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## **Making a profitable social service market: The evolution of the private nursing home sector**

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### **Introduction**

Nearly one-quarter of a million older Australians received residential aged care (RAC) services, including housing, support with activities of daily living and health care, during 2019–20 (ACFA 2021: 56). RAC facilities—often called nursing homes—are largely publicly funded. They are a major budget item for the Australian Government, which spent \$13.4 billion on this social service in the 2019–20 financial year. Older people themselves contributed a further \$4.9 billion (ACFA 2021: 10). Although mostly publicly funded, most nursing homes are privately owned, and provision is organised in a marketised system in which tendering, competition and consumer choice are the main instruments on which governments rely to drive quality, innovation and diversity.

Nursing homes have been much in the news in recent years and the marketisation of the system has been questioned. Well before the Covid-19 pandemic exposed the vulnerability of older people living in nursing homes, evidence of poor-quality care in some services prompted the establishment of the Royal Commission into Aged Care Quality and Safety in late 2018. The commission's interim report, called simply

*Neglect*, ‘found that the aged care system fails to meet the needs of our older citizens in the delivery of safe and quality care’ (Royal Commission into Aged Care Quality and Safety 2019a). The commission has argued that the direction of reform has put ‘too much faith in market forces and consumer choice as the primary driver of improvement in the aged care system’ (Royal Commission into Aged Care Quality and Safety 2019b: 3), and it flagged its intention to explore alternatives to market organisation for the sector in its final report (Royal Commission into Aged Care Quality and Safety 2019c: 80).

Two aspects of the marketisation of nursing homes over recent decades have been the increasing market share and growing size of for-profit businesses among providers, which are the focus of this chapter. In 2020, the share of RAC places operated for profit was 41 per cent (ACFA 2021: 58)—up from 27 per cent in 2000 (DHAC 2000: 5). Across this period, the number of places increased from about 140,000 to more than 217,000, and for-profit facilities accounted for more than two-thirds of this growth. What can we learn about the relationship between market design and market structure from this trend? Specifically, have—and, if so, how have—Commonwealth Government policies<sup>1</sup> shaped the ownership structure of the sector?

The question is important for two reasons. First, while there is an impressive body of research exploring the policy-driven development of the RAC sector over several decades (Cullen 2003; Fine 1999; Gibson 1998; Howe 1990, 2000; Le Guen 1993; Parker 1987), there has been no study of how changing market design has affected the ownership structure within the RAC market in the past half-century.<sup>2</sup> Second, and more importantly, the weight of evidence in international research is that quality is, on average, lower in for-profit nursing homes than in non-profit and public facilities. For example, a recent systematic review of 50 studies of the relationship between nursing home ownership and performance in the United States found:

For-profit nursing homes tend to have better financial performance, but worse results with regard to employee well-being and client well-being, compared to not-for-profit sector homes ...

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1 It is not possible within this chapter to discuss the complex role of state and local government policy on the development of the RAC market—or ‘markets’—since differences between the states remain today, long after the establishment of encompassing Commonwealth funding and regulation.

2 R.A. Parker’s marvellous book is an exception; it covers the period up to the mid-1980s only (Parker 1987).

[T]he better financial performance of for-profit nursing homes seems to be associated with worse employee and client well-being. (Bos et al. 2017: 352)

The limited available Australian research confirms this pattern (Baldwin et al. 2015). Further, emerging evidence from the Covid-19 pandemic suggests for-profit homes and homes with characteristics associated with for-profit status (including larger size and less-skilled staff) are linked to worse outcomes (Bach-Mortensen et al. 2021).<sup>3</sup> By examining the relationship between market design and ownership of RAC provision over time, our analysis could help identify risks with the current direction of residential aged care policy (see also Baldwin et al. 2015), to inform policies that steer the sector away from these risks.

## Market design and ownership structure

Our analysis is framed broadly around Gingrich's (2011) typology of 'welfare markets'. Gingrich distinguishes between two dimensions of service provision: allocation (how services are funded and distributed) and production (how services are delivered). When allocation is organised through market mechanisms such as user payments, the amount and/or quality of services people receive are more affected by how much they can afford. When allocation is organised more collectively, through public financing of a regulated system, access to good-quality services is less affected by the capacity to pay (Gingrich 2011: 10). In social service markets, production can be organised according to different structures of competition, which vary by how much control they give to the state, individual service users or private providers. Members of these groups have divergent primary aims: in Gingrich's account, governments seek efficiency, service users seek quality and producers seek profits and rents,<sup>4</sup> and different rules of the market give more or less power to one or another group to pursue its aims (Gingrich 2011: 10–12).

3 In Australia, while most deaths from Covid-19 in 2020 were of older people living in residential care, the relatively small size of the pandemic and the few facilities involved meant these associations have not been found (Ibrahim et al. 2021).

4 At this most abstract level, Gingrich's theory is framed starkly and differences between types of producers (for-profit, non-profit, professionals) are not accounted for. Accordingly, whether non-profit providers have the pursuit of profit and rent as their primary aim is an open question. Theories of institutional logic start from the position that different producer types have different primary aims (Thornton et al. 2012).

By exploring the different ways responsibility for allocation of services and control over their production can be distributed, Gingrich generates six ideal types of market design. In each, governments' chosen design settings present a specific set of incentives to providers and consumers and shape the extent to which the aims of each group are likely to be realised (Gingrich 2011: 12–19). In state-driven 'managed markets', governments retain more power over providers' cost structures with 'clear standards and tight control' on the production dimension, while on the allocation dimension, users are protected by guaranteed access. In state-driven 'austerity markets', the state retains power over public funding to providers on the production dimension, but limits access on the allocation dimension by, for example, targeting and increasing user charges. In consumer-driven 'consumer-controlled markets', users' choices drive producer behaviour on the production dimension, supported by strong regulation of access and collective financing on the allocation dimension. In consumer-driven 'two-tier markets', producers also respond to users' choices on the production dimension, but on the allocation dimension, more costs fall to users and governments do less to compensate for differences of, for example, income among users. In producer-driven 'pork-barrel' markets, the combination of generous public financing on the allocation dimension and lax regulation of private providers on the production dimension leaves providers relatively free to increase profits through rent-seeking from the state. In producer-driven 'private-power' markets, providers respond to tighter fiscal constraints in a weakly regulated environment by charging users more or reducing service quality.

In addition to theorising how market designs vary in their allocation and production dimensions, Gingrich emphasises the importance of partisan preferences in governments' policy choices. She argues that right and left parties use markets differently, 'as tools to empower groups who support their particular long-term partisan goals' (Gingrich 2011: 4–5). Partisan preferences are relevant to our analysis because some major marketising policies have been introduced by Labor as well as by Coalition governments (as might be expected) in Australia.

One aspect of market design theory that Gingrich does not develop fully is how policy choices affect the ownership profile of private provision, because she assumes that both non-profit and for-profit providers respond to the incentives that market designs establish and pursue rents or profits over the interests of governments or consumers when the opportunity arises. However, she does recognise that non-profit and for-profit providers may have different motivations, and 'incentives to

seek profits by overcharging users and/or cutting costs ... are amplified when providers are privately owned and responsive to shareholders' (Gingrich 2011: 11). This is an important concession that implies that market instruments that put few constraints on producers are those most likely to draw in for-profits, even if non-profit providers might also seek rents and profits when the opportunity presents. These instruments include, on the allocation dimension, generous subsidies and/or weakly regulated consumer co-payments and weak regulation of access to the subsidised market for both consumers (no, few or weak eligibility criteria) and providers (by enabling them to select clients). On the production dimension, instruments that may draw in for-profits include weakly regulated entry (few or only basic conditions of market access; removal of any proscription on for-profit provision), allowing providers to choose where they operate and weak regulation of quality.<sup>5</sup> It is also important to recognise that specific profit and rent opportunities arise in RAC because it offers accommodation, which entails real property, as well as care. Thus, for example, if governments liberalise policies on sources of capital for developing properties or control fees for care but not accommodation, new opportunities to make money from property investment in residential facilities emerge. Gingrich's concession also points to a related aspect of diversity among providers: the amplification of profit-orientation in those with shareholders. In other words, not all for-profit providers are the same; corporate operators that typically manage multiple facilities are likely to be more profit-oriented, while for operators with a single facility, 'the profit motive might [be] secondary to some professional motive to provide good quality care' (Morris 1999: 141).

## The changing market for residential aged care in Australia

It was not until the 1950s that what we understand today as residential aged care became an object of Commonwealth Government policy, and not until the 1960s that market logic was introduced and the sector came to approximate its current form. Nevertheless, a variety of institutions had fulfilled the analogous social function since Governor Lachlan Macquarie, military ruler of the colony of New South Wales, first funded the charitable Benevolent Society to provide care to Sydney's 'poor and

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5 Thanks to Bob Davidson for encouraging me to include a list of these instruments and for providing a handy distillation of them.

indigent' in 1821 (Cummins & NSW Department of Health 1971). In so doing, Macquarie used an approach that would persist to the present: providing public financial aid to an external organisation for services that he recognised would not be otherwise provided by voluntary (or market) means, judging that '[t]his would be cheaper and attract less opprobrium than direct government control' (Dickey 1987: 17). Between Macquarie's time and the entry of the Commonwealth Government, a mix of public and private institutions continued to offer accommodation and care for a subset of older people, albeit often poorly (Cullen 2003: 5–6), with a mix of public (state and local government) and private funding.

Within the general approach of public subsidies for largely private provision that has persisted across two centuries, the institutional organisation of RAC has changed considerably. This is because public funding of private provision does not always create or shape a 'market' for the service in question. Macquarie's intervention did not create a market for residential care for older people, for example. Rather, it supported private provision organised within the charitable logic of voluntary assistance of the time,<sup>6</sup> as did the Commonwealth Government's first intervention in the sector in the 1950s, which is discussed in more detail below. And as Gingrich's framework highlights, social service markets are not all the same. While market logic first began to shape the sector in the 1960s, governments' market design interventions since then have changed how both the allocation and the production of RAC are organised. In what follows, we divide the past nearly seven decades into six phases, drawing out how changing market designs have shaped—intentionally or otherwise—the ownership structure of the sector.<sup>7</sup>

## **Phase 1: 1954–63 — Supporting the development of 'homes for the aged'**

The first phase of Commonwealth Government involvement in residential aged care began in 1954, with the *Aged Persons Home Act 1954*, legislated by the ruling Liberal–Country party Coalition as part of its policy response to the postwar housing shortage. The shortage was partly driven by strong population growth after the war, but older people also emerged as a target

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6 See Thornton et al. (2012). The framework discussed there does not include a 'charitable logic', which was more dominant in the early nineteenth century than organised mutual aid within the working class, which is better characterised as being organised by what Thornton et al. would call an associational logic. We have taken the liberty of adapting their general argument to include charity.

7 Others have created periodisations; see Footnote 8.

group because of another demographic change: the prewar decline of the three-generation household, which left more old people living—poorer—in their own households (Snooks 1994: 91).

The *Aged Persons Home Act* legislated for matching grants to be made to ‘religious and charitable organizations towards the capital costs of building homes for the aged’ (HRSCE 1982: 10). The minister for social services of the time praised ‘the devotion and unselfishness’ of these volunteer organisations, which the government assumed were assisting the ‘needy aged’ (HRSCE 1982: 10). Note that neither public nor for-profit providers were eligible for these capital grants; public provision of general housing for low-income people was financed separately under the Commonwealth–State Housing Agreement established by Labor in the early postwar years, while the failure of the private market to provide affordable housing for poor older Australians was the problem the 1954 Act was seeking to remedy.

The Act did not support the building of what we would understand today as ‘residential aged care facilities’; no parallel legislated support was made until the 1960s for the provision of ‘care services’ to older people. In general, this phase might be best understood as the last in the prehistory of the policy-shaped market for RAC. Government intervention sought to address a (housing) market failure, but it did so by reference to the associational logic of the voluntary sector, which stepped in when the foundational institution of the family was absent (HRSCE 1982: 10–11). When family care was unavailable, there existed scattered small business providers of something resembling RAC alongside some charitable and state long-term care institutions, but competition and the pursuit of profit were not organising dynamics of the sector during this time. Nevertheless, this phase did enable the development of valuable real property assets in the non-profit sector in the form of hostel accommodation, to which later policies would attach new incentives and opportunities that were, in turn, extended to for-profit providers.

## **Phase 2: 1963–72 — Creating a producer-driven market promoting for-profit provision**

The Commonwealth Government’s next intervention targeted what we would now understand as residential aged care (Wheelwright 1992: 112) and was decisive in the consolidation and growth of a large, private nursing

home industry.<sup>8</sup> This intervention was directed at managing a problem in the health system.<sup>9</sup> While the states had responsibility for social service provision, and long provided and regulated the quality of care for older people, the Commonwealth Government co-funded hospital care. Having declined to introduce a national insurance system in the early postwar years, the Commonwealth paid a hospital benefit for patients in both public and approved private hospitals. By the early 1960s, many old people needing long-term care lived in institutions licensed as hospitals, but hospital financing (via a mix of the Commonwealth benefit and private insurance) did not cover them adequately (Parker 1987: 11). To deal with this group, in 1962, the government amended the *National Health Act 1953* to create two new categories of beneficiary: 'nursing home patients' and 'approved nursing homes'. The latter included some institutions already licensed as hospitals but was also extended to include others that had not been recognised as hospitals (Sax 1984: 63–64). Significantly, both for-profit and non-profit operators could be approved as nursing homes, which became eligible to receive a benefit of \$2 per patient per day, with no means test and no regulation of patient admission. In 1963, when this subsidy became available, the states administered around half of all nursing home beds (SSCPHNH 1985: 16). Between 1963 and 1968, the number of nursing home beds increased 48 per cent and 95 per cent of new beds were run by private organisations—non-profit and for-profit. By as early as 1965, half the non-public sector was run for profit (SSCPHNH 1985: 16).

The *Aged Persons Homes Act 1954* did not subsidise the building of nursing home beds, because its aim was to drive the building of more independent forms of housing. However, as residents in subsidised independent housing aged, their needs increased and the measures implemented under the Act also changed—without amendment to the Act itself (HRSCE 1982: 12–14). These changes led to further growth in nursing home accommodation, specifically in the non-profit sector. First, in 1966, capital grants were extended to subsidise non-profit providers to build up to one-third of any new properties as nursing home accommodation. Further changes in 1969 enabled these non-profit, subsidised providers to

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8 There are several excellent histories and analyses of this period—notably, Parker (1987), Howe (1990) and Wheelwright (1992). Others have called it the 'laissez faire' period (Howe 1990) or the period of 'commodification and entitlement' (Fine 1999: 12).

9 Parker (1987: 7–13) gives a detailed account of this period.



consolidate their nursing home beds into larger facilities and to take over the nursing home entitlements of organisations that did not wish to use them (HRSCE 1982: 14).

In 1969, matching capital grants were also made available to state governments to provide nursing home accommodation to older people of 'limited means' under the States Grants (Nursing Homes) Bill (Cullen 2003: 32). However, few funds were allocated to this scheme and state co-contributions were required—suggesting weak Commonwealth Government commitment to public provision.<sup>10</sup> Indeed, a member of the Labor opposition argued 'the Government's whole policy has been to provide minimal assistance in this field, and to allow private enterprise to come in on the basis of profit motive'.<sup>11</sup> Labor's assessment was evidently well founded. In the end, only half the allocated money was drawn on by the states (Cullen 2003: 32), so this measure had a negligible impact on both the ownership structure of the sector and the provision of beds.

Subsidies for care were also changed in 1969, affecting both non-profit providers of hostel accommodation and all nursing home providers, of which a majority were for-profit. Together, these changes filled in the continuum between independent accommodation at one end and hospital health care at the other, laying the foundation for the broader policy category of 'residential aged care' that would later encompass both hostels and nursing homes. Towards the independent end, a subsidy for personal care in *hostels* was introduced as a measure under the *Aged Persons Homes Act 1954*, to enable frailer residents to remain longer in this more independent form of accommodation, rather than moving to a nursing home (HRSCE 1982: 14). Towards the healthcare end, a supplementary benefit for nursing home residents who needed intensive nursing care was introduced under the *National Health Act 1953* (Cullen 2003: 50–51). The government saw this benefit 'as much as a means of maintaining the increasingly key private sector as of helping poorer patients pay their way'; the Labor opposition agreed with the first of these assessments, expressing concern that 'the extra benefit would "serve to subsidise private

10 Opposition leader Gough Whitlam pursued this issue on more than one occasion, asking about it in 1969 (*House of Representatives Hansard*, Wednesday, 28 May 1969, p. 2430, available from: [parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22hansard80%2Fhansardr80%2F1969-05-28%2F0150%22](http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22hansard80%2Fhansardr80%2F1969-05-28%2F0150%22)) and again in 1970 (*House of Representatives Hansard*, Thursday, 16 April 1970, p. 1311, available from: [historichansard.net/hofreps/1970/19700416\\_reps\\_27\\_hor66/](http://historichansard.net/hofreps/1970/19700416_reps_27_hor66/)).

11 *House of Representatives Hansard*, Thursday, 27 August 1970, available from: [parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22hansard80%2Fhansardr80%2F1970-08-27%2F0064%22](http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22hansard80%2Fhansardr80%2F1970-08-27%2F0064%22).

enterprise even further” (Parker 1987: 23). A senior bureaucrat from the administering Department of Social Security offered an explanation: ‘The financial stimulus provided by the intensive care benefit apparently helped promote amongst investors a widespread belief that nursing homes were low risk, high profit financial ventures’ (Wilson 1973–74: 22). At any rate, rapid growth in private, for-profit nursing home beds continued.

As noted above, the opposition Labor Party criticised the growth of the for-profit sector. Members used parliamentary debates on these measures to argue that housing and care for older people should not be opportunities for ‘ruthless investors ... looking for profits’.<sup>12</sup> They also lamented the poor quality of services in some private facilities, often citing media reports.<sup>13</sup> For example, Leader of the Opposition Gough Whitlam argued in May 1969 that abuses were ‘excessively prevalent among that class of private nursing home which caters for persons who can pay little more than their age pension and the Commonwealth nursing home benefit’.<sup>14</sup> Labor members also criticised some subsidised (and so non-profit) providers of independent housing for demanding ‘donations’ that were effectively ‘key money’, and which meant providers favoured older people with more resources.<sup>15</sup>

By the end of the second phase of Commonwealth involvement in RAC, what Gingrich (2011: 17–19) would call a producer-driven ‘private-power market’ was firmly established—the result of conservative governments’ efforts to foster the growth of private provision, both non-profit and for-profit, with very few controls. On the allocation dimension, collective financing was available, in the form of various direct care subsidies to all providers (non-profit, for-profit and public) along with capital grants to non-profit and, later (and minimally), to state providers. However,

12 Albert James, member for Hunter, Thursday, 13 April 1967, during the debate on the second reading speech on the Aged Persons Homes Bill 1967 (available from: [parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22hansard80%2Fhansardr80%2F1967-04-13%2F0073%22](http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22hansard80%2Fhansardr80%2F1967-04-13%2F0073%22)).

13 See, for example, this speech by Labor Member Hector McIvor, also during the debate on the Aged Persons Homes Bill 1967 (available from: [parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22hansard80%2Fhansardr80%2F1967-04-13%2F0085%22](http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22hansard80%2Fhansardr80%2F1967-04-13%2F0085%22)).

14 During the debate on the reading of the States Grants (Home Care) Bill 1969 (*House of Representatives Hansard*, Wednesday, 28 May 1969, p. 2388, available from: [parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22hansard80%2Fhansardr80%2F1969-05-28%2F0150%22](http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22hansard80%2Fhansardr80%2F1969-05-28%2F0150%22)).

15 These were the entry contributions for hostel accommodation that eventually became accommodation bonds. See, for example, the speech by Fred Collard, member for Kalgoorlie, available from: [parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22hansard80%2Fhansardr80%2F1967-04-13%2F0083%22](http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22hansard80%2Fhansardr80%2F1967-04-13%2F0083%22).

collective financing was extended without admission controls and user fees were unregulated, with ‘operators ... free to charge residents whatever fee they desired’ (Cullen 2003: 49). On the production dimension, providers controlled the size and structure of the market in their own interest, since the government did not regulate entry into the sector, nor the size and placement of facilities. Further, the government’s ‘hands-off approach’ gave for-profit operators many opportunities to push costs on to consumers through fees and/or to cut costs, including by carefully selecting residents and skimping on the quality of food, accommodation and care (Cullen 2003: 49–50).

By the late 1960s, rising costs to governments and to consumers became recognised policy problems. One policy response was to begin to direct resources at developing community-based supports for old people to remain at home.<sup>16</sup> But addressing problems in the nursing home sector—rising costs, uncontrolled growth and the unnecessary admission of old people—would also become policy goals for the Liberal–Country party Coalition (Parker 1987: 30). As Parker (1987: 30) puts it: ‘Ten years of an uncoordinated and unregulated free-for-all financed by guaranteed public subsidies was to be brought to a halt.’ Yet various aspects of the market established during the second phase—not least a large role for the private sector and the establishment of organised private interests (Howe 1990: 155)—had a long legacy.

### **Phase 3: 1972–86 — State attempts to manage the market**

Over the next decade and a half, care for older people was the subject of much policy activity. Several inquiries and legislative and regulatory changes occurred, as successive governments of both colours grappled with the legacy of the ‘free-for-all’ enabled during the earlier period. While the balance of provision between residential and home-based care was one object of policy, residential aged care was often subject to particular attention as the largest budget item by an order of magnitude. Both ownership and profits were explicitly discussed and policies made to address issues thereby identified.

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16 Accordingly, subsidies to the states to arrange home care were legislated in the *States Grants (Home Care) Act 1969* and the *States Grants (Paramedical Services) Act 1969*. The Commonwealth Government sought to share the cost of these services with the states and to promote, ‘stimulate and coordinate’ voluntary organisations as well as state and local governments to provide them (HRSCE 1982: 15).

Regulatory efforts to increase public control over costs both to the Treasury and to residents, as well as the entry of both producers and consumers into the residential care system, began in 1972, with amendments to the *National Health Act 1953* by a Coalition government. As Le Guen (1993: 5) outlines, admission to a nursing home now required approval by a medical practitioner. Responding to concern about conflicts of interest among doctors who could approve entry for old people into homes they themselves owned, approvals became subject to oversight by a Commonwealth Medical Officer. The fees charged by private nursing homes also became regulated, such that, after 1 January 1973, approved homes could not charge more than the maximum determined by the Department of Social Services (DSS).

Further efforts to rebalance aged care away from nursing homes and towards home care and less-intensive residential care were made by the Coalition government in 1972 (Le Guen 1993: 6–7). The new Domiciliary Nursing Care Benefit would subsidise family care as an alternative to institutional care, in line with conservative social thinking,<sup>17</sup> while the *Aged Persons Hostels Act 1972* provided further significant capital subsidies to non-profit providers of housing for older people, specifically to build hostel accommodation.<sup>18</sup>

In late 1972, Labor came to power for the first time in more than two decades. There were some significant continuities in approach to RAC policy between the outgoing and incoming governments, including the desire to shift the balance towards community rather than institutional care, and to gain and maintain some control over the size, growth and cost of institutional care. Indeed, Labor took over implementation of the reforms that were designed to gain some control over the growth and shape of the sector outlined above. Nevertheless, partisan differences are evident—notably, in the attitude to ownership of residential care facilities. While Labor’s Minister for Social Security Bill Hayden felt the need to allay for-profit providers’ anxiety that the new government might nationalise

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17 See, for example, the statement in Parliament on 29 August 1972 by Dr Jim Forbes, acting minister for health, in which he argues for the need to go beyond (mere) admiration of those ‘who feel deeply a sense of family totality and who make considerable sacrifices to keep elderly relatives within the home even when they may require constant nursing’ (available from: [parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22hansard80%2Fhansard80%2F1972-08-29%2F0081%22](http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22hansard80%2Fhansard80%2F1972-08-29%2F0081%22)).

18 Hostel building was already subsidised under the *Aged Persons Homes Act 1954* but was less well developed than independent housing (which was more lucrative for providers) on one hand, and nursing homes (which were more expensive for government), on the other (Cullen 2003: 33).

for-profit nursing homes, 'he did make plain that he was much concerned about standards and profits' (Parker 1987: 36–37). Some measures were addressed directly to this end—for example, by building on Coalition price-control policies. For-profit providers were funded under the new Participating Nursing Home Scheme, under which Commonwealth nursing home benefits were supplemented with controlled user fees for the minority of residents who paid them (Cullen 2003: 53).

However, in line with its social thinking, Labor also sought to encourage alternatives to for-profit provision of residential care. On the accommodation front, in 1973, capital matching grants to non-profit providers were extended to allow the building of nursing home places freed from the previous requirement that the provider also offer hostel places, and to allow the purchase of for-profit nursing homes that were for sale (Cullen 2003: 34–35; Le Guen 1997: 9; Parker 1987: 40). On the care front, the government recognised that operating costs were already stretching the resources of many non-profit providers, who would likely find it difficult to develop new property stocks without increased operational revenue flows (Parker 1987: 40). Accordingly, under the *Nursing Homes Assistance Act 1974*, an alternative to nursing home benefits was offered to non-profits, in the form of the Deficit Financing Scheme, which, as its name suggests, funded deficits incurred in running nursing homes.

Parker (1987: 40–41) documents Coalition criticisms of the new arrangements as a deliberate attempt to squeeze the private sector and a threat to the autonomy of religious organisations (assistance to which it was difficult for them to condemn). Parliamentary debates and policy differences reflected divergent partisan ideologies about the role of the non-profit sector: for Labor, it was a higher-quality alternative to for-profit provision; for the Coalition, it was to be protected from state incursions as an expression of religious freedom. The deficit financing scheme enabled non-profit nursing home providers to develop or acquire further properties, but the care subsidy remained too low in hostels for capital grants to significantly boost hostel development. Therefore, further assistance was given to non-profits through the Personal Care Subsidy for hostel residents, the value of which was tripled between 1972 and 73, and 1975 and 76 (Cullen 2003: 61).

The Labor government was dismissed in 1975 amid a constitutional crisis (Madden 2020). The incoming, small government-minded Fraser administration sought to gain yet more financial and planning control of the sector (Parker 1987: 59). One response was a four-year experiment with shifting some of the costs of nursing home care off the public accounts, by obliging private health insurers to replace the Commonwealth subsidy for nursing home residents insured with them. Problems in the design of this measure and poor compliance of nursing home proprietors saw funding revert to the Commonwealth in 1981, with little evidence of savings (Le Guen 1993: 10–11; Parker 1987: Ch. 7).

The failure of the fee-control regime introduced in 1972 to contain costs was a significant, ongoing problem recognised by two major inquiries during the early 1980s, led by Labor's Leo McLeay and Patricia Giles.<sup>19</sup> The fees private nursing home proprietors could charge to supplement the Commonwealth nursing home benefit were set in relation to that benefit, which was reviewed annually, and between annual reviews, proprietors could apply to the Department of Health for approval to increase their fees (Dreyfus 1984: 91; Parker 1987: 34, 61). Guidance for departmental determinations under the *National Health Act 1953* was vague, so several decisions were challenged by nursing home proprietors in court (Dreyfus 1984; Wheelwright 1992).<sup>20</sup> At their root, these cases concerned the profitability of nursing home enterprises. During this time, the department responded to court decisions by elaborating more explicit guidelines for decision-making,<sup>21</sup> which themselves were challenged in court and struck down as outside the authority granted by the Act.

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19 At the beginning of the 1980s, two inquiries dealing with RAC policy were established. In 1980, the House of Representatives Standing Committee on Expenditure decided to inquire into accommodation and home care for the aged, resulting in the 1982 report *In a Home or at Home* (HRSCE 1982). The committee, chaired by Labor's Leo McLeay, aimed 'to identify the reasons for the continued dominance of expenditure on institutional care and establish a framework which allows governments to make cost effective decisions on provision of both Accommodation and Home Care for the Aged' (HRSCE 1982: vii). In late 1981, the Australian Democrats called for a Senate inquiry into private hospitals and nursing homes and the Fraser Coalition government did not have the numbers in the Senate to prevent it. The background to the inquiry, chaired by Patricia Giles, were 'a number of areas of concern with respect to the nursing home industry', including the poor standard of care (which had been receiving negative press attention), that proprietors were making too much profit or too little and were facing bankruptcy, that there was an oversupply of beds and that admission procedures were inadequate (SSCPH&NH 1985: xiv).

20 See Dreyfus (1984) and Wheelwright (1992) for detailed analyses of the legal problems and cases. The remainder of this paragraph is drawn from these two sources.

21 An 'Efficiency Audit of Commonwealth Administration of Nursing Home Programs' by the Commonwealth Auditor-General in 1981 criticised the department's inconsistent administration and weak control of the nursing home benefits, and guidelines were further changed in response.

When Labor regained government in 1983, the relevant provisions of the *National Health Act* were amended to allow the minister to formulate more detailed principles for determining fees and approving new nursing homes (Parker 1987: 71). In his second reading speech, Minister for Health Neal Blewett argued this was necessary ‘to permit [the minister’s] delegates to take account of the lack of normal market constraints on the nursing home industry’ (cited in Dreyfus 1984: 105). Principles for fee determination were introduced in 1984 but did not solve the ongoing problem; the same year, the Giles Committee’s report called the system ‘an administrative disaster’ (SSCPHNH 1985: 67).

The core problem in setting fees arose from the nature of the nursing home market itself: half of all beds were in for-profit facilities that relied on public funding for the bulk of their revenue. Policymakers—legislative, judicial and administrative—were aware of the dilemmas this situation posed and, over the years, variously favoured either proprietors’ profits or consumers and the public purse (Wheelwright 1992; Parker 1987: 61–65). The fee-setting regime put ministers and their delegates in the invidious position of determining the ‘reasonable return’ the Giles Committee argued was due to ‘an honest proprietor’. On one hand, containing costs to the Treasury and ensuring the affordability and accessibility of services to consumers with low incomes pulled in the direction of lower subsidies and fees, respectively. On the other hand, keeping for-profit providers satisfied enough to remain in the sector and allowing them enough of a margin to provide services of an adequate, even improving, level pulled in the direction of higher subsidies and fees. Indeed, as late as 1985, a Labor government convened a Working Party on Nursing Home Profitability and took up its recommendation that providers could charge higher fees when ‘the profit component [was] below a certain level’ (Cullen 2003: 63).

The fear of ‘unreasonable profits’ made at public expense led governments to take available opportunities to restrict and control providers (Parker 1987: 63). Nevertheless, as Parker notes, the rarity of bankruptcies and the large sums paid for goodwill by purchasers of homes suggested the sector remained sufficiently lucrative for investors throughout these years. The strong overall growth in beds and particularly in public spending on nursing home benefits in the late 1970s and the first half of the 1980s reinforces Parker’s assessment of the positive expectations of nursing home business owners (Cullen 2003: 55).

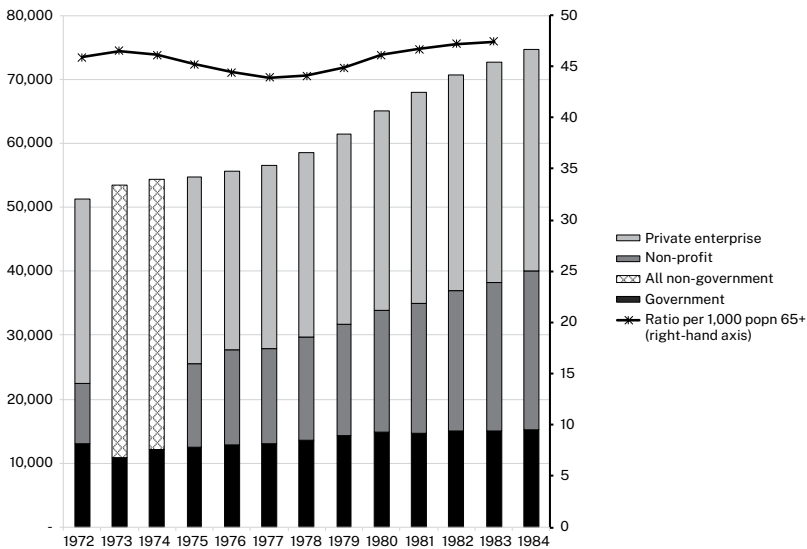
Meanwhile, the number of non-profit nursing home beds and the costs of their deficit financing also grew steeply between 1975 and 1987 (Cullen 2003: 58). As noted above, Labor's aim was to increase the share of non-profits because they were seen as offering better-quality care. However, policy-shaped market conditions also presented non-profit organisations with incentives that pulled against successive governments' attempts to manage growth in the number and cost of nursing home beds. The 'blank cheque' design of deficit financing made cost control difficult (Parker 1987: 66), while the integration of many non-profit nursing homes into campuses on which independent living and hostel accommodation were also found 'encouraged an internal progression from one level to the next', thereby maintaining demand for nursing home beds—whether or not that was the best option for older people (Parker 1987: 69).

During the third phase of Commonwealth involvement in RAC, governments attempted to gain some control over the producer-driven private-power market that the policies of the first two phases had engendered. However, they had limited overall success, measured by control over spending, access to the industry for providers, placement in and affordability of a nursing home for consumers and the quality of care (Parker 1987: Ch. 9). On the allocation dimension, collective financing continued to be available, while on the production dimension, provider decisions continued largely to determine the size and structure of the market, and the location of facilities. Quality requirements were inconsistent because they were largely under state jurisdiction, and systems of monitoring remained underdeveloped. Little headway was made on diverting resources from residential to home-based care, although important groundwork was laid with the Labor government's legislation of the Home and Community Care program in 1985 (Cullen 2003: 82–85).

Between 1972 and 1984, the number of nursing home beds increased by 45 per cent—largely in line with the share of older people in the population (see Figure 6.1). There was absolute growth in all ownership types, but the pace of growth differed among them. The number of beds in government homes increased by 17 per cent, in for-profit homes by 20 per cent and in non-profit homes by 163 per cent. Accordingly, the share of nursing homes in public ownership fell from 25 to 20 per cent, the share in for-profit ownership fell from 56 to 46 per cent and the share in non-profit ownership nearly doubled—from 18 to 33 per cent. Further, the geographical distribution of homes was uneven, since providers primarily decided where to locate, leaving some areas underserved and others with a surfeit of places.



Partisan differences were once again evident and the ownership structure of the market changed, if not its rising costs and otherwise relatively undirected growth. A Coalition government in 1972 put in place the first controls on fees and entry into a nursing home and sought to promote both family care and hostel accommodation as alternatives to nursing home care. The Labor government of 1972–75 continued these, but also sought to and succeeded in increasing the share of nursing homes run by non-profits (see Figure 6.1). The Coalition government of 1976–83 faced a tension between its desire to restrict government spending and intervention and its desire to foster the growth of the private sector, which seemed to demand liberal subsidies. Its experiment with private financing via private health insurance failed, and the attempt to restrict collective financing through tougher cost controls met resistance from ‘subsidised private sector interests [that sought] to entrench those interests through the mechanism of judicial review’ (Wheelwright 1992: 148).<sup>22</sup>



**Figure 6.1 Ownership of nursing home beds and ratio of beds per 1,000 population aged 65 years and over, Australia, 1972–84**

Note: This includes nursing homes only, not hostel facilities.

Source: SSCPHNH (1985: Table 1.8, p. 17; Table 1.5, p. 12).

22 The incoming Labor government faced a significant increase in litigation by for-profit providers challenging the fees determined for their nursing homes (Department of Health 1985: 120) and, in 1984, Minister Blewett announced ‘the Government had agreed in principle to introduce a new system of calculating nursing home profitability which would greatly assist the private nursing home sector’ (Blewett 1984).

Increasing community and hostel care was an important plank in the election platform of the Labor government elected in 1983. The new government quickly amended the *National Health Act* and the *Nursing Homes Assistance Act*, changing the process of approving new nursing homes to control their growth (Department of Health 1985: 116) and instituting an 18-month freeze on new approvals in March 1983 (DCS 1986: 21). In 1984, the new Hostel Care Subsidy, which contributed to funding for meals, laundry, cleaning and emergency on-call services, inter alia, was introduced alongside the existing Personal Care Subsidy (Cullen 2003: 62). New research was instigated to inform quality management, funding and staffing in residential care, and to chart new directions for community care (Department of Health 1985: 118–19). Yet, problems with the private-power market still needed to be managed and, in 1986, a programmatic ‘Statement on the care of aged people’ was made by the minister for the new portfolio of Community Services, Senator Don Grimes. Although some key reforms had already begun to be implemented, the statement clearly marked a new phase in aged care policy.

## **Phase 4: 1986–97 — Further towards a managed market**

Senator Grimes’s statement set out further dimensions of what had come to be known as Labor’s Aged Care Reform Strategy (Gibson 1996)—effectively the first attempt by an Australian government to develop an integrated *system* for the provision of appropriate support to older people. Framed within the government’s broader Social Justice Strategy (Howe 1997: 302), Senator Grimes’s statement emphasised consultation, planning, innovation, coordination and improving both quality and access for people who were disadvantaged or had special needs. In addition to these egalitarian and technocratic considerations, implementation of the Aged Care Strategy would also be strongly shaped by the ‘economic rationalist’<sup>23</sup> policy framework that informed how Labor governments understood policy problems and their solutions during these years (Head 1988; Cahill and Toner 2018). This framework emphasised efficiency

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23 Or ‘neoliberal’, as it would now be called. Public administration and public policy researchers also use the concept of New Public Management (Hood 1991).

and accountability—often to be achieved by the market mechanism of competition and through management models derived from private business.<sup>24</sup>

A key aim of the strategy was to address two decades of ‘huge and largely uncontrolled growth in expenditure on nursing homes’ (Grimes 1986) by further tightening government control over supply and demand for residential care and rebalancing provision away from nursing homes towards care in hostels or at home. As the previous section showed, successive governments of both major parties had pursued these goals for more than a decade with limited success. This time, the government’s efforts were more concerted and achieved some success. Legislative changes sought to address system-level problems identified in several reports, including those of the McLeay and Giles committees, and a review of nursing homes and hostels the government commissioned in 1985 (Howe 1990).

During this phase, among reforms to aged care too many to analyse here, three key sets of measures are most relevant to our concern with the policy drivers of the ownership structure of residential care and the distribution of power in the sector:<sup>25</sup> stronger controls on the number, type and location of residential care beds; a new funding formula for nursing home subsidies; and a freeze on Commonwealth benefits to state government-owned nursing homes.

Under the first set of measures, stronger controls on the number, type and location of residential care beds were introduced in 1987, building on the government’s already revised nursing home approval process. In the new system, needs-based planning replaced the earlier process, which assessed submissions from prospective providers. Planning benchmarks set ambitious targets to drive the growth of hostel places and to effectively reverse the ratio of nursing home to hostel beds, from where it stood at 67:33 in 1984 to 40:60 within three years. In addition to driving growth in hostel places, the government sought to use the available and new policy levers to increase equity of access to and the quality of hostel care, while also containing costs. Amendments to the *Aged or Disabled Persons Homes*

24 As a policy framework, economic rationalism under Labor had a complex relationship with more traditional Labor values of equality. In social policy, attempts to target support to the neediest in aged care coexisted with more universal approaches, such as the introduction of the national health insurance scheme, Medicare.

25 See Gibson (1996), Howe (1997) and Cullen (2003) for more comprehensive and detailed accounts of the Aged Care Reform Strategy.

*Act 1954* in 1987 sought to use the design of capital grants to non-profit providers to target new hostel places to frailer and disadvantaged older people. In the parliamentary debate, the Coalition opposition pushed for access to the hostel sector for for-profit providers. They argued that private sector investment was necessary to meet the growing demand for hostel care and the government should welcome it, especially since it was willing to consider privatising publicly owned airlines.<sup>26</sup> Minister Blewett countered with the claim: 'This Government does not believe that we can treat issues such as aged care and child care in the same way as we treat commercial organisations.'<sup>27</sup>

Further changes to hostel funding were implemented in 1989. Despite Minister Blewett's rhetoric, these changes effectively repositioned hostel providers and older people as more like businesses and their consumer rights-bearing customers (Staples 1988a). 'Entry contributions'—a form of private financing of aged care—had been chargeable to residents between 1954 and 1969, when they were disallowed because they gave hostel providers an incentive to offer accommodation to people who could afford contributions rather than to those who needed it (Cullen 2003: 39–40). The government reinstated these contributions, along with enhanced protections for hostel residents and their assets and incomes (Staples 1988a: 2–3). In 1990, the relatively new Hostel Care Subsidy was removed for residents who were not 'financially disadvantaged', creating the first means test for a subsidy in residential aged care (Gibson 1996: 167).<sup>28</sup> In an even more profound break with the past, for-profit providers of hostel care became eligible for recurrent (although not capital) hostel subsidies. While this decision was not justified at length, it was apparently related to the new nursing home funding model (discussed below), which treated for-profit and non-profit providers the same way.<sup>29</sup>

26 See, for example, debate on the Community Services and Health Legislation Amendment Bill 1987 (*House of Representatives Hansard*, Monday, 23 November 1987, p. 2508, available from: [parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansard%2F1987-11-23%2F0069%22](http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansard%2F1987-11-23%2F0069%22)).

27 Ibid., continuing the 23 November 1987 debate.

28 Alarmed by the loss of revenue removing the subsidy would cause, providers protested this measure, with support from the Coalition and Democrats; in response, the government further amended the legislation to make application prospective only (Le Guen 1993: 26).

29 Minister for Finance Ralph Willis's brief explanation noted that 'private enterprise has been a major provider in the nursing home industry over many years' and pointed to their historical exclusion from eligibility for the hostel subsidy program. To receive the subsidy, 'private enterprise organisations will be required to comply with *the same requirements* as religious and charitable organisations', and would be subject to all the same regulation, including the planning and approvals system. Notably, the general conditions of the Act were to be amended to allow for-profit providers to make a profit (Willis 1990; emphasis added).

The second set of measures was the new funding formula for calculating recurrent subsidies for nursing homes, announced with the 1986–87 budget and phased in over the following years.<sup>30</sup> Under the *Nursing Homes and Hostels Legislation Amendment Act 1987*, all homes—both non-profit and for-profit—were to be funded in the same way, removing, in the interests of efficiency and equity, the very wide variation by state and by ownership status identified in various reports (Gibson 1996: 165). Legislated at the same time, fee controls restricted resident charges to a maximum of 87.5 per cent of the age pension (and rent assistance, where applicable), on the reasoning that nursing care was free in public hospitals under the universal health insurance scheme, Medicare, which the ALP government had recently introduced (Howe 2000: 61). Up to 6 per cent of beds in each state would be approved to charge a higher rate to wealthier older people ‘who wish[ed] to pay for care and accommodation outside these funding arrangements’ (Staples 1988b).

The new formula separated funding into three modules, each with specific built-in incentives (for details, see Cullen 2003: 68–70; Le Guen 1993: 16–17). The Standard Aggregated Module was a uniform subsidy per resident per day to meet infrastructure and hotel costs. Unspent funds from this module, which was designed to promote efficiency, could be retained as profit. The Care Aggregated Module funded a certain number of nursing and personal care hours per week per resident in a home, based on individual need (dependency), as assessed under a new five-point Resident Classification Instrument. Providers’ spending of funds from this module, which was designed to improve quality, drive efficiency and increase the supply of care, was audited under a ‘validation program’. The third module, Other Cost Reimbursed Expenditure, reimbursed providers for non-wage costs of staffing, such as superannuation and payroll tax.

The third measure that directly impacted the distribution of ownership and power in RAC was a decision, in 1985, to freeze Commonwealth benefits to state government nursing homes in some states and territories—again, to address wide variation in subsidy levels. The freeze appears to have contributed to the ongoing decline in the share of public providers

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30 Both the McLeay and the Giles reports (HRSCE 1982; SSCPHNH 1985) had recommended that a new standardised system of program grants replace the differential arrangements for non-profit and for-profit homes (via the Deficit Financing and Participating Nursing Homes schemes, respectively). Reviews by the Department of Community Services of nursing homes and hostels and hostel care subsidy arrangements in 1985 and 1986 made similar recommendations. The new system was based on these recommendations.

(AIHW 1993: 228). The freeze was lifted in the 1992–93 budget and state homes were moved on to the funding system that applied to all private providers (Le Guen 1993: 12).

During the fourth phase of Commonwealth involvement in RAC, consecutive Labor governments had more success than governments in the third phase in gaining control over the private-power market that had evolved over three decades. By 1996, the sector had moved towards what Gingrich (2011) calls a ‘managed market’. On the allocation dimension, collective financing continued to be available and older people’s access to residential care was determined based on need under the new, publicly provided Aged Care Assessment Program. A new funding model largely removed providers’ opportunities to negotiate (or litigate) higher operational subsidies and reduced incentives to avoid admitting more frail residents. Meanwhile, resident fee controls increased accessibility and strictly limited providers’ capacity to shift costs on to consumers. On the production dimension, the government gained substantial control over the supply and distribution of RAC places through the new planning and approval processes. New mechanisms for quality oversight and for empowering residents had been introduced, in the form of national outcome standards for nursing homes and hostels (implemented in 1987 and 1991, respectively). Two of the three streams of funding (the Care Aggregated Module and Other Cost Reimbursed Expenditure) could be spent on staff expenses only, and unspent funds could not be retained. These requirements were enforced through the validation program, thereby retaining in the government’s hands a critical lever over care quality. ‘User rights advocacy services’ were introduced in 1989, followed by the ‘Charter of residents’ rights and responsibilities in nursing homes and hostels’ in 1990. Taken together, these policies put a brake on providers’ capacity to profit from cream-skimming and cost-cutting.

By the end of the period, the government had advanced its goals of reducing the ratio of nursing home to hostel places, and reducing overall provision of institutional care.<sup>31</sup> The average level of funding for more dependent residents was higher, while the share of the least frail in nursing

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31 The number of residential care places increased by nearly 30 per cent between 1985 and 1996 and almost all this increase (89 per cent) was in hostel places. The share of nursing home places fell from 67 per cent to 54 per cent and, while the number of residential care places increased, places per 1,000 people aged 70 and over fell from 99 to 91 (AIHW 1995: Table 5.17; 1997: Table 8.16).

homes fell, and savings from residential care were carried into community care, including the new, more intensive home care ‘packages’ introduced in 1992, which would become increasingly important in the next phase.

Despite increased controls, for-profit providers remained interested in RAC and nursing homes became more profitable: return on investment increased from \$4.89 to \$9.89 per resident per day between 1984 and 1985, and 1991 and 1992 (Cullen 2003: 70). Indeed, the for-profit share of nursing homes increased slightly from 46 per cent in 1984 to 48 per cent at the end of 1996 and their share of subsidised hostel care also began to grow—from zero to 7 per cent across the same period (PC 1998: Table 9A.28). The growth in for-profit hostels almost compensated for the policy-driven constraint on growth in nursing home beds. Taking nursing homes and hostels together, the share of for-profit provision fell from 31 to 29 per cent between 1985 and 1996. Meanwhile, public provision of nursing homes fell from 20 per cent in 1984 to 14 per cent at the end of 1996.

The Labor Party governed for the entire period, but partisan differences are clearly observable in parliamentary debates along predictable battlelines. The Labor government sought to gain financial and management control over the mostly private sector and to ensure that benefits did not go too disproportionately to better-off older people, at public expense, albeit using some market discourse alongside the social justice and human rights ideas that informed various aspects of its reforms. To achieve what favouring the non-profit sector had done in the past, the government appears to have been relying on measures aimed at increasing equity of access, service quality and older people’s rights within the system.

The Coalition opposition recognised the importance of high-quality RAC to older people’s wellbeing and professed to agree in general with the direction of government policy.<sup>32</sup> However, on providers’ behalf, the opposition rejected the government’s characterisation of private providers as ‘profit hungry entrepreneurs’<sup>33</sup> and vociferously resisted increased state control. In Parliament, opposition members, citing providers, complained

32 See, for example, the contribution from Opposition’s Spokesman on Community Services Charles Blunt to the debate on the Second Reading Speech on the Community Services and Health Legislation Amendment Bill 1987 (*House of Representatives Hansard*, Monday, 23 November 1987, p. 2508, available from: [parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansard%2F1987-11-23%2F0069%22](http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansard%2F1987-11-23%2F0069%22)).

33 Charles Blunt, this time in a debate on aged care as a Discussion of a Matter of Public Importance (*House of Representatives Hansard*, Wednesday, 13 April 1988, p. 1463, available from: [parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansard%2F1988-04-13%2F0040%22](http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansard%2F1988-04-13%2F0040%22)).

that the processes for determining the Standard Aggregated Module and Care Aggregated Module were shrouded in 'secrecy' and the administering department was 'using Gestapo-type tactics to harass and intimidate proprietors' in a 'denial of natural justice'.<sup>34</sup> The role of assessors as 'gatekeepers' in the new system to determine the eligibility of older people for nursing home entry was strongly resisted, as was the 'unfair', 'intrusive' and 'insurmountable' validation of expenditure.<sup>35</sup> Opposition members rejected fee controls and the restriction on places catering to those who wanted to pay more to get better accommodation and care as 'the politics of envy' and 'socialism gone mad'.<sup>36</sup>

In general, despite their overwhelming reliance on public funding, providers resisted what they framed as a violation of their rights as proprietors. While the opportunity existed, they continued the time-honoured strategy of seeking administrative review of their fees.<sup>37</sup> Across a decade, through their advocates among opposition parliamentarians, but also in submissions to inquiries, advertisements in newspapers and other means, private providers contested the tightening controls, which significantly disrupted business as usual, despite their staged introduction. In submissions to the review of 'the structure of nursing home funding arrangements' conducted by economist Bob Gregory, for example, a major provider industry association proposed major reversals, including fee deregulation and market competition (Gregory 1994: 31).

Labor's policies were contentious, intensively reviewed and amended in various ways. However, they remained largely in place when, in March 1996, Labor lost power to a new Coalition government under John Howard, which introduced new policies that industry preferred.

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34 Charles Blunt; see speech cited at note 32.

35 Cited in a speech by Shadow Minister for Social Security David Connolly (*House of Representatives Hansard*, Thursday, 12 November 1992, p. 3297, available from: [parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansard%2F1992-11-12%2F0113%22](http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansard%2F1992-11-12%2F0113%22)).

36 Bob Woods (Liberal) in the debate on the Community Services and Health Legislation Amendment Bill 1988 (*House of Representatives Hansard*, Thursday, 28 April 1988, p. 2358, available from: [parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansard%2F1988-04-28%2F0150%22](http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansard%2F1988-04-28%2F0150%22)); between two periods in Parliament, Woods also worked as a lobbyist for Doug Moran, owner of the largest chain of nursing homes at the time (Bagwell 1997).

37 In 1989, Minister Staples defended the introduction of a charge on providers seeking such reviews, following an increase in requests from an average of 20 annually to about 600 in 1987–88, which he argued was the result of 'an orchestrated form of protest' by the industry against the nursing home reforms; see *House of Representatives Hansard* (Thursday, 10 November 1988, p. 2844, available from: [parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansard%2F1988-11-10%2F0112%22](http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansard%2F1988-11-10%2F0112%22)).



## **Phase 5: 1997–2013 — A new *Aged Care Act* increases private power**

In a now well-established tradition of incoming Coalition governments (Weight 2014), on its election, the Howard government (1996–2007) established a National Commission of Audit (NCOA) to review the role of government and recommend how its efficiency could be improved. Like others since, the NCOA's report expressed a market logic. The NCOA (1996) found aged care insufficiently market-like and predicted exponential rises in outlays unless the government made changes, including introducing means-tested user charges and entry contributions for all residential facilities, not just hostels. Within a few months of receiving the NCOA's report, and picking up its proposals, the government announced plans for 'structural reform of residential aged care' in its first budget, 'to address major flaws in the existing system ... and save \$479 million over 4 years' (Costello 1996).

Accordingly, the Howard government legislated the *Aged Care Reform Act* in 1997, and various provisions came into force over the following years (see Howe 2000). The Act made sweeping, interrelated changes to the structure, funding and regulation of residential aged care, affecting both the real estate and the service aspects of its business model. The new policies opened the system to renewed growth of for-profit provision, including the proliferation and expansion of large corporate providers. They also shifted some power away from government and older people back to providers and increased the costs, both financial and administrative, for older people. Many proposed measures were controversial and the government faced opposition in the Senate, where it was in minority, and from religious and community groups.

Structural reform under the Act removed the distinction between nursing homes and hostels, unifying them into a single RAC program, as it is known today. The change was justified partly by reference to the concept of 'ageing in place', such that an older person in a hostel (or what became a 'low-care' place) would not need to move to a new facility when their needs increased to the level offered in a nursing home (what became a 'high-care' place). This policy aimed to address problems arising from the different funding models for nursing homes and hostels, which increasingly had resident populations with overlapping need profiles

(Cullen 2003: 73–75).<sup>38</sup> One important effect of this integration of the system and the associated funding changes was to align the policy treatments of for-profit and non-profit providers.

The Act changed policies for funding capital costs and accommodation and the recurrent costs of care and hostel services. The review of (Labor's) nursing home funding arrangements (Gregory 1993, 1994) had concluded that funding and incentives for capital investment were insufficient and the quality of accommodation was often poor, especially in for-profit homes. While Labor responded by rewarding providers that offered better-quality accommodation with higher public subsidies (Cullen 2003: 38), the Howard government's approach to remedying these problems aligned with its market-oriented policy goals and sought to shift costs to older people deemed to have the capacity to pay. Accordingly, the first Howard–Costello budget abolished general capital assistance programs for residential care, retaining only a small residual capital funding program to support some providers, such as those catering to special needs groups. The new *Aged Care Act* restructured recurrent funding by separating care and accommodation costs and requiring older people to make means-tested contributions to both. To drive providers to increase the quality of accommodation, building certification requirements were introduced and providers who failed to meet them risked losing their subsidies.

To cover the costs of accommodation and property maintenance and development, the government proposed to extend to high-care places (that is, to nursing homes) the user contributions to capital costs that had long existed in what were now called low-care places (hostels). Under the policy, the amount and payment of an 'accommodation bond', as they were called, were to be mostly a private matter between provider and client. Providers could not charge an older person so much that they would be left with assets below a specified (low) threshold;<sup>39</sup> there was no upper limit. The extension of bonds to high-care places was a very controversial proposal. On one hand, bonds were eyed with great interest by the owners of for-profit nursing home as a source of interest-free capital. The peak

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38 As Cullen (2003: 73–75) explains, two people with similar needs profiles could attract different levels of subsidy if one lived in a nursing home and the other in a hostel. Whether the integrated system functioned as intended is another matter; see Howe (2000).

39 The threshold was set at the equivalent of 2.5 times the annual rate of the single age pension (which was a bit more than \$9,000 in early 1998). The family home was exempt from the assets test under certain conditions, such as if a partner or dependent child of the resident continued to live in it (Gray 2001: 65–66).

body for this group urged the government to 'stand firm and resist calls for more concessions' (Dodson 1997). Non-profit providers mostly preferred ongoing public capital funding to user-paid bonds. They were concerned about the lack of prudential regulation, which left older people exposed to significant losses, and about the equity impacts of unregulated upper limits on bonds, which had the potential to promote selection of clients on the basis of their capacity to pay a (larger) bond and to promote 'a two-tiered system of care' with 'rich, plush nursing homes' in wealthier areas and 'poor, badly maintained homes' elsewhere (Hatfield and Jamal 1997). More politically decisive was the anxiety older people felt at the prospect of selling their family home to access a high-care place. Thus, towards the end of 1997, the government backed down, restricting bonds to low-care (hostel) places only (Howard 1997).

The policy quickly succeeded in drawing in more resources from older people: in the three years after the implementation of these changes, the proportion of people paying bonds and the average amount of bonds both grew (Gray 2001: 65–69). Under an amendment to the *Aged Care Act* in 1998, people occupying high-care places were obliged to pay a means-tested, capped accommodation charge instead of a bond. The charge initially had an annual cap and payment was limited to five years (Howe 2000: 63), but the five-year limit was later removed for residents entering care from July 2004 (Department of Health and Ageing 2005: 49). Residents whose resources fell below the (low) means-test threshold were not required to pay for their accommodation; instead, the government paid providers a daily accommodation supplement.

Subsidies for care and other recurrent costs (such as meals, cleaning and recreation) were determined across the now-unified sector using an eight-category 'resident classification scale', which linked funding per resident to need as determined by the scale. All residents were expected to (continue to) pay a 'standard resident contribution', which was set at 85 per cent of the single aged pension for the majority of residents.<sup>40</sup> However, additional, income-tested fees now applied across nursing homes as well as hostels. User fees were primarily an instrument of public cost control; provider subsidies were reduced by the amount charged to residents.

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40 This payment was the only user contribution to nursing home care required under Labor's policy before the introduction of the *Aged Care Act* 1997. The *Two-Year Review of Aged Care Reforms* reports that among new residents entering facilities after the reforms (from 1998 to 2000), 93–94 per cent paid the (lowest) pensioner rate of the standard resident contribution (Gray 2001: 62–63).

While providers decided the level of care fees, consumers received some protection as providers could not charge them more than the applicable subsidy. Within two years, these policies tripled the proportion of older people who paid fees, from 11 per cent (who had paid fees in hostels before the reform) to 33 per cent in 2000 (Gray 2001: 64).<sup>41</sup> In 2003, five years after the policy came into force, 40 per cent of residents paid care fees (Department of Health and Ageing 2003: 26).

While the new care funding model protected consumers from fee-gouging by providers, it did not protect them from cost-cutting that could critically compromise the quality of care. Under the Coalition's pro-market, deregulatory approach, quality and accreditation requirements were 'light touch'. Accordingly, the new system for subsidising care removed the obligations on providers to allocate specific proportions of the funding they received to care staff and to acquit public funding against expenditure on staffing, both of which had been required under the previous Labor governments' funding model. Further, while nursing staff ratios were specified in the original Act (as passed in 1997), they were soon removed in amendments, following 'consultation with providers and aged care professionals' (Gray 2001: 19). Instead, responsibility was delegated to providers 'to maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met'.<sup>42</sup> These policies had a profound effect on the business opportunity related to recurrent costs in residential aged care and providers took this opportunity over the ensuing decades by replacing more expensive professional staff with cheaper workers with lower skill levels. The Labor opposition predicted this outcome in parliamentary debates on the Bill in 1997; one member described it as a 'reckless act by a government that has been captured by the private nursing home-owners lobby'.<sup>43</sup> At any rate, anticipatory

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41 'High-care' users subject to fees paid more, having paid nothing beyond the basic resident contribution under Labor, while low-care users potentially paid less, since hostel user fees had not hitherto been regulated (Gray 2001: 64).

42 See *Aged Care Act 1997* (Cth), s. 54-1 (1)(b) (available from: [www.legislation.gov.au/Details/C2004C01675](http://www.legislation.gov.au/Details/C2004C01675)).

43 The latter part of this remark may have some basis in reality; hospital and nursing home magnate Doug Moran is widely reported as the source of key reform proposals (Bagwell 1997; Dodson, 1996). See also speech by Brenda Gibbs (Labor) (*Senate Hansard*, Tuesday, 24 June 1997, p. 5042, available from: [parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansards%2F1997-06-24%2F0120%22](http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansards%2F1997-06-24%2F0120%22)).

excitement about the business opportunities in RAC was high in 1997. Property developers, investment banks and private equity companies entered the market over the coming years.<sup>44</sup>

Despite this optimistic behaviour by new market entrants, the Howard government's structural reforms fell prey to the stubbornly persistent problem of RAC policymakers in Australia. The government's expressed ambitions to solve existing problems and put the system to rights once and for all notwithstanding, conflict with providers over funding design and levels endured and intermittent scandals about care quality emerged. Accordingly, policy shifts and restructuring of the administrative architecture—often following reviews and scandals—continued to roil the sector over the decade 1997–2007, during which there were no fewer than seven responsible ministers.<sup>45</sup>

The 2002–03 budget papers included the first *Intergenerational Report*, which aimed to provide 'a basis for considering the Commonwealth's fiscal outlook over the long term, and identifying emerging issues associated with an ageing population' (Treasury 2003: iii). The report projected the Commonwealth's aged care costs as a share of gross domestic product would increase by nearly 150 per cent over the coming 40 years (Treasury 2003: 39). The report and its projections contributed to the framing of ageing as a fiscal problem and underpinned ongoing emphasis on the need to increase the share of costs paid by service users.<sup>46</sup>

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44 To give a sense of the evolving business interest in residential aged care, House (1999) reports the entry of listed investor Development Capital of Australia (DCA) into the sector, noting it 'spent \$7.5 million on two nursing homes to seed its newly formed aged-care group', and planned to spend a further \$50–60 million on acquisitions over the coming year. DCA Agedcare was part of the share market-listed DCA Group acquired in 2006 by private equity firm CVC Asia Pacific for \$2.7 billion. In October 2007, CVC sold DCA Agedcare to Bupa for \$1.2 billion. At the time, Bupa (primarily a health insurance company based in the United Kingdom) owned 300 facilities in the United Kingdom and 43 in Spain (Reuters 2007), while DCA's Amity chain of RAC facilities in Australia and its Guardian chain in New Zealand owned 96 facilities across the two countries (CVC Capital Partners 2007). The bidding process before the sale drew interest from several large private equity companies, investment banks and healthcare corporations, including AMP Capital, Babcock & Brown Communities Group, Macquarie Bank, FKP Property Group and Ramsay Health Care (Clegg and Wilmot 2007).

45 These were Judi Moylan, Warwick Smith, Bronwyn Bishop, Kevin Andrews, Julie Bishop, Santo Santoro and Christopher Pyne. Whether this turnover was a symptom or a cause of ongoing problems with aged care policy is a question for another day.

46 For a critique of generational accounting and its implications for framing policy problems, see Spies-Butcher and Stebbing (2019).

In the 2002–03 budget, the government also announced it would commission a wide-ranging Review of Pricing Arrangements in Residential Aged Care. Led by academic economist Professor Warren Hogan, the review was published in 2004. Hogan made short, medium and long-term recommendations, many of which reflected his discipline's confidence in market mechanisms. One major short-term recommendation was that the resident classification scale, which determined funding per resident, be revised to reduce the 'administrative burden' on providers. Others included an expanded list of resident needs that would attract a funding supplement, better prudential regulation of accommodation bonds, improved information about service quality, including a star-rating system for consumers, and stricter reporting requirements about corporate owners and key personnel when places were transferred, to protect residents from providers who might evade the departmental process for approving providers<sup>47</sup> (Hogan 2004).

The government responded to the review's recommendations over the following years. The new Aged Care Funding Instrument (ACFI) was used to classify all residents entering care from mid-March 2008. The government also proposed to establish a provider-financed guarantee fund for accommodation bonds, instead of the stronger prudential oversight of providers Hogan had recommended. What eventuated, following consultations, Senate committee review and consultant reports, was a government-funded guarantee (ACFA 2017: 36–38). Hogan

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47 In a change that would have far-reaching implications for service quality and oversight, the *Aged Care Act* had redefined the relationship between the government (as public funder), residential care facilities, their owners and the provision of services to older people. Under the *National Health Act 1953*, specific premises defined as nursing homes were subsidised to provide care in a specified number of approved beds (Herd et al. 1998). As Herd et al. explain, the *Aged Care Act* detached 'places' for which a subsidy could be paid from certain premises and allocated places instead to 'approved providers', who were corporate (or government) entities that met specified conditions. To become an approved provider, the applicant must satisfy the secretary of the relevant department that they are a corporation and that none of their key personnel (executive managers, anyone responsible for nursing services or day-to-day operations) is a 'disqualified person'—that is, a convicted criminal, bankrupt or of unsound mind (Hogan 2004: 165). Applicants were also required under the Act and associated 'Aged Care Principles' to meet accreditation standards (related to service quality and governance), have systems in place to ensure they could do so and certification standards (related to building quality) (Hogan 2004: 21). Places were (and are) traded in a secondary market, and approved providers were also required to notify the department within 28 days of any changes in their 'key personnel' (Hogan 2004: 290). However, as Hogan (2004: 290) pointed out, departmental oversight could be 'circumvented by the ... practice of selling the entity owning places rather than the places themselves'. This practice, which became more common over time as the sector consolidated, may have concealed the entry of some very dubious characters (Houston 2021).

also recommended bonds be used as an alternative to accommodation payments in high care; however, the government was not yet prepared to take this political risk.

In the election of 2007, the Coalition lost to the ALP led by Kevin Rudd and reviews of, and policy tinkering with, the aged care system continued.<sup>48</sup> The new government introduced the *Aged Care Amendment (2008 Measures No. 2) Act 2008*, which included measures to improve protections for older people and to clarify lines of regulatory oversight, along lines recommended by the Hogan Review (see Elliot 2008). Interestingly for our purposes, the documents and debate relating to the Act referred to the growing role of corporate providers and indicated the bipartisan political consensus on this development. The existing:

regulatory framework reflected the ‘cottage’ nature of the sector as it then was. In recent years a different model of aged care has emerged, one in which the owner and operator of a facility have distinct roles and responsibilities and may function quite separately. The last decade has also seen a significant increase in the level of investment in the sector from large corporate entities. The regulatory framework has not kept pace with this shift in business practice. (Elliot 2008: 1)

Labor member James Bidgood argued in favour of the Bill: ‘It is obviously extremely important in terms of consumer confidence and *to maintain and increase the level of corporate investment* in the sector that the regulatory framework that governs these financial arrangements is as robust and current as possible.’<sup>49</sup> The opposition supported the Bill.

As part of Prime Minister Rudd’s ambitious plans for sweeping reform of the healthcare system, in 2010, the Council of Australian Governments (COAG) agreed to a federal takeover of aged care, which saw state government co-funding of home and community care and coregulation of residential care removed over the ensuing years. That same year, the (now) Gillard Labor government asked the Productivity Commission ‘to examine all aspects of Australia’s aged care system, and to develop detailed

48 For details on legislative changes made each year, see the appendices to the annual *Reports on the Operation of the Aged Care Act* (available from: [www.gen-agedcaredata.gov.au/Resources/Reports-and-publications/2020/September/Report-on-the-operation-of-the-Aged-Care-Act](http://www.gen-agedcaredata.gov.au/Resources/Reports-and-publications/2020/September/Report-on-the-operation-of-the-Aged-Care-Act)).

49 Emphasis added. James Bidgood (*House of Representatives Hansard*, Monday, 24 November 2008, p. 11177, available from: [parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansard%2F2008-11-24%2F0171%22](http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansard%2F2008-11-24%2F0171%22)).

options to ensure it can meet the challenges facing it in coming decades' (Butler 2010). The commission's report, *Caring for Older Australians* (PC 2011), proposed further marketisation of aged care and emphasised expansion of home-based care and increasing consumer choice. Informed by the Productivity Commission's report, the ALP government released its Living Longer, Living Better (LLLBB) policy in 2012. With bipartisan support, a suite of five Acts gave effect to the policy in June 2013, for implementation from July 2014, as discussed in the following section (see DSS 2013: 128–29).

Meanwhile, how and by how much the sector was funded were questions of ongoing contention with providers and of government efforts to control public expenditure and meet (remaining) partisan goals. As noted above, the *Aged Care Act 1997* had removed the requirement that providers spend a specified proportion of their funding on staff. Further, the Aged Care Funding Instrument, introduced in 2008, left providers to assess incoming residents' needs for the purposes of determining the level of funding for their care; whether higher amounts of care were delivered was not monitored. As the cost of ACFI funding grew, these policy settings meant governments looked to adjust the assessment criteria and to audit assessments to exercise some control over the amount and use of public spending. Accordingly, in the 2012–13 budget, the government proposed cutting spending by \$1.6 billion over five years, through 'improving' the ACFI by 'tightening the assessment criteria' and enhancing the compliance powers of the Department of Health and Ageing. The rationale was to 'better align the funding claimed by aged care providers with the level of care being offered' (Swan and Wong 2012: 184). However, in the same budget, Labor committed \$1.2 billion over five years to a 'workforce compact', with funding tied to measures that would improve pay, conditions, career structures and training (Swan and Wong 2012: 180). This funding had the potential to contribute to improved care quality by requiring providers to devote it to staffing costs of various kinds.

During this phase, there were both Coalition (1997–2007) and Labor (2007–13) governments, yet the general direction of reform was largely consistent. The *Aged Care Act 1997* was a decisive turning point towards re-empowering providers, which Labor resisted at the time. However, when in government, Labor acted within what appears to be a bipartisan consensus on marketisation and the appropriateness of for-profit provision, although it increased some protections for residents and workers, as might be expected. After a shaky start in an uncertain policy environment, the



share of for-profit RAC provision increased from 26 to 33 per cent during the Howard years and from 33 to 35 per cent during the years of the ALP government (see Figure 6.2). Another important development was the increasing role of large corporations operating chains of facilities.

At the end of this fifth phase, residential aged care seemed to have the features of austerity and private-power markets. On the allocation dimension, access to services was controlled by government-managed needs assessment (which had a collective logic). Collective financing remained in place for most residents but, over time, the government sought to squeeze public contributions and means-tested user charges with relatively low thresholds were levied on care and accommodation. Older people were, as before, expected to find and choose facilities themselves (on a consumer logic) and to make decisions based on increasingly complex, poor-quality information.

On the production dimension, the number and regional placement of facilities continued to be controlled through the planning and approval system (state power). But the changed funding system (the ACFI) increased producers' opportunities for rent-seeking by delegating the assessment of residents' needs to them, and therefore the level of funding received. The ACFI also presented opportunities for provider profiteering, since it increased their control over service quality, by removing dedicated funding for, and regulation of, staffing. More providers also gained access to cash and interest-free capital through user fees and accommodation bonds in low care. Quality was regulated, but ongoing changes to complaints and oversight arrangements and scandals about care quality persisted.

## **Phase 6: 2013–22 — More austerity and the consolidation of private power**

In September 2013, the ALP lost government to the Coalition under Tony Abbott. A National Commission of Audit followed in short order, reporting in 2014. In general, the commission supported the (marketising) direction of change, although proposed taking it further.<sup>50</sup> Policymaking has since been a mix of attempts to restrain public expenditure and

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50 Emphasising the need to ensure the system is 'sustainable', the NCOA's recommendations called for a deepening of user-pays principles, for both consumers (through including the family home in asset tests) and providers (through private insurance to cover the risk of bond default), in line with the Productivity Commission's earlier proposals that no government had yet taken up.

loosen restrictions on providers that might be expected from Coalition governments, along with the need to respond to consequent problems by enacting some consumer protections. Some changes were developed in a ‘red tape reduction plan’ (Department of Health 2019) put together by the government and the Aged Care Sector Committee—one of a long line of tripartite sectoral consultative bodies.<sup>51</sup> With an ideological flourish, following the work of a ‘red tape committee’, the government legislated the *Omnibus Repeal Day (Autumn 2014) Act 2014*. The Act, the first of a series, removed building certification requirements for RAC providers.

However, critical changes also occurred when Labor’s LLLB policy came into force on 1 July 2014. The Productivity Commission had recommended including the full value of the family home in aged care means testing but, like many before it, both Labor and Coalition, in framing the LLLB reforms, the then Labor government baulked at doing so. And, in line with Labor’s weaker commitment to user-pays principles for more universal services, the LLLB introduced annual and lifetime caps on means-tested care fees for both home and residential care. However, the reforms also allowed for optional additional fees for ‘additional services’,<sup>52</sup> such as ‘enhanced entertainment or lifestyle choices’ (Department of Health 2012: 11). Significantly, the LLLB completed a transformation attempted by the Howard government more than a decade before and which would be decisive for the future structure of the sector. With accommodation payments now well established for low-care places, the LLLB also introduced lump-sum accommodation bonds—now to be called ‘refundable accommodation deposits’—for all places (along with abolishing the distinction between high and low care in assessments). As Rick Morton (2017) put it: ‘[T]he immediate effect was to create

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51 The use, and outcomes, of industry consultative bodies in aged care policymaking has not been systematically studied. The Aged Care Sector Committee (ACSC) replaced the Aged Care Reform Implementation Council that was established by Labor to support the rolling out of the LLLB reforms. Some key personnel remained unchanged across the transition—not least the chair, Professor Peter Shergold, who left the ACSC in November 2014 to chair the board of Opal Aged Care, a private equity-owned chain of residential care facilities and Australia’s largest for-profit provider (Richardson 2021). He was replaced on the ACSC with David Tune.

52 There had long been provision for a small number of facilities or beds offering a higher standard of accommodation and hotel services under special arrangements, including the ‘exempt homes’ outside the public subsidy system during the 1980s and ‘extra service’ places under the *Aged Care Act 1997*, which were subject to specific regulations. Neither of these schemes is discussed here for reasons of space. ‘Additional services’ could be offered in all RAC facilities and are only very lightly regulated, as discussed below.

a modern-day gold rush ... opening up vast pools of capital in relation to residents classified as high care ... and laying the foundation for the corporatisation of care.'

Further changes by the Coalition government worked in the same direction. With the *Aged Care Amendment (Red Tape Reduction in Places Management) Act 2016*, the requirement that providers apply to the Department of Health for approval to transfer places to another provider was removed; previously, the requirement to seek approval gave the department a routine opportunity for oversight of to whom ownership of places was transferred, for the protection of older people (see Hogan 2004: 290; Footnote 50, this chapter). And while many of the LLLB reforms continued the marketisation of RAC under bipartisan agreement, one area of partisan difference was Labor's support for workforce development. Funding for the 'workforce compact' was 'reprioritised' in the Coalition's budget of 2014–15 and redirected into an (temporary, as we shall see) untied increase in funding to providers (Hockey and Cormann 2014: 208).

In 2015, the government also set in train yet another policy review process to inform future changes to the system. This time, the Aged Care Sector Committee—now chaired by David Tune (former secretary of the Department of Finance)—was commissioned to provide a 'roadmap' for the future of aged care. The resulting document pressed familiar themes, proposing further deregulation and marketisation (ACSC 2016). In 2017, the Legislated Review of Aged Care promised under the LLLB legislation, also undertaken by David Tune, recommended the removal of annual and lifetime caps on user fees to reduce costs to governments, and the removal of planning ratios in aged care, to allow the market to determine supply (Tune 2017).

However, despite the deregulatory direction of Coalition policy and the recommendations of reviews, provider discretion did not escape scrutiny when the risks fell on the public purse. After 2014, when the 'goldrush' took off, the government became concerned about 'continued higher than expected growth in ACFI expenditure' (Morrison and Cormann 2016: 101). As Morton (2017) also noted at the time: 'Politicians want deregulation—as well as control.' Thus, in the 2016–17 budget, the instrument's 'scoring matrix' was changed with the goal of saving \$1.2 billion over the coming four years (Morrison and Cormann 2016: 101). The minister, Sussan Ley, emphasised the inconsistency in

claims, the high rates of downgrading on audit and the need for a more independent and transparent approach to assessment (Cranston 2016). The sector resisted, as market analysts downgraded profit predictions for newly listed corporate chains (Cranston 2016), and representatives of for-profit providers called for fee deregulation and changes to means testing to bring in more funds from users if government funding was going to be cut (White et al. 2016). A government-commissioned review documented accelerating growth in ACFI claims after 2014, and noted as drivers the entry of new companies, the growing share of for-profit providers and the use of consultants to maximise funding (Applied Aged Care Solutions 2017: 36). In 2017, (yet another) Minister for Aged Care Ken Wyatt commissioned the ‘resource utilisation and classification study’ that would result in (yet another) system for determining need and linking it to funding in RAC. The Australian National Aged Care Classification will be used from 1 October 2022 (Department of Health 2021b).

Since 2013, more of the constraints on provider power and profitability introduced by ALP governments in the 1980s have been dismantled or proposed for dismantling. These include government controls over fees and over the number and location of RAC places through the planning ratios and annual tendering processes that are providers’ main opportunity to gain access to the market (Aged Care Approval Rounds).<sup>53</sup> Proponents of marketisation have railed against the Aged Care Approval Rounds for several years, including the Productivity Commission (2011), the Aged Care Sector Committee (2016) and the Legislated Review of Aged Care (Tune 2017). In the budget of 2018–19, the government announced a plan to phase out the Aged Care Approval Rounds process (Department of Health 2018). Effectively deregulating the supply side of the market, and justified as ‘increasing choice’ for consumers, all residential care places will be allocated directly to older people assessed as eligible from 1 July 2024, rather than to approved providers (see Department of Health 2022). In 2019, the government also announced that the independent and publicly funded and provided aged care assessment process would be put out to tender in 2020. This proposal was withdrawn early in 2020 following strong resistance from state governments, which currently provide these services (O’Keefe 2020). However, it resurfaced in 2021 in the former Coalition government’s response to the royal commission.

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53 Acquiring existing places is the alternative.

The royal commission's reports have shown that regulation of the quality of residential care has often been ineffective. While the accreditation process is part of the problem, rent-seeking by providers in the context of weak regulation of care 'production' is at least as important. There is clear evidence, for example, that providers took the opportunity to reduce their own costs by substituting less-skilled for more-skilled labour after staffing ratios were removed under the *Aged Care Act 1997*. Data on the skill mix have been available only since 2003; they show that between 2003 and 2020, the share of (more expensive) registered nurses fell from 21 per cent of the equivalent full-time staff to 15 per cent, the share of enrolled nurses fell from 14 to 8 per cent and the share of allied health workers fell from 8 to 4 per cent. These highly skilled workers were replaced with personal care workers, for whom there is currently no mandated minimum qualification and whose share of the full-time-equivalent workforce grew from 57 to 72 per cent across the period (Mavromaras et al. 2017: Table 3.3; Department of Health 2021c: Table 2.2).

Further, the costs to consumers in residential aged care are driven by user-pays principles, enacted through weakly regulated provider-determined accommodation charges and fees for 'additional services', in addition to means-tested, publicly imposed care fees. Along with weak regulation of quality, user-pays policies have presented significant opportunities for rent-seeking by for-profit providers (Allard 2016). For-profit providers are consistently and significantly overrepresented in the highest quartile of average annual revenue per resident, driven primarily by higher accommodation charges (ACFA 2015, 2021). The Royal Commission into Aged Care Quality and Safety (2021b: 199) heard evidence from a member of the board of Opal Aged Care, the largest for-profit chain, that 'accommodation is currently the only component on which aged care providers are able to earn a return, the aged care sector has effectively become a property industry rather than a care industry'.

Additional service charges cover 'amenities' such as food choices and entertainment, not care. Consultants Ansell Strategic euphemistically described these charges as a way providers could 'maximise sustainability' in the context of constrained public funding (Cox and Koumoukelis 2016). Charges are regulated in a minimal way in line with the logic of

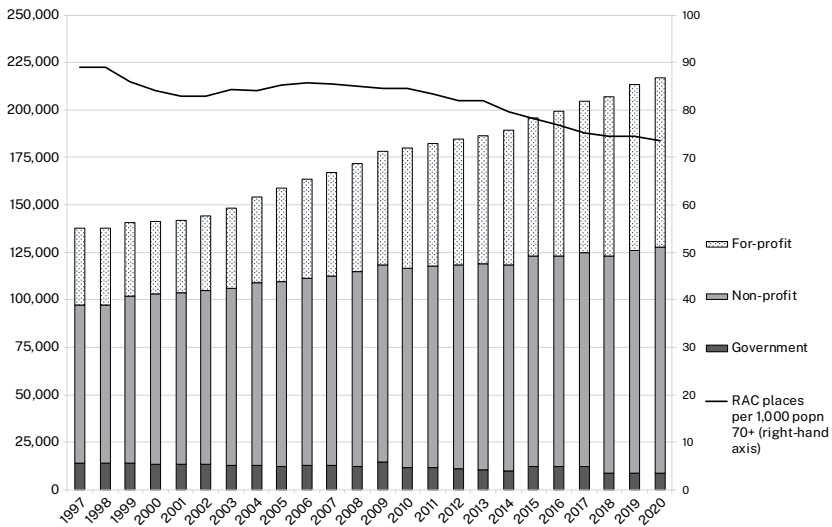
consumer protection<sup>54</sup> and providers can levy them as a condition of entry into a facility. There are few official data collected about them (ACFA 2021: 64), but available evidence suggests they are a small but rapidly growing source of provider income (ACFA 2021: Table 6.10), that for-profit providers are much more likely to use the model of bundled services for a regular fee rather than fees for ad hoc services and that many providers now charge for services they previously provided ‘free’ as part of their usual offering (Pride Living Group 2019). As might have been foreseen by the government, large for-profit providers found multiple creative ways to raise additional revenue from residents. Regulation of additional service charges has had to evolve, following interventions against providers by the Department of Health and the Australian Competition and Consumer Commission (Gadens 2018; Groshinski et al. 2020). The two largest for-profit chains, Bupa and Regis, ended up in the Federal Court, which found that various of their additional charges on residents were illegal.

During this sixth phase, there have been three Coalition governments, the first of which implemented the LLLB policies legislated under the ALP. Since 2013, the share of for-profit providers increased from 36 to 41 per cent (see Figure 6.2). Another important development, starting in the early 2000s and advancing rapidly since 2014, is the proliferation and consolidation of large corporations—some owned by families, some by private equity and some listed on the stock exchange. These providers tend to develop large facilities in which quality tends to be lower than in smaller ones (Royal Commission into Aged Care Quality and Safety 2021b: 168).

Changes during this phase further increased provider power. On the allocation dimension, access to services remained controlled by government-managed needs assessment (which has a collective logic). Collective financing, including the lifetime cap on care charges, continued. However, governments held down public subsidies and significantly expanded user charges, giving all providers potential access to interest-free capital and capacity to charge ‘market rates’ for accommodation and for ‘additional services’. In future, though, if funded and overseen appropriately, the new Australian National Aged Care Classification model has strong potential to ensure needs-based funding for the care component of RAC.

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54 According to the Aged Care Financing Authority: ‘An additional service fee can only be charged for services that have been agreed to by the resident, that are over and above those paid for by the Commonwealth under the Schedule of Specified Care and Services, and from which aged care residents receive a direct and tangible benefit’ (2021: 64).



**Figure 6.2 Ownership of residential aged care places, and places per 1,000 population aged 70 years and over, Australia, 1997–2020**

Sources: Data provided in appendix tables of chapters on aged care in PC (various years).

As the vignettes in the introduction to this collection show, older people's challenges in navigating the aged care market continue. If not of very low means, they face high administrative burdens in negotiating their accommodation costs and other charges. Producers have incentives for cream-skimming (selecting less needy and/or more resource-rich clients), and there is strong sorting between providers by capacity to pay, especially for better accommodation.

On the production dimension, government controls on the number and regional placement of facilities persist but are scheduled for removal, which will increase private power. New opportunities to profit from both the service and real property dimensions of RAC accelerated corporate interest in the sector. Producer control over service quality remained high. Regulation of quality standards was in place, but its effectiveness continued to be limited.

The private power of providers has been scrutinised and criticised, for example, in a Senate Economic References Committee (2018) inquiry into the financial and tax practices of for-profit aged care providers, which recommended greater transparency. The Royal Commission into Aged Care Quality and Safety has also provided a forum for questioning

the role of profit in aged care, and one of its commissioned reports has pointed to the complex business structures in aged care corporations that obscure how they use their revenues and derive profits. In 2020, in the absence of any government response to the Senate Economic References Committee report, independent Senator Stirling Griff proposed the Aged Care Legislation Amendment (Financial Transparency) Bill 2020. The Coalition government voted it down. The royal commission's final report did not explicitly question the role of the market as it had identified in its interim report.

Pressed by regulatory failures and media scandals into calling the royal commission, the Coalition government was obliged to respond to at least some of its recommendations (Department of Health 2021a). In the crucial area of staffing, the Morrison government committed to implementing the recommended minimum care time standard—in October 2024—of 200 minutes of care per day, including a specified proportion by a registered nurse. This is the most significant regulatory fetter on private power in the RAC market in decades.

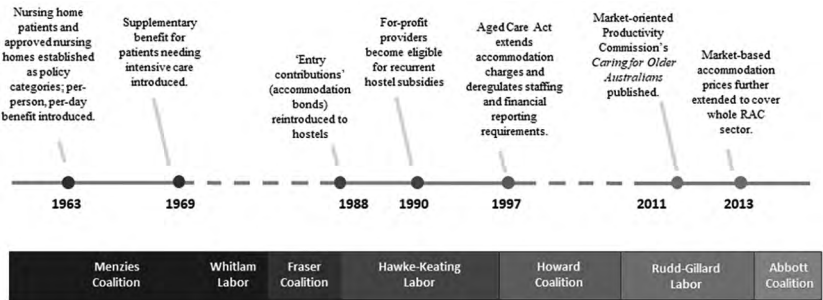
## Conclusion

The early and most recent phases of marketisation have empowered providers, while maintaining significant public funding. Profit-making and private power within the market have not been systematically problematised by policymakers as concepts of 'competitive neutrality' (between for-profit and non-profit providers) and arguments about the necessity of drawing in private capital to fund growth of the sector now have strong currency. The argument that private investment is needed to fund future property development is difficult to understand, given repayments on private borrowings are largely funded from the public purse. On its own terms, the market has failed: economists have found no evidence of increasing quality or falling prices and point to growth in the number of 'large and dominant providers that has further reduced competition and choice' (Yang et al. 2021). Meanwhile, in the face of market failure, successive revisions of systems of quality oversight do not appear to have maintained or improved service quality across the sector.

Some of the policies discussed above have been decisive in driving the development of for-profit provision in the first instance, followed by increased use of market practices in residential aged care (see Figure 6.3).



Weakly regulated subsidies offered to providers in the 1960s underpinned the growth of a large for-profit sector that, once established, sought mostly successfully to defend its position. Governments have attempted to contain the ‘institutional power’ (Busemeyer and Thelen 2020) they had seeded and ceded to the private sector with measures designed to contain costs or (perhaps less successfully) protect the interests of older people. Often these efforts have had partisan inflections. However, in recent years, confidence in market organisation of aged care and an unproblematised role for private businesses have become largely bipartisan. This does not mean governments no longer regulate residential aged care, but rather they do so in the context of the path-dependency and feedback effects of the early growth of for-profit provision.



**Figure 6.3 Timeline of decisive reforms for for-profit growth and marketisation of RAC**

Source: Based on authors' research.

That most older Australians would prefer to remain in their own homes is a foundational assumption of aged care policymakers today. On this basis, home care programs have been expanded significantly in recent years and have themselves been marketised. Yet residential care will always have an important role to play in assisting some older people. They will need skilled, compassionate care and support to live as well as they can; Australia is a rich country and our collective resources are up to the task of ensuring they get it.

## Epilogue

Market ‘solutions’ retain broad bipartisan support. However, the Covid-19 pandemic has put the government under considerable pressure to improve the quality of aged care and, along with the royal commission,

has increased the political salience of this important social service. The royal commission's recommendations call for a new *Aged Care Act* to underpin 'a system of aged care based on a universal right to high quality, safe and timely support and care' (Royal Commission into Aged Care Quality and Safety 2021a: 205). Enshrining a universal right to care would be a good start.

Part of the problem with the current system, the royal commission found, was that 'mission-based, social purpose and government aged care services have lost out to the expansion of the private sector' (Royal Commission into Aged Care Quality and Safety 2021a: 50). Accordingly, the structure of the sector (facility size and ownership) needs to become an object of policy again. The history presented above shows it is possible to drive differential growth by selectively offering support to preferred provider types. Careful design would be needed today to avoid running up against competition policy constraints. The establishment of networks of small, public facilities in regional health districts would be one good option,<sup>55</sup> rooting homes in local communities, responding to the call for more 'home-like' facilities and better enabling connections with health services.

Regulation of quality is another lever the government can pull to drive providers' behaviour. The incoming Labor government has at least partly recognised this. One of its first acts was to introduce legislation that, among other things, brings forward the implementation of the mandated minimum 200 care minutes per resident per day to October 2023, and increases daily care minutes to 215 in October 2024.

Further, the institutional power of business to resist regulatory oversight by threat of exit is not infinite. As the ABC Learning case in child care showed the exit of a large provider can be managed in an orderly fashion, especially with government support (Sumsion 2012). As with many problems in social service systems today, including weak regulatory oversight of providers external to the public sector, the loss of capacity in public organisations is one important driver (Ansell et al. 2021). Well-funded institutions of oversight with highly skilled and committed staff are more likely to be able to build genuine partnerships with providers and thereby re-establish trust within the system (Braithwaite et al. 2007). In a system where high trust is well founded, the risk of rent-seeking and

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55 See Davidson (Chapter 9, this volume) for the case for public providers in human service markets. See also Eagar (2020).

misuse of funds is diminished. Accordingly, regulatory procedures can be less burdensome, and tight oversight of providers' activities and taxpayers' and service users' funds is less likely to be necessary. In another promising action, the Labor government announced in July 2022 a 'capability review' of the ACQSC to consider whether it has the resources, knowledge and skills required to fulfil its responsibilities (Wells 2022). This is a step in the right direction.

Finally, many have pointed out how the pandemic has revealed who the real essential workers are: healthcare workers, supermarket, transport and other workers who help us all meet our daily needs, and those who look after children, people with disabilities and old people who need assistance. Yet (much like childcare and disability workers) aged care workers receive very low wages, their working conditions are typically poor, there are no mandated minimum training requirements for non-professional employees and career paths are weakly developed. In yet another promising action, the incoming Labor government has also supported aged care workers' application for a substantial pay increase that recognises the value of their work (Commonwealth of Australia 2022). Governments and employers can act to remedy these problems and thereby improve the lives of care workers themselves and the quality of care of older people.

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