

Inquiry into Caring for Older Australians
Productivity Commission
GPO BOX 1428, Canberra ACT 2601
Email: agedcare@pc.gov.au

Submission to the PC's Inquiry into Caring for Older Australians

Dear Commissioners,

Response to the DRAFT REPORT 'Caring for Older Australians' January 2011

I join with many others from the aged care industry, consumers and academic research community to commend the Productivity Commission on the production of the Draft Report 'Caring for Older Australians'. The scope and breadth of the study is impressive and the solutions proposed to a set of difficult problems are likely to shape provision for many years to come.

I welcome the opportunity provided by your invitation to respond to a number of the proposals. In doing so I should make it clear that I am not speaking on behalf of Macquarie University, my employer, but as a concerned academic researcher making an individual submission. My concern comes as social researcher with strong interest and publication record in developments in aged care over thirty years. Drawing on the research I have undertaken I address four issues in this submission:

1. Problems of the human services market in long-term care;
2. Future funding arrangements;
3. The aged care workforce; and
4. Case management and the coordination of services.

Sincerely,

Michael Fine, PhD

Associate Professor,
Head of Department, Department of Sociology; and
Deputy-Director, Centre for Research on Social Inclusion
Macquarie University
Sydney, 2109, Australia

1. Problems of the human services market in long-term care

The PC's *Draft Report* clearly recommends moving to an open market system of provision that encourages more extensive and open competition between suppliers for the provision of residential and community care. These recommendations and the rationale for this approach are spelt out clearly at a number of points in the report, including in the following statements¹:

'The Commission proposes **the removal of restrictions on the number of community care packages and residential care beds as well as removal of the distinction between high and low care**, with appropriate transitional arrangements to support this reform ... This will improve providers' ability to respond to the needs of users and facilitate greater choice of facilities where care can be provided.' (PC, 2011a: p167)

There is **strong empirical evidence that consumer choice leads to positive wellbeing outcomes ... Competition among providers also leads to a more dynamic system, with incentives for greater efficiency, innovation and quality improvements'** (PC, 2011a: pxxvi).

While I would not argue against enhancing consumer choice in most other contexts or dispute the general benefits of competition, the case made for the benefits of an open competitive market in aged care in the PC's *Draft Report* is not convincing. In particular, the report does not demonstrate a consideration of evidence (as spelt out above) from the field of long-term care.

Long-term care services are not like many simple consumer goods, such as those to be found in the supermarket. Rather, many of the conditions required for consumer choice are not present in the aged care market.

As the *Draft Report* points out (PC, 2011a: p69), consumers (including carers) in this field often lack information or expertise to make informed choice about many of the care options or are likely to be forced to make choices based on inadequate information about preventative or early intervention measures. Their decisions about aged care are typically made at short notice during times of crisis. Further, aged care is not a service people normally want to buy and many may not access support they need. Yet the consequences of not using the care they require constitutes not informed choice but market failure, as there are typically negative impacts on many others. Instead of choosing to use paid home support services (potentially requiring complex financial arrangements including home equity conversion or sale, as outlined in the report), for example, consumers may choose neglect. The beneficial preventative functions of care at home will be lost, and instead lead to increased use of expensive hospital services – at considerably greater cost to the community.

It is clear, too, that if left to the market services are often not provided in some areas, such as rural or remote areas, or in low income locations or to groups who have special needs. There are also many elderly and frail people may be vulnerable to exploitation and need protection.

¹ In each case the **bold text** indicates my emphasis. MF

This is particularly where there is evidence of cognitive impairment, poor self-esteem or social isolation, problems that compound with inadequate access and availability of services (Wallace, 1990). There is considerable evidence of these sorts of problems occurring in Australia prior to the introduction of many of the protections that characterise the current system (Senate, 1985; DCS, 1986).

Other research on the impact of open market competition in long-term care show strong evidence of cherry picking by providers, with some profitable client groups targeted while others ignored, the harmful effects of inappropriate service use, and many problems of over-servicing by service providers. In essence, this seems to be a product of the fact that healthy commercial markets need to expand, and this leads to providers seeking to maximise their income through ways and means that lead to increases in individual and overall system costs. While Australian experience in residential care is important in this field (Parker, 1987), perhaps the most strongly documented cases are from Israel (Schmid, 2001) and the USA, where there is evidence of overservicing combined with poor standards of care and less professional and lower levels of staffing in many of the commercial homes (Davis, 1993; Aaronson et al., 1994; Castle and Shea, 1998; Harrington et al., 2001; Grabowski et al., 2005; Hillmer et al., 2005).

Other research confirms these results. Perhaps the most comprehensive recent study, a meta-analysis of research on the benefits of for-profit homes by Canadian authors, published in the *British Medical Journal* identified over 956 articles judged appropriate for full text review, of which 82 met inclusion criteria. The conclusion was clear:

This systematic review and meta-analysis of the evidence suggests that, on average, not-for-profit nursing homes deliver higher quality care than do for-profit nursing homes. Many factors may, however, influence this relation in the case of individual institutions. (Comondore et al., 2009: 2732)

The evidence is clearly not all bad for for-profit provisions. However there is **no suggestion from research in this field that through competition an open market will lead to improved quality of services or reductions in price.** The evidence is worrying and strongly suggests that market failure is a characteristic of this field.

To call for more evidence of the impact of open market competition in aged care is not to reject the ideas of markets entirely. In particular, there has been considerable experience of the use of the mechanisms of **a managed market** (e.g. contracts, competitive tendering, licensing provisions linked to planning ratios), in recent decades. Sustaining and developing managed market models **appears to be associated with greater levels of success in terms of service quality, access and in control of total cost** (Forder et al., 2004).

History and economics both suggest that in the broad sense, public intervention in the market for aged care is a necessity and not a historic accident or passing fad. It has been a feature of aged care in Australia since the 19th century (Fine and Stevens, 1998), as it has in all other countries of the OECD. While there is no modern country, to my knowledge, that has a system with all the characteristics that completely resemble the one projected in the Draft Report, the USA comes the closest. As the data shown in the

Appendix C of the Draft Report shows, aged care there is not, in any sense, more affordable than in Australia. OECD data presented in Figure C3 demonstrates that the cost of aged care in the USA is almost identical to that of the Australian system, but the total cost does not include provision for community care. Nor is there the universal coverage to which we are accustomed in Australia. Further, there is a shameful and degrading process of asset run downs associated with procedures to access public funding for residential care, and a large segment of the population that is excluded from receiving appropriate care.

As the OECD makes clear, data on the costs of aged care is not comprehensive, limiting the capacity for cross-country comparisons. It is more informative, in this regard, to compare health care expenditures in the USA with those of other OECD countries. Table 1 below, shows health expenditures across a number of comparable countries in 2006. The USA has by far the highest cost, yet there is no evidence to suggest that there are population benefits commensurate with the additional costs. As you would be aware, a very sizeable proportion of the American population (around 40m people in 2006) did not have statutory access to health care services at all. A clear lesson is that competition between providers in this field has not reduced the total cost or ensured coverage for all who need assistance. Indeed, it is difficult not to suspect that the high cost and poor coverage are a consequence of the market based competition.

Table 1. Health Expenditure 2006

Country	Pct of GDP	Public expenditure (Pct of total)
Israel	8.0	56.0
South Africa	8.0	37.7
Japan	8.1	81.3
Finland	8.2	76.0
United Kingdom	8.2	87.3
Slovenia	8.4	72.2
Spain	8.4	71.2
Australia	8.7	67.7
Norway	8.7	83.6
Italy	9.0	77.2
Sweden	9.2	81.7
New Zealand	9.3	77.8
Netherlands	9.4	80.0
Greece	9.5	62.0
Belgium	9.9	72.5
Canada	10.0	70.4
Austria	10.2	75.9
Germany	10.6	76.9
Denmark	10.8	85.9
France	11.0	79.7
USA	15.3	45.8

Source: <http://www.who.int/whosis/whostat/2009/en/index.html>

2. Future funding arrangements

Affordability is one of the key terms of reference for the Productivity Commission's Enquiry and proposals to achieve that receive considerable attention in the report. A key principle, enunciated in the report is that

'Care costs need to be affordable both for people needing care and for taxpayers' (PC, 2011a: p185).

I strongly endorse this principle, but see real problems for older people, families and for politicians with the funding solutions proposed in the report based on liquidation of the freeing up of the housing assets of older consumers of aged care.

The PC's proposals sound fair but would be painful for consumers and families, highly complex and likely to lead to a potentially corrupt situation requiring specialised financial advisors and funds managers. Insofar as the availability of services offer protection to all older people, the proposals are inequitable in that only service users would pay them. Whether they would be capable of implementation by government is also an open question.

It is noted in the report that

'Community concerns about extending accommodation bonds to ordinary high care places have in the past been a major stumbling block to reform in this area. **In 1997, the Government proposed accommodation bonds for high level care but the proposal was quickly backtracked as the baby boomers** (supported by various stakeholder groups) **revolted at the prospect of losing control over their inheritances**. A more substantial concern relates to care recipients having to pay large up-front bonds when they are expected to only need high care for a short period of time (for example, the very frail or those entering residential care for end-of-life care)'. (PC, 2011a: p163)

While it is clear that the proposals would be unfair and unrealistic for the significant number of older people admitted to high care places for a relatively short stay (and this proportion is likely to increase in future years) the attribution of their earlier policy failure is not entirely correct. The extension of accommodation bonds to high care places was not a proposal, but a core provision of the Aged Care Act (1997) introduced on 1 October that year. The provision was initially implemented, but quickly led to deep embarrassment for the government and a rapid back down in face of widespread popular pressure. Despite the tone of the passage ridiculing the revolting 'baby boomers' and various 'stakeholder groups', this popular reaction is indicative of the deep attachment that most older Australians and their family to their home. Home ownership is part of the Australian dream and to confront vulnerable older people, at a deeply emotional time, with the necessity of liquidating their asset is, to my mind, unrealistic. It is also inequitable and inefficient.

The PC's housing equity proposals are, for a large part, built on the assertion in the *Draft Report* that **accommodation costs 'are reasonably predictable expenses of everyday life'** (PC, 2011a: p144). Owner occupied housing, of course receives favourable treatment under the Australian taxation system – and the costs to owner

occupiers are, to a large extent, quite predictable. However this would not be the case for someone forced to pay an accommodation bond, or to those forced to liquidate their home to pay through the other mechanisms proposed in the *Draft Report*. These costs, to the ordinary older people and their family, would be likely to be regarded by those affected as unpredictable, extreme and unfair. Most are not affluent, but income poor means tested recipients of the age pension. One day they are home owners who effectively pay little or nothing for their accommodation. The next, after admission to residential care, they are required to pay very high accommodation costs.

Even if it were possible to implement this proposal, it is difficult to see how it would not be a disincentive to those needing high level residential care. It is likely, in my view, to have the perverse effect of undermining the finance of residential aged care, particularly if those assessed as requiring high levels of care were eligible to remain at home and cash their care entitlements out on care delivered in the home.

A social Insurance Model and Taxation Reform

Yet the problem of funding remains. The Draft Report specifically requests responses concerning the desirability of a National LTC Insurance program (PC, 2011: pxxxvii). The problems of equitable contribution also deserve attention through the taxation system – in particular through the levying of a modest estate duty following death, at the time property and other resources are being passed on through inheritance. Australia is the only advanced economy without such duties. The wisdom of attempting to introduce payments based on housing equity for aged care in their absence is dubious.

A social insurance model, such as that of the National Disability Insurance Scheme (NDIS) proposed in the Productivity Commission's *Disability Care and Support, Draft Inquiry Report (PC, 2011b)*, could be extremely successful as a form of user pays instrument that helps fund an expansion of services. It does so by spreading the risk amongst all potential users. The costs would not fall simply on the unfortunate enough to require assistance, but on all people who contribute.

I have canvassed this approach extensively elsewhere (Fine and Chalmers, 1998; Fine and Chalmers, 2000), as have a number of other researchers cited in the report. Rather than repeat the evidence and argument set out there I seek here to simply add my support to the proposal for the instruction and development of the NDIS.

The existing proposal for the NDIS is targeted at those aged up to 64, only. It seems clear that an eligible recipient of support who turns 65 would no longer be eligible for support under the current proposal. If, instead, there were to be a combined disability and long-term-care insurance program, there would be both a sizeable constituency for its introduction and the problem of discontinuity would not exist. There are strong lessons that can be learned from the existing schemes in the Netherlands, Israel and Germany that would help ensure the insurance program was effective. One of these is that aged care funding should not be simply limited to the insurance funds. Rather, like the existing Medicare levy, contributions should become part, but not all, of the funding mix. Co-contributions could be a further component, as could payment from general revenue.

It is the success of the Japanese scheme that is perhaps most pertinent for considering the likely success of the introduction of a social insurance scheme. By making contributions compulsory only for those aged over 40 or 45, as is the case in Japan, contributions would not have a negative impact on younger workers needing finance to establish homes and families. Instead, as one approaches retirement age, there is much common sense about paying a modest additional levy on incomes that exceed an approved threshold. It is also a contribution that can continue past retirement age, as self-funded retirees and part-pension recipients alike would see the logic and self interest in continuing their contribution – as is currently the case for private health insurance contributions.

3. The aged care workforce

The *Draft Report* makes the case well – we do not yet have a crisis of staff in Australian aged care, but the demands for a larger workforce in future are significant and the future recruitment task is daunting. As well as searching for ways of improving conditions for those in employment, as the *Draft Report* recommends, we need to search for approaches that will attract and retain new recruits to the workforce.

A solution promoted by a number of those who have made submissions is to turn to increased numbers of migrants as way of getting around what is understood as the demographic trap of declining numbers of citizen residents of working age in relation to the projected increase in the numbers of older recipients of age care services. A number of submissions, I note, have recommended extending short term visas to overseas staff willing to work in this field.

It would be foolish to oppose the recruitment of migrants to aged care. The analysis of data from the National Institute of Labour Studies shows that already there are considerable numbers and proportions of migrants working in aged care – in approximately the same proportion as in the general workforce (Fine and Mitchell, 2007; Martin and King, 2008). Existing numbers are not evenly distributed – with strong evidence of concentrations of staff from migrant backgrounds in urban areas, and much lower proportions in regional remote areas. In regional and remote areas it is only in the higher status positions (such as geriatrician) that we find a high proportion of overseas born aged care staff (Fine and Mitchell, 2007; Howe, 2009). There is some evidence that short term visas (457 visas) have been used in Australia, but their operation has been troubling and their importance to date has been marginal. European and North American evidence suggests that turning to short term visa holders would not be productive (Stone and Wiener, 2001; Harris-Kojetin et al., 2004; Chaguturu and Vallabhaneni, 2005; Ungerson and Yeandle, 2006). For this reason there is reason to be cautious about the adoption of cash for care or as the *Draft Report* terms them ‘consumer-directed-care’ (CDC) programs, as these programs have been closely associated with exploitative and risky private employment practices away from the clear light of public regulation.

The profile of the aged care workforce, however, suggests that at present it is almost entirely feminine and largely part-time and casual. A key feature in all research is the increasing difficulty in attracting and retaining sufficient registered nursing staff.

A new vocational direction: the personal assistant/ fitness coach approach to long-term care

As well as developing pay and conditions, what is needed is a new approach that develops a direction in aged care that departs from the traditional emphasis on nursing as the keystone occupation. The shift towards increasing care in the home and the adoption of restorative and enabling approaches to care open up new possibilities that will enable us to target increasing numbers of males as well as more younger (first career step) and more older (career change) workers.

The sort of approach that should be encouraged will require recognition of the new directions in aged care. These require staff who are more socially oriented and more consultative and expert in communication, than has been the case for staff forced into the health care mould. Staff development should also be designed to enable an increasing emphasis on fitness and health maintenance. Think fitness trainer and coach, personal assistant not nursing assistant. Professional development that includes training in counselling and listening skills, in social engagement as well as in health care (especially physiology and anatomy) is needed, in a progression that enable career development from Certificate through Graduate Diplomas, Bachelors Degrees and Postgraduate Training. Such an approach to vocational development would enable nursing staff to assume a more professional, consultative role, comparable to that of General Practitioners in the Medical sphere.

Research we have been conducting as part of the *NSW Case Management Collaboration* with care managers in New South Wales (Simpson-Young and Fine, 2010) has shown that there has been significant recruitment to this new occupation from non-health fields in recent years. There are significant numbers of staff with backgrounds in welfare, undergraduate teaching, arts and social science programs, working alongside and at times taking responsibility for supervising and managing staff from more traditional nursing backgrounds, as can be seen from Table 2. Those with a welfare or generalist background predominate amongst the younger care managers. An extension of this sort of approach to develop a new workforce profile in aged care will help both revitalise the culture of care services and ensure that the recruitment pool of potential staff increases beyond the current, at times rather narrow focus it has assumed.

Table 2. Case manager occupational background (health; welfare/generalist) by age (NSW 2009)

Case manager age	Health (percent)	Welfare or generalist (percent)	Missing (percent)
<=30 (n=55)	27.3	69.1	3.6
31-45 (n=149)	44.3	40.3	15.4
46-55 (n=181)	51.4	33.7	14.9
56-65 (n=53)	43.4	45.3	11.3

Source: Simpson-Young and Fine, 2010: 23

4. Care Management and the Coordination of Services.

Finally, the *Draft Report* emphasises the need for increased coordination of aged care and at numerous points highlights the existing and potential contribution of case managed based service provision.

The *NSW Case Management Collaboration*, which links the a number of the leading care provider organisations concerned with care coordination² and Macquarie University, has undertaken research into care management and care packaging in New South Wales. The research to date (Fine and Prosser, 2009; Simpson-Young and Fine, 2010) supports the contribution of care management and care packaging services and has documented their capacity to adjust flexibly to a wide range of different programs to coordinate in a single personalised program of services what otherwise would be a series of disconnected, fragmented and specialised forms of assistance.

It is clear, however, that there will need to be continuing development and extension of care managed services as aged care develops – particularly as increasing use is made of short-term restorative interventions and as care payments, in the form of consumer directed care, become more important.

The development of consumer directed care in the USA was based on case management and it is clear that the success or failure of case managers have continued to be the reasons for the variable success of CDC programs there (Stone, 2000). Similarly in Europe where research has shown problems with the financial abuse associated with a number of cash payment services, it is clear that the outstanding program has been the Dutch program for personal budgets (PGBs or *persoongebonden budget*) (Pijl and Ramakers, 2006). A key feature of the program in the Netherlands has been the extensive use of case managers along with the requirement for formalised accounting and authorised formal payments for all purchases, including wages to assistants.

It is clear that in any proposal for development of aged care services that there will need to be an emphasis placed on the need for better coordination. This seems in part to be a response to the fragmenting impacts of competition, efficiency and specialisation. Yet many of the obvious attempts to enhance system effectiveness by improving service coordination have floundered because of poorly planned care management processes. The National Care Coordination Trials that concluded in 2000 are but one well known example of such shortcomings (Fine, 2001).

Given the transactions costs involved in care management as well as the potential of this form of management to enhance care outcomes, it is important that further research and evaluation be undertaken with the introduction of trial and innovative programs. It would be foolish to believe that requiring services to be coordinated will, of itself, deliver the outcomes that are desired.

² In 2009-10 the partnership included industry partners Community Care (Northern Beaches) Inc., NSW Community Options Projects Inc., Aged & Community Services Association (NSW & ACT) and NSW Department of Health, in collaboration with academic partner, Macquarie University's Centre for Research on Social Inclusion. KinCare and the Benevolent Society have joined the collaboration in 2011.

References

- Aaronson, W. W., J. Zinn and M. Rosko (1994), 'Do for-profit and not-for-profit nursing homes behave differently?' *The Gerontologist*, 34(6): 775-86
- Castle, N. and D. Shea (1998), 'The effects of for-profit and not-for-profit facility status on the quality of care for nursing home residents with mental illnesses' *Research on Aging*, 20(2): 246-263
- Chaguturu, S. and S. Vallabhaneni (2005), 'Aiding and Abetting -- Nursing Crises at Home and Abroad' *N Engl J Med*, 353(17): 1761-1763 <http://content.nejm.org>
- Comondore, V. R., P. Devereaux, Q. Zhou, et al. (2009), 'Quality of care in for-profit and not-for-profit nursing homes: systematic review and meta-analysis' *BMJ* 339:b2732 <http://www.bmj.com/content/339/bmj.b2732.full.pdf> downloaded 20 Feb 2011
- Davis, M. (1993), 'Nursing home ownership revisited: Market, cost and quality relationships' *Medical Care*, 31(11): 1062-68
- DCS (1986), *Nursing Homes and Hostels Review.*, Department of Community Services (DCS) Australian Government Publishing Service, Canberra.
- Fine, M. (2001), 'The Australian Coordinated Care Trials: A Review of the Diagnosis, Prescription and Treatment Regimes', in M. Fine, D. Perkins, A. Owen and M. Warner (Ed) *Coordinated Care on Trial. Background to the Emergence of the National Coordination Agenda in Health Care*, School of Health Services Management, Univeristy of New South Wales, Australian Studies in Health Service Administration No. 90, Sydney: 1-16.
- Fine, M. and J. Chalmers (1998), *The application of user pays principles to government programs for older Australians: the case of aged care*, NSW Committee on Ageing, Ageing and Disability Department, Sydney
- Fine, M. and J. Chalmers (2000), "User Pays and Other Approaches to the Funding of Long-Term Care for Older People in Australia" *Ageing and Society*, 20(1): 5-32
- Fine, M. and A. Mitchell (2007), 'Immigration and the aged care workforce in Australia: Meeting the deficit' *Australasian Journal on Ageing*, 26(4): 157-161
- Fine, M. and J. Stevens (1998), 'From inmates to consumers: developments in Australian aged care since white settlement', in B. Jeawoddy and C. Saw (Ed) *Successful Aging. Perspectives on Health and Social Construction*, Mosby, Sydney: 39-92.
- Fine, M. D. and E. Prosser (2009), 'A Human Service Revolution: Community Options and the Home and Community Care Program', in E. Moore (Ed) *Case Management and Community Practice*, , Oxford University Press, Melbourne.
- Forder, J., M. Knapp, B. Hardy, et al. (2004), 'Prices, contracts and motivations: Institutional arrangements in domicilliary care' *Policy and Politics*, 32(2): 207-222
- Grabowski, D. C., K. A. Aschbrenner, V. F. Rome and S. J. Bartels (2005), 'Quality of Mental Health Care for Nursing Home Residents: A Literature Review' *Medical Care Research and Review*, 67(6): 627-656
- Harrington, C., S. Woolhandler, J. Mullan, et al. (2001), 'Does investor ownership of nursing homes compromise the quality of care?' *American Journal of Public Health*, 91(9): 1452-55
- Harris-Kojetin, L., D. Lipson, J. Fielding, et al. (2004), *Recent Findings on Frontline Long-Term Care Workers: A Research Synthesis 1999-2003*, <http://aspe.hhs.gov/daltcp/reports/insight.htm> downloaded 4 June 2010
- Hillmer, M. P., W. P. Wodchis, S. S. Gill, et al. (2005), 'Nursing Home Profit Status and Quality of Care: Is There Any Evidence of an Association?' *Medical Care Research and Review*, 62(2): 139-166
- Howe, A. L. (2009), 'Migrant Care Workers or Migrants Working in Long-Term Care? A Review of Australian Experience' *Journal of Aging and Social Policy*, 21: 374-392
- Martin, B. and D. King (2008), *Who cares for older Australians? A picture of the residential and community based aged care workforce, 2007*, Department of Health and Ageing, Canberra, and the National Insitute of Labour Studies, Adelaide, Canberra.
- Parker, R. A. (1987), *The Elderly and Residential Care. Australian Lessons for Britain*, Gower, Aldershot
- PC (2011b), *Disability Care and Support, Draft Inquiry Report*, Productivity Commission, Canberra. <http://www.pc.gov.au/projects/inquiry/disability-support/draft> downloaded 4 March 2011
- Pijl, M. and C. Ramakers (2006), 'Contracting One's Family Members: The Dutch Care Allowance', in C. Ungerson and S. Yeandle (Ed) *Cash for Care in Developed Welfare States*, Palgrave MacMillan, Houndmills: 81-103.
- Schmid, H. (2001), 'Nonprofit organizations and for profit organizations providing home care services for the Israeli frail elderly: a comparative analysis' *International Journal of Public Administration*, 24(11): 1233-65
- Senate (1985), *Private Nursing Homes in Australia: their Conduct, Administration and Ownership*, Senate Select Committee on Private Hospitals and Nursing Homes, AGPS, Canberra

- Simpson-Young, V. and M. Fine (2010), *Case Management in Community Aged Care: Mapping the Landscape in NSW*, Centre for Research on Social Inclusion, Macquarie University,
<http://www.crsi.mq.edu.au/publications/reports.jsp>
- Stone, R. I., (Ed) (2000), *Special Edition - Consumer Direction in Long-Term Care*. *Generations* xxiv (111): 1-99
- Stone, R. I. and J. M. Wiener (2001), *Who Will Care For Us? Addressing the Long-Term Care Workforce Crisis*, The Urban Institute and the American Association of Homes and Services for the Aging, Washington.
http://www.urban.org/UploadedPDF/Who_will_Care_for_Us.pdf downloaded 10/9/2006
- Ungerson, C. and S. Yeandle, (Eds) (2006), *Cash for Care in Developed Welfare States*. Palgrave MacMillan, Houndmills
- Wallace, S. P. (1990), 'The no-care zone: availability, accessibility, and acceptability in community-based long-term care' *The Gerontologist*, 30(2): 254-61