A Recent initiatives to improve the financing and provision of aged care services

In recent years, the Australian Government has made a number of changes to policy settings with a view to improving the financing and provision of aged care services. These initiatives essentially encompass four broad areas:

- increasing the number of aged care places and extending the service mix
- refining regulatory and financing arrangements
- supporting innovation in service provision
- other policy initiatives designed to address emerging service gaps, improve the viability of service providers, address the needs of dementia sufferers and enhance the sustainability of the aged care workforce.

This appendix draws on a number of recent initiatives to illustrate broad directions of change in each of these areas rather than attempting to provide a comprehensive overview of policy developments. Detailed information about the evolution of aged care policy can be found in Cullen (2003) and the Department of Health and Ageing's *Report on the Operation of the Aged Care Act 1997* (DoHA 2007h).

Increasing the number of places and extending the service mix

Since 1985, Australia has had a needs based planning framework for aged care (chapter 2). Through this framework, the Australian Government aims to provide a sufficient number of residential and community care places to accommodate growth in the aged population and to provide an appropriate mix of services, including between people requiring differing levels of care and between metropolitan, regional, rural and remote areas. A key element of this framework is the aged care planning (or target) ratio. The Government signals its aged care funding intentions through the planning ratio which provides a medium term benchmark for achieving what is considered an appropriate balance between the demand for and supply of aged care services.

At the time of its introduction in 1985, the planning ratio was set at 100 aged care places relative to the target population (table A.1). In 2004, the ratio was increased to 108 places, as part of the *Investing in Australia's Aged Care: More Places, Better Care* package, with the Government indicating that this new target was to be achieved by December 2007 (DoHA 2007h). In 2007, as part of the then Government's *Securing the Future of Aged Care for Australians* statement, the overall planning ratio was increased to 113 places with the new target to be attained by June 2011 (DoHA 2007h).

Table A.1 **Target provision ratios announced between 1985 and 2007**

Aged care places/packages per 1000 people aged 70 years or older plus Indigenous people aged 50–69 years.

Year	*Residential high care places*	*Residential low care places*	*Total residential places*	*CACP packages*	*EACH & EACHD packages*	*Total community packages*	*Total aged care places & packages*
1985	40	60	100	..	..		100
1992	40	55	95	5	..	5	100
1993	40	52.5	92.5	7.5	..	7.5	100
1995	40	50	90	10	..	10	100
2004	40	48	88	20	..	20	108
2007	44	44	88	21	4	25	113

Sources: AIHW (1995, 2001a); Cullen (2003); Hogan Review (2004); SCRGSP (2006); Pyne (2007a); Santoro (2007).

As evident from table A.1, the Australian Government has also widened the care mix underlying the planning ratio. In 1985, all of the places covered by the planning ratio were for residential care with 40 per cent being nominated as high care places and the remainder as low care places. Since 1985:

- the residential care ratio has been reduced from 100 to 88 places per 1000 people
- within residential care, the planning ratio for low care places has been reduced from 60 to 44 places while the ratio for high care places has been increased from 40 to 44
- the planning ratio has been progressively modified to include the provision of community care places — first in the form of community aged care packages (CACP) (providing care equivalent to that provided via a low care residential place) from 1992-93 onwards followed by Extended Aged Care at Home (EACH) in 2002-03 and EACH Dementia in 2005-06 (providing care equivalent to that provided via a high care residential place), the latter as part of the initiative *Making Dementia a National Health Priority* (AIHW 2004c; DoHA 2005b)
- by 2007, community care places represented some 22 per cent of the total places covered by the overall planning ratio for aged care services.

The Australian Government's involvement in community care is not limited to forms of community care that represent substitutes for residential care. Indeed, the dominant form of its support for community care has been via a joint arrangement with the State and Territory Governments in providing community care services via the Home and Community Care (HACC) program since 1985. The Australian Government provides 60 per cent of the funding for this program although its day-to-day management is handled by State and Territory Governments.

An examination of changes in the number of clients handled by key residential and community care programs provides a clearer picture of the overall increase in the number of available aged care places and the effect of initiatives to enlarge the menu of services available to the aged.

As evident from table A.2, the number of older people receiving residential care increased from 123 086 in 1998 to 144 959 in 2007 — an increase of 21 873 corresponding to an average growth rate of 1.8 per cent per annum. Within residential aged care, the proportion of residents making use of high or low care has changed. Over the period 1998 to 2007, the number of high dependency residents increased by 30 613 at an average annual rate of 4.1 per cent whereas the number of low dependency residents decreased by 8740 at an average annual rate of -2.0 per cent.

The introduction of 'extra service' places has also broadened service choice for older people requiring residential aged care, although these places only account for a small share — around 4.8 per cent of operational places in 2007 (table A.3). The extra service provisions allow aged care residents (both low and high dependency residents) access to a higher standard of accommodation (in terms of, for example, room size, furnishings and fittings, temperature control, ensuites and living areas), food and other services (such as cable television, hairdressing, or daily newspaper delivery) by paying extra fees. High care extra service places continue to outnumber low care extra service places, partly as a consequence of its origins in nursing homes prior to 1997 (table A.3).

Table A.2 **Residential and community aged care clients of key programs**

Clients aged 65 years or older unless otherwise indicated[a]

As at 30 June[b]	*Permanent high care residents*	*Permanent low care residents*	*CACP clients*[c]	*EACH clients*[d]	*EACH Dementia clients*[e]	*HACC clients*[f]	*VHC clients*[g]
1998	70 639	52 447	9 313				
1999	74 142	48 626	12 197				
2000	76 400	48 008	15 453				
2001	78 739	47 043	19 362				..
2002	81 439	47 413	22 794			537 000	54 200
2003	85 198	47 815	24 620	..		544 000	64 100
2004	89 922	47 785	25 722	645		567 000	66 900
2005	95 028	46 462	27 061	1097	..	596 000	72 200
2006	98 557	45 452	29 252	1984	238	616 000	75 900
2007	101 252	43 707	32 983	2793	779	643 000	77 300

[a] Clients may receive care from more than one program. [b] Client numbers for HACC and VHC are for the year ended 30 June. [c] Excludes packages provided by the Multi-Purpose Services program and flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy. [d] The proportion aged 65 years or older in 2005 was used for 2004. [e] Aged 70 years or older. [f] Aged 70 years or older. The HACC Minimum Data Set (MDS) collection commenced in January 2001. 'Nil' and 'Not Stated' responses from the HACC MDS collection have been apportioned. The proportion of HACC funded agencies that submitted MDS data differs across jurisdictions and by year. The MDS data have been proportionally increased to adjust for non-responding agencies. [g] Aged 70 years or older. Veterans approved for VHC services including domestic assistance, home and garden maintenance, personal care and respite. The actual number of recipients is lower than those approved to receive assistance. The proportion aged 70 years or older in 2005 was used for 2002–2004. .. Year program commenced – no information on clients for this year.

Sources: AIHW (1999, 2000a, 2000b, 2001a, 2001b, 2002a, 2002b, 2003a, 2003c, 2004c, 2004d, 2005a, 2005b, 2006c, 2006e, 2007a, 2007f, 2008a, 2008d); SCRGSP (2003, 2004, 2005, 2006, 2007b, 2008); PC estimates.

Table A.3 **Extra service places**

As at 30 June	*Approved*				
	High care	*Low care*	*Total*	*Operational*[a]	*Total operational as % of total residential*
1998				1885	1.3
2003			6427		
2004	6324	1508	7832	5315	3.4
2005	7419	2079	9498	6449	4.0
2006	8066	2200	10 266	7712	4.6
2007	9300	2598	11 898	8136	4.8

[a] There are time lags between residential places being approved, allocated and then becoming operational. Service providers who receive an allocation of new places are required to make them operational within two years or the places are either reallocated or renegotiated.

Sources: Gray (2001); Hogan Review (2004); DoHA (2005f, 2005g, 2006f, 2007h); AIHW (2008d); PC estimates.

The decision to extend the menu of aged care services through the expansion of community care has allowed more older Australians who prefer to receive care in their own homes to do so. It is not possible to present aggregate figures for community care over the period because some older people received care and support through more than one program. Even so, increases in the number and range of community care places is apparent by examining changes for individual programs. Such an examination reveals that:

- The number of CACP recipients aged 65 years or older has increased by 23 670 in recent years, at an average annual rate of 15.1 per cent; from 9313 recipients in 1998 to 32 983 recipients in 2007
- The uptake of EACH packages as a substitute for residential high care has been strong since its introduction in 2002-03. The number of people aged 65 years or older receiving these packages has grown by 2148 at an average annual rate of 63.0 per cent; from 645 recipients in 2004 to 2793 recipients in 2007
- The estimated number of HACC recipients aged 70 years or older increased by around 106 000 between 2001-02 and 2006-07 at an average annual rate of 3.7 per cent; from 537 000 to around 643 000[1]
- The estimated number of clients approved for VHC that were aged 70 years or older has grown to around 77 300 since the program's establishment in January 2001. Between 2001-02 and 2006-07, VHC grew by 23 100 or at an average annual rate of 7.4 per cent. Its early growth reflected a large number of veterans transferring from HACC.

To date, community care programs providing services equivalent to that available in residential care facilities have displaced a much larger quantity of residential low level care than high level care places. Between 1998 and 2007, the number of CACP recipients as a share of all low care recipients aged 65 years or older, both community and residential, increased from 15 to 43 per cent (table A.2). In contrast, EACH and EACHD recipients only account for a very small proportion of all high care services; around three per cent in 2007. It is unclear how far high level community care can continue to substitute for equivalent residential care.

In the 2008-09 Budget, the Australian Government announced that it would be regularly reviewing the aged care planning ratios to take into account demographic changes and to ensure that the supply of aged care places appropriately meets current and future demand (Elliot 2008d).

[1] Reliable estimates of the number of HACC recipients have only been available since the HACC Minimum Data Set collection commenced in January 2001.

Refining regulatory and financing arrangements

The key elements of the institutional framework underpinning the provision of aged care services were outlined in chapter 2. This framework includes the *Aged Care Act 1997* which established new arrangements for the regulation, financing and administration of residential aged care. It also includes the *Home and Community Care Act 1985* and *A New Strategy for Community Care: The Way Forward* (DoHA 2004a).

In looking at how the institutional framework for aged care services has evolved over the past decade, the broad direction of change has been towards:

- creating a more integrated aged care system
- rebalancing public and private financing of aged care services
- streamlining parts of the regulatory and administrative arrangements
- improving service quality and enhancing consumer choice
- strengthening consumer rights and protections.

This section illustrates the nature of the first three of these trends by drawing on recent policy initiatives. The last two trends were discussed as part of the earlier examination of developments in aged care places and services.

Creating a more integrated aged care system

Over the past decade a number of changes have aimed to create a more integrated aged care system. The *Aged Care Act 1997* provided for the creation of a unified residential aged care system covering both low and high care services, by restructuring the funding and administration of hostels and nursing homes under one system.

Similarly, *A New Strategy for Community Care: The Way Forward* provides an overarching framework to coordinate all Australian, State and Territory government community care programs. Building on this, the *Review of Subsidies and Services in Australian Government Funded Community Aged Care Programs*, announced in September 2006, seeks to identify opportunities to more closely integrate community care programs to refine and improve service delivery.

Other joint initiatives between the Australian, State and Territory Governments have sought to strengthen linkages between the aged care system and other health and community services. For example:

- the Transition Care Program (TCP) which provides older people with a package of services following a hospital stay with a view to improving their functional capacity prior to returning home or going into residential care.
- the Multi-purposes Services (MPS) program which delivers a mix of aged care, health and community services in rural and remote communities.

The TCP provides older people with rehabilitation and enhanced care options after a hospital stay to avoid premature admission to residential aged care or extended hospital stays. It can be provided in either residential or community settings and aims to improve clients' functional capacity and assist them in making appropriate long-term arrangements. The average period of care is expected to be about eight weeks. From an aged care perspective, this has required a change in the underlying philosophy of service provision; from a traditional care and maintenance approach to one encouraging greater independence and improvement. Announced in the 2004-05 Federal Budget, the TCP has begun filling an emerging service gap through a new cost sharing model between the Australian, State and Territory Governments. As at 30 June 2006, there were 296 Transition Care recipients (AIHW 2007b). In the 2008-09 Budget, the Australian Government announced it would provide $293.2 million over four years to fund an additional 2000 transition care beds (Elliot 2008d).

The MPS program was established by Australian Governments to provide services directed at better meeting the health and aged care needs of people living in rural and remote parts of Australia. The program has expanded the care options of these people by alleviating the need to travel long distances to regional centres or to be left with limited access to health and aged care services. It provides sustainable solutions by combining aged care programs (both residential and community care) with health and community services programs that would otherwise be unviable if provided separately. From an initial set of 11 service centres in 1993, the program has expanded to 117 service centres by June 2008 (DoHA 2008c).

Measures to create a more integrated aged care system and improve service interfaces with the broader health and welfare systems can potentially generate significant efficiency gains. In addition to improving allocative efficiency, these measures also strengthen the capacity of the aged care system to respond to changing circumstances.

Rebalancing public and private financing of aged care services

Governments have also sought to rebalance public and private financing of aged care services by requiring those people who can afford to make a contribution towards the cost of their care to do so.

The *Aged Care Act 1997* reflects the view that it is appropriate to require residents of aged care facilities who can afford to do so, to make some contribution towards the cost of their accommodation and daily living costs, just as they would if they were living in the community. The Act introduced income testing of recurrent subsidies, with the additional funding being used to offset government subsidies. The Act also introduced new arrangements for accommodation payments, with all residential facilities able to seek a capital contribution from residents who can afford to make one, provided the facility meets standards in care and building quality.

A system of user contributions also underpins the provision of community care. For example, for CACPs, EACH and EACHD, this system allows for income testing of fees. However, for these services, all user contributions are retained by the service provider, without reductions in government subsidies.

While there has been some rebalancing of public and private financing of aged care services, this has been within a framework of the Australian Government continuing to bear the major cost of providing aged care services (chapter 2).

Rebalancing through means tested user contributions potentially improves equity of financial access to aged care services. This reflects the wide variation among the aged in terms of their capacity to contribute to the cost of their care and vertical equity is improved when public subsidies are targeted to those least able to pay for themselves.

Further, these measures potentially improve the long-term fiscal sustainability of aged care services, by reducing the burden on taxpayers of funding aged care services on a ‘pay as you go’ basis. Such measures may also enhance the social sustainability of aged care by creating more equitable financing arrangements from an intergenerational perspective.

Streamlining regulatory and administrative arrangements

While the regulatory burden on aged care providers has undoubtedly increased over the past decade, in a number of important ways the Australian Government has taken steps to try to streamline aspects of these arrangements. Examples include: simplifying the residential care income test, adopting a new funding model for residential care and introducing eBusiness to the aged care sector.

In the 2000-01 Budget, the residential care income test was changed from a daily assessment of fees to quarterly reviews. More recently, the Australian Government announced that it would further simplify and improve the fairness of this test. The new income test, which came into effect on 20 March 2008, treats all assessable

income the same, irrespective of whether it is pension or private income. This ensures that, for the first time, self-funded retirees are treated the same way as pensioners.

In response to a recommendation by the Hogan Review, the Government has replaced the Resident Classification Scale (RCS) with a new funding model, the Aged Care Funding Instrument (ACFI). Under the RCS, basic subsidies were paid according to an eight point scale, which was based on the level of care provided by a residential facility. In contrast, the ACFI attempts to measure residents' basic dependency (need for care), with residents being assessed as having low, medium or high care needs in relation to activities of daily living, behaviour and complex health care. Further, new arrangements associated with the introduction of the ACFI are intended to reduce the regulatory burden on providers. For example, the type and form of funding records that providers must maintain have been better defined to reduce incentives for overdocumentation. The ACFI replaced the RCS on 20 March 2008.

The introduction of eBusiness in 2005 has sought to reduce the paperwork burden on aged care providers by facilitating the electronic lodgement of information. The Department of Health and Ageing in collaboration with Medicare Australia and aged care providers has developed an Online Claiming system. This system now supports electronic lodgement of both community care and residential care subsidy claim forms from providers, and eligibility assessments from Aged Care Assessment Teams. It also supports access to key information online through a secure Medicare Australia website. The functionality of the system was extended in March 2008 to allow residential aged care providers to send ACFI data to Medicare Australia electronically.

Streamlining regulatory and administrative arrangements has the potential to improve efficiency (for example, by reducing the compliance burden on service providers associated with overly complex government regulations). Such measures may also improve fiscal and provider sustainability. The former by reducing the cost to taxpayers of administering the aged care system and the latter by reducing compliance costs for providers.

Supporting innovation in service provision

A key vehicle for improving consumer choice and flexibility is through trials and pilots that encourage experimentation in service design and delivery. They can provide valuable insights regarding the effect of local conditions and other factors that might confront programs introduced on a larger scale and the supporting regulatory architecture. It is, however, important to recognise that care under pilot

conditions is often provided at clinically optimal levels; often more intensively, responsively and comprehensively compared with the norm.

The majority of new programs directed at enhancing choice have been introduced following a period of intensive piloting, largely through the Aged Care Innovative Pool.

The Pool was established in 2001-02 to support the development and testing of flexible models of service delivery in areas where mainstream aged care services could not appropriately meet the needs of particular community groups. A range of areas have been targetted including the interfaces between aged care and hospital care, between aged care and disability services, older people in rural and remote areas and the provision of aged care services to people with high and complex needs, including dementia (DoHA 2006a).

In recent years, the Aged Care Innovative Pool has been instrumental in:

- broadening the range of community care services (CACP, EACH, EACHD and Retirement Village Care Pilot)
- meeting emerging needs by pooling funding and facilities across jurisdictions (MPS and TCP)
- involving clients in decision making to enhance choice in service delivery (Dementia and Rehabilitation pilots).

Pilots broadening the range of community care services

One of the key objectives of the aged care pilot trials has been to increase the choices available to older persons to remain in or return to community settings. For example, the Dementia pilot established that many dementia sufferers could remain in community settings for longer by extending the level and range of services they receive (Hales, Ross and Ryan 2006a). Similarly, the Innovative Care Rehabilitation Services pilots demonstrated that older people discharged from hospital were more likely to return to community settings where, rather than adopting the traditional care and maintenance approach, they were provided with supports to facilitate improvement and enhance independence (HMA 2005). Both pilots later influenced the design of more substantial initiatives — the introduction of the EACH Dementia program and TCP respectively.

Likewise, the Retirement Villages Care Pilot concluded that providing additional aged care services to residents in retirement villages could mitigate their premature entry to residential aged care facilities (Hales, Ross and Ryan 2006b). As a consequence, CACP and EACH packages were extended to older people living in retirement villages (Santoro 2006a).

Pooling cross-jurisdictional facilities and funding

Piloting has also been used to explore innovative cross-jurisdictional approaches to service provision involving pooled funding models and shared resources. For example, the MPS program developed from a pilot in 1993 that provided an opportunity for rural communities to pool funds from Australian, State and Territory Governments and apply them flexibly across all health and aged care programs according to community needs (DoHA 2002c).

Similarly, the Innovative Care Rehabilitation Services pilot (which contributed to the design of the TCP) involved joint government funding and resourcing — the Australian Government provided the aged care funding while the States and Territories supported the rehabilitation component and the development of some facilities (HMA 2005).

Pilots involving older people in decision making

Pilots have also been used to facilitate and assess the implications of providing enhanced opportunities for client involvement in decision making. In the case of the Dementia pilot, services were extended and tailored with input from clients according to their cognitive capacities (Hales, Ross and Ryan 2006a). Client control was also extended in the Rehabilitation pilot by allowing consumers greater involvement in the development of their care plans (HMA 2005).

Other policy initiatives

In addition to the measures outlined above, Australian Governments have also introduced a range of other measures, which can be broadly categorised as addressing service gaps, improving the viability of aged care providers and enhancing the ability of the aged care system to respond to emerging challenges (for example, providing appropriate care to the growing number of older Australians suffering from dementia and ensuring the long-term sustainability of the aged care workforce).

Addressing service gaps

Some policy initiatives introduced over the past decade can be characterised as seeking to address gaps in the existing suite of aged care programs by: improving the provision of aged care services in regional and rural areas; providing additional support for carers; improving the provision of culturally appropriate aged care; and improving access to information services. Examples include:

- Establishing the rural Multipurpose Health and Family Services Network, which extended the coverage of Multipurpose Services in rural and remote areas and improved the range and quality of care provided through increased use of information technology.
- Providing increased support for carers, most notably in the 1996-97, 2002-03 and 2005-06 budgets. These initiatives included establishing carer resource centres in each state and territory; expanding respite services; providing increased support for carers of people with dementia and ageing carers of people with disabilities; and measures to provide carers in paid employment and carers re-entering the workforce with access to respite services during working hours. In May 2008, the House of Representatives Standing Committee on Family, Community, Housing and Youth announced an *Inquiry into Better Support for Carers* which includes, among other issues, an investigation of practical measures required to better support carers. The Committee is scheduled to report in early 2009.
- Additional funding to support the provision of culturally appropriate aged care services. The 2001-02 Budget provided funding to expand 'ethnic clusters' that group numbers of people from a particular community together in aged care facilities, as well as to support the development of ethnic specific aged care facilities and culturally appropriate community aged care. Additional funding was provided in the 2004-05 Budget to further strengthen the provision of aged care services to established migrant communities.
- Access to information services has also been improved as the aged care service mix has broadened. The range of information sources has been extended to include a network of Commonwealth Carelink Centres, the Clever Networks program of innovative broadband services and seniors' websites such as 'agedcareaustralia.gov.au' and 'seniors.gov.au'. The latter has been designed as the premier entry point to information on government and non-government aged care services.

Addressing services gaps can improve equity of access to an acceptable standard of care. Further, by ensuring that there is an appropriate mix of services for the aged and their carers such policy initiatives can lessen the likelihood of under or over consumption of particular services.

Improving the viability of aged care providers

A second broad category of initiatives have sought to improve the viability of aged care providers, including assisting them to adjust to new regulatory requirements applying to standards of care and accommodation. Some of this assistance has been

specifically targeted at rural and regional aged care providers. However, significant assistance has also been provided more generally to the aged care industry.

Under the *Aged Care Act 1997*, some rural and remote aged care facilities receive viability supplements in recognition of the difficulties faced in relation to isolation, small size and high cost structures and where small services are largely caring for financially disadvantaged people and other groups with special needs. In response to the Hogan Review, the 2004-05 Budget included funding to increase the viability supplement to rural and remote providers. It also provided funding to extend the viability supplement to eligible residential aged care facilities funded under the National Aboriginal and Torres Strait Islander Aged Care Strategy. Further, eligibility requirements and the supplement rates were modified to remove perverse incentives for consolidation, particularly for operators of smaller residential facilities. The 2006-07 Budget included funding for a new viability supplement to providers of CACP, EACH and EACHD programs, the MPS and Aboriginal and Torres Strait Islander Flexible Care programs in rural and remote areas.

The Australian Government also provides capital assistance to aged care facilities in rural and remote areas, to assist them undertake capital works or other investments necessary to comply with accreditation and certification requirements.

Further, in recent years, the aged care industry as a whole has benefited from Australian government funded adjustment payments. In response to the Hogan Review, the 2004-05 Budget included funding of $877.8 million over four years for a conditional adjustment payment (CAP) which was introduced to provide additional medium-term financial assistance to residential aged care providers while encouraging them to become more efficient through improved management practices. The payment is in addition to the recurrent basic subsidy and is conditional on providers making audited financial statements publicly available, participating in a periodic workforce census and encouraging staff training.

In the 2008-09 Budget, the Australian Government increased the level of the CAP by 1.75 per cent from 7.0 to 8.75 per cent of the basic aged care subsidy. This measure is intended to provide an additional $407.6 million over four years to the aged care sector and brings total CAP payments over the next four years to $2 billion (Elliot 2008a). At the same time, the Australian Government announced that it had instructed the Department of Health and Ageing to undertake a review of the ongoing need for and level of the CAP. The Department is to conclude the review by the end of October 2008.

The payment of viability supplements for residential and community care and capital assistance helps ensure equity of access to an appropriate standard of care

having regard to the challenges arising from clients with special needs, remoteness of a service location and/or small service size.

Addressing the needs of dementia suffers

Over the past decade there has been increasing recognition of the challenge of providing appropriate care for the growing number of older Australians suffering from dementia. Initially, initiatives tended to be supported by relatively small amounts of funding. For example, the 1997-98 Budget provided additional funding of around $2.5 million to more accurately diagnosis and assess people with dementia, particularly those living in regional and rural areas. Further, the 1998-99 budget provided around $2.7 million a year for psychogeriatric care units to assist residential and community care providers meet the care needs of people with dementia, challenging behaviours and other psychogeriatric conditions.

However, more recently, the Australian Government has significantly augmented funding in this area. For example, in 2005 it identified dementia as a National Health Priority and provided increased funding of $70.5 million over five years for additional research, improved care and early intervention programs. The 2005-06 Budget also allocated $25 million over four years to provide dementia specific training for community and residential care workers and community workers such as police and transport workers. These initiatives are in addition to the $225 million that was allocated to the EACH Dementia program in that year.

These initiatives recognise that people suffering from dementia have special needs and require access to more complex care. Given the expected growth in the number of people with dementia over the next 40 years, these initiatives also potentially improve the long-term sustainability of aged care services, for example by taking pressure off services that are not designed to meet their specific care needs.

Improving the sustainability of the aged care workforce

As discussed in more detail in chapter 6, a key challenge for the aged care system is the sustainability of its workforce. In a number of recent Australian Government budgets, additional funding has been provided to support workforce development, including through enhanced opportunities for educational training and an expansion in the number of undergraduate nurse training places. For example, the 2004-05 Budget included funding of around $100 million over four years to enhance educational training opportunities for residential care workers, including by providing additional Workplace English Language and Literacy training places, vocational education and training places and medication management training places.

In the 2008-09 Budget, the Australian Government announced that it would be seeking to increase the nursing workforce in residential aged care by encouraging up to 1000 nurses to return to the nursing workforce over five years. This measure is part of a larger initiative that provides $138.9 million over five years across the Health and Ageing and Education portfolios to encourage 8750 qualified nurses to return to the workforce and to create 90 new Commonwealth supported training places in nursing in the second semester of 2008, with a further 1170 places in 2009 (Elliot 2008d).

Specific initiatives to support workforce development recognise that this issue is critical to the effective provision of aged care services (chapter 6).