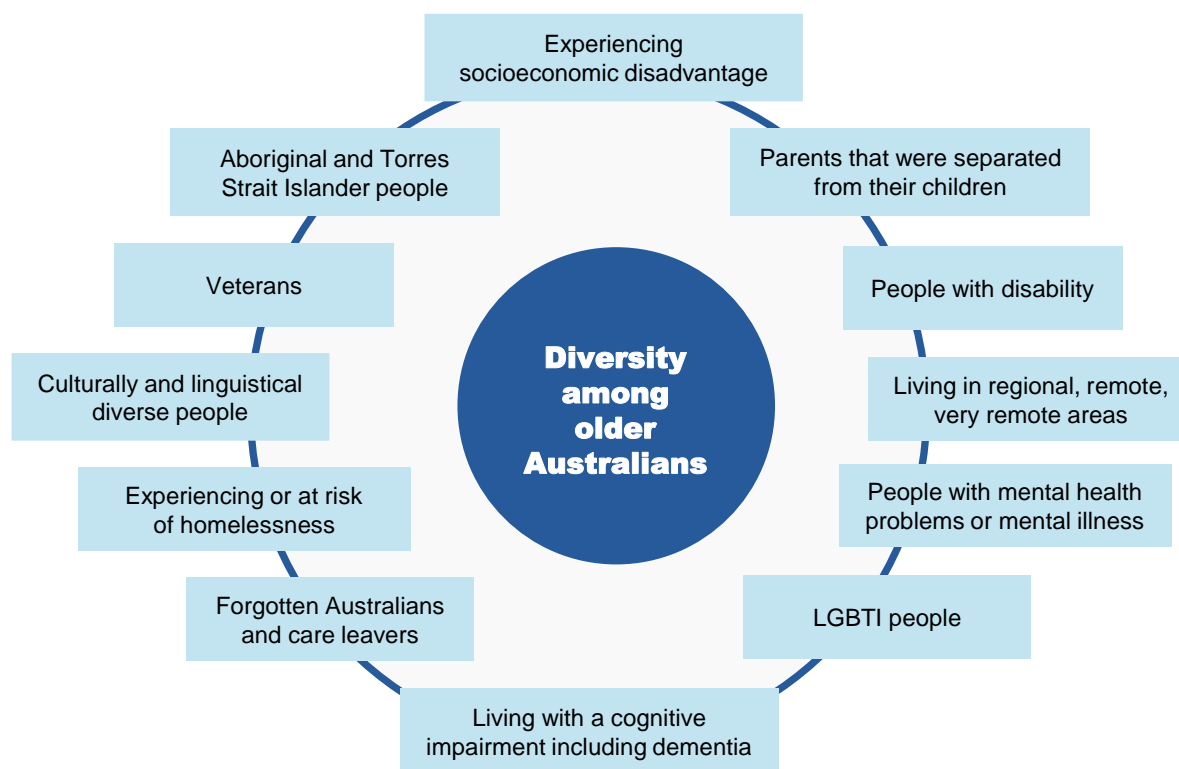
This diversity flows through to individual preferences of older Australians in terms of their care services. Self-management provides an avenue to enable this choice. For example, Laragy (sub. 16, p. 3) stated:

The diversity within the community in terms of personal preferences, culture, ethnicity, sexuality, location, etc., cannot be addressed by prescribed models of service provision. Self-managing home aged care packages provides opportunities for older people to purchase services to meet their individual needs.

Older people who identify with a particular LGBTI status, have a CALD background or are from an Aboriginal and Torres Strait Islander community represent just a few examples of diversity where service delivery needs to be sensitive and culturally safe. Carers Australia (sub. 34, p. 2) and OPAN (sub. 41, p. 2) both noted that the use of platforms enables consumers to search for personal care workers and nurses who speak their

native language, come from a particular faith, or identify as LGBTI, for example, and may deliver a better care outcome for these consumers.

**Figure 3.2 – Diversity in consumers of aged care services<sup>a</sup>**



**a.** Forgotten Australians and care leavers refer to persons brought up in care away from their family as state wards or children raised in children's homes, orphanages or other institutions, or in foster care.

Source: Adapted from OPAN (2022).

However, the ability to select workers based on some of these characteristics potentially raises the risk of discrimination. Some jurisdictions, such as Queensland, provide exemptions from anti-discrimination legislation for home based services and it is not unlawful to discriminate on any ground except race when recruiting someone to perform domestic work or childcare services within an individual's home (QHRC 2019). In Victoria, similar exceptions apply in the delivery of home care services under both direct and indirect employment models, whereby an employer may discriminate when hiring someone to provide domestic or personal services within their own home, or at the request of the person whose home it is (VEOHRC 2022). Such regimes can protect consumers who have a strong preference for care workers with certain characteristics, but policy makers may wish to investigate whether any demographic groups who routinely experience discrimination find it harder to source work or earn systematically less than other groups on platforms.

Some traditional providers are also responding in unique ways to the need for diversity and inclusion. As an example, ECH is a South Australian-based, not-for-profit, residential and home care provider that provides culturally safe access, navigation, advocacy and connection to aged care services for LGBTI community members in South Australia. ECH has developed a program to connect volunteers aged 55 and over from the LGBTI community to support older people to remain connected with each other. Volunteers can also meet with home care consumers once a month or attend other social activities together.

## Maintaining basic care needs during worker shortages

The results of a 2021 survey of workers who use the Mable platform suggests that platforms encourage new entrants to the care workforce as well as aiding the retention of workers who would otherwise leave the sector (chapter 4). Some study participants pointed out that the workforce support provided through indirect employment more generally (for example through labour hire agencies as well as platforms) is necessary to maintain basic care needs in a sector currently suffering from a workforce shortage. For example, Palliative Care Australia (sub. 2, p. 4) acknowledged 'that approved providers must be able to access a surge workforce during the ongoing COVID-19 pandemic and any future pandemics and emergency events'. Providers also need access to a pool of workers to backfill staff vacancies and absences. OPAN (sub. 41, p. 2) went further and stated that:

In some areas workforce shortages are having a significant impact on the availability of [Commonwealth Home Support Program] and Home Care Services. This includes a lack of consistency in support staff and frequent changes in care managers. Workforce issues are also resulting in providers being unable to fulfil care plans. ... A more flexible workforce model is needed that includes both direct and indirect workers, with relevant legislated protections built around both.

While this view does not necessarily speak to achieving higher quality care outcomes through independent contracting, it underscores that flexible employment approaches are needed to maintain a basic level of quality considering the extent of worker shortages across the sector. A proposition put forward by several stakeholders is that some care is better than no care.

## Enhancing consumer choice and control

As noted earlier, consumer representatives expressed a strong desire for an aged care system that prioritises choice and control for older Australians. Indeed, several consumer representatives presented this as the overarching objective of the aged care system now and in the future, following the implementation of the proposed new Aged Care Act. Some consumer groups argued that platforms: represent a comparatively new innovation into the aged care space (having started operating in the National Disability Insurance Scheme); enhance consumer choice and potentially better match consumers with personal care workers and nurses; and potentially allow consumers to remain at home for longer. Some groups were concerned that even though consumer-directed care was implemented some years prior to the Royal Commission, some providers still do not offer their customers the option to self-manage. COTA Australia (sub. 40, p. 6) stated:

We have seen the increased use of online platforms in the National Disability Insurance Scheme and consumers seeking to self-manage in home care are keen users of online platforms where their provider facilitates this. We see the continued development of online staffing platforms as important to providing choice to consumers in aged care.

Many platforms publish ratings and reviews of personal care workers and nurses on their websites, and allow consumers to rate workers' performance (based on their own experience) and provide written reviews, improving the transparency for other consumers who can also view this information in worker profiles. Being able to read these reviews, make an assessment, and engage independent contractors via a platform allows consumers to choose a team of personal care workers and nurses that best matches their needs, rather than be allocated a worker(s) through their home care provider's rostering system.

There has historically been strong support among older Australians for consumer choice. A survey commissioned by National Seniors Australia found that 95 per cent of its members who responded (4267 persons) ranked consumer choice in home care as extremely or very important, but far fewer were confident that they could choose a provider to best meet their needs in practice (McCallum and Rees 2017, p. 14). This may be a result of insufficient available information (at the time), and the associated switching costs

when changing providers, noting the survey was conducted in the infancy stages of consumer-directed care (chapter 2). This issue is also one which affects all existing models of consumer-directed care, not just those which make use of indirect employment. Regardless of these concerns, Laragy (sub. 16, p. 2) noted that older people wanted ‘... ‘dignity of risk’ where they decided what risks they would take, and they greatly resented service providers and others restricting their choices’.

Carers Australia (sub. 34) argued that choice and control over care was a major benefit of indirect employment models and facilitated greater choice for people from LGBTI or non-English speaking backgrounds. OPAN (sub. 41, p. 5) contrasted the level of choice in a typical rostering system with self-management, and noted that:

In direct employment rostering and timing of services means that older people often have to comply to the ‘providers’ hours rather than receiving services at the times that suit them. For example, waiting to have a shower at 9am as that is when staff are rostered on rather than being able to maintain their 7am shower.

National Seniors Australia (sub. 13, pp. 5–6) summarised consumers’ expectations based on data collected through its national surveys — the ability to access care services from people who share their identity, personal care workers and nurses who have been trained in specialised care delivery, and interpersonal relationships with their personal care workers. Whilst these objectives can be achieved through direct or indirect employment, consumers may be best placed to assess which method works best for them.

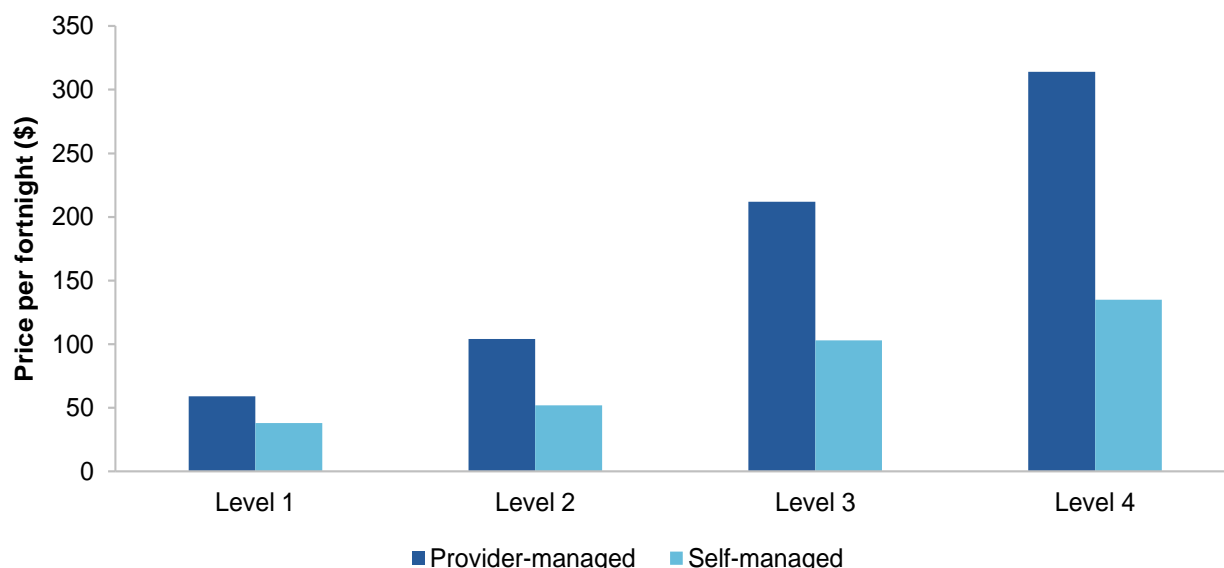
Where these choices require consumers to use a digital interface, engaging with them can require a level of digital literacy that not all older Australians necessarily have, or are comfortable with, which may restrict the benefits of indirect employment for some consumer groups, particularly those with no family or community support to help navigate platforms. That said, there is one provider that exclusively uses independent contractors (Country Home Services) that connects with consumers via phone or in person.

## Getting more from a home care package budget

Another motivation leading consumers to engage workers directly through platforms is to get more care hours out of their HCP. Providers are responsible for care coordination services, and typically charge care management fees for this service to consumers. Where a consumer chooses to self manage, the provider is still responsible for the oversight of any services delivered and continues to undertake a range of activities to meet this responsibility. As such, care management fees are still charged to self-managing consumers, albeit at a lower level compared with provider-managed consumers. Across each HCP level, the median fortnightly price of care management is noticeably higher in fully provider-managed packages than those that are self-managed (figure 3.3).

This supports the claims of consumers and platforms that engaging independent contractors themselves leads to savings, which in turn means that each individual’s government-allocated budget (a fixed annual amount) can potentially go further in terms of procuring more hours of care. This is relevant to those consumers who wish to self-manage their package, and do not require the additional service of a provider determining the right mix of services and sourcing workers; others may find those services more necessary.

**Figure 3.3 – Self-managing a Home Care Package costs less**  
**Price for care management at each HCP level, 30 June 2022**



Source: Department of Health and Aged Care (2022e).

Given that consumers can access and use their budget (that is, day-to-day savings are not withheld by government), this means that the difference between provider-managed and self-managed care management costs represents budget capacity that can be spent on procuring more care services.<sup>16</sup>

Using the published median personal care price of \$58 per hour in June 2022 (DHAC 2022e), these savings at each HCP level can be converted to additional care minutes to illustrate what could be purchased, showing:

- 22 additional care minutes per fortnight at level 1
- 54 additional care minutes per fortnight at level 2
- 113 additional care minutes per fortnight at level 3
- 185 additional care minutes per fortnight at level 4.

Utilising savings to spend on more care hours was also demonstrated by Mable (sub. 30, p. 47), which showed how HCP budgets (levels 1 through 4) equated to typical hourly costs for consumers who are fully managed through a traditional provider model, versus self-managed through Mable. Mable's data suggest that consumers can typically gain over 40 per cent more care hours through self-management and engaging independent contractors. Another participant (name withheld, sub. 20, p. 6) described their experience self-managing and using Mable, and noted that 'our family felt that we could have used the [HCP] funds more prudently by directly engaging reputable businesses or individuals for services needed'.

<sup>16</sup> Providers are allocated the government funding that comprises each person's budget and then consumers draw down the money that is held by providers, who then pay the independent contractor.

### 3.3 Indirect employment — disadvantages for consumers

Submissions to this study identified several disadvantages for consumers from an indirect employment model, with many focusing on a perceived lack of clarity around who is accountable for service delivery when a consumer engages a worker themselves.

Many study participants argued that because of the accountability concerns, there may be associated disadvantages of engaging workers through platforms, such as a lack of oversight of care delivery or coordination of care (Quality Aged Care Action Group (QACAG), sub. 12; National Seniors Australia, sub. 13; Australian Medical Association, sub. 19; Aged Care Crisis, sub. 39; Darwin Community Legal Service, sub. 46).

Other submissions noted the high turnover of staff (Carers NSW, sub. 7; QACAG, sub. 12; National Seniors Australia, sub. 13; Darwin Community Legal Service, sub. 46) associated with indirect employment, however many — but not all — of these concerns are more relevant to the residential care context, rather than to personal care workers and nurses engaged for home care through platforms.

#### Perceived lack of accountability, oversight and care coordination

Under current policy settings, when a consumer engages an independent contractor via a platform, their home care provider remains accountable for the safety and quality of service delivery, not the platform (box 5.2). However, various participants have suggested that consumers may not be fully aware of this or be in the best position to judge quality when engaging personal care workers and nurses through platforms. For example, referring to procuring workers through platforms, QACAG (sub. 12, p. 3) stated that:

... providers cannot have the same oversight regarding the qualifications and quality of those staff as they would have if they employed them directly themselves. If engaged by the recipient of care, a primary concern is that the recipient may not have the ability to assess the appropriateness of the worker to perform the tasks required.

Further, the Australian Medical Association (AMA sub. 19, p. 2) put forward the following.

Existing digital platforms connecting consumers to aged care workers lack transparency in the information they provide to older people who engage with them. The platforms do not disclose that they are not accredited to provide aged care services and that they are not required to comply with the Aged Care Quality Standards.

Related to the difference in accountabilities, there is some concern that in an indirect employment model the home care provider has less oversight of the care delivered by personal care workers and nurses. This issue was raised by several consumer-focused submissions (sub. 12, 13) and those of providers (sub. 17, 22). Other submissions (sub. 2, 7, 13, 19) have also criticised the accountability regime, contending that when consumers engage independent contractors themselves there is a lack of coordination and consistency of care because the care coordinator (or case manager) employed by the home care provider has less oversight of the care that is delivered. In these circumstances, there may be a greater reliance on the consumer, or their family/informal carer, to provide a coordination role, despite not being suitably equipped to take on this task. Some argued that relying on independent contractors will reduce the continuity of care provided to recipients. For example, the AMA (sub. 19, p. 1) said:

... continuity of care is crucial for provision of adequate health and personal care in the aged care setting. An indirect employment model that relies on independent contractors (including those in labour hire agencies) and workers engaged through digital platforms is not conducive to continuity of care and therefore the AMA cannot support it.



Palliative Care Australia (sub. 2, p. 3) further expanded on the theme of consistency, although was less definitive as to whether a consistent care workforce was one that was directly employed. It stated that:

A consistent and regular workforce are also more aware of each person's clinical and personal care needs and can identify when there is a change in symptoms. Consistency in personal care workers is especially important in home care where a personal care worker may be the only regular visitor the care recipient has and provides the only opportunity for regular reviews of a person's health and well-being.

It should be noted that traditional providers typically employ a case manager to ensure that even if different personal care workers and nurses are sent to a person's home, there is some consistency in the way care is provided, or in the model of care adopted by the organisation. Currently, when a consumer chooses to self-manage, responsibility lies with the approved provider to develop a care plan for types of services that are required and arrange payments to any contractors engaged through platforms (ACQSC 2022). Providers have a critical role in providing oversight and ensuring the wellbeing of older people, and they are funded for this responsibility through the receipt of care management fees (figure 3.3). This was evident in the COTA Australia self-management trial, where Laragy (sub. 16, p. 4) noted that the providers included in the trial took on their accountability responsibilities seriously, by monitoring payments and ensuring that spending was within approved guidelines and according to the person's plan; there could be an issue if a provider did not take their responsibilities seriously. Chapter 5 discusses the responsibilities of providers in more detail.

Nonetheless, issues of visibility are not unique to platforms or independent contracting — providers may still struggle to have full visibility over their direct employees in home care settings. And while it is true that platforms are not legally obliged to provide oversight and care coordination, there remains an incentive for them to work closely with approved providers to ensure consistency of care to at least retain their customer base. For example, Careseekers has agreements in place with providers, giving assurances to providers (and in turn consumers) that workers are appropriately qualified to deliver care and that it will meet its code of conduct. There is also a mutual understanding that they will provide reports to, and liaise with, the provider when servicing their clients, among other requirements (pers. comm., 9 August 2022). Mable has an aged care manager software function, which case managers can use to shortlist and review workers that meet their customer's needs and have full visibility over the services that their customer has procured directly (Mable 2021).

Some of the above-mentioned disadvantages, and the associated risks to consumers, may be more related to the nature of home care provision (that is, workers being in a person's home, with little or no supervision) and the use of platforms, rather than the form of employment used by home care providers or platforms. There is substantial reform being implemented in aged care, including the design of new legislation, regulations, and the introduction of the proposed Support at Home program, and it is expected that greater clarity will be provided to enable consumers to better understand where these responsibilities lie — this is discussed in more detail in chapter 6. With greater emphasis on consumer-driven care, consumers will need to take on more responsibility for their care management needs if they choose to self-manage their package.

## **Cancellations and complaints resolution**

One risk that is unique to home care services directly procured by consumers is whether they are left particularly vulnerable to cancellations by workers. As platforms are not accountable for the safety and quality of care delivered by independent contractors under the current policy settings, it is important to understand how cancellations and complaints are managed by platforms and contrast them with providers. It is noted that various cancellation policy approaches have been adopted (table 3.1), with some notable differences in who is responsible for finding replacement workers.

**Table 3.1 – Cancellation and complaints resolution policies****Digital care platforms and approved providers<sup>a</sup>**

	Cancellations – respective roles		Complaints / incident management policy		
	Responsibility for replacement	Secondary responsibilities	Process	Escalation	Resolution
<b>Selected digital care platforms</b>					
Care.com	Customer	Worker encouraged to give 24 hours notice	Safety concerns can be reported Complaints are via reviews	None	None
Careseekers	Customer	Worker notifies customer, their emergency contact, and their support coordinator	Reported to Careseekers and recorded in Complaints Register	Investigated and initially resolved by staff	Takes up to 10 days If not resolved, will be escalated to an independent body
Five Good Friends	Shared – Platform assists worker and customer to find replacement	Worker can only cancel if customer agrees, and the shift is covered	Should first be reported to the worker then the platform	Investigated and independent arbitrator can be engaged with costs shared	No timeline Agreements and membership can be cancelled if no resolution is reached
Hireup <sup>b</sup>	Customer	Worker must notify customer at least 2 hours prior Cancellations can lead to termination	Complaints are identified through feedback or proactively through insights	Complaints are investigated and resolved but can be reviewed Outcomes of reviews are final	Takes up to 21 days with high-risk complaints prioritised
Mable	Customer	Worker is encouraged to form a network of replacements	Notified to Mable via phone or online, or via monitoring processes	Handled by worker first, escalated to Trust and Safety team if required	Takes up to 10 days May include counselling, support, external reporting, suspension / removal of users
<b>Selected approved providers</b>					
Regis	Provider		Breaches of code of conduct are reported with whistle-blower protections	Complaints are investigated then formalised if a breach has occurred	May result in disciplinary action, penalties, and termination
Resthaven Inc	Provider		Complaints can be made in	Complaints should first be raised by	No public information available



Cancellations – respective roles		Complaints / incident management policy		
Responsibility for replacement	Secondary responsibilities	Process	Escalation	Resolution
		writing or via email	workers, then formalised	
Yorke and Northern Local Health Network	Provider	Complaints can be made directly to workers or through a feedback form	Complaints should first be raised with workers then formalised	Takes up to 35 days Can be escalated to the relevant Commission

**a.** While providers initially try to find replacement workers within their own employment pools, they occasionally rely on agencies to fill in gaps **b.** Hireup is included for comparison purposes only — it does not provide subsidised home care services — it provides disability support and private home care services and employs workers directly.

Source: Various provider and platform web pages (2022).

In a focus-group style discussion with a small number of independent contractors that use Mable's platform, workers described having an ongoing incentive to maintain relationships with their clients and will take actions to ensure care needs are met where a potential cancellation is foreseeable — either by giving advanced notice or arranging with other independent contractors to backfill them. In the latter example, a Mable worker had formed groups of local personal care workers to assist in this process, creating a team to provide consistent care to clients and manage any cancellations. However, it was also the case that most of their clients had family members and other providers to step in at the last minute. Other platforms provide more robust cancellation policies, including shared responsibilities for finding replacement workers, which may be more effective and desirable for consumers who lack a family or informal support network.

Part of the 'dignity of risk' is letting consumers choose for themselves whether they are concerned about cancellations and letting them manage this risk in the way they prefer. Some consumers could choose larger traditional providers if they judge them to have better processes to ensure continuity, while other consumers may be prepared to face the potential risks. Consumers who are more reliant on the support provided by their informal carer, such as those with higher needs or who do not have family available to help them, might be particularly at-risk from unexpected cancellations and so would be best-served by choosing a provider who can cater to their needs.

Independent contractors also face a business imperative to offer and deliver a high quality and reliable service. Even one cancellation at short notice could be enough for some consumers to seek out someone else that is more dependable, or lead to a negative rating or review. Platforms or other types of businesses matching personal care workers and nurses with consumers would face a similar business imperative, as their reputation would be at risk if consumers have a bad experience from using their service.

However, it should be noted that overall ratings only provide an aggregate assessment of a worker's quality as judged by previous customers. For example, where a worker occasionally cancels on a client, this may not be reflected in their overall rating if the other aspects of their services are considered highly satisfactory. A consumer whose highest priority is to have no cancellations will therefore not be able to assess the available information to find that detail, unless the worker has a particularly negative review.

Further, on face value, platforms seem to have adopted similarly robust complaints and incident management policies as providers, which suggests there is a business imperative for platforms to provide the same or similar levels of assurances to their customers as would a traditional provider. For each business highlighted in table 3.1, policies can be found online, and are therefore accessible to consumers to

make decisions about what level of assurance they need or desire. It would be expected that consumers who need a greater level of assurance would choose a provider or platform that meets this objective.

## **Social isolation**

During consultations some consumer groups expressed caution about the use of independent contractors in situations where the care recipient is socially isolated and without any regular visitors such as neighbours or family members, who can informally monitor the quality of care being provided.

Social isolation is a unique circumstance that can present itself across all employment models and is a challenge for any business that provides or facilitates home care services, including in disability care. There is likely to be a spectrum of impacts related to vulnerability of the consumer. For example, if a consumer is very socially isolated (for example, no other family or friends visiting their home) they may be more vulnerable to abuse from any worker — whether they are directly employed or not — compared with someone who has more regular people informally checking in on them.

However, such circumstances are rare and speak to the risks associated with social isolation rather than a risk associated with a particular form of employment. In these environments, to protect the consumer from negative experiences, whether via low quality care or some form of exploitation, many participants put forward that increased monitoring (for example, through in-home checks by the regulator) would be required to protect vulnerable consumers.

## **Other considerations for consumers**

### **Those with low digital literacy may be excluded**

Some study participants said that digital literacy may pose a barrier to some older people accessing personal care workers and nurses through platforms, creating a risk that as these platforms become more prominent there may be a cohort of consumers who may be excluded from this marketplace unless they have informal carers to assist. An example from one participant (name withheld, sub. 20, p. 5) illustrated this point:

We found the online Mable platform relatively easy to use and helpful for a time. Having said that, all online arrangements were with the assistance of family members as our mother is not confident online. Everything from research, engagement and paying invoices was with the assistance of younger family members.

The potential exclusion of those with low digital literacy was not presented as an argument to halt innovation in this space, but rather, it points to a broader issue about how consumer choice in aged care can best be promoted in a digital setting. A ‘no wrong doors’ approach, which allows those with less digital literacy to use other means to obtain care without sacrificing the gains to those who are digitally literate may be the most effective policy given the evolving nature of the platform market, with equity concerns (whereby consumers are excluded from the online market) being addressed through improved education and up-skilling campaigns for older people who lack digital literacy.

## **Search costs**

While self-management and engagement of independent contractors provides benefits to consumers, there can be increased time and effort associated with searching for suitable personal care workers and nurses for individual services. Aged care is considered an ‘experience’ service meaning that, it is not until the worker enters the home and provides care that the consumer is then able to judge the quality of the service provided. In circumstances where the consumer is unhappy, the process of searching for a replacement is repeated. One study participant (name withheld, sub. 20, p. 5) experienced a ‘distinct lack of assistance in

knowing what is available to you’ and that while they were able to source a cleaner through a platform, finding a replacement after the contract ended meant they were back at ‘square one’.

In the provider-managed model of home care, providers have sole responsibility for rostering and screening workers, whereas in a self-management model consumers and/or their informal carers will take on some of these screening costs (Carers NSW, sub. 7). However, search costs (for example, time and effort) also apply to consumers searching for a home care provider, with various consumer groups raising the difficulty and time associated with changing home care providers.

Consumer-directed care means that consumers who choose to self-manage are expected to play a more active role in assessing what is a good quality service, and what price they are willing to pay for it — with options for provider-management for those not willing to take on these responsibilities. However, some submissions have argued that consumers do not have the necessary information to judge the characteristics of the worker they are potentially engaging. For example, Hireup (sub. 33, p. 11) submitted:

The choice between an older person engaging an employee of a platform provider or a contractor through a platform provider is not always clear at the point of engaging that worker ... the principles of choice and control that Australia’s aged care system aims to facilitate are based on the availability of meaningful information about the repercussions of consumer decisions. We are concerned that users of aged care services are not furnished with adequate information to enable them to engage safely in the online care marketplace.

Hireup makes two important points — first that consumers may not be clear whether a worker they are engaging from a platform is a direct employee or independent contractor and, second, that consumers may not have adequate information to engage safely in online marketplaces. Although information about the employment status of personal care workers and nurses can be found on various platform websites, greater transparency could benefit some consumers who place a higher importance on how their care worker is employed. However, the Commission has not been made aware that this is a major concern.

While this latter argument has been raised in various forums, consideration should be given to the emerging role of ratings and review functions (not just in aged care, but other sectors as well) which typically provide consumers with information about the worker, their qualifications and other information which might be a preference (for example, speaking a second language) which can greatly enhance informed decision-making. Further, platform workers have indicated that the combination of the profile they put on the platform, plus the role of ratings and reviews aid transparency for consumers and provides an incentive for workers to deliver high quality care to get better ratings and reviews and be engaged by more consumers. Such reviews and ratings may increase transparency regarding the quality of individual services, which may provide more information to assess the quality of the service a consumer will receive compared with having to choose a home care provider to provide all their care needs.

### **3.4 Impacts of preferencing direct employment**

With growing demand for aged care, greater diversity among consumers, and a greater desire for independent living and individualised care, the delivery of home care is not and should not be a one size fits all approach.

Independent contractor-based models, most often provided through digital care platforms, offer many advantages to consumers, including the potential to improve care outcomes, enhance consumer choice, autonomy, and control over who enters their home, and facilitate more hours of care from savings in care management costs.

While risks have been identified (for example, stemming from misunderstandings about accountabilities), and these may be exacerbated in some settings (social isolation, low digital literacy, when cognitive impairment exists), many are inherent in the delivery of home care and are not unique to employment type.

From a consumer perspective, the Commission has not found compelling evidence that would justify a policy that preferences direct employment.



### **Finding 3**

#### **A policy that preferences direct employment would leave self-managing consumers worse off**

Indirect employment models (such as those used by digital care platforms) offer several benefits to self-managing consumers, and these models work particularly well for older people with good cognitive abilities, lower support needs and some level of digital literacy and family/community support.

There appears to be a perceived lack of understanding or awareness by consumers that engage independent contractors that the provider (rather than the platform) is accountable for the safety and quality of care. However, robust complaints management policies, combined with ratings and reviews systems, help mitigate risks to consumers and provide an incentive for platform workers to deliver quality care.

A policy preferencing direct employment would lead to worse outcomes for those consumers who value choice and control over how their care is delivered. While the proportion of consumers engaging independent contractors is currently small, for them, such a restriction would:

- restrict consumer choice, autonomy, and control
- reduce access to personal care workers and nurses, particularly in regional and remote areas, and during worker shortages
- reduce access to a pool of workers who are better able to meet the diverse needs of consumers
- increase the cost of care and result in fewer hours of care for a given budget
- dampen the development of innovative services tailored to diverse consumer needs.

## 4. Worker perspectives

### Key points

- \* Aged care workers who choose independent contracting do so because the benefits to them outweigh the costs. Given the job vacancies at many providers, most workers who choose independent contracting have the option of being directly employed.
- \* Flexibility and control over how much, when, where and how they work are among the key drivers for workers to engage as independent contractors in aged care. The ability to supplement income and hours from other jobs is also an important motivator for some.
- \* Most independent contractors engaged via digital platforms earn pay rates that are well above the award rates for employees, net of fees and non-wage payments, such as penalty rates and superannuation.
- \* Independent contractors can experience variable hours and income. However, these characteristics are not isolated to independent contractors; other directly employed workers — including casual and part-time employees who make up the bulk of employment in aged care — face similar challenges.
- \* Independent contractors must obtain insurance — either through a platform or independently — to cover for an injury at work. These insurances do not typically provide the same benefits as workers' compensation schemes.
- \* Opportunities for independent contracting and platform work are likely to attract some workers who would not otherwise work in aged care. Preferencing direct employment would likely reduce the pool of labour available to fill vacancies, and limit opportunities for workers to supplement their hours and income.

This chapter examines the available evidence on the advantages and disadvantages of independent contracting from the perspective of workers. The chapter uses the term 'workers' throughout to refer to individuals who provide aged care services, whether as employees or independent contractors.







### 4.1 Is independent contracting a choice?

#### Individuals weigh the potential benefits and costs

When workers face a choice between taking a job as an employee or engaging as an independent contractor, they balance the benefits and costs of each option (figure 4.1) and choose independent contracting if its benefits to them outweigh its cost. The benefits of independent contracting to individuals can include flexibility and autonomy, the potential to earn higher rates of pay than traditional employment and the

ability to supplement earnings from other work, making better use of workers' skills and opening up job opportunities in aged care. The potential costs include a lack of guaranteed wages and employment conditions, unpredictable or variable hours of work and income, taking on risks associated with self-employment and fewer opportunities for training and career progression. However, working as an employee or contractor is not a binary decision — many workers choose to do both. Workers may supplement their income and hours from working as an employee with some additional independent contracting work. Further, working as an independent contractor is not necessarily a long-term career choice.

**Figure 4.1 – Individual workers weigh the benefits and costs of independent contracting**

Pay and conditions	Hours of work	Autonomy and control
+ higher pay - no guarantee of award rates or conditions 	+ greater control and flexibility - variable and fragmented hours 	+ control over work - risks associated with self-employment 
Job opportunities	Skills and training	Type of work
+ relatively low barriers to entry - unclear how much work is available 	+ make better use of worker skills - responsible for own training 	+ more diverse tasks - lack of boundaries around required tasks 

The benefits and costs of working as an independent contractor are contingent on some key factors, including the:

- availability of alternative job opportunities
- characteristics of alternative jobs (for example, pay, working hours and conditions)
- personal characteristics of workers (for example, qualifications, experience, appetite for autonomy and risk, other demands on their time and lifestyle preferences).

## Workers are opting into independent contracting

The Commission has not found evidence that aged care personal care workers and nurses who engage as independent contractors are doing so unwillingly or reluctantly.

Widespread staffing shortages and vacancies in the aged care sector mean that workers are unlikely to need to take up independent contracting because of a lack of alternative job opportunities. Those workers who prefer to be employed are likely to be able to find work. Nonetheless, it could be difficult for some employees to obtain the hours of work that they desire (or at the times they desire) and so they might look to supplement their income from more flexible (independent contracting) work options.

International surveys of independent contractors suggest that the majority are there by choice rather than necessity (box 4.1). Independent contracting is more prevalent and more likely to occur through necessity in countries where labour market conditions are worse (Manyika et al. 2016).

In the event that a worker finds independent contracting to be unsatisfactory, there are currently few barriers to leaving to pursue forms of direct employment in aged care or other sectors.

### Box 4.1 – Is independent contracting a choice? Evidence from Europe and the US

Using data from a survey of independent workers in the United States and Europe<sup>a</sup>, Manyika et al. (2016) characterised independent workers into four groups, based on:

- whether income from independent work is their primary or supplemental source of income (including those who have a primary activity other than paid work such as students, retirees or carers)
- whether they are independent workers by choice (prefer independent work) or necessity (would prefer to have a traditional job if they could find one).

Across the countries surveyed, they found that about 70 per cent of independent workers chose that form of work and, for just under half, independent work was their primary income source. In the United Kingdom (the country in the study with a labour market most similar to Australia), the bulk of independent workers were classified as either ‘free agents’ or ‘casual earners’ (figure below). Only about one quarter worked independently because they could not find another suitable job or needed to supplement their income. Across the countries examined, independent workers who used digital platforms were more likely to be independent by choice than those who did not use digital platforms.

#### Independent workers in the United Kingdom, 2016

	Primary income	Supplemental income
Choice	Free agents <b>32%</b>	Casual earners <b>42%</b>
Necessity	Reluctants <b>12%</b>	Financially strapped <b>14%</b>

Workers who were independent by choice were more satisfied with their job than traditional workers. Free agents were significantly more likely to be satisfied with all aspects of their job than traditional workers, except for income security and benefits (such as health care). Casual earners were significantly more satisfied than traditional workers with some aspects, including flexibility of working hours and location. By contrast, workers who were independent by necessity were significantly less satisfied with the level and security of their income than traditional workers, and more satisfied with flexibility of hours and independence.

a. The survey defines independent workers as those who have a high degree of autonomy over their work and workload; are paid by the hour, day, task or contract rather than earning a fixed salary; and have assignments or contracts that last less than 12 months.

## 4.2 Indirect employment — advantages for workers

### Flexibility, autonomy and job satisfaction

One of the primary benefits of independent contracting that workers in aged care cite is being able to choose who they work for, and when, where and how much they work. A survey of platform workers across all industries found that 60 to 70 per cent valued being able to choose their hours of work, tasks and ways of working (McDonald et al. 2019, p. 52). Likewise, a survey of support workers who operate via the Mable platform (Mable 2022, p. 19) found that the top three motivations for joining Mable were:



- wanting control over the days and hours they worked (72 per cent)
- wanting to choose their own clients (68 per cent)
- wanting to help others in their community (63 per cent).

Flexibility of work arrangements to fit with non-work responsibilities, autonomy and task diversity have been found to be important determinants of job satisfaction among aged care workers generally, and crucial for attracting and retaining workers in the sector (Isherwood et al. 2018). Country Home Services (sub. 5, pp. 1–2) — an approved provider — reported higher levels of job satisfaction among independent contractors relative to directly engaged staff (though the workers were performing different roles), with contractors giving high ratings for their connection with customers, their control over time, independence, and how rewarding their work was.

There were also a large number of brief comments received for this study from workers that use the Mable platform, that explained why they prefer independent contracting. For example:

I think there are three benefits for being a support worker via Mable. Firstly, you can choose a client who you like. Second, you can choose time when you like. Thirdly, you can choose area where you like. (Brief comment C11)

Similarly, others said that Mable allows them to choose their hours of work, which can provide flexibility to work around family commitments and lifestyle (C13, C19), gives them control of which customers/jobs to apply for (C7, C15, C17, C25, C28) and a sense of purpose and job satisfaction (C15, C22).

## Potential for higher pay rates

In a sector with relatively low wages, one of the benefits to independent contractors is the ability to set their own rate of pay (which may be significantly more than their entitlement under an award) — a selling point that some digital care platforms highlight as part of their recruitment strategy.<sup>17</sup>

### Independent contractors negotiate their own pay rates

Independent contractors are not paid a wage, but negotiate a fee for the services they provide. Some independent contractors bid for contracts through a platform, while others are engaged directly by older people to provide services for an agreed fee.

The process for negotiating rates of pay on digital platforms varies. It usually involves potential workers posting indicative hourly rates (or ranges of rates) on their profiles, and customers choosing workers based on their profile. There may be additional negotiation between workers and customers once a match has been made. Some platforms enable independent contractors to list different rates for different tasks (for example, personal care, meal preparation, cleaning) or for work at different times (for example, higher rates for evening, night or weekend work, or flat rates for overnight visits). The Commission understands that some platform workers charge a flat fee for some services that are of relatively short duration, such as administering medication or wound care.

Some platforms require that minimum rates be charged to users. For example, Mable has an agreed minimum hourly rate (\$32, or \$28.80 for the support worker after fees). Similarly, independent contractors on Careseekers are not allowed to charge a rate below the minimum award wage (pers. comm., 9 August 2022).

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<sup>17</sup> For example, in their information for support workers the Mable website states: 'Earn more per hour with Mable's online platform' (<https://mable.com.au/provide-support/>) and the Five Good Friends website states: 'Earn more for your skills' (<https://www.fivegoodfriends.com.au/resources/for-helpers/helper-faq>).



In setting their fees, independent contractors have an incentive to offset the loss of employment-related conditions (such as superannuation, casual loadings or paid leave) and associated business costs (such as insurance, workers' compensation, accounting fees, training and costs associated with administering their business such as marketing and searching for work) (DIISRT 2012, p. 35). Platforms usually charge a service fee, which is taken out of the payment made from customer to worker. In return, platforms fund workers for some of the business expenses usually incurred by independent contractors such as some forms of insurance (section 4.3), online training materials and the functionality of the platform to find work and send invoices.

### **What pay rates are award-reliant employees entitled to?**

All adult employees not on an award are entitled to the national minimum wage, which was \$21.38 per hour (before tax) from July 2022. Casual employees covered by the minimum wage must also receive at least a 25 per cent casual loading (that is, \$26.72 per hour) and superannuation. However, most employees in the national workplace system are covered by a modern award, which contains minimum wage rates and other terms and conditions (for example, allowances and penalty rates) — both of which vary by award type.

In an attempt to compare the remuneration of independent contractors and employees, the Commission has examined what the equivalent casual rates of pay are under the *Nurses Award 2020* and the *Social, Community, Home Care and Disability Services Industry Award 2010* (SCHADS Award) (box 4.2).

Based on the casual hourly rate plus compulsory employer superannuation contributions (but excluding extra payments for shift work and allowances), entry-level award-reliant employees are entitled to the following minimum *total remuneration* from their employers for working weekdays:

- home care workers providing domestic and social support: \$31.69 per hour
- home care workers providing personal care: \$34.20 per hour
- enrolled nurses: \$34.84 per hour
- registered nurses: \$37.27 per hour.

However, this level of remuneration is not directly comparable with contractors' pay, because some of it (the superannuation component) is an entitlement that workers receive in the future. For those with a high discount rate, or for workers who already have superannuation accrued from another job, the intrinsic value of superannuation might be low. For the purposes of the comparative analysis below, the Commission has focused on presenting results that compare independent contractor earnings relative to casual employees' wage rates only (figure 4.2). However, a discussion of remuneration including superannuation is also presented.

### **Average pay rates for independent contractors are above minimum award rates**

Platforms provide varying estimates of the rates charged by independent contractors through their platforms for aged care-related services. Average rates paid to workers or default hourly rates of pay on the platforms for which data are available are typically higher than award minimum rates for weekday work (figure 4.2).

**Box 4.2 – Award pay rates for personal care workers and nurses in home care**

Home care workers engaged as employees in aged care are entitled to wages and conditions as set out in the *Social, Community, Home Care and Disability Services Industry Award 2010* (SCHADS Award) (for personal care workers) or the *Nurses Award 2020*. Rates of pay vary according to the tasks performed, employees' qualifications and experience, and whether they are engaged as a casual. Penalty rates apply for work at certain times of the day or week and additional allowances are paid in certain circumstances.

**Selected award hourly rates for casual home care employees**

**Dollars per hour, including casual loading, as at 1 July 2022<sup>a</sup>**

	Base rate	Afternoon shift	Night shift	Saturday <sup>b</sup>	Sunday <sup>b</sup>	Public holidays <sup>b</sup>
<b>Home care workers (SCHADS Award)</b>						
Level 1 (entry level)	28.68	31.54	32.12	40.15	51.62	63.09
Level 2	30.33	33.36	33.96	42.46	54.59	66.72
Level 3 (Certificate III)	30.95	34.05	34.66	43.33	55.71	68.09
Level 4	33.76	37.14	37.81	47.27	60.77	74.28
Level 5 (care manager)	36.20	39.82	40.54	50.68	65.16	79.64
<b>Nurses (Nurses Award)</b>						
Enrolled nurse (entry level)	31.53	34.68	35.31	47.30	55.18	63.06
Enrolled nurse (level 5)	33.16	36.48	37.14	49.74	58.03	66.32
Registered nurse (entry level)	33.73	37.10	37.77	50.60	59.03	67.46
Registered nurse (4 year degree)	35.21	38.73	39.44	52.82	61.62	70.42
Registered nurse (clinical nurse)	41.60	45.76	46.59	62.40	72.80	83.20

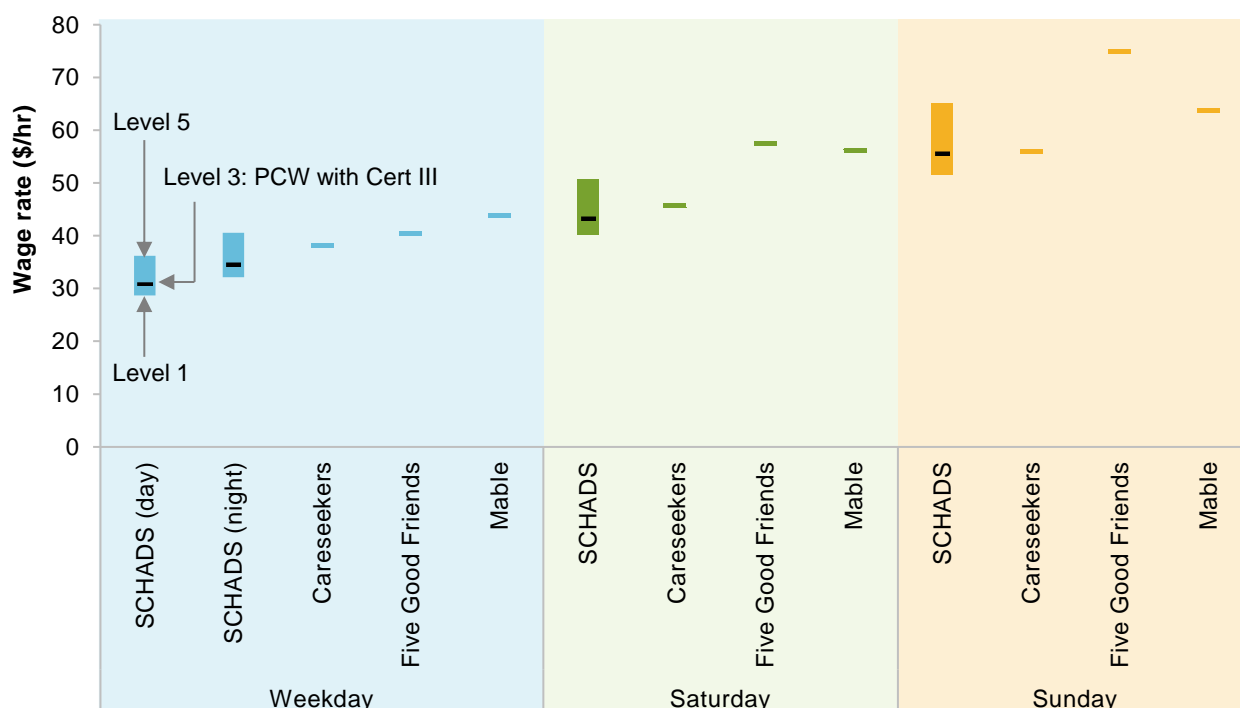
**a.** Award rates are not applicable to employees in Western Australia. **b.** Saturday, Sunday and public holiday rates are for daytime shifts.

Award-reliant employees are also entitled to a range of allowances, such as meal allowances, travel allowances (if employees are required to use their own vehicle in the course of their duties), and reimbursement for the cost of gloves, special clothing and safety equipment. Overtime rates are payable for hours in excess of ordinary hours. Casual home care workers covered by the SCHADS Award are entitled to be paid for a minimum of two hours for each engagement (the minimum engagement is two hours; prior to July 2022 it was one hour).

Finally, employers make compulsory superannuation contributions on behalf of employees. From 1 July 2022 compulsory employer superannuation contributions rose from 10 per cent to 10.5 per cent. Superannuation contributions were previously not paid to workers earning less than \$450 per month, but from 1 July 2022, all employees aged 18 years and over became entitled to superannuation contributions.

Sources: Commission estimates based on the *Social, Community, Home Care and Disability Services Industry Award 2010* and the *Nurses Award 2020*.

**Figure 4.2 – Most independent contractors are paid above the minimum award wage rate**  
**Hourly pay rates for home care workers, July 2022<sup>a,b</sup>**



**a.** Rates of pay under the SCHADS Award for casual employees, adjusted for penalty rates for shift and weekend work. Caution should be used when comparing actual pay rates (platforms) versus the SCHADS Award, as some employees might get paid more than the award rate. The SCHADS Award pay rates also do not include allowances, or the 10.5 per cent employer superannuation contribution, which all adult casual employees are entitled to. SCHADS range is for home care workers from level 1 (entry level) to level 5 (care manager). Level 3 (black lines) represent the rate for a personal care worker with a Certificate III. **b.** All platform wage rates are after fees. Platform rates are not comparable with each other. Mable rates are for 'personal care workers' in aged care and disability support, who have at least a Certificate III or two years demonstrable work experience. Careseekers rate is for aged care workers only. The Five Good Friends rate is their recommended default rate for aged and disability care workers. Default rates might be different to actual average pay rates.

Sources: Commission estimates based on the *Social, Community, Home Care and Disability Services Industry Award 2010*; Mable (pers. comm., 29 August 2022); Careseekers (pers. comm., 8 August 2022); and Five Good Friends (2022b).

For example, in July 2022, Mable's average hourly rate (after platform fees) earned Monday to Friday for social support, domestic assistance and personal care type services was \$42.10 and \$43.80 for personal care workers (Mable, pers. comm., 10 August 2022). This is well in excess of minimum award rates for weekday home care and personal care work (regardless of whether superannuation is included). Furthermore, the average rate paid to aged care workers after fees on Careseekers for weekday work (\$38.24) and Five Good Friends' recommended default rate (\$40.40 per hour after fees)<sup>18</sup> are also well in excess of the total remuneration for employees on the minimum award rate. Observed average pay rates for weekend work are closer to the minimum award rates, particularly on Sundays. However, the Commission understands that workers on platforms tend to perform a lot less work on weekends than weekdays.

There are limited publicly available data on the *distribution* of hourly rates of pay for independent contractors on platforms. Some participants and others have claimed that pay rates of contractors are low, but those assessments are typically based on analysis that is either dated, unreliable and/or not specifically examining

<sup>18</sup> Five Good Friends has a set of recommended default rates, which vary according to day of the week and public holidays. Workers must complete a form in order to charge a different amount to the recommended rate, which is regularly reviewed and updated by the platform (Five Good Friends 2022b).

personal care workers. For example, when reviewing platforms in the National Disability Insurance Scheme (NDIS), Per Capita (2022, p. 40) noted research by McDonald et al. (2019) which found that most carers said they received a wage rate between \$20 to \$30 (with a median rate of \$23.50). However, that was for 2018-19 (when the minimum wage rate after including loadings was \$23.66), for a broadly defined category of caring work including non-personal care,<sup>19</sup> and based on a small sample of 50 workers.

The Commission examined unpublished data from Mable on the distribution of earnings across all workers (that is, not the average rate presented above). The data showed that the bulk of independent contractors using Mable received levels of remuneration well above award minimum rates. For example, in July 2022, 98 per cent of personal care workers on Mable received more than \$30 per hour net of platform fees (the minimum SCHADS Award rate for a casual employee is \$28.68, or \$31.69 inclusive of superannuation), and 74 per cent received \$40 or more per hour net of platform fees during the week. (Mable, pers. comm., 29 August 2022).

While the data from Mable imply a small share of contractors received about \$30 or less in July 2022, the Commission understands that not all independent contractors on Mable performed work that would be covered by an award for employees.<sup>20</sup> The national minimum wage after casual loading is \$26.72. Mable's current minimum platform rate for workers (\$28.80) is set to approximately reference the national minimum wage, casual loading, 10.5 per cent superannuation and platform fees (Mable pers. comm., 29 August 2022).

## Supplementing hours and income

Independent contracting can provide existing aged care employees an avenue to supplement their work hours and income.

It is difficult to gauge how many workers use independent contracting to supplement income from other work and how many work exclusively as independent contractors. According to some unions (for example, the Health Services Union, sub. 35, p. 7), few of their members working as employees in aged care were also engaged through platforms.

On the other hand, a recent survey of 337 independent contractors using Mable found that 45 per cent provided additional support services outside of the platform, with the platform facilitating about 30 per cent of their work hours. Some also acquired work through competing platforms, but the majority worked either for another business providing care or as an independent contractor working directly for older people requiring care (Mable, pers. comm., 8 June 2022).

Other survey data also suggest that independent contracting is used by some workers to supplement income. For example, in a 2020 survey of union members working in disability services, only 18 per cent of workers who had used online platforms reported half or more of their work came through a platform. Use of platforms was higher among workers with non permanent contracts in their main job, including casuals and those on a fixed term contract (Cortis and van Toorn 2020, p. 81).

Low pay is regularly cited as a deterrent to attracting and retaining workers to the aged care sector (Aged Care Workforce Industry Council, sub. 8, p. 4; Isherwood et al. (2018, pp. 31, 34); Mavromaras et al. (2017)). In the absence of substantive increases in aged care employees' wages, independent contracting will likely continue to play a role in supplementing income for at least a proportion of the aged care workforce.

<sup>19</sup> It included aged or disability care; pet services; babysitting and nanny services.

<sup>20</sup> For example, personal care workers can provide additional services outside of caring (for example to support people's goals and independence). In practice, these more diverse services are usually provided by social support and domestic assistance workers.

## Making better use of workers' skills

Digital platforms have the potential to match workers and customers on the basis of skills, experience or even personal interests. This matching of workers' skills to customer needs is a key attraction of platform work. A survey of independent contractors using Mable's platform found that 85 per cent of respondents said one of the reasons they were able to provide a good service was that they could choose the clients they work for based on their skillset (Mable 2022, p. 19).

The usefulness of platforms in improving matching between worker skills to what older people want is limited by the reliability of information in workers' and customers' profiles. In a quantitative study of consumers' experiences of self-managed home care, some Home Care Packages recipients reported that profiles of workers they had engaged through a platform did not accurately reflect their skills (Russell 2021, p. iii). Nevertheless, many consumers who choose to self-manage their care are happy to be able to choose workers based on the specific skills they advertise (chapter 3).

## Offering a different type of role in the sector

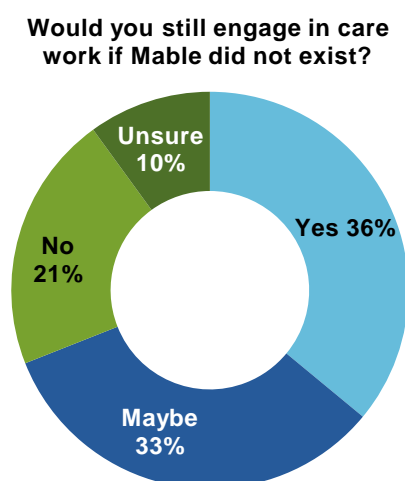
Independent contracting can open up job opportunities for people who might otherwise not work in aged care. In a sector where worker attrition is relatively high — a 2022 survey of union members working in aged care found that 75 per cent are considering leaving the sector within five years (United Workers Union, sub. 4, p. 1) — independent contracting could be an option for encouraging a small proportion of workers to stay in the sector. This was raised with the Commission by some workers who had left the aged care sector after working as an employee but later decided to return because they could obtain work through a digital platform.

There is also some evidence that independent contracting appeals to a new group of workers who might otherwise not work in the sector. A recent survey of support workers on Mable found that 50 per cent were new to the care sector (Mable 2022, p. 8). And 21 per cent indicated that they would not continue providing care and support services if they had to do so as an employee of a care organisation (figure 4.3, panel a). Independent contractors using Mable's platform to work as support workers (a category which includes personal care, social support and domestic assistance workers) are more likely to be younger and from non-English speaking backgrounds than workers in the 'other social assistance' industry (figure 4.3, panel b). Support workers using Mable's platform are also more likely to be male than the average personal care worker in home care.

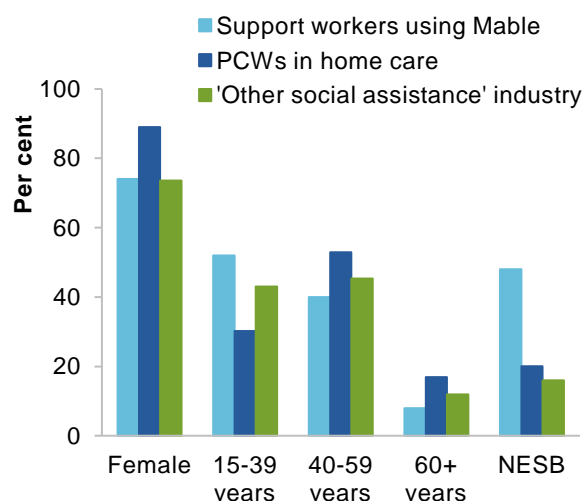
During consultations, the Commission heard that some students completing studies in a relevant field (such as nursing) obtain work in social support or personal care roles through platforms so that they can gain experience while completing their formal qualifications. There are nonetheless screening requirements for workers seeking to engage in platform work, and in some cases formal qualifications are also required (table 4.1).

**Figure 4.3 – Mable is attracting workers who might not otherwise work in aged care**

a) Survey question and response rate for support workers on Mable



b) Selected characteristics of platform workers on Mable and other home care workers in caring roles<sup>a,b</sup>



a. PCWs in home care = personal care workers in the Commonwealth Home Support Program and the Home Care Packages Program. b. NESB = non-English speaking background. Defined as speaking a language other than English by Mable and from a culturally and linguistically diverse background (as defined by providers completing the questionnaire) for PCWs in home care. 'Other social assistance' industry includes home aged and disability care and some counselling services.

Sources: ABS (*Characteristics of Employment Survey, August 2021*, Cat. no. 6333.0; *Census of Population and Housing: TableBuilder Basic, Australia, 2016*, Cat. no. 2072.0 (for NESB data for other social assistance industry)); Department of Health (2021a); Mable (sub. 30, p. 27).

**Table 4.1 – Screening and qualification requirements for workers on selected platforms<sup>a</sup>**

Platform	Qualification	Training	Screening
Mable	<ul style="list-style-type: none"> <li>Ahpra registration for nurses and allied health (as required by law)</li> <li>Certificate III, IV; 2 years of verifiable experience or nursing qualifications attained in certain countries for personal care workers</li> <li>Medication assistance; manual handling; first aid; CPR</li> </ul>	<ul style="list-style-type: none"> <li>COVID-19 infection control training</li> </ul>	<ul style="list-style-type: none"> <li>ABN</li> <li>Police check (unsupervised contact with vulnerable groups)</li> <li>Working with children check or working with vulnerable people card (for Tasmania and the ACT)</li> <li>2 references</li> <li>Photo</li> <li>COVID-19 vaccination</li> </ul>
Careseekers	<ul style="list-style-type: none"> <li>Must have the qualifications required by law for work undertaken</li> </ul>	<ul style="list-style-type: none"> <li>COVID-19 training</li> </ul>	<ul style="list-style-type: none"> <li>ABN</li> <li>Police check</li> <li>Working with children check</li> <li>2 references</li> <li>100 points of identification</li> <li>Photo</li> </ul>
Care.com	<ul style="list-style-type: none"> <li>Must have the qualifications required by law for work undertaken</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>None – screening is the responsibility of the consumer</li> </ul>

Platform	Qualification	Training	Screening
Hireup <sup>b</sup>	<ul style="list-style-type: none"> <li>• CPR or first aid certificate</li> <li>• NDIS orientation module certificate</li> </ul>	<ul style="list-style-type: none"> <li>• Online training modules to support workers</li> </ul>	<ul style="list-style-type: none"> <li>• NDIS worker screening check</li> <li>• COVID-19 vaccination</li> <li>• Police check (for workers who wish to provide transport)</li> <li>• Working with children check</li> <li>• Working with vulnerable people check (only for Tasmania and the ACT)</li> </ul>

**a.** Other platforms operating in the aged care sector are not included in this table due to a lack of publicly available information. **b.** Although Hireup is included for comparison, it only operates in the disability sector, and some workers on its platform provide only social support.

Sources: Careseekers (2022a); Care.com (2022c); Hireup (pers. comm., 12 September 2022); Mable (pers. comm., 16 September 2022).

## 4.3 Indirect employment — disadvantages for workers

### No guarantee of award wages and conditions

As noted above, independent contractors negotiate their rates of pay with consumers and are not guaranteed pay rates equivalent to employees' entitlements under the relevant award. Based on currently available data, most platform workers in aged care appear to be earning a rate of pay that is at least equivalent to the award rate for casual employees (section 4.2), suggesting that very few independent contractors get paid below-award pay rates.

Despite this, and in some cases, there might be people who choose independent contracting work out of necessity (perhaps in outer regional and remote areas with few, or no, providers). And some workers could find it difficult to understand what all the entitlements and monetary value from direct employment are when comparing forms of work. For example, for a part-time or casual employee, the travel time between jobs during the minimum payment period is counted as time worked and paid. Independent contractors, in contrast, do not typically get paid for this, and they must also spend time on the administration of contracts and have less comprehensive job-related insurance (discussed below). As a result, it is conceivable that some workers could end up earning less.

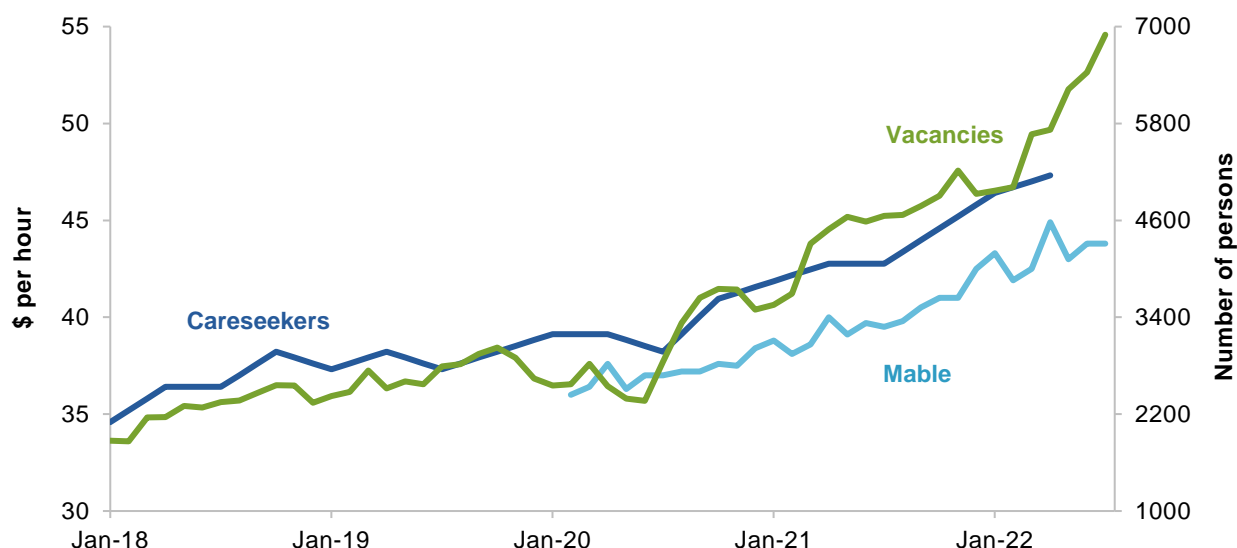
Some participants claimed that independent contracting could eventually lead to a 'race to the bottom' on wages and entitlements. For example:

Other research demonstrates that platform work has been associated with driving down wages and exposing workers to increased levels of risk and precarity (Graham et al. 2019). Once established, platform work tends to precipitate strong competition between workers, which can contribute to a 'race to the bottom' (Cook et al. 2018). (Associate Professor Angela Knox, Professor Philip Bohle, Professor Chris Warhurst, Dr Sally Wright sub. 32, p. 7)

There is no evidence to suggest that this is occurring. Indeed, while the labour market for aged care workers remains exceptionally tight, personal care workers using platforms are in a strong position to negotiate higher rates of pay. The average hourly rate for relevant categories of workers using Mable and Careseekers platforms' have increased considerably since 2020, coinciding with a rapid increase in job vacancy rates for aged and disability carers (figure 4.4).



**Figure 4.4 –Pay rates for workers on platforms have risen as the labour market tightens**  
**Platform hourly rates (dollars per hour, LHS) and job vacancies for aged and disabled carers (persons, RHS)<sup>a,b</sup>**



**a.** Pay rates are after platform fees. Platform rates are not comparable. Mable pay rates are for hours worked by personal care workers (providing aged care and disability support) on Monday to Fridays, Careseekers pay rates are for aged care workers only, for all days of the week. Data from Careseekers were quarterly and linear interpolation was used to generate a monthly series. **b.** Job vacancies are the total of 'aged and disabled carers' and 'nursing support and personal care workers' categories.

Sources: Careseekers (pers. comm., 20 June 2022); Mable (pers. comm., 10 August 2022); National Skills Commission (2022b).

## Fragmented and variable hours and income

While independent contracting provides autonomy and flexibility for workers, it can also lead to more unpredictable and variable hours and income. As stated by the United Workers Union (sub. 4, p. 1):

Indirect employment via gig economy platforms and labour hire agencies is by its nature insecure – workers cannot be sure of their next pay check, how many hours they will work in the next week or whether they will have any work at all.

Some disability workers interviewed by Cortis and van Toorn (2020, pp. 82–83) also said they had tried platform work but did not find it suitable:

These platforms are so hard to get work through, people don't get back to you or they have unreasonable expectations of you. The hours are so unpredictable and hard to get anyone to respond that all 3 people I know [who have tried to use them] have given up.

... [one platform looked] really attractive. Once in, I realize its nothing I expected. The hours are 3 to 5 hours. The notice is too short. It did not just work for me, perhaps because [of the location I work in].

However, fragmented hours and variable income are also common in direct employment where aged care workers often work irregular hours on a part-time or casual basis. This occurs because providers often seek to create a casualised, flexible workforce to match operational needs. As a result, there might not be a strong distinction between the variability of hours in direct and indirect employment:

Home care service providers' rostering and staffing practices are key contributors to the high levels of underemployment and multiple job-holding among home care workers. Fragmentation of



working time and underutilisation of labour arises as service providers seek to minimise labour costs and maximise flexibility by fashioning permanent part-time and casual workforces as on demand workforces. (Centre for Future Work, sub. 29, p. 3)

For 'direct' employees on zero or low hour contracts, even if they do work more than their minimum hours, there can still be other negative consequences, including 'a lack of security with regard to obtaining loans, leases and retirement income' as contracts of engagement do not reflect actual hours worked. (Australian Nursing and Midwifery Federation, sub. 38, p. 6)

Similar problems with regards to financial security arise for independent contractors. The uncertain nature of their work means they can have issues accessing mortgages and loans (Queensland Nurses and Midwives' Union, sub. 10, p. 8). Furthermore, they might not receive payments for invoices in a timely manner or face disputes.

The Commission also heard that in cases where a directly employed worker is effectively 'on call' due to them having highly uncertain hours, it can be very difficult to undertake other work or activities:

... the need to be available for work when required by the employer hinders the ability of workers to take up other employment. The need to respond to calls to attend work, frequently at short notice, disrupts life outside work and places particular strain on families and arranging care for children. (United Workers Union sub. 4, att. 1, pp. 15–16)

While independent contracting, by its nature, can be associated with uncertainty of hours and income, it is clear that this also applies to those directly employed aged care workers without regular hours. It can also be argued that, on the other hand, independent contracting gives a worker more control over their hours and income. As summarised by one participant to this study:

Self-employment (independent contracting) is and always has been about individual workers having control of their work situation, including how they receive their income. (Self-Employed Australia, sub. 11, p. 9)

## Worker health and safety

Aged care work can be physically and emotionally onerous. According to the 2016 Aged Care Workforce Census, about 12 per cent of aged care workers in home care and 14 per cent in residential care reported a work-related injury or illness in the previous 12 months (Mavromaras et al. 2017, p. 163). Most were sprains/strains or chronic muscle/joint conditions, with stress and mental health related conditions also reported. Indicating the seriousness of the injuries, 26 per cent of home care providers had one or more of its employees on Workcover in the fortnight the survey was conducted (with most of them being personal care workers) (Mavromaras et al. 2017, pp. 100–102).

Submissions to this study highlighted that aged care workers providing home care are at risk of injury because homes are not designed and built for personal care (Leading Age Services Australia, sub. 31, p. 6). Others highlighted the lack of peer support for these workers:

Home care workers face considerable health and safety risks in private homes and in informal care and work relationships. Isolation, including lack of peer support and poor access to supervisors' support and guidance, have long been identified as problems for home care workers' health and safety. (Centre for Future Work, sub 29, p. 5)

Beyond the health and safety risks that all aged care workers face, platform workers can also have insufficient information about the customer or task which exposes them to greater risk. As a result, platform workers often first meet a customer in a public place (like a café) before engaging in a carer relationship to gain more knowledge about the person (Australian Nursery and Midwifery Federation, sub. 38, p. 15). These

issues have also been raised about the NDIS (Australian Community Industry Alliance, sub. 36, p. 8, appendix B). Ambiguity about who is responsible for ensuring a safe workplace, less supervision and training of workers, and less generous benefits from worker insurance schemes for independent contractors in the event of an injury are also contributing risk factors for independent contractors.

### **Responsibility for workplace safety is not entirely clear**

Occupational health and safety or workplace health and safety (OHS/WHS) laws apply to anyone who has been engaged by a 'person conducting a business or undertaking' (PCBU) or employer, carrying out work in any capacity. This includes independent contractors, whether they are engaged directly by a consumer or through a platform.

WHS and OHS laws impose a primary duty of care on PCBUs to ensure, so far as is reasonably practicable, the health and safety of workers, including any independent contractors that they engage. These laws also impose a further duty on workers, including independent contractors, to take reasonable care for their own health and safety.

In a direct employment relationship these laws provide clear responsibilities to employers and employees (regardless of whether the worker is employed via a provider, agency or platform).

When a consumer hires an independent contractor, including via a platform, the provider that facilitates the package still has responsibilities. However, there is some uncertainty about who else has responsibilities. With regards to workers, complications arise because workers might be defined as both a PCBU *and* a worker, meaning they may both be owed WHS duties and be the holder of primary WHS duties.

In some circumstances you may be a PCBU as well as a worker. This will be if you are performing work as a delivery worker as your own business. It can be difficult to know if you are conducting a business as there are many factors to consider. Self-employment is one factor suggesting you may be a PCBU. (Safe Work Australia 2021b)

Similar uncertainties about who is the PCBU also arise in the disability support services sector, with Per Capita (2022, p. 19) noting that there is 'some legal uncertainty over whether an NDIS participant could be considered a PCBU under certain conditions'.

Uncertainties can also arise for platforms. The inquiry into the Victorian On-Demand Workforce received advice from WorkSafe Victoria that platforms have a duty to workers, regardless of the employment model they use alongside customers who procure services, although the extent of this duty varies with a number of factors (IRV 2020, p. 117).

Mable and Care.com are not approved providers. They facilitate matches between workers and consumers, but do not directly hire workers themselves and rule out holding any responsibility for WHS within their terms of use.

Mable does not ... involve itself in the terms of a Support Worker Contract between Customers and Support Workers or control their engagement with each other, including regulating or managing any workplace laws or any occupational health and safety laws (Mable terms of use, section 7.2)

And Care.com's terms of use explicitly state that customers are potential employers of independent contractors and have responsibility for compliance with workplace law, including WHS law:

We [Care.com] are not a party to any agreement between a Carer [worker] and a Care Seeker [customer]. Care Seekers are the potential employers of Carers and are responsible for compliance with all applicable employment and other laws in connection with any employment relationship they establish (such as applicable employment standards legislation (including

minimum wage laws), occupational health and safety legislation, and worker's compensation insurance or benefit programs). (Care.com terms of use, section 1.2)

Where customers are considered potential employers, there are potential risks, as Hireup (sub. 33, p. 10) noted:

... the wide definition of an employer, or "person conducting a business or undertaking" (PCBU), is likely to encompass the older person in this situation. The older person accessing care workers from a contracting platform typically is not warned of the above employer-like liabilities, and the associated risk.

By contrast, Five Good Friends is an approved provider and acknowledges a joint responsibility for WHS between workers and itself:

[Five Good Friends] will endeavour to take all reasonably practicable steps to provide and maintain a working environment that is safe and without risk to its employees, volunteers, independent contractors and subcontractors (collectively, **Workers**) and any other person whose health or safety may be adversely affected by the conduct of [Five Good Friends'] business. (Five Good Friends 2017)

Even where platforms and providers using contractors do accept some responsibility for WHS, they are generally limited by the lack of control over workers and their relevant work environments, which include consumers' homes.

Country Home Services (which exclusively uses independent contractors) explained to the Commission that they manage WHS through risk assessments conducted by independent contractors who provide care services in consumers' homes, annual training that is offered to workers for a fee, and incident reporting and investigation procedures (pers. comm. 8 September 2022). And Five Good Friends has a Work Health and Safety Policy and Procedure document which details their hazard and incident reporting procedures and provides information of safe work practices (Five Good Friends 2017).

The Victorian WorkSafe home care OHS compliance kit (WorkSafe Victoria 2011, p. 21) outlines that workplace assessment can be combined with a client's care plan, which can ensure that both workers and clients have a mutual understanding of each others' requirements. However, the extent that consumers and workers would be aware of this is difficult to verify. Again, similar concerns regarding a lack of awareness have been raised in relation to the NDIS (appendix B).

Where all parties involved in facilitating the provision of care are not fully aware of their own and others' responsibilities, problems can arise. Ways to manage workplace health and safety risks are discussed further in chapter 6.

## **Independent contractors have lower insurance coverage than employees**

The definition of 'worker' for the purpose of workers' compensation does not include independent contractors in most circumstances. According to Safe Work Australia (2021c, p. 7):

Independent contractors and sole traders are generally not covered by workers' compensation schemes and must make their own income protection insurance arrangements. ... This is due to the current definitions of worker and challenges with covering costs associated with these types of workers.

Many platforms provide insurances to independent contractors, but with varying levels of coverage, and others do not provide any insurance (table 4.2). However, even where platforms do provide insurance, they are under no obligation to and, therefore, there is no guarantee that they will continue to do so in the future.

Typically, independent contractors are required to have public liability and personal accident insurance to protect themselves and the consumer. Workers may also be required to have other types of insurance, such as vehicle insurance if they provide transport to consumers, which is often the case in home care.

**Table 4.2 – Insurance coverage of selected care platforms/providers using independent contractors**

Platform/provider	Personal Injury	Public Liability	Professional Indemnity
<b>Mable</b>	<ul style="list-style-type: none"> <li>Up to \$5 million</li> <li>85% of income up to \$1300 per week</li> <li>Death benefits up to \$250 000</li> <li>Includes accidents during meet and greet, and travel to and between clients</li> <li>Out-of-pocket expenses up to \$2500</li> </ul>	<ul style="list-style-type: none"> <li>Up to \$20 million for public and product liability</li> <li>Up to \$500 000 for property</li> <li>Includes advertising liability</li> <li>Excludes sexual abuse/molestation</li> </ul>	<ul style="list-style-type: none"> <li>Up to \$20 million</li> <li>Excludes sexual abuse</li> </ul>
<b>Careseekers</b>	<ul style="list-style-type: none"> <li>Up to \$100 000 accidental death sum</li> <li>Covers out-of-pocket expenses from injury</li> <li>Includes return to work assistance of up to \$20 000</li> </ul>	<ul style="list-style-type: none"> <li>Up to \$10 million for public and product liability</li> </ul>	<ul style="list-style-type: none"> <li>Up to \$10 million</li> <li>Excludes treatment prescribed or administered by medical professions, financial or legal advice, injections, and household maintenance or modifications.</li> </ul>
<b>Five Good Friends</b>	<ul style="list-style-type: none"> <li>85% of income up, to \$2500 per week</li> </ul>	<ul style="list-style-type: none"> <li>Up to \$30 million</li> <li>Up to \$5 million sexual abuse liability</li> </ul>	<ul style="list-style-type: none"> <li>Up to \$5 million</li> </ul>
<b>Care.com<sup>a</sup></b>	None	None	None
<b>Country Home Services</b>	None	Required, offered to workers via an hourly fee	None

a. Care.com's terms (section 1.3) state that consumers should either provide insurance coverage for workers or check that workers have appropriate insurances.

Sources: Careseekers (2022b), Care.com (2022c); Country Home Services (pers. comm., 8 September 2022); Five Good Friends (2022a); Mable (pers. comm., 16 September 2022).

There are many differences between the coverage offered by workers' compensation and the alternative insurances available to independent contractors. Safe Work Australia (2021c, p. 9) raised some concerns about the deficiencies of alternative insurances:

- Personal injury insurance does not provide rehabilitation expenses or assistance with return to work.
- Personal injury insurance has a shorter income replacement period than workers' compensation (which can be ongoing, up to 65 years of age).
- Income protection insurance — which provides comparable coverage to workers' compensation — can be prohibitively expensive for low-income earners.
- Alternative insurances impose costs on workers either directly when they take out their own insurance, or indirectly through costs passed on by the business entity.
- Insurances held by independent contractors do not provide the same incentive for employers to provide safe workplaces as does workers compensation (because workers compensation premiums increase when there is an increase in claims made by businesses).

Income replacement amounts are also lower under personal accident insurance than with workers compensation. As a point of comparison, NSW workers' compensation offers a lump sum payment for permanent impairment that is up to \$631 370 while Mable's insurance policy offers up to \$250 000.

## Opportunities for training and career progression

Training and upskilling can lead to better quality of care outcomes (chapter 3, Elsa Underhill, sub. 25).

Notwithstanding the fact that under-skilling of the workforce is a challenge facing the aged care sector as a whole (Royal Commission into Aged Care Quality and Safety 2021a, p. 24), some submissions to this study contend that workers on platforms do not receive the necessary training that directly employed workers do:

Gig economy platforms do not invest in workers and do not provide workers with the training they need to provide high quality care. (United Workers Union, sub. 4, pp. 1–2)

[Direct employment] ensures adequate supervision, training and professional development. This leads to the best possible outcomes for aged people. (Australian Services Union, sub. 43, p. 3)

The aged care sector has high rates of turnover and inconsistent work hours (chapter 1) and there are mandatory training requirements for certain roles, meaning there may be reduced incentive for employers to invest in their workforce even if they are directly employed. In practice, providers do bear the cost of training. For independent contractors, however, the cost of training and keeping their professional credentials up to date are partly borne by them (as a work-related expense, training cost is typically tax-deductible). The onus largely falls on independent contractors to ensure they take a long-term view of their career to make optimal decisions about the type and timing of training. Some argued that this might be less likely to occur for workers engaged in independent contracting than it is for permanent employees:

[Independent contractors] are responsible for their own training, ongoing development and upskilling. While directly employed workers also share this responsibility, employers also have obligations in relation to training and education to maintain standards of care and safety and continuous quality improvement which would be inherently more difficult in an indirect employment model, particularly if this practice became more widespread. (Queensland Nurses and Midwives' Union, sub. 10, p. 8)

However, some platforms offer access to online subsidised training courses. Although these are not mandatory, there is some evidence to suggest that the take-up rate is high (Mable, pers. comm., 10 August 2022).

If independent contractors do not make adequate ongoing investments in their training, they could end up worse off in the longer term. The quality of care that consumers receive might also be compromised. That said, independent contractors have an incentive to get appropriate training to the extent that consumers are likely to be prepared to pay more for someone who is adequately trained.

Indeed, there is no obvious 'training gap' between employees and independent contractors insofar as personal care workers are concerned. All personal care workers on the Mable platform need to have a Certificate III qualification (even though personal care workers are currently not required by law to have a formal qualification). According to Careseekers, about 23 per cent of workers using its platform have a Certificate III qualification in aged/disability care, and a further 48 per cent have a Certificate IV or higher qualification (Careseekers, pers. comm., 20 June 2022). Thus, more than 70 per cent of workers on its platform have at least a Certificate III qualification, which is more than the corresponding share for workers employed by approved providers for the delivery of Home Care Packages (63 per cent) (DoH 2021a, p. 32).

## 4.4 Impacts of preferencing direct employment

Independent contracting and the use of digital platforms to engage work is providing many aged care workers with the option to more directly manage their work.

The evidence from platform providers is that almost all independent contractors on platforms receive more than the equivalent award rate, and in some cases by a large margin.

The current regulatory requirements potentially expose independent contractors to higher safety risks than employed workers who can draw on the support and oversight of their employer. This is of greatest concern for high-risk aged care work in the home and the ambiguity surrounding legal rights and responsibilities for home care work. Better management of these risks (chapter 6) will ensure that independent contractors are far better protected.

Overall, preferencing direct employment over independent contracting would have a negative impact on workers who choose this type of engagement. In most cases, contractors currently have the option to work as employees and, while small in number in the aged care sector, they have chosen not to do so. Ultimately, restricting the use of independent contracting in aged care would be likely to cause some workers to leave the sector. This could be very costly, given current worker shortages.



### Finding 4

#### Independent contractors can earn more than the award wage and preferencing direct employment would reduce workers' options

Independent contracting offers workers a degree of autonomy and control over when, where and how they work. There is no evidence that workers are being 'forced' to engage as independent contractors in nursing and personal care jobs.

Independent contractors trade off sick leave, superannuation, training and insurance. However, most contractors engaged by consumers via digital platforms have rates of remuneration that are higher than award rates of pay and, in some cases, by a considerable margin. With widespread vacancies in the sector, independent contractors who are not satisfied with their earnings or conditions are likely to be able to find alternative work through more traditional employment arrangements.

From a worker perspective, preferencing direct employment would:

- reduce options and opportunities for some workers to engage in work that suits them
- limit opportunities for workers on low wages and/or hours to supplement their income.

In the current tight labour market, restricting indirect employment would also exacerbate labour shortages.

## 5. Business perspectives

### Key points

- \* **Home care providers prefer to directly employ their workforce and only rarely draw on independent contractors to provide nursing and personal care services. It is generally more expensive for providers to use independent contractors than their own staff, but contractors may be more cost effective for non-standard care (such as on weekends or for a short duration).**
- \* **The flexibility of independent contracting can allow providers to better service bespoke consumer needs and respond to fluctuations in demand.**
  - Independent contractors can also expand the labour pool that providers can draw on. However, independent contracting may not be the best source of workers in challenging or critical situations.
- \* **Independent contractors increase contestability in the home care market. Platforms allow consumers to compare prices and reviews of different workers, incentivising independent contractors to price competitively and provide quality care. This in turn places competitive pressure on providers for their service delivery business.**
- \* **Under the current *Aged Care Act 1997* (Cth) providers are legally responsible for the quality and safety of care provided to consumers, regardless of how it is delivered.**
  - This includes providers who administer packages for self-managed consumers who source their own care workers. Platforms that solely operate as intermediaries do not have a similar liability.
- \* **Some providers may lack the capability to oversee workers that are engaged by self-managed consumers. But direct employment is not a prerequisite for adequate oversight. Providers can implement measures to effectively manage and monitor workers sourced by consumers and they may reject the use of independent contractors where they have concerns about their suitability.**
  - Providers are also not required to offer self-managed packages. There is concern that some may be withdrawing from self-management and that this could limit the care options available to consumers.

The use of labour hire agencies is a well-established and necessary practice, particularly in residential care (chapter 2). As such, this chapter focuses on the engagement of nurses and personal care workers as independent contractors in the home care sector. Section 5.1 discusses the use of independent contractors by providers and self-managed consumers as facilitated by digital care platforms. Sections 5.2 and 5.3 consider the main benefits and disadvantages of independent contractors for providers and the operation of the home care market. Section 5.4 summarises the likely effects of a policy to preference direct employment on providers.



## 5.1 Independent contracting in home care

The two main programs delivered by home care providers are the Commonwealth Home Support Program (CHSP) and Home Care Packages (HCP) Program (chapter 2). In 2019-20, the average annual value of government-funded services per CHSP consumer was about \$3000 and \$23 800 per HCP consumer (Woods et al. 2022, p. 18). Personal care and nursing services are estimated to account for nearly 20 per cent of the government-funded income received by CHSP and HCP providers (Deloitte Access Economics 2020, pp. 18, 52; DoH 2020c, p. 40).

As described in chapter 2, home care providers largely prefer to keep their service delivery in-house by directly employing most of their personal care workers and nurses. Agency workers are used less often than in residential care and largely to backfill staff absences. Similarly, the available data and submissions to this study indicate that independent contracting is rare and more likely to be used to provide specialised nursing services than personal care (DoH 2020c, p. 43).

It is not our experience that providers would generally engage independent contractors or platform workers for nursing or direct care tasks, the need for additional staff would generally be filled through contracting with labour hire agencies. (Aged & Community Services Australia sub 42, p. 7)

Nonetheless, home care providers can use independent contractors as an additional source of labour to supplement their workforce capacity. More recently, the introduction of self-managed HCPs has made it possible for consumers to engage their own care workers who are often independent contractors operating through platforms. In this capacity, independent contractors are also in competition with HCP providers to deliver care services.

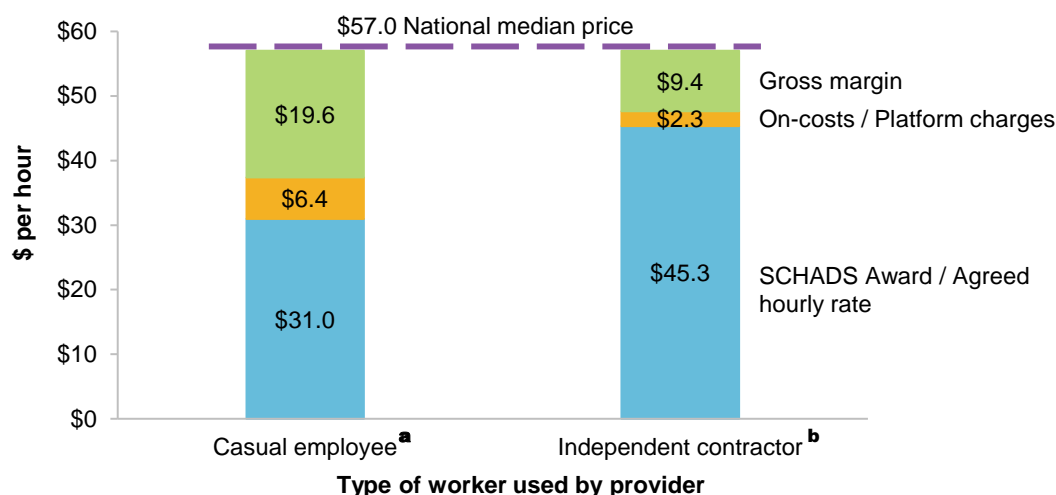
### Providers and their relationship to independent contractors

The financial impact on providers from using independent contractors to deliver nursing and personal care services is contingent on when and where they are used.

During normal operating hours, it is typically more cost-effective for providers to use directly employed workers to deliver basic care (BallyCara, sub. 22, p. 6; Regis Aged Care, sub. 37, p. 5; Resthaven, sub. 26, p. 4). As a simplified illustration, the Commission estimates that the cost of employing a casual worker to provide personal care for a daytime weekday shift is \$37.4 per hour (including on-costs), compared with \$47.6 (including fees) if they are sourced from a platform. This approximately equates to a 50 per cent lower gross service margin for personal care from using an independent contractor (figure 5.1).

Providers may be able to use independent contractors to deliver care at a lower cost where it involves non-standard hours, substantial travel time and/or a short visit. This is because independent contractors can negotiate their own rates and terms while directly employed care workers must be paid in accordance with the Social, Community, Home Care and Disability Services (SCHADS) Award 2010 (box 4.2). The SCHADS award entitles workers to penalty rates for evening and weekend work, overtime, and a range of allowances (including travel costs) which can significantly increase their total wage cost. As of July 2022, employers are now also required to pay part-time and casual workers covered by the SCHADS award for a minimum of two hours per engagement (it was previously one hour).

**Figure 5.1 – Approved providers pay more for independent contractors**  
**Estimated hourly cost and gross margin, by worker type**



**a.** Casual employee is a casual Certificate III home care worker under the SCHADS award. On-costs include superannuation (10.5 per cent), payroll tax (5 per cent after superannuation), payroll administration (3.5 per cent before superannuation) and workers compensation (1.5 per cent before superannuation). Actual wage costs will vary by remoteness and location of providers. **b.** Based on the average hourly weekday rates and platform charges (excluding fees charged to workers) of Careseekers and Mable.

Sources: Commission estimates based on Australian Payroll Association (2019); Careseekers (pers. comm., 9 August 2022), DoH (2022c); Mable (pers. comm., 10 August 2022); Payroll Tax Australia (2021); Safe Work Australia (2021a).

Providers fully manage most of their HCP consumers, whereby they provide and charge for package management, care management and service delivery (box 5.1). Only a small share of HCP consumers currently self-manage their package (estimated at 6 per cent) and not all will choose to source their own care workers. As such, competition from independent contractors is unlikely to threaten the viability of most providers.

Nonetheless, losing a share of their care delivery services to independent contractors has the potential to disrupt the traditional business models of some providers. While their labour costs are mostly variable, lower service delivery revenue may make it more difficult for providers to recover their fixed overhead costs. This is because under the current pricing arrangements, providers must factor all administrative and overhead expenses into their service delivery prices and cannot charge consumers separately for these costs (box 5.1).

### Box 5.1 – Pricing arrangements for home care services

The Commonwealth Home Support Program (CHSP) and Home Care Packages (HCP) Program are delivered via different funding arrangements. While CHSP providers are funded through grants (block funding) to deliver specific services, HCP consumers are allocated a budget to pay for services that they purchase from their chosen provider.

**CHSP** providers can deliver services in four sub-programs: Community and Home Support, Care Relationships and Carer Support, Assistance with Care and Housing, and Sector Support and Development. Providers are funded based on a unit price range for each type of service. In addition, providers can charge a client contribution fee for each service. Providers cannot charge additional fees to cover administrative expenses or overhead costs.

### Box 5.1 – Pricing arrangements for home care services

All HCP providers are required to publish a price list on the My Aged Care website for the full set of services they offer, including care services (for example, personal care, mobility and meal preparation), support services (for example, cleaning, gardening and maintenance) and clinical services (for example, nursing and allied health). Providers can specify higher rates for services provided on weekends or during non-standard hours.

Providers must also specify their **care management** fees and approach. Care management is an essential component of HCP delivery to ensure consumers receive supports that meet their needs. It includes preparing and reviewing a consumer's care plan, coordinating and scheduling services, ensuring services are aligned with other supports, liaising with the consumer and their representatives, ensuring that care is culturally appropriate, and identifying and addressing potential safety risks.

HCP providers may also charge **package management fees** to cover the costs of administering a consumer's package. This may include preparing monthly statements, managing package funds, and meeting compliance and quality assurance standards. Package management fees must exclude all care support and business operation costs (such as marketing, rent, insurance). Instead, **all overheads and operational expenses must be costed into a provider's service delivery unit prices**.

Other fees that providers may charge include:

- basic daily fees that providers can charge to any HCP consumer
- travel costs to cover home care workers travel expenses
- exit amounts that providers can charge to consumers transferring to a different provider.

HCP providers can charge self-managed consumers package management fees as well as care management fees that are proportionate to the work required to oversee their package (such as reviewing a consumer's care plan). They can also charge additional fees for subcontracted services that a consumer requests from a different provider or that they source themselves.

However, the Government is currently considering options to cap HCP administration and management charges and the Department of Health and Aged Care is consulting with the sector to inform the design of these caps. The Government is also considering amendments to eliminate the ability to charge exit amounts.

Sources: Department of Health (2021e, 2022a); Department of Health and Aged Care (2022a).

## Platforms and their relationship to independent contractors

Digital care platforms provide one way for both providers and self-managed HCP consumers to source independent contractors. Most platforms currently servicing the aged care sector operate as intermediaries that solely facilitate the matching of independent contractors with providers and self-managed HCP consumers (chapter 2). Such platforms have little control over how any care work is performed, and workers negotiate and set their own rates and conditions.<sup>21</sup> Under this model, platforms earn revenue by charging a fee that is typically a percentage of the agreed hourly rate to the consumer/provider, and/or worker.

While this is the most common platform business model for home care, platforms can also operate using a direct employment model. This typically involves workers being employed as casual staff with the platform

<sup>21</sup> Some platforms, such as Mable and Careseekers, impose minimum hourly rates for independent contractors (chapter 4).

setting their service price/hourly rate. Hireup and Sidekicker are two examples of platforms that operate using this business model in disability and residential care. Hireup advises that by directly employing its workers it can more easily monitor service provision and reinforce care quality requirements (sub. 33, p. 9).

Platforms that employ workers will typically have a higher cost base than those that solely operate as intermediaries. They must also adhere to the entitlements and conditions provided by any relevant industry awards (for example, minimum shift lengths). This means they are most likely to charge higher hourly service rates and/or have lower operating margins.

## **5.2 Indirect employment — advantages for businesses**

### **A flexible source of workforce capacity**

#### **Servicing intermittent and variable demand**

Independent contractors can allow providers to manage dynamic service delivery requirements and scheduling bottlenecks. It can be difficult for providers to maintain a directly employed workforce with the full range of skills and backgrounds required to care for consumers with evolving care needs. Providers can engage independent contractors to source specialised skills that are only needed for a small number of service hours across their consumer base (Aged & Community Services Australia, sub. 42, p. 11). The home care provider Resthaven (sub. 26, pp. 4–5) cited this as an important rationale for using independent contractors:

We often find that decision to use independent contractors is based on: Insufficient and variable service hours required per location that impact viability to employ a worker with specific skills (e.g. speech therapist, wound management specialist) ...

Similarly, Leading Aged Services Australia (sub. 31, p. 5) noted that third-party suppliers may be better able to effectively supervise, resource and train specialised staff (such as nurses) than a generalist provider.

A related challenge for providers is managing fluctuating demand and peak/off-peak service delivery periods. Demand for care workers is typically highest in the morning and comparatively lower in the middle of the day. Less predictably, care needs can change quickly resulting in a sudden need for more intensive care or the transition of a client with very high care needs into residential care. The 2016 National Aged Care Workforce Census found that more than a third of home care providers that engaged independent contractors used them to match staff to peaks in demand (table 2.1). In addition to using part-time and casual staff, independent contractors can give providers a flexible and cost-effective way to temporarily boost their capacity to manage conflicting preferred delivery times and unexpected increases in service demand.

#### **But independent contracting may not be suitable in challenging circumstances**

However, independent contracting may not be the ideal model in critical situations, for example, in highly challenging remote locations, or in a period of crisis. For example, the Commission heard that providers in challenging remote locations rely on fly-in-fly-out agency staff to fill gaps in their rosters, rather than flying in independent contractors. This has also occurred in regional areas facing severe aged care shortages, such as in the Illawarra (McIlwain 2022). Relatedly, independent contracting is unlikely to be the best model for quickly assembling a 'surge' workforce in a crisis such as the COVID-19 pandemic.

Labour hire agencies who employ and know their staff are more likely to be able to select workers with the skills and experience required for such difficult contexts. Labour hire agencies may also offer greater reliability for emergency staffing — they have visibility of their workforce availability, and their staff have an incentive to

accept their allocated assignments, for the sake of future opportunities with the agency. In contrast, independent contractors that operate via platforms have full discretion to decline new service requests.

### Meeting bespoke service delivery needs

Independent contractors have the right to negotiate their own rates and conditions. This can allow them to deliver services in ways that may not be feasible with direct employees. For example, as independent contractors can choose to accept shorter engagements and manage their own scheduling, they can potentially service demand for brief intervals of care. In contrast, the SCHADS award requires direct employees to be paid for a minimum of two hours per engagement (box 5.2). This condition can make it costly for providers to service consumers who only require and/or want a short interval of care (UnitingCare, sub. 18, p. 4). This problem is exacerbated for regional and remote providers who serve fewer and/or more widely dispersed consumers, making it difficult to combine short care visits into a 2-hour shift.

Providers may also be able to use independent contractors to service markets where they do not have an established presence or where there is a limited local workforce. For instance, Country Home Services (sub. 5, p. 1) has exclusively used independent contractors to service their consumers located in remote and regional areas. The case study of the town of Bell is also an illustrative example (box 3.5). Residents of the small Queensland town had little access to home care services as significant travel time limited the ability of external providers to service the town with their own staff. By partnering with the digital platform Mable, Trilogy Care was able to engage local residents as independent contractors and support them in delivering home care services to the town.

### Expands the available labour pool

Chronic workforce shortages across the aged care sector are a significant challenge for providers. In 2020, over half of all providers reported at least one vacancy, representing 5 to 11 per cent of their workforce. In this context, independent contracting can expand the available supply of labour by allowing existing workers to work more hours and attracting new workers to sector.

High rates of part-time and casual employment in the sector can result in providers underutilising the available workforce. The 2016 Aged Care Workforce Census found that 40 per cent of home care workers wanted to work more hours, while the 2021 Senate Select Committee on Job Security heard evidence that the rate could be significantly higher (Mavromaras et al. 2017, p. 27; Senate Select Committee on Job Security 2021b, p. 47).<sup>22</sup> Traditionally, providers have used brokering arrangements to source staff from other providers to fill vacant shifts and/or contract out their own staff where they have excess capacity. On the other side, some workers have sought to increase their hours by working for multiple providers.

Platforms can increase the effective capacity of the workforce by enabling workers and providers/consumers to be matched more efficiently. As independent contractors, workers can choose when and who they work for and negotiate additional engagements that fit within their availability (Careseekers, sub. 45, p. 3). This can be beneficial where providers need to fill shifts at short notice, or that are difficult to schedule with permanent employees (for example, short engagements or substantial travel time).

Independent contracting through platforms can also allow providers to source workers who may otherwise not participate in the workforce (chapter 4). This includes workers whose circumstances, or preferences mean they are only willing to work at specific times or for a small number of hours. For example, by enabling workers to determine their own hours, independent contracting can allow the sector to retain workers who might otherwise

<sup>22</sup> A survey conducted by the United Workers Union in 2021 found that 60 per cent of aged care workers wanted to work more hours (Senate Select Committee on Job Security 2021, p. 47).

retire (Laragy, sub. 16, p. 3). Similarly, the flexibility afforded by independent contracting can attract new workers to the sector by allowing them to experiment or gain experience (Ashford, Caza and Reid 2018, p. 4).

## **Increases contestability in home care**

Self-managed HCPs are an important enabler of consumer-directed care (Laragy and Vasiliadis 2020, pp. 1–2). The purpose of self-management is to enable consumers to design and make decisions about their own care (DoH 2021e, p. 74). This includes being able to choose their preferred support worker and manage their care schedule. Consumers who can and want to manage their HCP can do so rather than paying a provider for the full cost of this service. Self-managed consumers tend to have lower care needs (chapter 2) and pay lower care management fees (chapter 3). This suggests that self-management can support a more efficient allocation of HCP funding and provider capacity.

Independent contracting can play an important role in supporting this model by expanding the choice of workers available to consumers. Independent contractors can set and adjust their rates based on the particular service they are being asked to deliver. In their absence, consumers will typically be limited to the workers employed by their provider (or a nearby competitor).

Platforms facilitate the engagement of independent contractors in the home care market by lowering the search and transaction costs for individual consumers to find and match with workers. They also promote competitive pricing by allowing consumers to compare the rates and offerings of different workers. Furthermore, by publishing worker ratings and reviews platforms can help consumers to discern high- and low-quality workers (Self Employed Australia, sub. 11, p. 15). As described by one platform worker:

As a platform worker/independent contractor a lot of the onus falls upon me to provide a good service. I enjoy this as I believe it makes me a better worker and people can see I know what I am doing which gives me a sense of accomplishment and makes me want to learn to keep ensuring I offer a good standard of care. (name withheld, sub. 28, p. 3)

Overall, the presence of independent contractors creates greater contestability for care services. As consumers have an option to source their own workers, providers may have a stronger incentive to maintain and improve their service standards and responsiveness. In contrast, it is relatively more difficult for provider-managed consumers to leave their provider altogether given the time and costs involved (including exit fees). Analysis of data from the Department of Health and Aged Care suggests that in 2020-21 about 5 per cent of HCP consumers switched to a new provider (Department of Health and Aged Care, pers. comm., 16 September 2022).<sup>23</sup> On the other hand, increased contestability for care services does not guarantee improved quality and value. Continuity of care is highly valued and as such consumers may remain reluctant to switch to a new worker.

## **Diverse business models can help to foster innovation**

The Royal Commission found that the aged care sector has underinvested in technology and service innovation that could help improve service standards (Royal Commission into Aged Care Quality and Safety 2021b, p. 236). The use of enabling technology in business operations and service delivery varies considerably across the sector with many providers having a low-level of technological capability (Reynolds et al. 2017, p. 21).

Woods et al (2022, p. 40) argued that this is partly the result of pricing and funding arrangements that dampen incentives for providers to make cost-effective investments in their workforce and technology. In this context, competition from independent contractors and small businesses (enabled by digital platforms) has

<sup>23</sup> Note that the share of HCP consumers who switch their provider at any point over the lifetime of their package will be higher.



the potential to spur providers to invest in enhancing their operational efficiency. The Commission heard from a number of providers investing in solutions to provide the service delivery flexibility that consumers increasingly expect, or to improve scheduling certainty for workers. For example, Sydney-based provider Montefiore recently implemented a digital workforce management system to support more flexible rostering that accounts for staff preferences and improve shift allocation to meet care demand (McGrath 2022). Similarly, Leading Age Services Australia cites an example of a provider developing an in-house digital platform to manage their aged care and disability services and allow consumers to easily view their services and receive invoices (sub. 31, p. 9).

More generally, a diversity of business models and entities operating in any sector can increase the propensity for new service delivery approaches to emerge that respond to unmet and/or bespoke consumer needs (Knott 2003). Where such innovations can be more widely applied, they are likely to be replicated and scaled by larger providers as they compete for consumers.

## 5.3 Indirect employment — disadvantages for businesses

### Liability for the quality and safety of care

Under the current *Aged Care Act 1997* (Cth) providers have ultimate legal responsibility for the quality and safety of care provided to consumers, regardless of the employment status of the workers engaged to provide it. This includes self-managed consumers who source their own care workers.

Nonetheless, one of the Royal Commission's key concerns with indirect employment was that it creates uncertainty about accountability for compliance with quality and safety regulation (Royal Commission into Aged Care Quality and Safety 2021c, pp. 431–432). This perception was reiterated by providers and other participants who contended it is unclear who is responsible for care provided by independent contractors sourced through third-party platforms:

There is minimal, and often no, oversight of the platform workers providing direct care by the business who manages the platform. The accountability for lapses in quality of care in these situations has not been robustly tested under law to determine who is accountable. This is the major detractor in organisations using, or encouraging clients to use, platform workers. (Resthaven, sub. 26, p. 5)

It is not always clear who bears responsibility for the risks associated with the work [facilitated through digital platforms]; the older person, the digital platform workers or the approved provider holding the funds. (Anglicare, sub. 17, p. 7)

In July 2022, the Aged Care Quality and Safety Commission (ACQSC) issued updated guidance that reiterated that home care providers remain accountable for care delivered on their behalf and clarified their responsibilities for overseeing it (box 5.2).

Platforms (unless they are a provider) are not bound by the Aged Care Act and therefore are not directly accountable for the care provided by the workers who use them. However, the Government has accepted the Royal Commission's recommendation that platforms (or other entities that facilitate the provision aged care services) be given a legal duty to ensure their workers are appropriately qualified (DoH 2021c, p. 14).



## **Box 5.2 – Providers' accountability for care quality and safety**

### **Providers are legally responsible for care provided on their behalf**

When a provider allows a person to self-manage their Home Care Package (HCP), they also allow care to be provided on their behalf. In these circumstances the Aged Care Act states that the provider remains accountable for that care:

#### **96-4 Care provided on behalf of an approved provider**

A reference in this Act to an approved provider providing care includes a reference to the provision of that care by another person, on the approved provider's behalf, under a contract or arrangement entered into between the approved provider and the other person.

The aged care Code of Conduct which was passed in August 2022 also specifically includes independent contractors and subcontractors to reinforce that approved providers remain responsible for care provided on their behalf (chapter 6).

### **Further guidance explains providers' accountabilities when HCPs are self-managed**

Section 10.4 in the *Home Care Package Program Operations Manual: a guide for home care providers* explains the responsibilities of providers when a consumer wishes to self-manage.

Providers who offer this option should ensure that what is involved is fully understood. It is important that both the provider and the care recipient understand that the approved provider is ultimately responsible for compliance with the legislation (see section 2), Aged Care Quality Standards (see section 3), and scope and intent of the HCP Program (see section 2).

Providers will still need to have oversight over what self-managing care recipients spend their package budget on. Providers will also continue to undertake some required activities such as reviewing the care plan. (DoH 2021e, p. 74)

This fundamental accountability is summarised in the Operational Playbook (aimed at HCP providers):

Consumers may ask to self-manage their package. If a provider allows this it is important to remember that the provider remains responsible for the compliance and quality of the package services. (DoH 2020b, p. 17)

... and outlined in the regulator's guidance to providers:

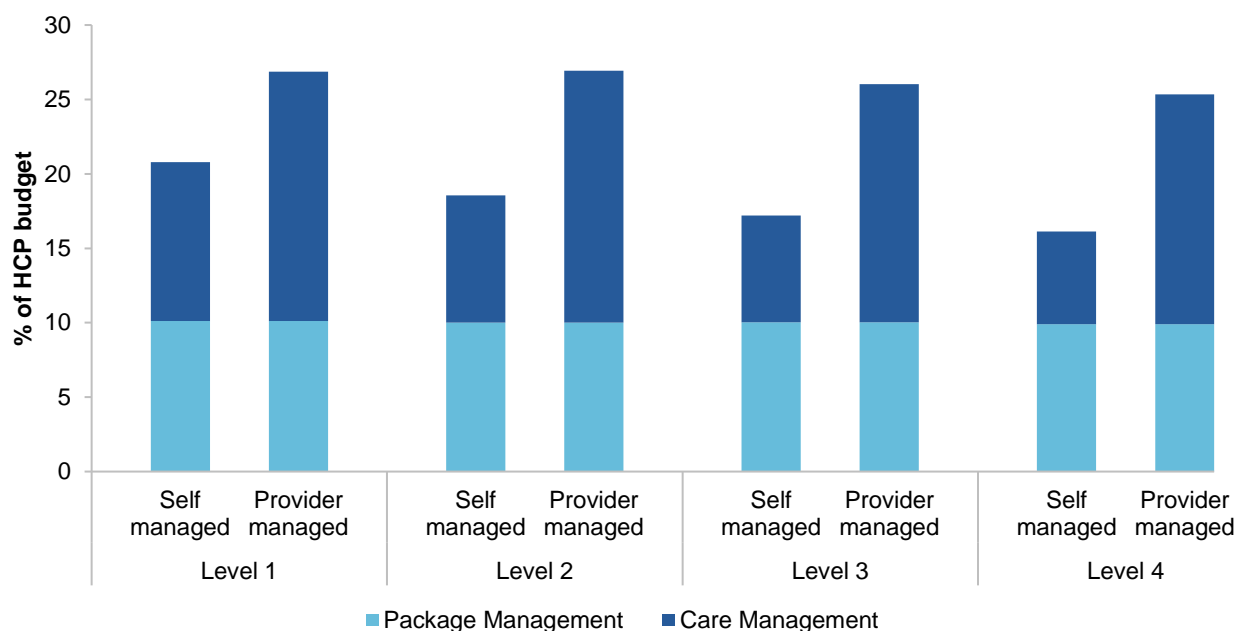
Subcontracted services will not be separately assessed against the Quality Standards. The organisation that receives funding directly from the Australian Government is expected to ensure its workforce (including subcontractors) meets its responsibilities. This is because ultimately the funded organisation will be held responsible for the delivery of safe and quality care and services in accordance with the Quality Standards. (ACQSC 2021a, p. 4)

## **Difficulties overseeing workers engaged by consumers**

Providers are entitled to charge self-managed consumers package and care management fees to cover the costs associated with overseeing their care (box 5.1). While these fees are typically lower than those charged to fully managed HCP consumers, they can still account for 16 to 21 per cent of a self-managed consumer's HCP budget (figure 5.2).

**Figure 5.2 – Providers charge self-managed consumers lower care management fees but equal package management charges<sup>a</sup>**

**Care and package management as percentages of annual HCP budget**



a. Estimates use July 2021 annual HCP budgets: \$9026, \$15 878, \$34 551, and \$52 378 for levels 1,2,3, and 4 respectively.

Sources: Commission estimates based on Department of Health (2022c, 2022d).

Even so, there is concern that not all providers have the necessary processes in place to ensure an adequate level of oversight. In June 2022, the ACQSC raised its concern with ‘high-risk’ home care business models that lack oversight and governance capability (ACQSC 2022, pp. 8–11). These include businesses that: employ a high proportion of subcontractors; subcontract or broker some or all of their services; and/or, service self-managed consumers. The ACQSC stressed the need for providers to have effective information, risk and incident management systems, and to maintain ‘appropriate knowledge and understanding’ of the supports delivered to self-managed consumers by third parties.

Some participants contend that the current regulation creates an uneven playing field between providers and platforms and that in practice, providers cannot maintain equivalent oversight over consumer sourced workers as they do their own staff (Aged Care Workforce Industry Council, sub. 8, p. 4; Anglicare, sub. 17, p. 4; BallyCara Limited, sub. 22, p. 6; Centre for Future Work, sub. 29, p. 4,7-8; Woolard sub. 24, p. 1).

One of the key difficulties cited with managing independent contractors is their lack of familiarity with a provider’s operating policies and procedures. This is in part because providers do not have the same ability to require independent contractors to complete specific training. For instance, Anglicare Australia (sub. 17, p. 4) stated that:

Direct employment means greater oversight and control of training of staff, they can make sure workers are familiar with their policies and procedures and clients, and it’s easier to manage incidents and respond to complaints.

Furthermore, depending on the systems and arrangements in place, independent contractors who are engaged by self-managed consumers may not be obliged to report back or debrief with the approved provider (Anglicare Australia, sub. 17, p. 7). This can be particularly problematic where an independent contractor does not notify a provider about changes in a consumer’s behaviour and needs:

There is no requirement for a platform worker to engage in appropriate reporting of and follow up to high-risk clinical events or deterioration in client condition ... The prevalence of dementia and cognitive decline also needs to be considered. People's capacity to engage in technology and direct and arrange their care may reduce over time, and this has the potential for poor outcomes. It is unclear what safeguards would exist if platform workers are the main form of engagement for a person with dementia. (Resthaven, sub. 26, pp. 7–8)

Providers also argue that it is more difficult to thoroughly vet independent contractors engaged by self-managed consumers (Australian Nursing and Midwives' Federation, sub. 38, p. 10; Leading Age Services Australia, sub. 31, p. 5). This includes assessing a worker's competence and suitability by checking their skills, experience, training and qualifications. While some digital care platforms verify a worker's qualifications on behalf of the provider, ultimately it is the customer making a decision about the suitability of the worker.

## Managing oversight in home care

As discussed in chapter 3, the challenge of ensuring adequate oversight for care delivered in the home is not limited to self-managed consumers who engage independent contractors. Providers have an imperfect line of sight of the interactions between consumers and workers in private settings (Royal Commission into Aged Care Quality and Safety 2021d, p. 524). This is true regardless of a worker's employment status and it is not evident that direct employment is a necessary or sufficient mechanism to ensure oversight.

Several participants expressed concern that self-managed consumers are encouraged to choose their care workers based on price or availability, rather than care quality (Recruitment, Consulting and Staffing Association sub. 23, p. 6). They argue that consumers may not be well placed to judge the quality of care they receive, particularly where it requires clinical skills (Leading Age Services Australia, sub. 31, p. 5; Quality Aged Care Action Group, sub. 12, p. 3). Resthaven also suggested that consumers may use independent contractors to bypass a provider's service standards and this can pose risks to the workers they engage (chapter 4):

For example, where an organisation has deemed mobility assistance/transfers to require two workers (and therefore a cost to the client), yet the client/family may seek to get this service with a single worker through a digital platform, placing that worker at risk. (Resthaven, sub. 26, p. 7)

However, as discussed in chapter 6, consumer-directed care necessitates allowing and empowering consumers to take and manage risk. Furthermore, there are a range of steps that providers can take to reduce the risks associated with self-managed consumers engaging independent contractors. These include:

- requiring independent contractors to sign agreements that establish the roles, responsibilities and expectations of all parties (ACQSC 2022, p. 24). This can include specific policies and procedures that must be adhered to and communication protocols.
- establishing service agreements with the platforms used by consumers to source workers. These agreements can clarify the checks the platform must conduct, information that will be shared with the provider, and the process for escalation of issues. Some platforms offer case management functionality that allow providers to track the care being provided to their consumers. For example, FiveGoodFriends offers access to a digital care management app that allows providers to remotely provide directions to workers and monitor their clients care (The Lookout Way 2022).
- ensuring that care coordinators regularly check-in with self-managed consumers and have processes in place to monitor their wellbeing and identify risks. The quality and appropriateness of any supports provided by independent contractors should be reassessed as part of regular care plan reviews.
- using technology to assist with monitoring and assessing care needs (chapter 6). Remote monitoring devices and systems (such as sensors and wearables) can help alert providers to incidents, support medication management and detect changes in a care recipients health condition (Barnett et al. 2020, pp. 74–85).

Ultimately, providers are not required to offer self-management and should not do so if they cannot assure the quality and safety of self-managed care. Furthermore, providers that permit self-management retain the right to veto any worker chosen by a consumer who does not meet their standards (DoH 2021e, pp. 46–47). Given the small number of consumers who currently self-manage, opting out of self-management is unlikely to materially impact a provider's market share or income.

This poses a potential risk to the viability of self-managed HCPs. If concerns about their liability causes providers to exit self-management, some consumers may find they have no option but to use fully-managed services. There is suggestion that some providers are turning away from allowing self-management. For example, COTA Australia advises that, according to reports from HCP consumers, it is becoming more difficult to find a provider that offers self-management (COTA Australia, pers. comm., 29 July 2022). However, this observation cannot be verified from the existing data collected on HCP providers.

## 5.4 Impacts of preferencing direct employment

Restricting the ability of providers to employ independent contractors risks exacerbating existing workforce shortages. It would also impede the capacity of providers to deliver services in ways that cater to the diverse needs and circumstances of individual consumers. In some contexts, this could result in providers being unable to service certain consumers and/or locations.

Moreover, curtailing the ability of self-managed consumers to engage independent contractors would diminish contestability for service delivery, weakening incentives for home care providers to improve and maintain the quality and value of their services. Reducing the diversity of businesses that can provide home care also has the potential to make the sector less dynamic and stifle the development of new service models and innovative practices.

Importantly, requiring providers and platforms to directly employ their workers would not address the underlying challenges in ensuring adequate oversight of services delivered in the home.



### Finding 5

#### A policy to preference direct employment could undermine the provision of consumer directed care

Nurses and personal care workers who operate as independent contractors are a small but important part of the home care market. It is generally more cost effective for providers to employ their personal care and nursing staff. However, independent contractors may provide a lower cost labour source to deliver care that involves non-standard hours, substantial travel time and/or a short visit.

While providers are responsible for the quality and safety of care delivered on their behalf, there is concern that some have inadequate oversight of independent contractors, particularly where they are engaged by self-managed consumers. However, it is not evident that preferencing direct employment would improve this. Overall, restricting the use of independent contractors would:

- constrain providers' flexibility to manage day-to-day fluctuations in demand and service diverse consumer needs
- reduce the size and capability of the workforce
- weaken market incentives to improve service quality and value.

## 6. Way forward

### Key points

- \* Introducing a policy to preference direct employment in aged care would reduce older Australians' choices and options for care. It would limit the options for those aged care workers who value self-employment and flexible work arrangements, and it could — given the current tight labour market — lead to a reduction in the aged care workforce to the detriment of care outcomes.
- \* Quality and safety in aged care are better addressed through more targeted measures. Many important reforms are underway or are planned for the coming years that will substantially address the risks inherent in the delivery of care services and the challenge will be to deliver these in a timely manner.
- \* The Government is considering a new regulatory framework for aged care which would better align regulation to the proportionality of risk. The principles underpinning this new framework are sound.
- \* The Quality and Safety standards are an important element of the safeguards in aged care. The Royal Commission into Aged Care Quality and Safety recommended standards be reviewed, and that quality indicators be developed for home care. Notwithstanding lead time and sequencing considerations, these reforms should not be delayed unnecessarily.
- \* As far as possible, approaches to quality and safety regulation should take into account who is best placed to understand and manage risk. In some cases, this will be the approved providers but in other cases it will be individual workers. The introduction of a new code of conduct covering all aged care workers is an important policy response.
- \* One of the major concerns with independent contracting and platform work in aged care is uncertainty around compliance with quality and safety regulation. Reforms underway or planned would directly address this concern. These include:
  - introducing a non-delegable statutory duty of care
  - the code of conduct for workers.
- \* The Aged Care Quality and Safety Commission should be the central party responsible for evaluating and managing risk. The reforms recommended, planned or underway to improve the regulator's effectiveness are among the most important to safeguard aged care quality and safety.

## 6.1 The risks of preferencing direct employment

The key question the Commission has considered in this study is whether the Australian Government should introduce a policy to preference direct employment in aged care.

Most importantly, stakeholder engagement throughout this study and the research undertaken in the preceding chapters have led the Commission to conclude that preferencing direct employment is unlikely to address concerns around the quality and safety of aged care. Direct employment is already by far the most common and preferred form of employment in aged care. While it is generally accepted that continuity of care is critically important in aged care, some consumers have been able to *improve* their continuity of care by directly sourcing personal care workers or nurses through digital care platforms (chapter 3). (Many concerns around continuity of care come from the residential care sector but are not just related to the use of indirect workers but also to direct workers, such as casuals.) Furthermore, independent contractors have a business imperative to offer good services to keep their customer base. Platforms have rating and review tools which mean care workers also have an incentive to offer good services to attract new customers. Platforms also enable consumers to choose workers who better meet their diverse needs, or who can deliver more culturally safe care, particularly for people who identify as Aboriginal and Torres Strait Islander, come from culturally and linguistically diverse backgrounds, and those who identify as lesbian, gay, bisexual, transgender and intersex — an important dimension of quality embedded in the quality standards for aged care (chapter 3).

From the perspectives of workers, it is also not clear that introducing a policy to preference direct employment would be unambiguously beneficial — some workers would lose access to a type of work they benefit from. Workers choose to be engaged as independent contractors, and some access platforms, rather than traditional (direct) employment, because it offers them more flexibility and potentially higher pay (chapter 4). It would be a concern if there were nurses or personal care workers who undertake independent contracting by necessity but would prefer direct employment. But ongoing workforce shortages in the sector suggest that most workers have the option of looking for these types of roles if they so desire.

An unintended consequence of restricting access to a type of work that some workers value could mean they leave the aged care workforce, exacerbating labour shortages. For a sector that is already struggling to meet the demand for aged care, fewer workers would undoubtedly undermine the quality and safety of care for older Australians.

Businesses, including in the aged care sector, are best placed to decide how to configure their employment arrangements. It will typically be more expensive for providers to use independent contractors than their own personal care workers and nurses. But the flexibility of independent contractors can allow providers to better service bespoke consumer needs and manage variable demand (chapter 5).

Independent contractors also increase competition in home care, which can benefit consumers (chapter 3). Restricting types of work would restrict the ability of self-managed consumers to choose their own workers and would diminish market incentives for providers to improve and innovate.

## 6.2 Protecting aged care quality and safety

High-quality and safe aged care is critical to the wellbeing of older Australians and their families and informal carers. There are different policies that could be used to achieve this goal — including funding, regulation and workforce development. The Royal Commission into Aged Care Quality and Safety considered these issues in depth and this study has not sought to revisit these points. That said, the policy approaches outlined below provide in the Commission's view a broad package of reforms that are better targeted at improving quality and safety than restricting indirect employment.

## Giving agency to older Australians

A key part of improving aged care is allowing for greater consumer choice and control. Consumer choice can lead to a wide range of positive wellbeing outcomes, including greater life satisfaction, more independent living and better continuity of care (PC 2011, p. 85).

But this often involves trade-offs — consumer choice and control supports more personalised services that better meet peoples' needs but also introduces uncertainty and risk. The current aged care system does not fully embrace these risks. It 'sometimes focuses on safety at the expense of a quality aged care experience that would allow people to take reasonably controlled risks to maximise their quality of life' (Royal Commission into Aged Care Quality and Safety 2021b, p. 219).

The Royal Commission outlined the importance of the 'dignity of risk' that comes with self-determination.

The right to take risks that align with personal goals and values is an important part of life. People have different risk appetites, so risk will mean something different to each person. Some people have a high-risk appetite, while others want to be largely protected from all risks. It is important to older people that they set the boundaries about what is acceptable and important to them, and that this is reflected in the aged care system. (Royal Commission into Aged Care Quality and Safety 2021c, p. 8)

In some circumstances, enabling greater consumer choice and control can actually improve risk management, because sometimes consumers (rather than governments) are best placed to manage risk. For example, while quality of care is often measured on an objective basis, an important dimension of quality is subjective — how people feel about who is delivering the service and how the service is delivered. Empowering people to have a greater say in who provides their care and how will also let them manage the 'risk' of poor care. In some circumstances, there can be a power imbalance between a consumer and their care provider (COTA, sub. 40, p. 4). The consumer is inviting the personal care worker or nurse into their home, potentially to provide an intimately personal service. But consumer advocates have emphasised to the Commission that giving older people greater choice and control will empower them and help them overcome these concerns (the power balance is shifted if the older person is now 'the boss').

## Better information to support choice

Governments still have an important role to play, even in an aged care system that promotes consumer choice and control. For example, people or families seeking aged care services may not have the information or expertise to accurately judge the quality of care (particularly clinical quality).

In 2011, the Commission argued that there was considerable scope to improve the quality of services and the experiences of care recipients by collecting and publishing user-friendly information about how well care services are performing (PC 2011, p. 207). Regulatory standards and approval processes alone do not provide incentives for providers to improve quality above the minimum. Better information would support informed user choice and foster a culture of continuous improvement in the delivery of aged care.

The Commission recommended that 'the quality assurance framework for aged care should be expanded to include published quality indicators at the service provider level to help care recipients and their families make informed choices about care and to enhance transparency and accountability about funds spent on care' (PC 2011, p. 218).

There appears to have been little progress since the Commission's 2011 report. A decade later, the Royal Commission still assessed that 'quality is not adequately measured in the Australian aged care system'



(Royal Commission into Aged Care Quality and Safety 2021c, p. 127). There were no quality indicators applicable to home care.

The Royal Commission came to the same conclusion as the Productivity Commission:

It is critical that the public has access to information that provides a meaningful overview of the performance of individual services and providers, in an accessible and easy-to-understand form ... This is particularly important for older people who are choosing an aged care service. (Royal Commission into Aged Care Quality and Safety 2021c, p. 132)

Similarly, it found the current ratings system only shows that services are meeting minimum standards and does not recognise or assess whether care exceeds the minimum standards, let alone whether care is high quality (Royal Commission into Aged Care Quality and Safety 2021c, p. 132).

The Royal Commission recommended the Australian Government develop and publish a system of star ratings based on measurable indicators that allow older people and their families to make meaningful comparisons of the quality and safety performance of services and providers (Royal Commission into Aged Care Quality and Safety 2021c, p. 131). A Bill to introduce star ratings for residential care was passed in August 2022, but it is unclear whether there are plans to also produce star ratings for home care — the Government's response to the Royal Commission said star ratings may be expanded to home care in 2024 'subject to the Budget process' (DoH 2021c, p. 20). Whether in the form of star ratings or not, the Government should maintain efforts to improve the information available to consumers. This will become particularly important in the context of reforms to support greater consumer choice and control, such as the proposed Support at Home program (box 1.4).

The Government also introduced a Bill in July 2022 that would require the Secretary of the Department of Health and Aged Care to publish information about approved providers to improve transparency and support consumer choice (Wells 2022a, p. 11). The information to be published is yet to be decided, but the Government said it expects it to include:

- expenditure on care, nursing, food, maintenance, cleaning, administration and profits
- levels of care time provided
- details of key personnel
- information about staffing (Wells 2022a, p. 11).

These indicators are more relevant for residential care, meaning there is still a need to collect and publish information relevant for home care consumers.

Many platforms like Mable offer consumer ratings and reviews, increasing the information available to consumers about the workers they may engage. On the effect of platforms generally, the Commission has previously concluded:

Digital platforms can help overcome information asymmetries, which have been a common justification for regulation. This can allow governments to reduce the restrictiveness of regulations seeking to provide consumer protections, subject to confidence in the information provided. (PC 2016, p. 63)

## A risk-based approach to regulation

The Royal Commission found numerous problems with the aged care regulatory framework.

The regulatory framework is overly concerned with processes and is not focused enough on outcomes. The system is insufficiently responsive to the experiences of older people. The oversight of home care is underdeveloped ... The regulatory arrangements lack the transparency, accountability and responsiveness that would be expected of a contemporary regulatory regime. Overall, the system has not provided the assurance of high quality and safe care that older people and the community would reasonably expect. (Royal Commission into Aged Care Quality and Safety 2021b, p. 226)

Some of these criticisms go to the effectiveness of the regulator, discussed below.

The Royal Commission recommended a new Aged Care Act to come into force 1 July 2023. As part of the process of developing the new Act, in February 2022 the Department of Health released a concept paper for a new framework for regulating aged care (box 6.1). The new approach was proposed to better align regulation to the proportionality of risk.

### Box 6.1 – Proposed principles for the new aged care regulatory framework

The concept paper released in February 2022 contained eight principles to underpin the design of the new aged care regulatory framework.

1. The foundation of the future regulatory framework is underpinned by a human-rights-based and person-centred approach.
2. The regulatory framework is contemporary, responsive and futureproof in its design and delivery.
3. Attention is prioritised to areas of the highest risk.
4. Sustainability of the aged care system is enabled without compromise to protections and service quality.
5. Regulatory alignment is pursued under the framework where possible.
6. Regulation is maintained through a graduated and risk proportionate approach.
7. Capability and design are informed by data and intelligence driven insights.
8. System stewardship is facilitated through all roles and functions.

The regulatory framework itself is made up of a range of elements: education; entry (registration, approval, agreement); rules and standards, monitoring, assessment and reporting; complaints; compliance and enforcement; and consumer information.

Source: Department of Health (2022b, pp. 5–6, 23–24).

Overall, the new regulatory approach looks sound, and has the potential to address concerns raised about independent contracting and sourcing of services via platforms. Importantly, the new approach is being considered alongside the proposed changes to home care. While it is too early to evaluate the framework fully, there are encouraging aspects including:

- a shift from provider-centred regulation to a person-centred approach. The current legislation is focused on the processes and requirements around regulating approved providers, rather than the safeguards that are needed to protect an older person. The new regulatory approach will focus on understanding the

safeguards required to ensure older Australians are protected from some risks, and then consider the rules, obligations and responsibilities needed to avoid or control those risks (DoH 2022b, p. 18).

- Moving away from provider-centred regulation would also support consumer choice and control, as it would no longer be premised on consumers having only one provider, but instead would clarify the responsibilities of each of the providers.
- a focus on the proportionality of risk. The framework considers stratifying risk across a number of factors:
  - service type delivered to the consumer
  - setting in which the service is delivered
  - entity/provider delivering the service (structure and behaviour)
  - needs of the consumer and their existing support structures
  - workforce capability and culture
  - relationship between the consumer and the service deliverer
  - level of harm/severity of potential consequences of the risk being realised. (DoH 2022b, p. 24)

One part of a risk-proportionate framework being considered is a new registration model for providers, which would have different application requirements and ongoing obligations attached to different service categories. This would be based on the National Disability Insurance Scheme (NDIS) registration system (appendix B). The Royal Commission endorsed this type of risk-proportionate approach.

Aged care services provided in the home range from services that pose a low risk to an older person, such as gardening, to services that require greater regulatory oversight, such as clinical services. Providers of home-based aged care services are similarly diverse. They range from very small community organisations to very large corporate entities. Given this diversity, a robust but flexible approval system is required ...

Home care providers should be able to seek approval for only a limited scope of services, and the regulator should be able to adjust the rigour of the approval process accordingly. While all applicants should be subject to a basic suitability assessment, the scope of an assessment of a provider's capability should be more confined for those seeking only to provide relatively low risk services, such as basic domestic assistance ... This will reduce the impact of the home care approval process on the regulator and providers alike, with no reduction in safety standards. (Royal Commission into Aged Care Quality and Safety 2021d, pp. 493–494)

The Government will have a careful balancing act to maintain standards and safeguards while also adjusting the rigour of the regulatory requirements. A more risk-proportionate approach to regulation should mean more providers are able to enter the aged care market, increasing competition and improving choices for consumers. The new regulatory framework could also promote innovation and continuous improvement. But innovation sometimes is stifled, and new entrants discouraged, by a regulatory approach that too heavily favours 'traditional' large incumbents. This new approach will need a more detailed and evidence-based view of the sources of risk and the ways in which risk can be managed.

One part of the proposed regulatory framework that would address potential accountability concerns with indirect employment is allowing individuals to become approved providers. The legislation currently requires all approved providers to be corporations or state/territory Governments. Allowing individuals to become approved providers (or registered providers as is the case in the NDIS), would clarify lines of accountability. However, moving to such a system would be a substantive change, and its feasibility would depend on the capability of the regulator to provide the necessary oversight.

The Government should be careful that the new regulatory approach does not undo the positive reforms it is undertaking elsewhere. For example, it may be difficult to produce star ratings (or conduct consumer

experience surveys, discussed later) when individuals can register as providers. Nonetheless, the broader ideas that consumers be given information to support choice and that quality indicators need to be collected to ensure effective regulation would remain relevant, and so should continue to be pursued.

While a more risk-appropriate regulatory regime is a shift in the right direction, it would be counter-productive if it led to less accountability or oversight of high-risk areas. It should not be a vehicle for undermining important safeguards. As the Australian National Audit Office commented:

Risk-based regulation is important in ensuring the burden of regulation is appropriate. However, it can only be successful if the accountable authority of an entity uses available evidence to develop a strategic, diligent and risk-based regulatory compliance approach and ensures that it is consistently implemented. While efficiency for the regulator and the sector is important, too strong a focus on 'red tape' reduction — including through not utilising the full range of regulatory powers provided by the Parliament — can often be at the expense of effective outcomes. (ANAO 2021)

Ultimately, it will be the operation of the Aged Care Quality and Safety Commission — the choices it makes and the priorities it pursues — that will determine whether the regulatory framework is achieving the desired outcomes. As the Commission noted in its report on *Regulator Engagement with Small Business*:

Regulators, by their conduct in interpreting, administering and enforcing regulatory requirements, can take considered, well designed regulation and produce regimes which discourage compliance, squander government resources or add to business costs and delays. Alternatively, a regulator might take an unwieldy accumulation of regulation and, by choosing judiciously what, when and how to enforce, deliver the desired regulatory outcomes in an efficient manner. (PC 2013, p. 3)



### Finding 6

#### A risk-based approach to regulation

Older Australians highly value the ability to make decisions about how their care needs are met. The principles underpinning the proposed new regulatory framework for aged care (released by the Department of Health in February 2022) are promising because they focus attention on addressing risks, in a proportionate way, while not unduly restricting older Australians' options for care.

## Quality and safety standards

There were two key parts of the regulatory framework that the Royal Commission recommended be reformed: introduce a new duty of care and review and improve the quality standards and indicators.

### Duty of care

The Royal Commission pointed out that the current Aged Care Act (the *Aged Care Act 1997* (Cth)) lacks a clear statement of responsibility for providers to deliver safe and high quality care, which it said was a 'major gap in the current legislative scheme' (Royal Commission into Aged Care Quality and Safety 2021c, p. 97). It recommended the new Aged Care Act include a general, positive and non-delegable statutory duty on any approved provider to ensure that personal care or nursing care they provide is of high quality and safe so far as is reasonable, having regard to:

1. the wishes of any person for whom the provider provides, or is engaged to provide, that care

2. any reasonably foreseeable risks to any person to whom the provider provides, or is engaged to provide, that care, and
3. any other relevant circumstances. (Royal Commission into Aged Care Quality and Safety 2021c, p. 97).

The Royal Commission was inspired, in part, by the obligations in work health and safety laws that require employers to take an active, imaginative and flexible approach to risk (Royal Commission into Aged Care Quality and Safety 2021c, p. 98). The intention is that parties take a proactive, not reactive, approach to risk. There are other policy areas that also deal with issues of accountability, not by restricting indirect employment, but by requiring parties to exercise a duty of care, even when using subcontractors (as recommended by the Royal Commission for aged care). For example, a similar non-delegable duty of care exists in the heavy vehicle transport industry, through chain of responsibility laws (box 6.2). Chain of responsibility laws require all parties in the supply chain to do whatever is 'reasonably practicable' to ensure safe and compliant driving.

The potential downside is that expanding the chain of responsibility could leave parties unclear about their duties, which in some cases in other sectors has led to duplicative risk-mitigation efforts (box 6.2). For the heavy vehicle transport industry, the Commission recommended the regulator be the one to clarify parties' obligations (box 6.2).

For the aged care general duty to be effective, the Government should empower the aged care regulator to be able to clarify obligations of parties (as the Commission recommended for transport). The regulator should issue guidance on how to comply with the duty and the responsibilities of different parties under the law. Returning to the work health and safety example, regulators have issued guidance for some platforms (particularly food delivery) around their obligations.

### **Box 6.2 – Chain of responsibility in transport**

Under chain of responsibility (CoR) laws, parties in the supply chain other than the driver (for example transport operators and clients) have a general duty to ensure that breaches of transport laws do not occur. These parties can be held accountable for breaches or safety incidents where they have influenced non-compliance.

The Commission reviewed CoR laws in its inquiry into *National Transport Regulatory Reform* and found many parties were uncertain about their obligations under the laws. In some cases, this lack of certainty, combined with risk aversion, led supply chain participants to impose unnecessary and costly requirements on transport operators to minimise potential liability. The Commission was also concerned these additional requirements may also provide opportunities for large transport purchasers to exercise market power in ways that could reduce competition in the market for transport services.

The Commission recommended the National Heavy Vehicle Regulator be empowered to clarify obligations under CoR laws. The Commission recommended the regulator be empowered to publish 'acceptable means of compliance' with CoR laws and to be able to accept other approaches to compliance, with the costs of accreditation to be borne by the regulated parties.

Source: PC (2020, pp. 151–153).

## Quality standards and indicators

The Aged Care Quality Standards are a key element of the regulatory framework. They are statutory-based obligations of services, which set consumer outcomes and service standards that all approved aged care providers must meet. And while the standards set the rules around quality, the indicators enable that quality to be measured.

### Quality standards

The Royal Commission compared the Aged Care Quality Standards unfavourably with the national health standards (the National Safety and Quality Health Service Standards), which it said were ‘far more comprehensive, rigorous and detailed’ (Royal Commission into Aged Care Quality and Safety 2021c, p. 121). To improve the process for setting the standards, the Royal Commission recommended the Australian Commission on Safety and Quality in Health Care (which it recommended be re-named the Australian Commission on Safety and Quality in Health and Aged Care) be tasked with formulating standards, guidelines and indicators relating to aged care safety and quality (Royal Commission into Aged Care Quality and Safety 2021c, p. 122). These would include non-clinical, quality of life, standards as well as clinical ones.

Nonetheless, the Royal Commission did not call for a new set of standards, reflecting the fact that the current standards had only recently come into effect. It did, however, recommend the standards be urgently reviewed (Royal Commission into Aged Care Quality and Safety 2021c, pp. 124–125).

The Government accepted part of this recommendation and transferred clinical care standards (more relevant for residential care) to the Commission on Safety and Quality in Health Care but retained non-clinical standards in the Department of Health (DoH 2021c, p. 17). The Department is currently reviewing these standards.

### Quality indicators

As outlined earlier, quality indicators can be used for a range of purposes, including informing consumer choice, measuring and monitoring care quality and safety, identifying problems in care performance, prompting improvements to care and providing transparency to people receiving care, their families and the community (Royal Commission into Aged Care Quality and Safety 2021c, p. 127). As well as introducing star ratings, the Royal Commission also recommended the Australian Commission on Safety and Quality in Health Care develop quality indicators for care at home and implement a comprehensive quality of life assessment tool for residential and home care (Royal Commission into Aged Care Quality and Safety 2021c, p. 126).

The Royal Commission noted that due to a lack of good quality indicators and data collection, it faced difficulties in getting a clear view about what drives good aged care performance (Royal Commission into Aged Care Quality and Safety 2021c, p. 128). The Productivity Commission has also faced similar problems in this study.

The Government accepted the Royal Commission's recommendations in-principle. It said it would retain responsibility for the quality indicators in the Department, and that quality indicators, including indicators of quality of life, would be developed and implemented across both residential and home care by the end of 2022.

Due to the wide range of significant reforms in this area, improvements to the quality standards and indicators may not be implemented for some time. Even so, their implementation should not fall by the wayside over the coming years. In fact, it could be argued that they represent a bigger gap in the regulation for home care than for residential care, which justifies an accelerated approach.

Still, it would be a challenge for providers if the Government were to introduce new quality standards and indicators independently of changes to home care arrangements (the proposed Support at Home program). These processes are linked. But in the meantime, consumers will remain without important information, while



the extended implementation timeline risks reform momentum being lost, priorities changing or unexpected events disrupting the process.

## Effective regulatory enforcement and oversight

Confidence in the aged care regulatory regime is greatly improved by having an effective regulator. The Royal Commission was highly critical of the aged care regulator, finding it had a poor track record of enforcement, in both home and residential care, and a reactive approach to monitoring and compliance (Royal Commission into Aged Care Quality and Safety 2021b, p. 226).

As a result, there have been a number of other initiatives to improve the performance of the Aged Care Quality and Safety Commission (ACQSC). It was provided \$262.5 million in the 2021-22 Budget to strengthen its powers, increase its ability to respond to complaints and develop tools to enable earlier detection of high-risk home care services, including an enhanced risk profiling tool (DoH 2021f). One input to the risk profiling tool will be the data collected by new quarterly financial reporting, which will include a range of indicators on staffing (costs and minutes of care, which will also be inputs to the star ratings). The quarterly financial reporting will give the ACQSC the data to investigate any potential effects from using agency staff (or independent contractors) (box 3.3). It will also allow the ACQSC to become more proactive in monitoring risks, such as financial viability of providers affecting quality and safety of care.

The ACQSC has also increased its regulatory focus on home care, through more regulatory activity and improved guidance for providers. In June 2022, it released guidance to providers about some of the key risks it had identified through analysis of complaints, regulatory processes and other data and intelligence (ACQSC 2022, p. 6; chapter 5).

The Royal Commission (Commissioner Briggs alone) recommended the ACQSC be 'reconstituted and revitalised' as an independent Aged Care Quality and Safety Authority (Royal Commission into Aged Care Quality and Safety 2021c, pp. 74, 76–77). (Commissioner Briggs noted the new Authority could come together with the NDIS Quality and Safety Commission in the future.) It said the new Authority would 'need to be more risk-based and more curious and energetic' in its pursuit of better aged care performance than the Commission it would replace (Royal Commission into Aged Care Quality and Safety 2021c, p. 74).

The Government announced a capability review of the ACQSC to consider whether it has the resources, workforce, regulatory and investigatory skills, clinical knowledge, assessment skills and enforcement skills to meet its regulatory responsibilities and keep older Australians safe (Wells 2022c). The capability review will inform the design of the new Authority.

Reforms to the regulatory framework that will allow individuals to become approved or registered providers will change the regulator's role, from oversighting a smaller number of larger organisations to a larger number of individuals providing services. Similarly, the worker code of conduct (discussed below) will also necessitate the regulator to take a closer look at individual workers. The capability review should consider the resources and skills needed to perform this type of role.

The performance of the regulator can also be improved through greater oversight of its performance. For example, the Royal Commission recommended the Australian Government establish an independent office of the Inspector-General of Aged Care to investigate, monitor and report on the administration and governance of the aged care system (Royal Commission into Aged Care Quality and Safety 2021c, pp. 80–81). The Inspector-General could, among other things, conduct reviews to ensure the quality and safety of aged care, review decisions of the regulator on a systematic basis to ensure integrity and performance and review the performance of functions by the regulator. The Government accepted this recommendation and



announced an interim Inspector-General, supported by a taskforce in the Department of Health, in December 2021 (DoH 2021c, p. 13; Hunt 2021).

The Royal Commission also made recommendations to improve the processes and information of the regulator. For example, under the current standards, assessors from the regulator are required to meet at least 10 per cent of residents, or the nominated representatives of residents, during a site audit to discuss the care and services that they are receiving. But there is no set proportion of people receiving home or community aged care who need to be interviewed. The Royal Commission recommended the regulator should:

- periodically publish a report on the experience of people receiving care from an aged care service
  - ensure that these reports are informed by interviews with at least 20 per cent of people receiving aged care through the service (or their nominated representative)
  - take into account information from people receiving aged care services and their representatives in accreditation assessments and other compliance monitoring processes
  - establish channels (including an online mechanism) to allow people receiving aged care services and their families to report their experiences of aged care and the performance of aged care providers, year round.
- (Royal Commission into Aged Care Quality and Safety 2021d, p. 498)

A consumer experience report should provide a valuable insight into the quality and safety of care. This will be particularly important for home care, where gaining these sorts of insights is potentially more challenging than for residential care where there is more visibility. The Department of Health and Aged Care has commenced a program of consumer experience interviews for residential care which it plans to incorporate in the star ratings. But, like several other reforms, it is unclear when this program will be extended to home care.

While the Department has taken on the consumer experience survey, the ACQSC has also established a process for gaining insights from consumers and other stakeholders to improve its regulatory activities. It has established a ‘consumers and families panel’ of residential and home care consumers, their informal carers or family members and older Australians who are considering using aged care services in the future. The panel will be asked to share issues that are of concern to them, as well as ideas and opinions about matters such as how to make the ACQSC’s education material useful and easy to understand.

The reforms recommended, planned or underway to improve the regulator are among the most important to safeguard aged care quality and safety. A sufficiently empowered and resourced regulator should be the central party responsible for evaluating and managing risk. Other reforms to increase oversight and to increase information available (such as quality indicators) would provide ongoing assurance the regulator is performing well.

## Worker regulation

As far as possible, approaches to quality and safety regulation should take into account which party is best placed to understand and manage the risks. In some instances, this would be approved aged care providers, but in other instances this would be individual care and support workers, who may be operating as independent contractors.

Given that the quality and safety of care ultimately comes down to the care provided by an individual nurse or personal care worker, a risk-based approach to regulation should therefore also encompass individual workers, as well as providers.

## Worker registration

Personal care workers stand out as facing few individual regulations. Medical professionals, including allied health providers and nurses, face individual registration requirements. For this reason, less concern has been expressed around the lack of accountability for these types of workers.

The Royal Commission recommended the Australian Government establish a national registration scheme for the personal care workforce with the following key features:

- a mandatory minimum qualification of a Certificate III
- ongoing training requirements
- minimum levels of English language proficiency
- criminal history screening requirements
- a code of conduct and power for a registering body to investigate complaints into breaches and take appropriate action. (Royal Commission into Aged Care Quality and Safety 2021c, p. 392)

The Commission understands that the Government intends to introduce a registration scheme as a part of the new Aged Care Act.

While many participants to this study supported a registration system for aged care workers (Palliative Care Australia, sub. 2, p. 4; Dementia Australia, sub. 6, p. 4; Carers NSW, sub. 7, p. 3; Karyn Cullen and Enid Cullen, sub. 14, p. 3; COTA Australia, sub. 40, p. 6; OPAN, sub. 41, p. 3; Aged and Community Services Australia, sub. 42, p. 11), a detailed examination of the relative merits of a worker registration scheme is beyond the scope of this study.

As a general proposition, the Government should consider qualification and training requirements as part of its new risk-based approach to regulation. Not all care work is the same, and so it seems unlikely that all roles would require a Certificate III. Minimum qualifications could act as a barrier to becoming a personal care worker. This could be particularly relevant to some Aboriginal and Torres Strait Islander people working as personal care workers in their local community (mpconsulting 2020, p. 37).

Nonetheless, the screening element of the registration system, even without mandatory minimum requirements, can be expected to provide additional reinforcement to the protection of aged care consumers.

## Code of Conduct

A Bill introducing the aged care Code of Conduct was passed by Parliament in August 2022. The new Code of Conduct is based on the existing NDIS Code which sets out high level expectations for safe and ethical supports and services. The ACQSC will be responsible for regulatory oversight of the Code, and it has been given new powers to impose banning orders on current and former aged care workers, and to impose civil penalties on workers and approved providers for breaching the Code.

The Code of Conduct will also reinforce the non-delegable statutory duty of care. If individuals are able to become registered providers, they will have obligations under both the Code of Conduct and other regulations, including the new duty of care. While the new regulatory framework may be some way off into the future, the new Code is potentially an effective way to improve oversight of aged care in the near term. However, its effectiveness will be contingent on how well it is enforced by the ACQSC.

The Code is intended to apply broadly, potentially addressing any uncertainty around accountability when independent contractors are used, for example. The Code of Conduct applies to (among others):

- approved providers
- aged care workers being:

- an individual employed or otherwise engaged (including on a voluntary basis) by the approved provider
- an individual who is employed or otherwise engaged (including on a voluntary basis) by a contractor or subcontractor of the approved provider to provide care or other services to care recipients. (DoH 2021d, p. 11)

The explanatory memorandum for the Bill noted the explicit inclusion of independent contractors and subcontractors in the Code was a way to reinforce the responsibilities of approved providers in relation to care provided by another person on their behalf (Wells 2022b, p. 64).

## The role of technology

Alongside regulation and other policy enablers, technology has a role to play in risk management and the delivery of safe and quality aged care. With an increased focus on consumer choice, technology not only broadens the care options available to older Australians (for example, by supporting independent living through assistive technologies (table 6.1)), but it can also support providers to deliver better care (for example, through electronic medication management systems and other digital information systems that add transparency to the management and reporting of care outcomes).

**Table 6.1 – Innovative technologies for aged care**

Area of technology usage	Key features	Examples
Assistive and supportive technologies	Provide physical or cognitive aids to activities undertaken by a care recipient as an adjunct component of the activity	Balance enhancement in walking frames Assistive robots
Monitoring devices and systems	Measure and analyse personal health characteristics of a care recipient	Wearables Telecare stations Ambient assistive environments Health smart homes for ageing
Communications and connection technologies	Allow care recipients to interact with health carers remotely	Health care management websites Conversational agents for health care assistance
Intelligent health information systems	Empower care recipients to access information and exercise informed control on their health circumstances	Health portals and support sites Care coordination

Source: Dyer et al. (2019, p. 41).

As part of the proposed Support at Home program a new service type is to be introduced — digital monitoring, education and support. It is designed to provide support for consumers to use digital technologies effectively, or subscription-based monitoring of consumers using digital technologies (DoH 2022e, p. 8). Another new service type would fund the acquisition and installation of digital technology that uses software to support consumer independence, care, monitoring, functioning, risk management or social support (DoH 2022e, p. 9).

On the provider side, there is also scope to do more. While there are many examples of technology-led solutions being adopted in aged care provision, the use of technology across the sector as a whole is inconsistent and fragmented, reflecting a number of factors including inequities in access, affordability and lack of awareness (Reynolds et al. 2017, p. 18). Any major transition to digital systems for aged care

providers may need to be supported by funding mechanisms that reward investments in these systems across both residential and home care settings.



#### **Recommendation**

##### **A policy to preference direct employment would be detrimental**

The Australian Government should not introduce a policy to preference direct employment in aged care as it would reduce choice and options for care for older Australians, and at the same time, limit the options for care workers who value self-employment and flexible work arrangements. Worse, it could — given the current tight labour market — lead to a smaller aged care workforce, to the detriment of care outcomes.

The Australian Government should instead expedite the broad reform agenda for aged care to enhance quality and manage any specific risks from indirect employment through a risk-proportionate regulatory framework. In doing so, it should ensure that the development of quality standards and indicators for home care are not unduly delayed.

# Appendices



## A. Public engagement

The Commission has actively encouraged public participation in this study. This appendix outlines the engagement process undertaken and lists the organisations and individuals that have participated in this study.

- Following the receipt of the terms of reference on 23 February 2022, a circular was sent to identified interested parties.
- An issues paper was released on 22 March 2022, to assist those wishing to make a written submission to the study. The Commission received 50 submissions (table A.1). The Commission also received a total of 37 brief comments. The submissions and brief comments are available online at [www.pc.gov.au/inquiries/current/aged-care-employment#report](http://www.pc.gov.au/inquiries/current/aged-care-employment#report).
- Consultations were held with representatives from Australian Government agencies, businesses operating in the aged care sector and their peak bodies, unions, industry groups, consumer and community groups, and academics and researchers (tables A.2 and A.3).

The Commission would like to thank everyone that has participated in this study.

**Table A.1 – Submissions**

Participants	Submission
Aged & Community Services Australia	42
Aged Care Crisis	39
Aged Care Workforce Industry Council	8
Aged Care Workforce Remote Accord	15
Anglicare Australia	17
Australian Business Industrial	47
Australian Community Industry Alliance	36
Australian Council of Deans of Health Sciences	9
Australian Medical Association	19
Australian Nursing and Midwifery Federation	38
Australian Services Union	43
BallyCara Limited	22
Business Council of Co-operatives and Mutuals	44
Carers Australia	34
Carers NSW	7
Careseekers	45
Centre for Future Work at The Australia Institute	29



Participants	Submission
Community and Public Sector Union	1
COTA Australia	40
Country Home Services	5
Cullen, Karyn and Cullen, Enid	14
Darwin Community Legal Service	46
Dementia Australia	6
Gibson, Professor Diane and Bail, Associate Professor Kasia	21
Health Services Union	35
Hireup	33, 49
Knox, Associate Professor Angela and Bohle, Professor Philip and Warhurst, Professor Chris and Wright, Dr Sally	32
Laragy, Dr Carmel	16
Leading Age Services Australia	31
Mable	30, 50
Name withheld	3
Name withheld	20
Name withheld	28
National Seniors Australia	13
Older Persons Advocacy Network	41
Palliative Care Australia	2
Quality Aged Care Action Group Incorporated	12
Queensland Nurses and Midwives' Union	10
Recruitment, Consulting & Staffing Association	23, 48
Regis Aged Care	37
Resthaven Incorporated	26
Self Employed Australia	11
Underhill, Dr Elsa	25
United Workers Union	4
UnitingCare Australia	18
Woolard, Peta	24
Yorke and Northern Local Health Network	27

**Table A.2 – Consultations****Participants**

Aged & Community Services Australia
Aged Care Quality and Safety Commission
Aged Care Workforce Industry Council
Aged Care Workforce Remote Accord
Australian Government Department of Health and Aged Care
Australian Healthcare and Hospitals Association
Australian Nursing and Midwifery Federation
Australian Regional & Remote Community Services
Australian Services Union
Benetas
Briggs, Lynelle AO
Business Council of Co-operatives and Mutuals
Calvary Care
Care Connect
Carers Australia
Careseekers
Centre for Health Services Research, The University of Queensland
Charlesworth, Professor Sara
Treasury
Consumers Health Forum of Australia
COTA Australia
Country Home Services
Deloitte
Dementia Australia
Federation of Ethnic Communities' Councils of Australia
Halstead, Rod
Health Services Union
Hireup
IRT Group
Leading Age Services Australia
LGBTIQ+ Health Australia
Mable (including aged care workers using the Mable platform)

## Participants

Mercy Health

Montefiore

Munton, Professor Joellen Riley

National Aboriginal Community Controlled Health Organisation

National Aged Care Advisory Council

National Disability Insurance Agency

National Disability Services

National Health Leadership Forum

Older Persons Advocacy Network

Pagone, Tony The Hon AM KC

Palliative Care Australia

Programmed Health Professionals

Recruitment, Consulting & Staffing Association

Regis Aged Care

Registry of Senior Australians

Sidekicker

South Australian Health and Medical Research Institute

Stewart, Professor Andrew

StewartBrown

United Workers Union

## Table A.3 – Roundtables

### Participants

#### 26 July 2022 – consumer perspectives

Carers Australia

COTA Australia

Dementia Australia

Laragy, Dr Carmel

National Health Leadership Forum

National Seniors Australia

Older Persons Advocacy Network

Palliative Care Australia

Quality Aged Care Action Group

## Participants

### 27 July 2022 – provider perspectives

Aged and Community Care Providers Association

Aged Care Workforce Remote Accord

Anglicare Australia

Australian Business Industrial

Australian Community Industry Alliance

Care Connect

Country Home Services

Mable

Recruitment, Consulting and Staffing Association

### 28 July 2022 – worker perspectives

Aged Care Workforce Industry Council

Australian Nursing and Midwifery Federation

Australian Services Union

Centre for Future Work

Charlesworth, Professor Sara

Health Services Union

Queensland Nurses and Midwives' Union

Self Employed Australia

Underhill, Dr Elsa

### 2 August 2022

Department of Health and Aged Care

Treasury



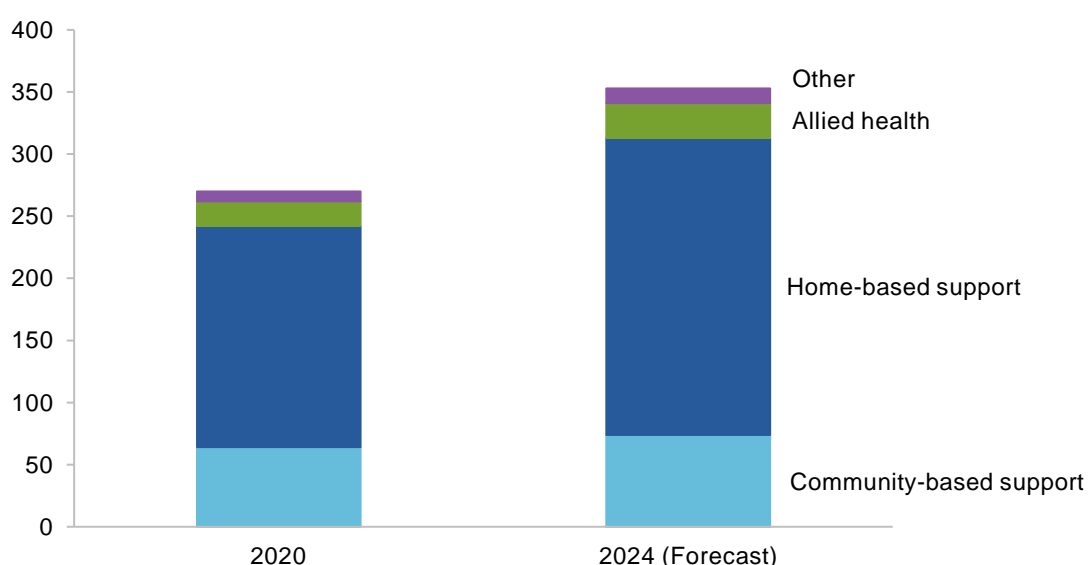
## B. Insights from the NDIS

The National Disability Insurance Scheme (NDIS) is a care scheme designed to support participant choice and control in the disability support sector, and thus provides a useful reference point for the aged care sector, which also aims to provide consumer-directed care. There are also links across both sectors in terms of their workforce.

### B.1 Profile of the disability care and support workforce

In 2020, the Department of Social Services (DSS 2021) estimated there were about 450 000 NDIS participants and 11 600 active NDIS providers (some of whom operate as independent contractors). About 270 000 workers provided disability care services in 2020, with 90 per cent of them either home- or community-based support workers, and the remainder allied health or other workers (figure B.1). The Department of Social Services estimates that the workforce will need to expand to 353 000 workers (or by 31 per cent) by 2024 to meet consumer needs.

**Figure B.1 – Most NDIS workers are in support work, with many more required in future NDIS workforce, 2020 and forecast for 2024 ('000s)<sup>a</sup>**



a. 'Other' occupations include chauffeurs, interpreters, driving instructors, gardeners and cleaners.

Source: DSS (2021).

Similar to aged care, the disability support services sector has a high rate of casualisation, part-time work and female workers. In 2021, National Disability Services<sup>24</sup> reported that, of providers that employ staff:

- about 79 per cent of permanent workers were employed on a part-time basis, a share that has remained almost unchanged since 2017
- the share of permanent workers increased from 51 per cent in December 2017 to 61 per cent in June 2021, while the share of casual workers fell from 41 per cent to 33 per cent over that period. Fixed term employees fell slightly, from 8 per cent in December 2017 to 6 per cent in June 2021. (NDS 2021)

Average hours worked ranged between 22 to 24 hours per worker over 2016 to 2021. About 69 per cent of workers were female (NDS 2021). The number of independent contractors performing disability support is not known (discussed below).

## Independent contractors and platform workers in disability care

### Independent contractors are likely to be a small share of the workforce

Available data indicate that the share of independent contractors providing disability support is likely to be small. ABS data on worker/occupation type do not distinguish disability workers from aged care workers and some other caring roles. In the 'other social assistance category of workers',<sup>25</sup> independent contractors represented about 7 per cent of that workforce in 2021 (appendix C) (increasing from about 3 per cent in 2016). Thus, independent contracting is likely to be a small but growing share of the disability support workforce if it has changed in line with other care sectors.

Separately, there are limited data from the NDIS on the number of independent contractors, but the data do not identify the share involved in support services. There were less than 10 000 active registered NDIS providers in June 2022, with about one-quarter of those being independent contractors (NDIA 2022b, p. 210). However, in the plan-managed segment of the market there were more than 120 000 unregistered providers including some which were inactive (NDIA 2022b, p. 100), with the share of those who are contractors and who provide disability support both unknown. Unregistered NDIS providers usually deliver lower risk supports to NDIS participants, including non-care services such as home maintenance (NDIS Quality and Safeguards Commission 2022a).

Even though the disability support and aged care systems operate quite differently (section B.2), both sectors' workforces face similar issues — including understaffing, misalignment/underuse of hours and casualisation (box B.1 describes disability support workforce issues).

When the NDIS was introduced, some expected that there could be greater casualisation. For example:

One of the concerns associated with the introduction of the NDIS was that it might lead to increased 'casualisation' of the workforce. Since the NDIS was introduced, participants now control funding and choose when and where their supports will be provided. Consequently, employers have less certainty about how many hours of support they will provide. One way they can deal with this uncertainty is by relying more on casual workers. (Jobs Queensland 2020, p. 21).

<sup>24</sup> The NDS data are from a twice-yearly workforce census for disability support workers and allied health workers. The census covers a relatively small sample of providers – less than 1000 in total. Most providers surveyed are organisations and results are reported for employed workers (not independent contractors).

<sup>25</sup> This occupation category includes aged care, disability care and various other roles (table C.2).



### **Box B.1 – Disability support workforce issues**

Early reviews of the NDIS found that there were issues regarding casualisation, conditions and retention. In an evaluation of the (then) NDIS trial, Mavromaras et al. (2018, p. xvi) said:

Presently the workforce is predominantly female, with low levels of vacancies and evidence of skill shortages. The evaluation found concerns about pay, staff retention, increasing levels of casualisation and the de-professionalisation of the workforce.

A Queensland Government review of the NDIS found that there is a misalignment between workers' preferences to work more hours and employers claiming that they are understaffed (Jobs Queensland 2020). That could be due to a mismatch in shift preferences, with similar concerns highlighted by the Productivity Commission (2017, p. 325):

... there are times of the day when more carers are needed than the average would suggest, which would require a greater headcount than the FTE figures suggest. This has implications for how 'flexible' the workforce needs to be.

And the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2020b, p. 253) said there was frustration by some about casualisation leading to discontinuity of care.

#### **Workforce issues may be worsening**

Cortis and van Toorn (2020) reported results from a survey of disability support workers in 2020, most of whom were unionised and likely to be directly employed. The respondents said that 'work patterns and working conditions had worsened since the NDIS was rolled out. Common problems related to unsuitable work time arrangements, unpaid work, lack of training and supervision, and understaffing.' (Cortis and van Toorn 2020, p. 7).

A survey by National Disability Services (NDS 2021) showed that about 70 per cent of providers found it difficult to recruit disability support workers (and 44 per cent found it difficult to retain them) in 2021. This was up from 64 per cent of providers reporting difficulties recruiting disability support workers (and 34 per cent with difficulties retaining them) in 2019 (NDS 2019, p. 55).

Similarly, the Australian Services Union (ASU, sub. 43, pp. 5–6) cited a survey from March 2020, which found that high turnover was a:

... major barrier to growing and maintaining the workforce. High turnover was linked to the casual and insecure nature of work, lack of supervision, unpaid work and the lack of relevant qualification pathways and professional training opportunities, as well as the low paying conditions offered to disability workers.

The ASU (sub. 43, p. 6) also stated that the pandemic exacerbated existing workforce churn.

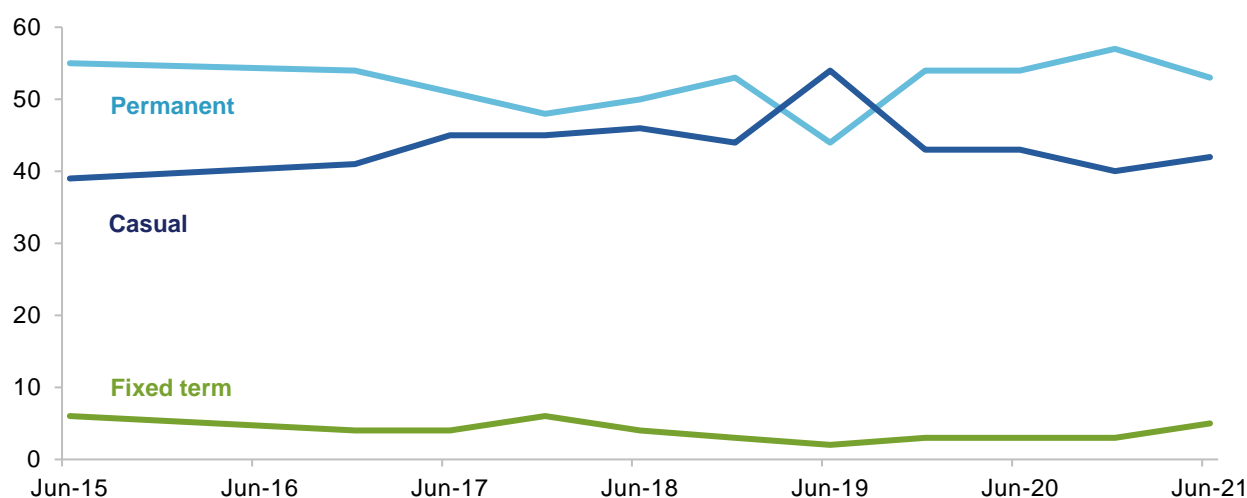
The Productivity Commission said that casualisation could help with providing labour needed in peak demand times, but there would also be factors working against casualisation, including:

- minimum shift requirements in the Social, Community, Home Care and Disability Services Industry (SCHADS) Award, and the cost of casual loadings for working hours at less desirable times of day
- continuity of care, as casualisation could lead to different persons caring
- supply concerns (for instance, workers might demand more hours or permanent work rather than shifts, which can be ad hoc). (PC 2017, pp. 325–326)

Despite these concerns, available data suggest that employers have not increased their use of casual staff (figure B.2), although it is possible that employers have increased their use of part-time staff with variable hours. And others have noted that casualisation of the workforce has been a feature of disability support services both prior to, and after, the rollout of the NDIS (Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability 2020b).

### Figure B.2 – Forms of employment for disability support workers have been relatively unchanged

Share of disability support workers, by employee type, per cent<sup>a</sup>



a. There were, on average, about 200 providers that took part in each survey.

Source: NDS (pers. comm., 9 May 2022).

### Digital platform workers are a small share of the disability care workforce

Available data suggest that only a small share of disability care workers find work using online platforms. One survey reported that about 5 per cent of disability workers (or 114 workers in the survey) had used an online platform to obtain work in 2020 (Cortis and Toorn 2020). Of those who had, nearly 90 per cent used Hireup or Mable.<sup>26</sup> Although comprising a small share of the workforce, providers like Mable and Hireup only began operations in 2014 and in 2015, respectively and have reported strong growth (Mable, sub. 30, p. 24). Independent contractors who use digital platforms provide a range of daily support activities. The types of supports provided by disability support workers are often broader than those for aged care (they include, for example 'capacity building' supports — section B.3). However, there is no detailed data on what services independent contractors provide to NDIS participants (or aged care recipients).

Platforms can enable workers in the care sector to obtain supplementary work that they might not otherwise be able to get (chapter 4). Platforms may also allow new workers to enter the industry: according to a 2020 survey, those disability support workers who had used an online platform were more likely to have fewer years of work experience compared with those who did not use a platform for work (Cortis and van Toorn 2020). Consequently, platforms provide a significant source of additional labour, given staff shortages.

<sup>26</sup> The other platforms were Careseekers, Care.com, Airtasker, Carer Solutions and Findacarers.

## Some caring roles are transferable

Some disability support workers may look to supplement their income through platform work or by working in other sectors, including aged care (box B.2). Carers NSW (sub. 7, p. 3) said the instability of working arrangements in caring roles means that many workers need to work across both the aged care and disability sectors, or have multiple employers, or use platform work to achieve their desired hours and income.

The relative working conditions in each sector, type of work and worker mobility will influence the extent that workers can switch between (or work in both) care sectors. Some aspects of aged care and disability care are likely to be similar (Cullen and Cullen, sub. 14, p. 4). Leading Age Services Australia reported that both mainly support daily living (Speirs and Hicks 2021, p. 14) and the Department of Social Services (DSS 2021, p. 9) noted that some key job roles are common across care sectors. However, there are some specialised services. The ASU (sub. 43, p. 7) stated that 'disability support and aged care are distinct areas of practice' and 'the skills required for each role are different'. In practice, it is likely there is enough similarity between aged care and disability care for some workers to be able to work in both sectors, although available data make it difficult to gauge the extent of this (box B.2).

### Box B.2 – Links between the aged care and disability care workforces

Some aged care and disability support carers work in a second job in the other sector, or transition between sectors. There is a lack of recent data to determine how prevalent this is. However, based on information for 2016, only 0.2 per cent of residential aged care workers and 0.6 per cent of home aged care workers were working in another job in disability care. The NDIS had only just commenced full roll-out at that time, so it is likely this share has grown since then.

Furthermore, in 2016 about 2.6 per cent of personal care attendants (working in residential care) and 4.5 per cent of community care workers (working in home care) had worked in disability care prior to their first job in aged care.

The importance of timely and detailed data to analyse the NDIS workforce has been noted by others, including the Productivity Commission (2017). More recently, the Joint Standing Committee on the National Disability Insurance Scheme (2022) and Per Capita (2022) both noted the need for collection of better data to analyse platform work.

Source: Mavromaras et al. (2017).

Employees providing home care in the aged care and disability support sectors are employed under the SCHADS Award. Participants said that disability support workers typically get paid more than aged care workers (Dementia Australia sub. 6, p. 7, BallyCara Limited, sub. 22, p. 6). Careseekers said that disability support workers get paid, on average, \$43 per hour compared to \$38 per hour for aged care workers (Careseekers, pers. comm., 14 September 2022). Higher pay in disability support would make it more attractive, all else equal, than working in aged care.

Aged care and disability support work have similar conditions, and many people work relatively few hours. Thus, any change to employment laws in one sector, including a policy to preference direct employment or changes in working conditions (such as pay rates), is likely to have spillover effects in related care sectors. As Carers NSW (sub. 7, p. 2) stated:

... improvements to aged care employment alone will result in emergent and worsening issues in other care employment sectors (such as disability), and will lead to increased pressure on family and friend carers.

## B.2 Differences between the NDIS and aged care models

This section explains how the NDIS works to support participant choice and control, while still affording protection to participants. Notable differences with home aged care and some of the risks and issues about the functioning of the NDIS are also highlighted.

### Key features and differences to aged care

Many of the key features in the design and operation of the NDIS are different to aged care. For example:

- participants in the NDIS have an individualised assessment plan
- funding is uncapped, and prices can be determined by negotiating with a worker/provider to spend funds how the individual wants
- workers are not always required to be registered.

The Government has been considering introducing a new Support at Home Program, with characteristics that would more closely resemble the NDIS model (table B.1). The Support at Home Program would replace the Commonwealth Home Support Program (CHSP), Home Care Packages (HCP) Program and the Short-Term Restorative Care (STRC) Program (DoH 2022e).

**Table B.1 – Key features of the NDIS and home aged care sector**

Current home aged care	Support at Home	NDIS
<b>Program/Scheme and assessment</b>		
CHSP, HCP Program and other programs	One program to replace CHSP, HCP Program and the STRC Program	One scheme
An approved provider is responsible for service delivery	Multiple service providers can be used	Multiple service providers can be used (registered or unregistered)
HCP: Individuals allocated to one of four broad support levels based on initial assessment, with capped funding at each level	Individualised support plans that specify eligible services, based on independent assessment of needs	Individual assessment plan, with ongoing (yearly) reassessments required
Regular (at least yearly) reassessment of plans	Type and amount of services tailored to needs of each individual	Type and amount of services tailored to needs of each individual
<b>Funding and plan management</b>		
HCP has 4 levels of subsidised funding for daily living supports, ranging from about \$9000 per year to about \$53 000 per year)	Variable funding for daily living, based on individualised support plan	Variable funding, based on individual assessment plan for core supports (mainly daily living)
CHSP is block-funded, limited funding for goods, equipment, assistive technologies and home modification	Specific funding for goods, equipment, assistive technologies, and home modifications	Funding also provided for capital supports program and capacity building.

Current home aged care	Support at Home	NDIS
HCP funding to provider, which allocates funding. CHSP has block funding, <sup>a</sup> leftover funds kept by provider	Funding paid at point of service (fee for service) delivery Multiple providers can be used	Fee-for-service delivery Registered and unregistered providers can be used
HCP can be self-managed (but low take up at present)	Can be self-managed	Choice of self-managed, plan-managed or NDIA (agency)-managed plans
Regulation and compliance <sup>b</sup>		
National standards for all providers	National standards for all providers	National standards, for registered providers
No code of conduct; new code to be introduced from 1 December 2022	Code of conduct for all providers/workers	Code of conduct for all providers/workers

HCP = Home Care Packages Program. CHSP = Commonwealth Home Support Program. STRC = Short-Term Restorative Care Program. NDIA = National Disability Insurance Agency **a.** Block funding refers to the process where governments purchase a 'block' of services from a provider, which is to be delivered to clients who meet certain criteria, or are referred to those providers as part of an individualised plan. **b.** Workers must also undergo screening/police checks.

Sources: DoH (2022e); NDIA (2022a, 2022c).

A report by Leading Age Services Australia (Speirs and Hicks 2021) stated that aged care recipients across all levels of care needs typically receive lower levels of funded support than that provided to NDIS participants with similar support needs. This was claimed to occur, in part, due to funding being capped under the HCP whereas for NDIS participants it is uncapped. Another key difference is that some home aged care services are means/income tested, while NDIS services are not. For example, HCP recipients may have to pay an income tested care fee if they are not full pensioners or earn above \$30 200 (DHAC 2022b). And HCP and CHSP recipients may have to make some co-contributions (chapter 2).

## The NDIS model provides users with more choice

In contrast to aged care, participants in the NDIS have greater control over how their allocated funds are spent, despite the potential risks.

### NDIS assessments are more individually tailored than in aged care

Eligibility for the NDIS is assessed on an individual's support needs and, if approved, they then create their NDIS plan. The plan is a written agreement including a person's goals, how they will manage their funding and what funding has been allocated for each of their support needs. Help is provided to manage this plan via a local area coordinator who is assigned to each participant of the Scheme.

There are regular (typically 12 monthly) reviews of each person's NDIS plan. This can lead to a continuation of the current plan, minor amendments or, in some cases, a full reassessment. People can access a tribunal if they do not agree with an assessment decision. The proposed Support at Home Program is intended to have an integrated assessment tool to assess eligibility for all aged care programs (including home and residential care) and have four different levels, with trigger points to guide assessors to the most appropriate level (DoH 2022e).

NDIS participants can further protect themselves by entering into a service agreement with their providers, which outlines when and what types of services will be provided and responsibilities of each party (box B.3).

### **Box B.3 – Service agreements in the NDIS**

A service agreement is negotiated between a participant and provider. Participants might nominate a person (such as a family member) to negotiate the agreement. A written service agreement is required for specialist disability accommodation supports under the NDIS rules, but for other NDIS services the National Disability Insurance Agency does not require written service agreements.

There are no rules on what an agreement must contain. It might include a description of the supports being provided (including when and how they are delivered), their cost, the responsibilities of each party and dispute resolution processes. In the event of a dispute, a service agreement has the same status as any other agreement under Australian Consumer Law.

Service agreements are not compulsory. Concerns have been raised on behalf of participants, for example, about the use of independent contractors who the client has no relationship with. The (Victorian) Office of the Public Advocate (2019, p. 14) said:

Some NDIS service agreements contain clauses that allow the service provider to sub-contract services to a future unknown service provider. By signing the NDIS service agreement, the participant consents to the service provider's ability to assign all or part of their interest rights, and obligation under the agreement to a third party that they select.

Source: NDIS Quality and Safeguards Commission (2022b).

### **NDIS supports, funding and plan management are more varied than in aged care**

There are three types of plan management in the NDIS: self-managed, plan-managed, and NDIA-managed, with the level of involvement by participants varying across each type (box B.4).

Many NDIS participants self-manage their plans and use unregistered providers. Only 14 per cent of NDIS participants had a plan managed by the National Disability Insurance Agency (NDIA) in June 2022. About 30 per cent of participants self-managed and 56 per cent used a plan manager NDIA (NDIA 2022b, p. 94). The share of participants using a plan manager increased rapidly, from 40 per cent to 56 per cent in the past two years, corresponding with a decline in the share of participants with NDIA-managed plans, from 28 per cent to 14 per cent.

In contrast to the NDIS, only about 6 per cent of HCP recipients self-managed their package in June 2021 (chapter 2). Given the NDIS experience, it is likely that the aged care sector will have a higher take up of self-managed plans if the Government proceeds with the Support at Home program (or another program like it).

### **Box B.4 – Managing funding for supports under the NDIS**

NDIS support budgets are determined on an individual basis, and vary according to need. They can be self-managed, plan-managed or NDIA-managed (also called agency-managed). People can choose to use one, or a combination, of these options.

- Self-managed – a person manages their own NDIS funding. The NDIS reimburses a participant directly for the NDIS supports received. Participants can decide what supports to buy (and from whom)

#### **Box B.4 – Managing funding for supports under the NDIS**

and pursue their own plan goals. There is flexibility to spend more or less than NDIS guidelines. Self-managed participants are not required to use a registered service provider (unless the worker is engaged in certain risk-assessed roles, in which case the worker also requires a NDIS worker screening clearance). Participants also manage their service agreements (if they use them).

- Plan-managed – a plan manager helps look after the service agreements with providers and the financial responsibilities of a participant's plan. However, participants have control over the provider used, and can choose to use unregistered providers. A plan manager must be a registered NDIS provider because they manage the participant's NDIS budget and manage funds received from the NDIA.
- NDIA-managed – the NDIA has full financial responsibility of a person's plan. It pays invoices, manages funding and keeps records of spending. Furthermore, only registered providers can be chosen to deliver services.

An important difference to the NDIS is that all aged care recipients must use an approved provider.

Source: NDIA (2020).

The NDIS funds a greater range of supports than aged care (box B.5).

#### **Box B.5 – Funding support types: NDIS and home aged care**

There are three broad types of supports that can be funded in a person's NDIS plan:

- Core supports – four support categories, to help with everyday activities and current disability needs. They are assistance with daily life (for example, everyday needs, household cleaning and maintenance), transport (to help travel to work and other places), support to help with social and community participation and required consumable items to maintain independence.
- Capacity building – helps to build independence and skills to pursue goals. It includes support to find and maintain a place to live, to find and keep a job, and to improve health and relationships.
- Capital supports – higher-cost pieces of assistive technology and equipment, home/vehicle modifications and, in some cases, specialist disability accommodation.

Home aged care programs have similar core and capital supports, but not the same capacity building supports. For example, services funded under the HCP Program are: hygiene and grooming, nursing, podiatry, physiotherapy and other therapies, meals and food preparation, help with impairments, cleaning and laundry, home maintenance, home modifications, aids to stay independent, transport and social outings, groups and visitors. Funding is capped at four different levels under the HCP Program, whereas it varies based on individual support needs under the NDIS.

Sources: DHC (2022c); NDIA (2022d).



A higher take up of self-managed plans in aged care, along with more services being available for funding, would come with potential risks, which will need to be managed. Two key aspects of risk in the NDIS are the type of provider and the needs and capacity of the participant; the latter may create more risks under self-management and plan-management.

Greater choice can create issues. Some NDIS participants have found the system to be 'intimidating and difficult to navigate' (Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability 2020b, p. 182). The Royal Commission also noted that there were some reported difficulties associated with developing plans under the NDIS (Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability 2020b, p. 366). The Productivity Commission heard through consultations that, in practice, parents and guardians are often nominated to 'self-manage' a participant's plan. Appropriate supports to help users manage their plans can lead to better outcomes. One review of the *National Disability Insurance Scheme Act 2013* (Cwth) found:

... people with disability who have support to navigate the NDIS from initial entry to being able to fully access and implement their plans tend to achieve better outcomes than those who do not have the help they need to navigate the system by themselves. (Tune 2019, p. 44)

That review also noted that, at the time, participants who wanted to plan-manage were not required to undergo a risk assessment (to assess their capability), whereas participants who chose to self-manage did have to undergo an assessment. Furthermore, plan-management offers the same level of choice and access to unregistered providers as self-management. Tune (2019, p. 127) argued that could potentially lead to risky supports being procured for some people who plan-manage (particularly those with limited decision-making capability) and recommended that participants who seek to plan-manage their funding be subject to the same considerations as those who wish to self-manage. Legislation was passed in March 2022 to amend the NDIS Act to adopt this recommendation and to improve NDIS processes and make it more responsive (Parliament of Australia 2022).

These issues highlight a tension with user choice models — while some users value autonomy and making their own choices (which may also lead to better outcomes), they must be capable to do so. Importantly, the NDIS is seeking to find the right balance of regulation and consumer autonomy.

### **Where are NDIS funds being spent?**

The NDIS has seen a high number of small unregistered providers enter the market. About 90 per cent of providers in the plan-managed segment of the market are unregistered. (About half of participants use a plan manager). However, while registered providers only represent 10 per cent of providers paid through plan managers, they received 61 per cent of payments in the June quarter 2022 (table B.2).

Smaller, unregistered providers may be providing less complex services, which require less funding. Many unregistered providers are likely to provide home maintenance and other non-clinical or personal care services. Thus, funding differences to providers could be due to the differing needs of participants and the services that providers offer. However, there is a lack of data to determine what services unregistered providers are providing. There are also some very large unregistered providers.

**Table B.2 – There are many unregistered NDIS providers receiving small payments****Number of providers servicing participants through a plan manager, 4<sup>th</sup> quarter 2021-22**

Payment band in quarter	Number of providers — plan-managed		Share of total payment in quarter (per cent)	
	Registered	Unregistered	Registered	Unregistered
Less than \$1000	1124	43 035	0	1
\$1000 to \$10 000	3732	53 688	1	15
\$10 000 to \$100 000	5195	24 598	9	46
\$100 000 to \$1 million	2968	1592	45	29
More than \$1 million	405	32	45	8
<b>Total (number/\$ mil)</b>	<b>13 424</b>	<b>122 945</b>	<b>\$1769</b>	<b>\$1307</b>
<b>Share (per cent)</b>	<b>10</b>	<b>90</b>	<b>61</b>	<b>39</b>

Source: NDIA (2022b, p. 100).

Most funds were allocated to supporting core daily activity support (table B.3). About 5 per cent of active NDIS participants access the Supported Independent Living (SIL) program, which is for people with higher needs, requiring some level of help at home all the time, including overnight support (NDIA 2021). Although a smaller cohort of the Scheme, SIL participants receive much more funding per person because they require more intensive care.

**Table B.3 – Most NDIS payments are for core support activities and are plan-managed****Total payments, by plan management type and activity, 4<sup>th</sup> quarter 2021-22, \$million**

	NDIA-managed	Plan-managed	Self-managed	Total
<b>Core support</b>				
Daily activities — SIL	1656	167	2	1824
Daily activities — non-SIL	542	1406	294	2242
Social and community participation	368	929	151	1447
Other core support	117	83	131	331
<b>Capacity building supports</b>	370	759	329	1458
<b>Capital supports</b>	127	80	32	238
<b>Total</b>	<b>3181</b>	<b>3423</b>	<b>938</b>	<b>7542</b>

SIL = Supported Independent Living program.

Source: NDIA (2022b, p. 97).

SIL participants receiving core daily activities support were also more likely to use NDIA-managed plans and registered providers. Of the payments for participants in the SIL program, less than 1 per cent of the total were self-managed, while 91 per cent of payments were NDIA-managed (NDIA 2022b, p. 96). In contrast, only 24 per cent of non-SIL participants' total payments were plan-managed. This suggests a higher use of NDIA-managed plans by SIL participants, which could reflect that they are assessed as being a higher risk to

manage their own plan, or that they do not want to manage it because they find it difficult to do themselves. Furthermore, many people under the SIL program require workers to provide restrictive practices (and such workers must be registered), which may explain the higher use of registered providers.

They key point is that although there is a high take-up of self-managed plans, many people with high needs are accessing registered providers via NDIA-managed plans. That is, the Scheme is able to offer tailored supports with varying degrees of safeguards, in line with the diverse types of consumers and their needs.

## B.3 Differences in NDIS and aged care regulations

Quality and safety in the NDIS are regulated in three main ways:

1. the NDIS Code of Conduct, which applies to all NDIS providers (registered or unregistered) and workers
2. the NDIS Practice Standards, which apply only to registered providers
3. worker screening requirements.

The NDIS Quality and Safeguards Commission (NDIS Commission) regulates and oversees services provided under the NDIS. (There are no restrictions on the use of different types of employment models.)

Key differences with current aged care settings are that NDIS providers do not have to be registered, there is a code of conduct and stricter worker screening. These are described below.

### NDIS Code of Conduct

A bill to amend the *Aged Care Act 1997* (Cwth) to 'require compliance with a code of conduct by approved providers and their aged care workers and governing persons' was passed on 2 August 2022 (Wells 2022b, p. 1). The aged care code of conduct will be based on the NDIS code, with the intention to 'align obligations between the care and support sectors to increase harmonisation' (Wells 2022b, p. 62).

The NDIS Code of Conduct outlines the expectations for the conduct of both NDIS providers (registered or unregistered) and workers. It covers topics like respecting individuals' freedom of expression, acting with respect and integrity, providing safe supports and taking reasonable steps to prevent violence, abuse, neglect and sexual misconduct. There are guidelines available to help both NDIS providers and workers understand their obligations. The Code of Conduct works alongside worker screening — breaches of the Code can lead to workers losing their screening clearance (discussed below).

While in aged care there may be some confusion regarding accountability with the quality and safety standards (chapter 4), there is no ambiguity in the NDIS about the application of the Code of Conduct. It applies to all workers, whether they are working for a registered or unregistered provider. However, the effectiveness of a Code relies upon strong enforcement by the regulator. As explained below, there are many complaints about NDIS providers, which suggests a code alone may not be sufficient to ensure quality of care.

### NDIS Practice Standards

Registered NDIS providers must also adhere to the NDIS Practice Standards. These are more nuanced than the standards in aged care, as they are tailored to the *type* of disability support services provided, and dependent on registration status. In contrast, all home aged care providers that receive government funding must be approved and face the same standards (figure B.3).

**Figure B.3 – Comparison of disability and aged care quality standards**

Both systems have a regulator to ensure compliance with Standards for regulated providers		
	Disability (NDIS)	Aged care
Regulator	NDIS Quality and Safeguards Commission	Aged Care Quality and Safety Commission
	NDIS Practice Standards and Quality Indicators	Aged Care Quality Standards
All registered providers	<b>Core module</b> <ul style="list-style-type: none"> <li>• Rights of participants and responsibilities of providers</li> <li>• Provider governance and operational management</li> <li>• Provision of supports</li> <li>• Provision of supports Environment</li> </ul>	<ol style="list-style-type: none"> <li>1. Consumer dignity and choice</li> <li>2. Ongoing assessment and planning with consumers</li> <li>3. Personal care and clinical care</li> <li>4. Services and supports for daily living</li> <li>5. Organisation's service environment</li> <li>6. Feedback and complaints</li> <li>7. Human resources</li> <li>8. Organisational governance</li> </ol>
Some registered providers	<b>Supplementary module</b> <ul style="list-style-type: none"> <li>• High intensity daily personal activities</li> <li>• Specialist behaviour support</li> <li>• Implementing behaviour support plans</li> <li>• Early childhood supports</li> <li>• Specialised support co-Ordinator</li> <li>• Specialist disability accommodation</li> </ul>	<b>Not applicable</b>
Non-registered providers	<b>Do not have to comply with any standards</b>	<b>Not applicable</b>

Source: NDIS Quality and Safeguards Commission (2021b) and chapter 3.

The NDIS Practice Standards are a benchmark for providers to assess their performance, and to demonstrate how they provide high quality and safe supports and services to NDIS participants. There are outcomes associated with each standard and, for each outcome, quality indicators are used by auditors to assess a provider's compliance with the Practice Standards. This is similar to how the aged care standards are monitored and audited (chapter 3).

In addition to periodic audits for most providers against the Standards, the NDIS also has the power to investigate reports of non-compliance in general and can impose penalties including banning workers, de-registering providers and seeking civil penalties (NDIS Quality and Safeguards Commission 2021a, p. 1).

## NDIS worker screening and contractor engagement

Workers and key personnel of registered providers must have a worker screening clearance, which forms part of the NDIS Practice Standards. This requirement is to help ensure that workers do not pose an unacceptable risk to the safety and wellbeing of NDIS participants.

The NDIS Commission provides specific information to organisations with regards to subcontracting work. The provider (not the care recipient) is considered to be the entity that has engaged the contractor:

... there are additional responsibilities and obligations for registered NDIS providers who engage another organisation or individual to perform work as part of their provision of supports and services in the NDIS. The organisation or individual will be a contractor engaged by the registered NDIS provider. The registered NDIS provider and the contractor need to work together to ensure that any workers of a contractor, including an individual contractor themselves, have an NDIS worker screening clearance. (NDIS Quality and Safeguards Commission nd)

The registered NDIS provider must take reasonable steps to satisfy itself that the individual has a clearance.<sup>27</sup>

An NDIS Worker Screening Database can be accessed to check the screening status of workers.

Unregistered providers and self-managed and plan-managed participants can also decide if they want to require workers to undergo a NDIS Worker Screening clearance.

Under legislation for the new Aged Care Act, greater sharing between the worker screening units in the NDIS and aged care (and disability and veterans' affairs) has been introduced. This provision was included 'because many individuals work across both sectors and such disclosure is intended to ensure the safety, health and well-being of [aged] care recipients and NDIS participants' (Wells 2022b, p. 111).

The use of unregistered workers has been extensive (section B.1), which may indicate that the process people undertake to start providing support services is straightforward without registration. However, that can pose risks. Unregistered providers operating as independent contractors have less safeguards. They are not required to meet the NDIS Practice Standards and are not actively monitored by the NDIS Quality and Safety Commission. Hireup noted this in their submission (sub. 33, p. 6):

NDIS Quality and Safeguard Commission checks and safeguards largely do not apply to unregistered, contractor support workers. There is little or no scrutiny of contractor work practices until something goes wrong and a complaint is made against them to the Commission, or a problematic workplace incident is reported.

There are some concerns regarding the lack of understanding of workers' occupational health and safety or workplace health and safety (OHS/WHs) requirements, with a Victorian Government study reporting that:

... workers ... had very little understanding of what health, safety or wellbeing protections are in place legislatively for those who work in the disability sector. None mentioned the Occupational Health and Safety Act 2004 and there was also very low awareness of their rights. Generally, workers agreed that there was a lack of genuine focus on health and safety across the sector.

This was attributed to a culture that didn't adequately prioritise safety, a lack of training, and lack of time to do adequate risk assessments before issues occur. (Department of Families, Fairness and Housing 2021, p. 18)

It is not clear if these concerns were relatively more apparent for indirect workers. However, it is likely that independent contractors would have less understanding of OHS/WHs than employees in organisations that provide relevant training. Similar issues were highlighted in the aged care sector (chapter 4).

## Enforcement and the role of the NDIS Commission

The NDIS Commission can investigate a potential breach of the Code of Conduct for many reasons, including from any information it receives about an NDIS provider or worker. Complaints can be made by

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<sup>27</sup> There are some exceptions. For example, a person can work in a risk assessed role if the person is in the process of obtaining a clearance and being supervised.

people with disability, family members, friends, workers, advocates and other providers (NDIS Quality and Safeguards Commission 2019, p. 32).

The NDIS Commission publishes a register of approved providers and compliance and enforcement actions on its website. However, unregistered service providers are not required to report incidents or allegations of harm against a person with disability to the NDIS Commission, and incidents of neglect or abuse that occur outside the context of NDIS supports and services are not classified as reportable incidents (Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability 2020a, p. 325). Despite that, there were still nearly 74 000 reportable incidents between July 2018 to December 2019 recorded by the NDIS Commission, with the vast majority (91 per cent) relating to unauthorised use of restrictive practices (mainly chemical and environment restraints) (Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability 2020a, p. 325).

Some organisations have said that the NDIS should be more proactive in enforcing adherence by service providers to the NDIS Practice Standards (Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability 2020b, p. 12). The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2020a, p. 19) also said that the complaints and resolution process is not working well for everyone:

We have been told about difficulties in reporting and complaining in a range of contexts, and that incidents are sometimes minimised, ignored or go unreported. We have also heard that some people with disability have been punished for making complaints about the care or services they receive. Some people with disability described fearing retribution or not being able to access confidential complaints procedures. We have also heard about complaint procedures that are inappropriate for people who are non-verbal or deaf. We have heard that complaints made by people with disability, particularly those with psychosocial or intellectual disabilities, are not always taken seriously or are considered minor. We have been told that reporting and investigation processes are often insufficiently independent and are inaccessible or re-traumatising for the complainant.

## How effective are safeguards in practice?

Some problems have been raised about the NDIS. Many relate to the risks and safeguards of the system. The Productivity Commission previously noted concerns from some groups (including NDIA staff) that the NDIS lacked sufficient safeguards in the area of self-managed participants, and it also raised questions about whether the NDIS Quality and Safeguarding Framework is appropriate for intermediaries (PC 2017, p. 426). As such, the Commission recommended regular monitoring and review of regulation and quality assurance arrangements to ensure problems were identified and addressed early.

Since then, the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability was established, in 2019. It came after 'repeated calls from people with disability, their advocates and representative organisations about the need to address violence against, and abuse, neglect and exploitation of, people with disability' (Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability 2020a, p. 68). While the terms of reference are very broad, one aspect the Royal Commission was asked to consider was the quality and safety of services, including those provided by the NDIS under the NDIS Quality and Safeguarding Framework (Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability 2020a, p. 30). The Royal Commission is expected to report on 29 September 2023. Its findings about the NDIS will provide the aged care sector with lessons to take on board, particularly for any reforms to enable greater choice and control, such as the proposed Support at Home Program.

## **B.4 Summary and insights for the aged care sector**

The NDIS provides a useful case study with insights into how the home aged care sector might evolve if it moves more towards a model where users can have more control on where and how their care funds are spent.

Many workforce issues raised in aged care and disability support services are similar and relate to understaffing, casualisation (which impacts continuity of care), a lack of training and mismatched hours.

Both care sectors are expected to face severe workforce shortages in coming years. Without a flexible workforce (which the preferencing of direct employment would prevent) those shortages are likely to be exacerbated.

There are opportunities to better align regulations across both sectors. The NDIS already has a code of conduct, and the aged care sector is moving towards alignment with the NDIS with a similar code.

As with the aged care sector, there is a continued need for better data on workforce attributes and performance.



## C. Data sources

Analysis of the share of indirect employment in the aged care workforce was based on data from the Department of Health's National Aged Care Workforce Census, commercial data provided by StewartBrown and the ABS' Characteristics of Employment Survey.<sup>28</sup>

This appendix describes these datasets and their limitations, as well as the methodologies used. A summary of this discussion and results for different measures of indirect employment are in table C.2. This appendix also describes the Commission's estimate of the number of aged care consumers.

### C.1 The National Aged Care Workforce Census

Many of the estimates in chapter 2 are derived from the National Aged Care Workforce Census, which has been administered by the Department of Health (now the Department of Health and Aged Care) and conducted about once every four years (2003, 2007, 2012, 2016 and 2020). The latest census (undertaken in 2020) provides information on the size of the workforce, types of employment contracts (permanent, casual, labour hire/agency), a worker's full-time/part-time status and other variables (DoH 2021a). The 2020 census was sent to all active registered providers that employed staff involved in care services (that is, nurses, personal care workers and allied health workers), in residential care, the Home Care Packages (HCP) Program and the Commonwealth Home Support Program (CHSP), although many providers did not respond (discussed below). Providers that did take part in the census answered in relation to their workforce in November 2020.

#### Issues with the 2020 National Aged Care Workforce Census

##### Sample size and survey design

The response rate for the 2020 census was relatively low (less than 50 per cent), meaning that it was 'effectively a survey' (DoH 2021a, p. 62). In contrast, the 2016 census had a 76 per cent response rate for residential care providers and 42 per cent for home care providers (Mavromaras et al. 2017, p. 8) census responses were weighted in both years to get more representative estimates.

Since the census was only sent to approved providers, workers who were not paid by approved providers were not included, such as those who only worked for privately-funded consumers.

Due to the COVID-19 pandemic, workers were not interviewed directly (unlike in previous years), so employment numbers for each aged care program were collected at the provider level. This may lead to overcounting if people worked at more than one provider as well as across aged care programs. Although

<sup>28</sup> The Commission investigated using data from the Household Income and Labour Dynamics in Australia survey, which has recently introduced questions about respondents' involvement with digital platform work. However, the sample size for platform workers in aged care roles was not large enough to provide robust results and was not included for this study.

the extent of this issue is unknown, about 5 per cent of residential care and 7 per cent of home care workers had another job in aged care in 2016 (Mavromaras et al. 2017). However, some (indirectly employed) workers might also be undercounted (described below), which would provide at least a partial offset.

Further, self-reported measures for workers — such as wages, working hour preferences and work-related injuries — were not asked in the 2020 census. As such, some estimates in this study use information from the 2016 census. Although these data are now dated, they provide the most recent information on aged care workers' self-reported working conditions.

## Measurement of indirect employees

The 2020 census distinguishes between employees, contractors and agency workers using three employment types:

- permanent (full-time or part-time)
- casual/contractor on the payroll (including casual employees and contractors who are on the payroll of providers, which the Commission interprets as including employees with a fixed term contract rather than independent contractors used for one-off tasks). The Commission has confirmed this interpretation with the Department of Health and Aged Care (pers. comm. 6 June 2022), however, it is possible that respondents may have misinterpreted the categories and included, for example, agency workers on the payroll of providers
- agency/subcontractor who are not paid directly by providers (including independent contractors and agency workers).

The third category is of interest to this study as it measures indirectly employed workers. However, there are some issues that might affect the interpretation of the data.

The prevalence of agency/subcontractor workers could be underreported in the census (in all years) if they are highly transient. The censuses are conducted at points in time and if employees hired via an agency are more likely to be filling in for short-term roles, this could lead to their use (throughout the year) being underreported compared with staff permanently on payroll.

The limitations of the 2020 census are evident in the large discrepancy between the estimated number of indirectly employed workers in the 2016 and 2020 census years. In 2016, the census estimated that the number of non-pay-as-you-go care workers was 28 000 — representing 10 per cent of the care workforce (nurses, personal care workers and allied health workers) — whereas in 2020 it was nearly 11 800 persons (3.5 per cent of the care workforce). As the Senate Select Committee on Job Security noted:

It seems doubtful that the actual number, and relative proportion, of aged care workers employed through agencies, labour hire or sub-contractors would have more than halved in four years. Particularly as, during 2020, COVID-19 reportedly led to an *increase* in the need for agency and labour hire staff to replace furloughed workers. (2021b, p. 26)

## Comparability across years

The 2020 census uses different definitions for certain categories compared with previous years. It is the first census to identify personal care workers on a formal traineeship. For the estimates in this study, 'personal care worker' refers to the combination of personal care workers and personal care workers on a formal traineeship. It is unclear if previous years' definition of 'personal care worker' included those on a formal traineeship.

The 2020 census was also the first to use the employment category 'agency/subcontractor' (discussed above). The 2016 census identified non-pay-as-you-go workers (agency, brokered and self-employed workers) instead of agency workers/subcontractors. The Commission understands that brokered workers are

workers sourced from one provider to another on a short-term basis, and self-employed workers as equivalent to independent contractors. Brokered workers were not captured in the 2020 census. The 2016 data on non-pay-as-you-go workers were used in chapter 2 in the analysis of the reasons underpinning providers' use of indirect employment.

Changes to the aged care system have also affected what this study refers to as 'home' aged care workers. 'Home' care refers only to the HCP Program and CHSP in the 2020 census, while it refers to the HCP Program, CHSP, Home and Community Care Program in Victoria and Western Australia, Multi-Purpose Services, National Aboriginal and Torres Strait Islander Flexible Aged Care and Transition Care Program with home care/home support places in the 2016 census. Further, the 2020 census did not include within its residential care data the National Aboriginal and Torres Strait Islander Flexible Aged Care Program and the Transition Care Program with residential places, which were included in the 2016 census (DoH 2021a). Though the 2020 census is narrower in scope, this study has used the 2020 definition of 'home' care where the 2020 census was used, and the 2016 definition of 'home' care where the 2016 census was used.

## C.2 StewartBrown data

StewartBrown is an accounting firm that provides performance benchmarking services to providers using detailed financial data. The results of their benchmarking are published quarterly in their Aged Care Financial Performance Survey Sector Report (StewartBrown 2022). They collect information from providers on a range of variables, including the hours and costs of agency workers, brokered workers and subcontractors.

StewartBrown provided de-identified unpublished data to the Commission. Data were provided for the 2015-16 to 2020-21 financial years, separately for both residential and home care. The data include the hours worked and costs of directly employed workers as well as agency workers, by service type for home care (direct services<sup>29</sup>, care management, and administration and support services). Though the data include hours worked by brokered workers and subcontractors, the Commission did not use this data as they may encompass work other than care services.

It is important to note that the data may not be representative of the aged care sector. The data come from a small non-random sample of providers (table C.1), who engaged StewartBrown for commercial benchmarking purposes.

For the residential care data, agency hours were imputed if facilities provided agency cost data but no agency hours data. Imputed agency hours were based on the survey average agency rate per hour for those facilities that provide both agency cost and agency hours data. No imputed agency hours were provided for the 2017 financial year. This study has included imputed agency hours where possible, though observations where imputed agency hours included hours for care management were not used.

In chapter 2, the estimates of indirect employment using StewartBrown data are based on the share of total hours completed by indirectly employed workers. This estimate is different to the share of the size of the indirectly employed workforce. The extent to which the share of the *number of indirectly employed workers* and the share of *hours worked by indirectly employed workers* are different will depend on how hours worked vary by worker type.

<sup>29</sup> Direct services only relate to caring work, such as domestic care, clinical care and any other client-related care services. The home care data only include the direct services category, while the residential data are more granular, categorising services by occupation.

**Table C.1 – Number of providers in StewartBrown data and in total sector<sup>a</sup>**

	Residential providers in StewartBrown data	Total residential providers	HCP providers in StewartBrown data	Total HCP providers
2016	126	949	46	496
2017	143	902	51	702
2018	150	886	60	873
2019	176	873	70	928
2020	182	845	75	920
2021	233	830	90	939

a. Provider counts from StewartBrown data are taken over the financial year. Total provider counts are as of 30 June.

Sources: DoH (2016, 2017, 2018, 2019, 2020, 2021b); StewartBrown (unpublished data).

### C.3 ABS Characteristics of Employment Survey

The ABS Characteristics of Employment survey contains data on employee earnings, working arrangements and trade union membership. Data are reported by industry, and the information on working arrangements of workers in the health care and social assistance industry is of specific interest to this study, as it includes the aged care sector.

However, the Characteristics of Employment Survey does not allow for the identification of working arrangements in the aged care sector separately from other care sectors, as the data use Australian and New Zealand Standard Industrial Classification industry categorisations, which are too broad to separately identify aged care workers. This issue was previously raised by the Productivity Commission (PC 2017) and noted in a submission by Professor Sara Charlesworth to the Royal Commission:

... the Australian Bureau of Statistics occupational (ANZSCO) and industry (ANZSIC) classifications, in particular, are increasingly inadequate in accounting for the rapidly growing employment of frontline aged care workers ... While industry level data is available for residential care, data on home care in aged care is not available with these services grouped with other very diverse community service sub-sectors including for example, not only 'aged care assistance services' but also youth welfare, disability support, adoption services, adult day care centre operations and marriage guidance services, at the aggregated level of 'other social assistance'. (2019, p. 20)

Nevertheless, this study examines a subset of workers contained in the 'residential care services' and 'other social assistance services' groups within the 'health care and social assistance industry'. The Commission used these data mainly as a check against other data sources. The 'residential care services' and 'other social assistance' groups cover aged care activities, as well as non-aged care activities (table C.2). The extent to which services relating to aged care are represented in each group is unclear, hence the need for caution in interpretation.

Another limitation that might influence results is that the survey question on industry of job asks respondents about their 'main job'. As such it would not include any independent contractors that have another (main) job in an unrelated field.

**Table C.2 – Aged care and related occupations in the ABS Characteristics of Employment survey<sup>a</sup>**  
**August 2021**

ABS ANZSIC industry of main job	Activities included	Number of independent contractors	Total number of workers
<b>Residential care services</b>	<ul style="list-style-type: none"> <li>• Accommodation for the aged operation</li> <li>• Aged care hostel operation</li> <li>• Nursing home operation</li> <li>• Residential care for the aged operation</li> <li>• Children's home operation</li> <li>• Community mental health hostel</li> <li>• Crisis care accommodation operation</li> <li>• Home for the disadvantaged operation</li> <li>• Hospice operation</li> <li>• Residential refuge operation</li> <li>• Respite residential care operation</li> </ul>	2,000	242,000
<b>Other social assistance services</b>	<ul style="list-style-type: none"> <li>• Adoption service</li> <li>• Adult day care centre operation</li> <li>• Aged care assistance service</li> <li>• Alcoholics anonymous operation</li> <li>• Disabilities assistance service</li> <li>• Marriage guidance service</li> <li>• Operation of soup kitchen (including mobile)</li> <li>• Welfare counselling service</li> <li>• Youth welfare service</li> </ul>	29,400	405,700

a. Based on the definition of independent contractors in the ABS' Forms of Employment framework.

Source: ABS (*Australian and New Zealand Standard Industrial Classification (ANZSIC) (Revision 2.0)*, Cat. no. 1292.0).

## C.4 Comparison of estimates of indirectly employed aged care workers

As explained in chapter 2 and above, the census provides the most robust estimate of indirectly employed care workers in aged care, albeit with some limitations. However, the small share of indirectly employed workers is confirmed via other available data sources either in aged care or the care sector more broadly. The similarity of results, and notes summarising the interpretation issues discussed in this appendix are presented in table C.3.

**Table C.3 – Comparison of data sets, limitations and results for indirect worker shares**

	Years used	Sample size	Measure of indirect employment	Result	Key data limitations
<b>National Aged Care Workforce Census</b>	2020	1329 residential, 616 HCP and 505 CHSP providers	Share of agency/subcontractor workers of total workers	3.5 per cent	Small sample size, possible misinterpretation of employment types
<b>StewartBrown data</b>	2016-2021 financial years	126 to 233 residential providers and 46 to 90 HCP providers	Share of hours worked by agency workers of total workers	3 per cent in residential care and 2 per cent in home care in 2021 financial year	Non-representative sample
<b>Characteristics of Employment</b>	2021	647,700	Share of independent contractors of total workers	0.8 per cent in residential care services, 7.2 per cent in other social assistance services	Industry and class definitions broader than aged care

## C.5 Estimate of aged care consumers

This study uses data from the 2022 Report on Government Services (SCRGSP 2022) to estimate the number of aged care consumers, though other data sources give similar estimates. The Report on Government Services data are sourced from the Department of Health's (now Department of Health and Aged Care) Aged Care Data Snapshot series.

The Commission's estimate of the number of aged care consumers in 2020-21 (1.4 million) is based on the sum of clients in: permanent and respite residential care; levels 1-2 Home Care Packages; levels 3-4 Home Care Packages; Transition Care and the CHSP. Since counts are taken over the financial year, it is possible that this estimate may overstate the number of unique consumers if, for example, a consumer moved from respite care into permanent care or moved to from a level 1-2 HCP to a level 3-4 HCP within the financial year. This estimate also excludes consumers receiving other government-funded aged care services, such as the Short-Term Restorative Care Program and Innovative Care Program.

# Abbreviations

<b>ABN</b>	Australian Business Number
<b>ABS</b>	Australian Bureau of Statistics
<b>ACQSC</b>	Aged Care Quality and Safety Commission
<b>Ahpra</b>	Australian Health Practitioner Regulation Authority
<b>AIHW</b>	Australian Institute of Health and Welfare
<b>AMA</b>	Australian Medical Association
<b>ANAO</b>	Australian National Audit Office
<b>ANMF</b>	Australian Nursing and Midwifery Federation
<b>ANZSCO</b>	Australian and New Zealand Standard Classification of Occupations
<b>ANZSIC</b>	Australian and New Zealand Standard Industrial Classification
<b>ASU</b>	Australian Services Union
<b>CALD</b>	Culturally and linguistically diverse
<b>CEDA</b>	Committee for Economic Development of Australia
<b>CHSP</b>	Commonwealth Home Support Program
<b>CPR</b>	Cardiopulmonary resuscitation
<b>DHAC</b>	Department of Health and Aged Care (current)
<b>DIISRT</b>	Department of Industry, Innovation, Science, Research and Tertiary
<b>DoH</b>	Department of Health (former)
<b>DSS</b>	Department of Social Services
<b>FTE</b>	Full-time equivalent
<b>FWA</b>	Fair Work Act 2009 (Cth)
<b>FWO</b>	Fair Work Ombudsman
<b>HACC</b>	Home and Community Care
<b>HCP</b>	Home Care Package
<b>IRV</b>	Industrial Relations Victoria
<b>LGBTI</b>	Lesbian, gay, bisexual, transgender and intersex
<b>NDIA</b>	National Disability Insurance Agency
<b>NDIS</b>	National Disability Insurance Scheme
<b>NDS</b>	National Disability Services
<b>NESB</b>	Non-English speaking background
<b>OHS</b>	Occupational Health and Safety (Victorian context)



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<b>OPAN</b>	Older Persons Advocacy Network
<b>PC</b>	Productivity Commission
<b>PCBU</b>	Person conducting a business or undertaking
<b>PCW</b>	Personal care worker
<b>QACAG</b>	Quality Aged Care Action Group
<b>QHRC</b>	Queensland Human Rights Commission
<b>SCHADS</b>	Social, Community, Home Care and Disability Services Industry
<b>SCRGSP</b>	Steering Committee for the Review of Government Services Provision
<b>SIL</b>	Supported Independent Living
<b>STRC</b>	Short Term-Restorative Care
<b>UWU</b>	United Workers Union
<b>VEOHRC</b>	Victorian Equal Opportunity and Human Rights Commission
<b>WHS</b>	Workplace Health and Safety (Commonwealth context)

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# Glossary

The following terms are defined in the context of how they are used in this report.

Term	Description
<b>Labour hire agency</b>	Businesses that source and provide workers to aged care providers on a temporary basis. Labour hire agencies typically employ their workers as casual staff who they hire out to providers.
<b>Agency worker</b>	Personal care workers, nurses, and allied health professionals who are typically a direct employee of a labour hire agency.
<b>Allied health professional</b>	A variety of care-providing occupations (that are not personal care workers or nurses), including audiologists, dietitians, physiotherapists and podiatrists.
<b>Approved provider / provider</b>	Businesses that are approved under the <i>Aged Care Act 1997 (Cth)</i> to deliver aged care services. In this report, the term provider is also used to mean an approved provider.
<b>Care worker</b>	A term used to describe nurses, personal care workers and allied health professionals.
<b>Carer</b>	A person, such as a family member or friend, who provides personal care, support and help to an older person in an informal setting.
<b>Consumer</b>	An older Australian who receives some form of government-funded aged care services, through a residential care facility, home care program or in the community. Consumers may also be referred to as a customer, care recipient, or client throughout the report.
<b>Consumer-directed care</b>	An approach that allows people to have greater choice and control over the care and support services they receive, to the extent that they are capable and wish to do so.
<b>Culturally safe</b>	An environment, determined by a consumer or their family, which is spiritually, socially, emotionally and physically safe and respectful.
<b>Digital care platform / platform</b>	Businesses that allow consumers and / or providers to match with, and engage, care workers through a website or 'app'. Digital care platforms may also be referred to as platforms.
<b>Direct employment</b>	Employment arrangements where a worker is employed by an approved aged care provider as a permanent employee (either full time or part time), or on a casual or fixed term contract.
<b>Home care</b>	Care and services that provided to an older person in their home, including personal care, nursing, domestic assistance, and social support, primarily funded through the Commonwealth Home Support Program and Home Care Packages Program.
<b>Independent contractor</b>	A self-employed person or entity contracted to perform work for — or provide services to — another entity as a non-employee. Technically, an independent contractor operates as a small business or sole trader and requires an ABN for tax purposes.
<b>Indirect employment</b>	Employment arrangements where a worker is engaged as an independent contractor or agency worker.
<b>Personal care services</b>	Services that include assistance with bathing, toileting, eating, dressing, mobility, managing incontinence, community rehabilitation support, assistance in obtaining health and therapy services and support for people with cognitive impairments.
<b>Personal care worker</b>	A person engaged to provide personal care services.
<b>Residential care</b>	Care provided to older people who are unable to live independently at home and have higher level care needs than can be provided in home. Residential care includes accommodation, personal care 24-hours a day and access to nursing and general health services. Residential care is provided on a permanent or temporary (respite) basis.



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