Uniting

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Marketisation of social care

What have been the empirical effects?

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Introduction

This paper presents the findings of a rapid review of academic and grey literature on the empirical impacts of establishing quasi-markets in social care. It seeks to complement a discourse analysis of official documents such as reports from the Productivity Commission and Royal Commissions, undertaken by the Centre for Social Impact on behalf of the Community Services Industry Alliance.

The literature on markets and quasi-markets in social care is vast. In the interests of practicality and relevance to the sponsoring organisation, this rapid review has focussed on the effects of the two main reforms to social care which have been led by the Commonwealth government over the 2010s: the introduction of the National Disability Insurance Scheme, and the introduction of consumer-directed funding into aged care. It does not consider reforms undertaken over the same period to primary health care, or reforms to social services which are primarily provided, funded or regulated by States and Territories (such as child protection or community services).

Methods

We searched for the results of academic research and official government publications. We then reviewed these for relevant insights, based on titles, abstracts and content.

Academic literature

We searched:

- for peer reviewed journal articles published in English since 2017 (the CSI work identified a review published in that year which answered most questions in relation to reviews published in previous years; Dickinson 2017).
- using the search string *(personalisation OR personalization OR "self-directed care" OR "consumer directed care" OR "individual* funding" OR marketisation OR marketization) AND ("disability" OR "social care" OR "social services" OR "aged care") AND Australia*.
- against the full suite of bibliographic databases available from the University of Technology, Sydney (the databases returning most results were Scopus, ProQuest Central, SciTech Premium, Biological Science Database, MEDLINE/ PubMed, Taylor & Francis Online, Sociological Abstracts, OneFile and Informa - Taylor & Francis).

This returned 973 results, reduced to 126 by eliminating duplicates and reviewing titles. A review of abstracts reduced this to 54 across five themes: consumer experience, workforce, providers, systemic efficiency/effectiveness, and equity/access.

Official publications

We searched for research relating to disability and aged care on websites for the Commonwealth Department of Health (aged care), Department of Social Service (disability), NDIA, and the recent royal commissions into aged care and disability.

Findings

There is some empirical evidence of the impacts of marketisation reforms in Australia, but it varies in strength. The available evidence is:

- **Limited**. There have been relatively few robust studies and among those that have been published some outcomes (e.g. short-term client choice and control) have

received more attention than others (e.g. long-term systemic impacts). A preliminary search for literature on the impacts of reforms outside Australia and over longer timeframes (e.g. the last 20 years) shows there have been enough studies in some areas to allow for systematic reviews, but these frequently find that the quality of evidence is not strong.[1]

- **Equivocal**. Although government-sponsored evaluations and some academic studies indicate improvements in some client outcomes (e.g. satisfaction), they also suggest reform exacerbates inequities for vulnerable groups. Comparative studies and systematic reviews generally show either no clear trend across all countries or reforms, especially for systemic impacts such as reduced public social expenditure, or clear negative outcomes under certain conditions.

This is consistent with the findings of the discourse analysis undertaken by the Centre for Social Impact, which this review seeks to complement. That analysis identified four main themes running through most inquiries in Australia in the last decade, and raised the possible implication that reform might, in practice, have been quite limited in achieving the outcomes reformers hope for.

Outcomes for clients

The evidence of impact outcomes of marketisation reform is stronger in the case of client experience than other outcomes. Even here, however, the evidence varies in quality and in strength across different domains.

With respect specifically to Australian reforms, there is more detailed evidence on the NDIS than aged care. The Department of Social Service commissioned an evaluation of the trial sites (Mavromaras *et al.* 2018), and the NDIA has published a longitudinal analysis of some individual client outcomes, using data collected through the LAC program (2019). There has been no equivalent evaluation of consumer directed aged care, although there was an evaluation of proposals prior to their implementation in home and community care (KPMG 2012). Within the academic literature, there have been several systematic reviews and cross-national comparisons focussing on direct client impacts of these reforms.

There is some evidence to suggest the NDIS has, on average, improved the capacity of individual people with disability to exercise choice and control with respect to their service provider and services they receive The evaluation of the NDIS trial sites (Mavromaras *et al.* 2018) found increased satisfaction among a substantial minority (35-40%) of participants with their choice and control, that satisfaction increased over time, and that this was due to the NDIS. Around 70% of participants reported either “a lot” or “some” choice and control, and while access to supports appears to have been improved by entry into the NDIS this did not change over time. Longitudinal LAC outcomes (2019) shows similar results. The evaluation of the CDC trial found higher proportions of agreement, above 90%, but this may have been inflated the fact by the trial involved participants selected by providers (KPMG 2012).

However, evidence for the impact of Australian reforms on wellbeing and life outcomes is less clear than for choice and control. Both sources on the NDIS, cited above, note that people with disability typically report poorer wellbeing, and have poorer health and life outcomes, than others. The evaluation found modest improvements in generalised

[1] It should be noted that the NDIA and Department of Health, as the public authorities overseeing the two reforms on which we focus here, are publishing an increasing volume of data on the these reforms. This is an incredibly important and relevant source of information. However, we do not examine it explicitly here because we focus on the results of analysis rather than raw data.

wellbeing as a result of participating in the NDIS (around 6%). LAC data present a mixed picture of life outcomes across domains. Around three quarters of respondents reported that the NDIS has helped with choice and control and activities of daily living; two thirds with social connectedness, health and wellbeing, and participation. Between a third and a fifth were positive about its impact on housing, education and work. There are several possible reasons for this mixed picture. Choice and control are shorter-term outcomes, and the causal connection between marketisation reform and satisfaction is more straightforward. Wellbeing, on the other hand, is a more complex concept, which is likely to change more slowly and to be influenced by factors other than marketisation reform.

Academic studies of international experience present a similar picture to government-commissioned reports: broadly positive results, with caveats around the strength of evidence. The evidence is most extensive in relation to the USA and the UK, with some systematic reviews also encompassing on Western Europe and the Westminster countries. A systematic review of personalised budgets for people with mental health problems (Webber *et al.* 2014) found "mostly positive outcomes in terms of choice and control, quality of life, service use and cost-effectiveness", but that available studies were of generally low to moderate quality. A Campbell Collaboration review of 73 programs worldwide found positive effects on "quality of life, client satisfaction and safety [and some evidence of] fewer adverse effects. There is less evidence of impact for physical functioning, unmet need and cost effectiveness" (Fleming *et al.* 2019).

One area where the academic literature goes further than government evaluations is in identifying the causes of variation in client outcomes. There is a significant body of literature on the importance of factors relating to service providers and the structure of the service system. These include relationships with paid and unpaid supports, and capacity within support organisations (Fleming *et al.* 2019), which matter in part because personalised budgets require "independent advice and support services, and confident, well-informed and trained staff" (Carr 2013). Systemic factors also matter, such as funding policy ("austerity") and the structure of state regulation. are identified as either barriers to client outcomes when poorly designed, or invisible when working effectively (Payne and Fisher 2019). This is relevant not just to explaining varying outcomes for clients, but for the Centre for Social Impact study which this review is intended to support: it suggests that opinions of those in the system, as recorded in inquiries, may be skewed towards identifying shortcomings and failures in institutional settings. Finally, there is also some evidence that effects are mediated by client factors, including knowledge, and acceptance-oriented behaviour driven by vulnerability (Gill *et al.* 2018).

Outcomes for social care workers

The literature identified in this review suggests social care workers mostly experience marketisation reform as negative, because of its impact on the employment conditions of the workforce as a whole. This is somewhat offset by neutral or positive impacts in their relations with clients.

The negative impact on employment conditions and labour market status emerges very clearly from academic studies of contracting out, privatisation and other similar reforms. For example, one review of 26 studies published between 2000 and 2012 found "both positive and negative effects for employees documented in the literature, although with a predominance of negative effects, including reductions in the workforce and other changes in the workforce composition such as the replacement of experienced employees with younger workers, poorer working conditions, lower salaries, fewer benefits, and reduced job satisfaction" (Vrangbæk *et al.* 2015). This is consistent with more recent studies from the UK, showing that austerity and marketisation can easily be experienced

as attacks on professionalism (Kirton and Guillaume 2019; Diaz and Hill 2020), and create practical and ethical challenges for individual workers in their relationships with clients due to the fragmentation of the service system (Higgs and Hafford-Letchfield 2018).

The evidence specifically on Australia paints a similar picture. The government-sponsored evaluation of the NDIS trial found that people working in the disability sector initially had positive expectations and experiences, based particularly on the opportunities for specialisation, flexibility and increased work (Mavromaras *et al.* 2018:Chapter 3). The trial of consumer directed aged care found similar optimism about the opportunities to be innovative and flexible in meeting client needs (KPMG 2012Section 8.3). However, over time the views of workers in NDIS trial areas became more negative, driven by concerns over casualisation, high workloads, inadequate training and other conditions. The evaluation specifically noted that this contrasted with conditions in the aged care sector. The evaluation also noted challenges in providing high quality care which arise at the intersection of care systems – in this case, the disability and aged care systems.

Academic studies also identify challenges and opportunities in the process of transition to a marketized environment. A small-scale study of workforce skills found that the NDIS requires different skills from the previous system, particularly regarding person-centred care and task-oriented service delivery, leading to skill gaps and requirement for training (Moskos and Isherwood 2019). Another small-scale qualitative study of staff experiences of consumer-directed aged care in Australia care found people varied considerably in the extent to which they perceived a shift in (power) relations with clients (Payne and Fisher 2019), with some reporting a significant shift towards consumer-directed behaviours and others reporting no change. This suggests complex patterns of persistence and change, likely mediated by organisational structures and cultures within providers.

Impacts on service providers

Marketisation reforms also affect the structure and operations of organisations providing care, and these changes are distinct from impacts on individual care workers and the care workforce.

Internationally and over the long term, not-for-profit organisations have become more “business-like” over the era of neoliberalism (Maier *et al.* 2016). This is a complex phenomenon, and clear trends are not always evident. specific changes range from adopting business-like language internally and externally, without substantial change to culture or operations, through to adopting organisational forms from the for-profit sector (corporatisation, marketisation, professionalisation) or commercial goals (commercialisation). There are some common consequences of this suite of reforms when viewed internationally, including an increase in reliance on philanthropic funding and consumer contributions over public funding (Cortis 2017),[2] an increase in formalised/standardised approaches to service delivery, and downward pressure on pay and conditions for front-line staff (O'Rourke 2020). The specific causal mechanisms by which neoliberalism leads to these outcomes also vary: they may be a direct and inherent result of marketisation reform, but some studies suggest ideological diffusion/isomorphism and rational adaptation to funding constraints and opportunities as relevant factors. The effect of neoliberalism can also be reinforced by reforms which are conceptually distinct but often accompany it, notably austerity.

Evidence from Australia confirms that marketisation in disability and aged care has played out in broadly similar ways here. The evaluation of the NDIS trial sites identified a “move

[2] The paper notes that inequities in access to these alternative sources of funding has implications for broader questions of social equity.

to more market-driven business practices and the entry of new providers in the NDIS trial sites" (Mavromaras *et al.* 2018:Chapter 3). It reported both positive and negative anecdotes on the impacts of this, ranging from admiration for entrepreneurial activity on the one hand, to a dissatisfaction with inflexibility and an increased focus on cost-recovery for once-free services on the other.

However, Australian academic studies suggest that the causal mechanisms connecting reform with these impacts are distinctive. It is not clear that austerity as such is a factor under the NDIS, for example, because overall funding at the macro level has not decreased significantly. However, the NDIS has combined uncertainty over long-term funding under the transition(Furst *et al.* 2018) with a significant increase in the administrative burden for individual providers, to raise significant concerns over financial sustainability (Carey *et al.* 2020a). There is also evidence of dissatisfaction among providers with central pricing mechanisms under the NDIS, which do not take sufficient "account of the actual context of service delivery (e.g. the actual costs interconnections between service activities that are priced separately) and are insufficiently flexible" (Carey *et al.* 2019b). In other words, providers believe prices as set by the NDIA are unrealistically low.

In addition, Australian studies also point to certain effects of reform which do not sit neatly in the "neoliberalism leads to providers becoming more businesslike" paradigm. These relate particularly to innovation and collaboration. One commonly-citied benefit of marketisation and personalisation is that it will encourage providers to be innovative in the sense of more flexible in their offering. The evaluations of both the NDIS and consumer directed aged care found evidence of increased flexibility in front-line service delivery, and (as noted above) some instances of entrepreneurialism in response to the opportunities presented by the NDIS. NDIA market data suggest a degree of competition between providers, with a relatively stable mix of large and small organisations and sole traders.[3]

However, there is also evidence that collaboration persists. A study of how providers were adapting to the transition found elaborate and differentiated networks were actively sustained between organisations as a form of mutual support (Malbon *et al.* 2019). Government remains a key figure in these networks of collaboration, and may even be a crucial partner in fostering some sorts of innovation (cf. Henderson *et al.* 2019, which focuses on Scotland). This suggests that there may be at least two kinds of innovation at work. One arises directly from marketisation, and emphasises product innovation and flexibility. The other occurs despite marketisation. It involves sustained collaboration and the development of new (especially integrated) services and models of service. This is not only contrary to the logic of the market, but requires relationships and capabilities (Taylor *et al.* 2020) that smaller, leaner or more commercially-oriented providers may not have the resources to develop. This matters, because sustained collaboration-style innovation are associated with improved outcomes for clients (Calò *et al.* 2018),.

Systemic social and financial impacts

In addition to having impacts on individual clients, care workers and providers, marketisation reform also has impacts at the level of society as a whole. These include impacts on public budgets (primarily overall levels of expenditure and the kinds of services on which money is spent), and equity issues (i.e. the distribution of access and outcomes among those who need support services).

[3] https://data.ndis.gov.au/reports-and-analyses/market-monitoring

Overall levels of spending

Evidence for the impact of reform on overall levels of expenditure is mixed, and surprisingly weak given its economistic roots. There are no clear impacts on social expenditure at the national level from a cross-national perspective.

Over the short run, this is partly because it is difficult to disentangle the impact of reform as such from other fiscal decisions such as austerity. With respect to Australia, data published by the Productivity Commission in the *Report on Government Services* show total real per capita government expenditure on aged care and disability services in Australia increasing as a proportion of GDP over the 2010s; the NDIS will result in a significant increase in spending on disability once fully implemented (Miller and Hayward 2017). Other countries follow different trajectories for idiosyncratic reasons. OECD data show a dramatic decrease in the UK in the early 2010s under austerity, for example.

Over the long run, there is no evidence at all for the fiscal impact of reform in Australia, largely because there has not yet been sufficient time for evidence to accrue. Attempts to assess the net impact of similar reforms in other jurisdictions have been hampered by the difficulty of capturing implementation costs and finding comparison groups (Dickinson 2017:6). Systematic reviews of other kinds of neoliberal reform – such as contracting out of services – suggest that achieving value for money is mediated by institutional structures of the environment in which it is implemented (Torfing *et al.* 2017). Factors include the nature and degree of competition/collaboration between service providers; the degree of support for reform from politicians, employees, and end-users; the opportunity for flexible adjustment of contracts and the building of trust and mutual learning; the competencies and capacities of contractors; and the nature of monitoring of performance.

There is some evidence that personalised budgets may lead to lower expenditure at the individual level. Dickinson (2017:7) cites studies from the UK and New Zealand that show decreases among those on higher care packages, implying that these are the result of incentives inherent in personalised care, but notes that robust conclusions are difficult because of methodological issues and suggests the overall evidence is equivocal.[4] Individual incentives are not the only possible mechanism at work: one study of the NDIS suggests that prices were deliberately set "too low to cover the full costs of disability support" as a form of cost containment (Cortis *et al.* 2018).

What money is spent on

There is some evidence that marketisation reform may lead to a shift in the activities to which funding is allocated. To some extent, this is an intended and reasonable result of transforming clients into customers, and giving them control over how money is spent on their support and care. The evaluation of the NDIS trial provides anecdotal evidence of the emergence of new services in direct response to client needs and preferences, such as disability-specific travel agencies. However, the shifts in expenditure are not always obviously efficient or in the customer's best interest. On a per-client basis, English studies suggest that the amount of time allocated to needs assessment compared with client care may increase (Dickinson 2017:7). In addition, management of individual care packages brings administrative burdens and transaction costs, which may lead either to increased expenditure or be absorbed by clients or care workers as unfunded activity.

[4] She also quotes the UK National Audit Office stating that individual savings are not the intent of the reform, but rather improved outcomes. This reinforces the point made by the Centre for Social Impact's discourse analysis, that the various rationales for reform may not be internally self-consistent.

Within provider organisations, Cortis *et al.* (2018) draw a direct link between low prices under the NDIS and downward “pressure on relationship-building and other tasks required for high-quality care”. This may be related to the finding of a cross-national study of for-profit nursing homes in Canada, Norway, Sweden, United Kingdom, and the United States, which found that they had higher rates of sanctions under quality standards (Harrington *et al.* 2017). This implies a structural incentive to under-invest in quality control mechanisms to prevent sanctions, and to factor in sanctions for quality breaches as a cost of doing business in marketized environments.

Equity

There is considerable evidence that marketisation reform has negative impacts on equity of access to services and of outcomes.

There is direct evidence for this in the Australian context. Both the main sources on the empirical effect of the NDIS both suggest individual benefits were not evenly distributed among all people with disability. The evaluation of the NDIS trial found that around one fifth of participants believed they had little or no control, and did not experience any improvement in this as a result of the NDIS (Mavromaras *et al.* 2018). Furthermore, it found this varies for different groups. It is lower for people with intellectual and mental/psychosocial disabilities, for carers and family of adults with disability, and for people living in regional and rural areas (although the difference is not always statistically significant). The evaluation also showed that improved wellbeing varied with primary disability type (it was lower for people with intellectual and mental/psychosocial disabilities). There was also no statistically-significant improvement for participants aged 8-15 or for carers/families. Longitudinal data from the NDIA (2019) shows that, while proportions agreeing the NDIS has helped are increasing across all outcome domains over time, respondents were more positive if they had used more of their plans, were older or lived in larger population centres. Market data published by the NDIA suggest the persistence of variations in market structure and outcomes between regions.[5]

This is consistent with the academic literature. A recent study of the NDIS found that the system itself is contributing to the inequitable distribution of choice and control (Carey *et al.* 2019a). This appears to be an inherent feature of markets; marketisation has been found to exacerbate health inequities for people with disability (Sakellariou and Rotarou 2017). More particularly, “private insurance and out-of-pocket payments as well as the marketization and privatization of services have either negative or inconclusive equity effects” for the population at large (Bambra *et al.* 2014). These market failures arise in a number of ways, which are widely discussed in both the popular and academic literature. They include:

- insufficient capacity, especially in regional and rural areas (Kullberg *et al.* 2018), due to high costs or lower/uncertain revenues (Jacobs and Lawson 2019);
- failure to meet the needs and preferences of specific cultural communities (Bernstock 2006; Adibi 2020) usually due to a combination of lack of cultural understanding, service inflexibility and insufficient demand;
- organisations cherry picking of “profitable” clients as a commercial strategy (Greer *et al.* 2018), leaving those with more complex or less profitable needs under-served;
- labour market shortages (Miller and Hayward 2017), which may be due to fiscal decisions around pay levels, labour market uncertainty. or regulatory barriers such

[5] https://data.ndis.gov.au/reports-and-analyses/market-monitoring

as the cost of registration and compliance (see also “Outcomes for social care workers” above); and
- the challenges which vulnerable people – including the elderly and people with disability – face in playing the role of consumer as required by neoclassical economic theory (Hall and Brabazon 2020), for reasons which include cognitive capacity, access to appropriate information, and learned acquiescence.

Systemic institutional issues

It is clear from the Centre for Social Impact’s discourse analysis that the proponents of marketisation are aware of the negative consequences of these reforms. This can be seen in the common resort to “stewardship” – which amounts to the claim that the state should continue to regulate, in order to avoid market failure and ensure desired outcomes. However, as the discourse analysis also notes, “stewardship” does not appear to be precise or coherent concept, but rather a rhetorical device to answer these critics.

The concept of stewardship does, however, have some empirical foundation ,in the sense that comparative studies clearly identify the influence of state structures and activities over outcomes. Many of the cross-national studies cited above find that the effects of reform are “inconclusive” overall. One example is Bambra *et al.* (2014) cited earlier, which also found that the “health equity effects of managed care programs or integrated partnerships between health and social services is inconclusive”. This does not imply they had no effect, but rather that their effect varies depending on the context in which they are implemented. The “welfare state [itself] determines and mediates the extent of inequalities in health through healthcare, social policy and public health” (Pfaff and Elgar 2019). In other words, the state matters, even to the success of reforms which are ostensibly about reducing its involvement.

Unfortunately, there is little empirical evidence on the specifics of how to do stewardship well (Carey *et al.* 2020b). Rather, as noted earlier, funding and regulatory matters usually only become an object of discussion when they work badly (Greig 2019). This is an area of emerging research, and may be a fruitful area for collaboration between service providers and academics. Possible areas for further investigation include:

- managing the intersection between markets and systems of care (e.g. aged care, disability services, mainstream health and education services);
- funding, particularly as it relates to spatial inequities and labour markets;
- quality and innovation, both of which require levels of investment which are beyond the reach of smaller providers or those operating on thin margins;
- oversight and accountability, whether from regulators or inquiries, can add significantly to costs in ways which are often not costed; and
- advocacy, both for individuals and by mission-driven organisations, is often seen as incompatible with market relations by reformers but is crucial to ensuring vulnerable people are able to contribute to decision-making in their communities.

Conclusion

This paper presents the findings of a rapid review of academic and grey literature on the empirical impacts of establishing quasi-markets in social care. It has focussed particularly on the two main reforms to social care which have been led by the Commonwealth government in Australia over the 2010s: the introduction of the National Disability Insurance Scheme, and the introduction of consumer-directed funding into aged care. But it has also considered systematic reviews which cover other jurisdictions and time periods, to better understand the nature of impacts here.

Overall, the evidence presented here suggests that marketisation probably achieves one of its core purposes: to improve client satisfaction with the services they receive, and choice and control over those services.

However, this positive finding must be set against a number of less positive findings. At the individual level, improvements in outcomes are not distributed equitably; there is also less compelling evidence that reform improves wellbeing in the broader sense, or over the longer term. For care workers, there are new opportunities for entrepreneurial activity but these two may not be equitably distributed and must be set against significant disruption in industrial conditions and the emergence of significant skill gaps (which it may be very difficult for individuals to address over the short term). Care providers also face significant disruption during the transition to a market. Once established, there appear to be some inherent challenges for any organisation seeking to differentiate on the basis of quality. These include structural disincentives to collaborate with other providers (despite this being associated with improved outcomes for clients), and the lack of a margin to invest in transformative innovation. At the structural level, there is limited evidence that marketisation reduces overall expenditure. There is, however, considerable evidence that it likely leads to increased expenditure on individual needs assessment, and to inequities such as thin markets in rural areas and under-servicing of certain client groups (such as those with complex needs, or from culturally or linguistically diverse backgrounds).

Overall, the evidence is mixed but the picture which emerges is of a reform that achieves its immediate goals, albeit at considerable cost in ways which advocates of reform may have difficulty recognising as significant.

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