
5 Quality and choice

Key points

- A growing and increasingly diverse cohort of older Australians are expected to demand higher quality aged care services and greater choice in the services they consume. In particular, pressure to improve these dimensions of Australia's aged care system is likely to come from those with the means to contribute (in part or in full) to their care needs.
 - A range of stakeholders have raised concerns about the capacity of the aged care system to respond to these challenges.
- Pressure for publicly funded goods and services to be more responsive to consumer preferences is not unique to aged care.
 - Over the last two decades, reforms across a wide range of industries have sought to strengthen the role of consumers through removing regulatory constraints on choice and competition.
- Various models of consumer centred aged care have been introduced overseas to strengthen the role of the recipients of aged care services.
- While acknowledging the limitations of directly transposing overseas experiences to Australia, the broader benefits of allowing older people to influence the nature and scope of the aged care they receive include:
 - greater autonomy and feelings of independence
 - decreased unmet needs and care related health problems
 - increased satisfaction with overall care arrangements and life more generally.
- If the public debate in Australia about the merits of alternative consumer centred care arrangements is to contribute to the development of more effective aged care services, it needs to address five key issues:
 - user preferences and decision-making capacity
 - the scope of services included in any arrangements
 - implications for regulatory settings covering, for example, information and quality assurance
 - the nature of the market for aged care services
 - the role of experimentation and trialling.

The nature and composition of aged care in the future is being inexorably shaped by two emerging trends: the growing diversity of the aged population and their expectations of greater choice in the availability of services; and a growing capacity for some older people to self-fund a greater part of their retirement needs (including for aged care) (chapter 3).

This chapter briefly explores the role of quality and choice in aged care, identifies recent initiatives aimed at improving these dimensions of service and examines some ideas and measures designed to further enhance quality and choice that have been advanced in Australia and overseas. It also highlights the need for continuing analysis to identify and aid the process of improving quality and choice in aged care services.

5.1 The role of quality and choice

Quality in aged care can be defined as the degree to which services match needs and preferences (SCRCSSP 1995). This broad definition encompasses both the ‘quality of care’ and the ‘quality of life’ dimensions of aged care. Although not clearly specified, ‘quality of care’ is generally considered to be the degree to which services support desired health and personal care related outcomes consistent with current *professional knowledge* (Podger and Hagan 1999). In contrast, ‘quality of life’ reflects the extent to which an *individual* perceives themselves able to function physically, psychologically and socially (DoHA 2004b). Quality of life is harder to define because of its subjectivity, although older people are able to discuss and define their own quality of life (Leeson, Harper and Levin 2003). Within aged care, quality of care is often viewed as an element of quality of life, together with a variety of other elements.

The Australian Government has instituted a quality assurance framework to ensure that older Australians receive quality aged care. The *Quality of Care Principles 1997* outline standards that cover the quality of care and quality of life dimensions of both residential and community aged care (table 5.1).

The Australian Government aims to ensure a minimum level of quality of services (through accreditation) and of facilities (through certification) (chapter 2). The associated standards have been specified to secure a minimum (or benchmark) prescribed level of service that is deemed adequate by society. Although broad in coverage, these standards may not meet all the needs and preferences of recipients. However, enhanced opportunities to exercise personal choice from among the range of services offered by aged care providers would give clients greater scope to tailor services to their individual needs and preferences.

Table 5.1 Quality of care and quality of life standards

<i>Community care</i>	<i>Residential care</i>
<ul style="list-style-type: none"> • Information and consultation • Identifying care needs • Coordinated, planned and reliable service delivery • Social independence • Privacy, dignity, confidentiality and access to personal information • Complaints and disputes • Advocacy 	<ul style="list-style-type: none"> • Health and personal care • Resident lifestyle • Management systems, staffing and organisational development • Physical environment and safety systems

Source: Quality of Care Principles 1997.

For the purposes of this study, service offerings include assistance with personal activities (such as self-care, mobility and communication), other everyday activities (such as housework, meal preparation and property maintenance), accommodation services (in the case of residential care), nursing services and palliative care.

Consumer choice involves clients being able to choose between services that are differentiated to some degree, including in relation to:

- the type of accommodation in which the care services are located (including private homes, assisted living environments and residential aged care facilities)
- provider type, whether for-profit or not-for-profit (such as religious, charitable, community based or government service providers)
- flexible arrangements for the payment of services (such as periodic and lump sum charges/bonds)
- quality above the benchmark standard (such as the provision of extra care services in residential care facilities)
- ‘menu of service’ options enabling providers to customise services to meet the specific needs and preferences of older people.

As outlined in section 2.5, the Australian, State and Territory Governments regulate the quality of residential and community aged care services to protect consumers’ interests.

‘Ageing in place’ is a key feature of the regulatory framework. This initiative provides older people the choice of ageing in a familiar environment as they require higher levels of care instead of, for example, needing to transfer between residential care facilities. The introduction of the *Aged Care Act 1997* created the opportunity

for providers to provide a wider continuum of care, by removing the legislative and administrative barriers that had prevented this in the past.

Quality assurance framework

In residential care, quality assurance standards cover both outputs (for example, ‘all residents are as free as possible from pain’) and inputs (for example, ‘management and staff have appropriate knowledge and skills to perform their roles effectively’). The building certification process aims to improve the physical quality of subsidised residential aged care facilities. After 2008, only providers that have met the higher building standards that address resident safety and privacy can receive concessional resident supplements and/or collect accommodation bonds or charges (*Certification Principles 1997*, s. 8.13). As at September 2007, all aged care facilities satisfied current safety requirements and more than 93 per cent satisfied the privacy requirements (ACAA 2007d). Service providers can elect to provide services that exceed the minimum standards, including through the provision of extra service places.

Further, the residential quality of care standards outlined in the *Aged Care Principles* are also subject to a comprehensive system of continuous improvement designed to lift service performance for each of the four residential standards listed in table 5.1. This means that:

... there is no ceiling to the level of quality. It is not just about meeting standards when standards have been met, the quality of service can always be improved. Even when excellent care and services are already being provided; applying the principles of continuous improvement is a matter of ‘raising the bar’. (ACSAA 2006, p. 8)

In community care, organisations providing CACP, EACH, EACHD and NRCP services must meet the standards specified by the *Aged Care Act 1997*, including the standards listed in table 5.1. This involves preparing a report on their systems for delivering quality services once every three years, undergoing desk audits and facing validation visits. In addition, providers must also report to the Department of Health and Ageing on their systems for continuously improving the quality of their services, such as quality control procedures, benchmarking activities, surveys and document-based reviews (DoHA 2005e).

The Australian, State and Territory Governments also use an agreed set of standards to regulate HACC service quality — the Home and Community Care National Standards Instrument and Guidelines (HACCSWG nd). These standards define service quality and indicate expected outcomes in all agreements between providers and government.

In addition to care and accommodation standards, the regulatory regime can also affect quality — that is, the degree to which services support desired outcomes — through the design of provider subsidies, controls over the supply of new places, restrictions on eligibility for care and controls over user contributions (PC 2003).

5.2 Recent initiatives to improve quality and choice

In recent years, the Australian Government has introduced a range of initiatives directed at improving quality and choice in residential and community care. A more detailed overview of these initiatives is provided in appendix A. Broadly speaking, initiatives directed at enhancing quality and choice have largely revolved around broadening the service mix and supporting innovation in service provision.

Broadening the service mix

Several of the Australian Government's key initiatives in this area have been aimed at widening the community care options that substitute for residential care to accommodate preferences for home based care. CACPs as an alternative for low level residential care were introduced in 1992-93. EACH packages for the equivalent of high level residential care were introduced in 2002-03 and expanded to cover high level care dementia sufferers in 2005-06. To date, the substitution of community for residential care has been greater for low level residential care.

The Government has also sought to enhance choice by extending extra service places to low level residential care to provide access to higher standard accommodation, improved food and other services. The Multipurpose Services Program has been used to enlarge the care options available to people living in small and remote communities by integrating and coordinating services across aged, health and community service programs. The Transition Care Program was introduced to aid older people with rehabilitation and other services after a hospital stay to avoid premature admission to a residential care facility. These initiatives have been accompanied by moves that improve access to information services so that clients can make informed choices regarding the range of services available to them.

Supporting innovation in service provision

A variety of trials and pilots have been used to facilitate experimentation in the design and delivery of aged care services under the Aged Care Innovation Pool which was established in 2001-02. Areas targeted under this initiative include

improving the interfaces between aged and hospital care, aged care and disability services, the provision of aged, health and community services to older people in rural and remote areas and the provision of aged care services to people with high care needs such as those suffering from dementia.

5.3 Demand for greater quality and choice

Quality control becoming increasingly important

Quality control in aged care is becoming increasingly important, with industry leaders and other stakeholders raising several key issues, namely: the expectation of greater satisfaction in service provision, the ongoing public concerns regarding the quality of residential care and the increasing reliance on community care. At issue is the adequacy of existing standards; the challenges governments face in monitoring service quality and achieving acceptable compliance with prescribed standards; and the challenge of adjusting standards to reflect changing community expectations over time.

There can be difficulties in interpreting and applying existing standards relating to quality of care and quality of life. For example, in relation to residential care, UnitingCare Australia (2003, p. 8) recommended that ‘adequate definition of required benchmarks of quality care and of quality of life be established as a first step in determining the product’.

Service providers have also highlighted the variation in standards between community care programs as an ongoing problem. There have been calls for a single set of standards for all community care programs, including a standard quality reporting framework, to reduce the level of red tape in community care (ANHECA 2004; ACS SA & NT 2007).

Other stakeholders have pointed to shortcomings in the standards arising from changing community expectations (Access Economics 2003; UnitingCare Australia 2003). For example, Access Economics has questioned the widespread use of chemical and physical restraints in dementia management by advocating that:

... firmer accreditation and monitoring of standards are required with tighter restrictions placed on chemical and physical restraint practices and more emphasis on person-centred care. (Access Economics 2003, p. v)

More broadly, the adequacy of existing quality assurance and regulatory mechanisms has been called into question following a number of well publicised incidents that have occurred in residential aged care facilities. In the case of

community care, concerns have been raised regarding difficulties faced by agencies in monitoring the interaction of workers with clients in their own homes (Kendig and Duckett 2001). This is a particularly sensitive issue where it involves care for older people with cognitive impairments.

Compliance is also an ongoing challenge, prompting renewed interest in examining the incentives faced by individual service providers. Many commentators argue that providers might be forced to skimp on care quality if funding is inadequate (Kendig and Duckett 2001; ACSA 2003b; ANF 2003; ANHECA 2003; NACA 2007a). Although continuity of government funding is already tied to maintaining satisfactory quality assurance, some observers note that providers not meeting minimum standards are unlikely to be forced out when there is a shortage of alternatives (Hogan 2008).

Pressure for more choice and flexibility

The pressure for more choice and flexibility in aged care services is likely to continue. As Kendig and Duckett (2001, p. 67) conclude in reviewing directions in aged care, 'ensuring consumer responsiveness and satisfaction is going to be an increasingly important component of the next generation of aged care policy'. This is largely due to baby boomers having a strong preference for independent living arrangements, a desire for greater control over the services they consume and higher levels of income and wealth (on average) with which to exercise choice.

Changing accommodation preferences of older people

Baby boomers are more mobile than previous generations with many seeking new 'lifestyle' experiences, often accompanied by a change in accommodation to low-maintenance home units and retirement villages (Kendig and Bridge 2007). Indeed, there is already considerable diversity among 'retirement villages' specifically designed to cater to the over 55s, including exclusive lifestyle resorts.

The growth in retirement villages has had knock-on effects for community based aged care services. Many retirement village residents are 'ageing in place' with some receiving HACC, CACP or EACH services to remain independent for as long as possible. Interestingly, many retirement villages form concentrations of older people providing scope for potential efficiency gains in delivering community care services (RVA 2007). These developments are likely to add to the pressure for further enhancements to existing programs or alternative service delivery and care models.

Desiring greater control

Baby boomers generally prefer to exercise greater control over their own lives and are likely to expect greater involvement in tailoring services to their needs and preferences (Ergas 2006; Quine and Carter 2006; Fujitsu Australia and New Zealand 2007).

These preferences and expectations are common in other developed countries. As pointed out by Felbo and Kahler (quoted in Leeson, Harper and Levin 2003, p. 47) in relation to the Danish experience, older people ‘will experience a greater degree of satisfaction if they are given more choice and more control with regard to the services they receive from the public sector’.

In part, this reflects baby boomers becoming more accustomed to having more choice across a wider range of goods and services than previous generations. Commenting on this, Dowding and John (2008, p. 12) observe:

In virtually every area, the private sector offers more options than in the past and so people might come to expect choice from the public sector too — and making the choice experience more common across all social groups.

At issue here is the extent to which current regulatory and institutional arrangements impede offering effective choices to consumers.

Greater capacity to exercise choice

A greater capacity to exercise choice is also likely to accompany baby boomers’ preferences for more choice and control. They are entering retirement with historically high levels of net wealth (chapter 3). Nevertheless, there is great variability in affluence and, as such, the demand for aged care services is likely to reflect this. While some will be satisfied with accessing the minimum available package of services, others will desire, and be prepared to pay for more.

Many also believe that collectively, older people are likely to be more demanding in the future because of their numerical strength, growing representation and lobbying capacity. Although Bernard and Phillips (1998) contend that older, especially retired people have little social power, UnitingCare (2001, p. 6) maintains that their increasing numbers ‘is very likely to make older Australians a potent political force when combined with the Baby Boomers’ propensity to speak up for themselves’. As Dychtwald and Flower (1990, p. 19) contend, ‘At each stage of their lives, the needs and desires of the Baby Boomers have become the dominant concerns.’

Existing constraints on choice and flexibility

Many commentators, including the Hogan Review (2004), the House of Representatives Standing Committee on Health and Ageing (HRSCHA 2005) and the Senate Community Affairs Reference Committee (SCARC 2005) as well as submissions¹ to the current *Review of Subsidies and Services in Australian Government Funded Community Aged Care Programs*, maintain that Australia's aged care system is constraining choice in a number of areas. Excessive and/or poorly designed regulation can inhibit innovation and quality improvement linked to the provision of choice and flexibility. As the regulatory framework differs between residential care and community care, it is useful to look at the impacts separately.

Constraints in residential care

Capacity utilisation associated with the bed licensing system has always been high and is currently around 95 per cent (AIHW 2008d). This affects the nature of care in two key ways. First, quality suffers because, except in extreme cases, providers not meeting minimum standards are unlikely to be forced out because the shortage of alternative facilities for residents makes moving affected residents difficult (Hogan 2008). Second, consumer choice (and provider responsiveness) is constrained because the bed licensing arrangements and associated high levels of capacity utilisation restrict competition in the aged care 'market'.

The regulated pricing regime also restricts the scope for consumers to exercise choice. There is little scope to add clients' funds to those publicly available in order to tailor prescribed care and services to meet their own needs and preferences (Kendig and Duckett 2001). Although extra service places may, for example, offer residents larger rooms and a wider choice of meals, this does not mean that higher levels of care or enhanced quality will be provided (DoHA 2006d).

While residents' fees can be negotiated with providers, the prescribed maximums combined with limits to the types of care and service that can be provided suppress the providers' ability to differentiate their services. According to Hogan (2007, p. 10):

... providers of aged-care services must adhere to the schedules or expose themselves to challenge. There is no allowance for the flexibility which should naturally arise from individual needs.

¹ See, for example, AIHW (2007g), Alzheimer's Australia (2007), Carers Australia (2007b), Ethnic Communities' Council of Victoria (2007), UnitingCare Ageing NSW.ACT (2007), and Victorian Government (2007).

That said, extra service places have been introduced to provide wider choice, although there has only been limited take-up of these places. The supply of extra service places has, in aggregate terms, remained well below the cap of 15 per cent of all licensed beds (appendix A). While the national data might suggest muted demand for these services, they mask considerable variation at a local level. In a recent survey, around one in five providers indicated that they would apply for as many extra service places as they could get, if there was no cap in place (WestWood Spice 2003). Indeed, WestWood Spice (2003) reported that a number of providers had extensive waiting lists at a regional level and that providers' own market research has indicated that there is demand for more of these places in some regions.

The regulations covering the management of accommodation bonds can also impede residents' freedom to exercise choice, including opportunities to transfer between residential aged care facilities.

Although accommodation bonds follow clients transferring between facilities, the Hogan Review (2004, p. 25) raised concerns that 'access to care may be based not so much on need as the size of the bond and the length of time the bond will generate income from retention amounts'. Specifically, the five-year limit on retention payments means that a provider's income stream from a relocatee's bond is potentially lower than that of a first-time resident (Hogan Review 2004). This concern is likely to be exacerbated when there are high residential occupancy rates and when asset prices are rising (thereby affecting the potential size of accommodation bonds).

Inconsistent funding arrangements between residential and community care programs have also been identified as limiting consumer choice over preferred care settings (Stone 2000; Bruen 2006). Given that community care recipients are almost entirely responsible for accommodation and 'hotel' costs, some older people are 'virtually forced to enter residential care in order to get an accommodation subsidy' (Kendig and Duckett 2001, p. 71). There remains a financial bias towards residential care that stifles competition between providers in the areas of accommodation and living options (PC 2003).

Constraints in community care

Rigid program guidelines and inadequately managed linkages across aged care and health programs mean that preferred care arrangements can be disrupted. The effects can be wide ranging, impacting on both residential and community care services as well as their interactions with HACC and other services interfacing with aged care.

For many community care recipients, interacting with multiple and sometimes overlapping community care programs can limit their choice and flexibility. Although such a system has the potential to provide enhanced flexibility (AIHW 2007g), the current fragmented funding and delivery arrangements inhibit the provision of continuous care and impair adaptation to changing care needs. For example:

- many clients and carers are reluctant to move from HACC to CACP because of higher user charges, loss of continuity in care with known providers and loss of eligibility to other subsidised programs (COTA 2007)
- rigid program rules and guidelines have created a gap in subsidy levels between CACP and EACH packages that prevents providers from offering appropriate care as clients' needs change (Alzheimer's Australia 2007; UnitingCare Community Aged Care Network 2007)
- some of the neediest people are missing out on services altogether because some programs are funded for limited periods and/or they are ineligible for programs that are tightly targeted in terms of location or specific needs (Eastern Sydney Home and Community Care Forum 2007).

Inadequate transport services have also been identified as an important factor constraining older people's access to a wide range of other age related services, including community services, social activities, general practitioners and health services more broadly (Carers Australia 2007b; UnitingCare Community Aged Care Network 2007; SCCA 2008). According to the latest ABS Survey of Disability, Ageing and Carers (ABS 2004b), older people were most likely to report inadequate transport assistance as an area of unmet need in 2003. The importance of this issue was underscored by the recent report of the House of Representatives Standing Committee on Health and Ageing which concluded that appropriate transport systems for older people were 'not optional but essential' (HRSCHA 2005, p. 55).

Many older people lack information about the range of community care services potentially available (Allen Consulting 2007). To address this shortcoming, the Australian Government commissioned the Access Points project in early 2007. The project aims to simplify entry and access to community care services for clients and carers across the broad range of programs including interfaces with other sectors such as primary care, acute care, residential aged care and disability services (DoHA 2007b). However, the way older people access aged care services varies markedly across Australia and any new initiatives directed at improving consumer choice need to consider appropriate information requirements.

Past experiences in enhancing choice

Pressures to strengthen consumer choice are not unique to aged care, but have been central to developing a stronger client focus in a range of other industries both in Australia and overseas.

Australia's reform experience

Enhanced choice through greater consumer involvement in the design and delivery of disability services has been a feature of services in this sector since the mid 1980s. Instrumental to this was the Review of Handicapped Programs in 1985 which took the 'unprecedented step of involving people with disabilities themselves, and their families, as part of an extensive and comprehensive consultation process' (Parliamentary Library 1996). The resulting national framework for providing disability support services promotes consumer choice by:

... providing increasing opportunities for people with disabilities, their families and carers to influence the development and implementation of supports and services through advocacy, representation and other measures. (Australian Healthcare Associates 2006, p. 9)

The strengthened client focus in these services has sustained a range of consumer and/or family direct support programs over many years in a social policy area with many similarities to aged care (box 5.1). The disability services sector in most states and territories now offer a variety of programs or trials designed to promote independence and choice (Laragy and Naughtin 2008).

Australia's health care system also affords consumers considerable choice including universal access to health care and the opportunity to purchase additional services and products through the private sector (Podger and Hagan 1999; Duckett 2001). Key to this flexibility are the Medicare card and the option to take out private health insurance. In the case of primary care, the Medicare card effectively operates as a consumption voucher with public funding following recipients, not providers (Hogan 2007). There is competition between general practitioners for the voucher users, albeit in a supply constrained market. In addition, people eligible for hospital care can choose from a range of facilities, including public and private wards across a range of hospital types (DHAC 2000b).

Recent reforms of Australia's child care system have also enhanced consumer choice following the removal of the cap on Child Care Benefit places for approved Outside School Hours Care and Family Day Care (Brough 2006). The sector now responds more freely to changes in demand instead of places being administratively allocated. Further, the range of eligible carers has widened to include grandparents, relatives, friends and nannies (FAO 2007).

Box 5.1 Consumer and/or family directed support in Australia's disability services sector

Some agencies offering consumer and/or family directed support have been operating in the disability area for over twenty years. Many have benefited greatly from support and seed monies provided by the Australian Government (Michael Kendrick, per comm. 28 May 2008).

For example, the Local Area Coordination (LAC) program in Western Australia has been successful in personalising disability services and supports for individual clients as well as acting as a conduit of Commonwealth and state funding directly to people with disabilities and their families and carers (Disabilities Service Commission 2003). In 2006-07, the number of LAC services users was 7836 while the number receiving direct consumer funding was 1521 (Disability Services Commission 2007). Similar LAC programs operate in Queensland and the ACT.

Small community organisations that offer consumer and/or family directed support operate in most states, generally involving groups of less than 25 people, such as the long-running Lifestyle Options Inc. in Brisbane and the Community Living Project Inc. in Adelaide. In recent years, larger organisations such as UnitingCare have introduced similar programs (such as its Individual Arrangements program in Melbourne's east, see box 5.6). There has also been a growing number of direct funding trials such as the New South Wales Department of Ageing, Disability and Home Care's trials (Fisher and Campbell-McLean 2007) and the Victorian Government's trial of direct payments (LDC Group 2007).

Beyond these social policy areas, interest in improving consumer choice has been part of wider policy debates across other industries. In particular, from the mid-1990s, national competition policy reforms were partly directed at making Australia's infrastructure industries more responsive to changing consumer needs and preferences. For example, the removal of regulatory barriers and fixed pricing regimes in the electricity and telecommunications industries sharpened incentives that improved the quality of services and increased the uptake of new technologies (PC 2005d).

Overseas reform experience

A number of OECD countries have sought to enhance choice in aged care by introducing consumer centred initiatives (table 5.2).

Table 5.2 Personal budgets and consumer directed employment of care assistants for eight OECD countries^a

<i>Country</i>	<i>Personal budgets and consumer directed employment of care assistants</i>	<i>Payments to the person needing care who can spend it as she/he likes, but has to acquire sufficient care</i>
Austria		• Cash Allowance for Care
Germany		• Cash Allowance for Care
Luxembourg		• Cash Allowance for Care
Netherlands	• Personal Budget for Care and Nursing	
Norway	• Care Wage	
Sweden	• Carer's Salary	• Attendance Allowance
United Kingdom	• Direct Payments	• Attendance Allowance
United States	• Consumer Directed Home Care • Cash & Counseling	

^a Includes those countries that have experience with arrangements allowing users more choice and flexibility with regard to the way care is provided, and for which sufficient information was available.

Source: Lundsgaard (2005).

Some countries have offered older people personal budgets which, in some instances, allow them to directly employ personal carers. Other countries have provided older people with personal budgets which they can spend as they like, as long as they acquire sufficient care. One of the most comprehensively evaluated programs (and also one of the most flexible) is the United States Cash and Counseling Demonstration and Evaluation (CCDE), which provided participants with a monthly allowance:

... to purchase household appliances, modify their homes or cars, set the wage rate of workers they hire, hire relatives as their workers, hire workers to perform a wide range of household activities as well as personal care, and even take a small proportion in cash for incidental expenses. (Carlson et al. 2007, p. 468)

For some CCDE participants, this increased flexibility has allowed them to maintain continuity of care by hiring family members and friends when agency workers were in short supply. Overall, the benefits to participants through improved service delivery were found to be: an increased likelihood of higher satisfaction with care arrangements and their lives more generally; and a decreased likelihood of unmet needs, care related health problems and adverse events (Carlson et al. 2007).

Improved service delivery has also been reported by many people using the Direct Payments scheme in the United Kingdom, including improvements in the:

- likelihood of obtaining their preferred carer
- attention paid to their individual likes and dislikes

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- scheduling of times that this support can be provided
 - service consistency and reliability (Witcher et al. 2000).

Further, older people receiving care through the Dutch Personal Budget for Care and Nursing scheme *felt* more independent because they had greater control over when care was provided and by whom:

... care recipients with a personal budget felt that they could manage their own life again, and that their feeling of dependence had decreased. Budget holders felt they had a significantly larger say concerning the extent and type of care, and concerning when and notably by which person care is provided. (Miltenburg and Ramakers 1999)

For some, the overall benefits from enhanced choice can be quite profound. A qualitative study of the effectiveness of direct payments across Scotland concluded that the perceived advantages added up to a 'quite different quality of life' compared to the more traditional service arrangements (Witcher et al. 2000). As one recipient observed:

Things couldn't be better now. It's given me much more freedom and control and I play a more active role in family life. Choice, freedom and control sums it up for me. It has been amazing, my life has completely changed. (Witcher et al. 2000, s. 6.10)

Despite the well documented advantages, participation rates in consumer centred care are typically lower than the traditional agency directed alternatives. Indeed, the largest scheme of its type among OECD countries in 2003, the Personal Budget for Care and Nursing scheme in the Netherlands, covered 6.5 per cent of the population aged 65 and over receiving publicly funded home care (Lundsgaard 2005). Originally tested on an experimental basis in 1991 and offered as a national program from 1995 it has experienced stronger growth since 2000. The program grew from around 23 000 to 54 000 between 2000 and 2003, of which about a third were older people. This growth reflects, in part, the progressive broadening of eligibility criteria. The program now extends to all people and is, in effect, a cash entitlement for those who are eligible for home based care.

The low participation rates may raise questions about their overall worth. However, in assessing their value, it is important to understand that at a broader level, even a relatively small number of active consumers switching between alternative services can induce providers to improve services as well as shaping innovation and quality improvements in aged care over time that benefit many consumers (box 5.2). While the information-gathering and decision-making processes of marginal consumers in particular contexts remains an area of ongoing research, securing the potential benefits arising from the actions of these consumers almost certainly requires competitive markets.

Box 5.2 The role of the marginal consumer as a ‘change agent’ or spur to improvement

In private competitive or contestable markets, marginal consumers are typically considered to be those with a ‘reservation price’ in the neighbourhood of existing market prices. The actions of these consumers who can be characterised as ‘careful shoppers’ generate competitive pressures that help keep prices reasonable and improve services for less informed, nonsearching consumers as well. These consumers are also seen as having an important role in the market for social and community services. In this context, Buckley and Schneider (2003, p. 126), in relation to potential choices about schools note:

... marginal consumers, by making the best choices for themselves, provide a positive externality to other consumers by their behaviour, even without directly communicating information to less informed citizens.

By extension, marginal consumers in quality sensitive industries can be considered to be those who have a ‘reservation quality’ in the vicinity of an existing quality level. In the case of aged care, initiatives directed at improving choice and quality through more consumer centred policies may only attract a small proportion of older people, but they may play an important role in driving innovation and quality improvements that benefit many other users through quality and/or price competition.

Sources: Rhoads (1985); Aiginger (2001); Buckley and Schneider (2003).

The reform experiences of other countries do point to clear benefits from consumer centred care models. These experiences offer insights into potential models for Australia, although any assessments of their applicability would need to take into account differences in regulatory settings, supporting infrastructure, funding arrangements as well as community expectations and social norms.

5.4 Mechanisms to promote consumer centred care

In the Australian aged care sector, a growing number of stakeholders and commentators have outlined alternative mechanisms for improving quality and choice by enhancing consumer control in both community and residential care (see, for example, Howe 2003a; Hogan Review 2004; Emerson 2005; Sullivan 2005a; ACAA 2006a; Bruen and Rees 2007; Tilly and Rees 2007; ACSA 2008b). Indeed, a former aged care minister, Julie Bishop (2005, p. 25) stated that:

We should explore the option of ‘consumer-directed care’ ... The implications for employment and fiscal sustainability are complex, as are issues of quality assurance — but the benefits are worth deeper consideration.

Many consumer centred² mechanisms have been suggested involving varying degrees of change to the existing system. They can be conveniently discussed by looking at three broad approaches:

- targeted reforms
- pooled funding with assisted choice
- cash entitlements.

Targeted reforms

Targeted reforms involving incremental refinements to the existing array of programs to offer an enhanced degree of service choice by:

- providing more individualised services that promote client independence and lessen the need for ongoing support
- increasing funding levels to reduce long waiting lists
- enabling greater access to active respite, centre based day care and emergency in-home respite services by increasing program flexibility
- improving access to, and information about, community care services which are offered at different levels of intensity and from alternative providers (Allen Consulting 2007).

The Active Service Model, recently piloted within the HACC program by the Victorian Government's Department of Human Services, provides an example of how existing services can be modified to enhance choice (box 5.3). The model seeks to maximise the independence of older people 'by supporting the development of more person centred, capacity building and restorative approaches to service delivery' (HDG 2007, p. 1). The initiative builds naturally on the preferences of many older people, who 'if given the right sort of support, encouragement and knowledge would make choices to increase their independence and restore, if they were able, their lost function' (HDG 2007, p. 44). It is also able to tailor services to better meet the needs and preferences of those older people who choose to continue living at home.

² Enhanced choice is promoted under several labels including consumer directed care, consumer oriented care, consumer centred care, person centred care direct funding and individual budgets. This study approaches the issue from a broad perspective and uses the term consumer centred care to encompass all mechanisms directed at enhancing consumer choice.

Box 5.3 Victoria's Active Service Model

The Department of Human Services (Victoria) has recently explored an 'active' service model approach for HACC service provision through a series of pilot trials. The trials sought to reshape HACC service delivery by moving from a 'dependency' approach to a restorative care and capacity building approach. This approach challenges the assumption that at a certain point older people become progressively less able to manage and will inevitably need formal support services to take over the tasks of daily living.

Critical to the model's approach is a more comprehensive assessment of the scope for improving an older person's ability to manage at home, including a thorough understanding of the causal factors underlying a person's request for HACC services. With improved understanding, more creative solutions are able to be considered including advanced rehabilitative techniques, ergonomic and labour-saving equipment and occupational therapy.

The Victorian Government has completed a series of consultations with the HACC sector with a view to developing an implementation plan by the end of this year.

Sources: HDG (2007); Department of Human Services (Victoria) (2008).

Pooled funding with assisted choice

Dissolving rigid program boundaries by moving to a much broader form of pooled funding for community and residential aged care services could enhance consumer choice by facilitating the provision of care services that are more responsive to changing needs and preferences. Under a pooled funding model of the type proposed by Kendig and Duckett (2001), all Australian, State and Territory government funds for aged care services — residential and community care, including HACC — would be pooled and managed at a regional level. A more ambitious proposal involving all health and aged care services has been canvassed by Podger (2006).

Case managers assigned to clients could play an important role under a pooled funding approach in assessing their clients' needs and planning their care. In particular, their role is likely to extend to advising clients of the services for which they are eligible, the level of care that would be appropriate to their needs and the extent of government assistance to which they are entitled. Although clients would then be free to choose their preferred provider, the case manager could assist in care coordination if necessary.

The main benefit to clients of a pooled funding model is access to better tailored care that can be adjusted as required to match changing needs and preferences, without encountering regulatory obstructions arising from discrete programs with their own eligibility criteria and administrative arrangements. Older people potentially able to benefit from this approach could include, for example, CACP clients that require a higher level of care but are ineligible for an EACH package.

The Wisconsin Community Options Program (WCOP) provides a useful example of a pooled funding model. It is a highly-structured brokerage model that has been drawn on in part to develop Australia's CACP (Howe 2003a). The WCOP aims to assist a variety of older people by providing flexible home and community supports and services, including to those:

- with severe medical problems
- with substantial medical problems with no informal support
- with chronic mental impairment
- being discharged from nursing homes to a community based alternative (Howe 2003a).

There are no benefit limits specified in the WCOP — it covers any services that a beneficiary may need. A functional impairment assessment determines client eligibility and a financial assessment determines the subsidy rate. Agencies manage all individual care budgets and clients are free to select providers and/or carers (including relatives and, in the majority of counties, spouses as well). The WCOP has proved a useful model although several refinements have been made to enhance its performance (box 5.4).

Box 5.4 Further reform in Wisconsin

The Community Options Program (COP), Community Options Program Waiver and Community Integration Program are mainstays in delivering long term care in Wisconsin. However, by the mid-1990s, several years of intensive study had revealed serious flaws in Wisconsin's COP relating to variable access, choice and quality across counties. There were also financial disincentives to care for people with the most expensive needs as well as difficulties integrating aged care with the acute and disability sectors.

In response to these shortcomings, a new pilot program for long term care (LTC) called Family Care was introduced by pooling the funding of around 10 key programs, including the COP. In commenting on this development, Thompson (1998) noted that:

... the current long-term system is intimidating, complex and sterile. There are 40 ways to access the system, people don't know how to get the appropriate care because it's so complicated, and the concerns of families are often ignored ... Family Care ... will combine our LTC programs into one system to provide the maximum range of care options for seniors and disabled. It is built upon consumer choice and one stop shopping for services.

An assessment of the Family Care program by APS Healthcare (2005) found that it continues to improve the quality of LTC services. Waiting lists for services have been eliminated, achievement of member outcomes remains high and each care management organisation has continued to improve its cost effectiveness by realising greater efficiencies and implementing innovative cost saving measures. APS Healthcare noted that there were several areas where these organisations could improve their performance, including by providing care manager training, clarifying service agreements and reviewing cost sharing guidelines between all stakeholders.

Following its successful piloting in selected counties, plans were announced in 2006 to expand Family Care to all counties in Wisconsin.

Sources: Thompson (1998); Wisconsin Department of Health and Family Services (2003); APS Healthcare (2005).

Cash entitlements

Cash entitlements offer the fullest expression of consumer choice because they give clients the freedom to determine the services they consume and from which providers. A cash entitlement arrangement is an alternative to supplier based funding or could extend the latter by allowing eligible clients to select services from a service menu.

The Hogan Review discussed vouchers or cash entitlements as a means of enhancing consumer choice. From the Commission's perspective, the existing ACAT process effectively establishes an entitlement to care. However, there is little

scope for exercising the choice that this entitlement carries, owing to the high utilisation of bed capacity and the fixed price regimes. In this respect, Hogan proposed a scheme that strengthened consumer choice by freeing up aged care places and increasing the availability of information (Hogan Review 2004).

As noted earlier, cash payment and entitlement arrangements have been used to improve choice in the delivery of aged care in other countries. The use of entitlements rather than cash payments may reduce the degree of choice that could be exercised by clients, but provides governments with greater assurance that payments are being used to provide care.

The scope for consumer involvement in the planning and coordination of aged care varies across consumer centred programs. At one end of the spectrum, the UK's Direct Payments scheme restricts cash entitlements to community care services (including equipment) that a local council assesses the recipient as being in need of (Department of Health (UK) 2007). At the other end of the spectrum, the German Cash Allowance for Care program provides high flexibility with minimal conditions over how the money is spent (Lundsgaard 2005). Nevertheless, older people and their relatives are obliged to acquire sufficient care under this program.

The scope for employing relatives as care providers also varies across consumer centred programs. For example, the Direct Payments program in the United Kingdom does not generally permit services to be secured from a spouse, partner or close relative living with a recipient (Department of Health (UK) 2007). In contrast, hiring of relatives is permitted by many United States aged care programs, with some states extending this flexibility to include spouses (Tilly and Wiener 2001).

New Zealand is piloting and evaluating consumer centred aged care through direct funding projects (box 5.5). Under the Individualised Funding for Elders project, government funding is available to eligible older people via a host agency (in this case, Standards Plus) that offers support services for anyone wishing to receive individualised funding. The support services include:

- direct management of the money and payment of wages
- employer liability insurance protection
- face to face advice and assistance
- follow up consultations and monitoring.

Funding under the pilot project can be used to employ a support worker, purchase services from an independent provider agency and/or purchase other services that support the family to provide care for a family member. During a recent evaluation, families reported that their participants' quality of life was significantly higher than if they were under any other available program (Standards Plus 2007).

Box 5.5 Individualised Funding for Elders — New Zealand

Since February 2006, Standards Plus has acted as a host agency for the Individualised Funding for Elders project in Dunedin. Funding is provided by the Otago District Health Board via Standards Plus for use at the discretion of the older person and their support network. The older person or their representative (such as a family member or nominated representative) can apply to be a budget holder. Under the program, funding can be used to employ a support worker (that is, a personal carer or assistant), purchase services from an independent provider agency and/or purchase services that support the family to provide care for a family member.

The project has supported around 10 participants ranging in age from 68 to 97 years with varying ethnic backgrounds, all of whom had been assessed as having high to very high support needs. The level of individual funding ranged from 360 to 1030 New Zealand dollars a week paying for support workers employed for between 12 to 42 hours a week. A recent evaluation of the project found that:

- all participants reported improvements in mental health and emotional wellbeing
- all participants reported enhanced quality of life
- many participants reported improvements in physical health
- several families reported enhanced quality of life and wellbeing for other family members
- people from culturally diverse backgrounds found this approach the most successful in supporting their older family members (Standards Plus 2007).

A similar project is commencing in the Taranaki District Health Board area and the possibility of a third project is currently being investigated.

Sources: Standards Plus (2007); Sullivan, L., Standards Plus (pers. comm. 2008).

Many of the initiatives offering consumer centred support in Australia's disability services sector also use direct funding mechanisms, often featuring cash payment or entitlement elements. In some instances, these initiatives have been instigated by families with a disabled member directly approaching providers seeking more flexible care options, as occurred, for example, in the development of the UnitingCare Community Options Individualised Arrangements (box 5.6). A recent evaluation of this program concluded that:

... families using individualised funding do have more control to decide what services and supports best meet the needs of their family member with a disability, and they are using funding flexibly to create and access new options. Families who participated in the outcomes evaluation are highly satisfied with the project which introduced them to a wide range of opportunities not previously available. (Laragy 2008, p. 2)

Box 5.6 Individualised Arrangements: consumer centred care for disabled people in east Melbourne

UnitingCare Community Options (UCCO) is a large community care agency that has traditionally provided case management, care and support services to people who are frail, aged or have a disability. Since 2003, UCCO has been providing individualised support to 22 families who have a member with a disability (their ages range from 8 to 55 years). Under the program, UCCO acts as a 'host' organisation for funding that has been allocated to that family member, generally from the Victorian Government Department of Human Services, but occasionally also from philanthropic trusts. The total value of this support ranges from \$5000 to \$90 000 depending on the assessed level of need. In general, each family and UCCO have a formal agreement that sets out the responsibilities of both parties.

Each family plans the mix and level of activities, services and supports that best meet the needs and preferences of the person with the disability, within a given budget. These plans typically include assistance in making the transition from school to adult life as well as traditional support services (such as respite and personal care). UCCO encourages families to consider support services beyond those traditionally available. Funds may be directed at recreational activities, vocational activities (including attending educational institutions) and the purchase of equipment or materials relating to vocational activities, depending on their source and purpose. Families usually provide the case management, but if their circumstances change, they can direct some of the funding to cover this dimension.

UCCO provides administrative support through its human resources team that includes, for example, assisting families to recruit support workers. Families can and do employ relatives, although they must first consider how this may affect the person receiving support and the family as a whole. Although flexibility is key to ensuring person centred support, the program continues to evolve to meet the changing needs of families in concert with UCCO's legislative and governance requirements.

Sources: Damonze, G., UCCO, Melbourne (pers. comm., 22 May 2008); UCCO (2008).

Consumer centred care rarely operates alone; it commonly complements a wider service program that includes standard agency directed programs (Howe 2003a). Further, consumers and their carers can, in general, choose a preferred level of involvement in designing their care mix and coordinating its provision. In particular, they can either manage the funds themselves or pay an agent to manage the funds for them.

5.5 Some issues for consideration

Any proposals to enhance consumer choice will need to take into account the nature and extent of the changes required and the effects these are likely to have on the

aged care system as a whole. While there is scope to enhance choice through predominately incremental changes, more fundamental changes would be required if opportunities for real enhancements to consumer choice are to be realised.

It is important to properly assess the costs and benefits of any proposed change. This includes having a good understanding of the level of choice provided under current arrangements and an appreciation of what consumers want in terms of enhanced choice. In many instances the supporting infrastructure is already available but may, nonetheless, require significant modification. Related to this are the potential costs associated with developing, implementing, monitoring and refining new programs and these need to be weighed against the perceived benefits. To this end, many valuable insights can be gained from the reform experiences of other countries that have introduced aged care programs with a stronger consumer focus, although appropriate regard needs to be had to the Australian context.

Against this backdrop, there are several issues that need to be considered as part of any assessment of the case for embracing mechanisms to enhance choice, including:

- user preferences for choice and their decision-making capacity
- the scope of services to be included
- implications for regulatory settings covering, for example, information and quality assurance
- the nature of the aged care market
- the role for experimentation and trialling.

Central to any consideration of ways to enhance consumer choice in aged care will be the need to ensure the long-term fiscal sustainability of these services. This reflects that a significant proportion of older people will continue to access these services on a concessional basis over the next 40 years. This suggests that the issue of enhancing consumer choice should be considered as part of a broader reform agenda rather than in isolation. Broader reforms, to among other things, strengthen incentives for innovation and improved productivity (chapter 7) would help mitigate the cost pressures associated with providing clients with more choice in the services they consume.

User preferences for choice and their decision-making capacity

The desirability and importance of choice varies across the older population. At one end of the spectrum, some users may be satisfied with an agency based delivery mechanism and the existing array of service offerings. Indeed, for some older people, greater choice may be unwelcome. At the other end of the spectrum, some

older people are likely to appreciate opportunities to exercise greater choice and control. As such, consumer centred programs typically exist alongside traditional agency directed programs (see, for example, Howe 2003a; Foster et al. 2005).

Consumer centred programs present special challenges for two groups of older people: the very elderly who do not have the active support of relatives or other carers; and people who are cognitively impaired (Hogan Review 2004; Howe 2003a; Tilly 2007). Many of these people lack the capacity to manage part or all of their care requirements, may be unable to defend their consumer rights and are at risk of exploitation in the absence of a close support network. These problems are widely recognised (see, for example, Tilly, Wiener and Cuellar 2000; Doty, Mahoney and Simon-Rusinowitz 2007).

To some extent these problems can be managed through the involvement of agents acting on behalf of vulnerable older people:

Although adults with cognitive impairment may have difficulty managing their services without assistance, unless they have very severe impairments, they retain the ability to indicate who should make decisions on their behalf and to make their preferences about services known. (Tilly 2007, p. 5)

Many OECD countries including Austria, Germany, France, the Netherlands and the United States do allow cognitively impaired persons to participate in consumer centred aged care programs (Tilly, Wiener and Cuellar 2000). When these people are unable to independently exercise choice, agents such as informal carers and family representatives may be able to assist them in making choices.

Scope of services to be included in consumer centred programs

As discussed in the previous section, the types of services included in consumer centred programs vary between countries, even at the more flexible end of the spectrum involving cash entitlements. For example, the UK's Direct Payments program is restricted by local council assessments whereas the German Cash Allowance for Care program imposes no explicit restrictions, although it does oblige older people and their relatives to acquire sufficient care (Lundsgaard 2005; Department of Health (UK) 2007). In Australia, consumer centred care mechanisms could be applied to some or all of the services available through existing agency programs.

Consumer centred care programs have the potential to offer a substantially wider range of services, including assistive technologies and other supports over which recipients can exercise control (Schore, Foster and Phillips 2007). Although the range of services available in traditional community care programs is adequate for

many recipients, these programs have also been criticised for ‘overmedicalizing services and not being flexible enough to effectively meet recipient needs’ (Schore, Foster and Phillips 2007, p. 446).

In addition, governments will often impose limits on the range or types of services available under consumer centred programs for a variety of reasons including concerns about:

- which services are suitable for purchase with government funds
- the appropriateness of close relatives or spouses providing services (discussed in relation to quality assurance below)
- some older people not having the ability or the information to make informed choices (discussed below).

Indeed, some services have been excluded or withdrawn from Australian aged care programs in the past. For example, the Department of Health and Ageing discontinued the provision of subsidised weekend retreats and massages for carers by some respite centres because they ‘did not consider that these activities were equitable, that is, they were mainly available to metropolitan carers, nor did they provide a longer term benefit to the carer’ (ANAO 2005, p. 47).

Implications for regulatory settings

International experience indicates that success with consumer centred care is shaped by regulatory settings in a number of areas including information, quality assurance/monitoring and by the need to accommodate other policy objectives.

Better information systems

The effective functioning of consumer centred aged care programs is heavily dependent on consumers and/or their representatives having access to adequate information. Consumers with sufficient knowledge of available service offerings (in terms of quality, prices, access rights and obligations) are better placed to meet their needs and preferences. In general, with such programs, there is a need to establish the appropriate level of information desired by consumers as ‘information overload’ can reduce the quality of consumer decision making (see, for example, Iyengar and Lepper 2000; Sethi-Iyengar, Huberman and Jiang 2004; Ergas and Fels 2008; Shafir 2008). Further, any assessment of alternative information systems needs to take into account the potential impacts on providers and the role for government involvement in terms of standardising and monitoring service parameters.

In general, people participating in consumer centred care programs are likely to have higher information requirements than those in standard agency directed programs (Aetna 2004; Baxter, Glendinning and Clarke 2007). Further, some aged care consumers are not well placed to inform themselves or decide between competing alternatives. This was, for example, explicitly recognised in the design of the United States CCDE through the counseling part of the program which involved peer professionals who were available to provide consumers with information and advice about decisions (Benjamin 2001). Similarly, in Australia, a move towards consumer centred aged care policies is likely to require improved information flows because ‘the information currently available to consumers does not meet their needs’ (Koch et al. 2005, p. 8).

To this end, Hogan Review (2004, p. xix) recommended ‘exploring, with consumers and the industry, a star rating system to assist consumers to more readily compare services and to provide incentives for providers to become more competitive in providing quality services’. In Hogan’s view, the Aged Care Standards and Accreditation Agency could play a useful role in this area. The Senate in its inquiry into *Quality and Equity in Aged Care* noted Hogan’s recommendation but went further, arguing that:

... the rating system should not be limited to a ‘star rating’ but should include easily understood descriptions of a range of attributes, such as type and range of services provided; physical features of homes; staffing arrangements; costs of care; and current accreditation status. (SCARC 2005, p. xvi)

The existing accreditation and monitoring arrangements would appear to provide an effective basis for providing consumers with information to aid making decisions about the relative merits of different service providers.

Quality assurance

The growth of consumer centred aged care raises complex issues surrounding quality assurance, particularly when consumers are allowed to purchase services directly from providers of their own choice (Gibson, Gregory and Pandya 2003; Wiener, Tilly and Cuellar 2003). Here, consumers may experience difficulty in assessing the quality of services, even after they have been purchased, and the consequences of purchasing poor services can be significant (Ergas and Fels 2008). Governments are therefore faced with the dual challenges of:

- designing quality assurance mechanisms that suit potentially larger numbers of more diverse care providers, many of whom may be unfamiliar with standard compliance, monitoring and reporting regimes

-
- providing society with adequate confidence that consumer centred care is of the type and quality needed and expected.

Government responses to quality assurance have generally been light handed in countries where consumer centred care has been adopted. It is outside the regulatory framework in England and subject to minimal oversight in Germany (Wiener et al. 2006). In the United States, beneficiaries are primarily responsible for their own quality assurance, although a number of state governments have provided a minimal level of quality assurance, consisting mostly of responding to complaints, periodic home visits and telephone contact with beneficiaries (Tilly and Wiener 2001).

Despite this widespread minimalist approach to quality assurance, there have been remarkably few shortfalls in care quality or incidents of outright neglect of frail older people participating in consumer centred care initiatives (Lundsgaard 2005). This is because the majority of ‘new’ consumer centred workers are likely to be relatives or friends of care recipients and are more likely to provide higher quality care than strangers (Schore, Foster and Phillips 2007; Wiener 2007). Where care workers are not closely connected with recipients, quality assurance relies on clients’ capacity to dismiss unsatisfactory workers and to hire replacements (Tilly and Wiener 2001).

Nevertheless, it is likely that there will be ongoing debate about the need for and the effectiveness of quality assurance mechanisms in the future. This is because, for many stakeholders, the issue of quality assurance — whether quality of care is adequate and how services should be monitored — remains highly contentious (Wiener, Tilly and Cuellar 2003). In this context, and as part of a framework to support the promotion of consumer centred care, the United States Alzheimer’s Association has developed recommendations that could help to prevent problems and ensure that quality of care and life is optimal for consumers with dementia (Tilly 2007). Such an approach has wide applicability — to both non professional and professional care workers — and could complement existing systems for accrediting or licensing care professionals on the basis of their qualifications, training and skills.

Broader policy objectives

Governments moving in the direction of consumer centred options may need to revisit policy settings in other dimensions of aged care, such as those involving equity and sustainability considerations. A number of equity and sustainability considerations can arise when considering alternative funding models for aged care. However, whether the funding mechanism involves a producer subsidy or a cash entitlement, the eligibility criteria for either will shape the budgetary costs. Under

the existing ACAT process and bed allocation system, the Government controls its fiscal exposure by in effect, fixing the number of subsidised places. If constraining the government's fiscal exposure is a priority for policy, then a cash entitlement arrangement could be designed which adjusted the eligibility criteria under the ACAT process to limit the number of entitlements provided.

Equity issues arise where consideration is given to splitting the accommodation and care components of aged care (chapter 4). According to Bruen and Rees (2007), considerable work would be required to develop an assessment methodology that could be applied fairly when determining the level of care subsidy across both residential and community care, in order to make the care component fully transportable.

Nature of the market

The scope to extend service choice and secure the potential gains is largely determined by the nature of the 'market' and, in particular, whether there are opportunities for competition. Where scope for competition is limited, opportunities for enhancing choice will be essentially limited to 'choice of offering' — that is, to additional personalisation and flexibility of provision (Audit Commission (UK) 2006). In these instances, government could introduce competitive bidding arrangements to allow potential providers to compete for the right to supply a market for a prespecified period. On the other hand, where the depth of the market does not impair opportunities for competition, choice can be expanded further to encompass choice of provider. Where competition in the market is feasible, providers have strong incentives to tailor their service offerings to match the needs and preferences of clients and thereby attract more consumers.

The nature of the aged care market in Australia varies considerably by locality. The larger markets in capital cities and retirement communities in regional areas offer opportunities for effective competition. Other parts of the market are 'thin' with relatively few providers and consumers, such as sparsely populated rural and remote communities as well as special needs groups such as Indigenous Australians and culturally and linguistically diverse people. Demand for aged care services in such instances is generally below the threshold level of economic and financial viability, particularly for residential care providers. In such instances, opportunities for real market competition is likely to be limited and different approaches to the provision of aged care may be more appropriate, such as the use of multipurpose services (ANAO 1998).

A role for experimentation and trialling

Experimentation and trialling have played an important role in extending and improving Australia's aged care services in the past, including in the area of strengthening client involvement in decision-making to enhance choice in service delivery (appendix A). Further, they have proved useful in developing new services and improved delivery arrangements, such as consumer centred care arrangements, in several overseas countries.

Reflecting this, many commentators and stakeholders believe there is a clear role for experimentation and trialling of consumer centred approaches to the provision of aged care in Australia in order to inform policy development (Kendig and Duckett 2001; Carers Australia, Alzheimer's Australia and COTA National Seniors 2003; Hogan Review 2004; Laragy and Naughtin 2008). In addition, between a third and a half of participants in a series of national seminars organised by Alzheimer's Australia indicated that trialling of consumer centred care should be implemented immediately (Bruen and Rees 2007). Indeed, experimentation could aid the process of wrestling with the four preceding issues and make a material contribution to policy innovation in this area.

To progress assessments of the role of consumer centred care in Australia, Bruen and Rees (2007) have proposed trialling in three broad areas:

- *Community care packages.* Applying consumer centred care principles to CACP, EACH, EACHD and HACC (at the packaged care level) would seem to be the most feasible option because these programs are already operational with a notional 'budget per person' which includes both government and user contributions. This option would enable consumers to receive tailored care services from preferred providers. A number of features of this model make it attractive for special needs groups, including:
 - the potential to employ local people or people of the same cultural background
 - CACP and EACH currently permit employment of family members where a formal employment agreement exists
 - care package providers could arrange services, thereby alleviating the need for recipients to act as employers.
- *National Respite for Carers Program.* Consumers would benefit under this existing program by sourcing higher quality respite care at times that best suit them from providers of their choice. Respite could be purchased directly by carers using brokerage funds normally allocated to Carer Respite Centres in combination with their own funds. The Carer Respite Centres could administer

the scheme and undertake assessment and information roles. Access to other respite services subsidised under HACC, National Respite for Carers Program or the Residential Care Program would be unchanged.

- *Choice between residential and community care.* This would enable consumers to choose the services they want in the location they want. Following an ACAT assessment to determine the level of care (rather than location of care), consumers, instead of providers, would be given the assessed subsidy which they could ‘top up’ with their own contributions to purchase services from their provider of choice.

The results from such trials could significantly influence the future direction of consumer oriented care approaches in Australia. However, any subsequent adoption of more consumer oriented care approaches would require ongoing evaluation and fine tuning of program parameters to realise cost effective outcomes. As was concluded following the CCDE many research questions remain to be answered including the persistence of the favourable results, long-term cost implications, patterns of switching back and forth between agency services and consumer-directed options (Mahoney et al. 2007).

Trials in Australia could draw on the experiences of other countries that have introduced consumer centred initiatives, while recognising, that these experiences have been gained within cultural and policy environments that differ from those in Australia. Therefore, as recognised by Howe (2003a, p. 18):

Rather than just importing overseas models, we need to graft them on to the elements of consumer direction that already exist in current programs and so grow our own hybrids that are best suited to local conditions and that will strengthen our culture of care.

