



Australian Government
Productivity Commission

Trends in
Aged Care Services:
some implications

Productivity Commission
Research Paper

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Foreword

The ageing of Australia's population will call for the provision of aged care services to much larger numbers of people over the next few decades. Services will also need to meet the challenges posed by the increasing diversity of older people in terms of their care needs, preferences and affluence.

It is clearly important that our aged care sector is able to meet these challenges in ways that promote the wellbeing of the oldest generation, while being cost effective for the community as a whole. This study seeks to make a contribution to this by analysing major trends in both demand and supply over the next 40 years. The study then draws some implications for the future structure and mix of aged care services, the aged care workforce and for the capacity for greater productivity in the sector. The associated policy issues are complex. However, some prospective directions for reform have been identified which warrant further, more detailed analysis.

The report is part of a series of studies undertaken by the Productivity Commission to examine developments in different sectors of the Australian economy. It also builds on earlier work by the Commission in the areas of demographic change, health and aged care.

Gary Banks AO
Chairman

September 2008

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Abbreviations

ABS	Australian Bureau of Statistics
ACAA	Aged Care Association Australia
ACAT	Aged Care Assessment Team
ACFI	Aged Care Funding Instrument
ACSA	Aged and Community Services Australia
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
ANAO	Australian National Audit Office
ASIC	Australian Securities and Investment Commission
CACP	Community Aged Care Package
CAP	Conditional Adjustment Payment
CCDE	Cash and Counseling Demonstration and Evaluation
CEPA	Centre for Efficiency and Productivity Analysis
CHA	Catholic Health Australia
COAG	Council of Australian Governments
COP	Community Options Program
COPO	Commonwealth Own Purpose Outlays
CPI	Consumer Price Index
CURF	Confidentialised Unit Record File
DEA	Data Envelopment Analysis
DHAC	Department of Health and Aged Care
DoHA	Department of Health and Ageing
DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home
EACHD	Extended Aged Care at Home Dementia
EBA	Enterprise Bargaining Agreement
FECCA	Federation of Ethnic Communities' Councils of Australia
GDP	Gross Domestic Product
HACC	Home and Community Care

LAC	Local Area Coordination
LTC	Long Term Care
MDS	Minimum Data Set
MPS	Multipurpose Services
NATSEM	National Centre for Social and Economic Modelling
NILS	National Institute of Labour Studies
NRCP	National Respite for Carers Program
OECD	Organisation for Economic Co-operation and Development
PC	Productivity Commission
RCS	Resident Classification Scale
RN	Registered Nurse
SCARC	Senate Community Affairs Reference Committee
SFA	Stochastic Frontier Analysis
TAFE	Technical and Further Education
TCP	Transition Care Program
UCCO	UnitingCare Community Options
VHC	Veteran's Home Care
WCOP	Wisconsin Community Options Program
WHO	World Health Organization

OVERVIEW

Key points

- Over the next 40 years, population ageing and growing diversity among older people — in terms of their care needs, preferences and affluence — are expected to pose a number of challenges to Australia’s aged care system. These include:
 - a significant increase in demand — those aged over 85 tend to be the main users of aged care services, and their numbers are expected to increase at least four-fold by 2047
 - the changing pattern of disease among the aged is expected to increase the proportion of frail older people with more complex care needs
 - an increased preference for independent living arrangements supported by community care, and a desire for greater autonomy and choice in aged care services generally
 - many of the aged having higher levels of income and wealth with which to leverage services, although significant numbers — over three quarters of those of age pension age — will continue to be eligible for the age pension
 - needing to secure a significant expansion in the aged care workforce at a time of ‘aged induced’ tightening of the labour market, accentuated by competing demands from the acute care sector.
- The policy implications of these prospective challenges are broad ranging and complex. This study highlights several areas where further analysis seems called for to aid the development of an improved framework for aged care, including:
 - assessing the potential for unbundling residential care (that is, accommodation, everyday living and personal care costs) to better reflect the underlying costs of these services and enable better targeting of public subsidies to those most in need
 - examining the current dual gate-keeping system and the scope to improve it by dispensing with the planning and allocation system (while retaining accreditation) and relying on the entitlement for aged care services established by aged care assessment teams
 - considering the feasibility of introducing ‘consumer-centred’ care arrangements to enhance the potential for older people to influence the nature and scope of the services they receive
 - looking at ways of improving responsiveness in aged care education and training arrangements and extending scopes of practice to overcome inefficiencies and inflexibilities in the workforce.

Overview

The Australian community places significant importance on older people having access to high quality and cost effective aged care services. This is reflected in current institutional and regulatory arrangements, which give considerable weight to achieving equity of access and a minimum acceptable standard of service quality. Australia's extensively regulated, highly subsidised and somewhat 'standardised' aged care system will come under increasing pressure as a result of population ageing and growing diversity among older people. These pressures will present a number of challenges for the current policy framework and require changes to enhance its effectiveness.

In recent years, the Commission has undertaken a number of studies of the aged care sector and the challenges it faces (see, for example, PC 1999, 2003 and 2005b). This study updates that work by examining trends in the demand for, and supply of, aged care services and their implications. It analyses how emerging challenges on the demand-side of the aged care 'market' are creating pressure for the supply-side to be more flexible, responsive and efficient. In particular, it examines impediments to Australia's aged care system being able to respond to demands for higher quality services and greater choice. It also considers how prospective developments in aged care will affect the aged care workforce and the types of services that are sustainable in the long term. Finally, it examines the scope for further productivity improvements in aged care, which will be central to helping to contain future cost pressures while improving service quality.

A profile of Australia's aged care sector is provided in box 1.

A larger and more diverse client base

Population ageing in Australia is a result of both a sizeable decline in fertility rates since the 1960s and an increase in longevity through advances in medical technology and public health initiatives (table 1). As a consequence, there will be a demand for aged care services by a significantly larger number of older people (both in absolute and relative terms) over the next 40 years. Today, those aged 65 years or older comprise around one in seven Australians. By 2050, about one in four will be aged 65 years or older (PC 2005b).

Box 1 Profile of Australia's aged care sector

Older Australians (aged 65 years or over)	<ul style="list-style-type: none">• 2.8 million (30 June 2007)• 13.4 per cent of the population
Assistance with personal and everyday activities	<ul style="list-style-type: none">• 32 per cent of those aged 65-74 years (2003)• 86 per cent of those aged 85 years and over (2003)
Mix of government-funded services	<ul style="list-style-type: none">• 144 959 people received permanent residential care (30 June 2007)• 101 252 permanent high care residents (69.8 per cent of residents)• 43 707 permanent low care residents (30.2 per cent of residents)• 756 855 clients of key government funded community care programs (30 June 2007)
Recurrent government expenditure (for clients aged 65 years or older)	<ul style="list-style-type: none">• Aged care assessments — \$58 million• Residential care — \$5398 million• Community care — \$2117 million• Financial support for carers — \$1018 million• Total — \$8591 million (2006-07)
Residential aged care providers	<ul style="list-style-type: none">• Private non-for-profit — 1762 facilities (61.4 per cent)• Private for-profit — 773 facilities (26.9 per cent)• Government — 337 facilities (11.7 per cent)• Total — 2872 facilities (30 June 2007)
Residential aged care workers	<ul style="list-style-type: none">• 156 823 (mid-2003) (1.5 per cent of the workforce)

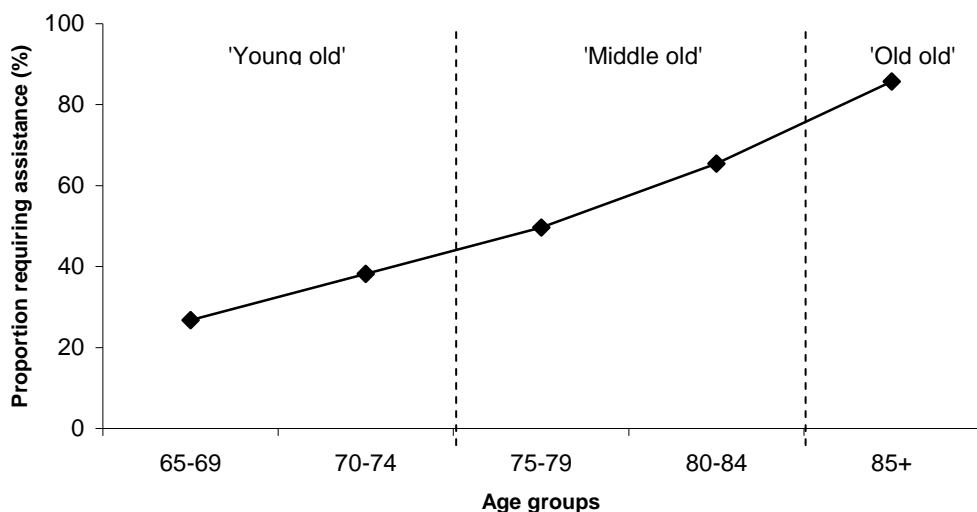
Table 1 Life expectancy at selected ages

Age	1901-1910	1965-66	1975-77	1985-87	1995-97	2006
Males						
65	11.3	12.2	13.1	14.6	16.2	18.3
75	6.6	7.3	7.9	8.8	9.8	11.1
85	3.6	4.1	4.4	4.9	5.4	5.9
Females						
65	12.9	15.7	17.1	18.6	19.9	21.5
75	7.6	9.2	10.3	11.4	12.3	13.4
85	4.2	4.8	5.5	6.1	6.5	7.1

Based on data from the ABS Disability, Ageing and Carers Survey, the need for some form of assistance with personal and everyday activities increases markedly as people move into older age cohorts, particularly for those aged 85 years and over (figure 1). Reductions in severe and profound age-specific disability rates in coming years will only partially offset the growing demand for aged care services.

Figure 1 Need for assistance by age of older persons

Percentage of population in 2003



A sizeable increase in the required *quantum* of services is not the only challenge in providing aged care services. Over the next few decades, older Australians are expected to become more diverse in terms of their care needs, preferences, incomes and wealth. This will have important implications for the *qualitative* aspects of aged care services (such as the range of services needed and the flexibility of service delivery) and the cost of these services.

The range of services provided will also need to respond to the changing health status of the aged. Much of the increased longevity over the past 30 years has arisen from declines in mortality from some diseases, such as heart disease and stroke. However, as more people live to older ages, the prevalence of chronic diseases increases markedly. For example, the number of Australians with dementia is expected to increase from around 220 000 to over 730 000 between 2007 and 2050. There will also be a growing prevalence of co-morbidity (people living with two or more diseases at the same time). This changing pattern of disease will create greater diversity in the care needs of older people, especially among the 'old old' where it will present new challenges in caring for the very frail.

Older age cohorts will progressively reflect greater ethnic diversity as Australia's post war migrants age. As a result, the demand for culturally appropriate, flexible and consumer centred age care services is expected to increase.

A large number of baby boomers will also have higher levels of income and wealth to purchase the aged care services they want. They represent the wealthiest households in Australia, having a net worth of around \$381 000 on average compared to about \$292 500 on average for all Australians. Even so, considerable diversity in the incomes and wealth of older Australians is likely to drive sharp differences in the demand profile for aged care services. As a result, the aged care sector will increasingly face the dual challenge of providing improved services for people with high incomes or wealth, while continuing to provide quality aged care services to those reliant, to varying degrees, on government income support.

Projections of the number of people receiving full, part and no age or service pensions over the next 40 years provide a useful guide to the proportion of older Australians who are likely to be reliant on publicly subsidised aged care. Between 2007 and 2047, the proportion of people of pension age receiving: a full pension is expected to decline from 55.1 to 35.8 per cent; a part pension to increase from 24.9 to 40.7 per cent; and no pension to increase from 20.0 to 23.6 per cent (table 2). These changes reflect the increasing value of individuals' superannuation and other private assets and income.

Table 2 Projections of people receiving full, part or no pensions
Per cent of those of pension age

	2007	2017	2027	2037	2047
People receiving pensions and no pensions					
Full pension	55.1	48.5	40.6	37.8	35.8
Part pension	24.9	31.1	36.6	38.6	40.7
No pension	20.0	20.4	22.8	23.6	23.6
Total	100.0	100.0	100.0	100.0	100.0

Challenges facing the aged care system

Many analysts and commentators question how well placed Australia's aged care system is to meet these emerging challenges. There are concerns about the degree to which the provision of aged care services is shaped by centralised planning and administrative processes, extensive government regulation and high levels of public subsidy. There are also concerns that the system is overly fragmented and difficult to access and navigate, reflecting the existence of multiple programs combined with the involvement of multiple government departments and agencies across different tiers of government. This fragmentation is seen as a barrier to the aged in understanding what services best meet their needs and to improving service interfaces within the aged care system, and between the aged care system and the broader health and community-welfare systems.

Currently, adjustments to the provision of aged care services occur primarily through periodic changes to regulatory and funding parameters. Governments largely determine how many aged care places are provided, where these places are located, the appropriate mix of services, the price of these services and how they are modified in response to changing community expectations. Competition and price play little role in signalling to providers the changing patterns of demand and the need to adjust decision-making accordingly (including the need for new investment). In effect, client needs and preferences are only revealed indirectly to providers through government planning and regulatory processes, rather than directly.

In part, these arrangements reflect the need to manage the fiscal risk borne by government in funding the provision of aged care. Currently, aged care programs are funded by government on a 'pay as you go' basis (that is, from consolidated revenue), supplemented by user co-payments. As a consequence, taxpayers bear a large part of the cost of providing these services. In the context of an ageing population and an increasing dependency ratio (reflecting a fall in the number of workers relative to Australia's population), this represents a significant and growing

burden for future taxpayers. Indeed, the Australian Treasury has estimated that, assuming no change in current policy settings for aged care services, Australian Government spending on aged care for those aged 65 years and over will increase as a proportion of gross domestic product from 0.7 per cent to around 1.9 per cent between 2006-07 and 2046-47. In that regard however, the Commission noted in its study of the *Economic Implications of an Ageing Australia* (PC 2005b), that Australia will be a richer country when these impacts are felt, having a greater capacity to absorb the additional costs associated with its ageing population.

Clearly, governments need to effectively manage the fiscal risk of funding aged care services. That said, there are concerns that current institutional arrangements, which rely on a planning mechanism in concert with aged care assessments and controls over extra service provision and pricing of services, could involve significant avoidable costs. For example, these controls in their current form combine to limit the scope for competition between providers, distort investment decision-making, restrict consumer choice and weaken incentives for innovation.

Enhancing equity, efficiency and sustainability

Over coming decades, pressures on the demand-side of the aged care market are expected to accentuate a number of weaknesses in the current policy framework, including: inequities arising from existing program design; inefficiencies arising from excessive government regulation; and the need to improve service interfaces within and between aged care services and other systems including acute care, housing and disability services. To varying degrees, a number of recent reviews (see, for example, the Hogan Review 2004) have considered these problems and identified a variety of possible reforms that warrant further consideration.

The Commission has previously argued the case for considering the ‘unbundling’ of the accommodation and everyday living expense components of aged care from the personal care component (PC 2003). Accommodation costs in particular are fairly predictable expenses of everyday life and are not exclusively associated with increasing frailty or disability. In contrast, personal care needs are often unpredictable and can be overly burdensome. Unbundling the different cost components would allow consistent public financing principles to be applied across different types of care, thereby improving the overall equity of the aged care system.

Unbundling provides scope to more accurately price the individual components to better reflect their underlying cost; better target government subsidies to those most in need; and overcome some of the inequities between users of residential and

community care. However, unbundling raises a number of implementation issues that would require resolution if this approach were to be introduced.

The current pricing arrangements covering accommodation payments give rise to inefficient cross-subsidies between low and high residential care and distort investment decision-making. The problems posed by these anomalies could be addressed in a number of ways. One previously proposed option would be to require all residents who can afford to make a capital contribution to pay either a lump sum bond, or a daily or periodic rental charge (at a level equivalent to the bond).

The efficiency and responsiveness of Australia's aged care system could potentially also be improved by reforming the current dual gate-keeping system. While there are a number of possibilities here, one approach which warrants further investigation would be to dispense with the aged care planning and allocation system (while retaining accreditation) and rely on the entitlement for aged care services established by aged care assessment teams. Further analysis would also be required to identify the appropriate form of any transitional arrangements to avoid the possibility of significant policy induced disruption to the market. There would also be a need for complementary reforms to secure the desired balance between concessional and non-concessional aged care places, and to promote cost effective provision and use of these services.

The need to improve service interfaces has emerged as a key challenge in recent years. There are significant crossovers between different bundles of aged care services and between the aged care system and other systems such as health and housing. These are most problematic for older people needing to access multiple services in order to continue to live independently in the community, and also for those needing to make the transition between related systems (for example, from hospital to home or to a residential care facility). Progress in this area will require a whole-of-government response, given the involvement of multiple government departments and agencies across different tiers of government.

Improving service quality and providing greater choice

The ability of older Australians to exercise choice is limited by regulatory and financing arrangements that effectively ration the quantity, and limit the mix, of available services. The ability of providers to differentiate their services in terms of price and quality is also highly constrained. For example, while 'extra service' places provide a degree of additional choice in residential care, this is limited to hotel type services (accommodation, food and other amenities) and does not extend to personal care. The ability of older people to exercise choice of community care

services is constrained by the current program and funding mix. And, their ability to remain in the community is affected by the availability of related support services, such as public transport and housing.

A number of issues need to be considered as part of any assessment of the case for introducing measures to enhance choice, including user preferences for exercising choice and their decision-making capacity. There are also issues about the scope of services to be included and the implications for regulatory settings covering, for example, the need for enhanced information and quality assurance for consumers. Also relevant is the feasibility and nature of competition in the market for aged care services and the role of experimentation and trialling in guiding the development of new arrangements over time.

The reform experiences of Australia's disability services sector and of aged care in some other countries suggest that consumer centred care arrangements can provide users with greater choice and autonomy in service selection and packaging, reduce the incidence of unmet need and enhance satisfaction with care services.

Within aged care, consumer centred care could be implemented through incremental refinements and/or extensions to existing programs. Alternatively, pooled funding mechanisms with assisted choice could involve Australian governments combining their aged care programs at a regional level, with case managers assisting clients to assess, plan and coordinate their care. A third option would be to issue a cash entitlement which clients could use to purchase aged care services directly from competing providers or through a brokering service. These options need further analysis and debate.

Implications for the aged care workforce

Changes in the level and composition of demand for aged care services, along with the challenges arising from an 'aged induced' tightening of the labour market over coming years, will also have implications for the aged care workforce. This, in turn, will impact on the sustainability of the services being supplied, because most are labour intensive and the relative costs of providing different bundles of services will be affected by broader workforce changes. The evidence suggests that over the next 40 years there will be difficulties in securing an adequate supply of personnel with the necessary skills to support the delivery of aged care services.

The sector will face stronger competition for paid workers from the acute care sector and other industries than it does at present. There is already a shortage of nurses in general, and of aged care workers in particular. On average, the age profile of the residential care workforce is markedly older than the health and community

care workforce and the Australian labour force as a whole. Over coming decades, the sector will need to replace a growing number of retiring workers. This will place a premium on attracting new workers and retaining existing workers.

The reason most commonly cited by employers experiencing difficulties in attracting and retaining staff in the sector is the substantially lower remuneration of its employees compared with the workforce in similar sectors.

In the context of a growing demand for aged care, there is clearly a need to moderate the extent of these cost pressures. Reflecting the multifaceted nature of the problem there are a number of possible policy responses. One would be to facilitate workplace change and innovation in job design through extending the training and scope of practice of certain groups of workers (such as registered and enrolled nurses). This primarily involves making the most of the skills and experience of workers in relation to the broad range of functions associated with the delivery of aged care services, while still ensuring the safety and quality of care provided to clients. However, there are currently various regulatory and funding barriers to making progress in this area. There is a need for ongoing investment in education and training to build a sustainable and competent workforce as well as for minimising the extent to which quality-related and other regulations unnecessarily magnify the administration and management tasks of providers and their staff.

The effectiveness of aged care services in Australia also relies heavily on informal carers who directly care for older people and play an important role in coordinating and facilitating formal community care services. However, the availability of these carers is expected to decline over the coming decades. While the demand for informal carers is expected to rise by 160 per cent between 2001 and 2031, the supply is expected to increase by less than 60 per cent. These combined changes are expected to contribute to the carer shortfall increasing from 150 000 to almost 600 000 over this period. In the absence of mitigating changes, such a shortfall could undermine the sustainability of community care and increase the demand for residential care.

Recent reviews suggest that there are five key areas of concern for informal carers of the aged: access to information about support services for those they care for and for themselves; the structure and adequacy of financial support; access to respite and other care services; flexibility of their own workplaces; and training and assistive technologies.

In acknowledging the importance of informal carers, the Australian Government has recently announced an inquiry to investigate how carers can be better supported. The inquiry will provide an opportunity to consider how these and other issues are impacting on the role and contribution of carers.

Volunteers also play an important role in supporting the aged. Demographic change is expected to increase the availability of volunteers. The Commission has previously estimated that the potential pool of formal volunteers will more than double between 2000-01 and 2044-45 (PC 2005b). However, the aged care sector is likely to face growing competition for volunteers from other community activities. As such, there will be increased pressure on aged care organisations to make effective use of their volunteers and provide them with a rewarding experience. Governments also need to be sensitive to unintended consequences of policies that impact on the scale and scope of volunteer involvement.

The scope to improve productivity

Aged care has many of the characteristics that constrain productivity improvements — being labour intensive, relatively ‘low tech’ and involving, to some degree, the tailoring of services to meet the individual needs of clients. Even so, over the long term, the cumulative effect of even relatively small productivity gains has the potential to enhance the ability of the sector to meet the growing demand for its services.

Given the limited data about the productivity performance of the aged care sector, which significantly curtails analysis in this area, the Hogan Review commissioned a study of the efficiency of Australia’s residential aged care sector. In assessing the scope for improving technical efficiency within the sector, the study looked at the performance of residential facilities relative to the best performers. Using this approach, it found that the cost of providing these services could have been reduced by 17 per cent or \$1.1 billion in 2002-03. This notional efficiency gain could, alternatively, have allowed providers to care for an additional 23 100 clients at the dependency levels that existed in 2002-03. The study also suggested that costs could be reduced by a further 7 per cent (or \$470 million) in 2002-03 through structural adjustment to improve the scale efficiency of the sector.

In practice, realising the full gamut of these potential gains would not be possible because not all providers are capable of matching the performance of the industry leaders. Some face higher costs or have less scope to raise productivity because they operate in rural or remote locations or provide care for a high proportion of clients with special needs. In addition, there may be significant up-front costs associated with improving technical and/or scale efficiency. Even so, as noted by the Hogan Review, the current regulatory framework impairs incentives for productivity improvement.

Anecdotal evidence from some providers suggests the potential for further productivity improvements from:

- adopting advances in information technologies to improve the efficiency of administration and care outcomes
- increasing the use of assistive technologies to improve workforce outcomes and client independence
- improving work practices by incorporating greater flexibility into operations through enterprise bargaining
- restructuring operations including outsourcing and adjusting the capital/labour mix in service provision.

There also appears to be scope to strengthen incentives and the capacity of providers to improve their productivity by modifying current regulatory settings. Areas where these settings seem to be constraining the capacity of the sector to operate efficiently include: constraints on the supply of aged care services; the duplication of building certification requirements; inconsistency in the application of accommodation bonds across service types; and administrative inefficiencies with contract management in community care.

In seeking to strengthen the incentives for providers to improve productivity through further regulatory reform, there is a need to ensure that any changes do not jeopardise the broader objectives of the aged care system, particularly in relation to equity and quality.

1 Introduction

1.1 Why a study of trends in aged care?

Over the last decade or so there has been a growing realisation that aged care policy is facing considerable challenges. In particular, the need to provide aged care to a significantly larger number of older people (both in absolute and relative terms) over the next 40 years raises questions about the sustainability of current financing arrangements and regulatory settings. As recognised by the OECD (1996, p. 3), these challenges are not unique to Australia:

All industrial countries are experiencing demographic ageing, with considerable consequences for public policy. As the numbers in the oldest age groups grow, the level of resources devoted to the care of frail elderly people rises dramatically. Consequently, long-term care policy has assumed a far higher profile in recent years in OECD countries.

Significantly, the challenges will be magnified by the increasing diversity of older people in terms of their care needs, preferences and affluence. For example, the ageing of Australia's population will give rise to a significant increase in the number of older Australians with dementia and other disabling conditions, with flow-on implications for aged care services and the aged care workforce. At the same time, a growing number of aged Australians prefer independent living arrangements supported by a mix of formal community care services and informal care. Reflecting this, there is growing interest in the implications of these and other developments for the future range of aged care services, their flexibility and quality, and for the workforce who provide these services.

These developments have, in turn, led to a renewed debate about the adequacy of Australia's aged care system in its current form. Notwithstanding recent policy changes to improve the sustainability of aged care services, many observers believe that without further reform, Australia's aged care system may have difficulty providing quality services for the growing number of older citizens which meet their increasingly diverse care needs and preferences.

In this context, the Hogan Review (2004), which was charged with examining the long-term prospects of the residential aged care industry (particularly, in relation to sources of funding and pricing arrangements), proposed a series of immediate,

medium and long-term reforms. There remain some important areas of ‘unfinished business’ arising from the review’s proposed reform agenda, notably in relation to accommodation payments for residential care and the provision of greater choice for consumers.

In 2004, research and actions to strengthen community care were outlined in *A New Strategy for Community Care: The Way Forward* (DoHA 2004a). The strategy identified a number of areas for improvement including addressing gaps and overlaps in service delivery, providing easier access to services, enhancing service management, streamlining Australian Government programs and adopting a partnership approach. Complementing this initiative a *Review of Subsidies and Services in Australian Government Funded Community Aged Care Programs* was initiated by the Australian Government in September 2006. The review was charged with examining areas where the current structure of community care programs and funding arrangements could be refined and service delivery improved, with a view to developing a more integrated set of aged care services. The review is expected to be completed later this year.

The recent change of government has seen the commissioning of further reviews and investigations into other aspects of the aged care industry:

- the National Health Reform Commission is to report by June 2009 on a long-term health reform plan to, amongst other things, better integrate acute and aged care services and improve the transition between hospital and aged care
- the Department of Health and Ageing is to undertake a review of the ongoing need for and level of the conditional adjustment payment to residential care providers
- the House of Representatives Standing Committee on Family, Community Housing and Youth has announced a parliamentary inquiry to investigate how carers can be better supported in their vital role.

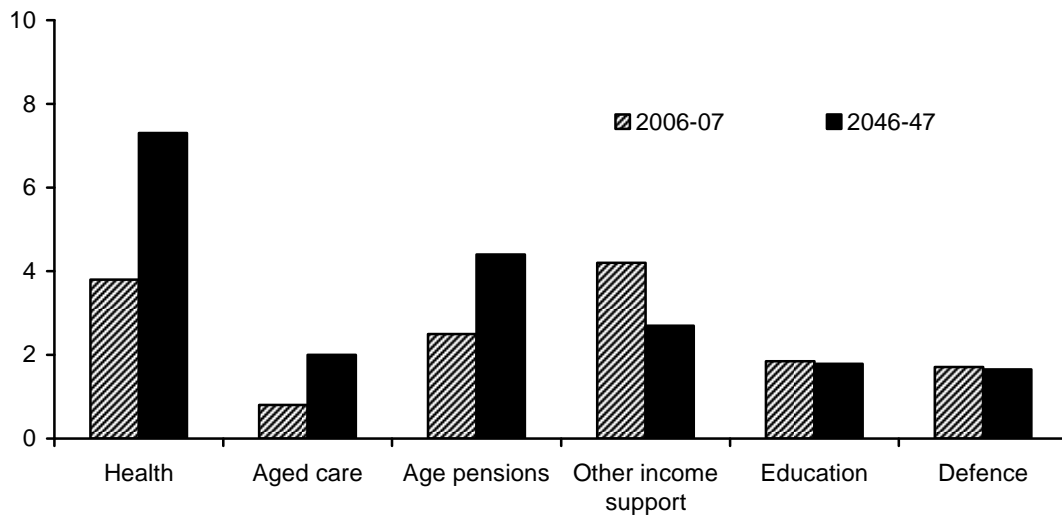
A new Ministerial Council on Ageing directed at facilitating ‘a consistent and coordinated approach to ageing and aged care policy across all levels of government, including reduced duplication of effort and better continuity of service delivery,’ was established following the March 2008 meeting of the Council of Australian Governments (COAG 2008, p. 8).

There has also been a recognition of the broader public policy challenges posed by population ageing. The Australian Treasury has highlighted the implications of population ageing for Australian Government expenditure through its Intergenerational Reports. The first report (Treasury 2002) identified seven priorities for ensuring fiscal sustainability — including developing an affordable and effective

residential care system that can accommodate the expected growth in the number of people aged 85 years and over.

The latest report (Treasury 2007) estimated that, under current policy settings, Australian Government expenditure on aged care (including for people aged less than 65) will increase from 0.8 per cent of GDP in 2006-07 to around 2.0 per cent in 2046-47. The report also observed that spending on health and aged care will account for much of the projected rise in overall spending over the next four decades (figure 1.1).

Figure 1.1 Projections of Australian Government expenditure by category
Per cent of GDP



Data source: Treasury (2007, p. 77).

The Commission's objectives in undertaking this study

The Commission has played a role in contributing to an improved understanding of the aged care sector and the challenges it faces. Specifically, it has undertaken inquiries and commissioned research such as *Nursing Home Subsidies* (PC 1999) and the *Economic Implications of an Ageing Australia* (PC 2005b), as well as supporting research including *Long-Term Aged Care: Expenditure Trends and Projections* (Madge 2000) and the *Productivity Commission Submission to the Review of Pricing Arrangements in Residential Aged Care* (PC 2003).

In light of the challenges outlined above, the Commission considers there is an opportunity for it to further contribute to informed debate in this important area of social and economic policy.

The focus of the present study is on trends in the demand for, and supply of, aged care services and their implications. Specifically, the study's objectives are to:

- analyse key demand and supply influences and the likely consequences of emerging trends for the future structure and mix of aged care services (the range, flexibility and quality of formal and informal services)
- examine the implications of changes in the structure of services for the future aged care workforce (nurses, doctors, ancillary staff, carers and volunteers)
- draw on overseas experiences covering consumer centred care arrangements to help identify approaches that may be worth further consideration in the Australian context.

It is intended that the study will inform governments and the broader community about likely developments over the next four decades. However, while it is anticipated that the research results will feed into policy debate, the study does not make any recommendations.

During the course of the study, the research team consulted a number of industry stakeholders to assist it to explore challenges associated with providing aged care services in Australia.

1.2 Some key terms

As a backdrop to the remainder of this study, this section clarifies the meaning of some key terms — such as the ‘the aged’, ‘aged care services’ and the ‘aged care system’.

Typically, ‘**the aged**’ are defined as those persons aged 65 years or over, and this broad definition is used in the current study. However, people included in this population grouping are far from homogeneous. For example, there are significant differences in living arrangements, family circumstances, income and wealth, social practices and health status. Reflecting these differences, there are important variations in the needs of the aged and in their use of aged care and other community and health related services. Although age itself is far from an accurate guide to these differences, it can be useful to distinguish between different age groups among the aged when examining trends in demand for aged care services. Reflecting this, the study sometimes draws a distinction between three subsets of the aged: those aged 65–74 years (the ‘young old’), those aged 75–84 years (the ‘middle old’), and those aged 85 years and over (the ‘old old’).

‘Aged care services’ are generally taken to include a number of care modes, the main forms of which are:

- community care, which is provided mainly in the care recipient’s own home, often with the assistance of informal carers in concert with formal community care service providers
- residential care (encompassing both low care ‘hostel’ and high care ‘nursing home’ facilities).

In providing these and other services, the **‘aged care system’** incorporates many different players, governance arrangements, layers of regulation and payment and incentive mechanisms. In common with other complex social product systems — such as the health and education systems — there are a number of subsystems within aged care (for example, community care, residential care and respite care). There are also important interfaces between aged care and other social policy areas.

Wherever possible, the Commission has sought to take a system-wide perspective in this study, looking at aged care in a holistic way. The study also considers the interaction between care modes, and between the aged care system and the health, disability and housing systems.

1.3 Guide to the study

The study comprises a further six chapters as follows:

- a profile of the aged care system which provides a snapshot of the sector and summarises some important changes over the past decade (chapter 2)
- a consideration of factors shaping the future demand for aged care services and what they imply for the future provision of care (chapter 3)
- an examination of emerging challenges in securing desired outcomes in relation to equity, efficiency and sustainability in aged care (chapter 4)
- issues associated with quality and choice notably in relation to challenges arising with securing a more consumer oriented approach to aged care (chapter 5)
- challenges in adapting the workforce to changes in the makeup and composition of aged care services (chapter 6)
- opportunities to secure future productivity improvements (chapter 7).

An overview of recent initiatives aimed at improving the financing and provision of aged care services is presented in appendix A.

2 A profile of aged care

Key points

- Older Australians are an increasingly diverse group in terms of their backgrounds, care needs, preferences and incomes and wealth.
- Aged care services are provided both in the community and in residential facilities.
 - Community care is primarily provided by informal carers.
- The need for some form of assistance with personal and everyday activities increases with age. In 2003, 32 per cent of those aged 65–74 years needed some form of assistance, compared with around 86 per cent of those aged 85 or older.
- Publicly subsidised aged care services are extensively regulated and predominantly funded by the Australian Government, although all levels of government are involved to some extent. Government is involved in: allocating places to approved providers; assessing client eligibility for services; funding services; setting prices; and regulating quality.
- The regulated aged care sector has changed significantly over the past decade or so. Key trends include:
 - increasing numbers of older Australians requiring subsidised care — the number of residential and equivalent community care places increased by nearly 52 per cent between 1998 and 2007.
 - greater reliance on user contributions — their share of total residential care expenditure increased from 22 to 25 per cent between 2003-04 and 2005-06.
 - increasing emphasis on community care — its share of subsidised places under the *Aged Care Act 1997* increased from 2 to 20 per cent between 1995 and 2007.
 - greater proportion of residents in high level care — their share increased from 58 to 70 per cent between 1998 and 2007.
 - decreasing numbers of smaller residential facilities — the share of facilities with 40 or fewer beds decreased from 53 to 34 per cent between 1998 and 2007.
 - increasing investment by private for-profit providers — their share of residential care beds increased from around 29 per cent in 1998 to 32 per cent by 2007.

This chapter's overview of aged care services, clients and providers serves as a basis for the subsequent analysis of future challenges facing the aged care sector. It provides a current snapshot of the sector and highlights key changes within the sector over the past decade or so.

Detailed information about the aged care system is available from a variety of sources notably *Australia's Welfare* (AIHW 2007b), *Residential Aged Care Services in Australia* (AIHW 2008d), *Aged Care Packages in the Community* (AIHW 2008a) and *Report on the Operation of the Aged Care Act 1997* (DoHA 2007h).

The aged care sector encompasses a broad range of services reflecting differing client needs and funding arrangements. It is also characterised by extensive government regulation and high levels of public subsidy. There are two broad categories of aged care services — community (or home based) care and care provided in residential aged care facilities.

Some older people purchase aged care services that are not funded or regulated by the Australian Government. However, data on the extent of these services are not readily available. Hence, this study focuses on the regulated system of aged care service provision in Australia.

2.1 Aged care represents a 'social product system'

Aged care is essentially concerned with providing appropriate care for older Australians as the ageing process impairs their ability to care for themselves. The provision of aged care can be thought of as a complex 'social product system' (see, for example, Marceau and Basri 2001 — who examine healthcare in this context). Features that characterise the social product system for aged care services include:

- the production of 'bundles' of services tailored to the individual needs of clients, that may include personal care services, other everyday assistance, accommodation, nursing care and palliative care
- a high degree of direct contact between providers and clients rather than through arms length market transactions
- the presence of many different organisations, governance arrangements, funding instruments and incentive mechanisms
- a marked variation in the cost of service provision, with some services being particularly high cost relative to others

-
- the social value nature of these services justifying a high degree of government involvement, with regulations determining how, where and to whom these services are provided and governing what prices are charged
 - high, and increasing, community expectations about the provision of these services (for example, in terms of access, flexibility and responsiveness).

In common with other complex social product systems, such as the health and education systems, there are subsystems within aged care (for example, community care, residential care and respite care) and there are important interfaces between aged care and other social policy areas, such as allied health, hospitals, disability and housing services.

Service delivery in each of these areas affects the performance of the aged care sector. For example, changes in the availability and nature of care provided by hospitals can affect the demand for community and residential care. These service interfaces are explored further in chapter 4.

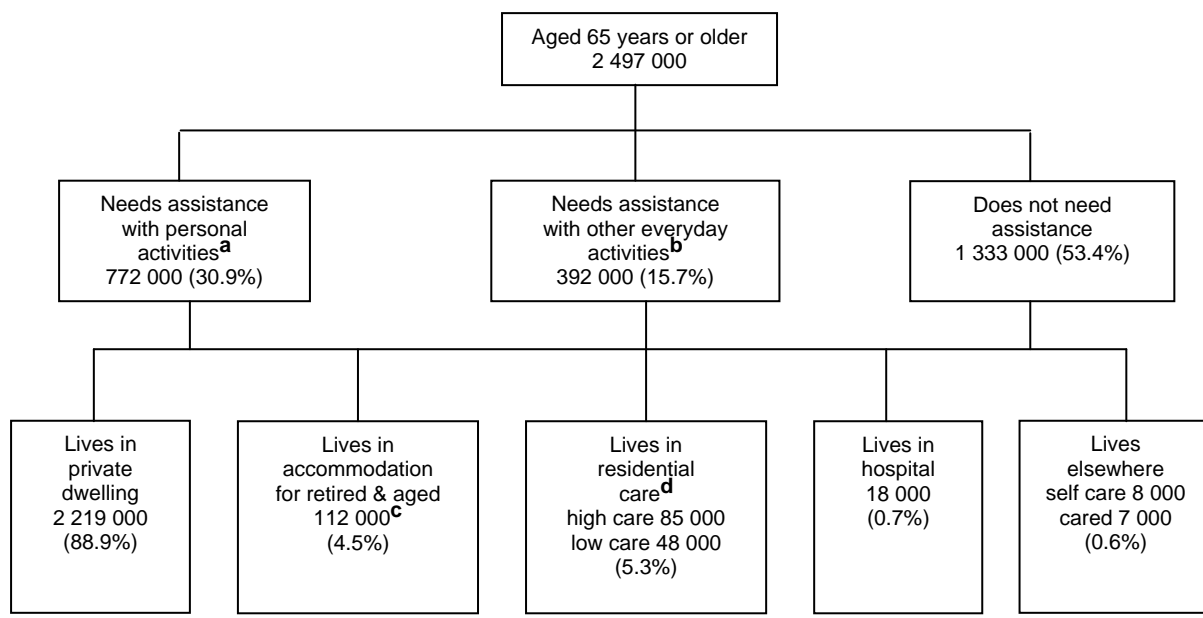
2.2 A profile of older Australians requiring care

The aged are a diverse group, having different preferences, backgrounds, functional capacities, living arrangements, income and wealth. Reflecting this diversity, older Australians enter the aged care system at different points, requiring different levels of care and combinations of services in a range of different settings. Three important points of diversity that drive much of the variation in demand for aged care services are differences in older people's need for care, their income and wealth and accommodation arrangements.

Need for care

In 2003, almost half (46.6 per cent) of all Australians aged 65 years or older reported needing assistance with personal or everyday activities such as self-care, mobility and communication (figure 2.1). As the incidence of physical and cognitive disability increases with age, so to does the need for assistance. In 2003, 32 per cent of those aged 65–74 years needed some form of assistance, compared with around 86 per cent of those aged 85 or older (figure 2.2).

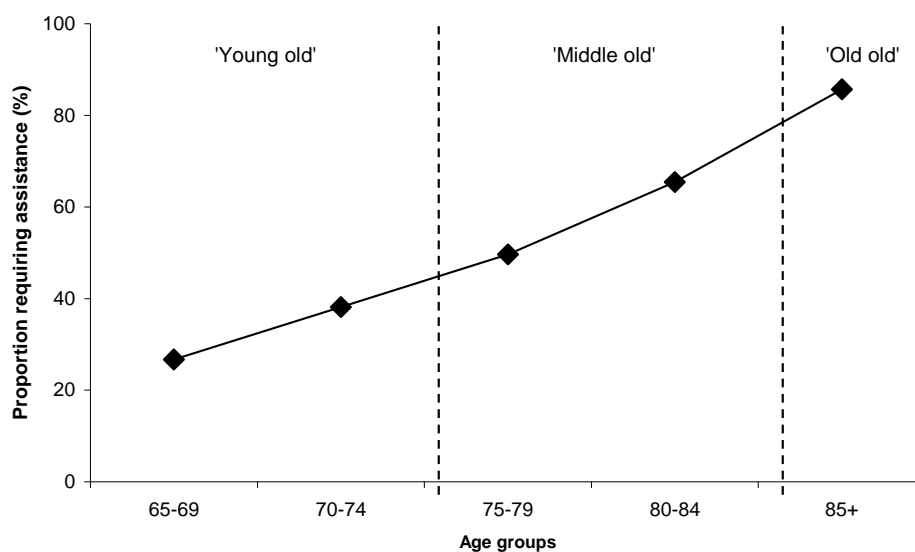
Figure 2.1 Need for assistance and living arrangements of older persons
Aged 65 years or older, 2003



^a Personal activities comprise self-care, mobility, communication, cognitive or emotional tasks and health care. ^b Other everyday activities comprise paperwork, transport, housework, meals and property maintenance. ^c Predominately retirement villages. PC estimate from ABS data allowing for difference between ABS and AIHW data regarding the number of older people in residential care. ^d AIHW (2004d).

Data source: ABS (Survey of Disability, Ageing & Carers, 2004, Basic CURF, CD-ROM).

Figure 2.2 Need for assistance by age of older persons, 2003



Data source: ABS (Survey of Disability, Ageing and Carers: Summary of Findings, Cat. no. 4430.0).

Income and wealth

The income levels of older Australians play an important part in their use of care as well as the extent of user contributions for this care. The most important source of income for a sizeable proportion of the current cohort of older Australians is the age pension. In June 2007, 66 per cent of Australians over the current qualifying age (65 years for men; 63.5 years for women) received the age pension (FaCSIA 2007). In addition, some in this cohort also received similar means tested income support from the Department of Veterans' Affairs, bringing the total Australian government age and service pension take-up for this group to 75 per cent.

Of the 1.95 million Australians who received the age pension in 2006-07, some 60 per cent received a full rate pension and 40 per cent a part rate (FaCSIA 2007).

During 2005-06, government pensions and allowances accounted for at least 90 per cent of the income for nearly half (47 per cent) of those households with at least one member aged 65 years or older (ABS 2007f). Even so, a significant proportion of households (almost 20 per cent) received less than 20 per cent of their income from the age pension in 2005-06. Further, there is great variation in wealth among older Australians whether home ownership is included or excluded (chapter 3).

Accommodation arrangements

The home is an important dimension of community care — 89 per cent of those aged 65 years or older live in a private dwelling with a further 4.5 per cent living in accommodation for the retired or aged such as retirement villages (figure 2.1). Importantly, the security of accommodation arrangements for the elderly (that is, stability of tenure) impacts on the scope to provide community care services. In 2006, 82 per cent of households with at least one member aged 65 years or older owned their own home, with or without a mortgage, and 15 per cent rented (ABS unpublished data).

2.3 Types of care

Older people's care needs can be thought of as a spectrum, depending on the degree to which the ageing process has impaired their ability to care for themselves. Older people will often experience increasing support needs either gradually or following acute care episodes. Various bundles of services are available to cater for these needs, ranging from in home support with some everyday and personal activities, through to full-time personal and nursing care provided in a residential care facility.

Community care

It is government policy and the wish of most older people to remain in the community for as long as possible. A wide range of services can assist older people to live independently: from living and personal care through to nursing, medical and palliative care. Informal carers (for example, family and friends) typically supply such services, often in conjunction with one or more formal community care providers through a range of government subsidised programs.

The Home and Community Care (HACC) program serves as the mainstay of community care by providing basic maintenance and support services to older people (and some younger people) wishing to live independently at home. HACC providers offer a wide range of services including domestic assistance, meals, nursing, transport, allied health, home maintenance, personal care, social support, aids and equipment.

Around 643 000 people aged 70 years or older received HACC services in 2006-07 (table 2.1). Most HACC clients (90 per cent) received less than two hours of service each week, although a small proportion (3 per cent) received more than 4.5 hours each week, some up to 28 hours each week.

Two programs administered by the Department of Veterans' Affairs (DVA) also assist a significant proportion of older people by offering a range of services similar to that delivered through the HACC program. The Veteran's Home Care (VHC) program provided services to around 72 100 veterans aged 70 years or older in 2006-07 while the DVA Community nursing program assisted 33 365 veterans of all ages in the same year (table 2.1).

The Australian Government also funds three programs designed for older people eligible for residential care but who have expressed a preference to remain in the community:

- Community Aged Care Packages (CACPs) provide a bundle of services averaging 7 hours a week as an alternative to low level residential care
- Extended Aged Care at Home (EACH) programs target older people eligible for high level residential care by providing an average 23 hours of packaged care a week
- EACH Dementia (EACHD) is designed to provide the highest level of community care for those with complex cognitive, emotional or behavioural needs (table 2.1).

As at 30 June 2007, there were 36 555 older people receiving packaged care through these programs, the majority receiving CACPs (32 983) with the balance (3572) receiving EACH and EACHD packages (table 2.1).

Table 2.1 Profile of main community care programs
People aged 65 years or older, unless otherwise indicated^a

<i>Program</i>	<i>Recipients</i>	<i>Service usage^b</i>	<i>Usage of main service types (% of clients)</i>
Home and Community Care ^c	• 642 650 in 2006-07	<ul style="list-style-type: none"> • 90% use < 2 hours a week; • 97% use < 4.5 hours a week 	<ul style="list-style-type: none"> • Domestic 30% • Meals 22% • Nursing 21%
Veterans' Home Care	• 72 100 in 2006-07 ^d	<ul style="list-style-type: none"> • 79% received 1 service • 98% received up to 2 services 	<ul style="list-style-type: none"> • Domestic 89% • Home & garden 19% • In-home respite 16%
DVA Community Nursing	• 33 365 in 2006-07 ^e		<ul style="list-style-type: none"> • Bathing 54% • Dressing 45%
Community Aged Care Packages	• 32 983 as at June 2007	<ul style="list-style-type: none"> • average 7 hours a week • 50% use 4.5–9.5 hours a week 	<ul style="list-style-type: none"> • May include bathing, toileting, dressing, meal preparation, laundry, home help, gardening and mobility.
Extended Aged Care at Home (including EACH Dementia)	• 3572 as at June 2007	<ul style="list-style-type: none"> • average 23 hours a week • 50% use 17–29 hours a week 	<ul style="list-style-type: none"> • As for CACPs, but may also include nursing, allied health, oxygen and enteral feeding.
National Respite for Carers Program	• 42 884 in 2004-05 ^f		<ul style="list-style-type: none"> • In-home 46% • Commonwealth residential 21%

^a Due to data availability, numbers refer to different time periods. Some recipients receive services from more than one program. ^b Hours standardised to 'personal care equivalent hours' (DoHA 2007g). ^c Aged 70 years or older. Usage rates are for 2004-05. ^d Estimated number of veterans provided with services who were aged 70 years or older. 96.7 per cent of veterans who were assessed for services were 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 will be lower than those approved. ^e Clients of all ages. ^f Covers carers looking after people of all ages who received direct respite care services through Commonwealth Carer Respite Centres.

Sources: AIHW (2007b, 2008b); DoHA (2007g); DVA (2007, 2008); SCRGSP (2008); PC estimates.

A number of government initiatives provide support to informal carers. The role of an informal carer is often demanding — financially, physically, socially and emotionally. As such, caring diminishes opportunities to engage in full-time employment and limits the scope to have a break from this role.

In recognition of these demands, governments provide assistance to carers through respite services for the person they are assisting (such as through the National Respite for Carers Program), as well as through carer specific payments and allowances (table 2.1). Such assistance also influences the ongoing feasibility of providing informal care and thereby affects the demand for formal modes of care, including residential aged care services.

Residential care

Aged people with physical, medical, psychological or social care needs that cannot be practically met in the community are eligible for residential aged care. There are two main classes of residential care — low level care and high level care. Low level care covers the provision of suitable accommodation and related living services (such as cleaning, laundry and meals), as well as personal care services (such as help with dressing, eating and toileting). High level care covers accommodation and related living services, personal care, nursing care and palliative care within a full-time supervised framework.

At 30 June 2007, there were around 145 000 permanent residential aged care recipients in Australia aged 65 years or older, with around 70 per cent receiving high level care (table 2.2). Over 50 per cent of recipients were aged 85 years or older and by far the greatest number were women.

Table 2.2 **Characteristics of permanent residential care clients**
30 June 2007

		<i>High care^a</i>	<i>Low care^b</i>	<i>Total</i>
Age				
64 years & under	%	4.6	3.3	4.2
65–74 years	%	8.8	7.9	8.5
75–84 years	%	33.4	32.6	33.2
85 years & over	%	53.2	56.2	54.1
Permanent clients aged 65+^c				
Female	'000	73.4	31.8	105.2
Male	'000	27.9	11.9	39.8
<i>All</i>	'000	101.3	43.7	145.0
Average length of stay^d				
Less than 1 year	%	35.7	44.5	36.9
1–3 years	%	27.8	30.7	28.1
More than 3 years	%	36.5	24.8	35.0

^a Residential Classification Scale 1–4. ^b Residential Classification Scale 5–8. ^c Data from 0.8 per cent of residents whose dependency levels were not reported have been allocated proportionally. ^d Level of care for permanent residents at time of separation during 2006–07.

Sources: AIHW (2008d); PC estimates.

2.4 Profile of aged care providers

Community aged care providers

Community aged care providers can be characterised as either informal or formal. Family and friends are the main providers of informal care. Of those older Australians receiving assistance in community settings in 2003, 83 per cent received assistance from informal carers and 64 per cent from formal care providers (table 2.3). Most informal assistance is for communication, paperwork, mobility, cognitive or emotional tasks, and transport. Only in the area of health care do formal carers provide a larger proportion of support than informal carers. Many older people who are dependent on informal carers rely increasingly on formal sources of care as they age (figure 2.3). This arises because of changes in their assistance needs and because access to informal carers who can continue to provide assistance diminishes over time. Counter to this pattern is assistance with cognition or emotion. Here older people generally become more reliant on informal carers and less reliant on formal carers over time for assistance with decision making, maintaining relationships and coping with feelings or emotions (figure 2.3).

Table 2.3 **Likelihood of receiving assistance by provider type**

For those aged 65 years or older in 2003 (per cent)

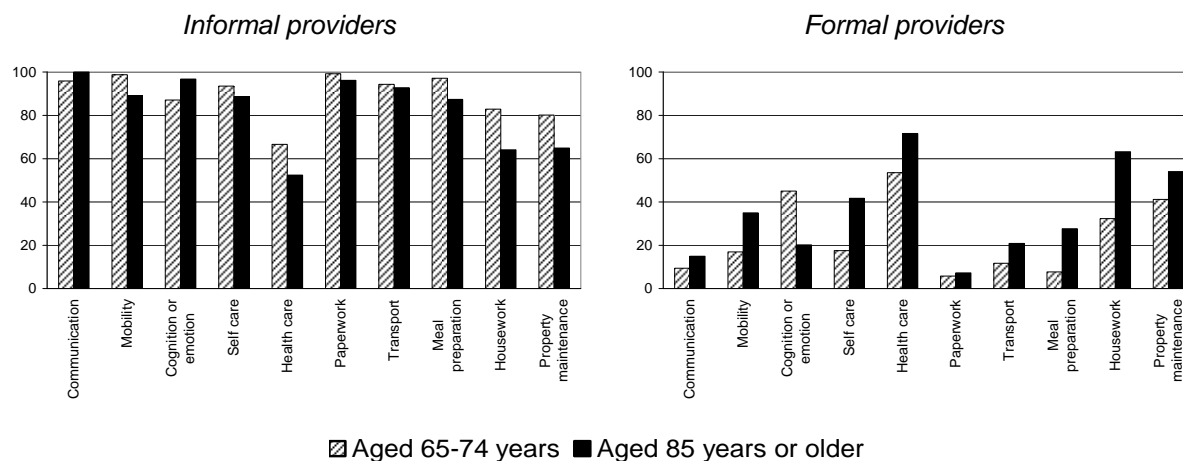
	<i>Informal providers^a</i>		<i>Formal providers</i>				<i>Both informal & formal providers</i>
	<i>All informal</i>	<i>Partners only</i>	<i>All formal</i>	<i>Govern-ment</i>	<i>Private non-profit</i>	<i>Private commercial</i>	
Personal activities							
Communication	98.4	42.5	7.8	4.4	1.9	1.5	6.2
Mobility	93.8	38.1	26.6	16.6	7.1	4.3	20.3
Cognition or emotion	93.6	39.3	29.2	12.0	1.7	19.5	22.7
Self care	89.1	53.6	28.8	18.5	6.6	4.8	17.9
Health care	54.2	30.5	65.9	26.3	6.4	37.9	20.1
Other activities							
Paperwork	97.5	34.8	6.1	2.2	1.0	2.9	3.6
Transport	93.4	29.8	16.0	8.4	3.6	4.8	9.4
Meal preparation	86.7	41.3	24.3	14.6	5.3	4.4	11.1
Housework	70.6	34.8	51.0	29.8	6.8	15.3	21.5
Property maintenance	71.6	26.5	49.7	9.3	6.4	36.4	21.3
All assistance^b	83.0	36.7	63.7	31.1	10.5	42.0	46.7

^a Informal providers include partners, children, other relatives, friends and neighbours. ^b Persons may receive assistance from more than one provider.

Source: ABS (*Survey of Disability, Ageing and Carers: Summary of Findings*, 2004, Basic CURF, CD-ROM).

Figure 2.3 Assistance with personal and other activities by provider type and client age^a

Likelihood of receiving assistance in 2003 (%)



^a Persons may receive assistance from more than one provider.

Data sources: ABS, (Survey of Disability, Ageing & Carers, 2004, Basic CURF, CD-ROM); PC estimates.

Residential aged care providers

There were around 2900 residential aged care facilities operated by accredited providers in 2007 (table 2.4). Private organisations owned 88.3 per cent of these facilities with most being not-for-profit organisations such as religious, community-based and charitable organisations.

Table 2.4 Ownership of residential aged care facilities

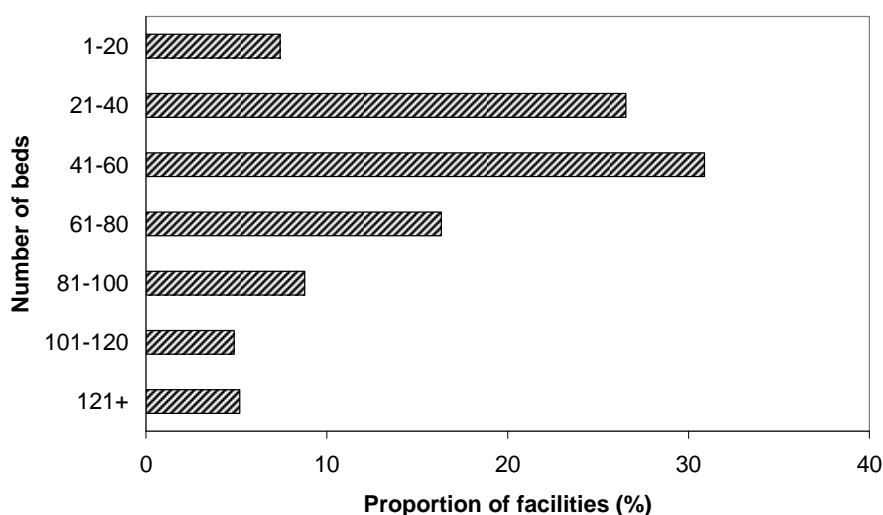
As at 30 June 2007

	Number of facilities	Per cent
Private not-for-profit	1762	61.4
Religious	827	28.8
Community-based	504	17.5
Charitable	431	15.0
Private for-profit	773	26.9
Government	337	11.7
State/ Territory	262	9.1
Local	75	2.6
Total	2872	100.0

Source: AIHW (2008d).

Around 65 per cent of all residential facilities offer less than 60 places while around 10 per cent offer over 100 places (figure 2.4).

Figure 2.4 Size of residential aged care facilities
As at 30 June 2007



Data source: AIHW (2008d).

2.5 The role of government in aged care

Australia's aged care sector is subject to extensive regulation and high levels of public subsidy. A summary of the current policy and legislative framework and the main areas of regulatory control follows.

Current policy and legislative framework

National Strategy for an Ageing Australia

The *National Strategy for an Ageing Australia* (Andrews 2002a) was introduced to provide a strategic framework for a coordinated national response to the challenges associated with population ageing. The strategy is structured around four key elements: independence and self provision; attitude, lifestyle and community support; healthy ageing; and world class care.

In relation to providing ‘world class care’, the national strategy specifies four goals:

- A care system that has an appropriate focus on the health and care needs of older Australians and adequate infrastructure to meet these needs
- A care system that provides services to older people that are affordable, accessible, appropriate and of high quality
- A care system that provides integrated and coordinated access, assistance and information for older Australians with multiple, significant and diverse care needs
- A sustainable care system that has a balance between public and private funding and provides choice of care for older people (Andrews 2002a).

Aged Care Act 1997

The *Aged Care Act 1997* is the principal regulatory instrument of the Australian Government relating to aged care. Section 2-1 of the Act nominates the Government’s objectives in this area, including:

- to provide funding that takes account of the quality, type and level of care
- to promote a high quality of care and accommodation and protect the health and wellbeing of residents
- to ensure that care is accessible and affordable for all residents
- to plan effectively for the delivery of aged care services and ensure that aged care services and funding are targeted towards people and areas with the greatest needs
- to provide respite for families and others who care for older people
- to encourage services that are diverse, flexible and responsive to individual needs
- to help residents enjoy the same rights as all other people in Australia
- to promote ‘ageing in place’ through the linking of care and support services to the places where older people prefer to live.

These objectives are elaborated in the *Aged Care Principles* that accompany the Act.

The Act also recognises the need to efficiently integrate aged care planning and service delivery across the related areas of health and community services.

The Act specifies that in interpreting its objectives, due regard must be given to: the limited resources available to support services and programs under the Act; and the need to consider equity and merit in assessing those resources (s. 2-1(2)).

Thus, although the Act does not explicitly identify sustainability as an objective, it does recognise that resources are limited. The Act was clearly framed in the context of meeting the challenges associated with Australia's ageing population. On the introduction of the legislation to the House of Representatives, the then Minister for Family Services, the Hon. Judi Moylan, stated:

It is essential we undertake reform now, to meet the challenges of our ageing population. In little over 30 years, Australia's population of over 65s will increase by more than 50 per cent to 5 million people. This bill provides the path forward. (Commonwealth of Australia 1997, p. 3192)

The Home and Community Care Act 1985

The *Home and Community Care Act 1985* provides for the HACC program to be jointly administered and financed by the Australian, State and Territory Governments. The HACC program has a number of principles and goals including several that encompass notions of equity and efficiency:

- to ensure access to HACC among all groups within the target population, including migrants, Indigenous Australians, persons suffering from brain failure and financially disadvantaged persons
- to ensure that, within available resources, priority is directed to persons within the target population most in need of HACC
- to ensure that, within available resources, HACC services are provided equitably between regions and are responsive to regional differences
- to ensure that HACC services are delivered in a manner that is cost effective, achieves integration, promotes independence and avoids duplication
- to promote an integrated and coordinated approach between the delivery of HACC and related health and welfare programs, including programs providing residential or institutional care (*Home and Community Care Act 1985*, s. 5(1)).

Charter of Budget Honesty and Intergenerational Reports

Aged care policy, like other areas of government policy, is framed in the broader context of the *Charter of Budget Honesty Act 1998* and the *Intergenerational Reports*.

The *Charter of Budget Honesty Act 1998* sets out the principles of sound fiscal management and commits the Government to preparing an intergenerational report at least every five years. These reports assess the long-term fiscal sustainability of current government policies (such as aged care) over the next 40 years, including by taking account of the financial implications of demographic change.

The first intergenerational report identified seven priorities for ensuring fiscal sustainability. One of these was to develop an affordable and effective residential care system that can accommodate the expected high growth in the number of very old people (people aged 85 years or older) (Treasury 2002).

The second intergenerational report noted that, looking out over the next 40 years, aged care continues to be one of the main pressures on government expenditure (Treasury 2007).

State, Territory and Local government regulation

State, Territory and Local government regulation also impacts on the provision of aged care through regulations covering building planning and design, occupation health and safety, fire, food and drug preparation/storage and consumer protection (Hogan Review 2004).

Beyond these measures, Australian, State and Territory governments do not actively regulate the operation of their aged care sectors, except for the Northern Territory. The Northern Territory Government still licenses aged care facilities that receive Australian Government subsidies and controls their conduct through annual inspections and powers over licence renewals (Hanks and De Ferrari 2003). The Territory Government has designed its inspection and licensing processes to complement those of the Australian Government (Aagaard 2002).

The main areas of regulatory control

In order to meet the objectives outlined above, governments control key aspects of aged care by: allocating aged care places to approved providers, assessing client eligibility, funding services, setting prices and controlling quality.

Some guidance on the nature of involvement in each area is presented below.

Allocating aged care places to approved providers

The Australian Government funds and allocates new aged care places each year to broadly match growth in the target population — those aged 70 years or older plus Indigenous people aged 50–69 years. It signals its long-run intentions through a target provision ratio which provides some guidance to investment by the private sector.

The Government is currently aiming to achieve a ratio of 113 places per 1000 of the target population by 2011. It comprises 88 residential places (44 high care and 44 low care) and 25 community care packages (21 CACPs and 4 EACH).

The Government also balances the provision of services between metropolitan, regional, rural and remote areas, as well as between people needing differing levels of care. The Secretary of the Department of Health and Ageing, acting on the advice of the Aged Care Planning Advisory Committees, allocates places to each Aged Care Planning Region within each state and territory.

Following the allocation of new places to regions within each state and territory, the Government conducts an open tender to allocate these places to approved providers. Because of the time required for building approval and construction, providers have two years to make residential places operational. CACP packages and EACH places tend to become operational sooner after allocation (DoHA 2007h).

The Government also expects service providers to meet regional targets for places for concessional residents. These targets range from 16 to 40 per cent of places and aim to ensure residents who cannot afford to pay an accommodation bond (low care) or accommodation charge (high care) have equal access to care.

Assessing client eligibility

The Australian Government provides grants to State and Territory Governments to operate Aged Care Assessment Teams (ACATs), or Aged Care Assessment Services in Victoria, under the Aged Care Assessment Program. ACATs may include doctors, nurses, social workers and other health professionals.

Their role is to assess the care needs of frail older people and help them receive the most appropriate care and support in accordance with the aged care legislation and *Aged Care Assessment Program: Operational Guidelines* (DoHA 2002a). This may involve simply referring clients to community care providers such as those available under the HACC program. Alternatively, they may approve their eligibility for residential or community care services (DoHA 2007h).

Funding services

Aged care in Australia is largely publicly funded. The Australian Government provides most of the recurrent funding for residential aged care services, an estimated \$5.4 billion to people aged 65 years or older in 2006-07 (table 2.5). State and Territory Governments also provide some funding for these services.

Table 2.5 Recurrent government expenditure on aged care programs in Australia, 2006-07

Estimated share for clients aged 65 years or older

<i>Mode of care</i>	<i>Government expenditure^a</i>	<i>Care mode expenditure to total expenditure</i>
	\$m	%
Aged care assessments	58	0.7
Residential aged care^b	5398	62.8
Community care	2117	24.6
HACC ^c	1151	13.4
CACP	381	4.4
VHC	93	1.1
Flexible care ^d	248	2.9
Respite care ^e	191	2.2
Information, support & other community care ^f	53	0.6
Financial support for carers^g	1018	11.9
<i>Total</i>	8591	100.0

^a Expenditure estimates are based on the proportions of clients aged 65 years or older. Where applicable, estimates are for total Australian, State and Territory government expenditure. Components may not add due to rounding. ^b Includes expenditure on residential aged care by the Department of Veterans' Affairs and State and Territory government funding. ^c Estimated aged care share of total government HACC expenditure. Includes some respite services. ^d Includes EACH and EACHD, TCP, MPS and flexible care pilot projects. ^e National Respite for Carers Program and Australian Government funded Day Therapy Centres. Residential respite expenditure estimated as a share of total residential expenditure on basis of days occupied. ^f Includes Commonwealth Carelink Centres, information and assistance with continence, dementia, housing, Indigenous specific issues and other care needs. ^g Estimated share of total government expenditure on carers payments and allowances received by those caring for people aged 65 years or older.

Sources: AIHW (2007b); FaHCSIA (2008 unpublished data); SCRGSP (2008); PC estimates.

Residents' fees and charges provide most of the remaining service revenue, around \$2.1 billion in 2005-06 (AIHW 2007b). Since most user contributions are financed indirectly from aged pension payments — around 88 per cent of permanent residents receive Centrelink or DVA pensions (AIHW 2008d) — the bulk of the cost of residential care is effectively sourced from general revenue.

Residents' assessed care needs largely determine government funding of residential aged care. Until recently, the instrument used to classify residents and determine care subsidies was the eight-level Resident Classification Scale (RCS).

On 20 March 2008, the Aged Care Funding Instrument (ACFI) replaced the RCS with a three-year phase-in period. The Australian Government developed the ACFI in consultation with industry following two reviews (DoHA 2003a; Hogan Review 2004).

The ACFI calculates basic care subsidies according to each client's level of need (none, low, medium or high) in three care domains:

- activities of daily living (such as nutrition, mobility, personal hygiene, toileting and continence)
- behaviour supplement (cognitive skills, wandering, verbal behaviour, physical behaviour and depression)
- complex health care supplement (DoHA 2007c).

For example, a resident with high care needs in all three care domains would attract a basic care subsidy of around \$138 a day under the new ACFI (DoHA 2008d). However, the basic subsidy payable to some residents is reduced by an income test reflecting their income and the cost of care. Providers can recover this amount directly from clients through an income tested fee. Additionally, the Government pays a variety of other subsidies including an oxygen supplement, enteral feeding supplement, conditional adjustment payment and a viability supplement that is paid to rural and remote providers.

The HACC program receives the bulk of community care subsidies — around \$1.15 billion in 2006-07 for people aged 65 years or older (table 2.5). The Australian, State and Territory Governments fund the bulk of HACC services; the shares being approximately 60 and 40 per cent respectively. In general, the States and Territories allocate HACC funds to meet regional priorities. Within individual programs and projects, service providers seek to allocate funds to provide the most benefit to the greatest number of people.

The Australian Government also contributed around \$774 million towards other community care programs including CACP, EACH, MPS and VHC in 2006-07. Funding for packages allocated under these programs provide recipients with a constant level and quality of care. As at 1 July 2008, the basic subsidies for community care were: CACP (\$34.75 a day), EACH (\$116.16 a day) and EACH Dementia (\$128.11 a day) (DoHA 2008d). Additional supplements are also available for oxygen, enteral feeding and remoteness. Many recipients of community care contribute towards the cost of these services.

Older people and their carers largely fund the provision of their informal care, although the Australian Government funds a range of carer support programs. Total funding for the National Respite for Carers Program, Australian government funded day therapy centres, carer payments and carer allowances was around \$1.2 billion in 2006-07 (table 2.5).

Setting prices

The Australian Government regulates the amount that aged care clients pay for subsidised care. For most standard service offerings, charges are means tested and capped, with concessional rates applying to pensioners. Additional charges may apply to remote residents.

As of 1 July 2008, the three main daily user fees and charges for *new* non-pensioner residents receiving standard care in residential facilities that are 2008 compliant are the:

- basic daily care fee, up to \$32.05 a day
- asset tested accommodation charge, for high care residents with assets worth more than \$34 500, the rate increasing from zero to \$26.88 a day when assets exceed \$90 410.40
- income tested fee, with residents being charged up to \$56.57 a day or the cost of their care, whichever is the lesser (DoHA 2008e).

An accommodation bond may be required of people entering low care or extra service residential facilities. The regulations do not cap bond amounts. However, providers cannot levy a bond that leaves a resident with assets worth less than a threshold amount — \$34 500 as at 1 July 2008 (DoHA 2008e). Providers are able to deduct a retention amount over five years and charge interest on bonds paid periodically, the rate being 11.75 per cent as at 1 July 2008 (DoHA 2008e). The balance of the bond is refundable on departure. Accommodation charges are levied on residents in high care, providing their assets exceed a certain amount. The ACFI classifies a resident as ‘high care’ if they are in any one of the following categories:

- medium or high care needs in activities of daily living
- high behaviour needs
- medium or high complex health care needs (DoHA 2008b).

The value of a resident’s home is counted as an asset for aged care accommodation payment purposes unless their:

- partner or dependent child/student lives in it
- carer who is eligible to receive an Australian income support payment has been living in it for the past two years
- close relative who is eligible to receive an Australian income support payment has been living in it for the past five years (Centrelink 2008).

Further, if a resident is renting out their former home and paying either an accommodation charge or bond by periodic payments at the same time:

- the rental income from the former home is exempt in full for both the pension income test and aged care fees
- the value of the home is exempt from the pension asset test (Centrelink 2008).

The fees for community care services vary with the type of service and the client's capacity to pay. State and Territory Governments develop their own HACC service fee policies and scales, guided by the principles outlined in the *Draft HACC Fees Policy* (Commonwealth of Australia 2007). For those care recipients whose income exceeds the basic rate of pension, the maximum fee for CACP, EACH or EACH Dementia packages is 17.5 per cent of the person's income to the level of the basic pension, plus up to 50 per cent of their income (minus tax and the Medicare levy) above the basic pension (DoHA 2008a). However, people assessed for community care services cannot be refused service on the basis of their inability to pay (DoHA 2006b).

Regulating quality

Both community and residential aged care services are subject to quality regulation. This is justified on the basis that 'providers and aged care recipients have unequal access to relevant information and the frailty of residents can make them vulnerable to exploitation' (Hogan Review 2004, p. 273).

Australian government funded residential facilities are subject to a quality assurance system based on:

- legislated responsibilities, which are specified in the *Aged Care Act 1997* and in the Aged Care Principles
- an accreditation based quality assurance regime, encompassing four accreditation standards: management systems, staffing and organisational development; health and personal care; resident lifestyle; and physical environment and safety systems
- a certification process to encourage improvement, particularly of the physical standard of residential aged care buildings.

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 Aged Care Standards and Accreditation Agency assesses compliance with the quality standards and the Department of Health and Ageing monitors compliance

with other legislated obligations. Services found to be noncompliant face sanctions, including suspension of funding and, in the case of the most serious breaches, revocation of approval.

Since the 2004-05 Budget, Australian Governments have also allocated funding to the development of a quality assurance and monitoring system across a number of community care programs (CACP, EACH and NRCP). This system involves a three step process: self-reporting against uniform quality standards; departmental monitoring through desk audits; and validation visits.

The 2007-08 Budget included additional funding to enhance the community care quality assurance system and provide for the development of best practice models and benchmarking in key areas of community care.

2.6 Recent trends in aged care

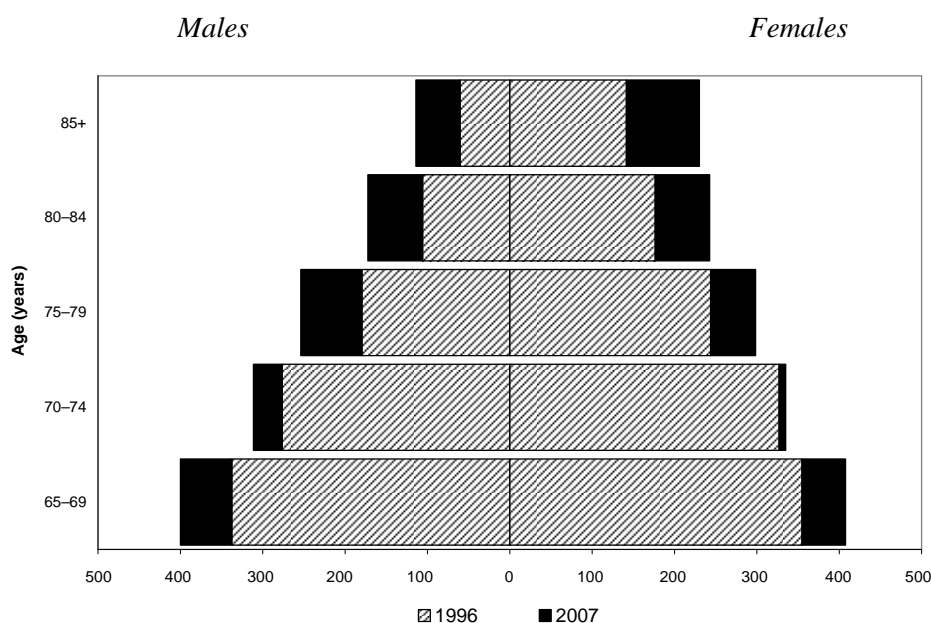
The aged care sector has changed considerably over the past decade or so, driven by a combination of demographics, changing care needs, increased funding for community care and restructuring by service providers. The most important trends have been:

- increasing numbers of older Australians requiring care
- greater reliance on user contributions
- increasing emphasis on community care
- greater proportion of residents in high level care
- decreasing numbers of small residential facilities
- increasing investment by private for-profit providers.

Increasing numbers of older Australians requiring care

The number of older Australians requiring assistance with day to day activities has increased over the past decade. As disability rates for those aged over 65 years have been roughly stable (ABS 1998, 2004b; AIHW 2006a), the main growth driver has been the increase in the numbers of older Australians. In 1996, there were around 2.2 million people aged 65 or older. By 2007, this had grown to almost 2.8 million (ABS 1997, 2007a). Importantly, most of this growth has occurred in the older age groups (figure 2.5) — the groups that are more likely to require assistance. Indeed, while the total number of people aged 65 years or older increased by 25.5 per cent between 1996 and 2007, the number of people aged 85 or older grew by almost 70 per cent.

Figure 2.5 **Numbers of older Australians, 1996-2007**
Thousands



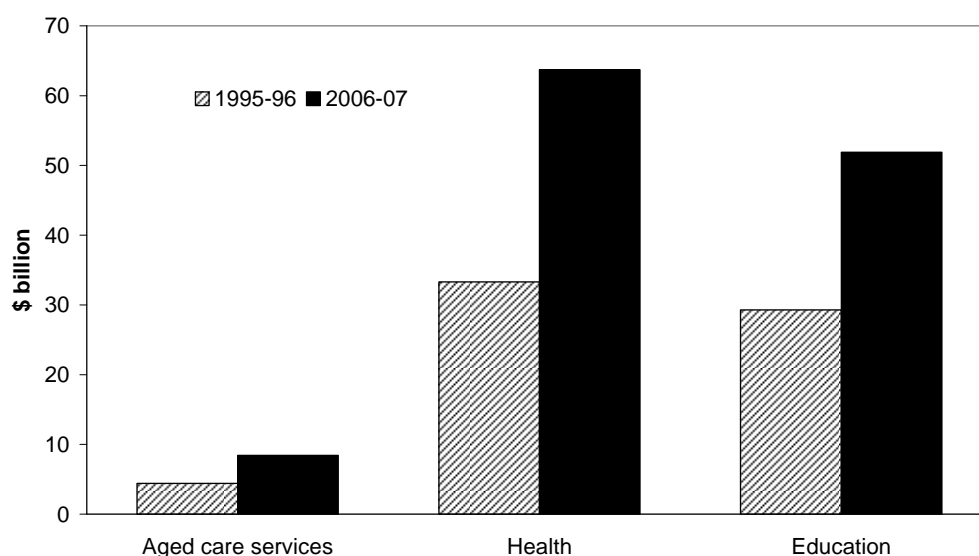
Data sources: ABS (*Australian Demographic Statistics*, Cat. no. 3101.0); ABS (*Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0).

The growth in older Australians requiring assistance has driven a large increase in the number of subsidised care places. In 1996, there were around 141 282 operational residential and equivalent community care places in Australia. By 2007, the number of these places had grown to 214 250, an average annual growth rate of 3.9 per cent (AIHW 2008d).

The growth in the aged care sector over the past decade has, not surprisingly, been associated with a large increase in funding for the sector, from both private and public sources.

Aged care funding by Australian, State and Territory Governments increased from \$4.4 billion in 1995-96 (2006-07 dollars) to \$8.6 billion in 2006-07 — an average annual real increase of 6.1 per cent in real terms (figure 2.6). This compares with an average annual increase of 6.1 per cent for health and 5.3 per cent for education.

Figure 2.6 Government real expenditure on selected social services
2006-07 dollars



Data sources: ABS (*Government Finance Statistics, Australia 1997-98*, Cat. no. 5512.0); ABS (*Government Finance Statistics, Education, Australia, 2006-07*, Cat. no. 5518.0.55.001); AIHW (2007d); SCRCSSP (1998); SCRGSP (2008).

Greater reliance on user contributions

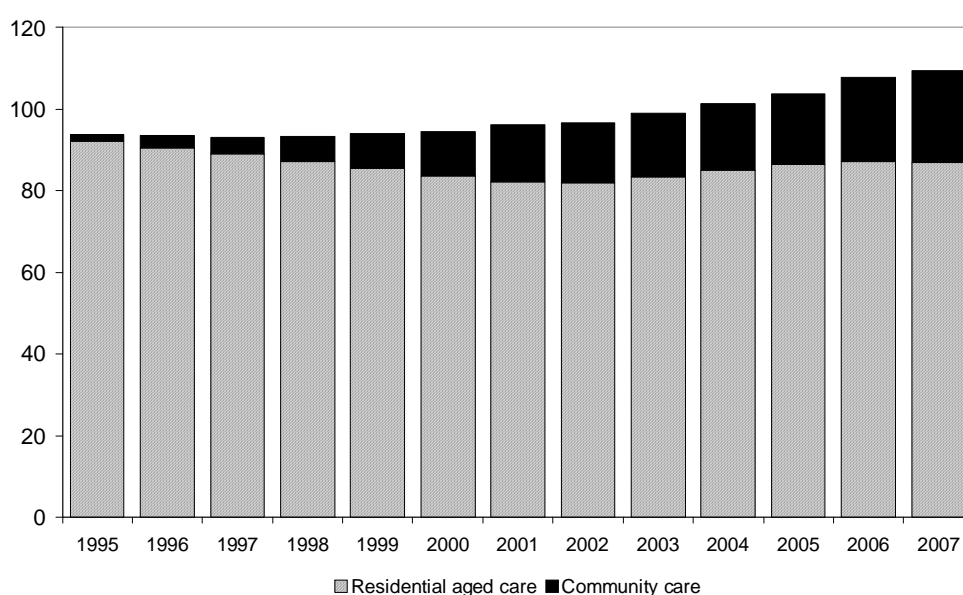
The past decade has seen a shift towards greater private funding of aged care services. As part of the structural reform of the residential aged care sector in 1997, accommodation payments and income testing of daily care fees, which previously only applied to low level care, were introduced for all residential care. The daily care fees paid by residents, plus income tested fees, as a proportion of the total expenditure on care in residential aged care facilities increased from 22 per cent in 2003-04 to 25 per cent in 2005-06 (AIHW 2007b).

Additionally, residential care providers have been able to request an accommodation bond from clients entering low care or making use of extra service high care facilities since 1997. Providers are able to retain the interest and deduct a retention amount over five years. Between October 1997 and June 1999, accommodation bonds were held by 63 per cent of aged care facilities, with the average bond being \$58 400. By 2006-07, 78 per cent of facilities held bonds with an average value of \$167 450 (DHAC 1999; DoHA 2007h).

Increasing emphasis on community care

Government policy, and the choice of most aged people, is to receive assistance in their own residence when possible. As a result, there has been a trend away from residential care towards community care in recent years (figure 2.7). Indeed, between 1995 and 2007, 54 per cent of the growth in funded places under the *Aged Care Act 1997* has been in community care (AIHW 2008d).

Figure 2.7 Aged care places and packages
Places and packages per 1000 people aged 70 year or older^a



^a Community care includes CACP, EACH and EACH Dementia packages and TCP places.

Data source: AIHW (2008d).

In 1995, there were around 2500 subsidised community care places on offer across Australia, representing less than 2 per cent of total subsidised care places. By 2007, community care places had grown to around 44 000, representing around 20 per cent of total places (AIHW 2008d). An important part of this growth has been the expansion of funding to support flexible care places (EACH, EACH Dementia and Transition Care Program). The first of these programs started in 2002-03, and by June 2007 there were almost 6200 such places (AIHW 2008d). The growth of these places reflects the broadening range of community care services that are provided to older people. In the past, many of the services that are now provided in community settings through CACP, EACH and EACH Dementia would only have been accessed in a residential care setting.

Increasing support for carers

With greater reliance on community care, there has also been an increase in funding for carers and for respite services. For example, the combined payments and allowances for carers (caring for people of all ages) increased from around \$450 million in 1995-96 to almost \$2.8 billion in 2006-07, representing an average annual increase of 15 per cent in real (constant dollar) terms. Similarly, funding for the National Respite for Carers Program has increased in real terms by an average of 19 per cent annually since it commenced in 1996-97, to around \$170 million in 2006-07 (SCARC 2005; SCRGSP 2008). In addition, the number of occupied place days for respite care within residential care facilities increased by 7.1 per cent between 1998-99 and 2006-07 (AIHW 1999, 2008d).

Greater proportion of residents in high level care

Older people are more likely to use residential aged care facilities for high level care than in the past. Between 1998 and 2007, the proportion of all permanent residents receiving high care increased from 58 to 70 per cent, an increase of around 32 000 (AIHW 1999, 2008d). High care residents aged 85 years or older accounted for most of this growth, increasing by around 31 127 to 56 446 (AIHW 1999, 2008d). This trend has resulted from ageing in place initiatives and accompanying changes to the target provision ratio.

Australian Governments have rebalanced the mix of aged care services on a number of occasions since 1985 by adjusting the target provision ratio (table A.2). This has had two effects. First, the proportion of community care places has increased relative to residential places over the past 20 years — largely by substitution for low level care residential places. Second, the proportion of high level care residential places has increased relative to those available for low level care.

Decreasing number of small facilities

Although the number of residential care places has increased in recent years, the number of aged care facilities has declined by 4.7 per cent, from 3015 in 1998 to 2872 in 2007 (table 2.6). The increased average size of residential aged care facilities reflects this consolidation. For example, around 47 per cent of facilities offered more than 40 beds in 1998. By 2007, this proportion had increased to around 66 per cent. In particular, the number of facilities with more than 100 beds increased by 121 per cent over this period.

Table 2.6 **Number and size of residential aged care facilities, 1998 and 2007**

As at 30 June

	1998		2007		Percentage change
	Facilities	Per cent	Facilities	Per cent	
Size of facilities (Number of places)					
1–20	396	13.1	213	7.4	-46.2
21–40	1194	39.6	762	26.5	-36.2
41–60	831	27.6	887	30.9	6.7
61–80	322	10.7	469	16.3	45.7
81–100	141	4.7	252	8.8	78.7
101–120	64	2.1	140	4.9	118.8
121+	67	2.2	149	5.2	122.4
Total	3015	100.0	2872	100.0	-4.7

Sources: AIHW (2000b, 2008d).

Increasing investment by private for-profit providers

Private not-for-profit operators own and operate the bulk of residential aged care homes and beds (table 2.4). Even so, a number of private for-profit operators have emerged as important players in the market, such as the Moran Health Care Group, TriCare and Macquarie Capital Alliance Group/Retirement Care Australia.

Reflecting this, the share of residential care beds provided by private for-profit operators has increased, from around 29.5 per cent in 1998 to 32.5 per cent in 2007 (SCRCSSP 1999; SCRGSP 2008). These for-profit facilities also tend to be larger, offering an average of 70 places in 2007, compared with 57 for not-for-profit facilities and 37 for government facilities (AIHW 2008d; SCRGSP 2008).

3 Future demand for aged care services

Key points

- Population ageing is expected to lead to a burgeoning demand for aged care services over the next 40 years. This is likely to be only partially offset by reductions in severe and profound age-specific disability rates.
 - The number of people aged 65 and over is expected to increase from 13.4 per cent of the total population in June 2007 to 25.3 per cent by 2047. An even bigger relative increase is anticipated for the ‘old old’ – those aged over 85 years, who tend to be the main users of aged care services. This group is expected to increase from 1.7 to 5.6 per cent of the total population over the period.
 - The trend towards increased longevity at older ages is also expected to continue. Based on assumed improvements in mortality, on average, men aged 65 in 2047 could live 3.7 years longer than those aged 65 in 2007, and women 2.8 years longer.
- Demand will also be influenced by the growing diversity among older Australians in terms of their:
 - care needs reflecting the changing pattern of disease associated with increased longevity, including an increase in the prevalence of co-morbidities
 - cultural and linguistic backgrounds reflecting Australia’s post-war immigration patterns
 - preferences and expectations (including an increasing preference for independent living arrangements supported by community-based aged care services)
 - incomes and wealth.
- While the future demand for aged care seems set to become markedly more heterogeneous, the extent to which aged care providers are able to respond will be an important determinant of the care mix that eventually develops and the contribution they make to the wellbeing of older Australians.

It is now widely recognised that the ageing of Australia's population will have far-reaching implications for society, for the economy and for the ability of governments to meet the expectations of the community. Ageing will also place significant additional demands on Australia's aged care system and the associated financing and delivery of its services. In contrast, we do not currently have as good an understanding of the implications of the growing diversity among older Australians on the demand for these services. This chapter briefly outlines the effects of population ageing on the demand for aged care services, explores some emerging trends that point to increased diversity among the aged and considers how the future demand for aged care is also likely to be shaped by the availability of care (that is, the supply side of the aged care 'market').

Notably, the chapter does not consider the impact of price on the future demand for aged care. While the price of a service would normally be expected to be a prime determinant of demand, in the case of aged care, prices are largely determined by the levels of subsidy available to service providers and the fee structures chargeable to recipients for aged care services. These arrangements are set by the Australian Government as part of the wider institutional and regulatory framework. The direct influence of 'price' on demand is therefore significantly muted. However, if in the future, governments decide to relax these pricing arrangements, the effective price charged by providers for residential and community care may become a more relevant consideration as a factor affecting demand.

3.1 The effects of population ageing

Over the next 40 years, the Australian population is projected to both grow and age (see, for example, PC 2005b and Treasury 2007). Population ageing largely reflects the combined effects of: lower fertility rates since the 1960s that have led to slower growth in younger age cohorts; and increased longevity that has contributed to stronger growth in the number of people in older age cohorts. As a result, the number and proportion of older people in the population is increasing.

While not a new phenomenon, population ageing is expected to accelerate over the next few decades, particularly from 2020 onwards. In 2007, those aged 65 years or more comprised around one in seven Australians. By 2047, almost one in four Australians will be aged 65 years and over. Population ageing is expected to lead to a burgeoning demand for aged care services. At the same time, there will be relatively fewer persons in younger cohorts available to support the provision of these services (as aged care workers, as working age taxpayers and as informal carers).

Since the Commission's report *Economic Implications of an Ageing Australia* (PC 2005b), the Commonwealth Treasury (2007) has released updated demographic projections in its *Intergenerational Report 2007* (table 3.1). These projections reveal that:

- The number of people aged 65 and over is expected to increase from 2.8 million (13.4 per cent of the total population) in June 2007 to 7.2 million (25.3 per cent) by 2047.
- An even bigger change is anticipated for the 'Old old' — those aged over 85 years, who tend to be the main users of aged care services. This group is expected to increase from 400 000 (1.7 per cent of the total population) in June 2007 to 1.6 million (5.6 per cent) by 2047.
- The aged dependency ratio (the proportion of people aged over 65 to people of traditional working age, 15-64) is projected to increase from almost 20 per cent in 2007 to over 42 per cent by 2047.

Table 3.1 Australian population projections
As at 30 June (millions)

<i>Age range</i>	<i>2007</i>	<i>2017</i>	<i>2027</i>	<i>2037</i>	<i>2047</i>
0–14	4.0	4.1	4.2	4.3	4.3
15–64	14.1	15.2	15.9	16.4	17.0
65–74	1.5	2.2	2.7	3.0	3.0
75–84	1.0	1.2	1.8	2.3	2.6
85 and over	0.4	0.5	0.7	1.1	1.6
65 and over	2.8	3.9	5.2	6.4	7.2
Total	20.9	23.2	25.3	27.1	28.5
<i>Percentage of the total population</i>					
0–14	19.1	17.7	16.7	15.7	15.0
15–64	67.4	65.6	62.7	60.7	59.7
65–74	7.0	9.5	10.6	10.9	10.7
75–84	4.7	5.0	7.2	8.5	9.1
85 and over	1.7	2.2	2.7	4.2	5.6
65 and over	13.4	16.7	20.5	23.6	25.3

Source: Treasury (2007, p. 16).

A number of recent studies have considered the likely effect of population ageing on the future demand for aged care services and government expenditure (box 3.1). Despite some methodological differences, these studies paint a broadly similar picture. Treasury's latest projections, assuming no change in current policy settings for aged care services, show that:

- Australian Government spending on aged care for those aged 65 years and over is expected to increase from 0.7 per cent of GDP in 2006-07 to 1.9 per cent by 2046-47. This is due largely to increasing expenditure on residential aged care, which is projected to rise from 0.5 per cent of GDP to around 1.5 per cent in 2046-47 (table 3.2).

Most of the projected growth in government expenditure on aged care is due to the effects of population ageing, which is expected to account for around three-quarters of the projected increase in real spending per person over the next 40 years (Treasury 2007).

Of particular interest to policy makers is how population ageing may affect the demand for different types of aged care services and the consequences for government expenditure, assuming no change in current policy settings (table 3.2). Treasury's projections suggest there will be stronger growth in high care residential and community care places relative to low care residential places. This view accords with the expectations of many commentators. For example, Ergas (2006, p. 2) contends that:

Demand for care may ... shift from being a continuum that moves from home, into low-level care and then (typically for only a short time) into high-level care, towards a pattern concentrated at the two ends of the spectrum. Moreover, the duration of care at each of those ends seems likely to rise, so that high-level care becomes less of an immediate antecedent to death.

Box 3.1 Recently published projections of aged care use and expenditure

- *Productivity Commission*
 - *Long-Term Aged Care: Expenditure Trends and Projections* (Madge 2000) discussed the factors that influence long-term aged care demand and provided projections of total expenditure on aged care at 10-year intervals to 2031. The cost projections, covering residential and community care, incorporated associated usage projections based on the number of aged care places that would be available at different points in time.
 - *Submission to the Review of Pricing Arrangements in Residential Aged Care* (PC 2003) was prepared as the Commission's contribution to the Hogan Review. The submission provided projections for residential aged care use at 10-year intervals to 2041 and for Australian Government spending on residential aged care.
 - *Economic Implications of an Ageing Australia* (PC 2005b) included an analysis of aged care expenditure. The report provided projections for the number of persons expected to receive residential and community care at 10-year intervals to 2044-45 and the associated Australian Government and State and Territory government expenditure.
- *The Financial Implications of Caring for the Aged to 2020* (Allen Consulting 2002) was commissioned in conjunction with the Myer Foundation Project 2020, 'A Vision for Aged Care in Australia'. The report focused primarily on future costs and investment requirements and included projections of the number of people expected to need aged care services (residential and community) in 2020 and the associated expenditure requirements for the Australian Government, State and Territory Governments and individuals.
- *The Review of Pricing Arrangements in Residential Aged Care* (Hogan Review 2004) included aged care projections derived from the Aged Care Dynamic Cohort Model developed by Access Economics (2004). The projections, at 10-year intervals to 2042-43, covered the number of people expected to need aged care services (residential and community) and the associated expenditure requirements (Australian Government, State and Territory Governments and individuals) assuming no change to funding arrangements. This left a funding shortfall that would need to be sourced either from the Australian Government or elsewhere.
- *The Intergenerational Report 2007* (Treasury 2007) provided a basis for considering the Australian Government's fiscal outlook over the long term and included expenditure projections for both residential and community care at 10-year intervals to 2046-47. The report updated the projections in the first Intergenerational Report, released in 2002 (Treasury 2002).

Sources: Madge (2000); Allen Consulting (2002); Treasury (2002, 2007); PC (2003, 2005b); Access Economics (2004); Hogan Review (2004).

Table 3.2 Projected persons receiving care and aged care expenditure

Persons aged 65 year or older^a

	2006-07	2016-17	2026-27	2036-37	2046-47
Number of places/persons	'000	'000	'000	'000	'000
High care residential	108	148	205	303	405
Low care residential	58	60	82	122	162
Total residential	167	208	287	426	567
CACP	31	50	71	100	125
HACC ^b	518	697	976	1251	1448
Australian Government expenditure (share of GDP)	%	%	%	%	%
Residential	0.54	0.68	0.87	1.21	1.53
CACP	0.04	0.06	0.08	0.10	0.12
HACC ^b	0.09	0.12	0.15	0.18	0.20
Other	0.04	0.05	0.06	0.07	0.08
Total	0.71	0.90	1.16	1.57	1.93

^a These data relate to the projected demand for aged care and Australian Government expenditure on aged care programs by those persons aged 65 years or older. They are lower than Intergenerational Report (Treasury 2007) published results that include access to aged care programs by persons of all ages.

^b Support for persons aged 70 years or older.

Source: Department of the Treasury, unpublished modelling results (2007).

Increased longevity

In terms of the demand for aged care services, a key trend has been towards increased life expectancy at older ages (table 3.3). Although life expectancy at age 65 increased only slightly between 1900 and 1970, since that time it has consistently improved (AIHW 2008b). This largely reflects successful attempts to prolong life through advances in medical technology and public health initiatives. Among OECD countries, Australia's life expectancy at age 65 for males ranked equal second with Iceland in 2006 (behind Switzerland and Japan who were ranked equal first), and for females was fifth (behind Japan, France, Switzerland and Spain) (OECD 2008).¹

Increasing longevity is expected to continue. Based on assumed improvements in mortality, on average, men aged 65 in 2047 could live 3.7 years longer than those aged 65 in 2007, and women 2.8 years longer (table 3.4).

¹ The differences between the top ranking countries for this measure are quite small. For example, there was less than 3 months difference in life expectancy for males aged 65 between Australia (in equal second position) and Switzerland and Japan (in equal first position).

Increased life expectancy at older ages has important consequences for patterns of disease and disability among older people (discussed further below).

Table 3.3 Life expectancy at selected ages

Age	1901-1910	1965-66	1975-77	1985-87	1995-97	2006
Males						
65	11.31	12.16	13.13	14.60	16.21	18.30
75	6.58	7.33	7.91	8.78	9.82	11.10
85	3.65	4.07	4.45	4.89	5.40	5.90
Females						
65	12.88	15.70	17.13	18.56	19.88	21.50
75	7.59	9.22	10.29	11.37	12.26	13.40
85	4.19	4.85	5.49	6.09	6.53	7.10

Sources: ABS (*Australian Historical Population Statistics*, Cat. no. 3105.0.65.001); ABS (*Deaths, Australia*, Cat. no. 3302.0).

Table 3.4 Life expectancy at selected ages, based on assumed improvements in mortality^a

Age	2007	2017	2027	2037	2047
Males					
65	18.78	20.42	21.24	21.84	22.45
75	11.40	12.50	13.08	13.60	14.12
85	5.98	6.49	6.78	7.17	7.57
Females					
65	21.98	23.39	24.04	24.43	24.82
75	13.79	14.85	15.35	15.70	16.04
85	7.29	7.87	8.17	8.45	8.73

^a These life expectancy figures are based on assumptions about future levels of mortality in Australia. There can be no certainty that any particular outcome will be realised.

Sources: ABS (*Population Projections, Australia, 2004 to 2101* Cat. no. 3222.0) unpublished data.

Disability levels

The growth in demand for aged care may partly be offset by improvements in health status and reductions in severe and profound age-specific disability rates. For people aged 65 years and over, severe and profound age-specific disability rates provide a useful guide to the proportion of older people likely to require aged care services.

In recent years, there has been considerable debate about the implications of increased longevity for morbidity and disability. Some argue that improvements in

health and medical care will compress morbidity into a shorter period at the end of life. Others consider that increased longevity will be accompanied by an expansion of morbidity in the later years of life. Another view is that the overall prevalence level of diseases may increase, but the average severity of diseases may decrease due to a reduction in the rate of disease progression (see AIHW 2006d and OECD 2006a).

The OECD (2006a) has cited work suggesting that a country's transition from one morbidity regime to another will depend on the relative size of four factors:

- an increase in the survival rates of sick people that would result in an expansion of morbidity
- control over the progression of chronic diseases that would lead to a subtle equilibrium between the fall in mortality and the increase in disability
- an improvement in the health status and health behaviour of future cohorts of old people that would result in a compression of morbidity, and eventually
- the emergence of very old and frail populations that would result in a new expansion of morbidity.

Although age-specific disability rates appear to be falling in a number of developed countries, the evidence is not clear cut (see, for example, PC 2005b). The underlying patterns are obscured by data inadequacies, changing definitions, shifting attitudes to disability, new and varying methods of diagnosis, and inexplicable differences in trends across countries with similar living standards.

The Hogan Review (2004) pointed to a growing body of evidence in the United States showing falls in disability rates among older people and observed that countries such as France, Italy, Belgium, the Netherlands and Switzerland also appeared to be experiencing declining disability among the elderly.

The OECD (2007) has recently assessed disability trends in 12 countries. It found evidence of a decline in disability among people aged 65 and over in only five countries (Denmark, Finland, Italy, the Netherlands and the United States). Three countries (Belgium, Japan and Sweden) reported an increasing rate of severe disability among older people during the past five to ten years while two countries (Australia and Canada) reported a stable rate. Evidence for the United Kingdom and France was inconclusive.

In Australia, the AIHW (2006d) considered the evidence on ‘health expectancy’ in its study *Life Expectancy and Disability in Australia 1988 to 2003*. This work suggests that most of the recent gain in life expectancy was spent with disability, much with a severe or profound core activity limitation.

Looking to the future, there are reasons to believe that disability rates are likely to decline:

- Socioeconomic improvements, including rising incomes and wealth, are among the strongest predictors of declines in disability rates (see, for example, Redfoot and Pandya 2002). On average, the future aged will almost certainly be wealthier and have higher incomes than the current aged (see below).
- As in the past, technological improvements and continuing medical advances are likely to lower age-specific disability rates over the next 40 years. The Commission’s report *Impacts of Advances in Medical Technology in Australia* (PC 2005c) identified Australia’s ageing population as a key factor influencing these developments, in part, because of the increased need to treat chronic diseases.
- There is also the possibility of health improvements through better illness prevention and disease management. As part of its study of the *Potential Benefits of the National Reform Agenda*, the Commission (PC 2006) found the proportion of ‘avoidable’ chronic diseases resulting from lifestyle behaviour changes, detection and early intervention varied from around 75 per cent for some mental disorders to around 3 per cent for some types of musculoskeletal conditions.² Although this study focused on persons of working age, the effects of health promotion and disease prevention is also applicable to older people.

That said, there are concerns about the extent to which the increased prevalence of obesity among younger age cohorts may affect disability rates among the future elderly. The prevalence of obesity has been rising in Australia over at least the past 20 to 30 years (AIHW 2008b). Obesity is a risk factor for many debilitating health problems including respiratory difficulties, chronic musculoskeletal problems, cardiovascular disease, type 2 diabetes, certain types of cancer and gallbladder disease. The OECD (2006b, p. 79), in commenting on obesity trends in member countries, has observed that:

Rising disability rates among the future elderly could wipe out recent reductions in disability among today’s elderly, who have benefited from reduced exposure to disease, better medical care, and reduced smoking. Appreciating that these are studies on

² The Commission (PC 2006) examined six chronic diseases — mental illness, type 2 diabetes, cardiovascular diseases, cancer, serious injury and musculoskeletal conditions.

American citizens, the trend appears global in nature, and there is no compelling reason why the trend in other western countries should diverge.

While there is still much uncertainty about the magnitude of any future reductions, the Hogan Review (2004) judged that age-specific rates of severe and profound disability among older people are likely to decline moderately in the future.

In its recent work the Commission, like the Hogan Review, has assumed a 0.25 per cent annual decrease in the relevant age-specific disability rates (and conducted sensitivity testing assuming no change, and higher reductions in disability) (PC 2003, 2005b). This work has highlighted that even relatively modest reductions in disability rates among the aged can potentially have a significant impact on the number of people requiring residential care.

Overall, the Commission remains of the view that in coming decades, reductions in age-specific disability rates are likely to only partially offset the effects of population ageing and increased longevity. This view is consistent with a key finding from the OECD's (2007, p. 7) assessment of recent trends in disability:

... it would not seem prudent for policy-makers to count on future reductions in the prevalence of severe disability among elderly people to offset the rising demand for long-term care that will result from population ageing. Even though disability prevalence rates have declined to some extent in recent years in some countries, the ageing of the population and the greater longevity of individuals can be expected to lead to increasing numbers of people at older ages with a severe disability.

Pulling these trends together

In combination, these trends suggest that over the next 40 years the community will need to provide aged care services to a much larger cohort of older Australians (both in absolute and relative terms). However, in looking out over this period considerable uncertainties remain. As the Commission has emphasised, notwithstanding the importance of the past in shaping Australia's future demographic structure, different assumptions about future mortality rates, fertility rates and net migration can produce significant variations in demographic scenarios (PC 2005b). This point is underscored by differences between the first and second intergenerational reports, with Treasury (2007, p. 11) noting that:

Several developments since IGR1 are projected to continue into the future and will have an impact on both the size and average age of the Australian population. Mortality rates have fallen more rapidly than anticipated in IGR1, tending to raise slightly the average age of the projected population. Higher-than-anticipated fertility rates and changes to Government policy encouraging greater numbers of skilled migrants — who are younger on average than the resident population — tend to lower slightly this

average age. Taken together, these changes have led to a projection of a significantly larger and slightly younger population than in IGR1.

These uncertainties about the future extent of population ageing suggest a need for ongoing monitoring of demographic trends and the development of flexible policy approaches. In this regard, the *Charter of Budget Honesty Act 1998* commits the Australian Government to preparing an intergenerational report at least every five years. This will provide a mechanism for assessing the long-term fiscal sustainability of current government policies (including aged care), in light of reassessments of past demographic projections.

3.2 Growing diversity among older Australians

While demographic projections provide a useful indication of the *number* of older people likely to require aged care in coming decades, this is clearly not the whole story. Another key influence on the future demand for aged care is the growing *diversity* among older Australians in terms of their care needs, backgrounds, preferences, incomes and wealth. Arguably, we do not currently have as good an understanding of the likely implications of this growing diversity for aged care services as we do of the changing demographics.

As revealed by the AIHW (2007e, p. 2) there is already considerable diversity among older Australians:

The health, family circumstances, physical abilities, economic circumstances and service needs of an average 65 year old are likely to be very different from those of a 90 year old. In addition, there is a considerable diversity of backgrounds and a variety of lifestyles, living arrangements, family circumstances and cultural, social and religious practices. Finally, the health status, activity and interaction with social and government systems that contribute to the health and welfare of Australians vary widely.

However, a key finding of this study is that, in several respects, older Australians are likely to be even more diverse in the future. As explored in chapter 5, this trend has important implications for the range and mix of aged care services that will be demanded by older Australians. Like demographic change, growing diversity will place the aged care system under increased pressure.

More diverse care needs

One consequence of increased longevity is that the pattern of diseases people suffer and die from changes. The gains in life expectancy among older Australians over

the last 30 years have arisen from declines in mortality for some diseases, particularly heart disease and stroke. However, as more people live to older ages, the prevalence of chronic illness increases markedly. In addition, increased longevity is associated with the increased prevalence of co-morbidity (people living with two or more diseases at the same time). This changing pattern of disease is creating greater diversity in the care needs of older people. Further, among the 'old old', it is giving rise to new challenges in caring for frailer people with more complex and demanding care needs.

Evidence of the effect of increased longevity on the pattern of disease among older people is provided by AIHW (2007e) analysis of the leading causes of death for the aged. This reveals some important differences among different age cohorts. For example, in 2004:

... the top 12 causes of death for persons aged 65–74 years included pancreatic cancer, cirrhosis of the liver (men) and ovarian cancer (women). At ages 75–84 years, deaths from dementia and related disorders become relatively more important, and influenza and pneumonia appear in the top 12 causes of death for the first time. For those aged 85 years and over, influenza and pneumonia become relatively more important and deaths from kidney failure appear in the top 12 causes of death. (AIHW 2007e, p. 59)

There is a strong link between ageing and chronic diseases, such as cardiovascular disease, osteoarthritis, cerebrovascular disease, chronic kidney disease, chronic obstructive pulmonary disease, colorectal cancer, diabetes and osteoporosis (AIHW 2006b). These diseases are often associated with prolonged illness (sometimes leading to other health complications), functional impairment and disability. As such, they give rise to quite specific and varied care needs among older people.

Growing attention is being given to the implications for aged care of the increased prevalence of neurodegenerative diseases. For example, over a decade ago, Broe and Creasey (1995, p. 57) observed:

... an emerging and increasing cause of this increased morbidity in advanced old age is the group of disorders which dominate geriatric medicine: confusion, incontinence, immobility and falls. Underlying this group of morbidity producing syndromes of old age are the neurodegenerative diseases; Alzheimer's disease, Parkinson's disease and cerebellar atrophy.

And, more recently, the AIHW (2006b, p. 3) has argued:

As the Australian population ages and people survive longer with cancer and chronic diseases of the circulatory and respiratory systems, dementia and related neurodegenerative disorders are likely to become more prevalent and have a greater impact on the health and wellbeing of older Australians.

The challenges for the aged care and health systems associated with dementia are becoming more apparent. Dementia is a progressive condition characterised by the impairment of brain functions, including language, memory, perception, personality and cognitive skills. The AIHW (2007e, p. 86) has observed that:

In older people, dementia is more likely than other health conditions to be associated with severe or profound limitations in self-care, mobility and communication, is more likely to be the main health condition resulting in disability, and is very likely to be associated with multiple health conditions.

Importantly, as recognised by the AIHW (2007c, p. 93) dementia gives rise to quite complex and diverse care needs:

The disabling impact of dementia means that people with severe or advanced dementia may require a variety of assistance, including help with activities of daily living (ADLs) related to basic self-care (e.g. bathing, dressing, toileting, getting in and out of bed, continence and feeding). Even those with mild or moderate dementia may require assistance with instrumental activities of daily living (IADLs) central to independent functioning in the community (such as light housework, laundry, meal preparation, grocery shopping, outside mobility, travel, money management, and telephoning).

The number of Australians with dementia is expected to increase considerably in coming years. For example, Access Economics (2005a) has estimated that the number of people with dementia will increase from around 220 000 to over 730 000 between 2007 and 2050. This will have significant implications for the provision of both residential and community care. In 2003, around three quarters of people aged 65 years or more reporting dementia lived in cared accommodation (including residential care) (AIHW 2007c). In analysing the future of community care, Allen Consulting (2007, p. 30) has argued that the increasing prevalence of dementia among older people will mean that a greater proportion of community care clients ‘will have very complex needs, raising the average cost per client of delivering community care’.

As with other chronic illnesses, there may be scope to delay the onset of dementia and reduce age-specific incidence rates by altering modifiable risk factors such as the level of physical and cognitive activity (Nepal et al. 2008).

There is also a growing demand for palliative care to be an integral part of aged care services. The World Health Organization (WHO 2004) has observed that traditionally, palliative care has mostly been offered to people with cancer, partly because the course of this illness is more predictable and thus easier to recognise and plan for the needs of patients and their families. Reflecting this, palliative care is often viewed as only relevant to the final few weeks of life. In contrast, the WHO argues that, given the likelihood more older people will be living with the prolonged

effects of chronic illness, there is a need for forms of palliative care that provide support over many years and also allow for an unpredictable time of death.

In relation to depression, while its prevalence is similar across age groups, it is somewhat less in persons aged 65 years and over (AIHW 2006b). However, older people may be at risk of depression for a variety of reasons, including: an increase in physical health problems; chronic pain; side-effects from medication; death of a spouse or family member; social isolation; injury through falls; and significant changes in living arrangements, such as moving from independent living to a residential setting (Beyondblue 2008).

Estimates of the prevalence of depression among older people living in the community vary widely from less than 1 to 35 per cent (cited by Frazer, Christensen and Griffiths 2005). They tend to be higher for people living in residential care facilities, with estimates ranging from 30 per cent of low care residents to around 50 per cent of high care residents (Hammond Care Group 2004). Like other chronic illnesses, depression can be expected to increase the diversity of care needs among older people, for example through its interaction with existing medical conditions.

Increased longevity is also associated with a rise in the prevalence of co-morbidity, which is often associated with functional impairment. An AIHW (2006b) analysis of chronic diseases found that while almost 10 per cent of children aged 0–14 years had three or more long-term conditions, this proportion increased to more than 80 per cent for those aged 65 years and over. A recent study by Walker (2007, p. 206) observed that:

... the vast majority (83 per cent) of 60 + – year – olds with three or more conditions had at least one NHPA [National Health Priority Area] disease, and thus could be considered seriously ill.

These trends point to the likelihood of Australia's aged care system having to provide care to an increasing number of frail clients with more complex and demanding needs. This will have significant implications for the delivery of aged care services. For example, in the area of community care it suggests there is likely to be an increasing demand for services at the higher-end of the care spectrum to help bridge a potentially widening gap between the level of care some older people will require and the level of care that informal carers are capable of providing. It is also likely to bring into sharper focus the need to improve the effectiveness of interfaces between the aged care and health systems, to ensure that older people have an acceptable quality of life (chapter 4).

More diverse backgrounds

Australia's population of older people from culturally and linguistically diverse backgrounds is growing faster than that of other older Australians (box 3.2). Over coming decades, this growth is likely to be particularly pronounced for those aged 80 years and over, the cohort who are the biggest users of formal aged care services. Further, as different ethnic groups begin to move into older age cohorts in substantial numbers at different times, reflecting post-war immigration patterns, there will be greater diversity among the largest ethnic groups that makeup Australia's elderly overseas-born population (Rowland 2007). As the Ethnic Communities' Council of Victoria (2008, p. 3) argues, these developments 'will require culturally and linguistically responsive, flexible and consumer oriented age care services'.

These developments are likely to increase and extend the demand for culturally appropriate aged care services. This is in the context of current concerns about the ability of culturally and linguistically diverse older Australians to access aged care services. For example, the Department of Health and Ageing (DoHA 2007f, p. 2) has found that:

Older people from culturally and linguistically diverse communities are not accessing aged care services commensurate with their proportion of Australia's ageing population. This is evidenced by their under-representation in the use of residential aged care services.

Older people from culturally and linguistically diverse backgrounds share with the broader aged population many characteristics associated with the need for aged care (such as increasing need associated with advancing age). However, Howe (2006, p. 26) argues that cultural diversity adds two broad dimensions to the need for aged care:

First, culture imbues these characteristics with meanings that differ from Australian mores to varying degrees — by way of attitudes to the elderly and especially towards older family members; in expectations of family caregiving and especially the roles of women; and in beliefs about health and disability. Second, culture brings with it a wide variety of beliefs and practices that affect propensity to use care services, most notably associated with religion, but also in behaviour and preferences, such as diet and forms of address.

The provision of culturally appropriate aged care services recognises the benefits to the quality of life of older people of being able to maintain continuity with life patterns established at younger ages (Rowland 2007). It also recognises that different cultural backgrounds and social circumstances can give rise to attitudes and expectations that may not always be met by mainstream aged care services.

Box 3.2 **AIHW projections of culturally and linguistically diverse groups**

In 2001, the Australian Institute of Health and Welfare (AIHW) produced a range of projections showing the likely growth in the proportion of older people from culturally and linguistically diverse backgrounds. These show:

- Between 1996 and 2026, the number of older people from these backgrounds is projected to increase from 392 800 to 939 800 — a 139 per cent increase over the 30 year period.
 - Over this period, the proportion of older Australians from such backgrounds is expected to increase from 17.8 to 21.2 per cent.
- Growth in the population from these backgrounds is even more pronounced in the 80 plus age group. In 1996, there were 64 000 people aged 80 plus from such backgrounds, while in 2026 this number is projected to reach 269 600, an increase of 321 per cent. In comparison, the Australian-born population is expected to increase by 90 per cent over the same period.
 - Over this period, the proportion of people aged 80 years and over from these backgrounds is expected to increase from 13.2 to 25.2 per cent. Thus, by 2026, one in four people aged 80 and over will be from these backgrounds.
- A number of linguistic groups will exhibit pronounced growth rates within the total aged population at different stages across the next 30 years:
 - Between 1996 and 2011, growth rates are projected to be particularly high in the Italian, Greek, Cantonese and Maltese-speaking populations aged 80 and over, and in the Croatian, Arabic and Spanish-speaking populations aged 65 and over and 80 and over.
 - Between 2011 and 2026, growth rates are projected to be particularly high in the Vietnamese, Filipino and Mandarin-speaking population aged 65 and over, and in the Spanish and Croatian-speaking populations aged 80 and over.
- Geographically, a number of states (in particular, Victoria) are likely to have relatively higher growth in culturally and linguistically aged populations over time.
 - In 2011, Victoria is projected to have the most diverse older population, with 30.8 per cent of its older population being immigrants from these backgrounds. This is followed by the Australian Capital Territory (26.6 per cent), the Northern Territory (25.9 per cent), New South Wales (24.2 per cent), Western Australia (20.7 per cent), South Australia (20.6 per cent), Queensland (11.6 per cent) and Tasmania (7.9 per cent).
 - In 2026, Victoria is again projected to have the most culturally and linguistically diverse population (28.3 per cent). This is followed by New South Wales (26.0 per cent), the Australian Capital Territory (23.9 per cent), the Northern Territory (21.9 per cent), Western Australia (18.2 per cent), South Australia (16.1 per cent), Queensland (10.5 per cent) and Tasmania (6.0 per cent).

Source: Gibson et al. (2001).

Clearly, language plays a vital role in all aspects of the care and treatment of older people (FECCA 2007). However, the provision of culturally appropriate care also recognises differences between clients in terms of their belief systems, socioeconomic status, geographic location, histories, family and support systems, and life experiences relative to the broader community. Aged and Community Services Australia (ACSA 2007a, p. 1) has observed:

The best quality aged care is designed around the unique and complete needs of the individual. People from any particular ethnic or cultural group are different from one another: values, opinions and family practices may differ, English proficiency varies, settlement experiences and their lives in Australia have affected them differently. ‘Culture’ is not a separate need, it is integral to all aspects of care and support provided.

An example of the importance of culturally appropriate aged care to the quality of life of older people concerns the care of people suffering from dementia. Studies show that the language most recently acquired is lost first for people with dementia (Access Economics 2006). When this occurs, carers need to be able to communicate with patients using the person’s first language.

Of course, culture and language are dynamic and the special nature of the needs of older members of culturally and linguistically diverse communities will be shaped by their experiences in Australia as well as their cultural background. However, in reviewing the literature in this area, Howe (2006, p. 26) observes:

Rather than finding that those needs associated with cultural and linguistic diversity will diminish over time, the studies reviewed here indicate that the nature of this need will become increasingly diverse in future. Convergence to Australian norms in some areas will run alongside maintenance of different cultural norms in others, and there will continue to be variations in the mix and pace of change between different CALD [culturally and linguistically diverse] communities.

Over coming decades, there will also be a growing demand for culturally appropriate aged care services among Indigenous Australians. According to a report by the Steering Committee for the Review of Government Service Provision (SCRGSP 2007a, p. 11) *Overcoming Indigenous Disadvantage: Key Indicators 2007*:

The most recent estimates indicate that life expectancy at birth is 59 years for Indigenous males compared with 77 years for males in the total population, and 65 years for Indigenous females compared with 82 years for females in the total population.

Life expectancy at age 65 for Indigenous males is 11 years compared with 18 years for males in the total population; and 12 years for Indigenous females compared with around 21 years for females in the total population (ABS 2007c).

In December 2007, COAG committed to closing the gap in life expectancy between Indigenous and non-Indigenous Australians within a generation (COAG 2007). Among other things, this can be expected to: increase the future demand for aged care services by Indigenous people; significantly alter the timing of the need for access to these services (that is, Indigenous people will be more likely to access aged care services at older ages than is currently the case); and re-shape the service interfaces between aged care and broader health, disability and community welfare systems.

Meeting the needs of a larger cohort of older Indigenous people for culturally appropriate aged care services will draw into sharper focus many of the existing challenges associated with service delivery in this area. For example, Cotter, Anderson and Smith (2007, p. 89) have noted that:

Providing culturally appropriate care is not cheap. A Western Australian study of an Aboriginal health service found that for every dollar spent on services that might be deemed equivalent to mainstream, there were 75 cents spent on ‘culturally secure’ aspects of care. ... Indigenous aged care providers face other challenges to viability. Many are small organisations serving small populations, so there can be difficulty achieving economies of scale and sharing infrastructure across a range of services. The majority of residents are financially disadvantaged, reducing the ability of services to raise capital through accommodation bonds. Together, these factors build a case for resource allocation to Indigenous aged care in line with greater need and the real costs of service delivery.

More generally, policy makers will continue to face the challenge of developing flexible models of care that can deliver services to culturally and linguistically diverse recipients in urban, regional, rural and remote locations; ensure there is adequate and easily accessible information available about aged care services; and ensure aged care workers have appropriate linguistic skills and adequate training in providing culturally appropriate care.

Changing preferences and expectations

There is growing policy interest in the extent to which the progressive entry of the ‘baby boom’ generation (those born between 1946–65) into the age cohorts of the over 65 year olds will be the catalyst for a change in the preferences and expectations of older Australians.³ Of itself, there is nothing new about this process of generational change. As noted by Kendig and Duckett (2001, p. 2):

³ The ABS (2003) defines the baby boomer generation as being from 1946 to 1965 (inclusive). Baby boomers are a sizeable cohort, accounting for almost 5.4 million Australians or around 27 per cent of the population in 2006. Thus, there is also an absolute numerical impact on the future demand for aged care services from the baby boomers.

... each of the successive groups entering old age bring with them a legacy arising from the historical circumstances of their childhoods, when they formed core values and orientations, and the economic and social opportunities and constraints faced in the course of their adult lives.

However, there appears to be a wide-spread expectation that the values and attitudes the baby boomers will bring with them into older age are sufficiently different from previous generations as to have a potentially transformational effect on the provision of aged care services. Compared to previous generations, it is not uncommon for baby boomers to be characterised as being more individualistic, liberal, assertive and having weaker family ties due to higher rates of divorce and separation. During the course of their adult lives, baby boomers have also become habituated to having a wider choice in the goods and services they consume.

Typical of this kind of view, Hamilton and Hamilton (2006, p. 1) argue:

The size of the boomer generation, along with their radical demands, saw them emerge as the most important generation of the second half of the twentieth century and they have become accustomed to setting the social and cultural agenda in the West. ... the boomers 'reshaped many social norms, including family composition and living arrangements, assisted by enhanced contraceptive choices, secularisation, and the women's movement' ... and have a reputation for maintaining their cultural and social influence through the decades as they age. Thus, they have progressively redefined marriage, parenthood, middle age and menopause and are now turning their attention to old age and retirement.

The preferences and expectations commonly attributed to baby boomers can reasonably be expected to accentuate some existing trends in the provision of aged care.

Many older people, including those with a disability or chronic illness, do not need, nor seek, support in their day-to-day living (chapter 2). For those that do, it has been consistently observed that most, whether in Australia or overseas, desire autonomy, self-reliance and independent living arrangements. This usually translates into a preference for remaining in their own homes for as long as possible, with appropriate care support as required. For example, Anglicare Australia (2007, p. 15) has noted:

There is no doubt that, given a choice, the majority of people will choose to remain living in their own home with support rather than moving to a residential facility.

Catholic Health Australia (CHA 2007b, p. 13) has similarly observed that ‘clients have an increasing expectation that they will be supported at home longer and that higher levels of care needs will be met’.

The trend towards delaying entry into residential care for as long as possible is being supported by a broadening of the housing options available to older people. Over the last two decades there has been significant growth in retirement villages and other forms of assisted living accommodation. Moreover, there is growing diversity in the ‘life style’ options offered by these forms of accommodation, extending to recreational facilities, social activities and varying levels of integrated care. These developments offer older people the option of ageing in place within a community environment, with access to community care programs and, in some cases, a range of care services offered by the organisations managing these forms of accommodation.

The trend towards more diverse housing options is likely to continue, with McFee (2007, p. 8) noting a number of interesting developments in the United States:

NORC [Naturally Occurring Retirement Communities] is a term describing neighbourhoods or buildings in which a large segment of residents are older people. The ultimate goal of NORC is to help transform communities which are ageing naturally, into good places to grow old — communities that support healthy, productive, successful ageing and respond with calibrated supports as individual’s needs change.

A very recent trend also in the US is the emergence of Intentional Communities where groups of older people with similar interests pool their resources and provide purpose built adaptable housing.

Taken together these trends add further weight to the view that, over coming decades, the demand for community care is likely to be stronger than that for low care residential places.

Along with a desire to remain at home, there is overseas evidence — for example, in the United Kingdom and the Netherlands — that older people’s preferences for support appear to be moving towards the use of formal rather than informal care, that is towards the services offered by professional aged care providers rather than those supplied by family and friends (Hogan Review 2004). In Australia, McCallum (2003) has cited evidence suggesting that almost 60 per cent of people aged 70 years or over would prefer to receive formal care in their own home in the event they were unable to care for themselves, compared to 28 per cent who would prefer to receive residential care. Around 5 per cent would prefer to be taken care of by their family at home.

The trend towards greater use of formal aged care services is likely to strengthen in coming years, to the extent that baby boomers may have a stronger preference to remain independent and exercise autonomy in their decision-making. For example, in commenting on the preferences of baby boomers in the United States, Yee (2005, p. 3) has observed that:

The idea of instilling a sense of guilt and obligation as a motivation to provide supportive care for the older generation over an extended number of years is denied among most boomers, who foresee a lifetime of independent decisions for themselves. ... Adult children of this modern age are more likely to be well-trained negotiators with their parents and [on] behalf of their parents who need care. At the same time, parents may be less willing to accept the care offered by their adult children if it means compromising their own preferences.

Baby boomer preferences in this area are also likely to be influenced by the availability of informal carers (such as children, other family members and friends) (chapter 6). Among other things the future availability of informal carers will be shaped by changes in: the number of children per household; the proximity of children to their elderly parents; and the willingness and capacity of children to care for their elderly parents. For example, over a decade ago, de Vaus (1996, p. 21) in analysing the complexity of how children in Australia view their responsibilities to elderly parents observed:

In promoting an aged care policy that relies on adult children providing support and care for elderly parents due attention must be given to the fact that demographic changes mean that such carers will not necessarily be available and, even if available, they may not see it as their responsibility to provide the level of care required.

The view that, baby boomers are likely to have a stronger preference for independent living is also supported by the results of a recent survey conducted by Fujitsu Australia and New Zealand (2007) (box 3.3). For example, in the Fujitsu survey of baby boomers, which focused on those aged 58 to 61, four out of five respondents indicated a high or very high preference for independent living. As part of this study, the Commission also sought the views of several aged care providers who confirmed these expectations and preferences of baby boomers in relation to aged care services (box 3.4).

Clearly, the desire for greater choice is going to be a key influence on Australia's aged care system over coming decades and is discussed in chapter 5.

However, there are three important caveats. First, baby boomers are a heterogeneous group and there are obvious dangers in making broad generalisations about their values, attitudes and preferences. Second, the attitudes and preferences of baby boomers *in old age* are likely to be influenced by a broad range of factors including their health and disability status, affluence, changing family structures

and support networks and the sustainability of different models of care in the medium to long term. Finally, any generational shift in attitudes and preferences among older people could be expected to have a stronger and more direct effect on the provision of aged care services if Australia had a more market-oriented aged care system. Australia's highly centralised and somewhat 'standardised' aged care system means that such changes need to be accommodated through adjustments to existing institutional, planning and regulatory arrangements. Thus, in the absence of changes to existing policy settings, any changes to better accommodate the needs and preferences of users of aged care services would have to be communicated through the political process rather than relying on market-based signals to adjust the allocation of resources.

Box 3.3 The Fujitsu survey

In July 2007, Fujitsu Australia and New Zealand conducted a national online survey of 1291 people focusing on those aged between 58 and 61 (78 per cent of respondents). Respondents were in geographically diverse locations and the survey was neutral in terms of the gender of respondents (51 per cent male and 49 per cent female). Key results included:

- 36 per cent of respondents were already retired while another 37 per cent planned to retire at or before the age of 65
 - 27 per cent indicated they did not plan to retire until the age of 70 or older
- 50 per cent of respondents owned their own house while 28 per cent had a current mortgage, but 22 per cent were renting
 - 20 per cent of respondents thought they would not be in a position to buy into accommodation in 10 years time and would have to continue renting
- 80 per cent of respondents said they preferred independent living, with this preference apparent even for people with significant health problems and an associated high dependence on health services
- a strong preference was also shown for independent or solo accommodation as opposed to communal or centralised facilities
- 92 per cent nominated privacy as a high or very high priority; and
- those baby boomers who have experience of aged care facilities rate them poorly and based on this, 40 per cent feel their accommodation choices will be limited.

Source: Fujitsu Australia and New Zealand (2007).

Box 3.4 **Comments received by the Commission as part of this study**

In the course of conducting this study, the Commission invited a number of aged care providers and peak bodies to comment on the likely future care preferences of the baby boomer generation. Comments included:

Mercy Aged Care:

... already the baby boomer generation have very high expectations for their parent's care – expectations which often cannot be met under the current system. Their requests on behalf of their ageing parents can be extrapolated to their own future care preferences. They will be prepared to pay extra to receive services of superior quality, they will demand greater choice, and they will want to tailor-make services to meet their individual needs. This will be especially true in community based services. They will use their inherent assertiveness and considerable consumer power to challenge and shape service design. They will expect to maintain a high level of influence and will expect to be involved in all decision-making processes. They will not accept paternalistic policy and will expect to be able to change the rules to meet their needs. (Mercy Aged Care 2007, p. 1)

Catholic Health Australia:

The prevailing view is that the 'baby-boomers' will be more demanding, will expect services to be available when they need them, will expect them to be built around and tailored to their individual needs and will want the choice of where their care is delivered, in their own home or in a residential aged care service. They will want to stay at home as long as possible. They will want a range of different types of residential aged care facilities, will be prepared to pay more for their accommodation, but will expect better services and greater choice. (CHA 2007a, p. 1)

IBIS Care:

It is anticipated that baby boomers will ensure that the service they receive is of high quality and is flexible enough for them to remain at home for as long as possible. They consider nursing homes as palliative care units and in the majority will pay for services to enable them to stay at home... they will expect one provider for all their needs as they do not want the hassle of coordinating services. (IBIS Care 2007, p. 2)

TriCare:

The expectation of baby boomers, who are currently placing their parents in extra service, is likely to be far greater than the current preference of their parents who came to maturity during the second World War and Great Depression. Baby boomers have extended their asset base from ownership of property to the acquisition of substantial superannuation investments. This has provided them with increased personal wealth and a greater capacity to exercise choice over standards, service and location in retirement. (TriCare 2007, p. 5)

Diverse trends in income and wealth

Baby boomers are not only likely to have different attitudes and preferences than previous generations, they are also expected to enter retirement with higher levels of income and wealth (on average) with which to leverage the aged care services they want.

Indeed, the baby boomers are estimated to live in the wealthiest households in Australia, with each baby boomer in 2004 on average having a net worth of around \$381 000 compared to an average for all Australians of about \$292 500 (AMP and NATSEM 2007).⁴ The distribution of wealth has been shifting towards older Australians since the mid-1980s and these trends are expected to continue over the next few decades. Kelly (2002) estimated that between 2000 and 2030, the real average family wealth of older Australians will grow at a significantly faster rate than the rest of the population, with the share of total family wealth for those aged 65 and over increasing from around 22 to 47 per cent.

However, as revealed by AMP and NATSEM (2007), this overall picture of increased affluence among older Australians masks considerable diversity:

- Almost three-quarters of people in the 45–64 years age group carry a combined total debt of around \$150 billion. The average debt per household is about \$59 000. However, the impact of debt needs to be assessed having regard to total assets.
- The average personal net worth of the wealthiest one-quarter of baby boomers is \$910 400, while the least wealthy one-quarter of baby boomers have an average personal net worth of \$68 300.

It means that the poorest one-quarter of baby boomers possess 4.4 per cent of the group's net worth while the wealthiest one-quarter enjoy 60 per cent of the boomers' \$1 648 billion net worth. (p. 18)

- Around 40 per cent of the baby boomers current net worth is held through home ownership. Wealth disproportionately held in the family home can create problems when money is required for day-to-day retirement living expenses.
- Some 40 per cent of all 'one parent with children' baby boomers are in the poorest wealth quartile. 'Lone male' and 'lone female' are also over-represented in the poorest quartile. Conversely, 'couples' are over-represented in the rich quartiles and under-represented in the poorest quartile.

The effect of this distribution towards people in couple households being wealthier than people in single parent households, allied with the large number of couples in the age group, sees more than 92 per cent of the wealth of the boomer group being controlled by couple households. (p. 19)

Australia is currently making an important transition to its income support and retirement system directed at lessening the reliance on government funded aged

⁴ In the AMP and NATSEM (2007) study 'net worth' is defined as being the sum of the value of their assets — the family home and its contents, other property, money invested with financial institutions, shares, superannuation, vehicles, own incorporated business (net), and other assets — minus any debts.

pensions, towards a greater emphasis on people self-funding their retirement needs through superannuation. However, when the Superannuation Guarantee Charge was introduced in 1992, the oldest of the baby boomers were already in their mid-40s. It is therefore not surprising that the AMP and NATSEM analysis shows a significant proportion of baby boomers will have only limited means to self-fund their retirement, including any future need for aged care.

Some groups in the community are likely to be particularly vulnerable. For example, Anglicare Australia (2007), has pointed out that some older women may not have accumulated much superannuation because they have been raising families and hence, had less time and/or reduced incomes with which to save.

Commentators are also drawing attention to the implications of these developments for other areas of social policy such as housing. This recognises the importance of security of housing accommodation for the delivery of community care. The AMP and NATSEM analysis shows that 20 per cent of households headed by a baby boomer do not own or are buying their own home. While the Fujitsu survey (2007, p. 16) found that:

... more than 20 per cent of baby boomers will not have the financial resources to remain living in their own homes and will require affordable rental retirement accommodation.

That said, the AMP and NATSEM (2007, p. 1) analysis also shows that many baby boomers are saving hard for retirement noting that:

Baby boomers put twice as much each week into their superannuation as those who are aged under 45, although this is still less than one-third of the weekly amount baby boomers currently spend on entertainment and recreation.

Further, the youngest of the baby boomers are now aged in their mid 40s, and still have another twenty or so years potentially in the workforce. In this context, it is worth noting that the analysis also shows some significant increases in workforce participation rates over the last ten years, particularly for older Australians aged 60–64 years. Moreover, the Simplified Superannuation reforms introduced in 2007 will increase the purchasing power of superannuation based savings as Australians aged 60 years or more are now eligible to draw tax free income from these contributions.

The wealthiest one-quarter of baby boomers will have considerable wherewithal to purchase aged care services. As discussed in more detail in chapter 5, this purchasing power is expected to have a significant influence on the desired type and range of aged care services — strengthening existing trends towards higher quality services and greater choice.

However, it is notable that the wealth of many baby boomer households is predominantly in the form of home ownership. When these people retire, it may be a case of being ‘asset rich’ but ‘income poor’. This is likely to further encourage financial product innovations, such as reverse mortgage schemes, that enable older people to draw on the equity in their home to fund their day-to-day needs in retirement, including for aged care services (chapter 4).

Overall, this picture appears consistent with Treasury projections of the number of people receiving full, part and no age pensions⁵ (table 3.5). Between 2007 and 2047, the proportion of people of pension age receiving: a full pension is expected to decline from 55.1 to 35.8 per cent; a part pension to increase from 24.9 to 40.7 per cent; and no pension to increase from 20.0 to 23.6 per cent. This change in the extent to which those of pension age rely on government funded age pensions reflects the increasing value of individuals’ superannuation and other private assets and income.

Table 3.5 Projections of people receiving full, part or no pensions^a
Persons of pension age

	2007	2017	2027	2037	2047
Number persons receiving:	<i>million</i>	<i>million</i>	<i>million</i>	<i>million</i>	<i>million</i>
Full pension	1.53	1.86	2.09	2.40	2.57
Part pension	0.69	1.19	1.88	2.45	2.92
<i>Total receiving a pension</i>	2.22	3.06	3.97	4.86	5.49
No pension	0.55	0.78	1.18	1.50	1.69
Total	2.78	3.84	5.15	6.35	7.18
People receiving full and part pensions (% of total number of pensioners)	%	%	%	%	%
Full pension	68.8	60.9	52.6	49.5	46.8
Part pension	31.2	39.1	47.4	50.5	53.2
Total	100.0	100.0	100.0	100.0	100.0
People receiving pensions and no pensions (% of those of pension age)	%	%	%	%	%
Full pension	55.1	48.5	40.6	37.8	35.8
Part pension	24.9	31.1	36.6	38.6	40.7
No pension	20.0	20.4	22.8	23.6	23.6
Total	100.0	100.0	100.0	100.0	100.0

^a Includes the age pension and similar payments to veterans and war widows.

Source: Department of the Treasury, unpublished modelling results (2007).

⁵ Including the age pension and similar payments to veterans and war widows.

In sum, it appears highly likely that, on average, baby boomers will benefit from higher income and wealth levels than previous generations. Even so, the impacts of increased affluence on the demand for aged care services are complex. On average, a more affluent elderly population in the coming decades is expected to contribute to a reduced likelihood of disability and an increased likelihood of the elderly staying at home for as long as possible with support from family and/or community care. Increased financial autonomy will also make community care more tenable, allowing some older people to buy more care services to support them in their own homes or permitting them to reside in retirement villages or assisted living apartments for a longer period of time.

However, this assessment clearly does not apply to all. Disparities in income and wealth will sharpen the differences in the demand profile of the aged, resulting in a dual challenge for the aged care sector of providing improved services for high income/wealth users, while continuing to provide quality aged care services to those older people who are reliant to varying degrees on government income support.

Further research is needed

While this section points to growing diversity among older Australians, further work is needed to assess the relative importance of different influences and emerging developments to isolate, with greater confidence, their overall implications for the provision of aged care services. There is also a need to integrate this information more fully with what we know about the changing demographics.

Some of the trends discussed above are likely to put Australia's aged care system under greater pressure and require relatively more policy attention. A major challenge is the social implications arising from the increasing diversity in incomes and wealth of older Australians, which is likely to give rise to a growing demand for greater 'product' differentiation in aged care services. However, as discussed in the following two chapters, some aspects of current regulatory and institutional settings constrain the ability of providers to respond to changing client needs and preferences, thereby exacerbating the tensions associated with moving away from Australia's somewhat 'standardised' service offerings. Beyond this, further analysis would be desirable to help inform the community about the choices it faces in seeking to ensure that older Australians receive appropriate aged care services.

3.3 Availability of aged care services

As the preceding section highlighted, over the next 40 years there is likely to be a burgeoning demand for aged care services which will be even more heterogeneous in nature than is currently the case. Ultimately, how the demand for aged care services manifests and the care mix develops will, in part, be shaped by how aged care providers respond to these pressures. As in the past, the policy framework for aged care services will obviously have a key determining influence. In effect, developments on the demand-side of the aged care ‘market’ are creating pressure for the supply-side of the ‘market’ to be more flexible, responsive and efficient.

The remainder of this study considers several emerging challenges on the demand and supply-sides of the aged care market and impediments to change. As part of this, the study identifies ways in which current institutional, financing and regulatory arrangements may be impeding the aged care sector becoming more responsive and efficient. This is in the context of evidence indicating that there is already unmet need for aged care services in the Australian community, which is taken up in the next chapter. However, the Commission has not considered as part of this mix, the adequacy or otherwise of government funding levels for aged care services, which is clearly beyond the scope of this informational study.

As outlined in chapter 2, Australia’s aged care policy framework is underpinned by objectives of equity, efficiency, sustainability, quality and choice. The remaining chapters consider how the pressures associated with population ageing and growing diversity among older people are likely to challenge policymakers in trying to ensure Australia’s aged care system meets these objectives over the next 40 years. Integral to this changing policy landscape are the tradeoffs the community will continue to have to make between these objectives, including deciding on where to draw the line between public and private financing of these services (particularly in view of the cost pressures outlined in this chapter).

4 Equity, efficiency and sustainability

Key points

- Underpinning the aged care policy framework are notions of equity, efficiency and sustainability. The pressures associated with population ageing and growing diversity among older people are stimulating debate about how these concepts are interpreted and applied to the delivery of aged care services.
- The community has to decide how much weight should be given to equity, efficiency and sustainability including possible trade-offs between these objectives and those relating to quality and choice. Importantly, community expectations concerning the provision and funding of aged care services will continue to evolve.
- Notwithstanding recent initiatives to improve aged care services in Australia, some significant challenges remain, including:
 - tackling inequities arising from existing program design
 - achieving a more efficient regulatory regime
 - improving the responsiveness of services to changes in the care needs of older people
 - improving service interfaces
 - securing sustainable outcomes.

The previous chapter highlighted that over the next 40 years the community will need to provide aged care to a significantly larger number of Australians (both in absolute and relative terms). Moreover, among the aged, there is likely to be greater diversity in terms of their backgrounds, care needs, preferences and affluence. These developments pose a number of challenges for policymakers in seeking to ensure that the aged care system delivers outcomes that are broadly consistent with the community's expectations.

This chapter examines these challenges from the perspective of the equity, efficiency and sustainability objectives underpinning the aged care system. It begins by discussing these objectives and exploring the implications of population ageing and growing diversity among the aged for these objectives and associated trade-offs between them. It then provides a brief overview of recent initiatives to improve these dimensions of the aged care system. Finally, it outlines some of the emerging challenges recognising that, without ameliorative policy action, population ageing will accentuate these challenges.

4.1 The roles of equity, efficiency and sustainability

The overarching objectives of government involvement in aged care have been to ensure that frail older people have access to high quality and cost effective care and that their carers are supported (see outcome 4, DoHA 2007d). Reflecting this, the aged care policy framework is underpinned by concepts of equity, efficiency, sustainability, quality and choice (chapter 2). Such objectives are not peculiar to aged care. Indeed, they are common to other areas of social policy such as health care.

Reflecting their multifaceted nature, the community faces choices about how to interpret and apply notions of equity, efficiency and sustainability to aged care, including how much weight should be given to each, relative to the others. Importantly, what the community expects from the provision and funding of aged care services continues to evolve.

The quality and choice dimensions of aged care are dealt with in chapter 5.

Equity

Australia's aged care system gives considerable weight to achieving equity of access to appropriate care. In reporting on the operation of the *Aged Care Act 1997*, Department of Health and Aged Care (DHAC 1999, p. 7) observed:

A key objective of the Act is to ensure that access to aged care services is according to need and regardless of race, culture, language, gender, economic circumstance or geographic location. Underlying this objective is the need to ensure that services are targeted towards the people with the greatest need for those services, and to ensure that access to care is affordable by and appropriate to the needs of those who require it.

This commitment to equity of access is reflected in current policy settings in a number of ways:

- Equity is achieved through an objective assessment of a person's need for care. This recognises that there is a wide variation among older people in terms of their physical and mental wellbeing and, given the limited availability of resources, priority should be given to those with the greatest need for care.
- Subsidy and fee arrangements seek to ensure aged care is affordable for those who need it, having regard to their ability to pay. This does not imply that all clients of aged care services should be equally subsidised, but that public funds are targeted to those individuals needing care who are least able to pay. Income and asset tested care charges recognise this principle. Further, subsidies are

calibrated to reflect that the cost of providing aged care varies markedly depending on the complexity of a person's care needs.

- As a third dimension of equity, the quality assurance and accreditation system aims to ensure that all clients receive care which at least satisfies minimum standards of safety and quality (chapter 5).

However, increased recognition of the pressures associated with population ageing and growing diversity among older people (chapter 3) is drawing into sharper focus other dimensions of equity.

- Increased community awareness of Australia's changing demographics has prompted a wider discourse about the welfare of older people (for example, the *National Strategy for an Ageing Australia: An Older Australia, Challenges and Opportunities for all*, Andrews 2002a). Underpinning this discourse has been the view that age should not be a barrier to people participating in the community and economy. For aged care, this has focused attention on ensuring that these services promote equity of opportunity for older people to remain engaged in the community for as long as possible. This has been reflected in the decision by governments to expand the provision of community care, in order to enable more older people to exercise their preference to receive care in their own home.
- The pressures associated with population ageing have also focused attention on the long-term fiscal sustainability of aged care services and, hence, the intergenerational equity of current funding arrangements. Intergenerational equity requires that the overall funding mechanism encourages broadly even contributions between groups over time. In part, this will require striking an appropriate balance between public and private funding of aged care services.
- Concerns about fiscal sustainability have also encouraged more attention to be given to the cost effectiveness of providing different types of aged care services. Thus, the notion of equity of access underpinning aged care recognises it is appropriate for the types of services available at a particular location to reflect the level of demand for those services and the cost of delivering them at that location. That said, a choice needs to be made about trade-offs to, for example, determine how to accommodate the higher costs of service provision to rural and remote areas so as to reflect the collective preference of the community.
- Many commentators argue that in the future older people will demand more choice in the services they consume (chapter 5). In terms of equity, this is reflected in the view that a commitment to ensuring a minimum standard of service quality should not preclude people, who can afford to do so, paying for extra services. For example, the Hogan Review (2004, p. 10) argued 'the ability of some to purchase a higher standard or another form of care should not be denied'.

It is also important to recognise that equity has a dynamic dimension. As a community, we are not only concerned with equity when clients first enter the aged care system, but expect that it will continue to be taken into account as clients' circumstances and needs change over time. In practice, this means that policy makers must have regard for clients' access to changing amounts and types of services, the quality of these services and the outcomes of these services in terms of quality of life.

To some extent, what equity means in the context of aged care remains controversial, including what weight should be given to the various dimensions of equity. Policy makers also face the challenge of striking an appropriate balance between equity considerations and the other objectives of aged care (efficiency, sustainability, quality and choice), particularly in view of the emerging cost pressures identified in chapter 3.

Efficiency

Within the aged care policy framework, the current focus of efficiency appears to be largely on the integration and coordination of services, including the interface between aged care and related services (such as health care and public housing). The Hogan Review (2004, p. 11) exemplifies this view:

Aged care's regulatory and financing arrangements must promote and reward efficiency. This includes integration and coordination. The arrangements must also address service gaps, allowing a smooth transition between types of care and ensuring that funding methodologies are, where possible, consistent across sectors. They should also be simple, transparent and accountable for residents, providers or purchasers.

In broad terms, efficiency is concerned with the community's ability to maximise its overall welfare and living standards, given available resources. In looking for ways to improve efficiency in an area such as aged care, it is important to consider the incentives within the system to:

- provide services needed by clients having regard to the overall costs of their provision
- improve the per unit cost of producing services
- be innovative and flexible in the face of changing economic and social circumstances.

Reflecting this perspective, efficiency can be thought of as having a number of dimensions:

- *Allocative efficiency* — is concerned with ensuring that resources are allocated among different types of aged care, and between aged care and the wider

economy, so as to produce the combination of services that represents the best value for clients and the community. Allocative efficiency focuses attention on whether, due to market failures or regulatory and institutional settings, some aged care services may be over or under consumed from a community wide welfare perspective.

- *Productive efficiency* — involves the delivery of an appropriate level and quality of care services at the lowest possible cost, by using the least cost combination of inputs. Productive efficiency incorporates technical efficiency, which refers to the extent to which it is technically feasible to reduce any input without decreasing the output, and without increasing any other input. It should be emphasised that productive efficiency does not mean producing the lowest quality service or at the least cost to government. Put simply, productive efficiency is primarily concerned with avoiding waste in providing aged care services.
- *Dynamic efficiency* — refers to the capacity to improve efficiency over time. This can mean innovating to create better products and better ways of producing goods and services. It can also refer to the ability to adapt quickly, and at low cost, to changed economic and social conditions. From a systems perspective, the quality of service integration, coordination and planning are clearly important as well. This is because service interfaces are often the points within systems that come under the most pressure as a result of changing conditions. Rigidities and inefficiency at these points can impose significant avoidable costs on clients, providers and the wider community.

In the Commission’s view, given the cost pressures associated with population ageing, the welfare of the community as a whole would be best served by taking a broad view of efficiency, one that encompasses its allocative, productive and dynamic dimensions. In practice, this would include giving more consideration to whether current policy settings may be distorting the allocation of resources between different types of aged care services and weakening incentives for innovation.

Sustainability

In the context of aged care, sustainability has tended to be considered in terms of the long-term fiscal sustainability of government policy settings. As outlined in chapter 2, aged care subsidies are largely funded by the Australian Government on a ‘pay as you go’ basis (that is, from consolidated tax revenue). Population ageing has focused attention on the need to ensure that such subsidies remain affordable for the community in the medium to long term. Treasury (2002, p. 2) has defined fiscal sustainability as:

... the government's ability to manage its finances so it can meet its spending commitments, both now and in the future. It ensures future generations of taxpayers do not face an unmanageable bill for government services provided to the current generation.

One of the key requirements for sustainable government financial arrangements is a balanced budget over the medium to long term, given a reasonable degree of stability in the overall tax burden.

As in other areas of social policy, fiscal sustainability has drawn attention to the need to ensure there is an appropriate balance between public and private financial support for aged care services.

However, sustainability can be thought of more broadly as the ability over the long term to continue to provide services of an appropriate standard and in a way that meets community expectations in relation to their accessibility, affordability, quality and environmental impact. Accordingly, fiscal sustainability is only one dimension of sustainability. Other aspects include:

- **Provider sustainability** — is concerned with the financial viability of aged care providers in the long term. In the aged care sector, providers operate within a highly regulated environment and the design of regulatory and funding arrangements should not undermine the financial viability of providers or distort signals for new investment.
- **Workforce sustainability** — is concerned with the ability of the aged care industry to attract and retain people with the requisite skills needed to provide the level of safe, quality care expected by the community. This dimension of sustainability focuses attention on whether future models of care are able to be supported by the available workforce.
- **Social sustainability** — is the ability to maintain social harmony within the community concerning the distribution and use of available resources. Demographic change is reshaping family structures and values as well as the distribution of resources between generations (see, for example, Ozanne 2007). Social sustainability focuses attention on concerns that changing perceptions about intergenerational inequities may create tensions between generations. For example, the then Governor of the Reserve Bank of Australia, Ian Macfarlane (2003, p. 19) observed at the *2003 Economic and Social Outlook Conference* that:

If we are not careful, there is a potential for conflict between generations. The young may resent the tax burden imposed on them to pay for pension and health expenditure on the old. This will particularly be the case if they see the old as owning most of the community's assets. Housing is the most obvious example, where people of my generation have benefited from 30 years of asset price inflation, while new entrants to the workforce struggle to buy their first home.

All of these dimensions of sustainability are important to ensuring older Australians continue to have access to appropriate aged care services.

4.2 Recent initiatives to improve equity, efficiency and sustainability

In recent years, Australian Governments have taken a number of steps to improve the funding and provision of aged care services. This section provides some illustrative examples of recent policy changes that have sought to improve the equity, efficiency and sustainability of these services. A more detailed overview of these changes (along with those directed at improving the quality and choice dimensions of aged care) is provided in appendix A.

Increasing the number of aged care places and adjusting the service mix

Over the last decade Australian Governments have substantially increased the number of operational aged care places in order to better match supply with the growing demand for these services (chapter 2). In the eleven years to 30 June 2007, the number of operational aged care places increased from 141 282 to 214 250 (AIHW 2008d). At the same time, through adjustments to the aged care planning ratio, governments have sought to rebalance the mix of services provided. This has included expanding the number of community care places more rapidly than those for residential care to allow more older Australians to exercise their preference to receive care in their own homes; and within residential care, increasing the proportion of high care places.

Refining regulatory and financing arrangements

Australian Governments have also refined regulatory and financing arrangements. Some of these changes have sought to create a more integrated aged care system and improve interfaces between aged care and the broader health and community welfare systems. For example, the *Aged Care Act 1997* provided for the creation of a unified residential aged care system covering 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* (DoHA 2004a) sought to strengthen the provision of community care by addressing gaps and overlaps in service delivery; providing easier access to services; enhancing service management; streamlining Australian government programs; and adopting a

partnership approach. Other joint initiatives between the Australian, State and Territory Governments have aimed to strengthen linkages between the aged care system and health and community services through, for example, the Transition Care and Multipurpose Services programs.

Other changes have 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 to a greater extent.

While the overall regulatory burden on aged care providers has undoubtedly increased over the last decade, Australian Governments have streamlined some regulatory settings and administrative arrangements. This has included: simplifying and broadening the residential care income test; replacing the resident classification scale with a new simplified funding arrangement (the Aged Care Funding Instrument) for residential care; and introducing eBusiness to the aged care sector.

Other policy initiatives

Australian Governments have introduced a range of other measures, which can be broadly categorised as addressing service gaps, improving the financial viability of aged care providers and enhancing the ability of the aged care system to respond to emerging challenges. Examples of initiatives in the latter case include new measures to improve care for the growing number of older Australians suffering from dementia; changes directed at improving the effectiveness of funding arrangements for providers; and increased funding for nursing education and training places to enhance the aged care workforce.

4.3 Some emerging challenges

Notwithstanding the policy initiatives outlined above, there is broad agreement among key stakeholders including providers, consumer groups and various commentators that Australia's aged care system faces some significant challenges. It is also widely accepted that without ameliorative policy action these challenges are likely to be further accentuated in coming years by the pressures associated with an ageing population (chapter 3). However, there are a range of views on how these problems should be addressed as part of any future reform agenda.

This section concentrates on those issues that are most likely to challenge policymakers in seeking to ensure Australia's aged care system delivers equitable, efficient and sustainable outcomes in the future, namely:

- tackling inequities arising from existing program design

-
- achieving a more efficient regulatory regime
 - improving the responsiveness of the aged care system to the changing needs of older people
 - improving service interfaces
 - securing sustainable outcomes.

Another important issue is the need to improve the productivity of the aged care sector. While this clearly has equity, efficiency and sustainability dimensions, it is dealt with separately in chapter 7.

Tackling inequities arising from program design

In recent years, commentators have identified a number of inequities arising from current program design, which also have important implications for the long-term sustainability of aged care services. These issues include service gaps in the provision of community care relative to residential care; some elements of residential care (notably accommodation and everyday living expenses) being more heavily subsidised than is the case for equivalent care received in the home; and accommodation bonds being able to be drawn upon by providers of low care and ‘extra service’ high care places but not ‘ordinary’ high care.

Service gaps in community care

The extent to which community care programs cover the spectrum of care needs of older Australians has improved over time, particularly with the addition of EACH and EACHD to the suite of government programs. Many community care programs ostensibly provide the equivalent of low and high residential aged care services to those wishing to receive care in their own home. An issue, however, is the extent to which community care packages are fully substitutable for residential care and the ease with which clients can make the transition to higher levels of care as their needs change.

For example, in a recent submission to the *Review of Subsidies and Services in Australian Government Funded Community Care Programs*, the Australian Institute of Health and Welfare (AIHW 2007g, pp. 23–24) argued that:

Changes in residential aged care have occurred to provide continuity of care with the desired outcome that many older people are now able to move from low to high care within the same facility. This ease of transition is more difficult to achieve in community care due to allocation and funding arrangements that distinguish CACP and EACH packages and which create a gap for those clients who need a level of assistance

somewhere between the two (i.e. clients new to community care who do not qualify for EACH but who are unattractive CACP clients).

A similar view is held by UnitingCare Ageing NSW.ACT (2007, p. 3), which in its submission to the same review observed:

The current gap in subsidy levels between CACPs and EACH is far too great to allow continuity of care and sufficient flexibility to respond to changing/increasing needs. It is proposed that a middle level of package be established. Eligibility for these packages could be determined by ACAT assessment.

The AIHW has suggested this problem could be addressed by adopting a single continuous community care program. It argues that a single program could deliver any type of assistance for any level of care within the scope of the entire program. Importantly, such a program would be able to provide access to nursing care to two groups of CACP clients who currently must go to another program for assistance:

- low care need clients who may require care on an episodic basis
- high and complex need clients where the availability of informal care means that while total hours required are low, skilled nursing assistance is nonetheless required (AIHW 2007g).

From a sustainability perspective, service gaps in the current suite of community care programs may result in more frequent hospital admissions (for those with episodic health care needs) and premature admission to residential aged care facilities (for those with high and complex care needs). To the extent this occurs, it results in unnecessary dislocation and stress for clients and their carers, as well as adding to cost pressures in both the residential care and hospital systems.

The subsidisation of residential care relative to community care

As a general principle, efficient decision making requires that government subsidies for aged care services should be neutral as to whether the personal and health care components of these services are provided in the home or in a residential care facility. Any financial bias that distorts the choice between residential care and community care may lead to a less than socially optimal allocation of resources across the aged care system.

There are concerns that under current arrangements, some older people in residential care may receive a higher level of public support than if they were receiving equivalent care in the community (see PC 2003 and Hogan Review 2004). Older people using community care receive subsidised personal and health care, but generally have to meet the cost of their accommodation and everyday living expenses from private means or out of income support payments. In contrast, some

users of residential care, in addition to receiving subsidised personal and health care, may also receive a subsidy for accommodation and everyday living expenses.

These inequities arise because the public financing principles generally applying in the health system have been applied to all components of residential care, even though some components are more akin to services that are typically provided through the welfare system. In relation to the accommodation component of residential care, Gray and Kendig (2002, p. 5) have observed that:

Residential care has evolved within a ‘health needs’ framework in which Australians generally expect the universal availability of good quality provision at public expense (as with hospitals). On the other hand, accommodation and income support have generally been conceived in a ‘welfare’ framework, for example, pensions and public housing available on the basis of both income and wealth means tests. Within this framework, the accommodation component of residential care remains problematic. Benefits to carers and community services do not fall so easily into one or another of these alternatives. Many of the specific debates in aged care hinge on prior ideological assumptions concerning the place of aged care in broader debates concerning public and private responsibilities and between health and welfare approaches.

‘Unbundling’ the service components that make up aged care provides a way of ensuring that appropriate and consistent public financing principles are applied to each of these components across different types of care. It is also a way of ensuring consistency between aged care services and equivalent services provided through the broader health and welfare systems.

From a public policy perspective two key issues arise in this context. First, deciding how to ‘unbundle’ the service components that make up aged care. Second, for each of these components, deciding on what public financing principles should be applied to determine the nature and extent of public as distinct from private contributions.

Aged care services can be unbundled in different ways (box 4.1). That said, equity requires that effective safety net provisions are in place to ensure all older people assessed as needing care have access to an appropriate level of care. The option of ‘topping up’ services (whether accommodation, everyday living services, personal care or health care) is also important to providing clients with greater choice in the services they consume (chapter 5).

There is a strong case that those receiving aged care in their home or in a residential facility should be required to meet the cost of their accommodation and every day living expenses from private means. These are fairly predictable expenses of everyday life and are not exclusively associated with increasing frailty or disability. While recognising the additional capital costs of providing residential aged care facilities (especially specialised facilities catering to more complex care needs), the conditions attaching to subsidies provided to residents should have regard for the income support and other safety net provisions applying more generally across the community.

More contentious are decisions about how to unbundle the ‘care’ component of aged care services and what public financing principles should apply. The care component of aged care is essentially the additional costs of being looked after because of frailty or disability (such as, assistance with eating and drinking, personal hygiene, managing urinary and bowel functions, managing problems with immobility, management of prescribed treatment, behaviour management and ensuring personal safety). To some extent, the costs associated with these services are unpredictable and may be overly burdensome.

As highlighted in box 4.1, these care services can be grouped as a single cost component ‘personal care’, or a distinction made between ‘personal care’ and ‘health care’. In principle, such a distinction should be possible since, in the context of aged care, health care largely consists of nursing and palliative care. However, in practice, the boundaries between personal care and health care are often blurred. For example, services such as podiatry, massage and swimming exercises could be grouped under either form of care. When provided in response to an existing medical condition they could be readily seen as a ‘health care’ item. However, if seen as discretionary, they could be classified as items of ‘personal care’ even though they contribute to good health and mobility.

It would need to be determined whether, from a community wide perspective, the benefits of unbundling ‘care’ in this way, and applying different financing principles to ‘personal care’ and ‘health care’ would outweigh the associated costs of greater regulatory complexity.

Box 4.1 Different approaches to ‘unbundling’ aged care services

There are different views about how aged care services could be unbundled and the public financing principles that should apply.

In the United Kingdom, a key recommendation of the Royal Commission on Long-Term Care (Sutherland Report 1999, Chapter 6) was that:

The costs of long-term care should be split between living costs, housing costs and personal care. Personal care should be available after assessment, according to need and paid for from general taxation; the rest should be subject to a co-payment according to means.

In the event, England, Wales and Northern Ireland chose not to follow the recommendation that personal care should be provided free to older people. In contrast, Scotland introduced free nursing and personal care in 2002 for those aged 65 years and over living in their own home or in a ‘care home’ (Bell and Bowes 2006).

The Productivity Commission (2003), in its submission to the Hogan Review, advocated the same approach to unbundling aged care services as the UK Royal Commission, but raised concerns about providing free personal care for those receiving residential care. It suggested one way of ensuring appropriate pricing of personal care for those in residential care would involve:

- providing a subsidy for a minimum benchmark level of care, which individuals could ‘top up’ (along the lines of the current extra service arrangements)
- introducing income adjusted co-payments, up to a maximum (such that those needing expensive care are not faced with costs which are overly burdensome)
- providing a subsidy that is restricted to certain forms of care, for example, only the nursing component of personal care. (PC 2003, p. 101)

The Hogan Review (2004) distinguished between hotel and accommodation services (the equivalent of everyday living expenses and accommodation), personal care and health care. Thus, the Hogan Review identified ‘health care’ services as separate from ‘personal care’. Like the UK Royal Commission and the Productivity Commission, the Hogan Review argued that accommodation and everyday living expenses should be seen largely as a personal responsibility. With regards to personal care and health care it argued:

- Personal care services — these should be seen as primarily a personal responsibility, with a limited suite of basic necessary services available at Australian Government expense on a means-tested basis to those who are independently assessed as needing them. Individuals should be able to use their private resources to purchase additional personal care services.
- Health care services — basic necessary services should be provided free of charge to all those who are independently assessed as needing them. A specific co-payment is unnecessary as the bundling of services, together with the financing arrangements for hotel and accommodation and personal care services, means that the individual has already made a considerable private contribution. Individuals should be able to use their private resources to purchase additional health care services. (Hogan Review 2004, p. 126)

Sources: Sutherland Report (1999); PC (2003); Hogan Review (2004); Bell & Bowes (2006).

More generally, unbundling the cost of aged care services raises a number of broader implementation issues (see PC 2003; ACAA 2006b). These include:

- developing workable definitions of each of the service components in order to determine the financing principles and sharing of costs between the individual and the government
- decisions about the appropriate pace of change — whether such a restructure should be introduced gradually or as a one-off change with a grandfathering clause covering existing users
- the most appropriate forms of user payments and interactions with income and asset tests within the aged care sector and the broader welfare system
- the cost implications of having different funding streams with differing copayments and safety net arrangements.

Nevertheless, the Commission remains of the view that the arguments in favour of unbundling the underlying cost components of aged care in order to achieve greater equity across different types of care, and better targeting of the public subsidy, are fundamentally sound and warrant detailed analysis. Moreover, as discussed below, unbundling is a key dimension of other potentially worthwhile reforms.

The availability of accommodation bonds

The introduction of new arrangements for accommodation payments for residential care was a key element of the Aged Care Structural Reform Package announced in the 1996 Budget. Accommodation payments encompass accommodation bonds (for ‘low care’ and ‘extra service’ high care places) and accommodation charges (for ‘ordinary’ high care places). The money raised through these capital contributions was intended to meet the cost of acquiring funds to upgrade and maintain residential aged care facilities. Earlier, the Gregory Report had found there were major deficiencies in the capital works of nursing homes and that funding arrangements were providing neither sufficient funding nor incentives for providers to maintain their buildings (DHAC 1999).

Over the last decade, accommodation bonds have provided an important source of funding for the expansion of aged care facilities. As Hogan (2007, p. 3) has observed:

Bonds have allowed access to funds for meeting the servicing costs of capital funding not otherwise effectively provided through government subsidies and payments, or approved charges on residents.

Anomalies arising from the current accommodation bond arrangements

A number of anomalies are created by accommodation bonds being available to providers of ‘low’ care and ‘extra service’ high care places but not ‘ordinary’ high care places (see PC 2003).

First, the accommodation bond arrangements increase the likelihood of providers having to use the capital made available through low care and extra service accommodation bonds to cross-subsidise the capital requirements of ordinary high care places. As the amount of low care bonds is effectively uncapped, there are concerns that cross subsidisation is putting upward pressure on the level of these bonds. Commentators have observed that the average level of low care accommodation bonds now appears to materially exceed the replacement cost of a residential place (Ergas 2006).

Cross subsidisation creates inequities and inefficiencies in meeting the capital requirements of ordinary high care places and is unlikely to be sustainable in the long term. As the Aged Care Association of Australia (ACAA 2007a, p. 17) recently argued:

Many aged care facilities have been cross subsidising their high care building costs from low care and extra service capital streams. However, as the percentage of vacant beds continue to rise across the industry continued cross subsidisation is becoming highly problematic.

Second, there are concerns that the arrangements might discriminate among elderly Australians requiring residential care. Hogan (2007, p. 2) has observed that:

The distinction drawn between extra-service high care, where bonds may be sought, and ordinary high care where they are not, brings a remarkable discrimination. Those with substantial assets may effectively buy their way into high care by offering substantial bonds. Those lacking substantial wealth — not only pensioner and part-pensioner residents but also those of relatively modest wealth — are not able to offer anything to support the provision of services for them. *Thus the discrimination is against the less well-off in Australian society.* [Author’s italics]

Another exception effectively applies to those residents initially in low care who elect to ‘age in place’; that is, they remain in the same location while receiving what amounts to high care. This measure ensured that residents of low-care facilities did not have to move to another location so long as they could receive effective care. A substantial proportion of residents in low care are ‘ageing in place’.

Third, as a result of these arrangements the capital funds available to providers of ordinary high care places are considerably more limited than those available for low care places (PC 2003). This reflects that the average income from accommodation bonds per low care client has substantially exceeded the average income derived from accommodation charges per high care client.

Fourth, the arrangements may create perverse incentives for providers to attempt to facilitate clients entering residential care through low care places, even though some of these people may require a higher level of care.

Finally, the current arrangements undermine the long-term viability of the aged care system by making investment in ordinary high care places less attractive to providers, despite those in need increasingly entering residential facilities at the higher end of the care spectrum (chapter 3). For example, Ergas (2006, p. 3) has observed:

... the current arrangements ... make the financing of 'high care' depend, at least in part, on the flow of admissions into (and hence bond payments for) 'low care'. However, demographic trends are likely to reduce demand for 'low care' relative to 'high care', compromising this source of funding just as the need for 'high care' places increases.

The equity, efficiency and sustainability of residential care would be improved by placing low care and high care on an equal footing in terms of meeting their capital requirements. This would involve all permanent clients of residential care, subject to a safety net, having the choice of paying either:

- a lump sum bond, or
- a daily or periodic rental charge (at a level equivalent to the stream of capital available to providers through the bond).

Addressing community concerns

Community concerns about extending accommodation bonds to ordinary high care places have been a significant stumbling block to reform in this area. Bruen (2006, p. 15) has noted that these objections include:

- low care is largely a housing option, whereas high care is largely about care
- long stay residents in hospitals are not charged accommodation bonds, though the care is similar
- some 19 per cent of high care admissions stay less than three months and 27 per cent less than six months ... yielding little return for the provider
- an accommodation bond that forces a person to sell the family home is politically undesirable and equivalent to a 'death duty'.

These concerns may be assuaged to some extent if the accommodation component of residential care was clearly 'unbundled' from the everyday living, personal care and health care components of aged care and further, if the principle that accommodation is largely a private responsibility (subject to a safety net) was consistently applied across residential and community care settings. One

implication of this, is that those receiving residential care who can afford to do so, should be required to make a contribution towards the cost of their accommodation for the full length of their stay (subject to the current exemption for those people entering residential facilities for respite care).

There are valid concerns about requiring clients, who are expected to need high level care for only a matter of weeks or months (for example, the very frail or those entering residential care for palliative care), having to pay large up-front accommodation bonds. However, these clients could have the option of paying the daily or periodic rental charge and therefore should not be disadvantaged. That said, this is predicated on providers being required to genuinely offer clients this choice.

In this regard, it is worth noting that clients currently entering low care residential places have the option of paying a lump sum bond, an equivalent periodic payment or a combination of both. Historically, clients' take-up of the periodic payment option has been surprisingly low (PC 2003; Hogan Review 2004). This could reflect that clients are not well informed about these options. However, there are concerns it may also reflect constraints on competition in the aged care industry, with high occupancy rates enabling providers to enter into only limited negotiation with clients around their preferred method of payment (see Hogan Review 2004). This underscores the importance of broader reforms in aged care, including measures to strengthen competition and consumer choice (chapter 5).

Finally, there is likely to be stronger community acceptance of this change if capital contributions accurately reflect variations in the cost of supplying accommodation, such as those arising from differences in location (and hence land values) and building costs. The Commission has previously raised concerns that under current institutional arrangements, accommodation bonds may include a quasi-rent reflecting the scarcity premium created by government controls on the supply of places (PC 2003). In commenting on clients facing more responsibility for meeting the cost of their accommodation, Sullivan (2005b, p. 3) has contended:

This seems sensible as long as consumers get more if they pay more.

That is not the case at present. Some consumers are paying higher bonds than others even though they reside in homes that are not as recently built as others.

Achieving a more efficient regulatory regime

Over the last two decades aged care, like many other areas of economic activity, has seen a significant increase in government regulation (see, for example, Banks Review 2006). In large part, this has been in response to changing community expectations about consumer rights and the quality of aged care services. However,

groups representing both aged care providers and their staff argue that, in some areas, the level of government regulation has become burdensome and imposes avoidable costs on providers, clients and the wider community.

It needs to be stressed that arguments favouring a reduction in the burden of government regulation are not about imposing a lower level of service quality on older Australians. There is a strong rationale for government intervention to ensure that aged care services at least meet an acceptable standard of care and the consumer rights of the frail aged and others are adequately protected. At issue is whether there is scope to achieve these objectives at a lower overall cost to the community through more efficient regulatory design.

The Banks Review (2006, p. i) considered aged care regulation as part of its much broader remit to identify opportunities to address areas of Australian Government regulation that are ‘unnecessarily burdensome, complex, redundant, or duplicate regulations of other jurisdictions’. The aspect of aged care regulation that particularly attracted the attention of the review was the quality assurance and accreditation regulatory framework existing on top of, and in many respects duplicating, other Australian, state, territory and local government regulations and administering agencies. The Banks Review (2006, p. 33) noted that:

There is, however, an increasing level of concern by industry that this additional and separate level of regulation is not well matched to desired policy goals. The duplication appears unnecessarily costly for both providers and government. It may also restrict the development of a mature industry able to take responsibility for its own actions.

The Review made three recommendations to improve the regulation of aged care services. First, it recommended rationalising the certification process in order avoid duplicating the Building Code of Australia, and related state, territory and local government laws and monitoring arrangements. The Review argued that requirements not currently addressed by the code and state, territory and local government mechanisms could be mandated separately. Second, the review recommended introducing competition into aged care accreditation by allowing providers to select from a range of approved quality improvement and quality management agencies. Among other things, this change was seen as a way of ensuring that providers did not have to deal with multiple accreditation systems to cover all of their activities. Finally, the review recommended that the DoHA should expedite its review of Resident Classification Scale documentation to implement improvements as soon as possible.

The first two of these recommendations were not accepted by government (Australian Government 2006).

The Commission notes that the Australian National Audit Office (ANAO) recently released a performance audit of building certification of residential aged care homes by DoHA. The ANAO (2008, p. 15) contended that:

The focus on building certification has created a specialised and professional industry for the design, building and management of aged care facilities that did not exist prior to the program. The certification program was developed and implemented by DoHA with wide ranging and active involvement of all sectors of the aged care industry. Overall, these industry stakeholders supported the certification program and considered that it had been both needed and successful in achieving improvements to the building stock of aged care facilities.

The ANAO (2008, p. 14) also noted that the building certification program is expected to be reviewed in 2008 and suggested two areas that could be strengthened:

- a more effective performance information framework to assist internal decision making and provide more comprehensive information on program outcomes
- a more formal, structured communication strategy that better allows DoHA to engage with key industry stakeholders to identify emerging certification issues.

DoHA has agreed with ANAO's recommendations in these areas.

While the Commission welcomes improvements to the building certification program, it considers that the Banks Review (2006) concerns about the potential duplication of the Building Code of Australia remain unanswered (chapter 7).

More generally, Aged and Community Services Australia, a national peak body for aged and community care providers, has argued that further consideration needs to be given to reducing red tape in the industry (ACSA 2008). Notably, ACSA has reiterated the case for addressing industry concerns about building certification and the accreditation process. In addition, ACSA (2008) has argued for:

- ceasing or redesigning the unannounced spot check program using a risk management approach
- ending regulation of extra service places
- streamlining the community care reporting burden.

It is beyond the scope of this informational study of aged care trends to consider the merits of these or other proposals to streamline government regulation in the industry. That said, in view of the need to improve efficiency (chapter 3), it is clear the community can ill-afford regulatory arrangements that impose excessive and unnecessary costs on aged care providers or that stifle the efficiency benefits arising from greater competition. This underscores the importance of rigorously assessing

the merits of proposals to reduce red tape in the industry as part of any future reform agenda.

Further, regulation can have significant implications for the aged care workforce. This issue is explored in more detail in chapter 6. However, it is worth noting here that regulation can affect the ability of the aged care industry to attract and retain staff and adapt work practices in response to changing labour market conditions. For example, some argue that excessive government regulation is resulting in registered nurses having to spend more time on administration and less time on providing care, which is undermining job satisfaction in the industry (see, for example, Venturato, Kellett and Windsor 2007).

Given the high level of community concern at any suggestion of poor treatment of our elderly, the industry is particularly vulnerable to regulatory creep in response to high profile incidents. Recognising this, it is especially important that governments adhere to the principles of good regulatory process (Banks Review 2006). These principles include clearly establishing the need for regulation; considering all feasible policy options (including self-regulatory and co-regulatory approaches) and consulting widely. In addition, these principles require policy options to be assessed within a cost-benefit framework, with only the option that generates the greatest net benefit for the community (taking into account all impacts) being adopted.

Improving the responsiveness of the aged care system

There is evidence of unmet need for aged care services in the Australian community. In this context, a key issue is the extent to which the aged care system can provide the level and mix of services that best meets the needs of clients and is sustainable in the long term. As outlined in chapter 3, all the indications are that Australia's aged care system will need to be more flexible and responsive if it is to efficiently and equitably meet the needs of a growing and increasingly diverse cohort of older Australians in a sustainable manner.

This section begins by briefly considering the evidence of unmet need for aged care services. It then discusses the scope to improve the flexibility and responsiveness of the aged care system.

Evidence of unmet need

The issue of unmet need is distinct from the extent to which there may be unsatisfied demand among older Australians for greater choice in consuming aged care services. The former is essentially concerned with the ability of older people to access an appropriate level of care that meets their individual care needs, while the

latter focuses on the extent to which they are able to choose from a range of differentiated service offerings (chapter 5).

In terms of community care services, a report by the Allen Consulting Group (2007) for the Community Care Coalition estimated that in 2003, 433 000 older Australians living at home had unmet needs. This estimate was based on data from the ABS survey *Disability, Ageing and Carers: Summary of Findings* (ABS 2004b). The data revealed that in 2003, 1.2 million people aged 60 years and over living at home reported needing assistance with 10 broad areas of activity: self-care, mobility, oral communication, cognitive or emotional tasks, health care, household chores, meals preparation, property maintenance, private transport and paperwork. Taking into account the availability of both formal and informal care:

- 788 000 people (64 per cent) said their needs were being fully met
- 363 000 people (30 per cent) said their needs were being partly met
- 70 000 people (6 per cent) said their needs were not being met at all (Allen Consulting 2007).

The AIHW (2007b) included an analysis of unmet need among older Australians for assistance in *Australia's Welfare 2007*. The analysis focused on the need of persons aged 65 years or over with a disability (including those older people without disability but who have a long-term health condition), living at home, for formal or informal assistance with the 10 broad areas of activity listed above. Among other things, it found:

- Older people who report unmet need for assistance can be divided into two broad groups according to type of unmet need. Nearly all of those who report unmet need for assistance in core activities (mobility, self-care and oral communications) are people with profound or severe limitations. On the other hand, those who report unmet need in other activities, such as transport, household chores or home maintenance, are a mix of people with core activity limitations and others who have a disability without core activity limitations.
- Key areas of unmet need for assistance (both formal and informal) in 2003 included property maintenance (27.3 per cent of people with a need for assistance in this activity), cognitive or emotional tasks (23.6 per cent), household chores (20 per cent), mobility (17.4 per cent) and private transport (16.4 per cent).

These studies lend support to the Senate Community Affairs References Committee report *Quality and equity in aged care* (SCARC 2005), which found evidence of considerable unmet need for community care. The report also noted there were waiting lists for many community care services.

There is also evidence of unmet need for residential care. Under current institutional arrangements, waiting lists are an indicator of the unmet demand for residential care. With both the number of subsidised aged care places and the price of these places effectively determined by government, changes in the demographic and economic determinants of demand only impact on the private non-financial price of these services (that is, they affect waiting times) (Hogan Review 2004). The Hogan Review found the average wait for residential care was around 50 days, but it could be as long as a year in some rural areas. In an environment of high occupancy rates, the report accepted that waiting lists were evidence of unmet demand for residential care in Australia.

More recently, in relation to the waiting times for residential and community care, Ergas (2008, p. 3) has observed that:

Although many difficulties are involved in measuring waiting times, they appear to be reasonably substantial. In 2007, some 40 per cent of people assessed as needing high level residential care had to wait more than a month before they could access the care they need and around 17 per cent had to wait more than three months. Moreover, waiting times for care recipients in the lowest income and asset brackets are greater than average, suggesting that providers ‘cherry pick’ the residents with the greatest capacity to pay. Waiting times for community care packages have also been high, with the mean waiting time being some 15 per cent greater than for low level residential care.

Implicit in recent changes to the aged care planning ratio is the view that the supply of certain forms of aged care have been falling short of the underlying need for these services (appendix A).

Further, the accessibility of community and residential care services can be gauged from the extent to which the incidence of unmet need varies across different groups in the Australian community. In particular, commentators generally emphasise the higher incidence among special needs groups, including: people from culturally and linguistically diverse backgrounds; Aboriginal and Torres Strait Islander people; people with dementia; financially disadvantaged people (including the homeless); and people living in remote and isolated areas. For example, the SCARC (2005) found evidence that these groups find it more difficult to access HACC services. Among other things, the Committee observed:

While many people in these [remote and very remote] areas are eligible for HACC and other community care programs there are often long waiting lists. For those receiving services there is often difficulty moving through the various levels of care as their needs change. In rural and remote areas, with relatively more limited access to residential aged care, it is important to ensure people can access community care services. (SCARC 2005, p. 158)

There is a need for better data with which to assess the extent of unmet need for aged care services among older Australians, including how its incidence varies across different groups in the community. In a recent submission to the *Review of Subsidies and Services in Australian Government Funded Community Care Programs*, the AIHW (2007g) strongly recommended a comprehensive study of unmet need for formal and informal assistance among older Australians, by type of assistance, in order to investigate the adequacy of existing community aged care programs and services. Such a study would be a useful first step in improving the type and quality of evidence available to help guide policy development.

Some observations on unmet need

Unmet need for aged care services can potentially have serious consequences for the physical, mental and emotional wellbeing of older Australians, and the aged care and broader health and community welfare systems. For example, the effect on those needing but not receiving community care could include functional loss, depression, impaired access to everyday services and greater social isolation. It could also lead to more frequent hospital admissions and premature admission to residential aged care. Similarly, unmet need for residential care can put considerable pressure on those requiring this type of care, their carers and families, and the hospital system.

Conceptually, unmet need for aged care services could arise as a result of:

- existing programs not being adequately funded (either publicly or privately)
- service gaps (in the sense that some services for which there is a need in the community are not being provided)
- potential clients of aged care services finding it difficult to access existing services because, for example, of geographic isolation, a lack of information or cultural barriers
- aspects of regulatory and financing arrangements that distort decision making and make the aged care system less responsive to the changing needs of older people.

Based on the available literature, this study has found evidence of unmet need for aged care services. The extent of the shortfall and its underlying causes, while beyond the scope of this study, deserves detailed policy analysis.

Reforms to improve the responsiveness of the aged care system

Currently, adjustments to the provision of aged care services occur largely through periodic changes to planning and funding parameters, and regulatory settings. Governments largely determine how many aged care places should be supplied, where these places are located, the appropriate mix of services, the price of these services and how to respond to changing community expectations with regards to quality and choice. Separately, ACATs independently assess eligibility for these services — that is, the level of demand.

Competition and price play little role in signalling to providers changing patterns of demand and the need to adjust decision making accordingly (including the need for new investment). In effect, client needs and preferences are revealed only indirectly to providers through government planning and regulatory processes, rather than directly.

In recent years, an emerging theme in the literature has been the scope for reforms to make the aged care system more responsive to the changing needs of clients (see, for example, PC 2003 and Hogan Review 2004). This is generally considered important to improving the quality of investment decision making in the industry and sharpening incentives for innovation in service design and delivery. For example, Ergas (2006, p. 11) argues that:

... population ageing will place the aged care system under great stress, though it also creates significant opportunities for innovation in service design and delivery. A more market-oriented approach to aged care would provide a framework that allowed and encouraged that innovation, and more generally help ensure that older Australians can continue to obtain high quality aged care services into the future.

Any proposal to strengthen the influence of clients through reforms to existing arrangements needs to ensure that it would not undermine the accessibility, safety and quality of aged care services. For example, there are concerns about the provision of adequate aged care services in rural and remote areas, where the markets for these services are thin and the scope for effective competition is limited. As Sullivan (2005b, p. 1) has observed:

There are always downsides to market approaches if the market created is not consumer friendly. But moving a highly regulated program into a more sophisticated competitive environment requires a market structure.

If market forces produce better more affordable services then they should be encouraged. If particular people become priced out of the market or are less commercially attractive to providers, then safety nets are vital.

Improvements in the responsiveness and flexibility of aged care services are likely to require the re-design of current regulatory and funding arrangements. A menu of reform options *might* encompass:

- relaxing restrictions on the number of aged care places and the prices that are charged
- more clearly signalling to clients the underlying cost and quality of alternative types of aged care services
- empowering clients to exercise greater choice in consuming aged care services.

The last option is explored in chapter 5 in the context of providing clients with enhanced choice.

Easing quantity and price restrictions

One of the ways the government manages the fiscal risk associated with the provision of aged care services is to limit the number of subsidised aged care places. Two mechanisms — the aged care planning and allocation system and ACATs — are used for this purpose. Through the aged care planning and allocation system the government determines the notional number of aged care places it is prepared to fund based on a judgement about the number of people aged 70 years and over likely to require these services. These places are then allocated at a regional level. At the same time, ACATs perform a gate-keeper role, as an ACAT assessment and approval is required before people can access subsidised residential aged care, CACPs, EACH and EACHD packages. In effect, a positive ACAT assessment represents an entitlement to access care and, if eligible, a subsidy for that care.

Restricting the number of aged care places requires price controls to ensure that providers do not abuse the localised market power that this creates. This effectively mutes the role of prices in signalling changing market conditions and in inducing appropriate responses from clients and providers. In such an environment, there is a risk that prices will not be allowed to cover efficient costs, thereby compromising incentives to invest in aged care (Ergas 2006).

It is increasingly recognised that these restrictions combine to limit the scope for effective competition between providers, weaken incentives for innovation in service design and delivery, distort investment decision making, and risk the long-term sustainability of aged care services (see, for example, PC 2003 and Hogan Review 2004).

As recognised in the Intergenerational Reports (Treasury 2002, 2007), the Australian Government faces a significant challenge in attempting to manage the

fiscal risk associated with providing subsidised aged care services in the context of an ageing population. However, a key issue going forward is whether there are other ways of managing this risk that allow greater flexibility within the aged care sector to respond to the changing needs of clients.

One possibility, which warrants further analysis, would be to dispense with having dual regulatory controls over the number of aged care places. This would involve abolishing the aged care planning and allocation system (while retaining accreditation) and relying on the gate-keeping role performed by ACATs and on complementary regulation to ensure sufficient places for those needing concessional access. This would require strengthening the current assessment process, which is oriented towards helping match people with available services. As Bruen (2006, p. 19) argues:

A further challenge for Government in deregulating supply is to retain effective management of the demand for subsidised care. This would have to be achieved through a much more rigorous eligibility assessment system than at present, which in turn would require increased funding for Aged Care Assessment Teams. Otherwise, the pressure from unlimited supply could create huge expenditure problems for Government. The current assessment system is influenced considerably by the availability of places.

Consideration would also be need to be given to the need for transitional arrangements to accommodate this change to the current gate-keeping mechanisms to avoid the possibility of significant policy induced disruption to the market. Beyond this, such a change could be supported by other complementary reforms designed to help lessen the fiscal risk associated with subsidised aged care services. For example, measures intended to more clearly signal to clients the underlying cost and quality of different types of care; and encourage, where possible, people to make better financial provision for meeting the costs of their care in later life. These issues are discussed further below.

At the same time there may be scope to relax price controls. However, some form of price control is likely to remain necessary to help manage the fiscal risk associated with the large number of older people seeking access to aged care services on a concessional basis and to lessen the potential for providers to ‘cherry pick’ clients with the greatest capacity to pay.

To protect vulnerable members of the community, it would be desirable to delay easing price restrictions until effective competition and appropriate safety net provisions were in place.

More generally, policymakers could usefully consider the scope for the design and implementation of reforms directed at improving the responsiveness and flexibility

of services across the aged care sector to be informed by the reform experience of other social policy areas, such as health care and childcare.

More clearly signalling the underlying cost and quality of aged care services

Over the next 40 years it is likely that clients will demand greater choice in the types of aged care services available to them (chapter 5). At the same time, a substantial proportion of these clients will continue, to varying degrees, access aged care services on a concessional basis (chapter 3). From a community wide perspective, it is important that the individual decisions of clients reflect variations in the underlying social costs and benefits of these services. This would help ensure there is an efficient allocation of resources across the aged care system, improve choice of services and lessen the risk of the community either over or under consuming particular services.

While easing quantity and price restrictions would be a useful step towards better communicating to clients the underlying cost and quality of aged care services, of themselves, these measures are unlikely to be sufficient. This is because on equity grounds, a substantial number of older people will continue to access aged care on a concessional basis and thus, to some degree, be shielded from the full cost of providing these services. In these circumstances, there is a need to explore other ways institutional arrangements could be refined to more clearly signal to clients the underlying cost and quality of different types of care.

Conceptually, unbundling the components of aged care services could assist in this regard, in that it would:

- more accurately price the components of aged care services
- apply consistent public financing principles across different types of care (discussed earlier in this chapter)
- better target government subsidies to those most in need
- strengthen the role of competition in the provision of those elements of aged care services where this is feasible.

Such suggestions are not unique to the Australian aged care debate. As noted earlier, in the United Kingdom, a key recommendation of the Royal Commission on Long-Term Care (the Sutherland Report 1999) was that the costs of long-term care should be split between accommodation, everyday living expenses and personal care.

In addition, there may also be scope to strengthen the ACAT assessment process. Access to appropriate care should be based on an objective assessment of need through that process, with clients nominating to assessors their preferred mix of services and assessors having regard to the cost effectiveness of different service mixes in establishing the appropriate service entitlement. In cases where a client's preferred method of receiving care is less cost effective from a community wide perspective (that is, exceeds the benchmark minimum standard of care) they should be required to contribute more to the cost of their care.

This would be similar to some other areas of social policy, where there have been attempts to develop institutional arrangements to encourage clients and providers to take into account the underlying cost-effectiveness of providing goods and services involving significant public funding. For example, applications for new listings under the Pharmaceutical Benefits Scheme are assessed in terms of their clinical efficacy and cost effectiveness relative to listed products. In effect, the costs of securing particular health outcomes are compared with the benefits, to assess the relative merits of different drug treatments. Australia is seen as a leader in using such assessment processes to inform listing and funding decisions.

Accurately assessing the underlying cost effectiveness of different types of aged care services would require much better data than is currently available. For example, little is known about how variations in economies of scale impact on the cost effectiveness of providing care in different settings; and the extent to which different types of care may affect clients' quality of life (encompassing, for example, indicators of mortality, morbidity, the frequency of hospitalisation, the incidence of depression, the quality of social engagement, perceptions of happiness, and carer wellbeing).

Despite the inherent difficulty, there is a need for further research in this area, particularly in view of the demand pressures outlined in chapter 3. To illustrate one of the issues; there is a perception that in terms of public expenditure, delivering aged care through community care programs is less expensive than through residential care. However, from a community wide perspective, there is some uncertainty. For example, Gray and Kendig (2002, p. 3) have observed:

It is frequently asserted that community care is less costly than residential care. However, the cost of community care may be similar to residential care but the government contribution less. In community care, the capital costs of accommodation are provided by the user. The hotel services (cleaning, meals, heating etc) generally are provided by informal carers or paid for by the older person, or not provided at all. A large proportion of the personal care is provided by informal carers.

Improving service interfaces

In terms of public debate and policy development, ‘care’ is often viewed narrowly, for example through an ‘aged care’, ‘health care’, ‘social welfare’, ‘veterans affairs’ or ‘disability services’ lens. Moreover, even within areas such as aged care, there has been a tendency to base policy development on a largely static and siloed view of the care needs of older people at particular points in the system, for example; ‘nursing homes’ versus ‘hostels’, ‘residential care’ versus ‘community care’, and ‘high care’ versus ‘low care’.

While such an approach can be useful in helping identify and address particular problems within complex systems, there is growing recognition of the need to view ‘care’ more holistically. This recognises that older people potentially need access to different forms of care during their later years in order to maintain what the community would consider to be an acceptable quality of life. For example, older people managing one (or more) chronic illnesses may move back and forth between general practitioners, acute health care, respite care, residential care and their own homes. In view of the demand and cost pressures outlined in chapter 3, from a community wide perspective, a key issue is how efficiently and effectively aged care services can be supplied in concert with other health and welfare services to meet these individual care needs.

In this context, service interfaces are clearly important. They are essentially points where there are significant crossovers between different bundles of aged care or between the aged care system as a whole and other systems. These crossovers work in both directions, for example, how community care is configured and resourced can have implications for residential care and vice versa.

Within the aged care system there are interfaces between residential care, community care, respite care and transitional care. There are also interfaces with various elements of the health system (encompassing acute care, general practitioners, allied health services, health promotion and disease prevention); mental health; disability services; income support; public housing; community residential and supported care (including services to the homeless); public transport; and urban planning and design. This complex web of interfaces presents a significant challenge to policy makers in trying to adequately meet the care needs of older people.

Poor service interfaces are particularly seen as a problem for those older people needing to access multiple services in order to continue to live independently in the community, and those needing to make the transition from one environment to another (for example, from hospital back home or to a residential care facility).

These types of problems are not unique to aged care. For example, Bird et al. (2007, p. 451) note in relation to the health system that:

It is widely acknowledged that many countries face serious challenges in caring for a growing population of older people with multiple health problems. Part of this problem is that many health care systems have fragmented geriatric services, discontinuities within the system of geriatric care, system inefficiencies and a community/hospital split. In these systems, elderly patients may fail to receive all the services they require and, as a consequence, suffer detrimental impacts upon their health status and quality of life.

Typical of stakeholder concerns about service interfaces are those presented in box 4.2.

In recent years, there have been a number of initiatives to try and improve service interfaces, including:

- a national action plan for improving the care of older people across the acute-aged care continuum (2004–2008), which was endorsed by Australian Health Ministers in July 2004 (AHMAC 2004)
- the introduction of the Innovative Pool of flexible care places, which has trialled services linked to the acute-aged care interface, the disability-aged care interface and dementia care
- the establishment of the Transition Care Program to provide older people with low level rehabilitation and support to improve their independence and confidence after a hospital stay
- the pathways home program funded under the 2003–2008 Australian Health Care Agreements, which provides one-off capital and infrastructure funding to assist states and territories to expand their provision of step down and rehabilitation care.

While these are welcome initiatives, as the selection of views presented in box 4.2 illustrates, there appears broad agreement that there is still considerable scope to do better.

In the first instance, further research and analysis is required. This needs to be underpinned by better data than is currently available, if we are to move away from a largely static ‘stock’ view of aged care and develop a much better understanding of ‘flows’. For example, to investigate how the care needs of older people change over time; how these changes trigger interactions between different parts of the aged care system (and between the aged care system and the broader health and community welfare system); and how efficiently and effectively the care needs of older people are being met.

Box 4.2 Some views on service interfaces

National Aged Care Alliance on the aged care — health care interface:

Progress toward a continuum of care for older people requires policies and strategies across the acute, community and residential aged care settings. Health and aged care services need to be integrally linked to achieve a system of services where access is determined by the needs of people, rather than the particular point of contact or service setting, taking into account culture, geography and means. (NACA 2007b, p. 2)

... on transport and access to health care services for older Australians:

The quality of older people's health is inextricably linked to their capacity to get transport to health services. The present lack of transport to take older people to health care is a barrier to good health. (NACA 2007c, p. 3)

Aged and Community Services SA and NT:

People with a disability who are ageing are presenting to community services in a new manner. Providers will need to have assistance to adapt their service offering to this new client group, who has not previously sought extensive aged community support. Agencies and staff will need to acquire new skills and capacities to deliver responsive services to people with a disability and new partnerships formed. The ambiguity around program boundaries will need to be addressed to support service provision. (ACS SA & NT 2007, p. 8)

Australian Medical Association:

Thousands of Australians are trapped in the wrong environment for the type of care they need. There are many people in hospital who no longer need acute care, but are unable to care for themselves at home and cannot access appropriate residential or community care. Similarly, there are people in nursing homes who should be in hospital, and people in the community who ought to be in either hospital to treat particular conditions, or in aged care homes. (AMA 2004, p. 8)

Australian Institute of Health and Welfare:

... our understanding of how older people use services is still too heavily reliant on data about the 'stock' of people within a program (e.g. residential aged care), despite the acknowledged importance of interfaces between different service components (e.g. acute care hospitals and nursing homes) and the importance of understanding flows of people into and through the service system (e.g. the changing needs of older people receiving home based care over a period of say a decade). Some limited work has been done in this area, particularly at the interface between hospital care and residential aged care, but this remains an area where further research and statistical analysis is needed. (AIHW 2007e, pp. viii–ix)

Senate Community Affairs References Committee report *Quality and equity in aged care*:

A number of initiatives have been taken at the Commonwealth and State levels towards improving the effectiveness of current arrangements for the transition of older people from hospital settings to aged care settings or back to the community. While these initiatives are welcome, evidence suggests that a more co-ordinated approach needs to be adopted between different levels of government to address a system that remains fragmented and ill-equipped to meet the transitional care needs of the elderly now and into the future. (SCARC 2005, p. 182)

Hal Kendig and Catherine Bridge in a contribution to *Longevity and social change in Australia* :

The future of community care will depend heavily on government's capacities to resource an adequate accommodation base for frail older people who do not have housing or other assets. (Kendig and Bridge 2007, p. 232)

In this respect, the AIHW has been developing an event-based data linkage method to link national hospital morbidity data and residential aged care data, in order to help understand the movement of people between these sectors (Karmel et al. 2008).

The Commission also notes that a team of researchers lead by Len Gray has developed a computer simulation model of the interface between aged care and acute health care. The model is intended to assess a variety of different policy scenarios. Gray et. al. (2006, p. 456) has noted that:

Dynamic systems simulation provides a method of conducting policy experiments at low risk and cost with instant results. While the outcomes will not necessarily be precise, the development process and interactions with stakeholders, with the opportunity for users to conduct their own experiments, are likely to raise the quality of the debate around futures for the acute-aged care system.

Notwithstanding these developments, further research and analysis is necessary to identify those service interfaces where reforms could potentially yield significant benefits to the community as a whole. Depending on the circumstances, there is, in the Commission's view, potentially a wide range of barriers that might need to be addressed (box 4.3).

The mechanisms for diffusing examples of best practice and innovation in service design and delivery also need improvement to help inform policy development in other parts of the system.

Given the involvement of multiple government departments and agencies across multiple levels of government, making progress to improve any of the service interfaces affecting the quality of life of older people will require a whole-of-government response.

Box 4.3 **Potential barriers to improving service interfaces**

- Existing programs not being adequately funded.
- An excessively fragmented policy and program environment.
- Poor program specification and design, including overly rigid program boundaries.
- Poor program evaluation leading to the perpetuation of existing problems.
- Unnecessary variations across programs in terms of eligibility criteria and financing arrangements.
- Regulatory and financing arrangements that fail to provide sufficient incentives to encourage innovation in service design and delivery.
- A lack of clarity about roles and responsibilities leading to service gaps and/or unnecessary duplication of effort and waste. In areas such as aged care, this is complicated by the confluence of interfaces with the involvement of multiple levels of government.
- Inadequate mechanisms for holistically assessing the needs of older people and keeping track of how these change over time. Particularly important here are likely to be barriers to appropriately sharing information across professional boundaries.
- Rigidities in professional scopes of practice and models of care (chapter 6).
- Professionals working at an interface having a poor understanding or inadequate information about the full range of services available to older people at these points.

Securing more sustainable outcomes

As outlined in section 4.1, there is a strong case for taking a broad view of sustainability in the context of aged care. Two issues that are inextricably linked to the sustainability of aged care services, namely the workforce and the need to improve productivity, are discussed in chapters 6 and 7 respectively. The remainder of this section focuses on two broad issues that are not elsewhere covered in this study, namely the potential to:

- encourage greater self-provision for meeting the costs associated with aged care
- improve the financial viability of aged care providers.

Encouraging greater self-provision in meeting the costs associated with aged care

Currently, aged care subsidies are funded by the Australian Government on a ‘pay as you go’ basis (that is, from consolidated revenue), supplemented by user co-payments (chapter 2). As a consequence, working age taxpayers bear a large part of the cost of providing aged care services. In the context of an ageing population,

this represents a significant and growing burden for future taxpayers. While few people would advocate totally moving away from the existing arrangements, there is an argument for some degree of re-balancing of public and private financial support for aged care services to ensure their long-term fiscal sustainability.

The trend towards seeking a higher level of co-payments from clients is already evident, with Ergas (2008, pp. 4–5) noting that:

A trend for the effective copayment rate in the Australian aged care system to increase has already been evident for some time. Thus, new entrants to low level residential care paid approximately 40 per cent of their residential care costs in 1995-96 and that proportion had risen to 57 per cent in 2005-06. Equally, while new entrants to high level residential care paid approximately 21 per cent of their residential care costs in 1995-96 (the remainder being covered by payments from the Commonwealth), that proportion had risen to 29 per cent in 2005-06. The growth in the role of ‘extra service’ places makes the increase in copayments all the greater.

Those trends notwithstanding, it is likely that the Australian arrangements are still at the relatively redistributive end of the international spectrum, and that longer-term pressures for a rising element of ‘user pays’ will persist, regardless of which Government is in office.

This raises the question of what additional policy measures may be desirable to encourage those members of the community who can afford to make financial provision for the possibility of requiring aged care services to do so. The government would continue to fund a minimum acceptable level of aged care services for a targeted group of those not well placed to make such contributions.

As Kendig and Duckett (2001, p. 63) have observed:

While there is little reason to fear a financial doomsday ahead, it is clear that both older and younger people could be advantaged by having better financial mechanisms to enable older people to pay in advance for their aged care should they require it.

As canvassed by the Commission in 2003, there are three broad mechanisms for allowing people to effectively ‘pre-pay’ some of the costs associated with their care later in life:

- voluntary savings schemes
- voluntary private aged care insurance
- compulsory private aged care insurance (PC 2003).

Voluntary savings schemes

Voluntary savings schemes include dedicated ‘aged care’ savings accounts and the ability for people to draw on their housing assets, through equity release or reverse mortgage schemes.

Generally, voluntary savings schemes are unlikely to be a very effective or efficient way of helping fund the future cost of providing aged care services. In part, this reflects the considerable unevenness in the incidence of needing high cost aged care services across the elderly population. As Allen Consulting (2002, p. 16) has observed, this tends to reduce people’s willingness to voluntarily save to meet these costs:

The risk of needing expensive, high-intensity aged care is not high relative to the probability of using other government services (such as health care). For some people, though, the costs can be high. People generally do not expect to need such care and so are not inclined to save for that eventuality [Author’s italics].

Given these characteristics, there is a risk of people either not saving enough or over saving. From a community wide perspective, such outcomes would not represent an efficient use of available resources.

A second option would be to enable people to draw on their housing assets, through equity release and reverse mortgage schemes. These schemes provide a mechanism for older people to take a non-recourse loan, which is repaid with interest when their home is surrendered (for example, at the death of the final equity holder). In the case of residential care, this loan can be used to pay a lump sum accommodation bond or be periodically drawn down if the periodic payment option for paying an accommodation bond is preferred. The income stream that reverse mortgages can provide is limited by the need to avoid negative equity.

The evidence suggests that there is a growing market for reverse mortgage products in Australia. Indeed, the size of Australia’s reverse mortgage market more than doubled in the two years to December 2007 (SEQUAL and Deloitte Touche Tohmatsu Australia 2008). This was not withstanding some slowing in the sales of these products in the second half of 2007 reflecting tighter credit market conditions, rising interest rates and growing economic uncertainty. However, the extent to which these products are currently being used to fund aged care, or to fund consumption, or to effect inter-generational wealth transfers within families is not clear. That said, for some people, these products are likely to be an attractive option for meeting the private costs of higher quality aged care. One significant consideration is to ensure that the needs of the surviving member of a married or other joint-owning couple are adequately protected.

As highlighted in chapter 3, the wealth of many older people is predominantly in the form of home ownership. Recent research suggests that while around a third of retirees expect to rely on their home as a source of retirement funding, most thought they would be forced to downsize to release equity and did not have a good understanding of other financial options (SEQUAL 2008). This suggests there may be scope to improve the information available to older people about these products. More generally, ASIC's (2007) work on reverse mortgages suggests that several factors can inhibit good consumer decision making including difficulties estimating how much equity might be available at any future point in time, a reluctance by consumers to consider the risk of declining health in future years and the impact this may have on their financial needs.

Voluntary private aged care insurance

Voluntary private aged care insurance would allow people to insure against the risk of requiring high cost aged care services in the future. This would be somewhat akin to the insurance that many people already take out to cover unpredictable and catastrophic events such as damage to or destruction of their homes, early death or injury, and loss of income.

There are likely to be many practical difficulties in the development of private insurance markets for aged care. Ergas (2008, p. 5) argues that:

International experience suggests it is not easy for voluntary insurance markets to efficiently underwrite this added risk [the longevity risk associated with requiring aged care], for reasons that include adverse selection, the very long-tail nature of the risk and the associated policies (which need to be entered into long before the risk eventuates), and the likelihood that the underlying risks are correlated. Moreover, individual incentives to insure may be low if entry into aged care signals a reduction in life-time income needs (so that those individuals who do not enter into aged care could rationally choose to run down their assets). This would further narrow the insurance pool, and limit its ability to achieve economies of scale. Additionally, and importantly, for so long as Commonwealth support is reasonably widely accessible, the take-up of voluntary insurance is likely to be low.

In its submission to the Hogan Review, the Commission outlined the demand and supply-side characteristics of the market for voluntary private aged care insurance, which are likely to limit its extent and coverage. The Commission also noted that there appears to have been a relatively low uptake of this form of insurance in those countries where such policies are available. Nevertheless, the Commission argued that people should have the option of using voluntary aged care insurance as an alternative to precautionary savings and other forms of private insurance, as a tool for covering the possibility of incurring private residential care costs. Accordingly,

it argued that private health insurance funds should no longer be precluded by regulation from offering such cover (PC 2003).

Compulsory aged care insurance

A final broad option for encouraging greater self-provision for the costs of aged care is some form of compulsory aged care insurance. In the context of the Australian aged care debate, this has usually been advanced as a social insurance or public long term insurance scheme.

Anna Howe (2003b, p. 8), who advocates the introduction of a social insurance scheme, has observed:

Current aged care funding relies on only two ‘pillars’ — taxation revenue and user charges. Adding a pillar of social insurance would add a third pillar and so strengthen the whole of the funding arrangements. In particular, by providing a source of forward funded capital, social insurance would serve as a buffer against downturns in the wider business cycle for aged care investment, and in turn, marginally moderate the business cycle.

A social insurance approach to aged care funding in Australia is highly consistent with and would complement both the Medicare Levy and the Superannuation Guarantee that are already in place. Both have proved ‘painless and popular’ taxes with the community, and a social insurance scheme for aged care could be expected to gain similar acceptance.

The Commission considered the case for some form of compulsory aged care insurance scheme in its submission to the Hogan Review. It noted that although there were potentially some advantages of such an approach, there were also a number of significant design issues (PC 2003). It argued that it was unclear whether this type of insurance would represent a substantial improvement over existing arrangements, and suggested that further work may be warranted to more fully assess the advantages and disadvantages of a compulsory aged care insurance scheme.

Summing up the self provision options

Options for encouraging greater self-provision in meeting the costs associated with aged care are best considered as part of a broader reform agenda rather than in isolation. Aged care services are heavily subsidised in Australia and various regulations constrain the extent of client choice. Arguably, this considerably weakens the incentives for people to voluntarily make financial provision for the possibility of needing these services. Changing this perception would require signalling to younger generations the extent to which they are likely to have to meet

more of the costs associated with consuming aged care, and the benefits that would arise from being able to access higher quality services. In this context, some of the reforms discussed earlier in this chapter are likely to be important, such as:

- tackling inequities arising from existing program design
- easing quantity and price restrictions
- improved signalling of the underlying cost and quality of alternative types of aged care.

Such changes are only likely to be acceptable to the community if there are appropriate safety net provisions to protect those who cannot provide for themselves, and clients of aged care services having more choice in the services they consume (recognising a preparedness of a number of them to pay for higher quality services) (chapter 5).

Any appreciable re-balancing of public and private financial support for aged care will raise inevitable transitional issues. As in relation to superannuation, current taxpayers face both a tax burden (reflecting current ‘pay as you go’ arrangements for meeting the costs of those already receiving a pension) and a requirement to pre-pay for their own future retirement.

Finally, it is important to recognise that given the demographic and other trends outlined in chapter 3, any new policy measures in this area are unlikely to result in a dramatic shift in the balance between public and private financial support for aged care services in the short to medium-term. Future taxpayers will almost certainly be faced with having to fund a significant proportion of the growing cost of providing aged care to the baby boomer generation. Indeed, recognising the importance of the timing of any future policy measures, Howe (2003b, pp. 9–10) has argued that:

If the baby boomers are to contribute to their own future aged care, they need to be provided with a vehicle for doing so in the near future. A fund established by 2005 would have matured and be generating substantial funds precisely at the time when demands on public funds for health care for the ageing population will be growing most rapidly.

Improving the financial viability of aged care providers

As noted in section 4.1, provider sustainability is an important issue. There are aspects of current regulatory and financing arrangements that potentially impinge on the financial viability of providers and, hence, may jeopardise the future provision of these services. They include:

- indexation of government subsidies paid to aged care providers

-
- retention value of accommodation bonds
 - phasing-in of the Aged Care Funding Instrument (ACFI).

Indexation of basic subsidies

A longstanding concern of the aged care industry has been that the indexation of basic subsidy rates is not based on movements in industry-specific costs. Rather, subsidies are indexed using the Commonwealth Own Purpose Outlays (COPO) index, which is weighted 75 per cent for wage costs and 25 per cent for non-wage costs. The COPO is premised on the view that virtually all wage increases are productivity based. Hence, it only makes provision for safety net increases in wages and for economy-wide movements in non-wage costs. Thus, if productivity gains within the aged care sector do not keep pace with other sectors, the subsidy, as indexed, will be increasingly inadequate.

In addition, eligible residential aged care providers receive the Conditional Adjustment Payment (CAP). This was introduced following a recommendation of the Hogan Review (2004) and is intended to provide an incentive to residential aged care providers to improve their efficiency and productivity. In line with the recommendation of the review, the Commonwealth initially only committed to paying the CAP for four years (2004–2008). However, the Australian Government announced in the 2008-09 Budget that it would be increasing the level of the CAP, in order to provide additional funding for investment in the aged care sector. It also announced a review of the ongoing need for and level of the CAP (Elliot 2008a).

In this context, it is worth noting that the Hogan Review saw the CAP as an interim measure, while a broader re-structuring and re-ordering of policy arrangements occurred (Hogan 2007, p. 8). Arguably, this restructuring has not occurred to the extent envisaged by the review.

ACSA (2008, p. 13) is one who has raised a number of concerns:

Even with the CAP, costs are outstripping funding. Costs have been rising in all areas including wages (which represent approximately 75% of a provider's expenditure); insurance premiums; compliance costs with workers' compensation regulations and Government administrative requirements; costs of refurbishing or replacing older buildings and/or constructing new ones; fees and other costs associated with accreditation for residential care; and accountability costs for community care.

... It is clear that either the COPO indexation method must be changed or that the CAP must be maintained for residential care providers and extended to cover community care services. If this does not occur service providers will inevitably become unviable. Given the increasing demand and need for aged and community services this must not be allowed to happen.

Reflecting these concerns there have been calls for the current indexation arrangements to be reviewed, with the continuation of CAP until new arrangements can be put in place (see, for example, Hogan 2007). However, the Commission notes that the recently announced review of the CAP does not encompass the broader issue of the effectiveness of current indexation arrangements.

The Commission considered COPO indexation procedures as part of its inquiry into nursing home subsidies (PC 1999). At the time, it noted that with other sources of income for providers largely tied, inadequate increases in subsidies after allowing for efficiency improvements would, in one way or another, compromise the delivery of quality care (PC 1999). The Commission did not endeavour to come to a final view on the most appropriate indexation methodology, as it was not in a position to assess all the benefits and costs of the various alternatives within the limits of that inquiry. Nevertheless, it recommended:

Basic subsidy rates should be adjusted annually according to indices which clearly reflect the changes in the average cost of the standardised input mix, less a discount to reflect changes in productivity. Revised indexation arrangements should be introduced as soon as possible. (PC 1999, p. 97)

This approach recognises the importance of both ensuring subsidies accurately reflect the cost pressures faced by the aged care industry and providing an incentive for providers to look for ways of improving their efficiency and productivity.

Other issues potentially impinging on the financial viability of aged care providers

Stakeholders have identified a number of other issues relating to current regulatory and financial arrangements that potentially impinge on the financial viability of aged care providers.

Although the value of accommodation bonds has risen sharply over the last decade the amount that aged care providers can retain in order to fund capital servicing has remained largely unchanged. Hogan (2007, pp. 9–10) argues that this should be re-visited in order to provide an increment to the funding of productive capacity:

Retention sums have remained much as they were a decade or so ago. Any reasoned reflection would suggest that the present retention limit, now around \$3,000 per year and arrived at long ago, is trivial in relation to present values, whether measured in asset or cost terms.

The time is opportune for this aspect of funding to be revisited, so as to offer an increment to the funding of productive capacity. Rather than rest on some fixed sum as at present, the maximum retention might be set as a specified percentage of the value of the accommodation bond, say 5%.

Some in the aged care industry are concerned about the phasing in of financial arrangements for the new ACFI. In part, the ACFI is intended to recognise the higher costs associated with meeting the increasingly complex care needs of older people entering residential care. However, it was decided to phase-in the new arrangements over four years. The ACAA (2007b, p. 3) argues that:

... the former Government decided to defer to fully implement the scheme and it will now take four years for the top end subsidy to be gradually introduced in \$10.00 tranches over the four year period.

The high care subsidy rates struck by the Government's contracted consultant was an attempt to make a realistic assessment within the bounds of the existing budget of the real cost of providing care to high care residents. Deferral of this payment ignores the service the industry already delivers and is a major factor in the declining financial performance of the industry.

As discussed in chapter 7, there are a number of other aspects of the ACFI that have caused concern in the aged care industry. The Australian Government has scheduled a review of the instrument for 18 months after its implementation (Elliot 2008b).

It is beyond the scope of this study of trends in aged care to assess these or other policy issues relating to current regulatory and financial arrangements that stakeholders have identified as potentially impinging on the financial viability of aged care providers, but clearly there may still be some important areas of 'unfinished business'.

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		<ul style="list-style-type: none"> • Cash Allowance for Care
Germany		<ul style="list-style-type: none"> • Cash Allowance for Care
Luxembourg		<ul style="list-style-type: none"> • Cash Allowance for Care
Netherlands	<ul style="list-style-type: none"> • Personal Budget for Care and Nursing 	
Norway	<ul style="list-style-type: none"> • Care Wage 	
Sweden	<ul style="list-style-type: none"> • Carer's Salary 	<ul style="list-style-type: none"> • Attendance Allowance
United Kingdom	<ul style="list-style-type: none"> • Direct Payments 	<ul style="list-style-type: none"> • Attendance Allowance
United States	<ul style="list-style-type: none"> • 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

-
- 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.

6 Workforce: emerging issues

Key points

- The aged care workforce is part of the broader health and community care workforce and comprises three key segments: formal workers, informal carers, and volunteers.
- Like health and community services, the demand for aged care services is expected to increase substantially over the next 40 years. Retaining and attracting staff poses several challenges for service providers and the broader community including: ensuring competitive rates of pay; improving the work environment in areas such as workloads, workforce culture and scope of practice; as well as improving opportunities for training and career advancement.
- Informal carers are instrumental in providing community aged care but their relative availability is expected to decline in the future.
 - This relative decline could be moderated somewhat by ensuring that informal carers are appropriately supported in their caring role.
- Volunteers also play an important role in the provision of aged care.
 - Although the potential pool of volunteers is expected to increase, the challenges for aged care providers will be to compete for and utilise them effectively.

This chapter provides a profile of the aged care workforce, including key trends over the last decade or so. The chapter then examines a number of challenges facing the aged care sector if it is to successfully adapt its workforce to the significant increase in demand for aged care services over the next 40 years. The examination extends the analysis of workforce issues related to aged care undertaken by the Commission as part of its study into *Australia's Health Workforce* (PC 2005a) for each of the three segments making up the aged care workforce, namely: the formal paid workforce; informal carers; and volunteers.

6.1 The aged care workforce — a snapshot

Workforce overview

The aged care workforce is part of the broader health and community services sectors that provide care and support services to the aged, either directly or indirectly.

As with health and community services, aged care providers will be seeking, in future years, to replace a growing number of retiring workers and retain existing staff to meet an accelerating demand for services. This will occur at a time when growth in the effective labour supply is expected to be lower than population growth. Given that most aged care services are labour intensive, as with health care, sizeable wage pressures are likely. However, as shown in this section, these pressures are likely to be more pronounced in aged care for a variety of reasons.

In 2001, the health and community services sectors employed 800 000 people, of which around a quarter were estimated to be employed in the aged care sector, mainly in residential and community care (AIHW 2003b; Richardson and Martin 2004; PC estimates¹).

Unfortunately, workforce data covering the two main areas of aged care — residential and community care — and the three main categories of workers — formal paid workers, informal carers and volunteers — are limited. Moreover, there are several problems with existing data sets including incompleteness, incomparability over time and a high level of aggregation (box 6.1).

¹ The number of residential care workers was estimated to be around 149 000 in 2001. Community care is provided to disabled persons of all ages. Around 75 per cent of home and community care services, which comprises the bulk of community care, are provided to persons aged 65 years or older (DoHA 2006e). Accordingly, the Commission estimated the community care workforce for the aged to be around 39 000 in 2001. This estimate does not include nurses and personal care assistants who provide nursing services to older persons as data on employment setting is not collected.

Box 6.1 **Aged care workforce — data limitations**

The main agencies involved in workforce data collection are the Australian Bureau of Statistics (ABS), the Australian Institute of Health and Welfare (AIHW) and the National Institute of Labour Studies (NILS). Aged care workforce data are predominantly collected from periodic surveys. The *Census of Population and Housing* also provides information on the aged care workforce but is confined to primary labour, that is, it records only a person's 'main' job.

The usefulness of the data is limited for a variety of reasons. First, the survey methodology used by the ABS to collect data has not been designed to clearly distinguish the aged care workforce from the wider health and community services workforce. For example, community based care workers providing services to the aged are incorporated into a broad industry classification 'non-residential care services not elsewhere classified' (ABS 1993). Further, data relating to informal carers and volunteers do not distinguish between services provided to those who are aged and/or disabled (ABS 2004b, 2007h).

Second, surveys have not been conducted regularly or consistently over time. In addition, changes to survey methodologies make it difficult to identify changes in the number, composition and characteristics of workers. For example, changes in data definitions and survey coverage between periodic volunteer surveys make it difficult to compare data over time.

Finally, changes in aged care policy have not been reflected in the surveys and/or category definitions. For example, the amalgamation of 'nursing homes' and 'accommodation for the aged' to 'residential aged care' almost a decade ago has only recently been reflected in the updated standard industry classifications (ABS 2006a). In addition, there is no specific information relating to the community based aged care workforce, despite the growing emphasis placed upon 'ageing-in-place' (DoHA 2006c).

The most reliable and comprehensive survey of the formal paid workforce in residential settings was commissioned by the Department of Health and Ageing and undertaken by NILS in 2003. The Department, has commissioned a second survey that has been expanded to include the community care workforce. Results from this survey are expected to be available later in 2008.

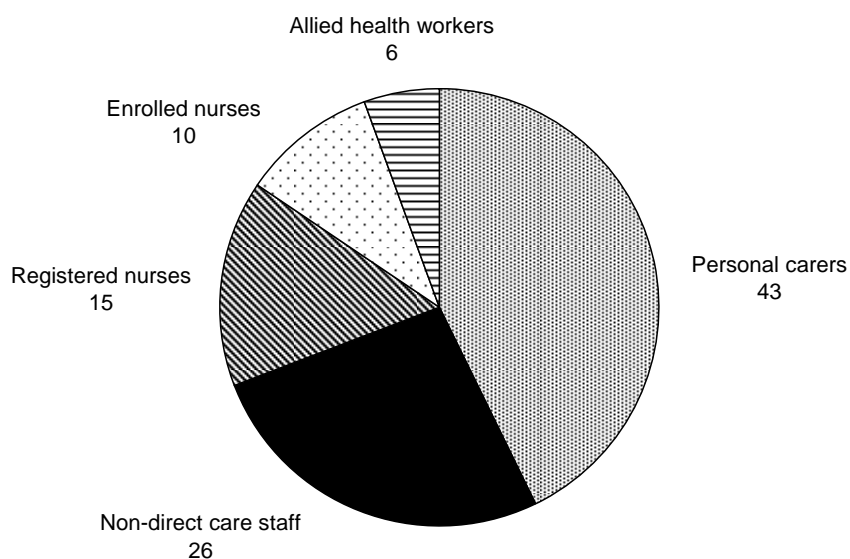
Sources: ABS (1993, 2004b, 2006a, 2007h); Healy and Richardson (2003); DoHA (2006c).

Residential aged care workforce

Residential aged care facilities employed at least 156 000 people or 1.5 per cent of the Australian workforce in mid-2003 (Richardson and Martin 2004). As illustrated in figure 6.1, over 40 per cent of the paid workforce is made up of personal carers, although it also features several other key groups including registered nurses, enrolled nurses, some allied health workers (such as diversional therapists and recreation officers) and non-direct care staff (such as cooks, cleaners and

administrators). Doctors and other allied health professionals (such as occupational therapists, dentists, physiotherapists, podiatrists and pharmacists) also contribute to the care of residents but are not considered to be part of the dedicated aged care workforce.

Figure 6.1 Composition of the residential aged care paid workforce
Per cent in 2003



Data source: Richardson and Martin (2004).

A 2003 profile of the aged care workforce shows significant differences with most other sectors, including health and community services. Residential aged care employees are more likely to be female, work shorter hours and be older than workers in the combined health and community services sectors and employees in general (table 6.1).

Table 6.1 Workforce characteristics: profiles for selected sectors

	<i>Residential aged care</i>	<i>Health and community services</i>	<i>All industries</i>
	%	%	%
Female	94	78	45
Part time	65	43	29
45 years or older	57	46	37

Sources: Richardson and Martin (2004); DEWR (2007).

In general, more clients were supported by fewer employees in metropolitan and regional areas compared with rural and remote areas in 2003. Just over half of residential care employees are located in metropolitan areas which account for 66 per cent of the sector's clients. In regional centres, there is an equivalent proportion of staff to clients, around 23 per cent. However, in rural and remote locations, 25 per cent of the residential workforce cares for only 11 per cent of the sector's clients (AIHW 2004d; Richardson and Martin 2004). The relatively smaller size of residential care facilities in rural and remote locations and the reduced opportunities to outsource some services (such as meal preparation and laundry) may, in part, explain the larger ratio of workers to clients in these areas (Richardson and Martin 2004).

The paid residential care workforce has changed in both size and skill mix over the past decade as a result of growth in the demand for aged care services and policy changes. In terms of size, the data suggest that the workforce declined between 1996 and 2000 despite servicing more clients, as indicated by the reduction in employees per operational place from 1.07 to 1.02 (table 6.2). However, the workforce expanded between 2000 and 2003 at a rate somewhat in excess of the growth in the number of operational places.

Table 6.2 Residential care employees and operational places, 1996 to 2003

	30 June 1996 ^a	30 June 2000 ^a	Mid-2003
Total employees	146 852	145 005	156 823
Operational places	136 851	142 342	151 181
Employees per operational place	1.07	1.02	1.04

^a Employees reported in the 1996 and 2000 Community Services Survey do not cover publically operated residential aged care facilities. Total employees are estimated by adjusting this data to incorporate publically operated places assuming that staffing ratios are equivalent across all types of operators.

Data sources: ABS (2001); AIHW (1997, 1998, 2007f); DHAC (2000a); Richardson and Martin (2004); PC estimates.

There has also been a shift in the skill mix of workers. Despite an overall increase in both the workforce and operational places, the number of registered and enrolled nurses working in aged care facilities decreased from 38 633 to 34 031 between 1995 and 2005 (AIHW 2008c). Factors contributing to this decrease include nurses preferring to work in other sectors and providers substituting personal carers for nurses. The later effect has resulted from changes to regulations prescribing staff numbers and work practices relating to how providers meet standards of care and resident's needs (Hogan Review 2004).

Community care workforce

In contrast to the residential care workforce, there is a dearth of information relating to the formal community aged care workforce.

Paid carers to the aged and disabled with support workers from other occupations provide the bulk of formal community care (AIHW 2003b). Formal carers provide services to the aged in their own homes as well as in other settings including nursing homes, other accommodation for the aged and community health centres. As the standard industry classifications provide only a limited breakdown of workers by industry setting in this area, it is not possible to accurately identify the size of the workforce. However, the rapid growth of HACC, CACP and EACH programs over the past decade has significantly increased the demand for formal aged and disabled workers.

According to the 2001 *Census of Population and Housing*, there were almost 52 000 formal carers providing some HACC and CACP services, such as general household assistance, emotional support, care and companionship to the aged and disabled in their own homes (ABS 2006b; AIHW 2003b). Concurrent with the growth in community care, the number of formal aged and disabled carers increased by 44 per cent between 1996 and 2001. Nurses and personal care assistants also provide nursing services to older persons in their homes but data on employment setting are not collected.

Informal carers and volunteers

The aged care workforce also includes informal carers and volunteers. Again, data relating to the number of these workers, the services they provide, the quantity of hours involved as well as changes over time are quite limited. The latest available data indicate that the number of informal carers of the aged was around 2.3 million in 2006 (PC estimates²). While the services of volunteers are also important in the provision of aged care, the ABS survey of volunteers does not provide data on their specific contributions to the aged (ABS 2007h).

² The ABS General Social Survey estimates that, in 2006, around 3.1 million persons cared for someone with a disability, illness or old age in the last 4 weeks (ABS 2007e, data sheet 25). The Commission assumed that the distribution of informal care recipients was similar to formal community care services, where 75 per cent of services are provided to older people.

Current and prospective challenges

As outlined in chapter 3, demographic changes, various social trends and the preference of most older people to ‘age-in-place’ will present significant challenges to the aged care sector and its workforce over the next 40 years.

The *National Strategy for an Ageing Australia* (Andrews 2002a, p. 55) noted that in providing world class care over the coming decades:

Governments, service providers and professional organisations have the challenge of improving the attractiveness of the aged care sector for care professionals as well as addressing training, career progression and other issues.

From a workforce perspective, the aged care sector faces four key challenges in this context:

- Building an effective workforce with the necessary flexibility to provide appropriate care for older Australians in an environment where labour intensive activities will face growing pressures for workers given the anticipated slow down in workforce growth.
- Responding to the increasing demand for formal care services as Australia’s population ages and accommodating an expected decline in the availability of informal family carers and growing competition for voluntary workers.
- Upgrading the skills base and training opportunities available to workers to accommodate improved delivery of aged care services to older Australians.
- Adapting the aged care sector and its workforce to changes in consumer needs and preferences which seem likely to increase the demand for community based care relative to institutional forms of care.

Reflecting these challenges, a number of recent government aged care workforce initiatives have been shaped by recommendations from reviews including the *National Review of Nursing Education* (DEST 2002) and the Hogan Review (2004). These initiatives have focussed on improving the attractiveness of aged care wages relative to competing activities, providing extra support for education and training, and expanding assistance for informal carers. Beyond this, the National Health and Hospitals Reform Commission is due to report by June 2009 on a long term health reform plan to, among other things, provide a well qualified and sustainable health workforce in the future (COAG 2007).

Specific challenges pertaining to each of the three main categories of aged care workers are examined in the following sections.

6.2 Formal paid workforce

The Commission's *Australia's Health Workforce* (PC 2005a) study examined many parts of the broader health workforce involved in providing care services to the aged, either directly or indirectly. For example, general practitioners and allied health care professionals, including physiotherapists, podiatrists, dentists and pharmacists, all contribute to the provision of health care to the aged although they are not considered part of the formal aged care workforce. Residential care service providers have expressed concerns about difficulties in accessing regular and reliable services from general practitioners as well as allied health services for their clients (HRSCHA 2005).

Although these services are important in supporting a healthy aged population, the focus in this section is on the formal paid workforce of nurses and personal carers that deliver community based and residential care services to the aged. Due to the limited data available on the community care workforce, most of the analysis relates to the residential workforce.

A number of key studies and parliamentary inquiries have highlighted longstanding concerns about the size and make-up of the formal paid aged care workforce as well as the capacity of providers to retain staff (box 6.2). Representative of these is the Hogan Review (2004) which identified several key issues pertaining to the residential aged care workforce including:

- a general shortage of trained nursing staff, which is greater in the residential aged care sector than in other areas of the health system
- specific barriers to recruitment, retention and re-entry to the workforce
- the ageing of the nursing workforce
- differences between the states' and territories' regulatory frameworks governing training, medication management and employment conditions
- the changing profile of consumers which is expected to affect the nature and extent of demand for future services and the required skill mix of the workforce.

These issues are broadly similar to those identified by the Commission in its *Australia's Health Workforce* study (PC 2005a).

Accordingly, the remainder of this section examines those issues most likely to influence worker's decisions to enter, re-enter or remain in the aged care sector, namely: remuneration; working environment; and education and training.

Box 6.2 Aged care workforce issues highlighted by parliamentary inquiries and workforce surveys

The main issues identified by various stakeholders in submissions to parliamentary inquiries and workforce surveys encompass the absence of wage parity, unfavourable working conditions including excessive documentation and workloads, lack of education and training opportunities and the perception of a poor public image of working with the aged. Issues have also arisen concerning the availability of suitable workers in rural and remote communities as well as the handling of the needs of culturally and linguistically diverse clients.

In 2002, a Senate inquiry into nursing found that:

... the shortage of qualified staff (in aged care) has now reached a crisis point ... There needs to be a concerted and sustained effort to act and ensure that ... aged care nurses receive working conditions, remuneration and recognition commensurate with their training and professionalism. (SCAC 2002, p. 158)

These ideas were reiterated in a subsequent Senate inquiry covering aged care where the growing importance of community care workers was recognised. The reasons given for high turnover rates in this area included:

... low pay, lack of career path, having to work in relative isolation, occupational health and safety challenges associated with working in the client's own home and the age profile of the community care workforce. (SCARC 2005, p. 10)

A House of Representatives inquiry examining long term strategies for ageing noted that aged care workforce issues were among those most frequently raised in submissions. In addition to the issues raised above, the inquiry observed that:

Occupational health and safety issues, in particular those associated with managing challenging behaviours, the amount of lifting associated with frailty, and longer working hours to cover absences all contribute to shortages. (HRSCHA 2005, p. 182)

The University of Southern Queensland in conjunction with the Queensland Nurses' Union, undertook comparative surveys of the attitudes of registered nurses, enrolled nurses and personal carers in acute and aged care workplaces during 2001 and 2004. The 2004 study concluded that:

Reflecting the nature of work in aged care, these nurses were more likely to report that nursing work is emotionally challenging and physically demanding and that the workload is heavy ... They also believe that 'very seldom' are there sufficient staff employed to meet patient/resident needs ... half of the aged care sector nurses perceived morale to be low and over half considered morale to be deteriorating. Reflecting their low morale, they have the highest levels of reported workplace stress, believe their colleagues are unsupportive and are most dissatisfied with remuneration. (Hegney et al. 2005, pp. 219–221)

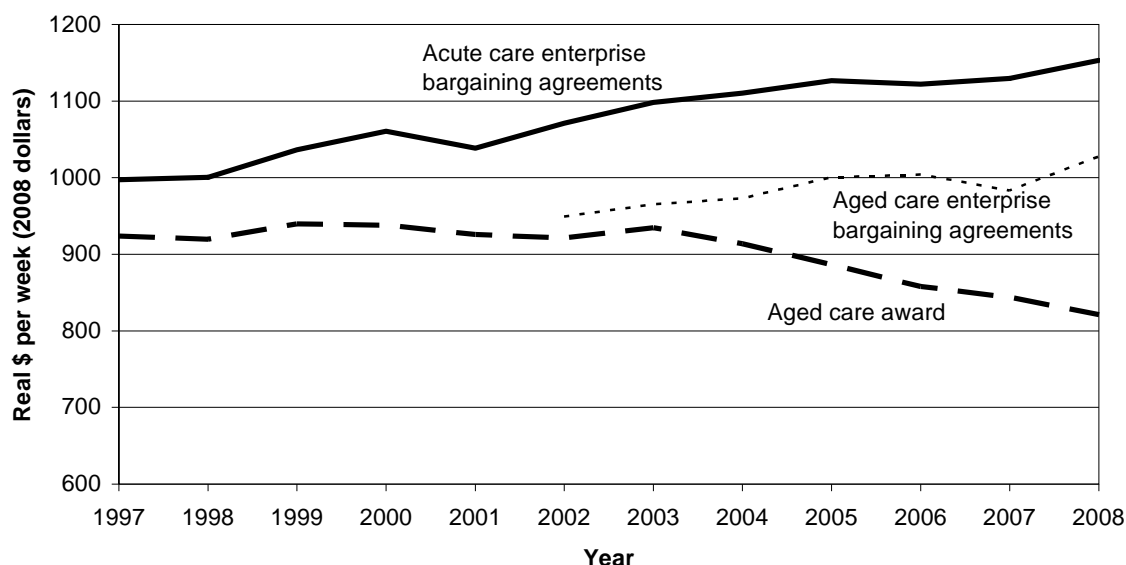
Recently, the NSW Nurses' Association undertook a survey of registered and enrolled nurses in aged care to investigate the use of unlicensed workers in medication management as well as broader workplace issues. Issues that participants would most like to see pursued by their association are excessive and unreasonable workloads, wage parity, protection of working conditions, inadequate staffing levels, training and education of unlicensed workers, excessive documentation and increased funding (Fethney et al. 2007).

Remuneration

The reason most commonly cited by employers experiencing difficulties in attracting and retaining staff in the aged care sector is the substantially lower remuneration of its employees compared with similar employment settings (see, for example, Richardson and Martin 2004; SCARC 2005; Fethney et al. 2007).

It is not uncommon for nurses employed in aged care to be paid at least 10 per cent less than their peers in the acute care sector for performing similar or equivalent work. For nurses in most settings, there has been a general trend, over the last 10 years, to adopt enterprise bargaining agreements and move away from award wage structures. As evident from figure 6.2, the median real wage gap between aged care nurses on enterprise based agreements and those working in public hospitals has been maintained since 2005. As a result of the comparatively low wages in aged care, registered and enrolled nurses continue to be attracted to other parts of the health and community care sectors.

Figure 6.2 Comparison of registered nurse remuneration^a



^a Median national Registered Nurse (Level 1, year 8) wage in January of each year, adjusted using the GDP deflator.

Data sources: ABS (*Australian National Accounts: National Income, Expenditure and Product, March 2008*, Cat. no. 5206.0); ANF (Melbourne, pers. comm. 21 May 2007 and 16 June 2008).

Dissatisfaction with remuneration among the aged care workforce is not just confined to nurses. Relative to their skills and responsibilities, comparatively low wages are also paid to personal carers who comprise the bulk of the formal paid aged care workforce (figure 6.1). In a submission to the *Inquiry into Quality and Equity in Aged Care* (SCARC 2005), the Health Services Union NSW (2004, p. 70) representing residential aged carers commented that:

Members find it grossly unfair that they receive \$13.53 an hour for the complex, emotionally and physically demanding work they perform, many of them with TAFE certificate qualifications in aged care, when their children if they worked as a checkout operator for Bi-Lo or Coles could earn \$14.13 an hour, or at Hungry Jacks for \$14.86 an hour. Further, members get very frustrated that they receive substantially lower pay than workers doing similar or equivalent work in a public hospital setting.

As outlined in section 4.3, funding arrangements for aged care constrain the capacity of service providers to offer competitive wages to their staff. Currently, adjustments to recurrent aged care funding are determined according to movements in the Commonwealth Own Purpose Outlays (COPO) index which reflects changes in both the Safety Net Adjustment, that is, the minimum wage as determined by the Australian Fair Pay Commission, and the Consumer Price Index (CPI), using weights of 3:1 respectively. The basic annual indexation outcome has averaged just over 2 per cent for the past decade. But according to ACSA (2008a, p. 13), the funding formulae 'do not reflect the real costs nor bear any direct relationship to the costs of providing care' which is conservatively estimated to be rising by 7 per cent per annum.

That said, there have been several government initiatives directed at enhancing the capacity of the residential aged care sector to offer competitive wages relative to the acute care sector. These began with the allocation of \$211 million over four years in the 2002-03 Budget (Andrews 2002b). In addition, the Conditional Adjustment Payment (CAP)³ provided a further \$877.8 million over four years from 2004-05. This represented an annual increase of 1.75 per cent above the basic care subsidy and formed part of the *Investing in Australia's Aged Care: More Places, Better Care* package (Bishop 2004). This package was pitched at encouraging residential care providers to 'pay competitive wages' and improve the flexibility of staff training arrangements. As part of the 2008-09 Budget, the CAP was increased by a further 1.75 per cent to 8.75 per cent of the basic aged care subsidy and a review announced to evaluate the effectiveness of this measure in encouraging efficiency through improved management practices (Elliot 2008a). The review will also examine the need for and level of any further medium term financial assistance and is due to report by the end of October 2008.

³ The CAP was conditional on providers supplying audited financial statements and a summary of training undertaken for each facility to the Department of Health and Ageing. In addition, facilities were required to participate in periodic workforce censuses.

Despite these initiatives, wage differences between the aged care and acute care sectors have not narrowed (figure 6.2). There are two main reasons for this (SCARC 2005). First, the extra funding is broadly similar to funding increases in the acute care sector. Second, there is no requirement on aged care providers to direct the extra funding towards paying higher wages to their workers.

The cost of achieving wage parity has been estimated at around \$450 million in 2008 (ANF 2008). Additional amounts of around \$100 million in subsequent years would be necessary to maintain wage parity under the current COPO adjustment arrangements.

The capacity of the sector to recruit and retain staff depends, in part, on aged care providers' ability to offer comparable wages and conditions with other sectors (DoHA 2005c). The pressure on providers to improve wages and conditions will increase in line with the growing demand for aged care services and as competition for workers intensifies across the economy as a result of slower workforce growth arising from overall population ageing. These pressures, however, may be moderated somewhat through productivity improvements linked to the wider use of information and assistive technologies and the application of more flexible workplace practices (chapter 7).

Working environment

In addition to relatively low remuneration, a number of aspects of the current working environment in aged care settings negatively impact on the job satisfaction of employees, thus contributing to high rates of turnover. Providers, industry groups and researchers consistently raise three key issues in this area, namely: workloads (including documentation and quality of care); workplace culture; and scope of practice.

Workloads, documentation and quality of care

High workloads relative to comparable nursing environments diminish the job satisfaction levels of aged care staff. Workloads in aged care settings have been elevated by a number of factors.

Increasing numbers of residents with higher and more complex care needs have added to the workloads of care staff in residential care settings. Indeed, the staff ratio has exhibited little change despite the proportion of residents classified as requiring 'high care' increasing from 56 to 69 per cent between 1996 and 2006 (AIHW 1999, 2007f) (see table 6.2). As a result, a 2003 survey reported that over two-thirds of direct care employees in residential facilities felt they were not able to

spend enough time with each resident and were too rushed to do a good job (Richardson and Martin 2004).

The provision of quality care requires adequate staffing levels with an appropriate skill mix. Over a quarter of aged care nurses responding to a Queensland survey stated that they did not believe that there were enough qualified staff to meet client needs (Hegney et al. 2005). Another more recent study of aged care nurses in NSW found that:

... just under three quarters of respondents did not support a model of care whereby registered nurses fulfil the role of care facilitator/planner only with all direct care tasks, including medication administration, delegated to unlicensed workers. (Fethney et al. 2007, p. 2)

The amount of documentation necessary to comply with various regulatory requirements affects how workers allocate their time. For example, some workers feel they have to perform unpaid overtime to complete their work as there is not enough time allocated in their shift. Others claim they reduce the amount of nursing care provided so they can complete the necessary documentation. For many, the documentary requirements are seen as reducing the time available for staff to provide services that enhance the quality of life and care of residents (Richardson and Martin 2004; Hegney et al. 2005; Fethney et al. 2007).

The regulatory burden associated with some aspects of the Resident Classification Scale (RCS) reporting framework was considered excessive by workers, managers and government (Hogan Review 2004; Australian Government 2007). As a result, the new Aged Care Funding Instrument (ACFI), implemented in March 2008, was developed in consultation with the sector to lessen the documentary burden through the introduction of a paperless (electronic) system. In addition, the ACFI does not require ongoing care documentation to support funding claims. Unlike the RCS, it is only necessary to perform an assessment when a client requires a significant change in their underlying care needs, necessitating a movement between funding categories (DoHA 2007a). In the view of Holy Family Services (2007, pp. 3–4), the ACFI places ‘a greater focus on essential documentation related to resident care rather than documentation for the sake of documentation obligations’.

This initiative highlights the benefits of governments focussing on best practice regulatory design and review principles so as to minimise the extent of unnecessary or avoidable regulatory burden. The introduction of new technologies may also result in better care through more effective management of client records.

Workplace culture

A supportive workplace culture that takes account of professional and personal needs and aspirations is essential to securing an adequate nursing workforce. Service providers and managers can nurture a constructive workplace culture, in aged care settings and nursing in general, through:

- engendering a positive work environment in which staff feel valued and are able to make their full contribution
- supporting professional development
- promoting workplace safety and cultural sensitivity
- encouraging a better work/life balance (DEST 2002).

Workplace culture is a multi faceted concept encompassing areas such as morale, safety, development opportunities, job design, conflict resolution, cultural sensitivity, and equity and diversity.

Staff morale has been reported as lower in aged care than in other nursing settings (Hegney et al. 2005). A contributing factor was the amount of abuse that aged care workers received from managers and their colleagues and violence from clients and their families. Given the level of abuse and high workloads, it is not surprising that over 50 per cent of aged care nurse respondents reported extremely high stress levels. These conditions result in a considerable level of workforce turnover, agency employment and workforce shortages in some occupations such as registered nurses.

Managers can contribute to improving workplace culture by encouraging workers to undertake professional development. Support may involve flexibility in rostering hours, time off to study and financial assistance to cover incurred costs. Development may be either formal, such as through a TAFE or university program, or informal, such as attending a relevant seminar.

Occupational health and safety is also a concern among aged care workers reflecting relatively high levels of physical injury arising from excessive workloads and the need to move patients (SCAC 2002; SCARC 2005). For example, in South Australia, the three most common hazards, on average, are:

- Manual handling — one in 15 workers each year
- Slips, trips and falls — one in 50 workers each year
- Aggressive or resistive residents — one in 200 workers each year (WorkCover Corporation 2001).

Respect for cultural sensitivities is an important facet of aged care. For example, services for Indigenous clients are expected to respect gender taboos, ensure adequate community contact (for example, with traditional healers, younger generations and local organisations) and maintain a dedicated core of local Indigenous staff in addition to fulfilling the normal requirements of aged care services (Kimberley Hostels 2003).

Various recent workforce surveys continue to highlight workplace culture as an area of concern (Hegney et al. 2005; Sargent et al. 2006; Fethney et al. 2007). However, service providers and workforce managers who promote a positive workplace culture which supports employees may increase job satisfaction and improve the attractiveness of aged care settings.

Scope of practice

Continuing health workforce shortages, combined with the need to efficiently use existing resources in the face of increasing demands for services, have contributed to calls for the scope of practice of workers in health as well as aged care to be extended to improve the effectiveness and productivity of the overall workforce (WGACWQ 2001; PC 2005a).

Scope of practice refers to ‘the full spectrum of roles, functions, responsibilities, activities and decision-making capacity which individuals within a profession are educated, competent and authorised to perform’ (Fox-Young and Ashley-Coe 2006, p. 2).

Within aged care there are several opportunities to realign workforce roles and create new roles to promote better care outcomes. For example, the effective provision of community care services often requires that workers are flexible and capable of performing a variety of tasks. Similarly, in rural and remote settings, there is a premium on making good use of available skills and being adaptable in the workplace.

Nurse practitioners are registered nurses whose scope of practice can be extended to include prescribing particular medications, referring patients to other health care professionals and ordering particular diagnostic investigations in accordance with clinical guidelines (ACT Health 2006). Nurse practitioners have the potential to significantly improve access to medical services for the whole community.

However, regulatory and funding barriers to the wider use of nurse practitioners constrain their capacity to provide services. Nurse practitioners are not permitted to bulk bill under the Medicare Benefits Scheme and do not have access to Pharmaceutical Benefits Scheme provider numbers which limits access to

subsidised medications. This means that clients receiving services from nurse practitioners in aged care settings generally have to pay more than if the same service was performed by a general practitioner (PC 2005a). Further, there is, as yet, no uniform national accreditation and registration regime for nurse practitioners (DoHA 2007e).

One way to reduce the workloads of registered nurses is to increase the scope of practice of enrolled nurses, specifically in medication management (WGACWQ 2001; DEST 2002). The previous Australian Government supported training for enrolled nurses in aged care settings to undertake courses in medication management in an attempt to ease workforce shortages (Bishop 2004). However, regulations that limit the range of medications that enrolled nurses with appropriate qualifications can administer, in some states, have limited scope for improvements in this area.

Increasing the scope of practice may also be feasible for personal carers who support allied health services. The Commission in its *Australia's Health Workforce* study noted 'that many submissions called for greater development of an "assistant-in" stream of workers to take over some of the less skilled tasks' (PC 2005a, p. 14). For example, some participants argued that developing 'assistants-in-physiotherapy' could allow basic movement and exercise services to be provided without the direct supervision of a physiotherapist. This may be beneficial for the client and cost effective, provided that safety and quality are maintained.

The Australian Medical Association and nursing organisations, among others, have expressed concerns about expanding scopes of practice and the impact this could have on safety standards and public confidence (see, for example, ANF Victoria 2005; NSW Nurses Association 2005; Nurses Board of Western Australia 2005; PC 2005a). The Commission has proposed a health workforce improvement agency which would undertake an objective and transparent assessment of the potential opportunities for, and concerns relating to, expanding the scope of practice (PC 2005a). In response, the National Health Workforce Taskforce was established by COAG to inform development of practical solutions on workforce innovation and reform (COAG 2006).

Facilitating workplace change and innovation in job design through extending the scope of practice is also likely to improve job satisfaction. Allowing workers with appropriate training to provide services in more flexible ways may make the aged care sector more attractive to current and prospective workers and thereby help to alleviate workforce shortages.

Education and training

In a broad sense, the objective of aged care workforce education and training is to underpin the efficient and effective delivery of aged care services. This can be achieved by ensuring that there is an appropriate number of workers who are equipped with the right skills and competencies. In addition, pathways for career progression through upgrading and retraining should be available to ensure that the skills of workers are responsive to the changing demands placed on them.

Education and training outcomes for aged care workers are significantly shaped by the configuration of the broader health and education systems. Settings in these systems clearly impact on the demand for and supply of aged care workers and the resources available to educate and train them.

In addition to formal education, ongoing training for residential aged care workers is available through *The Aged Care Channel* (Martin 2008). Satellite technology is utilised to deliver live, interactional, educational programming to participating aged care facilities. The programs are designed to complement formal training and cover topics important to aged care including infection control, continence management, mental health, teamwork, elder abuse, medication management and occupational health and safety. *The Aged Care Channel* was launched in 2003 and since then its membership has grown to over one third of all aged care facilities.

In rural and remote areas, the costs of education and training are higher due to a lack of local infrastructure and the need to replace workers for longer when they travel for training. Satellite transmission services through *The Aged Care Channel* and the development of nursing degrees through distance education for enrolled nurses may help to alleviate these challenges.

This section is divided into two parts to reflect the demand for different types of workers and how they are trained. Registered nurses are highly skilled, extensively trained and in demand from all sections of the health care sector, both in domestic and international settings. By comparison, enrolled nurses and personal carers have shorter training programs and are not considered to have the same current and prospective shortages.

Registered Nurses

Registered nurses (RNs) receive three years of undergraduate training in a university setting and undertake clinical placements before registration. RNs are a crucial component of the aged care workforce. They manage teams of care staff and provide specialist skills, including complex medication and care tasks.

The *National Review of Nursing Education* highlighted a shortage of RNs in all settings of around 10 000 (more than 5 per cent of RNs at the time) (DEST 2002). This shortage is expected to continue as more ‘baby boomer’ nurses retire and the demand for health care services, including nursing, increases due to an ageing population (CDNM 2006).

Since the Review, Australian Governments have recognised the need to fund an expanded number of undergraduate places. Provision has been made to increase the number of places by 10 141 or 43 per cent between 2003 and 2011. However, aged care specific places, as allocated to those universities with aged care specific specialisations, only make up around 11 per cent of the total increase and there is no requirement for graduates to enter the aged care sector. Further, just increasing the number of funded places alone will not be sufficient to attract RNs to aged care in the absence of supporting initiatives to improve remuneration and working conditions.

Australian Governments have also developed specific scholarship programs to encourage RNs into aged care settings. In response to the *National Review of Nursing Education*, funding was provided for up to 2000 aged care scholarships over eight years from 2003 (Andrews 2002c; Santoro 2006b). To ensure that recipients are dedicated and likely to remain in aged care, preference has been given to existing enrolled nurses and personal carers, especially in rural and remote areas. More recently, an additional 410 post graduate nursing scholarships were provided to increase skills and encourage more people to enter (or re-enter) the community aged care sector (Pyne 2007b).

Tertiary institutions are increasingly recognising aged care as a specialist field because of its growing importance in health care. For example, the Queensland University of Technology’s School of Nursing has reviewed the adequacy of its undergraduate nursing courses covering aged care. The review identified the need for specific teaching resources in areas such as the management of challenging behaviours including pain management, medications and polypharmacy⁴, wound management, continence, nutrition and hydration, transitional care, Indigenous and culturally and linguistically diverse ageing issues and palliative care for those with end stage dementia (QUT 2004).

Since then, and in collaboration with the sector, Queensland University of Technology and Flinders University, have developed specific courses and practical rotations to train RNs for aged care roles and to promote a positive image of

⁴ Polypharmacy refers to the concurrent use of multiple medications which occurs more frequently with aged clients. The risk of adverse drug events such as falls, confusion and functional decline rises with the use of multiple medications (NPS 2000).

working in the sector (QUT 2004; Flinders University 2006). In addition, Charles Sturt University has begun RN training for enrolled nurses through its distance education program to help increase the skills of the rural aged care workforce (CSU 2007).

Although enrolments and completions for undergraduate nursing courses have increased over the last 7 years, there is still a significant degree of unmet demand — that is, the number of potential students who are eligible and would like to study nursing but are not offered a place (table 6.3). Targeted programs to increase the number of undergraduate places since 2003 have reduced the level of unmet demand from its peak.

Table 6.3 Unmet demand for selected undergraduate courses, 2001-2008

	2001	2002	2003	2004	2005	2006	2007	2008
Number of eligible entrants in nursing not offered a place	1544	2934	4861	4545	2716	2408	2866	2833
Unmet demand (%) ^a								
Nursing	14	26	37	33	20	17	18	18
Health other ^b	22	29	33	34	23	19	17	15
All courses	19	24	28	28	19	15	15	15

^a Unmet demand is the difference between eligible applicants and those offered a place. ^b 'Health other' includes allied health services, such as podiatry, occupational therapy and physiotherapy, but excludes medical and dental studies.

Sources: Australian Vice-Chancellor's Committee (2002—2007); Universities Australia 2008.

Concerns about insufficient places are ongoing despite the recent increases. In this context, the Australian Nursing Federation has suggested that recent initiatives are unlikely to adequately satisfy the expected demand for RNs, as almost half of existing nurses are older than 45 years and will be looking to retire over the next 20 years (ANF 2006).

Increased funding for training of itself will not be sufficient as changes in client demand, such as the increasing incidence of dementia and frailness, will impact on the type of training required. More teachers and preregistration clinical places will also be necessary to impart the specialised skills required for providing quality care to clients with these special needs.

Enrolled nurses and personal carers

Personal carers and enrolled nurses account for over half of the aged care workforce (figure 6.1) and train at TAFEs to Certificate Levels III and IV respectively. Personal carers are unlicensed workers who generally have vocational qualifications

and undertake routine tasks in the provision of services to assist clients in their daily living activities. By contrast, enrolled nurses must be qualified and register with the relevant state or territory Nurse Registration Board or Council. They may undertake more complex tasks than personal carers including medication management and client monitoring.

The sector may face shortages of personal carers and enrolled nurses due to the ageing of the working population and the diminishing pool of potential workers in general. This is not to say that these potential shortages will be chronic. The relatively short training periods needed to prepare workers for these roles affords the sector with some flexibility and may create opportunities for older or overseas workers to enter the aged care sector.

In recent years, Australian Governments have introduced a range of initiatives directed at strengthening the workforce of personal carers and enrolled nurses, including funding for:

- vocational education training for more than 24 000 personal carers, over four years, to gain basic skills to a Certificate III level, in response to the Hogan Review (2004)
- 6000 enrolled nurses to increase their scope of practice by undertaking training in medication management to partially reduce the burden on RNs, also in response to the Hogan Review (2004)
- an extra 6000 training places for personal care workers delivering CACP and EACH packages over the next four years under *Securing the Future of Aged Care for Australians* (AIHW 2007b)
- an additional 50 000 vocational training places over the next three years from July 2008 to address the current health workforce crisis with priority areas including enrolled nurses, dental health workers, allied health assistants, ambulance officers and Aboriginal health workers (Gillard and Roxon 2008)
- improved training and resources for some 1400 Indigenous home and community care workers who care specifically for Indigenous people (Elliot 2008c).

Where necessary, support has been given to personal carers to improve their basic language skills before vocational training in aged care. According to the Federation of Ethnic Communities' Councils of Australia (FECCA 2007), there is a pool of aged care workers who cannot undertake training because they do not speak fluent English. While the Australian Government has realised the importance of providing support for some workers to become fluent in English and to undertake aged and community care skills training, there is scope for further expansion.

There are significant benefits to clients, providers and funding agencies from appropriately matching workers with culturally and linguistically diverse clients. Communication in a client's original language can reduce the costs of care and distress, especially where clients suffer from dementia. However, the residential aged care workforce survey undertaken by NILS in 2003 noted that only 10 per cent of personal care employees from a culturally and linguistically diverse background use their language skills in their work (Richardson and Martin 2004).

The importance of enrolled nurses and personal carers in providing direct care services to the aged continues to grow. While government initiatives aimed at increasing the skill base of these workers have been successful over the last decade, more investment in training and education programs for those who have the most contact with clients is required. Such measures will contribute to building a sustainable and competent workforce as the demand for aged care services increases significantly.

6.3 Informal carers

As outlined in chapter 2, informal carers are integral to the ongoing welfare of older people, especially those with disabilities. The economic value of the services provided by these carers is significant and has been estimated to be in the vicinity of \$4.9 billion to \$30.5 billion in 2005 (0.6 to 3.5 per cent of GDP)⁵ (Access Economics 2005b). To place these figures in perspective, the 2004-05 gross value added by other sectors of the economy, expressed as a percentage of GDP, were: accommodation, cafes and restaurants (2.1 per cent), agriculture, forestry and fishing (4.2 per cent), and health and community services (6.0 per cent) (ABS 2004a).

Not only do informal carers provide services directly to the aged, they also play a role in the co-ordination and facilitation of formal community care services.

Given the importance of informal carers in the delivery of support services to the aged, two key issues arise. First, what is the likely future availability of informal carers? Second, are existing supports for these carers adequate or is there a need for improvement?

⁵ The upper bound was derived by estimating the cost of replacing informal care with comparable services from formal providers while the lower bound estimate reflects the opportunity cost to the nation of informal carers not participating in the workforce.

Views on the future availability of informal carers

Informal care is predominantly provided by spouses, partners or relatives and their relative availability is expected to decline over the next 40 years. The magnitude of the decline is uncertain as it will depend on a number of factors that are likely to have differing impacts (see, for example, AIHW 2004a; NATSEM 2004; PC 2005b). The major factors seen as influencing the availability of these carers are:

- increasing longevity of partners — raise availability
- increasing numbers of single person households — lower availability
- decreasing family size — lower availability
- increasing age of first time mothers — lower availability
- increasing female workforce participation rates — uncertain impact
- changing attitudes towards care by carer givers — uncertain impact.

The increasing number of partners that are living longer could increase the availability of informal carers. According to the *ABS Survey of Disability, Ageing and Carers*, partners comprise 34 per cent of all informal carers (ABS 2004b). The narrowing of the gap between male and female life expectancy is expected to reduce the need for formal care of widows and widowers.

The increasing prevalence of single person households (due to increased rates of separation and divorce and the decision of more people not to marry) is likely to decrease the availability of informal carers. Currently, 44 per cent of persons aged 65 years or older live by themselves (ABS 2005).

The decreasing average family size is likely to reduce the availability of children who can act as informal carers for their ageing parents. This trend is being driven by couples having fewer children than in the past together with the increasing incidence of single parent families (ABS 2005).

The decision to have children later in life may also reduce the number of women who are in a position to undertake caring responsibilities for their ageing parents. However, increased longevity is expected to result in the onset of disabilities at older ages which could partially offset this trend. Over the past 20 years, the average child bearing age has increased in line with the life expectancy of those reaching the age of 65 (ABS 2006d, 2007b).

Increasing female workforce participation may compound the anticipated shortage of potential informal carers. That said, most of the increase in female labour force participation in Australia over the past 20 years can be attributed to the growth in part time employment which need not be incompatible with performing a caring

role and may enable this group to provide informal care if they desire. The proportion of women working part time has increased from 37.6 to 45.2 per cent between 1986 and 2006 (ABS 2007g). Further, the trend towards greater flexibility in employment arrangements for some occupations may increase the capacity of some workers to provide informal care.

Changes in the willingness of family members, especially children, to provide informal care could lessen the availability of such care in the future. Some analysts of social trends point to a society that is becoming more fragmented with a diminishing sense of obligation and responsibility to family suggesting that the availability of informal carers may decline in coming years (see, for example, Johnston 1995). Others, such as Ozanne (2007), have highlighted the diversity and complexity of family forms and underlying values. Allied to this, de Vaus (1996), drawing on data from the Australian Family Values Survey conducted in 1995, notes that there is considerable variation in the extent to which people accept family obligations. In his view, the survey results:

... did not support the model of a society in which a sense of responsibility and obligation to older family members had been destroyed by rampant individualism. Nor was there evidence of generational self-interest. However, the acceptance of responsibilities and obligations to care and support elderly parents was by no means universal, unequivocal or without qualification. (de Vaus 1996, p. 20)

Interestingly, de Vaus (1996, p. 19) also observed that:

There appears to be a hierarchy of obligations. The more the obligation has a direct impact on people's lives the more reluctant they are to accept responsibility.

A number of analysts expect a shortage of informal carers to emerge over the coming decades (AIHW 2004a; NATSEM 2004; PC 2005b). These analysts have used a number of approaches to explore this development. One indicator of the potential availability of informal carers is the 'caretaker' ratio — that is, the population of females aged between 50 and 64 relative to the population of people aged 80 years or older. The caretaker ratio was designed on the basis that 70 per cent of family support is provided by women and that the majority of people aged 80 years or older need assistance (see figure 2.2 and Kelly 2005).

For Australia, the caretaker ratio is projected to decline from 2.5 potential carers per person aged 80 years or older in June 2004 to less than 1.0 in June 2044 (figure 6.3). The Hogan Review (2004) considered that this particular ratio is of limited use because most carers are not women aged between 50 and 64. But, a similar trend is observed, if the group of potential carers is broadened to include all females aged 20 to 69. The ratio of females in this wider age range to the population aged 85 or older (this age reflects greater life expectancy) falls from 25 potential

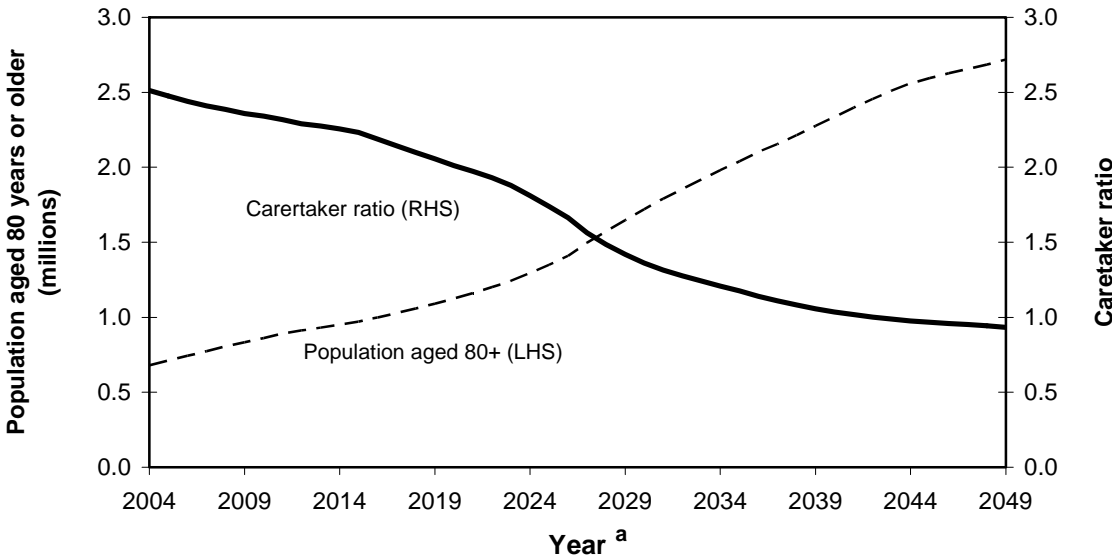
carers per person in 2001 to a little over 7 in 2041 (PC 2003). Regardless of which metric is used, the relative supply of informal carers is expected to decline.

Another measure of the future availability of informal carers is a comparison of all potential carers, male and female, with older persons who have severe or profound disabilities. According to NATSEM (2004, p. 30), this ratio is expected to decline over the coming decades:

When the projections for the number of persons aged 65 years and over with a severe or profound disability and those likely to provide informal care are compared, it is clear that the growth in disabled persons will be much greater than the growth in carers.

NATSEM (2004) expects the demand for informal carers to rise by 160 per cent between 2001 and 2031, while the supply of informal carers is expected to increase by around 60 per cent during this period. These changes would combine to contribute to the carer shortfall quadrupling from 150 000 to almost 600 000 over this period.

Figure 6.3 Older female carers relative to the population in need
 Females aged 50–64 years relative to the population aged 80 years or older



^a As at June for years shown.
 Data source: Calculated using Series B from ABS (2006c).

The relative decline in informal carers may reduce the effectiveness and sustainability of community care programs in some instances. The presence of an informal carer generally facilitates the delivery of community care services, especially as a client’s condition deteriorates. For example, a CACP census (AIHW 2004b) found that program recipients were more likely to have an informal carer as

the number of severe or profound core activity limitations increased (table 6.4). However, it should be noted that informal care is not necessarily essential for the formal delivery of community care as only half of the recipients of formal community care have an informal carer (AIHW 2004b; DoHA 2006e).

In many instances, however, informal carers play a crucial role and the expected relative decline in their availability could affect other aged care modes. In this context, the NSW Health submission to the *Inquiry into Quality and Equity in Aged Care* (SCARC 2005, p. 169) highlighted that the ‘lack of an informal carer ... is the single most common trigger for an older person moving into residential care’.

Table 6.4 Carer status of CACP recipients in 2002 by the number of severe or profound core activity limitations

Carer status	Number of severe or profound core activity limitations			
	0	1	2	3
Has no carer (%)	61.5	49.9	36.6	24.8
Has a carer (%)	38.5	50.1	63.4	75.2
Number of recipients ^a	3817	7674	10 867	2469

^a Excludes 612 care recipients for whom carer status or the number of severe or profound core activity limitations was not stated.

Source: AIHW (2004b).

Can existing support for informal carers be improved?

Informal carers provide support services, either with or without formal assistance, to the aged who predominantly reside in the community.

The adequacy of support provided to these carers impacts on their willingness and capacity to undertake and maintain a caring role. Informal carers are among the lowest socio-economic groups as they seldom undertake full-time work, thereby foregoing associated benefits such as superannuation and paid leave (ABS 2004b). Surveys of informal carers have also concluded that, in general, their caring responsibilities can also diminish their physical, mental and emotional health and wellbeing (see, for example, Briggs and Fisher 2000; Independent Living Centre of WA 2006).

Given the high personal costs that informal carers may experience, support mechanisms will play an important role in encouraging and ensuring that informal care services continue to be provided.

A number of reviews and commentators have been critical of existing support for informal carers despite the expansion of carer support programs by Australian Governments over the past few years (Carers Australia 2007a; Aged Care Assessment Service Victoria 2007; St Laurence Community Services 2007; UnitingCare Ageing NSW.ACT 2007). Among the issues raised, there are five key areas of concern:

- access to information about support services for clients and carers
- structure and adequacy of financial support
- access to respite and other care services
- workplace flexibility
- training and assistive technologies.

Access to information regarding appropriate services and assistance available to aged care clients and their carers plays an important role in helping the aged remain in the community for as long as possible. Recent initiatives to improve access to information regarding aged care services are outlined in appendix A. Notwithstanding these initiatives, the complexity of the system and confusion about how support programs interact limits access and use of aged care services. For example, Allen Consulting (2007, p. 16) found that:

... clients and carers identified a lack of information on community care services as a major barrier to access. This has the biggest impact on those who would be eligible to receive community care but are not currently in the system ... Carers in particular highlighted that access to services before a crisis point would be beneficial for the clients and also for the carer.

Financial support to eligible informal carers is provided by the Australian Government through a carer payment and allowance. This direct financial support does not fully compensate carers for the cost of their time, out of pocket expenses and lost opportunities. The level of support provided, over 50 per cent of private consumption per capita in 2003, is at the higher end of the spectrum compared with some OECD countries, such as Japan, Sweden and the United States, but is comparable with that provided in the United Kingdom (Lundsgaard 2005). However, these comparisons only take direct financial payments into account. For some OECD countries, indirect support to informal carers may be available through the personal care budgets of care recipients. Hence, the above comparison may be somewhat misleading.

The structure of financial support to carers has been subject to criticism because it can reduce the range of opportunities for some carers to participate in the workforce. Some carers value such opportunities for a variety of reasons, including engagement with the wider community. For example, the Taskforce on Care Costs,

representing 45 non-government organisations and businesses, highlighted that the structure of the Carer Payment works against maximising workforce participation because it does not consider the increased costs of providing alternative care arrangements when carers are at work (TOCC 2007). In addition, carers may not enjoy other benefits from working including opportunities to contribute to superannuation and participate in professional development activities.

Access to respite and other care services is important for informal carers. Respite care provides a break for carers to carry out other responsibilities or tend to their own needs. The Australian Government has recognised the importance of providing respite care. For example, funding for the National Respite for Carers Program increased from around \$20 million to almost \$170 million between 1996-97 and 2006-07 (Bishop 2004; DoHA 2007h).

The array of programs offering respite services has been widened to provide services during the day (for a few hours), overnight and for longer periods (up to three weeks) across a variety of settings. The Australian National Audit Office (ANAO 2005, p. 16) has commented that there is ‘insufficient communication and coordination between the National Respite for Carers Program and other community care programs’. Inconsistencies, gaps and duplication in the provision of respite services reduces its effectiveness with attendant impacts on the use of community care. Despite increased funding for community care, a significant unmet demand for respite services remains (Carers Australia 2007b; SCCA 2007). Further, Alzheimer’s Australia (2007) maintains that respite services may not be allocated equitably across all types of clients due to the high demand and low availability of these services. For example, carers of clients with high needs, such as dementia, often miss out on respite as providers choose clients with less complex and challenging behaviours.

A number of stakeholders have noted that integrating the array of respite programs (in terms of funding and administration) could enable better monitoring of client use and promote more equitable outcomes (ACAA 2007e; ACSA 2007b; Queensland Government 2007). In addition, greater integration of respite programs with other community care services has the potential to increase the continuity and flexibility of care.

Access to broader community care programs also remains a concern for informal carers (Allen Consulting 2007). For example, constraints on the availability of CACP and EACH packages create increased pressures on carers that are supporting care recipients waiting for a package to become available. In addition, limited flexibility in funding arrangements restricts the capacity of carers to respond in emergency situations that fall outside the scope of normal service arrangements.

More flexible work environments may provide opportunities for informal carers to undertake caring activities while maintaining their participation in the workforce. In 2003, approximately one quarter of carers reported that they either reduced their hours of work or ceased participating in the workforce altogether because of their caring responsibilities (ABS 2004b). In addition, the Taskforce on Care Costs found that 44 per cent of informal carers work in a role below their skill level because it gives them the flexibility they need (TOCC 2007).

The Business Council of Australia and Carers Australia have both recognised the need for workplace reforms that encourage employers to develop and implement more flexible strategies to assist carers in their caring roles (TOCC 2007). More specifically, the Business Council of Australia has proposed the establishment of a working group comprised of government, non profit organisations and business stakeholders to address the current barriers to workforce participation, including those experienced by carers. The Business Council of Australia (2007, p. 32) envisages developing a ‘Workplace Diversity Kit for business which highlights the need for and benefits of greater diversity in the workplace’.

Training and education can assist informal carers to maintain their caring role for longer. The state and territory branches of Carers Australia and Alzheimer’s Australia offer courses, workshops and seminars for informal carers in stress management, supporting families and coping with change. The Australian Government has funded dementia training for informal carers through these two organisations as part of making dementia a national health priority in 2005. However, there is no recurrent funding mechanism for the general or specific training of informal carers (Carers Australia 2007a).

The use of *assistive technologies* may also help carers support older people and reduce some of the physical and emotional burdens associated with caring. For example, assistive technologies may increase the capacity of informal carers to live independently of the person for whom they care. These include aids for those with disabilities, such as remote control appliances, movement sensors and voice reminders, can increase the ease of caring and prolong independence (McNelis 2007).

In acknowledging the importance of carers, the Australian Government has recently announced an inquiry to investigate how carers can be better supported (Macklin 2008). The Committee will report on:

- the role and contribution of carers in society and how this should be recognised
- the barriers to social and economic participation of carers, with a focus on helping carers find and/or retain employment

-
- the practical measures required to better support carers
 - strategies to assist carers to access the same range of opportunities as the wider community, including increasing the capacity for carers to make choices within their caring roles, transition into and out of caring and effectively plan for the future.

In the Commission's view, this investigation is timely as the effectiveness of support for informal carers influences the willingness and capacity of these carers to contribute their services. As the Department of Health and Ageing (DoHA 2003b, p. 21) has indicated:

The effectiveness of health and aged care services depends in part on the availability of informal carers. In turn, the capacity of carers to continue to maintain their caring role for a family member or friend and their attachment to the labour market, depends on the availability of quality, accessible and affordable aged and community care services, including respite care services.

6.4 Volunteers

In the context of aged care, volunteers provide a variety of support services including assistance with transport, home maintenance, and meal preparation and delivery. Volunteers may also help older people to feel less isolated by transporting them to social activities, developing social networks with the wider community and providing companionship. These services can assist older people to remain in their own homes, thereby reducing the likelihood of premature entry into residential care. As such, volunteers represent an important element of Australia's social capital and generate benefits to society through the support and services they provide.

The pressures on the aged care system outlined in chapter 3, together with the expected relative decline in the availability of informal carers, will increase the importance to society of making effective use of volunteers as a resource to complement other support services for the aged. In particular, the retirement of the baby boomers, associated with their better health and increased longevity, will potentially enhance the capacity of the 'Young-old' to support the 'Old-old'.

This section profiles the general characteristics of volunteers in Australia, considers their future availability and reviews the opportunities to make more effective use of them in future years. It is important to note specific data on the extent and nature of volunteering for aged care is not readily available. Further, comparing trends in the types of volunteering over time is difficult, other than at an aggregate level. This arises as various surveys are incomplete, not conducted at regular intervals and subject to changing methodologies.

Importance of volunteers in Australia

Volunteers in Australia contribute a significant amount of unpaid time and effort to a variety of activities and organisations including health and welfare, sport and recreation, emergency services, childhood development, overseas aid, conservation and animal welfare.

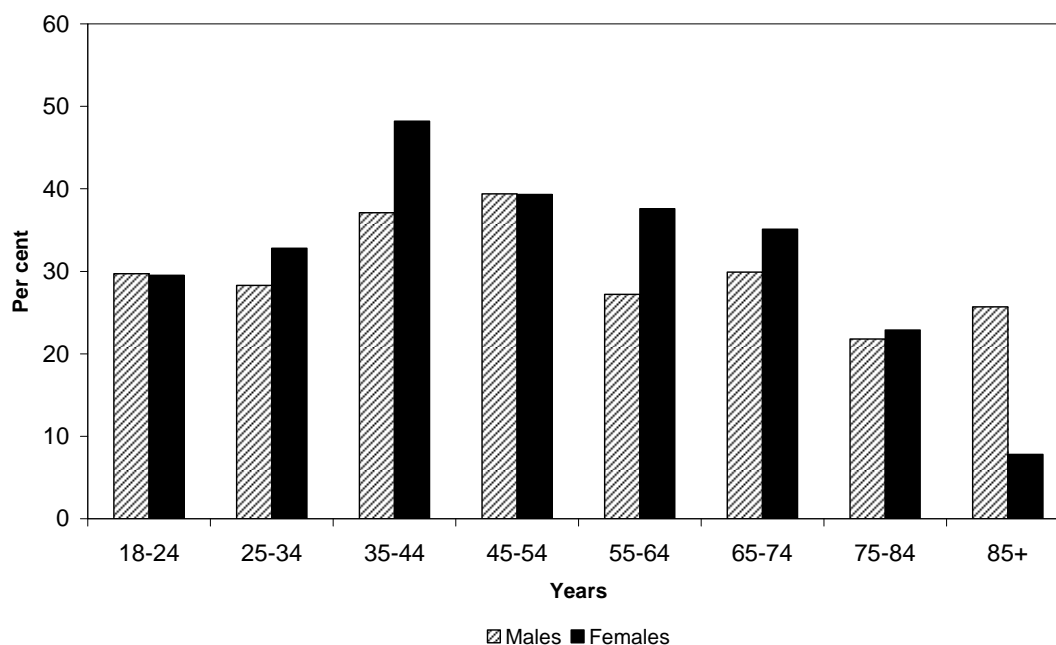
There are two broad types of volunteers: formal and informal. A formal volunteer is someone who willingly provides unpaid help as time, service or skills through an organisation or program (ABS 2007h). An informal volunteer, by contrast, may assist with caring and doing favours for family, friends, neighbours and others, but does not have a direct link to an organisation. By and large, volunteers are not substitutes for paid workers or informal carers; rather, they complement their contributions.

Informal carers are usually considered to be part of the broad definition of informal volunteers but this chapter treats informal carers separately to volunteers due to their direct relationship with the care recipient either as a relative, friend or neighbour. As such, informal volunteers are defined here to have no direct relationship with the service recipient. Using this definition, there were some 500 000 informal volunteers in 2006 who provided a service to someone other than a relative, friend or work colleague (ABS 2007h).

Over one third of the Australian population aged 18 years or older participated in some kind of formal volunteering activity in 2006. In total, it is estimated that 5.2 million people volunteered for formal organisations, contributing some 713 million hours of unpaid services to the community (ABS 2007h). The proportion of formal volunteers in the overall population has increased from around 24 to 35 per cent between 1995 and 2006.

Formal volunteering rates vary significantly according to age (figure 6.4). Overall, volunteering rates are highest for the middle aged (35–64 years). However, persons aged 65 years or older also have significant rates of volunteer involvement, except for women aged 85 years or older.

Figure 6.4 Participation in formal voluntary work by age and sex
Per cent of population, 2006



Data source: ABS (2007h).

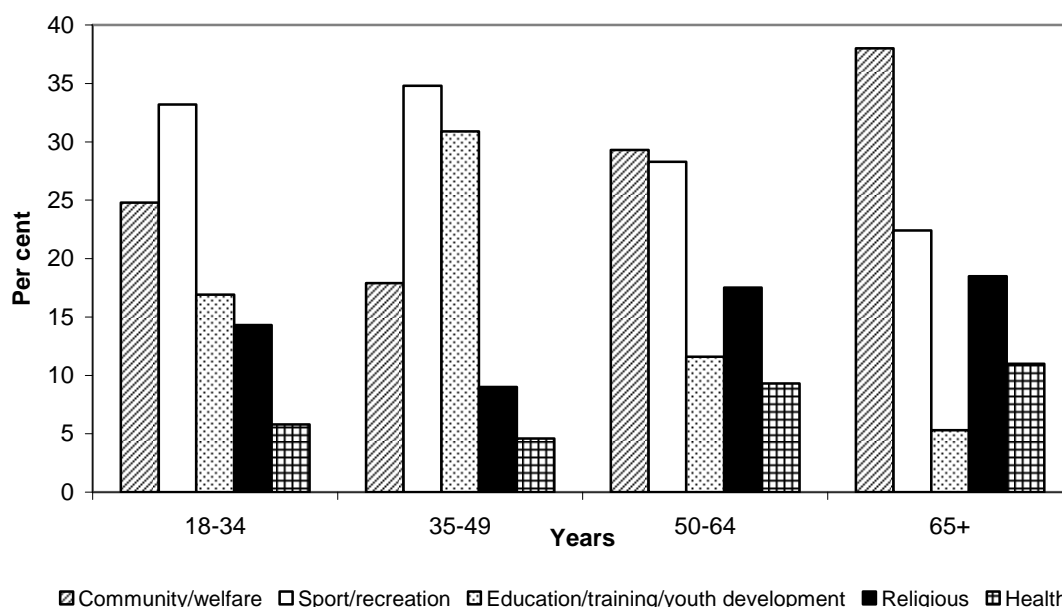
There are also distinct differences in participation rates between different volunteering areas⁶ (figure 6.5). Those aged 35–49 years predominantly volunteer in sport/recreation and education/ training. For volunteers aged 50–64 years, the two key areas of participation are community/welfare and sport/recreation. For those aged 65 years or older, the primary area of volunteering is community/welfare.

The average number of hours spent volunteering each year increases up to and including the 65–74 age group, reflecting the greater availability of time with retirement (ABS 2007h). However, after the age of 75 physical and mental health problems begin to hamper the capacity of many to volunteer.

⁶ The ABS defines five main types of volunteering areas — community and welfare (including emergency services and environment and animal welfare); education and training (includes parenting and children and youth); sport and recreation (including arts, heritage and other interests); religious; and health.

Figure 6.5 Participation in formal voluntary work by type of organisation and age

Per cent of population, 2006



Data source: ABS (2007h).

Volunteering services provide substantial benefits to the Australian economy, even though they are not counted as part of the nation’s GDP. Estimates of the economic value of these services depend on the definition of volunteering and method of estimation employed. For example, the Commission estimates⁷ the value of unpaid voluntary work, excluding care for adults and children, to have been \$14 billion in 2006. Alternatively, Ironmonger (2000) valued volunteer services at \$42 billion in 1997 using a broad definition of volunteering which included formal volunteering, doing favours for family friends outside the home, caring for adults and supporting other’s children.

A significant number of volunteers work in aged care. In 2000, there were 32 628 volunteers working in nursing homes and other forms of accommodation for the aged (ABS 2001). Of these, 70 per cent provided community service activities such

⁷ The value of volunteer services was estimated using data from *How Australians use their time 2006* (ABS 2008b, table 15), *Employee Earnings and Hours 2006* (ABS 2007d) and the *Census of Population and Housing 2006* (ABS 2008a). A market replacement cost approach, that is, what it would cost organisations and households to hire others to do the work for them, was used to derive these estimates based on de Vaus et al. (2003). The estimate, based on the 2006 survey by the ABS (2008b), is comparable with an earlier analysis by de Vaus et al. (2003), updated to reflect growth in population and wages.

as companionship and entertainment. Around 98 per cent of volunteers provided their services through non-profit organisations.

Data specific to volunteering in community care are not available. However, volunteers in programs such as meals-on-wheels have been essential to the success of the development of community care as a viable alternative to residential care (PC 2003).

Future availability of volunteers

A variety of factors are expected to influence the future availability of volunteers for aged care. They include:

- demographic change
- changes to age-specific participation rates
- changes to preferences for types of volunteering
- the capacity of aged care providers to attract volunteers.

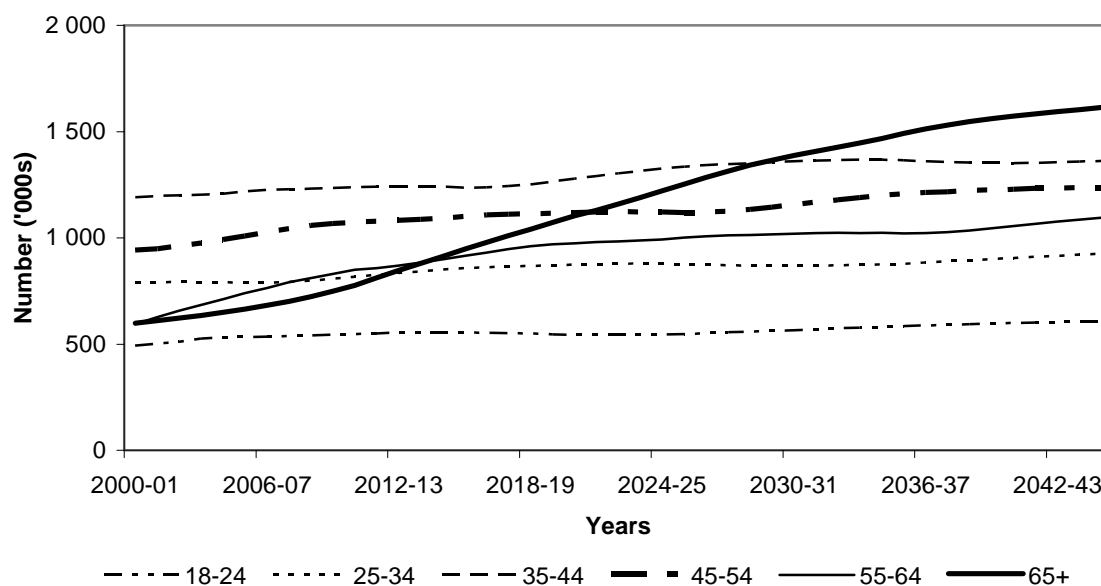
In general, future demographic changes are expected to increase the availability of volunteers.

Reflecting the growing share of the population aged 65 years or older, the Commission (PC 2005b) estimated that the potential pool of formal volunteers from this group is likely to more than double, from around 600 000 to 1.6 million between 2000-01 and 2044-45 (figure 6.6). In addition, the number of volunteers aged 45-54 and 55-64 years are expected to increase by 31 and 84 per cent respectively. By contrast, the Commission expects the number of younger volunteers aged 18-45 years to increase only slightly. These estimates assume constant age-specific volunteering rates over time.

Volunteers aged 65 years or older are more likely than younger volunteers to support the aged through community and welfare groups (figure 6.5). In this context, the ACT Government (2004, p. 18) has commented:

Volunteering is likely to be one of several areas in the community that will benefit from an ageing population in the ACT. The Territory currently has one of the highest rates of volunteering among the States and Territories, and the rates of volunteering among the growing number of retirees are expected to continue to grow over the next two decades.

Figure 6.6 Projected number of formal volunteers
2000-01 to 2044-45 assuming constant participation rates



Data source: PC (2005b).

What is not known is whether the propensity of older people to volunteer for organisations that support older groups will change. For example, changes in the perceived need for volunteers may influence the willingness of people to volunteer. Hence, the large projected growth in the number of older people may prompt others to volunteer for support roles.

The high rates of volunteering among the current cohort of middle aged (45–64 years) may continue into later life as this group is expected to be healthier and more active in their later years (Victorian Government 2004). Comparisons of volunteering surveys suggest that the participation rates of older volunteers are rising at a similar pace to other age groups (ABS 2007h). Workers seeking a partial transition from the workforce may create niche opportunities for volunteer organisations. However, the total amount of volunteering actually provided could be offset by higher workforce participation rates if the recent trend towards extended working lives continues.

Further, competition for volunteers from other areas may reduce their availability in community and welfare activities and religious organisations where older volunteers have traditionally been the main contributors. Organisations that currently rely on younger volunteers, such as sport, recreation, education and training, might face difficulties in attracting recruits in the future (Volunteering Australia 2004). In these circumstances, older volunteers may become relatively more attractive if their health and lifestyles enable them to perform such activities.

The availability of volunteers in helping the aged will also depend on the capacity of organisations that support the aged to tailor programs and activities which maintain and encourage participation by volunteers.

Making effective use of volunteers

Making effective use of volunteers presents a significant challenge for service providers and the community. For service providers, the goal is to get the most out of their volunteers' time while providing a rewarding experience for the individual. From a community wide perspective, the issue is whether there are regulatory or institutional barriers that inhibit these contributions. As a result, volunteer organisations and governments need to consider a range of issues including the role of information channels in effectively promoting and encouraging volunteering, the need for adequate and appropriate training and support (including compensation for expenses) and whether regulatory settings in certain areas (such as insurance and liability) may impair volunteering activities.

The growing competition for volunteers between entities both within and outside of aged care means that those organisations that do not provide a positive experience for volunteers (such as valuing their participation and showing an interest in connecting with them) will find it increasingly difficult to retain and attract them. Volunteers could be expected to look for well managed organisations that provide adequate support and a productive, interesting volunteering experience. In addition, the role of volunteers should be well defined and understood by the volunteer, organisation, recipient and other workers (Volunteering Australia 2005).

There is scope to expand volunteer participation in all age groups directed at providing support to the aged by better tailoring activities to volunteer characteristics. Organisations are responding to this challenge by facilitating:

- on-line volunteering — providing advice and skills from the home or office
- episodic volunteering — short-term opportunities to volunteer without regular or long term commitments
- corporate volunteering — employers encouraging teamwork, staff morale and giving back to the community
- family volunteering — combining the benefits of volunteering with the opportunity to spend time together as a family (Team Consultants 2002).

Where organisations find it difficult to match volunteers with recipients, governments can implement programs to act as a broker and reduce information asymmetry problems. For example, the Community Visitors Scheme provides a service that connects volunteers with residents of aged care facilities to enrich their

quality of life and reduce social isolation (DoHA 2002b). More broadly, the Australian Government has funded Volunteer Resource Centres to provide assistance and training to a wide range of organisations that use volunteers (FaHCSIA 2008).

The impact of rising costs associated with volunteering, especially out of pocket expenses, is likely to affect participation rates (Volunteering Australia 2007). In many instances, the costs associated with transport, uniforms, telecommunications, safety equipment, training and accreditation (such as first aid courses and police checks) may be partially or entirely borne by volunteers. The recent *Inquiry into the Cost of Living Pressures on Older Australians* (SCCA 2008, p. 105) concluded that ‘the capacity of older people to continue to provide such volunteer support was being diminished by increases in living costs’.

While volunteers do not want to be paid for their services, they do not want to be out of pocket (Volunteering Australia 2007). To address this problem and maintain a high level of volunteer participation, the Costs of Volunteering Taskforce, an initiative of Volunteering Australia, has suggested that these personal costs (at either an organisational or individual level) could be reimbursed through a number of options including government grants and tax benefits (Volunteering Australia 2007).

In 2008, the Australian Government announced it would expand the Volunteers Grants Program to \$64 million over the next three years, to help community organisations and their volunteers (Macklin and Stephens 2008). Part of this expansion is in response to a 40 per cent increase in petrol costs over the past five years. This will help around 6000 community organisations and their volunteers, particularly those delivering food, visiting older people in their homes, transporting them to various activities and giving other assistance requiring private transport.

Legislative reforms by federal, state and territory governments to the law of negligence, and specifically around volunteer liability, have reduced some of the impediments faced by organisations in accessing insurance (Barnett 2006).

However, the rising costs of liability insurance is an area of on-going concern for the volunteering sector (Volunteering Australia 2008). Volunteer organisations may lessen the extent of premium increases through reducing the risk and liability associated with their activities by ensuring:

- volunteers work in safe environments
- any ambiguity about where responsibility lies is reduced as far as is practical prior to the volunteer’s actual involvement

-
- there is adequate training and supervision for volunteers, and that appropriate policies are in place and made available to the volunteers
 - there is adequate insurance coverage (Volunteering Australia 2006).

That said, the limits placed on policy coverage exclude some older volunteers (aged 80 or older) from participating as risk is considered to increase with age (Volunteering Australia 2008).

Addressing excessive regulatory burdens on volunteers and their organisations, particularly smaller groups, could improve their sustainability. For example, introducing transferable police checks for volunteers who provide services to multiple organisations would reduce the time and costs spent duplicating these processes. In addition, the COAG Business Regulation and Competition Working Group is considering ways to reduce the regulatory burden in relation to food regulation for not-for-profit groups (COAG 2008).

More broadly, some smaller organisations often do not apply for government funding because the complicated application forms, contracts and conditions would impose a significant demand on their resources (Stephens 2008). The Australian Government is aware of this problem and is exploring options to reduce red tape associated with securing government funding.

By promoting the skills and value of older people to the wider community, governments may influence societal attitudes towards older volunteers to overcome participation barriers that some volunteers may face. This approach may attract baby boomers that see themselves as ‘young’ and want to participate in challenging and creative volunteering opportunities (Team Consultants 2001). However, government ‘directives’ aimed at encouraging volunteerism are likely to be unsuccessful or even counterproductive as research suggests that top down approaches are not well received (NHMRC and Volunteering Australia 2003).

Volunteering activities not only benefit those directly involved but are also likely to have spill-over effects within the community which may reduce the costs of providing support services and/or improve outcomes in areas such as health and welfare. There will always be an excess demand for volunteer services as the spill-over effects of volunteering are not valued appropriately by the market. Therefore, governments need to be sensitive to the unintended consequences of policies that impact on the scale and scope of volunteer involvement, such as with liability and insurance, and which may inadvertently reduce the range of policy options available in the future.

7 Productivity in aged care

Key points

- Productivity growth in aged care is important. It allows providers to reduce costs in providing services, absorb cost increases and/or improve service quality. From a fiscal perspective, productivity improvements could lessen upward pressure on public expenditures.
- Measuring productivity growth in the aged care sector is challenging due to:
 - limited data availability
 - client and service diversity, including differences in service quality.
- A study by the Centre for Efficiency and Productivity Analysis (University of Queensland) suggests that if all Australian residential aged care facilities were to operate on a notional best practice frontier and restructuring occurred to realise opportunities for improved economies of scale, there could be efficiency gains of around \$1.6 billion (in 2002-03 dollars).
 - However, realising all of these gains is not possible as some differences in efficiency are due to factors — such as remoteness — which are beyond the control of individual providers. Further, securing improvements would require new investment and involve adaptation costs. Even so, there appears to be considerable scope for worthwhile improvements.
- Substantial productivity gains have been realised by some providers in recent years through the use of flexible workplace agreements, investing in better technology and restructuring their activities.
- Opportunities to further improve productivity in the aged care sector may result from:
 - extending better practices in enterprise bargaining across the sector, improving the use of information and assistive technologies to lessen costs and additional restructuring of activities
 - relaxing or redesigning regulatory settings which unnecessarily raise the cost of providing services and/or impair competition and other incentives for enhancing efficiency.

This chapter outlines why productivity growth is important, discusses issues related to productivity measurement (including quality aspects) and examines productivity levels in residential care. It also identifies some emerging opportunities to improve productivity within aged care by using information and assistive technologies, improving workplace flexibility and reducing excessive regulatory burdens. In the

absence of appropriate data and studies covering productivity movements in community care, the focus is on residential care.

7.1 Why is productivity growth important?

In the context of aged care, productivity growth is important because it enables service providers to reduce costs in providing services, absorb cost increases and/or improve service quality. Aged care clients could benefit from productivity improvements through downward pressure on user contributions and access to higher quality services. From a fiscal perspective, productivity improvements in the delivery of aged care as well as other social services lessen upward pressures on public expenditures.

How the benefits of productivity growth are shared among stakeholders is likely to depend on the extent of competition in the market for aged care services and the influence of funding and regulatory arrangements on cost sharing and service provision. Consumers are likely to benefit more where there is greater contestability and competitiveness in the market as service providers are encouraged to pass on the benefits to consumers or risk losing clients.

Although the importance of productivity growth in aged care is generally accepted, analysts and commentators are divided over the scope for growth.

Many industry analysts argue that the scope for further productivity improvement is limited. They point to the large proportion of clients who require hands-on care which is inherently time and labour intensive. Reflecting this, Aged Care Australia (1998, p. 11) has claimed that ‘the opportunities for productivity gains by nursing homes through enterprise bargaining or through the substitution of labour inputs with equipment are extremely limited’. This is due to:

... the nature of the industry, quality care standards, the high level of productivity and staff flexibility that already exists, and insufficient funding or productivity gains to offset further changes in working conditions. (Aged Care Australia 1998, p. 11)

Faced with the prospect of limited productivity improvement, these analysts highlight growing constraints on the capacity of aged care providers to attract resources, particularly labour resources, arising from the challenge of the so-called Baumol effect. In general, industries experiencing higher rates of productivity growth have the ability to pay higher returns to factors of production, such as labour and capital. As a result, rising wages in industries with strong productivity growth impose cost pressures on industries with lower productivity growth, particularly the labour intensive service industries with limited opportunities for raising productivity (McLachlan, Clark and Monday 2002; AIPC 2003).

Over the last decade or so, the health sector (including the acute care sub sector) has undergone a number of reforms. These have included a shift to case mix funding and changed work practices to make better use of staff. Changes to regulations to enhance incentives for productivity growth have also facilitated improvement, as have advances in technology.

Despite this, the Australian Institute for Primary Care (AIPC 2003, p. 11) maintains that residential aged care providers:

... cannot match the productivity gains made in the acute care sector where technology and workforce reforms have significantly reduced length of stay and thereby unit costs. Over time, as wage rates in related sectors flow through to aged care, unit costs for the delivery of care rise.

Some analysts are less pessimistic about the opportunities for improving productivity in aged care, particularly in areas with relatively high levels of regulatory control. As the Hogan Review (2004, p. 289) highlights:

All the work on the aged care industry supported and funded by the Review points to the large potential gains in efficiency and productivity to be secured by changes in policy towards some regulatory features bearing on providers.

For example, some providers wanting to diversify or expand their operations to secure improved economies of scale and scope claim they have been stymied by the needs based planning approach and other regulations (CEPA 2003; IBIS Care 2007; TriCare 2007). In addition, targeted reforms including changes to permit greater competition would provide additional incentives for improving productivity. This could, for example, be achieved by relaxing bed and place allocation restrictions and relying on ACAT assessment criteria to determine an entitlement for services (Hogan Review 2004; Ergas 2006).

Other opportunities for productivity growth may arise from adopting more flexible workforce practices, improving management practices, using assistive and information technologies more widely and changing regulatory arrangements to facilitate innovation and improvements in efficiency.

7.2 Measuring productivity

What is productivity?

Productivity measures provide a basis for assessing and comparing production and service activities in terms of the amount of inputs (labour, capital, materials) required to generate outputs. Productivity *levels* measure the ratio of outputs to inputs at a point in time, for example, the number of aged care clients handled per

full time equivalent staff. Measures of efficiency (allocative, productive and dynamic — chapter 4) capture different underlying influences which combine to shape both productivity levels and growth.

Productivity *growth* arises where output growth exceeds input growth over a specified period. Evidence of productivity growth usually means that ways have been found to generate more output from given inputs or to produce the same output with fewer inputs.

How is productivity measured?

Productivity is often measured in relation to a single input, such as labour or capital, yielding a partial measure of productivity performance. Labour is the most commonly used partial measure because data are often readily available and, for many service industries, it is the single most important input. Indeed, in the case of aged care, labour's share of input costs is dominant, typically ranging from around 65 per cent for low care residential services to around 80 per cent for HACC services (Access Economics 2004).

However, partial measures of productivity can be misleading because they tend to attribute all productivity change to a single factor and fail to capture changes in the use of other inputs.

Multifactor productivity (growth in output relative to the combined contribution of key inputs, usually labour, capital and intermediate goods and services) provides a more comprehensive productivity measure. This is particularly important in the aged care sector where providers have realised efficiency gains by altering their use of capital and different types of labour inputs. Examples include the introduction of lifting devices in residential aged care facilities and the increased use of personal carers relative to registered nurses. In this latter case, if the measure of labour inputs is purely a physical one (such as full time equivalent staff) then labour substitution which may facilitate reduced wage costs would not be captured as a productivity improvement (presuming no change in quality adjusted output).

The choice between partial and multifactor productivity measures is generally influenced by the purpose of productivity measurement but also by the availability and quality of data. Limitations in available data often heavily circumscribe productivity analyses in the health and welfare sectors. Indeed, for Australia, the Commission is aware of only one study of productivity covering aged care services and this study only covers residential care (section 7.3).

Defining and measuring the intangible outputs of service industries, such as health services, aged care and educational instruction, can be more difficult than for

physical products associated with agricultural and manufacturing processes (Dean 1999; Bloor and Maynard 2001; McLachlan, Clark and Monday 2002; Jacobs, Smith and Street 2006). This arises because a single output indicator (such as the number of beds occupied or home-based services dispensed) often does not adequately capture various dimensions of an industry's output, including service quality. Further, the inputs to, and outputs from, service industries can be more heterogeneous than in goods producing industries. For example, in the residential aged care sector, the majority of international studies attempt to deal with output heterogeneity by categorising patients according to broad dependency levels, which may not accurately reflect the associated input combinations.

Further, the treatment of quality has far-reaching consequences for productivity measurement. Quality is an integral dimension of both inputs used, and outputs generated, for many industries and should be taken into account to avoid biases in measured productivity (Gullickson and Harper 1999; OECD 2001). Improvements in output (input) quality need to be taken into account when measuring productivity growth to avoid understating (overstating) real productivity growth (McLachlan, Clark and Monday 2002). This is particularly relevant for Australia's aged care sector where providers face pressure to improve residential care standards through a mandated system of continuous quality improvement (chapter 5).

Of particular importance to service industries, such as aged care, is the effect on productivity growth of changing labour force composition (OECD 2001). Measuring productivity in terms of quality adjusted labour inputs provides a better measure of labour's contribution to production, particularly in those industries where the workforce is becoming more diverse. For example, using quality adjusted labour input measures may help to explain growth arising from investment in human capital or changes in the labour force mix. Techniques used to adjust the number of hours worked to allow for differences in input quality typically use characteristics such as occupation, education and experience. Adjusting for quality in aged care may be particularly relevant where there has been a substantial shift towards using lower skilled staff that have been trained to provide safe, quality care for a specific range of activities. Without an adequate adjustment for quality, comparisons between firms at an industry level or across countries could be misleading.

7.3 Performance of the residential aged care sector

The Hogan Review (2004) commissioned the Centre for Efficiency and Productivity Analysis (CEPA) at the University of Queensland to examine the efficiency of Australia's residential aged care sector. The CEPA study drew on data derived from a KPMG survey. The first stage of the study assessed the technical and

scale efficiency of a representative sample of facilities using data envelopment analysis (box 7.1). A second stage investigated the importance of factors affecting the observed performance of these facilities.

Box 7.1 Estimating technical and scale efficiency using data envelopment analysis

Data envelopment analysis (DEA) is a linear programming technique that identifies those providers able to produce the highest level of services with a given set of inputs, or to produce a given level of services with the least amount of inputs. Other service providers receive an efficiency score determined by their performance relative to the best performers. This technique can be used to identify the likely origins of 'efficiency gaps' relative to the best providers.

Technical efficiency is the ability to convert inputs (such as labour and capital) into outputs (such as days of care) and is measured with reference to the 'efficiency frontier' defined by the most productive providers. Organisations that are the most productive are considered to be technically efficient.

Scale efficiency measures the degree to which changing the size of a facility could improve its ability to operate more efficiently.

DEA is often employed to compare health and aged care organisations because:

- it can readily incorporate multiple inputs and outputs to measure technical (and scale) efficiency levels can be determined as well as possible sources of inefficiency
- it is potentially a useful tool for benchmarking by identifying 'best practice' role models for other providers.

However, there can be limitations with DEA, including:

- producing results that are particularly sensitive to the presence of 'outliers'
- measuring efficiency only relative to best practice within a particular sample.

While DEA is a useful tool for examining the efficiency of residential aged care facilities, the challenge in undertaking policy relevant studies is to identify the drivers of efficiency variations (such as regulatory impediments and management quality), especially those that could be changed through improved policy settings.

Sources: SCRCSSP (1997); CEPA (2003).

The results from the CEPA's preferred model (box 7.2) suggest that if all facilities operated with a technical efficiency equivalent to the best performers, then combined input usage could have been reduced by 17 per cent or \$1.1 billion in 2002-03 (Hogan Review 2004). This notional efficiency gain could, alternatively, have allowed providers to care for an additional 23 100 clients at the dependency levels that existed in 2002-03. The average level of technical efficiency (83 per cent) present in Australia's residential aged care facilities is broadly

comparable with that determined by international studies which have used similar methods of analysis (box 7.3).

Box 7.2 Technical aspects of the CEPA study

CEPA undertook a two stage analysis to calculate the technical efficiency of each residential care facility relative to the best performers and the factors likely to influence their performance.

KPMG collected data from 912 aged care facilities across Australia, representing around a third of all facilities. However, largely due to incomplete responses, data from around 500 facilities was used in calculating the level of technical efficiency. Broadly speaking, the sample was fairly representative of the population except for two categories that were underrepresented: Queensland and privately owned facilities.

In the first stage, DEA and stochastic frontier analysis (SFA) were used to calculate the level of technical efficiency using a variety of specifications. The analysis specified a combination of input variables (number of beds or facility area, labour costs and other costs) that were used to deliver bundles of care services. These services (or 'outputs') were measured in two ways: scores reflecting assessed needs for accommodation, personal care, nursing needs and cognitive and emotional behaviours; and the number of high and low care bed days provided.

DEA was the preferred method as it produced more information on the level of technical and scale efficiency and the results were considered more robust. It has also been the preferred method in many similar international studies. However, DEA can be susceptible to data noise (that is, data errors and omitted variables) — when the initial results were compared with those from SFA, the mean technical efficiency scores from DEA were significantly lower. As a result, CEPA concluded that the DEA results were most likely affected by measurement error, unlike those from the SFA which explicitly deals with data noise. Accordingly, the sample was adjusted by removing the initial set of frontier firms and recalculating the DEA technical efficiency scores so that they were closer to those obtained by SFA. The preferred DEA model specified outputs in terms of high care and low care bed days using inputs of labour costs, other costs and facility floor area (a proxy for size).

In the second stage, a multivariate (Tobit) regression analysis was performed on the adjusted technical inefficiency scores from the DEA calculations to investigate the importance of a number of environmental and inefficiency factors that may have influenced the performance of residential aged care facilities. Most factors were not found to be statistically significant and, reflecting this, much of the variation in technical efficiency could not be explained. This suggests that other factors beyond the scope of the analysis influence the performance of facilities.

Source: CEPA (2003).

The feasibility of realising these improvements is constrained, at least in the short to medium term, by fixed capital and policy settings which limit the scope for restructuring to secure least cost outcomes. Further, choices made by governments as to the level and quality of service delivered to satisfy equity and social objectives impact on the costs of delivery and often involve a trade-off between cost and outcomes.

An array of factors influence the productivity performance of residential aged care providers including:

- location — state and remoteness (capital city, other metropolitan, rural, remote)
- ownership status
- quality of care
- chain membership
- proportion of complex and special needs clients within a facility's case mix (Indigenous, culturally and linguistically diverse, respite, concessional).

In all, the CEPA study tested the importance of a wide range of environmental and inefficiency factors in explaining differences in technical efficiency across the sample. Although several factors were found to be likely determinants of efficiency, most (84 per cent) of the variation in their preferred model was caused by unknown factors. Further, of those factors that were found to be significant, many are beyond the control of individual operators, for example, the location of facilities. Despite the obvious modelling limitations, the results of the preferred model suggested that, on average:

- The location of aged care facilities can affect their relative efficiency. Although some states may not be significantly different from others, variations in observed efficiency may reflect differences in input prices or other characteristics (for example, the lower average efficiency score of Victorian facilities may reflect the larger number of government services in that State).
- Remote residential aged care facilities were found to be less efficient (but not statistically so) compared to providers in other locations, in part due to the increased costs of employing labour (especially skilled labour).
- For-profit facilities were found to be more efficient than not-for-profit facilities and substantially more efficient than government facilities. This is consistent with international studies (box 7.3). These results may reflect the stronger incentive mechanism associated with a commercial operation. However, the study also found that for-profit providers were less likely to operate rural and remote services where lower efficiency scores were typically observed. Further,

for-profit facilities may select less complex clients in an operating environment where demand is high.

- Quality factors, as proxied by certification scores, were found to significantly affect efficiency in the provision of residential aged care. Indeed, facilities with certification scores above the minimum proscribed standard were found, in general, to register lower efficiency scores, reflecting the higher costs of providing a higher standard of care.
- There appeared to be little difference in the average efficiency scores between providers operating more than one facility (that is, chain providers) and independent providers. This result is possibly affected by the existence of quasi-chains operating in the not-for-profit sector, such as religious or charitable affiliates, where members are effectively part of a broader organisational group or entity but act like individual operators and are not, therefore, able to capture the benefits of economies of scale or scope. International studies indicate that chain providers generally have higher average efficiency scores (box 7.3).
- Facilities catering for complex and special needs groups were found to register lower notional levels of efficiency. For example, Indigenous and culturally and linguistically diverse clients appear, on average, to require more inputs, reflecting their higher servicing requirements. Facilities accommodating a higher proportion of respite patients were found to be less efficient, reflecting the greater administrative burden associated with admission and discharge procedures. However, facilities with a higher proportion of concessional residents were found to register higher notional efficiency scores possibly reflecting the benefits of providing a largely standardised service to these clients.

The study also estimated that costs could be reduced by up to a further 7 per cent, or \$470 million in 2002-03, through structural adjustment to improve the scale efficiency of the sector (CEPA 2003). However, these additional gains may be overstated. For example, it is likely that smaller facilities (those with less than 30 beds) are heavily represented in rural and remote areas where larger facilities are not practical and occupancy rates are often lower than in more densely populated locations.

Due to limitations in the range of data available, the CEPA study was unable to address broader policy questions, such as the extent to which different management practices impact on the efficiency of aged care facilities or the degree to which identified inefficiencies were caused by regulatory settings as distinct from variations in the quality of management.

Box 7.3 International efficiency studies of residential aged care

Several international studies have examined the efficiency of residential aged care facilities. In examining the results of these studies and their implications for Australia, it is important to recognise inter country differences in the structure of aged care services as well as in their corresponding regulatory frameworks.

A study of long-term care units in Finland found average technical and scale efficiencies of 0.85 and 0.92 respectively using data collected in 1995 (Bjorkgren et al. 2001). However, the study's sample size was relatively small and only publicly owned facilities were examined. In addition, quality of care was not controlled for in the analysis.

A study of Dutch nursing homes over the period 1984 to 1993 estimated average technical and scale efficiencies of 0.89 and 0.94 respectively (Eggink and Blank 2000). Nursing homes that provided care solely to physically disabled patients were found to have higher efficiency when compared with homes providing services exclusively to psycho-geriatric patients. Higher notional efficiency scores were also found in homes with a higher proportion of males and high occupation rates.

Various studies of nursing home efficiency in the United States that used DEA have calculated technical efficiencies between 0.66 and 0.89 (CEPA 2003). In general, for-profit nursing homes were found to have higher efficiency scores than not-for-profit providers while increased quality of service provision was found to reduce efficiency scores (see, for example, Nyman and Bricker 1989; Fazel and Nunnikhoven 1992).

A study using data collected in 1996 on Florida nursing homes found that without controlling for quality, for-profit facilities were slightly more efficient than their independent (non-chain) and not-for-profit counterparts. However, chain affiliated facilities scored lower on quality than independents and for-profit facilities scored lower on quality than not-for-profit facilities (Anderson et al. 2003).

Hence, it remains unclear how much of the assessed efficiency gap could be captured by improved management and work practices. Accepting that some of the efficiency gap may have arisen due to differences between operators that are beyond their control (such as a remote area location and the attendant higher costs of operation) some of the gap undoubtedly reflects genuine differences in operator efficiencies.

As noted above, regulation as a source of inefficiency was not examined explicitly by the CEPA study. Importantly, however, as recognised by the Hogan Review (2004), the design and administration of regulation can have a significant effect on the performance of the aged care sector by constraining the flexibility of providers to efficiently allocate resources. For example, the current bed allocation system may restrict capital investment decisions. This could result in sub-optimal sized facilities being constructed. It also constrains competition between providers.

Exploring opportunities for improving the efficiency and effectiveness of existing policy settings and some specific regulations within aged care will assume growing importance in the coming years as the sector and governments respond to the challenge of meeting the growing demands for, and costs of, aged care services.

7.4 Some emerging opportunities for improving productivity

In light of the research undertaken for the Hogan Review (including by CEPA) and the experiences of the health sector (see, for example, PC 2006), there are opportunities for providers to improve their productivity by adopting innovative practices in their operations within the existing regulatory framework. Beyond this, from a forward looking perspective, removing unnecessary regulatory constraints and improving the effectiveness of remaining regulations across the sector offers scope for further productivity improvements (Hogan Review 2004; Ergas 2006).

In examining the opportunities for productivity improvements, however, there is limited research available to indicate their relative size and to whom the benefits would accrue. Quantification of the potential for productivity gains is beyond the scope of this study and is not attempted in the following analysis.

Opportunities for providers to improve their productivity

The earlier analysis of the results of the CEPA study (2003) suggest that significant productivity gains within the current regulatory framework are possible if more providers were to adopt the practices of the better performers. However, in practice, the scope to realise these gains is likely to be circumscribed by factors beyond the control of individual operators (section 7.3). Further, some industry representatives and providers maintain that the scope to achieve productivity gains by making changes within their operations has already largely been exhausted (see box 7.6).

But the industry, and therefore the productivity frontier, is dynamic. Industry leaders continue to innovate, thereby creating new best practice benchmarks. This affords further opportunities for other providers to extract productivity gains from adopting these practices in an environment of continual improvement.

Insights from some providers and industry representatives are drawn on to give illustrative examples of ‘best practice’.

Information technology

Greater use of information technologies can contribute to productivity gains in a number of ways. They enable more efficient data capture, storage and shared access and can augment productivity gains arising from greater use of some assistive technologies.

Digitally recording clinical assessments and other data at the bedside and transferring them using broadband and wireless technology can facilitate clear and concise communication between staff. For example:

IBIS Care has introduced a fully computerised management system into all of its facilities ... focussed on care/clinical management with all assessment, care planning and evaluation carried out on computers ... The introduction of this system has:

- Reduced significantly documentation and paperwork at all staff levels
- Increased the capacity of our care staff to provide more care and services to residents
- Reduced administration of reporting systems and collection of data — for example, Head Office (HO) has access to each of the facilities systems and if a problem is identified such as a resident complaint or significant event, HO staff can easily access the records to provide advice and assistance to facility staff and management rather than wait for the information to be collated and faxed, etc. (IBIS Care 2007, p. 5)

Further, wider use of these systems could reduce the likelihood of duplicate records and mistakes caused by transcribing information (DoHA 2005a).

Adopting compatible information technology platforms that better integrate health and aged care settings may also lead to productivity improvements. For example, such integration could reduce the incidence of medication and other errors that occur when clients are transferred between aged care facilities and health care providers such as hospitals and general practitioners (DoHA 2005d).

There are also opportunities to more efficiently organise and schedule community care services. For example, some providers are now employing geographic information systems to reduce service scheduling and transport costs. Initial applications of these systems to community care indicate that these costs may be reduced by over a third (Howie 2008). Use of these systems can increase productivity directly and also generate indirect benefits through reduced management and administration costs, reduced staff turnover and improved client satisfaction.

It needs to be recognised, however, that it may prove difficult for some providers to upgrade their systems in line with advances in best practice. In particular, the cost and time associated with purchasing and installing the software and hardware, and

subsequent staff training may diminish the net benefits from implementing information technology solutions. In this context, Holy Family Services (2007, p. 3) note they:

... have looked at the options available ... to utilise IT advances in managing communications, resident records and regulatory obligations. At this point, given the extremely high costs for software and hardware required and few clear benefits, we have taken the matter no further. It remains under review and consideration as we expand our organisation and mix of services.

Assistive technologies

Assistive technologies can contribute to productivity growth by reducing the care burden on formal and informal care givers. These technologies encompass devices, systems or designs that allow individuals (both carers and clients) to perform tasks that they would otherwise be unable to do, or increase the ease and safety with which tasks may be performed (ILCA nd). As noted by Catholic Health Australia (CHA 2007a, p. 3), ‘advances in assistive technologies will increasingly be used in home care and to some extent residential care as the workforce shortage grows’.

Assistive technologies can enhance client independence, thereby reducing the level of care required and raising staff productivity. For example, the use of portable aids (such as canes, walkers and lifting devices), structural modifications (such as grab bars and ramps) and other devices (such as medication reminders and dispensers, emergency call devices and global positioning system bracelets — box 7.4) may reduce the amount of supervision needed in both community and residential care settings. Even simple assistive technologies, such as Velcro closures on clothing or leveraged jar openers, have the potential to increase the functional independence of older persons (Elliot 1992). These technologies may create opportunities for improving labour productivity and/or service quality through enhanced scope for contact between staff and clients covering, for example, social activities.

In conjunction with information technology networks, more sophisticated monitoring and scheduling systems can allow staff to spend more time with clients and increase the quality of care provided (ACSA 2007c). For example, centralised networks can monitor client movements and activities remotely and allow routine tasks, such as controlling air conditioning, lighting and opening and closing doors, to be performed more efficiently. An analysis of the application of wireless technologies in a Canadian long-term care facility estimated that staff productivity gains of up to 25 per cent could be achieved by using small pendants, equipment tags and location monitoring sensors to quickly locate equipment and identify staff and residents (Klassen 2008). As a result, more time would be available to focus on client care.

Box 7.4 Examples of assistive technology for the aged

Assistive technologies encompass a wide variety of types and applications. They have the potential to improve provider productivity either directly or through improving client independence and include:

- Medication dispensers — automatically provides access to the correct medication by using visual and audible alerts to the user when required. An alert is raised with a monitoring centre or carer if the medication is not taken.
- Personal monitoring devices such as bracelets, emergency call buttons and sensors. These devices allow client monitoring from a remote location while still permitting an immediate response in the case of an emergency. Global positioning system bracelets are especially useful for monitoring clients who tend to wander or stray, such as those with dementia.
- Intelligent keyless entry — when a client leaves their house or room, a swipe of their finger can turn off all lights, lock the doors, close the blinds and turn off the air conditioning. Upon returning, a finger swipe will turn all devices back on.

Source: Soar and Croll (2007).

Employing assistive technologies can also reduce physical injury among formal and informal care workers. As discussed in chapter 6, staff injury can arise from regularly moving clients in aged care settings. The installation and proper use of lifting devices throughout community and residential settings could reduce the number and duration of worker compensation claims. Of course, the benefits of reducing the likelihood of physical injuries arising from caring activities also extends to informal carers in home settings.

Work practices

As noted to in chapter 6, opportunities for productivity growth may arise through creating more flexible work practices and a supportive workplace.

Over the past decade, collective and individual employment agreements (including enterprise bargaining agreements (EBAs)) have enabled greater flexibility in service delivery that was not possible under the traditional award structure (box 7.5). Although the extent of these efficiency gains is not easily measured, some providers indicate gains in operational efficiencies in areas such as staff deployment. For example, Mercy Aged Care (2007, p. 2) maintains:

Whilst EBAs have enabled improvements to cost structures and service quality, the main improvements have been in relation to flexibility of service delivery. Awards are extremely prescriptive of staffing duties and mirror outdated task orientated practices.

To meet increasing demand for higher quality and flexibility, EBAs allow providers to design the workforce to meet services requirements.

In some instances, these efficiency gains have been used to provide more competitive wages than would otherwise have been possible. This has improved the capacity of these providers to retain valuable employees and lessened staff turnover.

Improved support services for employees may also generate further improvements in operational efficiency. Examples of such initiatives include child minding, flexible meal breaks that provide opportunities to attend to family responsibilities and offering casual relief work to employees on long term unpaid leave (Office of Industrial Relations NSW 2004). Enhanced flexibility of this nature can reduce the need to employ agency staff and lessen staff turnover and absenteeism, resulting in cost savings and improvements in the continuity of care.

Box 7.5 Flexible work practices introduced through innovative workplace agreements

The introduction of innovative workplace agreements has enabled some aged care providers to use workers more effectively by introducing greater flexibility into their operations.

TriCare, for example, has implemented a single (Union certified) collective agreement covering all levels of staff. Improvements in productivity have been achieved by:

- the abolition of demarcations — staff may now undertake any duty for which they have been properly trained
- the replacement of a seniority based career structure with a competency based structure
- the development of some aged care specific competencies
- easier access to additional hours and duties for permanent staff
- organisational funding for external training courses in exchange for guaranteed periods of service
- financial recognition of cross training in other areas.

That said, TriCare is of the view that the scope for further productivity gains through new workplace agreements is limited.

Source: TriCare (2007).

Restructuring activities

Aged care providers may realise productivity growth by restructuring their activities in various ways, such as increasing the scale of their operations, outsourcing auxiliary services and/or adjusting the mix of capital and labour to reflect changes in relative prices.

In some instances, residential providers may be able to achieve greater scale economies by increasing the number of facilities they own or manage, streamlining administrative activities and extending their purchasing power.

A recent analysis of the residential care sector noted that there is evidence of some consolidation occurring among providers although ownership is still thinly spread. This consolidation is taking a variety of forms including rationalisation of smaller units among religious groups and the creation of larger operating units through acquisitions (Grant Thornton 2007).

However, increasing the scale of operations may not always be feasible for smaller facilities that are not attractive merger targets or for providers operating in remote areas. To assist single facility providers, the Hogan Review (2004) advocated the formation of cooperatives to secure gains in managerial accounting, technological and educational arrangements not available to any one entity acting alone. In response to industry demand, ACAA established Aged Care Efficiency Services to assist providers by offering a service to reduce facility operating costs by acting collectively and exerting purchasing power. This initiative has achieved savings of over 20 per cent in areas such as telephony, office stationary, energy and food products (ACES nd).

By reducing the risks associated with their activities, some providers have been able to lower the costs of insurance and improve productivity as a result. For example, TriCare (2007, p 10):

... acquired from Q-comp a self-insurance licence enabling the company to internally manage its workers compensation claims and it is self insured through Aged Care Employers Self-Insurance Group. The result is that TriCare has comprehensive risk management standards, employee orientation processes aligned with those standards, policies and procedures for self insurance and an emphasis on workplace health and safety. TriCare has secured sufficient savings in premium outlays while reducing injury rates in conjunction with a focus on good practice, process and training.

There may also be scope to outsource some auxiliary activities to improve the productivity of aged care facilities (such as administration, food preparation and laundry services). Employing contractors for various tasks has, for some, generated greater cost efficiencies than providing these services 'in-house'.

Opportunities to realise productivity gains through regulatory reform

Further opportunities for productivity improvement could be secured through changes to the regulatory regime directed at improving its overall effectiveness. Regulation of the aged care sector exists to satisfy certain social and economic objectives, such as the provision of quality services, equity of access and management of the government's fiscal exposure. Hence, the case for regulatory reform needs to consider the effectiveness of the existing regulatory regime in addressing these objectives and the scope for changes to this regime to secure more cost effective outcomes.

Industry representatives, providers and analysts maintain that a number of regulations constrain the ability of the sector to effectively and efficiently respond to changes in the demand for aged care services (box 7.6). In particular, they maintain that the current regulatory regime weakens incentives for providers to invest in ways that could potentially enhance their productivity.

Box 7.6 **Some views on the scope to improve productivity through regulatory reform**

Aged Care Association of Australia:

The aged care industry is one of the most heavily regulated segments of the Australian economy. Whilst recognising the need to protect the most frail persons in our society, ACAA believes that it is counter productive to pursue excessive regulation and compliance at the expense of efficient administration and service quality delivery. (ACAA 2007b, p. 5)

Holy Family Services:

Aged care remains the most regulated and monitored of the whole of health care. All this compliance costs substantial time and money. (Holy Family Services 2007, p. 4)

TriCare:

The current width and breadth of regulation of the sector as identified in the Hogan Report remains unchanged in 2007. Consequently, the opportunity to improve both efficiency and cost effectiveness remains severely limited. TriCare sees no significant opportunities over the next 10–15 years unless there is fundamental reform of the regulatory regime, particularly in the following areas of bed allocation, extra service quotas, high care capital funding mechanisms and care funding. (TriCare 2007, p. 13)

Professor Warren Hogan:

Regulation serves to shield providers from the competition which would induce greater efficiencies and improved quality of service ... What is being witnessed in this major service sector activity is a playing out of the familiar competition versus protection scenario witnessed in Australia's international trade two decades ago. And this prevails while national competition policies are supposedly in place to ensure competitive outcomes which will secure gains in efficiency and quality. (Hogan 2007, pp. 6–7)

Analyses by various industry bodies together with the Commission's analysis in chapter 4, indicate that poorly designed regulations constrain the capacity of the sector to operate efficiently and undertake appropriate investments. Some key areas include:

- the supply of aged care services
- excessive building certification
- inconsistency in accommodation bonds across service types
- contract management in community care
- the subsidy mechanism for residential care.

Supply

As outlined in chapter 4, regulations restricting the supply of aged care services reduce efficiency within the market for these services. There are two 'gatekeeper' mechanisms in aged care — a planning/allocation system and an aged care assessment process. The former determines the number, location and allocation of aged care places. In addition, the eligibility of individuals to access aged care services is dependent on the evaluation of an ACAT. Inefficiency arises where these mechanisms do not work in concert to deliver appropriate care, such as where clients meet the assessment requirements but are unable to access services.

The planning and allocation system effectively lessens competition between providers, thereby reducing incentives for cost consciousness, efficiency improvement and innovation in service delivery. Relaxing this barrier to entry would create more competition in the market for aged care services. Beyond this, restrictions over the quantity and type of extra service places impose additional constraints on the capacity of residential service providers to accommodate client preferences. Any concerns about the quality and safety of care within a more competitive environment could be addressed through existing quality assurance mechanisms. Similarly, the current ACAT process provides a mechanism to control the extent of government funding for aged care services.

In addition, the current planning and allocation system for community and residential care places constrains the capacity of providers to undertake investments that are responsive to demand. In this context, TriCare (2007, p. 14) contends:

The current system of annual bed allocation results in a lag in new construction to meet the growth in demand. The uncertainty of securing additional beds means that providers cannot secure land for expansion based on the normal commercial or business planning basis as would be the case with other businesses operating in regulated markets. Where a provider acquires land, the holding costs may extend over years while successive annual applications fail.

The operation of gate-keeping arrangements needs to be improved so that providers can respond promptly and flexibly to changes in client needs and developments in the industry, such as the growth of retirement villages with assisted living arrangements.

Building certification

Building certification was introduced as part of the 1997 reform package to improve the physical standards of aged care facilities.

The Banks Review (2006) highlighted that the Australian Government certification arrangements largely duplicate the Building Code of Australia standards administered by the States and Territories. While the Australian Government maintains that its certification standards address issues of poor building stock within the industry, there are only two criteria — privacy and space requirements — that are not covered by the Building Code of Australia. These criteria could be mandated separately, thereby reducing the costs of duplicating the certification standards.

Aged and Community Services Australia (ACSA 2008) has estimated that removing the unnecessary duplicative aspects of the building certification requirements would save the Australian Government around \$350 000 per year and allow providers to improve the quality of care they provide and/or reduce costs.

Accommodation bonds

As noted in chapter 4, regulations surrounding the levying and retention of accommodation bonds for different types of aged care services currently distort capital investment decisions within the industry.

The disparity between who can and cannot be charged accommodation bonds is resulting in inefficient capital investment outcomes. Providers may request accommodation bonds from low care but not high care clients, unless they are extra service clients. This differential in access to bonds creates perverse incentives for aged care providers to preferentially invest in developing low care places relative to standard high care places. As a result, aged care providers have told the Australian Government that ‘without sweeping changes, the nursing homes we need to cater for an ageing population will not be built’ (Mundy and Young 2008, p. 1).

In addition, current bond retention arrangements inhibit the efficient provision of residential aged care services. The amount of the bond that may be retained to cover the costs of maintaining existing and constructing new facilities has only been adjusted to reflect changes in the consumer price index since the introduction of the

Aged Care Act 1997. But construction costs have risen faster than the consumer price index over this period. Further, new certification standards have meant that some existing facilities have required major renovations to comply. This has the result of lessening incentives to provide new facilities and thereby reduces the long term capacity of the system to absorb the expected increase in demand for services.

Contract management

Providers of community care can offer a variety of services to clients under various programs including formal packaged care (CACPs, EACH and EACHD) as well as HACC, NRCP and other community care services.

Administrative inefficiencies arise as the allocation and funding of community care contracts occurs on a program rather than client package basis. As a result of differing reporting and evaluation requirements across programs, there is no consistent approach for managing program contracts even where similar programs are administered by the same agency. In this context, BlueCare (2007, p. 9) contends:

The fragmented structure of the community aged care system creates a heavy administrative burden for service providers that manage diverse client groups across multiple programs. High administrative costs divert dollars from care service delivery.

Similarly, Aged and Community Services SA & NT (ACS SA & NT 2006, p. 1) highlights:

There is a growing array of largely compatible community care programs with separate reporting arrangements and different eligibility rules. Often the same organisation provides a mix of community care programs and must complete multiple sets of essentially similar information. These different requirements are inhibiting the provision of quality care to individuals whilst replicating overhead costs.

There would appear to be opportunities for reducing the current costs of providing these services by adopting a consistent contractual management framework for administering different aged care services and programs.

The subsidy mechanism for residential care

The Australian Government subsidy for residential aged care services is set having regard to the care needs of each resident. Between 1997 and 2008, the basic subsidy per resident was set according to an eight category RCS.

The RCS and accompanying regulations were seen as unduly complex with a high associated compliance burden for providers. Indeed, research found that residential

care staff spent, on average, 9 per cent of their time on classification scale documentation and registered nurses up to 16 per cent of their time (ACSA 2003a).

In response to industry concerns, a review of the RCS was set up in 2003. The review (DoHA 2003a, p. 6) found that:

... the current RCS system does not work as intended and needs to be modified... It is our view that any minor evolution of the existing system will not overcome the fundamental difficulties associated with the RCS approach (ie linkage between assessment and funding aspects).

This view was supported by the Hogan Review (2004) which recommended that the RCS be replaced with a simplified three category scale covering low, medium and high care.

In response, the Australian Government introduced a new aged care funding instrument (ACFI) on 20 March 2008. The ACFI is designed to:

- better match funding to the complex care needs of residents
- reduce the documentation required from aged care providers to justify funding
- achieve higher levels of agreement between aged care staff and departmental review officers in review audits (DoHA 2007a).

Although it is generally accepted that the ACFI will reduce the administrative burden on aged care providers, other aspects of the new instrument have caused concern within the industry. For example, just before the introduction of the ACFI, Catholic Health Australia (CHA 2008, p. 3) claimed:

Member studies that have compared the funding presently received under the Resident Classification Scheme with that which is likely to be achieved under the ACFI indicate that one third of facilities would be financially worse off and that up to ten per cent more residents would be assessed as needing High care, thus seriously impacting on the Accommodation Bond earning capacity of the sector.

Reflecting concerns within the industry about the new funding instrument, a reference group has been set up to consult with providers and consumers on all aspects of its implementation. In addition, a review of the instrument has been scheduled for 18 months after its implementation (Elliot 2008b).

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 care packages & packages	Total aged
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			Operational ^a	Total operational as % of total residential
	High care	Low care	Total		
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 000¹
- 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:

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- 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 sufferers

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).

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