Royal Commission
into Aged Care Quality and Safety

AUSTRALIA'S AGED CARE SYSTEM: ASSESSING THE VIEWS AND PREFERENCES OF THE GENERAL PUBLIC FOR QUALITY OF CARE AND FUTURE FUNDING

RESEARCH PAPER 6

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The Honourable Tony Pagone QC and Ms Lynelle Briggs AO have been appointed as Royal Commissioners. They are required to provide a final report by 26 February 2021.

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INSPIRING ACHIEVEMENT

Australia's aged care system: assessing the views and preferences of the general public for quality of care and future funding

A research study for the Royal Commission into Aged Care Quality and Safety

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Australia's aged care system: assessing the views and preferences of the general public for quality of care and future funding

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Contents

Executive summary

- This report summarises the background, methods and findings from a large-scale study to investigate the views and preferences of the Australian general public for quality of aged care and the future funding of aged care. The study is the first of its kind in Australia and internationally. It provides a unique and timely general public perspective to inform aged care policy and practice as the Royal Commission into Aged Care Quality and Safety works towards its final recommendations and the proposed re-design of Australia's aged care system.

- The study uses data collected from a survey of a representative sample (by age, gender and state or territory) of over 10,000 Australian adults not currently receiving aged care services, aged 18 to 91 years. The survey design was informed by a prior literature review and comprised four main sections. Section A included a series of attitudinal statements about the importance of various quality of care attributes. Section B included a discrete choice experiment, a quantitative approach enabling the relative importance of salient quality of care attributes to be measured and valued on a common scale. Section C comprised a series of questions about the future funding of quality aged care focusing upon two main components of funding: co-contributions (individual payments or fees) and income tax contributions. The final survey component (Section D) comprised a series of socio-demographic questions.

- Sections A and B of the survey were designed to reflect key quality of care attributes applicable across both home and residential care settings. Section C income tax contribution questions were also framed generically in terms of willingness to pay additional income tax to ensure satisfactory and high levels of quality aged care for all Australians in need. Section C co-contributions questions differentiated between home (community based) and residential (nursing home) care.

- The survey findings show both a strong awareness and a high level of agreement amongst members of the general public about what constitutes quality in aged care. A discrete choice experiment revealed that the most important quality of care attributes determining the choice of aged care provider across home and residential care were older people being treated with respect and dignity, aged care staff having the skills and training needed to provide appropriate care and support and the provision of services and supports for daily living that assist older people's health and wellbeing. When considering the quality rating of a single (chosen) aged care provider these three attributes were also found to be the most important influencers when considering the characteristics that elevate a provider from being rated as 'Unacceptable/Poor' to 'Satisfactory' quality. When considering the characteristics that elevate a provider from being rated as 'Satisfactory' to 'High/Very high' quality, the most influential were the ability to lodge complaints with confidence that appropriate action will be taken, followed by aged care staffing and the services and supports that assist older people's health and wellbeing. Being supported to make your own decisions about care and services was among the less influential characteristics, even though this is a central tenet of the recent policy reform towards Consumer Directed Care in community aged care service delivery.

- When asked about the success of Australia's aged care system in achieving quality aged care, it was clear that the general public feel that there are current deficiencies and some work to be done to elevate the aged care system to one that would generally be regarded as a high quality system.

- Co-contributions were viewed as a valid funding mechanism to support quality aged care. There was overall support from the general public for individual payments, in line with ability to pay, as a fundamental component of aged care funding to achieve a high-quality aged care system for Australia in the future. As expected, those respondents reporting higher income levels were generally willing to pay more to access aged care services than those reporting lower income levels. Respondents with current experience of the aged care system were also generally willing to pay more than those without current experience.

- On average respondents who indicated a willingness to pay a co-contribution indicated that they would pay $162.52 per week to receive a satisfactory level of quality home care and $240.95 per week to receive a high level of quality home care (equating to an additional quality payment of $78 per week or 48%).

- It is well documented that the overwhelming preference of the vast majority of Australians when they need aged care is to remain independent and living at home and avoid moving into a residential care facility if at all possible. Consistent with this, 72% of respondents were willing to pay a co-contribution fee to facilitate staying in their own home. The average co-contribution amount these respondents were willing to pay to avoid moving into residential care was $184 per week (equating to $9,568 per year).

- If unable to avoid moving into a residential care facility, the average willingness to pay co-contribution amounts increased to $528.75 per week to receive a satisfactory level of quality residential care and $693.11 per week to receive a high level of quality residential care (equating to an additional quality payment of $164 per week or 31%).

- There was recognition amongst the general public of the central role that government funding plays in the financing of a quality aged care system and respondents saw a need for further funding. The vast majority (87%) either 'agreed' or 'strongly agreed' that the government should provide more funding for aged care. The Australian government currently allocates 4% of the income tax collected from each taxpayer to aged care. The majority of respondents felt this was not high enough to fund a high-quality aged care system and that this proportion should be raised to around 8% on average (mean 8.6%, median 8%). This equates to a doubling of the current proportion of taxpayers' dollars allocated.

- Most members of the general public indicated that they would be willing to support aged care quality improvements by paying more tax. Two-thirds of the sample indicated that they currently pay income tax and the majority of current income taxpayers (61%) indicated they

would be willing to pay more income tax to support a quality aged care system. These taxpayers were willing to pay an additional 1.4% per year on average to ensure that all Australians in need have access to a satisfactory level of quality aged care, and an additional 3.1% per year on average to ensure that all Australians in need have access to a high level of quality aged care.

- In conclusion, this report highlights the strong significance that Australians place on the care of our most vulnerable citizens and that quality in aged care is highly valued. It shows the general public recognise the current deficiencies of Australia's aged care system and believe significantly more government funding should be allocated to achieve higher quality aged care. In addition to using co-contributions based on care recipient's capacity to contribute, it shows a majority of current income taxpayers would be willing to pay more income tax to ensure a high-quality aged care system is achieved. These findings provide an important and timely societal perspective with which to inform aged care policy and practice in Australia and in other countries which share similar values, aspirations and circumstances.

1. Introduction

The Caring Futures Institute at Flinders University, was commissioned by the Royal Commission into Aged Care Quality and Safety (the Commission) to design, analyse and report upon the findings from a survey to investigate the views and preferences of the general public regarding the quality of care and future funding of aged care in Australia. The key activities for the project included:

- A literature review to extract key themes relating to how quality in aged care is defined
- The design and analysis of a discrete choice experiment incorporating these key themes to identify the preferences of a representative sample of the general public for quality aged care
- The design and analysis of a suite of questions related to the future funding of aged care (focusing upon the two main existing funding mechanisms - co-contributions or fees and government funding via income tax payments).

The findings from this survey provide a better understanding of the general public's perceptions of the key attributes that define the quality of aged care, how well Australia is currently performing in each of these attributes and the views of the general public about the future funding of aged care.

Aged care services in Australia are provided to older people in their own homes and in residential care (nursing homes). In 2017-2018, almost one million people accessed home care services to allow them to continue living independently at home [AIHW, 2018]. Home care services are provided through the Commonwealth Home Support Programme and Home Care Packages and include varying levels of support according to the person's assessed care needs. This may include assistance with daily living activities such as shopping, cooking, cleaning and gardening, personal care to assist with showering and dressing, nursing care and access to allied health services (e.g. physiotherapists, podiatrists) to maintain and/or improve health, quality of life and wellbeing [Khadka et al, 2019]. If their health deteriorates, some older Australians will need to access higher levels of care provided in residential care facilities. In 2017-2018 over 230,000 people were permanently living in residential care [AIHW, 2018]. These estimates are expected to increase exponentially in the coming decades due to expansions in Australia's ageing population.

The quality of aged care provided to older Australians is a concern for all Australians. Most younger Australians have parents and/or grandparents receiving aged care services, while middle aged and older Australians are currently receiving care or have an awareness that they may eventually be recipients of care. However, what constitutes quality of care in aged care from the perspective of the Australian population has not been investigated to date.

In practice, quality in aged care is difficult to define. In health systems settings, quality of care is often understood as the extent to which services meet individuals' needs to improve their health outcomes. The World Health Organization indicates that high quality care is care that is safe (minimises risks and harm), effective (provides services based on evidence guidelines), timely (reduces delays), efficient (uses resources in the best way possible), equitable (delivery of care should be the same despite personal characteristics) and person-centred (taking into account the unique preferences, values and needs of the individuals accessing it) [WHO, 2019].

Prior to the introduction of the new aged care quality standards in July 2019, quality of aged care was measured using organisational outcomes and quantitative measures of clinical care e.g. pressure injuries, use of physical restraints and unplanned weight loss. Whilst these clinical indicators undoubtedly measure important aspects of quality in residential care that can affect an older person's health and wellbeing, they do not incorporate the wider attributes of quality of care that impact on an older person's perspective of their quality of life and wellbeing in home and/or residential care settings [Milte et al., 2018A]. The terms 'person-centred care' and 'quality of care' are often used interchangeably [Slater, 2006; Kitson et al., 2012]. In his pioneering research working with people with dementia in aged care settings, Kitwood [1997] used the term person-centred care to describe care that moves away from the physical aspect of care towards more individualised care focusing on an individual's needs. More recently, the definition of person-centred care in an aged care context has been extended to encompass the unique preferences, values and needs of the individual [Koren, 2010].

The actions taken by care providers to respect and focus on a person's essential needs to ensure their physical and psychosocial wellbeing is referred to as fundamental care [Feo et al., 2018]. Fundamental care consists of three core elements; the relationship, integration of care and the context of care. It emphasises the importance of developing positive, trusting relationships with recipients of care as the starting point for providing care. Care recipients' different fundamental needs, for example, physical needs (e.g., nutrition, mobility), must be addressed in tandem with their psychosocial and relational needs (e.g., dignity, privacy, respect, compassion). Fundamental care also recognises the contextual factors that affect the way in which care is carried out [Kitson, 2018].

The recent introduction of a new policy initiative, Consumer Directed Care in the community aged care sector, places consumers (older people and their family carers) at the heart of aged care decision-making. The underlying philosophy of Consumer Directed Care is that older people and their family carers have choice and control over the types of care and services they access and the delivery of those services, including who delivers the care and services and when [Kaambwa et al., 2015]. The interim report of the Commission has highlighted that applying the principles of Consumer Directed Care in practice has been challenging for many aged care providers and for consumers. This is particularly the case for older people living in rural or more remote areas where, due to the absence or scarcity of trusted providers, little or no market exists within which to make a choice about care and services [Royal Commission into Aged Care Quality and Safety, 2019].

Commencing 1st July 2019, all aged care providers are expected to adhere to new aged care quality standards and provide evidence of meeting these standards [Australian Department of Health, 2019]. The quality standards are made up of eight individual standards and have been introduced to provide a framework of core requirements for quality and safety and to make it easier for older people and their families to make decisions about the quality of care provided by aged care providers [Australian Government Department of Health, 2019]. The new quality standards are consumer focused and consistent with the philosophy of Consumer Directed Care. Organisational systems and processes, which have previously been assessed as an indicator of the quality of aged care, are now assessed according to their ability to support quality consumer outcomes.

The eight individual standards are as follows:

[1] Dignity and choice
A culture of inclusion and respect, supporting consumers to exercise choice and independence and respect their privacy.

[2] Ongoing assessment and planning
Initial and ongoing assessment and planning for care and services working in partnership with the consumer.

[3] Personal care and clinical care
Safe and effective personal care, clinical care (including restorative care, reablement and rehabilitation), or both personal care and clinical care, in accordance with the consumer's needs, goals and preferences to optimise their functional independence, health and wellbeing.

[4] Services and supports for daily living
Safe and effective services and supports for daily living that optimise the consumer's independence, health, wellbeing and quality of life.

[5] Organisation's service environment
Safe and comfortable service environment that promotes the consumer's independence, function and enjoyment.

[6] Feedback and complaints
Regularly seek input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

[7] Human resources
A workforce that is sufficient, and is skilled and qualified to provide safe, respectful and quality care and services.

[8] Organisational governance
A governing body that is accountable for the delivery of safe and quality care and services.

The new quality standards have a focus on person-centred care, consumer experience and consumer outcomes as these relate to older people accessing home care and aged care residents. The new quality standards recognise and acknowledge that strong interdependencies exist between processes and outcomes, with high quality care processes typically associated with better quality of life and wellbeing. The standards also acknowledge that high quality care processes require aged care staff who are trained in the clinical needs of residents, in addition to meeting their personal care needs.

The strong inter-connections between care processes and outcomes were first identified in the seminal work of Donabedian [1988]. Whilst originally applied in a health system context, Donabedian's theoretical framework also holds strong resonance for the aged care system.

Donabedian proposed that quality of care can be measured through a theoretical framework that encompasses three principal components: structures (organisational features and context of the care); processes (tasks undertaken between the consumer and provider); and outcomes (the effects of the care on the consumer and the wider population). This framework is reflected in the framing of the new aged care quality standards which are consumer focused and encompass the workforce and organisational responsibilities required to achieve quality outcomes.

The desired outcomes in aged care include the maximisation of wellbeing and quality of life for the older person and family carers. The processes and structures of care can be affected by different influences, which in turn affect the outcomes achieved. The quality of the care provided in aged care is widely recognised as highly influential and potentially ranks as the most important determinant of wellbeing and quality of life for older people [Ratcliffe, 2019; COTA Australia, 2018; Ratcliffe et al., 2010].

1.1. Characteristics of quality of care

In order to inform the development of the survey questions, it was important to identify the salient characteristics of quality of care for older people accessing aged care services. A comprehensive literature search was undertaken to identify relevant literature pertaining to quality of care and/or person-centred care in aged care within the last decade.

The review involved a two-stage process. The first stage involved identifying grey literature on the topic area through an online search for recently published government reports and other relevant research and policy documents on government websites. The second stage of the review involved searching SCOPUS (the largest abstract and citation database of peer reviewed literature including scientific journals, books and conference proceedings) and PubMed (an archive of biomedical and life sciences journal literature) using the following terms: ‘quality of care’, ‘person-centred care’, ‘aged care’, ‘residential care’, ‘nursing home’.

The results of the search were as follows.

- Identified articles: 655 from PubMed and 1431 from SCOPUS.
- Removal of duplications: 1174
- Title and abstract screening: 72
- Full text screening and final inclusion: 28

Two reviewers screened the titles and abstracts identified by the literature searches for eligibility to be included in the review based upon the following criteria:

Inclusion criteria

- Addressing the topic of quality of care and/or person-centred care within aged care
- Including the older person’s perspective or a suitable proxy
- Participants aged 65 years and over
- Presented in the English language
- Quantitative or qualitative design
- Studies published in the last 10 years

Exclusion criteria

- Not presented in the English language
- Included a large majority of participants aged below 65 years
- Studies mainly addressing a family members perspective
- Staff training interventions focusing on person-centred care

1.2. Themes emerging from the literature

The themes emerging from the literature review relate to both home care and residential care. However, it is important to note that research in this area has predominantly focused on residential aged care rather than aged care services provided in the home and community. The themes relating to quality of care and person-centred care identified by the literature review are summarised below.

1.2.1. Respect and dignity

Older people have a right to be respected and treated with dignity and a variety of studies in Australia and internationally have indicated that this is of fundamental importance to older people accessing aged care [Milte et al., 2016; Bangerter et al., 2016; Jeon and Forsyth, 2016; Hall et al., 2014; Woolhead et al., 2004]. A recent study by COTA Australia conducted with over 700 older people and family carers in the community found that being treated with respect and dignity was the most important characteristic that they would look for when choosing an aged care provider. Furthermore, when describing what 'quality' meant to them, individuals highlighted the need for 'quality' to involve aged care staff supporting them with dignity and respect, and the need for aged care staff to be trained to fully understand the importance of respect and dignity as fundamental elements of care delivery. Family members also stressed the value of respect for the older person including understanding the older persons' past, their preferences and their identity [COTA Australia, 2018].

1.2.2. Spiritual, cultural, religious and sexual identity

Knowledge of the older person's identity, culture and personal preferences has been identified by several key Australian studies as an important aspect of providing good quality aged care [Poey et al., 2017; Jeon and Forsyth, 2016; Edvardsson et al., 2010]. COTA Australia found that 90% of survey respondents highlighted that good quality care involved the provider maintaining and supporting their spiritual, cultural, sexual and religious identity [COTA Australia, 2018]. Studies reporting upon older peoples' experience of residential aged care have found that the ability of residential care staff to support, respect and value individuals' identity, including their personal preferences and needs, is a key indicator of good quality care [Poey et al., 2017; Jeon and Forsyth, 2016; Edvardsson et al., 2010]. By embedding diversity in the design and delivery of aged care, the Aged Care Diversity Framework seeks to support all older people to access safe, equitable and quality aged care, while enabling carers and family members to be partners in this process.

1.2.3. Aged care staff

It is of central importance for high quality care to ensure adequate staffing levels and that aged care staff possess appropriate skills and training [Australian Aged Care Quality Agency, 2019; McCallum et al., 2018]. Research has shown that staffing levels and the professional skills and training of aged care staff are key predictors of quality aged care [Jeon and Forsyth, 2016; Hasson et al., 2010]. COTA Australia found that most older people and family carers would prefer to know the qualifications and skills of staff when choosing aged care providers for both residential care and care at home, although this was found to be more important to older people in residential care than those receiving home care [COTA Australia, 2018].

1.2.4. Informed choices

Research has indicated that the majority of older people have a preference to be actively involved in decisions about their care providing that they have the cognitive capacity to do so [Abbott et al., 2018; Wells et al., 2018]. A recent study by Milte et al. [2016], undertaken with Australian aged care residents with mild cognitive impairment and dementia and family carers, found that the ability to exercise independence, autonomy and flexibility were highly valued. Participants strongly indicated that care needed to align with the individual needs and preferences of the older person to enable good quality of life and wellbeing outcomes. Similarly, Jeon and Forsyth [2016] highlighted maintaining independence and autonomy through being able to make informed choices as a crucial characteristic of good quality Australian residential care homes. Studies undertaken in community settings have found that enabling older people to make informed choices about their aged care supports them to be independent and have increased control over their life [COTA Australia, 2018; Kaambwa et al., 2015; McCaffrey et al., 2015; Ottmann et al., 2013]. The ability to be independent and have control over their life has also been recently identified as potentially the most important component encapsulating quality of life and wellbeing from the perspective of older Australians [Ratcliffe et al., 2017].

1.2.5. Social relationships and community engagement

The importance that older people accessing aged care place on maintaining social relationships and social engagement, and the positive impacts resulting for their health and wellbeing, is well documented in the literature [Abbott et al., 2018: Cooney et al., 2014; Tester et al., 2004; Berkman et al., 2000]. COTA Australia found that a large majority of survey respondents valued maintaining social relationships and contact with the community as important for a good quality of life and were interested to know how aged care providers' services facilitate social connections to improve older people's quality of life [COTA Australia, 2018]. Having access to social activities has been found to be important to older people living in Australian residential care to establish friendships and to experience good quality care and a good quality of life [Milte et al., 2016; Jeon and Forsyth, 2016]. Losing contact with family and friends is seen as a major concern for Australian residents [Milte et al., 2016]. The ability to maintain and foster social relationships with family and/or friends whilst in residential care allow for bonds and connections to the outside to continue with positive impacts on individual's quality of life [Drageset et al., 2017; Milte et al., 2016; Cooney et al., 2009].

1.2.6. Supporting older peoples' health and wellbeing

Research by our team and others has highlighted that older people place a very high value on their health and wellbeing including the ability to remain independent and living in the community for as long as possible [Ratcliffe et al., 2017; Milte et al., 2014; Bowling et al., 2013]. Clinical services, including rehabilitation, reablement and restorative care that aim to restore and/or maintain an older person's physical functioning, are integral to achieving this objective and are widely supported by evidence and clinical practice guidelines [Cognitive Decline Partnership Centre, 2016; Resnick, 2004; Tinetti et al., 2002]. The provision of meaningful activities for older people is another important aspect of person-centred care that has been found in several studies to have a highly positive impact in supporting individuals' health and wellbeing [Roberts et al., 2018A; Edvarddson et al., 2014; Edvarddson et al., 2010]. Roberts et al. [2018B] assessed preferences that were important to aged care residents in the US to effectively deliver person-centred care and found engagement in meaningful activities was an important preference impacting positively upon quality of life and wellbeing. Similarly, Edvardsson et al. [2010] found that the provision of meaningful activities to older people with dementia living in Australian residential care facilities was a crucial element of person-centred care that improved quality of life, supporting individual's self-esteem and providing feelings of contentment. Other research in Ireland, Norway and Sweden has also illustrated the benefits of participating in activities for older people's quality of life and wellbeing [Drageset et al., 2017; Edvardsson et al., 2014; Cooney et al., 2009]. For example, Edvardsson et al. [2014] explored the participation and outcomes of activities amongst older people living in residential care in Sweden. Residents reported significantly higher quality of life and wellbeing if they had taken part in everyday activities such as walks, church visits and excursions than if they had not participated in these types of activities.

1.2.7. Safety and comfort

Feeling safe and comfortable is an important aspect to fulfil a good quality of life and older people have a right to feel safe in their surroundings. Older people living in Australian residential care place high value on feeling safe and it has been found that the safety and security of a residential care facility is a fundamental feature that older people and their families look for when choosing a suitable aged care provider [Jeon and Forsyth, 2016]. Kajonius et al. [2016] found that older people's satisfaction levels in Swedish residential care facilities were highly correlated with how safe they felt and noted that higher feelings of perceived safety in residential care facilities were often related to higher resident to staff ratios. Australian research has also shown that older people value feeling safe in their home and community, both emotionally and physically [COTA Australia, 2018; Wells et al., 2018; Jeon and Forsyth, 2016].

1.2.8. Feedback and complaints

The ability to provide feedback and make complaints and to have any identified issues addressed appropriately are an important component of the provision of quality aged care. In their recent review of the quality of Australian residential care, Jeon and Forsyth [2016] highlighted the importance to older people and family members to be able to raise any concerns with their aged care provider, but they also highlighted the need to be able to do this without any consequences to the older person's care. Similarly, COTA Australia [2018] identified confidence in being able to make

complaints and have these appropriately addressed as a key indicator of quality care for older people and their families.

2. Methods

2.1. Attitudes to the current quality of home and residential care

Section A of the survey comprised a series of attitudinal statements relating to the quality of home and residential care. Respondents were asked to rate the importance of each statement, in their opinion, in ensuring quality aged care on a five-point Likert scale ranging from 'Not important' to 'Very important'. Draft statements were initially developed in consultation with our Advisory Group members, based upon the findings from the literature review and piloted with a sample of the general public (see Section 2.5) prior to being finalised. The final set of attitudinal statements is presented in Table 1.

Table 1 Attitudinal statements

Statement
Older people should be treated with respect and dignity
Aged Care Staff should have the skills and training needed to provide appropriate care and support
Older people and their families should be supported to raise any concerns they have with the aged care service they are receiving from organisation(s) providing their care
Older people should be supported to make informed choices about the care and services that they receive
Older people should be supported to live the life they choose
The care and services provided to older people should meet their needs, goals and preferences
Older people should be supported to maintain their social relationships and connections with the community
The identity, culture and personal history of the older person should be known and valued by staff
Older people should feel safe and comfortable receiving aged care services whether in a nursing home or in their own home
Older people should have a trusting and supportive relationship with the staff providing their care

2.2. Assessing the preferences of the general public for quality in aged care

The next stage of the project involved developing Section B survey questions to assess the preferences of the general public for quality in aged care. Discrete choice experiments (DCEs) provide an established methodological approach for the quantitative assessment of patient and general population preferences that has been applied in a number of studies assessing quality in the health care sector [Cutler et al., 2017; Berhane and Enquselassie, 2015; Hanson et al., 2005]. The DCE approach has also been successfully extended into aged care with several recent studies led by our team members focused on older people and family carer preferences for a Consumer Directed Care model of community aged care service delivery [McCaffrey et al., 2015; Kaambwa et al., 2015], resident and family carer's preferences for the quality of care provided in nursing homes [Milte et al., 2018A] and older people's preferences for food quality in nursing homes [Milte et al., 2018B].

DCEs are based upon stated preferences and are typically administered through a survey in which respondents are presented with a series of hypothetical choices between alternative scenarios and asked to choose the scenario that they would prefer. The alternative scenarios are described in terms of key characteristics (or attributes) and their associated levels. DCEs provide information about the acceptability of different characteristics of scenarios, the trade-offs that respondents are willing to make between these characteristics, and the relative importance of each of these characteristics in determining individuals' preferences [McCaffrey et al., 2015; Kaambwa et al., 2015]. DCEs therefore provide a systematic approach for valuing and assessing the relative importance of characteristics about the quality of aged care with members of the general public.

The literature review identified eight key themes as potentially important candidate attributes for the DCE in defining quality in aged care. Our previous research, and that of others, indicates that simpler DCE designs with a maximum of 5-6 key attributes are easier for a sample of the general public including people of all ages to comprehend and complete [Jonker et al., 2019; Kaambwa et al., 2015; Ryan et al., 2008]. The eight key themes were therefore condensed using a deliberative process with our Advisory Group members, to six key attributes or characteristics each with five levels defining increasing gradations of quality.

The characteristics relating to being treated with respect and dignity (1.2.1) and spiritual, cultural, religious and sexual identity (1.2.2) were combined to form a single attribute. A decision was made to exclude feeling safe and comfortable (1.2.7) from the DCE on the basis that this attribute overlaps somewhat with the characteristic being treated with respect and dignity (1.2.1). In addition, whilst the creation of a safe and secure environment represents a foundational characteristic which should always be present for the provision of quality aged care in residential care facilities, this is less easily influenced by home care providers. For an older person, feeling safe and comfortable in their own home has been found to be influenced by factors beyond aged care, extending beyond the home to the wider community and the neighbourhood in which they live [Kemperman et al., 2019]. The final set of attributes and levels included in the DCE are presented in Table 2.

Table 2: DCE Attributes and Levels

Attributes
I am treated with respect and dignity and can maintain my identity
I am supported to make informed choices about the care and services I receive and to live the life I choose
I receive care and support from aged care staff who have the appropriate skills and training
I receive the services and supports for daily living that are important for my health and wellbeing
I am supported to maintain my social relationships and connections with the community
I am encouraged and supported to give feedback and make complaints and I have confidence that appropriate action will be taken
Levels (common to all attributes)
Never, Rarely, Sometimes, Mostly, Always

These six attributes, each with five levels, resulted in 15,625 possible profiles, and a total of more than 122 million possible pair wise choices. In order to reduce the number of scenarios required for presentation to respondents to a manageable level, an efficient statistical design was employed. A total of 200 choice questions (each with two alternatives) were created and blocked into 40 versions of 5 choice questions using the Ngene DCE design software (www.choice-metrics.com). A further additional choice task was placed as the first (common) choice question in all versions to test respondent's understanding of the DCE task and the extent to which logical and rational choices were made.

The following two considerations were also implemented in the DCE design using the Ngene software [Choicemetrics, 2018]. Firstly, to reduce the potential cognitive burden of the DCE, an explicit partial profile design (created using a modified Federov algorithm) was applied such that in each DCE choice task, three attributes varied and the other three attributes remain identical between the two presented scenarios [Jonker et al., 2019]. Secondly, to avoid the presentation of infeasible scenarios, comprising highly improbable attribute level combinations, 16 constraints (which were discussed and agreed among the research team) were imposed in the utility function at the DCE design stage. Figure 1 presents an example of the first choice task (Scenario 1) included in Section B of the survey for all respondents.

Figure 1: DCE Scenario 1

CHARACTERISTIC	PROVIDER A	PROVIDER B
I am treated with respect and dignity	**Never**	**Always**
I am supported to make my own decisions about the care and services I receive	**Never**	**Always**
I receive care and support from aged care staff who have the appropriate skills and training	**Never**	**Always**
I receive services and support for daily living that are important for my health and wellbeing	**Never**	**Always**
I am supported to maintain my social relationships and connections with the community	**Never**	**Always**
I am comfortable lodging complaints, with confidence that appropriate action will be taken	**Never**	**Always**

If you had to make a choice between these two providers based on these characteristics which one would you choose?

Provider A ● Provider B ●

Think about the provider you have chosen and the quality characteristics associated with it. How would you rate the overall quality of their care?

Unacceptable	Poor	Satisfactory	High	Very High

In this first scenario Provider B clearly dominates by always providing the highest level of quality care according to all of the described characteristics. As such Provider B should logically be the chosen alternative. Respondents who failed to choose Provider B in the first choice task were excluded from the remainder of the survey on the basis that this response signalled a lack of understanding of the DCE task and therefore their responses to the DCE could not be assessed as reliable.

The remaining scenarios presented a mix of alternative characteristics such that no single provider clearly dominated (see Figure 2 for an example). Each respondent was therefore required to make trade-offs in the quality characteristics of the two presented providers within each choice question. The ordering of the choice questions were randomised across respondents [Nguyen et al., 2015; Carlsson et al., 2012]. To reduce the complexity of the task, improve choice consistency and reduce the drop-out rate, colour coding was adopted for the presentation of attribute levels with the lightest colour for the highest level (Always) and the darkest colour for the lowest level (Never).

Figure 2: DCE Scenario 2

CHARACTERISTIC	PROVIDER A	PROVIDER B
I am treated with respect and dignity	Sometimes	Sometimes
I am supported to make my own decisions about the care and services I receive	**Sometimes**	**Mostly**
I receive care and support from aged care staff who have the appropriate skills and training	**Rarely**	**Sometimes**
I receive services and support for daily living that are important for my health and wellbeing	Mostly	Mostly
I am supported to maintain my social relationships and connections with the community	**Mostly**	**Rarely**
I am comfortable lodging complaints, with confidence that appropriate action will be taken	Always	Always

If you had to make a choice between these two providers based on these characteristics which one would you choose?

Provider A ○ Provider B ○

Think about the provider you have chosen and the quality characteristics associated with it. How would you rate the overall quality of their care?

Unacceptable	Poor	Satisfactory	High	Very High

Each choice question was followed with a supplementary quality rating question in which the chosen provider and the characteristics associated with it were re-presented to the respondent and the respondent was asked to rate the overall quality of their care on a five point Likert scale ranging from 'Unacceptable' to 'Very High'. The quality rating questions were introduced for two main purposes. Firstly, to assist respondents in forming relevant concepts about what they would consider to be satisfactory and high levels of quality care (relevant for Section C responses). Secondly, to facilitate an empirical analysis to investigate the influence of individual attributes on the overall quality ratings of alternative aged care providers.

It is important to recognise there are limitations to the DCE method. Individuals' stated preferences are likely influenced by a myriad of factors including their present-day views and perceptions of the quality of Australia's aged care system and their current and expected future likelihood of needing to access aged care. These factors may change over time and hence individuals' stated preferences may not necessarily equate to their true or revealed preferences if they were faced with similar decisions in reality at some future time-point. It is also possible that some of the criteria which influence choice of service provider and quality ratings were not included within the DCE. As a case in point, in the quality ratings task the ratings were subjective and it is evident that there was some variation amongst respondents, with a significant proportion (15%) rating the profile which included the highest levels for all of the six presented attributes (Provider B Scenario 1 in Figure 1) as

providing a 'Satisfactory' level of care. The reasons are not entirely clear, but it is possible that for these respondents, other criteria beyond those included within the DCE may be pertinent in influencing quality ratings. It is also possible that these respondents adopted a threshold approach to the quality rating task, with anything less than the highest levels for all of the six presented attributes representing sub-standard care.

2.3. Assessing the preferences of the general public for aged care funding

Australia's aged care system is funded by governments (federal, state, territory and local governments), non-government organisations (charities, religious and community groups) and personal contributions from those receiving care. The majority of total expenditure on aged care (approximately 75%) is financed by the Federal Government with the remainder (approximately 25%) being financed mainly from fees and payments charged by service providers to individuals accessing home or residential care [Australian Government Department of Health, 2018].

The final stage of the project involved developing Section C survey questions to assess the preferences of the general public for the future funding of aged care. These included two types of questions:

a) individual perspective: the respondent's willingness to pay personal 'out of pocket' contributions for their own care if needed, either in their own home or in residential care
b) societal perspective: the respondent's willingness to pay through general taxation to support government funding of Australia's aged care system for the benefit of all Australians in need.

The contingent valuation method is a stated preference approach for guiding the measurement of individual and/or social benefits that has been widely applied in the evaluation of public programmes and services. Using this approach individuals are asked to consider a hypothetical scenario and asked to indicate the maximum amount that they would be willing to pay to receive it. The monetary value specified is then taken as a measure of the individual's perceived value or the welfare gain attached to the scenario under consideration [McIntosh et al., 2010].

Members of the general public as represented in this survey (i.e. those not currently receiving aged care services) may value quality in aged care for several reasons which are not mutually exclusive. Firstly, they may have a vested interest as a close family member may be currently receiving aged care. Secondly, they may be potential future aged care recipients i.e. they may place a value on aged care because they anticipate the possibility of using it in the future. This is often referred to as 'option value' in the contingent valuation literature. Thirdly, the provision of quality aged care may have 'existence value' to the person, that is, the person may value quality in the aged care system even if they never anticipate actively using it themselves. A motivation for this type of action is altruism: a desire to ensure that quality aged care is made available either to the current generation, or to future generations. Fourthly, quality in aged care may have a 'donor value', that is, members of the general public may also be willing to pay to ensure that quality aged care is distributed in a way they view as desirable. The motivation may be altruistic, or it may also be driven by values of equity or fairness towards those who are less fortunate/more dis-advantaged members of society [Haveman and Weimer, 2001].

It is important to note that a common finding of studies employing the contingent valuation method is that, in general, people with higher incomes levels and more wealth would be willing to pay more to guarantee themselves and others access to public programmes and services that they value. An implication of this general tendency is that the aggregate willingness of a society to pay for a specific public programme or service is dependent upon the distribution of wealth among its members that exists in the society at the time that the survey is administered [Donaldson, 1990].

The contingent valuation questions were developed from two main perspectives. Firstly, in relation to an individual perspective: what (if anything) would the respondent be willing to pay in the form of a co-contribution to guarantee themselves access to what they would consider to be satisfactory and high levels of home or residential care should they need access to these services at some point in the future. Secondly, in relation to a societal perspective: what (if anything) would the respondent be willing to pay in the form of additional taxation to support government funding of aged care to guarantee that all Australians would have what they consider to be satisfactory and high levels of home or residential care should they need access to these aged care services.

A payment scale question design was adopted for the contingent valuation questions whereby respondents were presented with a range of values from which to choose [Mitchell and Carson, 1981]. For the questions relating to the individual perspective, the range of values were based upon the current range of means tested (according to ability to pay) co-contribution amounts paid by older Australians to access home or residential care [AIHW, 2018] with an extended upper bound to allow the possibility of higher co-contribution amounts for a high level of quality of care. For home care the range of values extended from $0 to $450 per week with the option for the respondent to indicate a preference to pay more than $450 per week should they choose to do so and to specify the amount they would be willing to pay (Figure 3). For residential care the range of values extended from $0 to $1400 per week with the option for the respondent to indicate a preference to pay more than $1400 per week should they choose to do so and to specify the amount they would be willing to pay.

Figure 3: Payment scale example

How much would you be willing to pay **per week** to guarantee that you have access to what you consider to be a **satisfactory level** of quality **home care**?

$75	$150	$225	$300	$375	$450	More than $450
●	●	●	●	●	●	●

If you would be willing to pay more than $450 per week please specify the amount here …….

Responses to these co-contribution questions were obviously influenced by respondents' individual subjective views of what constitutes satisfactory versus high levels of quality in aged care and it is evident that there was some variation amongst respondents in this regard. It should also be noted these questions were likely particularly challenging for younger respondents who may not yet have

any familiarity with Australia's aged care system, or their projected future income levels and their ability to pay co-contribution fees to access aged care services a long way into the future.

For the questions relating to a societal perspective, respondents were initially asked to respond to a series of attitudinal statements about the funding of Australia's aged care system, including whether the government's current funding for aged care is high enough and, if not, what share of tax revenue aged care should be allocated. Respondents were not presented with the opportunity costs of this decision in terms of potential reductions in expenditure upon other public services or asked to indicate which public services should receive less funding in the absence of an overall increase in public expenditures. In addition, other potential payment vehicles for aged care beyond direct co-contributions and government funding from income tax payments (e.g. private insurance, other forms of taxation such as goods and services tax and the re-direction of superannuation) were not included in this survey but could be investigated in the future.

Following this, respondents who indicated that they were current income taxpayers were asked to indicate what (if anything) they would be willing to pay in the form of additional income taxation (in the form of a percentage income tax increase, similar to the Medicare levy) to ensure satisfactory and high levels of quality aged care delivered across Australia's aged care system. The range of values was based upon the current percentage level of income tax paid annually by members of the general public in Australia to support the funding of aged care. The range of possible options commenced at 0% (not willing to pay any additional income taxation) to 2.5% increase per year with the option for the respondent to indicate a preference to pay an additional specified amount (more than 2.5%) to support the future funding of Australia's aged care system should they so choose.

2.4. Survey participants and administration

The survey was piloted via a face to face interview using a think aloud approach with twelve members of the general public from a variety of socio-economic backgrounds, residing in metropolitan Adelaide and ranging in age from 18-70 years. Following the pilot study, some minor revisions were made to the introduction and the survey questions to improve phraseology and question layout. The final version of the survey was then formatted and programmed for an on-line mode of administration.

Section A of the survey contained 10 attitudinal statements relating to the quality of home and residential care. Section B consisted of the DCE questions presenting characteristics of hypothetical providers relating to salient attributes of quality of care and quality ratings of the chosen providers. Section C contained questions about individual payments (co-contributions) and future funding for aged care (taxation). The final section (Section D) elicited participants' socio-demographic characteristics and their exposure to aged care services, either for themselves or through the experiences of a close family member.

Ethics approval for the project was sought and obtained from the Flinders University Social and Behavioural Ethics Committee (Project no: 8378).

Survey respondents were sourced from Quality Online Research, an online fieldwork provider with an extensive panel network and national coverage. Panel members were invited to participate if they met the selection criteria (aged 18 years and over, able to read and respond in the English language, residing in Australia, no personal experience of accessing aged care services). In order to ensure that a broad representation of the views of the Australian adult population was achieved, demographic quotas were applied. In addition to the application of demographic quotas, the final dataset was weighted to further align the respondent data with population statistics of the Australian population according to age group, gender and state or territory. The weights were based upon the June 2018 population estimates provided by the Australian Bureau of Statistics [ABS, 2018].

Whilst the sample was representative of the Australian adult population in terms of age distribution, gender and state or territory, it is not entirely representative because respondent's self-selected and comprised people who were computer literate and largely familiar with on-line surveys. We are therefore unable to exclude the possibility that our main findings were influenced by the mode of administration and the socio-demographic characteristics of the on-line panel respondents.

2.5. Data analysis

The data analyses were performed using STATA version 15.1 [StataCorp, 2017]. Descriptive summary statistics were estimated for socio-demographic variables, attitudinal statements and willingness to pay variables. Econometric techniques were then used to estimate the relative importance of the various quality attributes to the choice of aged care provider and the quality rating assigned by respondents.

Quality attributes determining choice of aged care provider

The DCE responses were analysed according to the random utility maximisation framework which assumes that respondents choose the alternative (service provider) that maximises their utility or value [Ryan et al, 2008; Lancsar et al, 2017]. The utility (*U*) of alternative *j* for individual *n* in choice set *k* is specified as:

$$U_{nkj} = \beta_n X_{nkj} + \varepsilon_{nkj}$$

where *X* is a vector of observed attributes (quality characteristics), β is a vector of corresponding coefficients (parameters) to be estimated and ε is the model error term which is assumed to be independently and identically distributed (IID) with a type I extreme value distribution. For a traditional linear-index model (i.e. $X'_{nkj}\beta_n$), the probability of participant *n* choosing alternative *j* in choice set *k* can be specified as:

$$\Pr(Choice_{nk} = j|\beta_n) = \frac{\exp(X'_{nkj}\beta_n)}{\sum_{m=1}^{J}\exp(X'_{nkm}\beta_n)}$$

The model was estimated using two econometric approaches commonly applied in the analysis of DCE data. A traditional conditional logit model was firstly applied which assumes that respondents have homogenous preferences (i.e. $\beta_n = \beta$); this was followed by using a mixed logit model which relaxes this assumption and allows for potential preference heterogeneity among respondents, i.e.

the estimated regression parameters are assumed to vary among respondents [McFadden and Train, 2000; Greene and Hensher, 2003]. For example, respondents who had close family members with experience of aged care services may have different preferences as compared to those who did not have any close family members with such experience. To account for preference heterogeneity in the modelling, β_n was specified to follow a distribution using estimates of the mean and standard deviation (SD) [Hole, 2007]. The results for both models are in Table 7. The optimal model selection was based on information criteria, including the commonly used Akaike information criterion (AIC) [Akaike, 1974] and Bayesian information criterion (BIC) [Schwarz, 1978].[1] The latter is increasingly used as the preferred option [Hensher, 2012]. The BIC considers the number of observations in the calculation whilst the AIC does not. For both information criteria, as previously specified a lower value indicates a better model.

Aged care provider quality ratings

Following the completion of each DCE task, respondents were presented with their preferred option and asked "Think about the provider you have chosen and the quality characteristics associated with it. How would you rate the overall quality of their care?" and they were requested to select one quality rating out of five options: Unacceptable, Poor, Satisfactory, High, and Very High.

A total sample of 10,315 respondents each providing 6 quality ratings should produce 61,890 observations. However, owing to a technical issue of the online platform, responses of 1 DCE task as well as its quality rating question were not recorded, which led to 1 missing observation in this section. In the analysis, 22 respondents (0.2%) who rated the first profile as 'Unacceptable' were also excluded since they either lacked variation in their quality ratings or a clear disorder was present in their quality ratings across choice questions. Of these 22 respondents, 3 indicated a quality rating of 'Unacceptable' for all six choice questions, the remainder (19 respondents) provided illogical responses i.e. at least one higher quality rating in the following choice questions where the presented attribute levels were less desirable.

It was found that among the 61,889 valid observations, 10.3% were rated as 'Very high' quality, 13.9% 'High', 32.0% 'Satisfactory', 30.2% 'Poor', and 13.5% 'Unacceptable'. In the regression analyses, the bottom two quality levels and the top two quality levels were combined, such that the comparisons were made among three key quality levels: 'Unacceptable or Poor', 'Satisfactory', and 'High or Very High'.

Using the re-coded overall quality rating, an ordered logit model was initially applied however the proportional odds assumption required for this type of model did not hold. Consequently, a multinomial logit model was adopted. Here the quality rating was treated as a nominal outcome variable. Since there were 3 categories, this approach estimated a set of 2 equations, one for each category relative to the reference category. The advantage of using a multinomial logit model here also lies in its ability to directly investigate the relationships between aged care provider characteristics and each pair of quality ratings.

[1] The formula of AIC is 2*k-2*ln(likelihood) and the formula of BIC is ln(N)*k-2*ln(likelihood), in which k refers to the number of parameters estimated and N refers to the number of observations. In the DCE result table, N=103,148; if instead using sample size of the 10,315 the conclusion remains the same (i.e. conditional logit model is preferable as compared to the mixed logit model based on BIC).

To further control for unobserved individual heterogeneity, a multinomial logit model with fixed effects was applied [Pforr, 2014]. In the fixed-effects multinomial logit model, if respondents gave identical answers in all six quality rating questions, their responses were excluded from the analyses owing to the lack of variation, providing a final valid sample size of 57,028 (i.e. 92% of the total observations) in the regression analysis.

The detailed regression results for the choice of aged care providers are presented in Table 7 and illustrated in Figure 5, whilst results for the quality ratings of aged care providers are presented in Table 8 and illustrated in Figure 6 and 7 of this report. The weighted versus unweighted results for the DCEs are very close; however, the sampling weight cannot be used in the fixed effects multinomial logit model. To be consistent therefore, sampling weights were not applied in the DCE regression modelling.

3. Results

3.1. Respondent characteristics

In total 15,798 people attempted to participate in the survey, of whom N=10,315 (65%) fully completed it and passed all specified quality control criteria. The average survey response time was approximately 22 minutes. Table 3 provides a full breakdown of respondents and indicates the reasons for exclusion.

Table 3: Response status

Criteria	N	Percent (%)
Completes	10315	65
Drafts (incompletes)	1440	9
Removed at the first DCE question (unreliable)	632	4
Demographic Quota full (quota already closed)	2800	18
Removed Speedster (completed survey in less than 5 mins)	289	2
Screen-outs (not meeting inclusion criteria)	322	2
Total	15798	100

The socio-demographic characteristics of respondents are presented in Table 4. As highlighted previously, the final sample was purposively chosen to be representative of the Australian population according to three main criteria: age group, gender and state or territory of residence. The majority of respondents were born in Australia (72%), were employed either full-time or part-time (58%) and indicated that they had no prior experience of aged care through a close family member receiving aged care services (78%).

Table 4: Socio-demographic characteristics

Variable	Labels	N (10,315)	Unweighted percent (%)	Weighted percent (%)
Gender	Female	5,357	51.9	50.8
	Male	4,958	48.1	49.2
Age category (years)	18-29	2,102	20.4	25.2
	30-39	1,846	17.9	17.7
	40-49	1,724	16.7	16.1
	50-59	1,671	16.2	15.1
	60-69	1,402	13.6	12.6
	70+	1,570	15.2	13.3
State	New South Wales	3,434	33.3	32.1
	Victoria	2,644	25.6	25.2
	Queensland	1,774	17.2	20.0
	Western Australia	1,003	9.7	10.0
	South Australia	830	8.0	6.9
	Tasmania	302	2.9	2.8
	Australian Capital Territory	211	2.0	1.9
	Northern Territory	117	1.1	1.1
Living arrangements (Do you live with)	On your own	2,232	21.6	22.1
	With spouse	4,555	44.2	42.3
	With family	3,080	29.9	30.8
	With other-not relatives	448	4.3	4.8
Highest education level	Primary school	61	0.6	0.6
	Some secondary school	970	9.4	9.1
	Completed high school	1,737	16.8	17.2
	Some additional training (e.g.TAFE, apprenticeship)	3,120	30.2	29.4
	Undergraduate University	2,902	28.1	28.8
	Postgraduate University	1,525	14.8	14.9
Country of birth	Australia	7,424	72.0	71.1
	Europe	756	7.3	6.9
	Asia	719	7.0	7.3
	Other	1,416	13.7	14.1
Close family member receiving aged care	Yes	2,223	21.6	21.8
	No	8,092	78.4	78.2
Employment status	Full-time	3,787	36.7	38.4
	Part-time	1,985	19.2	19.4
	Student	459	4.4	5.3
	Retired	2,402	23.3	21.0
	Unemployed	1,026	9.9	9.9
	Other	656	6.4	6.0
Annual household Income	Up to $19,999	834	8.1	8.6
	$20,000-$39,999	1,829	17.7	17.4
	$40,000-$79,999	2,766	26.8	26.3
	$80,000-$124,999	2,118	20.5	20.6
	$125,000 plus	1742	16.9	17.0
	Prefer not to say	1,026	9.9	10.1

3.2. Attitudinal statements

The responses to the attitudinal questions (Table 5) indicate that all 10 statements were viewed as either 'important' or 'very important' to a quality aged care system by most respondents. The overwhelming majority of respondents indicated that it is 'very important' or 'important' that: older people are treated with respect and dignity (94%), that aged care staff have the skills and training needed to provide appropriate care and support (94%) and that older people should feel safe and comfortable receiving aged care services whether in a nursing home or in their own home (94%).

When asked about how well they understood Australia's aged care system, two-thirds of respondents (67%) indicated that they had at least some understanding (approximated by 'somewhat', 'fairly well' or 'very well' responses) with one-third (33%) indicating little or no understanding (approximated by 'slightly' or 'not at all' responses). The results stratified by age group and gender (Figure 4) illustrate that the majority of respondents in each sub-sample reported having at least some understanding of the aged care system. Not understanding the aged care system at all was more prevalent amongst younger people (aged 18-59 years) than older people (aged 60 years and above).

Figure 4: Level of understanding of Australia's aged care system stratified by age group and gender (M=male, F=female)

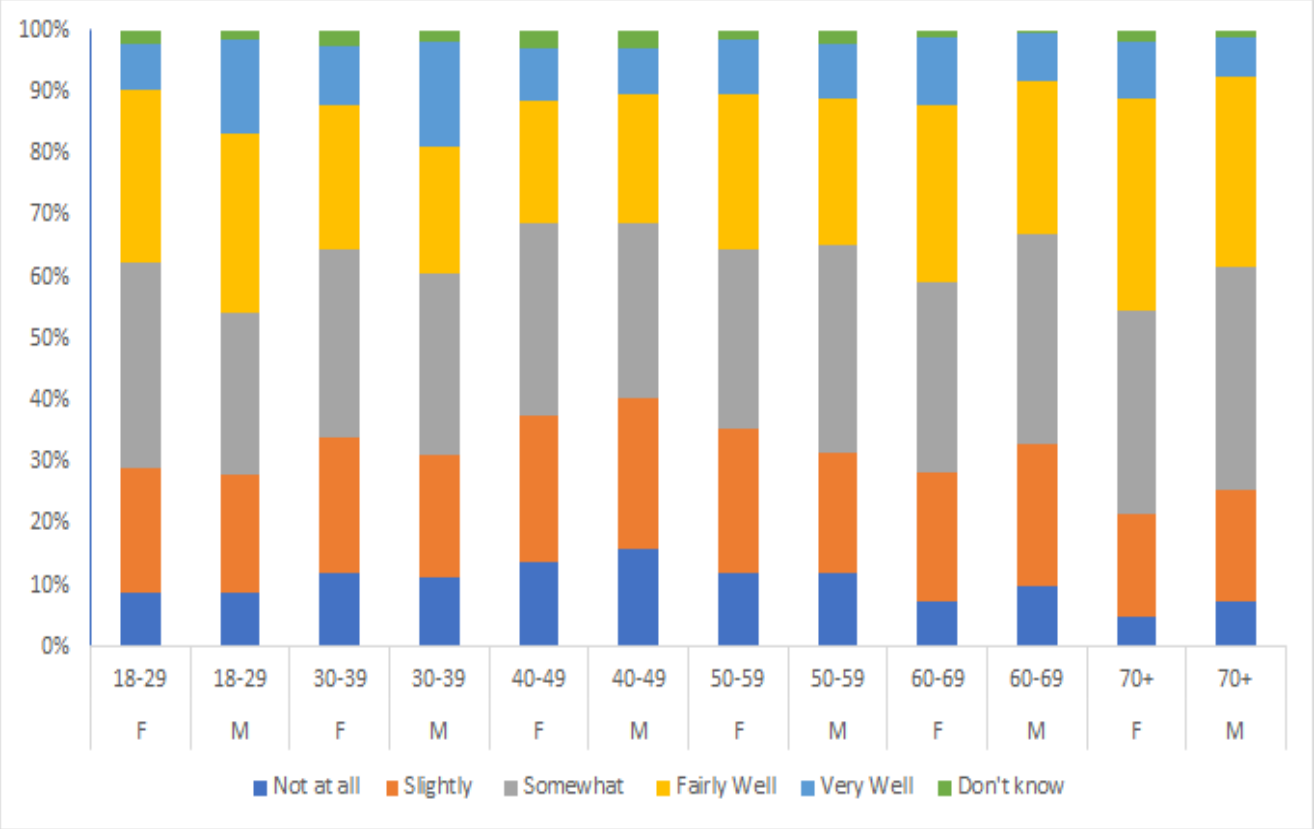


Table 5: Attitudes towards aged care in Australia

Statements	Categories	N	Unweighted Percent (%)	Weighted percent (%)
1. Older people should be treated with respect and dignity	Very important	8,264	80.1	79.1
	Important	1,485	14.4	14.8
	Moderately important	440	4.3	4.7
	Slightly/Not important	126	1.2	1.4
2. Aged Care Staff should have the skills and training needed to provide appropriate care and support	Very important	7,943	77.0	75.8
	Important	1,780	17.3	17.9
	Moderately important	456	4.4	4.9
	Slightly/Not important	136	1.3	1.4
3. Older people and their families should be supported to raise any concerns they have with the aged care service they are receiving from organisation(s) providing their care	Very important	6,914	67.0	65.7
	Important	2,609	25.3	25.9
	Moderately important	646	6.3	6.8
	Slightly/Not important	146	1.4	1.6
4. Older people should be supported to make informed choices about the care and services that they receive	Very important	6,601	64.0	63.0
	Important	2,910	28.3	28.5
	Moderately important	655	6.3	6.9
	Slightly/Not important	149	1.4	1.6
5. Older people should be supported to live the life they choose	Very important	6,268	60.8	59.9
	Important	3,023	29.3	29.6
	Moderately important	827	8.0	8.4
	Slightly/Not important	197	1.9	2.1
6. The care and services provided to older people should meet their needs, goals and preferences	Very important	6,776	65.7	64.7
	Important	2,760	26.8	27.1
	Moderately important	624	6.0	6.6
	Slightly/Not important	155	1.5	1.6
7. Older people should be supported to maintain their social relationships and connections with the community	Very important	6,265	60.7	59.9
	Important	3,019	29.3	29.6
	Moderately important	859	8.3	8.7
	Slightly/Not important	172	1.7	1.8
8. The identity, culture and personal history of the older person should be known and valued by staff	Very important	5,541	53.7	52.9
	Important	3,291	31.9	32.0
	Moderately important	1,160	11.3	11.8
	Slightly/Not important	323	3.1	3.3
9. Older people should feel safe and comfortable receiving aged care services whether in a nursing home or in their own home	Very important	7,963	77.2	75.9
	Important	1,766	17.1	17.8
	Moderately important	450	4.4	4.8
	Slightly/Not important	136	1.3	1.5
10. Older people should have a trusting and supportive relationship with the staff providing the care	Very important	7,132	69.1	68.1
	Important	2,484	24.1	24.5
	Moderately important	553	5.4	5.8
	Slightly/Not important	146	1.4	1.6

Those respondents who indicated that they had at least some knowledge of Australia's aged care system were then asked to choose their top three attitudinal statements in terms of their importance for quality aged care for older Australians. They were also asked to indicate how successful the current aged care system is in achieving each of the criteria specified in each statement. The top three chosen statements (Table 6) mirror the previous findings. The most prevalent response category was that Australia's aged care system is sometimes successful in achieving each of these criteria, with relatively fewer respondents indicating that each of these criteria are often or always achieved. These findings indicate that the general public feel that there are current deficiencies and work to be done to elevate Australia's aged care system to one that would generally be regarded as a high-quality system.

Table 6: Priority statements and success of Australia's aged care system in achieving these

Rank	Statements	N	Success categories	N	Unweighted percent (%)	Weighted Percent (%)
1	Older people should be treated with respect and dignity	4,055	Always	280	6.9	7.5
			Often	1030	25.4	25.7
			Sometimes	1,973	48.7	48.2
			Rarely	484	11.9	11.7
			Not at all	175	4.3	4.2
			Don't know	113	2.8	2.8
2	Older people should feel safe and comfortable receiving aged care services whether in a nursing home or in their own home	3,602	Always	196	5.4	5.9
			Often	1030	28.6	28.9
			Sometimes	1,800	50.0	49.3
			Rarely	333	9.2	9.3
			Not at all	122	3.4	3.2
			Don't know	121	3.4	3.5
3	Aged Care Staff should have the skills and training needed to provide appropriate care and support	3,556	Always	245	6.9	7.5
			Often	959	27.0	27.7
			Sometimes	1,676	47.1	46.2
			Rarely	408	11.5	11.1
			Not at all	172	4.8	4.7
			Don't know	96	2.7	2.8

3.3. Quality attributes determining choice of aged care provider

The results from the analysis of the quality attributes that determine choice of provider are presented in Table 7. The size of the coefficient attached to each attribute level indicates its relative importance in determining the choice of service provider. Panel A shows the results for the conditional logit model and Panel B shows the results for the mixed logit model. Based on AIC, the mixed logit estimate was preferred whilst based on BIC, the conditional logit estimate was preferred. Overall, it was concluded that the conditional logit model was preferred considering the complexity of the model and the relatively similar pattern of the estimates regardless of the choice of model. The discussion in Section 3 therefore focuses on the results from the conditional logit model.

It can be seen that on average respondents valued all the presented quality attributes (all attribute levels were statistically significant in influencing preferences). As expected, there was an increasing trend on the magnitude of the coefficients within each attribute as the attribute levels increased from 'Never' (the reference group) to 'Always'. The only exception to this general rule was for the characteristic 'I am comfortable lodging complaints, with confidence that appropriate action will be taken' where the size of the estimated coefficient of the top level 'Always' was slightly lower than the second top level 'Mostly'; however, the difference between these two levels was found to be statistically insignificant for both econometric models.

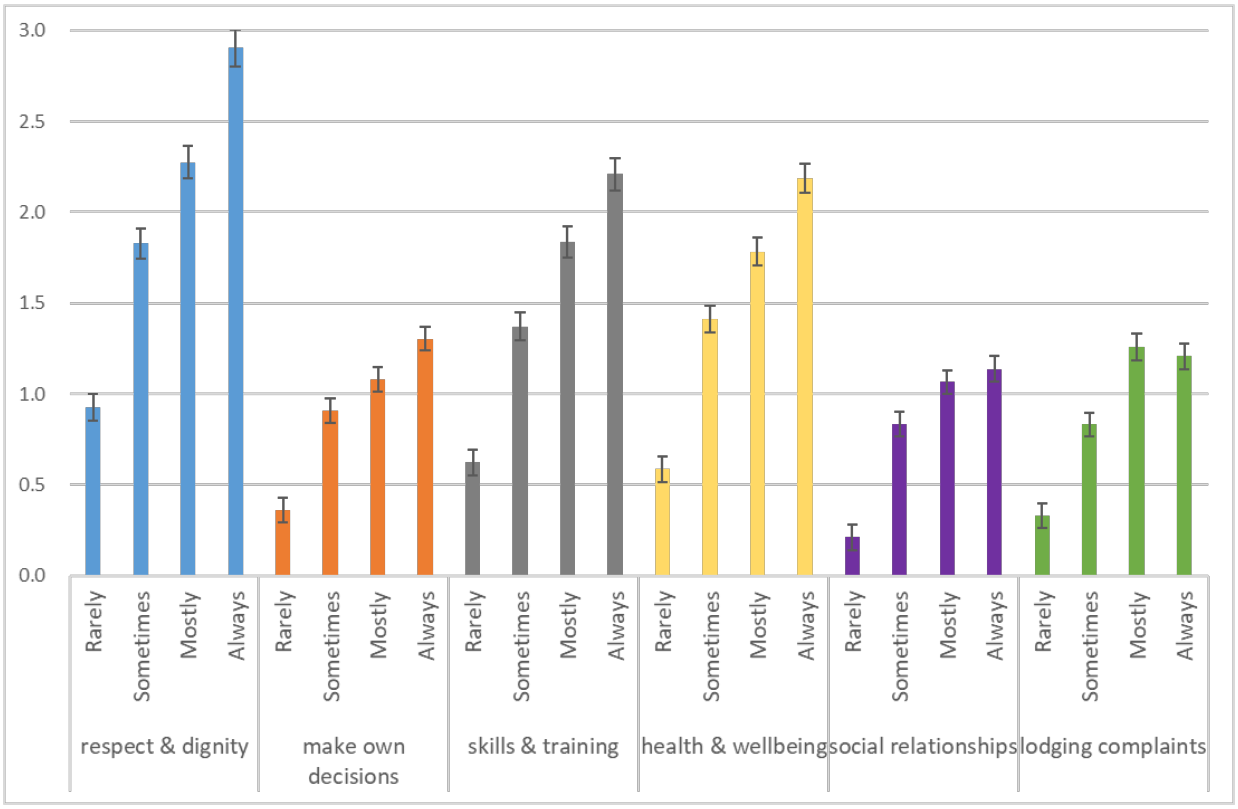
Table 7: Relative importance of attribute levels in determining choice of aged care provider

	Panel A		Panel B			
	Conditional logit estimates		Mixed logit estimates			
	Coefficient	[SE]	Coefficient	[SE]	SD	[SE]
I am treated with respect and dignity (Ref. Never)						
Rarely	0.928	[0.037]**	0.969	[0.042]**	0.629	[0.117]**
Sometimes	1.829	[0.042]**	1.948	[0.050]**	0.008	[0.014]
Mostly	2.274	[0.045]**	2.482	[0.057]**	0.009	[0.183]
Always	2.903	[0.052]**	3.223	[0.070]**	0.806	[0.114]**
I am supported to make my own decisions about the care and services I receive (Ref. Never)						
Rarely	0.360	[0.035]**	0.385	[0.040]**	0.456	[0.132]**
Sometimes	0.908	[0.033]**	0.956	[0.038]**	0.013	[0.016]
Mostly	1.078	[0.035]**	1.184	[0.045]**	0.256	[0.149]
Always	1.304	[0.034]**	1.436	[0.043]**	0.030	[0.031]
I receive care and support from aged care staff who have the appropriate skills and training (Ref. Never)						
Rarely	0.624	[0.036]**	0.675	[0.040]**	0.469	[0.142]**
Sometimes	1.372	[0.039]**	1.484	[0.046]**	0.260	[0.153]
Mostly	1.838	[0.044]**	2.044	[0.057]**	0.622	[0.128]**
Always	2.210	[0.046]**	2.420	[0.059]**	0.655	[0.128]**
I receive services and support for daily living that are important for my health and wellbeing (Ref. Never)						
Rarely	0.586	[0.035]**	0.592	[0.038]**		
Sometimes	1.414	[0.037]**	1.508	[0.043]**		
Mostly	1.783	[0.040]**	1.884	[0.046]**		
Always	2.188	[0.041]**	2.332	[0.050]**		
I am supported to maintain my social relationships and connections with the community (Ref. Never)						
Rarely	0.211	[0.037]**	0.229	[0.040]**		
Sometimes	0.835	[0.034]**	0.905	[0.039]**		
Mostly	1.066	[0.034]**	1.144	[0.039]**		
Always	1.137	[0.036]**	1.212	[0.041]**		
I am comfortable lodging complaints, with confidence that appropriate action will be taken (Ref. Never)						
Rarely	0.332	[0.035]**	0.344	[0.039]**	0.016	[0.133]
Sometimes	0.832	[0.034]**	0.899	[0.039]**	0.365	[0.143]**
Mostly	1.260	[0.037]**	1.370	[0.044]**	0.396	[0.133]*
Always	1.208	[0.037]**	1.297	[0.043]**	0.414	[0.141]**
Observations	103,148		103,148			
Log likelihood	-24075.41		-24029.18			
AIC	48198.82		48138.36			
BIC	48427.88		48520.12			

Note: ** p<0.01, * p<0.05. Robust standard errors (SEs) reported in the table. AIC, Akaike information criterion; BIC, Bayesian information criterion; SD, standard deviation. For all random coefficients, normal distribution was used and they were assumed to be independent. 200 Halton draws used for the simulation. For "health & wellbeing" and "social relationship" characteristics, the SDs were consistently insignificant for all levels and thus were assumed to be fixed coefficients in the final model. All attributes were dummy coded. A lower AIC or BIC value indicates a better fit.

Figure 5 presents the results from Panel A (the preferred model) in a graphical format with the coefficient values plotted for each attribute level. It can be seen that the characteristic 'I am treated with respect and dignity' was found to exhibit the largest relative importance (approximated by the size of the coefficients attached to attribute levels as compared the reference level of 'Never') in determining the choice of service provider. This was followed by 'I receive care and support from aged care staff who have the appropriate skills and training' and 'I receive services and support for daily living that are important for my health and wellbeing'. These aspects were prioritised above 'I am supported to make my own decisions about the care and services I receive'. These observations are supported by both econometric models.

Figure 5: Relative importance of attribute levels in determining choice of aged care provider (Panel A: conditional logit estimates)



Note: Relative risk ratios are presented and error bars represent 95% confidence intervals.

3.4. Aged care provider quality ratings

In the previous section the focus was on the findings from the DCE which involved eliciting the most important quality attributes determining choice of aged care provider through repeated choices between two aged care providers with different characteristics. In this section the focus is on the quality rating for the chosen (preferred) aged care providers in the DCE task. The detailed regression results from this analysis using a fixed effects multinomial logit model are presented in Table 8A&B. Two sets of results are reported and they are empirically identical results with the only difference being the choice of the base outcome category. In Table 8A, the worst quality of 'Unacceptable' or

'Poor' was used as the base outcome, whilst in Table 8B, the 'Satisfactory' level of quality was used as the base outcome.

In these Tables (8A and 8B) the relative risk-ratios (RRRs) indicate how influential the particular attribute level was to the aged care providers being rated at a particular quality level of interest as compared to the base outcome. For example, 'Satisfactory' level quality rather than 'Unacceptable/Poor' (Table 8A) and 'High/Very High' level quality rather than 'Satisfactory' (Table 8B), as what we select to present in the figures below. Where the RRRs are higher than 1 it means that providers who achieve that particular attribute level are more likely to achieve the quality level rating of interest than the base outcome, and conversely, RRRs lower than 1 mean that providers who achieve that particular attribute level are less likely to achieve the quality level rating of interest than the base outcome. The RRRs were calculated by exponentiating the multinomial logit coefficients.

Figure 6 shows how the attributes influenced the rating between 'Satisfactory' level versus 'Unacceptable/Poor' level quality. It can be seen that any improvement from the worst level (i.e. 'Never') of each aged care quality attribute was significantly associated with a higher likelihood of that provider being rated as 'Satisfactory' level quality. The one exception was for maintaining social relationships and connections with the community, in which the second lowest level of 'Rarely' was not statistically different from the lowest level. All else holding constant, the most important quality attributes contributing to improving a provider's quality rating from 'Unacceptable/Poor' to 'Satisfactory' are identical to those found in the prior DCE task. That is, the most important quality attributes were that the person is treated with respect and dignity, followed by aged care staff who have the appropriate skills and training, and services and support for daily living that are important for health and wellbeing.

Figure 7 shows how the attributes influenced the rating between a 'High/Very high' level of quality versus a 'Satisfactory' level of quality. When an aged care provider had the highest level 'Always' for any of the presented attributes, it was considerably more likely to be rated as 'High' or 'Very High' quality than a 'Satisfactory' quality level. Those attributes most likely to influence the chances of elevating an aged care provider quality rating from 'Satisfactory' to 'High/Very High' were the ability to lodge complaints with confidence that appropriate action will be taken, aged care staff who have the appropriate skills and training, and services and support for daily living that are important for health and wellbeing.

Overall, the results shown in Figures 6 and 7 clearly indicate that the influences of different quality attributes on the quality ratings scale were non-linear when considering movements from 'Unacceptable/Poor' to 'Satisfactory', and from 'Satisfactory' to 'High/Very High'. It is also noteworthy that being supported to make your own decisions about care and services was amongst the less influential characteristics, even though this is a central tenet of the recent policy reform towards Consumer Directed Care in community aged care service delivery.

Table 8A: Relative importance of attribute levels in determining aged care quality rating

	Base outcome - Quality of Care: Unacceptable/Poor			
	Quality of Care: Satisfactory		Quality of Care: High/Very High	
	RRR	[SE]	RRR	[SE]
I am treated with respect and dignity (Ref. Never)				
Rarely	1.320	[0.119]**	0.765	[0.107]
Sometimes	3.594	[0.326]**	2.471	[0.354]**
Mostly	5.858	[0.525]**	5.185	[0.722]**
Always	9.257	[0.902]**	15.545	[2.301]**
I am supported to make my own decisions about the care and services I receive (Ref. Never)				
Rarely	1.214	[0.093]*	0.861	[0.101]
Sometimes	2.163	[0.163]**	1.940	[0.226]**
Mostly	2.886	[0.214]**	2.762	[0.310]**
Always	3.521	[0.290]**	5.403	[0.652]**
I receive care and support from aged care staff who have the appropriate skills and training (Ref. Never)				
Rarely	1.235	[0.087]**	1.144	[0.124]
Sometimes	2.923	[0.185]**	3.207	[0.309]**
Mostly	3.888	[0.257]**	4.920	[0.498]**
Always	5.530	[0.376]**	11.634	[1.148]**
I receive services and support for daily living that are important for my health and wellbeing (Ref. Never)				
Rarely	1.282	[0.101]**	0.894	[0.106]
Sometimes	2.675	[0.210]**	2.456	[0.294]**
Mostly	4.140	[0.317]**	4.649	[0.537]**
Always	5.386	[0.446]**	11.098	[1.344]**
I am supported to maintain my social relationships and connections with the community (Ref. Never)				
Rarely	1.106	[0.073]	0.927	[0.101]
Sometimes	2.208	[0.147]**	2.171	[0.232]**
Mostly	2.359	[0.152]**	2.524	[0.266]**
Always	3.202	[0.227]**	5.414	[0.590]**
I am comfortable lodging complaints, with confidence that appropriate action will be taken (Ref. Never)				
Rarely	1.374	[0.083]**	1.271	[0.120]*
Sometimes	2.446	[0.150]**	2.161	[0.206]**
Mostly	2.859	[0.174]**	3.182	[0.301]**
Always	3.696	[0.231]**	7.913	[0.738]**
Observations	57,028			
Log pseudolikelihood	-12865.77			

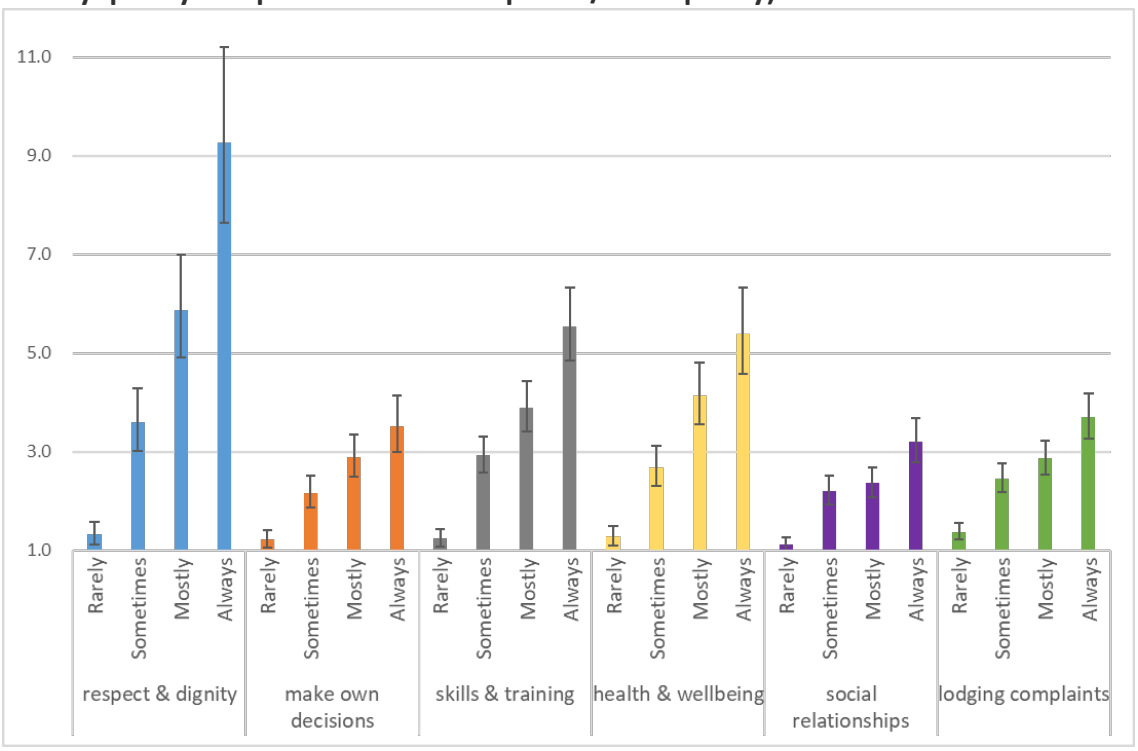
Notes: Relative-risk ratios (RRRs), calculated via exponentiating the multinomial logit coefficients, and robust standard errors (SEs) reported in the table. In general, if RRR<1, the outcome is more likely to be in the base outcome group than the comparison outcome group and vice versa. ** p<0.01, * p<0.05.

Table 8B: Relative importance of attribute levels in determining aged care quality rating

	Base outcome - Quality of Care: Satisfactory			
	Quality of Care: Unacceptable/Poor		Quality of Care: High/Very High	
	RRR	[SE]	RRR	[SE]
I am treated with respect and dignity (Ref. Never)				
Rarely	0.757	[0.068]**	0.580	[0.067]**
Sometimes	0.278	[0.025]**	0.688	[0.080]**
Mostly	0.171	[0.015]**	0.885	[0.099]
Always	0.108	[0.011]**	1.679	[0.199]**
I am supported to make my own decisions about the care and services I receive (Ref. Never)				
Rarely	0.824	[0.063]*	0.710	[0.073]**
Sometimes	0.462	[0.035]**	0.897	[0.091]
Mostly	0.346	[0.026]**	0.957	[0.092]
Always	0.284	[0.023]**	1.534	[0.158]**
I receive care and support from aged care staff who have the appropriate skills and training (Ref. Never)				
Rarely	0.810	[0.057]**	0.926	[0.085]
Sometimes	0.342	[0.022]**	1.097	[0.090]
Mostly	0.257	[0.017]**	1.265	[0.107]**
Always	0.181	[0.012]**	2.104	[0.169]**
I receive services and support for daily living that are important for my health and wellbeing (Ref. Never)				
Rarely	0.780	[0.062]**	0.697	[0.071]**
Sometimes	0.374	[0.029]**	0.918	[0.093]
Mostly	0.242	[0.019]**	1.123	[0.109]
Always	0.186	[0.015]**	2.060	[0.206]**
I am supported to maintain my social relationships and connections with the community (Ref. Never)				
Rarely	0.904	[0.060]	0.838	[0.080]
Sometimes	0.453	[0.030]**	0.983	[0.091]
Mostly	0.424	[0.027]**	1.070	[0.099]
Always	0.312	[0.022]**	1.691	[0.158]**
I am comfortable lodging complaints, with confidence that appropriate action will be taken (Ref. Never)				
Rarely	0.728	[0.044]**	0.925	[0.076]
Sometimes	0.409	[0.025]**	0.883	[0.072]
Mostly	0.350	[0.021]**	1.113	[0.091]
Always	0.271	[0.017]**	2.141	[0.170]**
Observations	57,028			
Log pseudolikelihood	-12865.77			

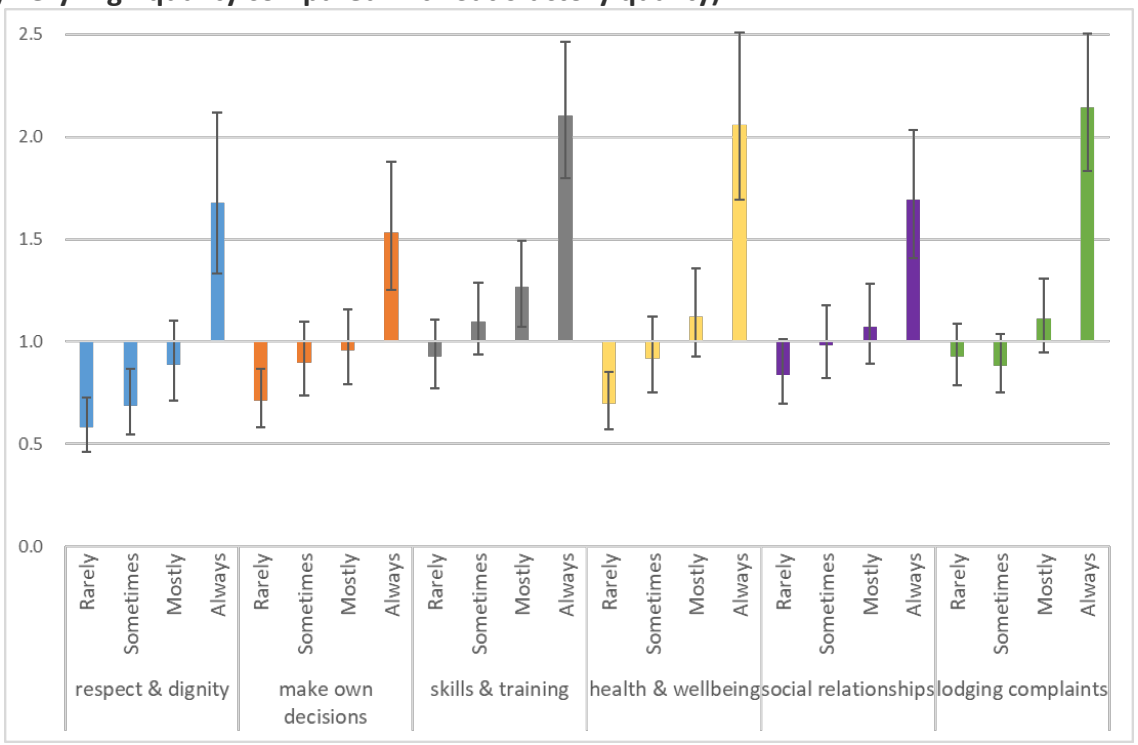
Notes: Relative-risk ratios (RRRs), calculated via exponentiating the multinomial logit coefficients, and robust standard errors (SEs) reported in the table. In general, if RRR<1, the outcome is more likely to be in the base outcome group than the comparison outcome group and vice versa. ** p<0.01, * p<0.05.

Figure 6: Relative importance of attribute levels in determining aged care quality rating (Satisfactory quality compared with Unacceptable/Poor quality)



Note: Relative risk ratios are presented and error bars represent 95% confidence intervals.

Figure 7: Relative importance of attribute levels in determining aged care quality rating (High/Very High quality compared with Satisfactory quality)



Note: Relative risk ratios are presented and error bars represent 95% confidence intervals.

Table 9 presents the characteristics of the 5 top rated profiles and the distribution of their corresponding quality ratings. As expected, the top profile was Provider B from Scenario 1 which had the level of all attributes at 'Always'. Nearly 84% of respondents rated this profile as reflecting either 'High' or 'Very High' quality. The proportion of respondents rating profiles as 'High' or 'Very High' quality decreased significantly as two or more of the presented attributes moved away from their highest levels.

Table 9: Characteristics of the 5 top rated profiles and their corresponding quality ratings

Profile rank	Characteristics						Quality rating (%)†		
	respect & dignity	make own decisions	skills & training	health & wellbeing	social relationships	lodging complaints	Very High/ High	Satis.	Poor/ Unsatis.
1*	Always	Always	Always	Always	Always	Always	83.9	15.2	0.9
2	Always	Mostly	Mostly	Always	Always	Sometimes	30.7	48.2	20.2
3	Always	Mostly	Always	Sometimes	Always	Mostly	30.0	50.4	19.7
4	Always	Always	Always	Mostly	Sometimes	Sometimes	28.2	54.6	17.3
5	Always	Always	Mostly	Mostly	Always	Sometimes	30.2	58.1	11.7

Note: * Profile 1 is the fixed profile which was rated by all 10,315 respondents.
† Percentages are based upon the total number of respondents who directly rated this profile.

3.5. Attitudes towards aged care funding

3.5.1. Individual perspective (co-contribution)

When asked to think about their willingness to pay to access a satisfactory level of quality home care, the overwhelming majority of respondents (80%) indicated that they would be willing to pay a co-contribution and 62% indicated that they would be willing to pay a higher co-contribution to receive high quality home care. On average these respondents indicated a willingness to pay a co-contribution of $162.52 per week to receive satisfactory level of quality home care and $240.95 per week to receive a high level of quality home care (Table 10).

Approximately one-fifth of the total sample of respondents (22%) indicated that they had current experience of aged care through a close family member. Respondents with current experience were willing to pay more than those without current experience. On average, respondents with current experience of aged care indicated a willingness to pay a co-contribution of $187.97 per week to receive satisfactory level of quality home care and $268.76 per week (equating to an additional quality premium fee of $81 per week) to receive a high level of quality home care. Respondents without current experience of aged care indicated lower willingness to pay values but the additional fee they would be willing to pay to move from satisfactory to high level care was similar (equating to an additional fee of $77 per week).

Table 10: Willingness to pay co-contributions for home care (total sample and by current experience of aged care)

	Total Sample (N=10,315)						
	WTP NO			WTP YES			
Quality level	**N**	**Unweighted %**	**Weighted %**	**N**	**Unweighted %**	**Weighted %**	**Fees (weekly amount)[1] Weighted mean (SE)**
Satisfactory	2106	20	20	8209	80	80	$162.52 ($1.76)
High	4009	39	38	6306	61	62	$240.95 ($1.92)
Current experience of aged care (N=2,223)							
Satisfactory	334	15	15	1889	85	85	$187.97 ($6.01)
High	673	30	29	1549	70	71	$268.76 ($4.67)
No current experience of aged care (N=8,092)							
Satisfactory	1772	22	22	6320	78	78	$154.77 ($1.38)
High	3335	41	40	4757	59	60	$231.70 ($2.01)

[1] YES WTP respondents only

Willingness to pay amounts also varied by quality rating and by age group. Younger people who indicated a willingness to co-contribute were more likely on average to indicate higher co-contribution amounts overall. However, greater proportions of older people were more accepting of the need to co-contribute (especially at the lower levels) to access satisfactory and high levels of quality home care respectively relative to younger people (Figures 8 and 9).

Figure 8: Willingness to pay per week for home care of satisfactory quality by age group

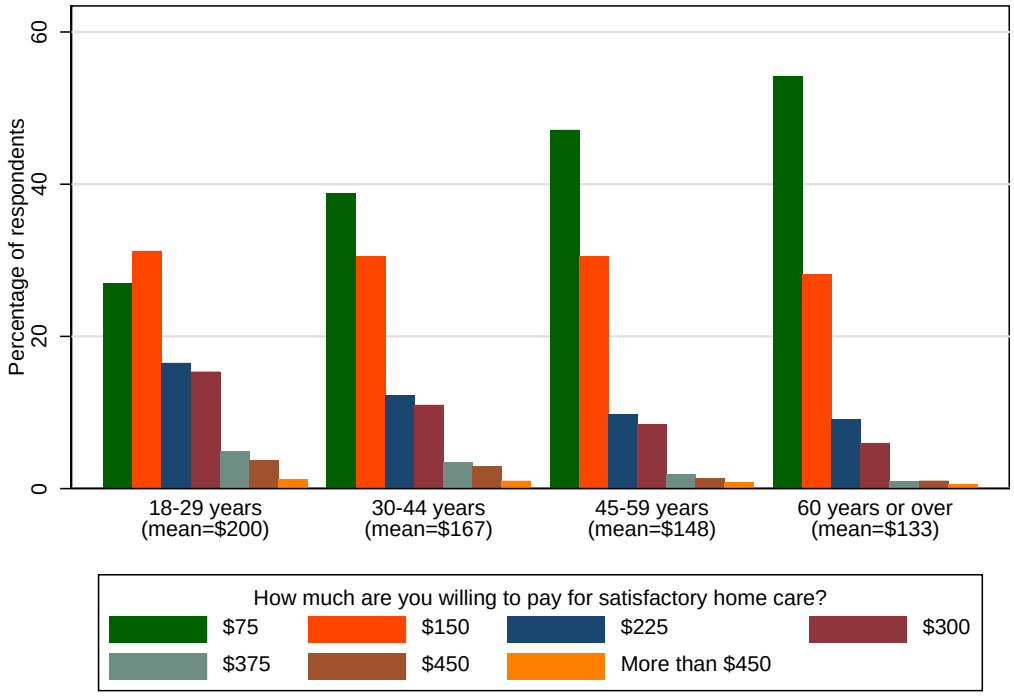
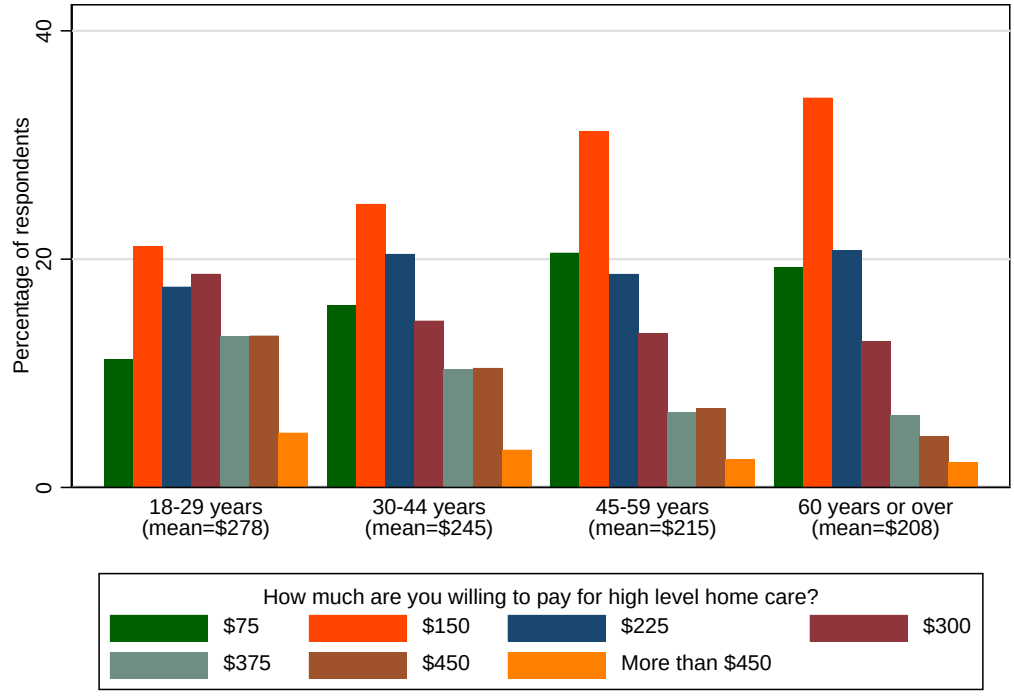


Figure 9: Willingness to pay per week for home care of high quality by age group



As expected, willingness to pay amounts also varied by income, with those reporting higher income levels being more likely in general to indicate a willingness to pay higher co-contribution amounts than those reporting lower income levels. However, this response pattern is more evident for satisfactory levels than higher levels of quality home care (Figures 10 and 11).

When asked about their willingness to pay to receive an extended home care package to allow them to remain living at home rather than entering a residential care facility, a significant majority of respondents (72%) indicated a willingness to pay a co-contribution to facilitate this. These results varied slightly overall by age group, with a greater proportion of older people aged 60 years and over (75%) indicating a positive response relative to younger people aged 18-29 years (70%). On average, respondents were willing to pay a co-contribution fee of $184 per week to remain living at home rather than entering residential care. Younger people were more willing to pay a higher co-contribution amount than older people to remain living at home (Figure 12).

As expected, people who reported higher income levels were generally willing pay a higher co-contribution fee on average to remain living at home than those with lower income levels (Figure 13).

Figure 10: Willingness to pay per week for home care of satisfactory quality by income group (weekly income)

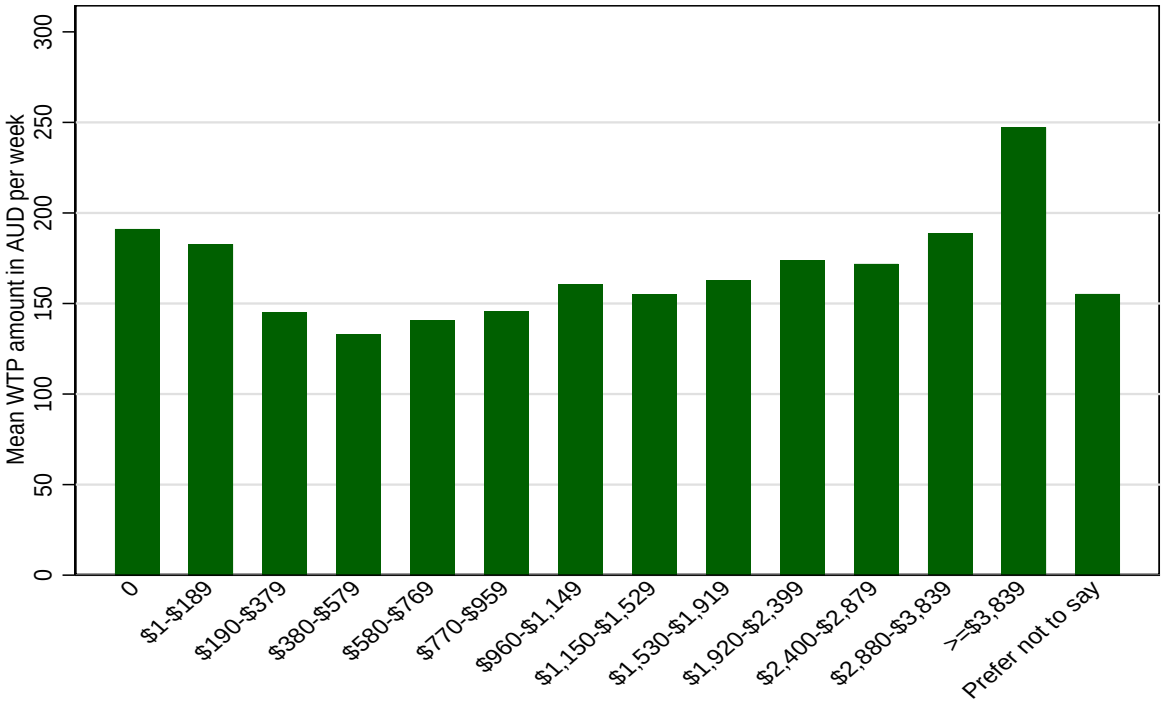


Figure 11: Willingness to pay per week for home care of high quality by income group (weekly income)

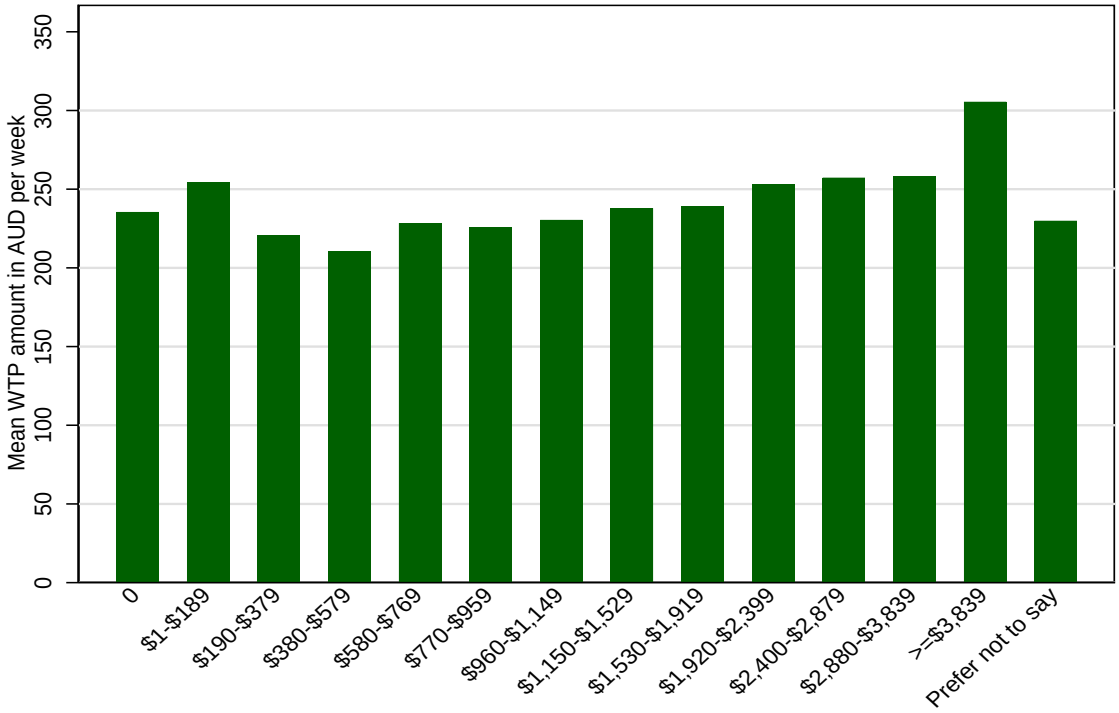


Figure 12: Willingness to pay to remain at home rather than enter residential care by age group

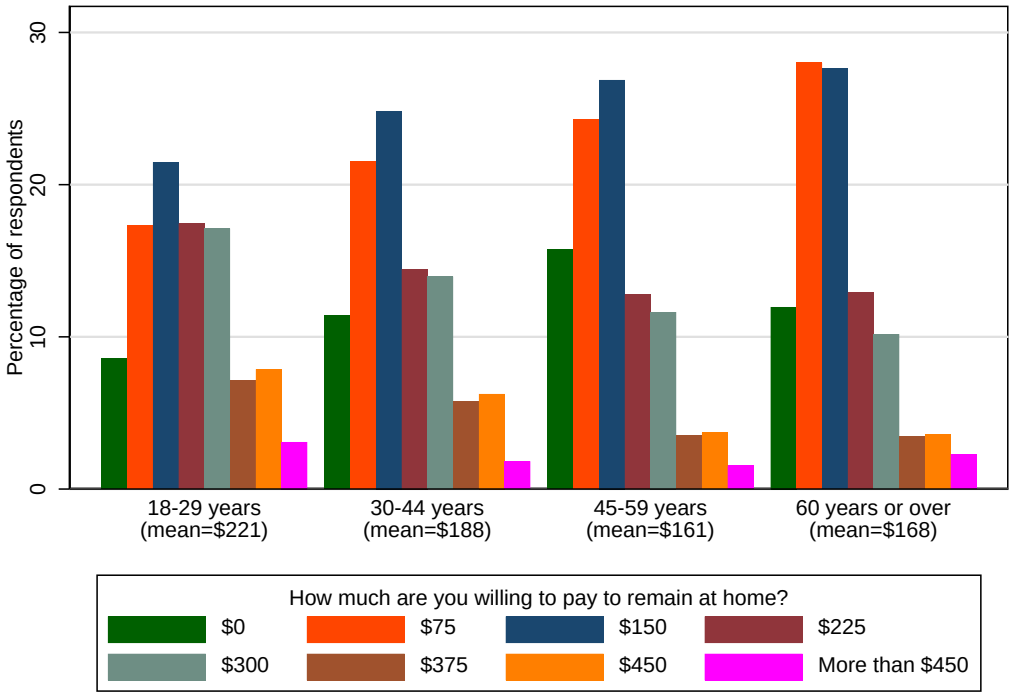
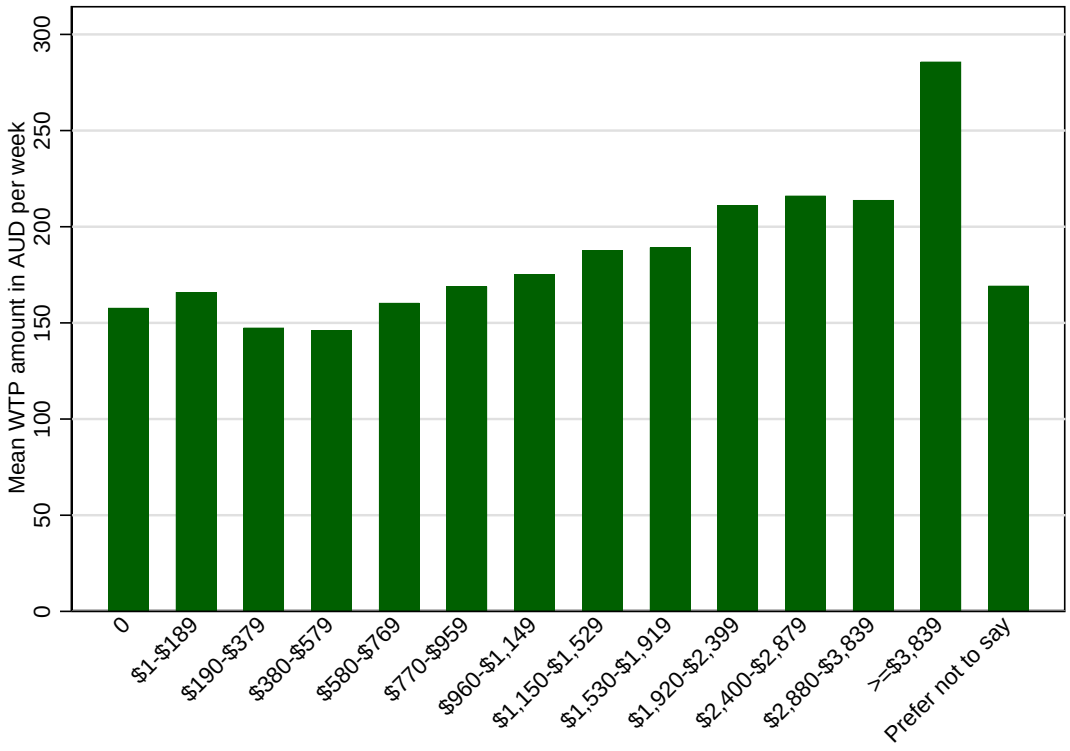


Figure 13: Willingness to pay to remain at home rather than enter residential care by income group (weekly income)



When asked to think about their willingness to pay (in the form of a co-contribution or fee) to receive access to a satisfactory level of quality residential care, the majority of respondents (64%) indicated that they would be willing to pay this contribution and 46% indicated that they would be willing to pay a higher co-contribution amount to receive high quality residential care (Table 11). On average these respondents indicated a willingness to pay a co-contribution of $528.75 per week to receive a satisfactory level of quality residential care and $693.11 per week to receive a high level of quality residential care (equating to an additional quality payment of $164 per week or 31%).

Respondents with current experience were willing to pay more than those without current experience. On average, respondents with current experience indicated a willingness to pay a co-contribution of $580.85 per week to receive satisfactory level of quality residential care and $769.32 per week to receive a high level of quality residential care (equating to an additional quality premium fee of $188 per week or 32%).

Table 11: Willingness to pay co-contribution fees for residential care (total sample and by current experience of aged care)

	Total Sample (N=10,315)						
	WTP NO			WTP YES			
Quality level	**N**	**Unweighted %**	**Weighted %**	**N**	**Unweighted %**	**Weighted %**	**Fees (weekly amount)[1] Weighted mean (SE)**
Satisfactory	3709	36	36	6606	64	64	$528.75 ($3.34)
High	5663	55	54	4652	45	46	$693.11 ($5.26)
Current experience of aged care (N=2,223)							
Satisfactory	634	29	28	1589	71	72	$580.85 ($7.62)
High	973	44	42	1250	56	58	$769.32 ($12.81)
No current experience of aged care (N=8,092)							
Satisfactory	3075	38	38	5017	62	62	$511.92 ($3.64)
High	4690	58	57	3402	42	43	$664.71 ($5.32)

[1] YES WTP respondents only

Younger people were more likely on average to indicate higher co-contribution amounts to receive a satisfactory level of quality residential care than older people (Figure 14). The willingness to pay co-contributions were more similar between age groups for a high level of quality residential care, and unsurprisingly, the distribution of responses was more towards the higher co-contributions amounts than for satisfactory quality (Figure 15).

As expected, willingness to pay amounts also varied by income. Those reporting higher income levels were more likely on average to indicate a willingness to pay higher co-contribution amounts than those reporting lower income levels (Figures 16 and 17).

Figure 14: Willingness to pay per week for residential care of satisfactory quality by age group

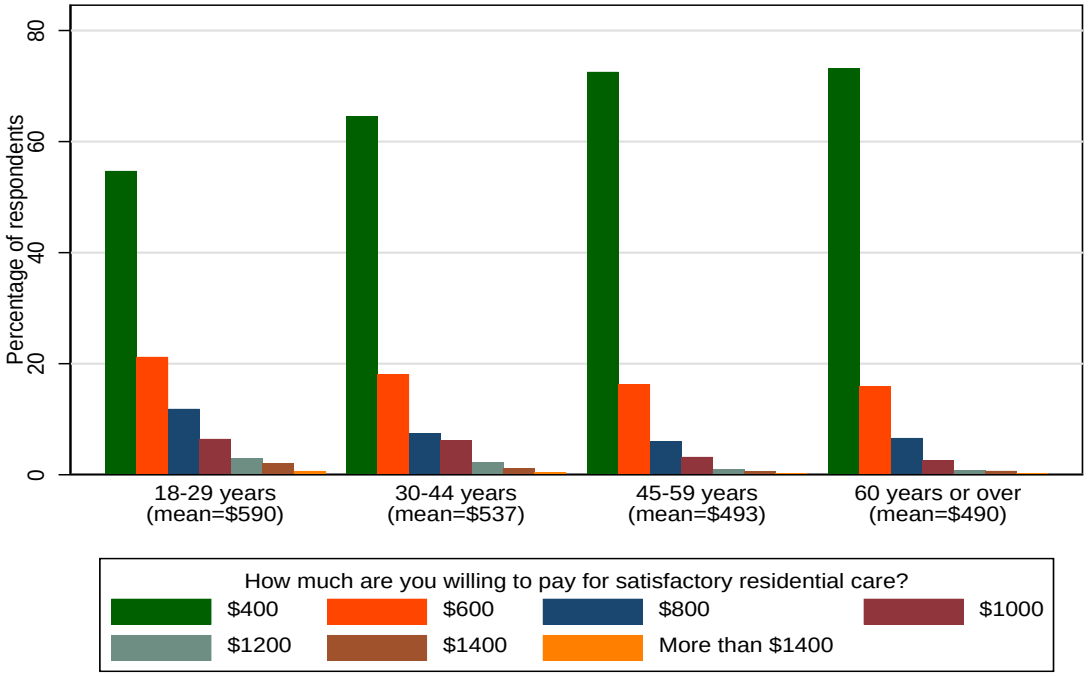


Figure 15: Willingness to pay per week for residential care of high quality by age group

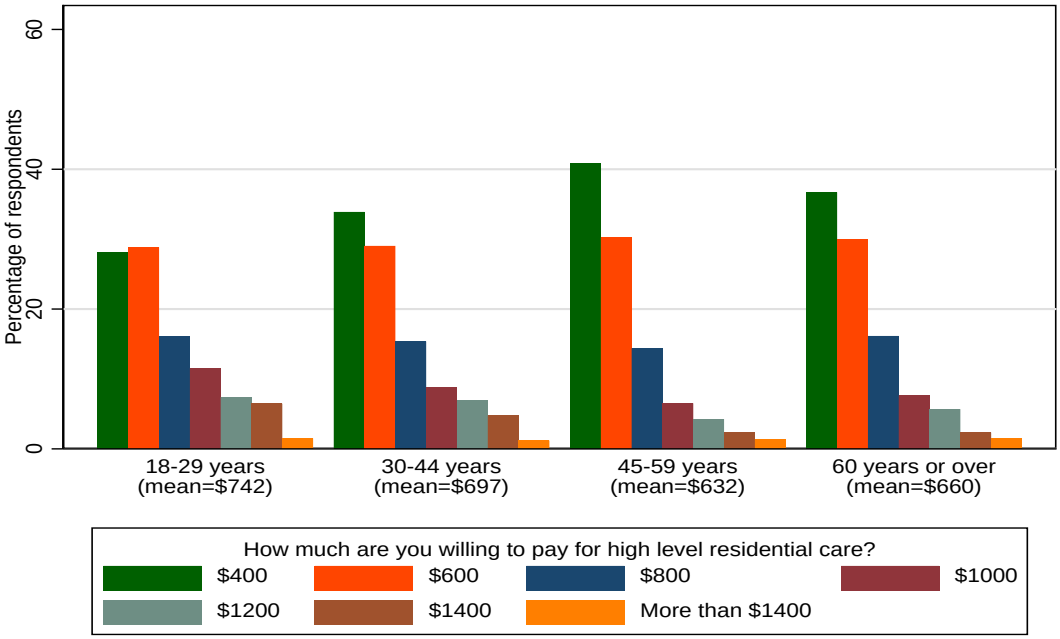


Figure 16: Willingness to pay per week for satisfactory level of quality residential care by income group (weekly income)

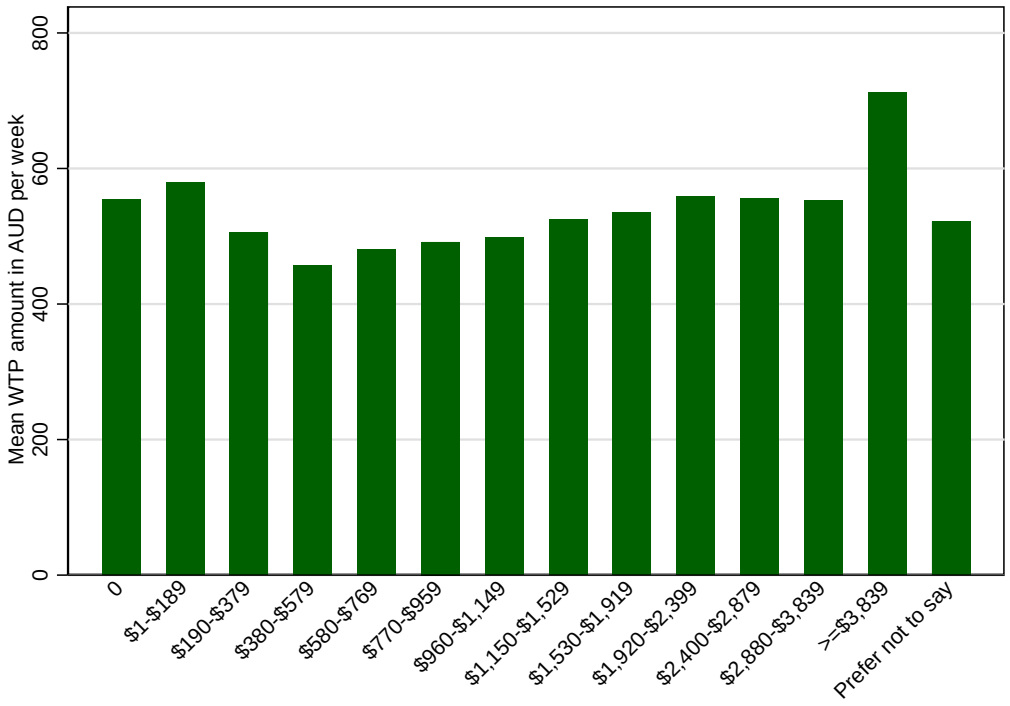
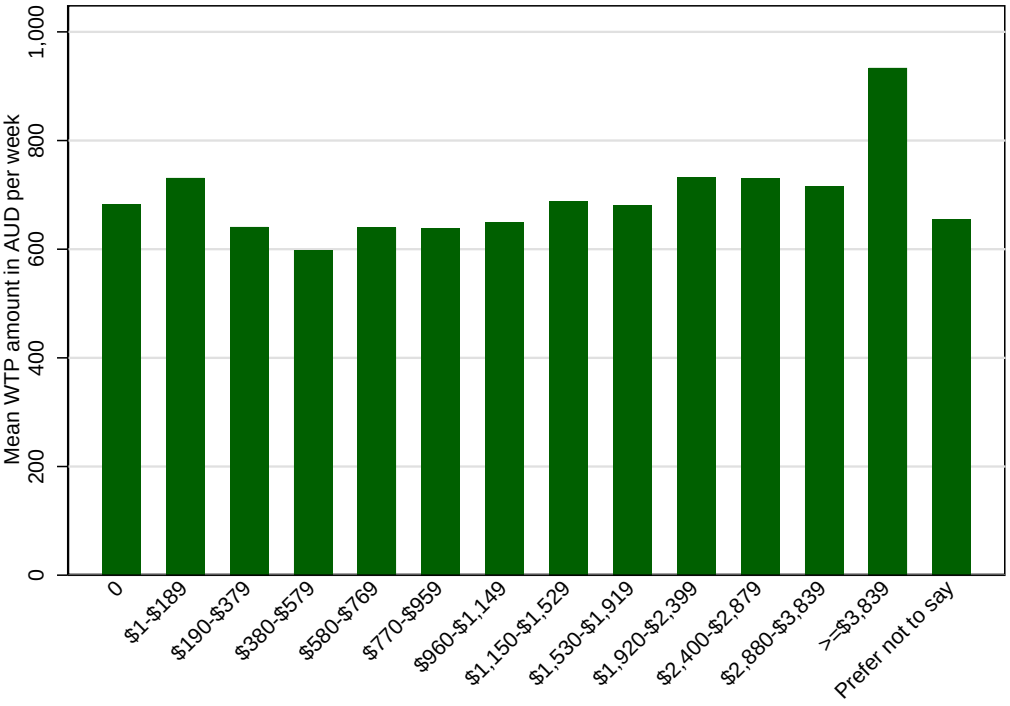


Figure 17: Willingness to pay per week for high level of quality residential care by income group (weekly income)



3.5.2. Societal perspective (taxation)

The responses to the attitudinal questions about the funding for Australia's aged care system (Table 12) indicate that the overwhelming majority (87%) of respondents either 'agree' or 'strongly agree' that the government should provide more funding for aged care. A majority of respondents (68%) also either 'agree' or 'strongly agree' that Australians should contribute towards the funding for the aged care services that they receive in line with their ability to pay. The results in relation to a willingness to pay more tax to ensure a high quality aged care system are relatively more mixed, with (49%) of respondents indicating that they either 'agree' or 'strongly agree' with the statement that 'I would be willing to pay more tax to ensure Australians are able to access aged care services when they need them' and 34% neither agreeing or disagreeing with this statement. Similarly, 50% of respondents indicated that they either 'agree' or 'strongly agree' with the statement 'I would be willing to pay more tax to improve the quality of the aged care services being provided to older Australians' with 34% neither agreeing or disagreeing with this statement.

Table 12: Attitudes towards funding for aged care in Australia

Statements	Categories	N (10,315)	Unweighted Percent (%)	Weighted Percent (%)
1. The government should provide more funding for aged care	Strongly Agree	5,469	53.0	51.9
	Agree	3,567	34.6	35.2
	Neither Agree nor Disagree	936	10.3	10.6
	Disagree	133	1.3	1.4
	Strongly Disagree	85	0.8	0.8
2. I would be willing to pay more tax to ensure Australians are able to access aged care services when they need them	Strongly Agree	1,533	14.9	14.8
	Agree	3,523	34.2	34.4
	Neither Agree nor Disagree	3,538	34.3	34.1
	Disagree	1,119	10.8	10.9
	Strongly Disagree	602	5.8	5.7
3. Australians should contribute towards the funding for the aged care services that they receive in line with their ability to pay	Strongly Agree	2,275	22.1	21.8
	Agree	4,753	46.1	46.0
	Neither Agree nor Disagree	2,443	23.7	24.0
	Disagree	582	5.6	5.7
	Strongly Disagree	262	2.5	2.5
4. I would be willing to pay more tax to improve the quality of the aged care services being provided to older Australians	Strongly Agree	1,579	15.3	15.2
	Agree	3,578	34.7	35.0
	Neither Agree nor Disagree	3,477	33.7	33.5
	Disagree	1,123	10.9	11.0
	Strongly Disagree	558	5.4	5.3

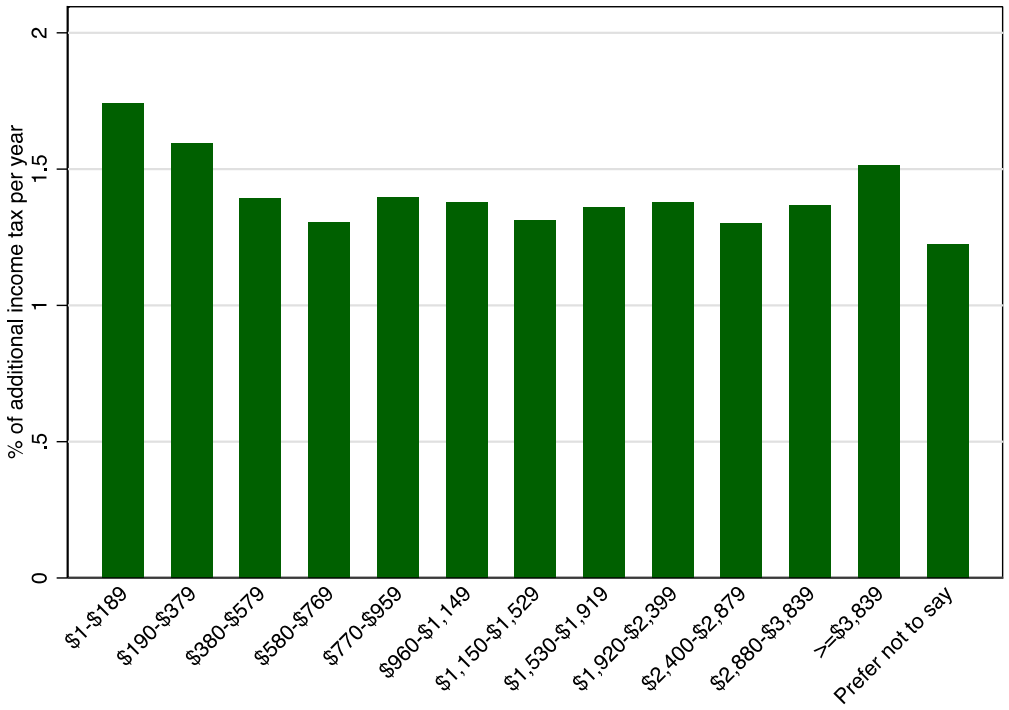
As a component of this survey, all 10,315 respondents (regardless of whether they indicated that they currently paid income tax or not) were informed that currently the government spends approximately 4% of tax collected from Australian taxpayers on aged care and asked whether they thought that the government should spend a greater proportion of taxpayers' dollars on aged care and less on other public services. In total, 59% of respondents agreed with this statement, with 9% disagreeing and 31% indicating that they were uncertain. Of those who agreed with this statement, (following the truncation of the data through removal of a small proportion of outliers providing implausible responses of >20%) the mean percentage of tax collected that respondents indicated should be spent on aged care (as opposed to other public services) was around 8% on average (mean 8.6%, median 8%, range 4-20%). This equates to a doubling of the current proportion of taxpayers' dollars allocated to support the funding of Australia's aged care system.

Those respondents who indicated that they currently pay income tax were then asked whether they would be willing to pay an additional amount in income tax (over and above their current income tax payment level) to ensure that all Australians have access to what they would consider to be (a) satisfactory and (b) high quality aged care. On close inspection it was found that a small proportion of respondents classified themselves as current income tax-payers whilst also indicating in Section D of the survey that their annual household income prior to deducting taxation was negative or zero ((n=30, 0.5% in total). Excluding these unreliable respondents provided a total useable sample of N=6563 current income tax payers of whom 61% (N=4030) indicated that they would be willing to pay an additional amount in income tax to ensure that all Australians have access to a satisfactory level of quality aged care. Of these, a very small proportion (n=17) provided implausibly high values for willingness to pay additional taxation rates of greater than 10% per year and one respondent had a missing value. Following these exclusions, the mean additional tax rate per year that respondents indicated they were willing to pay to ensure a satisfactory level of quality aged care was 1.4% (Table 13). A small proportion (3.6%) of respondents indicating a willingness to pay more than 2.5% additional taxation (with an extended upper bound of 10%) to ensure that all Australians have access to what they would consider to be a satisfactory level of quality aged care. When dis-aggregated by income group (Figure 18) it can be seen that there are some slight variations with those in the lowest weekly income bracket indicating a mean willingness to pay value of 1.7% in additional income tax and those in the highest income bracket indicating a mean willingness to pay value of 1.5% in additional income tax.

Table 13: Willingness to pay additional income tax to fund satisfactory quality aged care

Additional tax	**Satisfactory level of quality aged care**		
Percentage	N (4030)	Unweighted Percent (%)	Weighted Percent %
0.5%	1201	29.8	29.6
1%	1206	29.9	29.8
1.5%	525	13.0	13.2
2%	617	15.3	15.5
2.5%	321	8.0	8.2
More than this	160	4.0	3.6

Figure 18: Willingness to pay additional income tax to ensure equal access to a satisfactory level of quality aged care by income (weekly income)



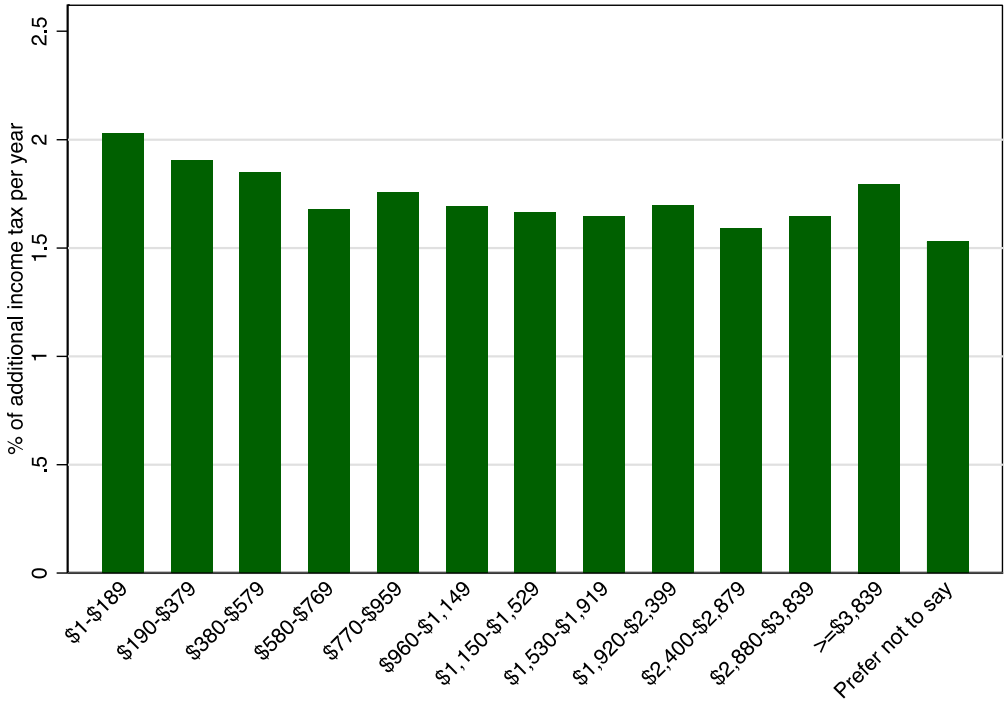
A smaller proportion of tax payer respondents (N=3591, 55%) indicated that they would be willing to pay a higher additional amount in income tax (beyond that previously indicated to achieve satisfactory quality aged care) to ensure that all Australians have access to what they would consider to be a high level of quality aged care. The mean additional income tax rate per year to move from a satisfactory level to high level of quality in aged care was a further 1.7% (Table 14) providing a combined total of 3.1%. A small proportion (6.8%) of respondents indicated a willingness to pay more than 2.5% additional taxation (with an extended upper bound of 10%) to ensure that all Australians have access to what they would consider to be a high level of quality aged care. Similar to the previous findings it can be seen that when disaggregated by income group (Figure 19) there are some slight variations. Respondents in the lowest weekly income bracket indicated a mean willingness to pay value of 2% in additional income tax and those in the highest income bracket indicated a mean willingness to pay value of 1.7% in additional income tax.

Table 14: Willingness to pay additional income tax to fund high quality aged care [1]

Additional tax[1]	**High level of quality aged care**		
Percentage	N (3591)	Unweighted Percent (%)	Weighted Percent (%)
0.5%	768	21.4	21.0
1%	809	22.5	22.3
1.5%	553	15.4	15.4
2%	623	17.3	17.3
2.5%	598	16.7	17.2
More than this	240	6.7	6.8

[1] Beyond the amount already indicated to secure satisfactory quality aged care

Figure 19: Willingness to pay additional income tax to ensure equal access to a high level of quality aged care by income (weekly income)



4. Discussion and conclusions

This research study is the first of its kind in Australia and internationally to undertake a large-scale assessment of the views and preferences of the general public for quality of aged care and the future funding of quality aged care. These are issues of critical importance for Australia's aged care system and for all Australians, especially as the Royal Commission moves towards its final recommendations and the proposed re-design of Australia's aged care system.

As with any study of this nature, this study has limitations that are important to understand and were discussed earlier in the report. Notwithstanding its inevitable limitations, the strengths of the research include its coverage of a large sample of the general public, representative of the Australian population by age group, gender and state or territory. It draws upon the data collected from a survey comprising responses from over 10,000 Australian adults, not currently receiving aged care services and hence potential future recipients, aged 18 to 91 years.

Overall, the findings from this survey indicate high levels of agreement amongst members of the general public about what constitutes quality in aged care. Salient characteristics consistently rated as highly important in encapsulating quality in aged care service delivery are largely reflective of the fundamentals of care: older people being treated with respect and dignity, aged care staff having the skills and training needed to provide appropriate care and support, the provision of services and supports for daily living that assist older people's health and wellbeing, and older people feeling safe and comfortable. Current deficiencies in this regard, particularly in relation to under-staffing and the need for more skills and training to deliver a uniformly high quality aged care workforce, are potentially strong in the public's conscience having featured prominently in recent media reports and the proceedings of the Commission.

When asked about the success of Australia's aged care system in achieving the most important priority characteristics for defining quality in aged care, it was evident that the public feel that there are current deficiencies and some work to be done to elevate the current aged care system to one that would generally be regarded as a high quality system. Whilst a small minority (less than 5%) of respondents felt that these characteristics were not being achieved at all, the most prevalent response indicated by approximately half of all respondents was that these characteristics were being achieved only 'sometimes' across Australia's aged care system. These findings may reflect the general public's awareness (and in some instances potentially an acute first-hand awareness) of the instances of neglect and abuse highlighted by the media and emanating from the witness statements and hearings of the Commission, and also recently documented in the Commission's Interim report [Royal Commission into Aged Care Quality and Safety, 2019].

The findings from the DCE largely reinforced the responses to the attitudinal statements. It is evident that respondents feel very strongly that an older person has a right to be treated with respect and dignity by a skilled and trained workforce should they need to access aged care, and to receive services and support important for their health and wellbeing. These characteristics were the most important influencers of the choice of service provider in the DCE with relatively less

emphasis overall placed on being supported in making your own decisions, a central tenet of the recent policy reform towards Consumer Directed Care in community aged care service delivery. These findings largely concur with a recent survey of older people and family carers conducted by COTA Australia [2018] which found that being treated with respect and dignity and the qualifications and skills of staff were among the most important characteristics that they would look for when choosing an aged care provider.

The results from the supplementary quality ratings task for the chosen aged care providers mirror the results from the DCE when considering the characteristics that elevate a provider from being rated as 'Unacceptable/Poor' quality compared with 'Satisfactory' quality. The most important quality of care influencers here were that an older person has a right to be treated with respect and dignity by a skilled and trained workforce should they need to access aged care, and to receive services and support important for their health and wellbeing. When considering the characteristics that elevate a provider from being rated as 'Satisfactory' to 'High/Very high' quality, the additional importance of the ability to lodge complaints with confidence that appropriate action will be taken is evident. Being supported in making your own decisions about care and services was again among the less influential characteristics.

In relation to attitudes towards funding, there was generally support amongst the public for co-contributions (in line with ability to pay) to access satisfactory or high-level quality care.

- On average respondents who were willing to pay a co-contribution indicated that they would pay $162.52 per week to receive a satisfactory level of quality home care and $240.95 per week to receive a high level of quality home care.
- It is well documented that the overwhelming preference of the vast majority of Australians when they need aged care is to remain independent and living at home and avoid moving into a residential care facility if at all possible [Australian Institute of Health and Welfare, 2018; Productivity Commission, 2011]. Commensurate with this preference, a significant majority of respondents (72%) indicated that they would be willing to pay co-contribution fee to allow them to remain living at home rather than enter residential care. On average, respondents were willing to pay $184 per week (equating to $9,568 per year) to achieve this. A significant minority of respondents (10%) indicated that they would be willing to pay relatively high amounts of at least $450 per week (equating to $23,400 per year) to remain living at home and avoid moving into a residential care facility.
- On average, respondents indicated a willingness to increase the co-contribution to $528.75 per week to receive a satisfactory level of quality residential care and $693.11 per week to receive a high level of quality residential care (equating to an additional quality payment of $164 per week or 31%).
- Respondents with current experience of the aged care system were willing to pay more on average in co-contributions than those without current experience. As expected, those respondents reporting higher income levels were also willing to pay more on average in co-contributions than those on lower incomes.

There was a recognition amongst the general public of the central role that government funding plays in the financing of a quality aged care system. When asked directly about their level of agreement with the statement 'the government should provide more funding for aged care' the vast majority (87%) indicated that they either 'agreed' or 'strongly agreed' with this statement. The responses in relation to where this additional funding should come from were more mixed. A majority (59%) of respondents indicated that this additional funding should come from a re-configuration of public expenditures. The Australian government currently allocates 4% of tax collected to Australia's aged care system, whereas the mean percentage of tax collected that respondents indicated should be spent on Australia's aged care system (as opposed to other public services) was 8.6% with a median of 8%.

Approximately half of all respondents were willing to pay more tax to ensure equity of access to aged care for all Australians in need and/or to improve the quality of the aged care services being provided. However, when considering current income taxpayers only, these estimates increased with 61% of current taxpayers indicating a willingness to pay more income tax to ensure equal access to a satisfactory level of quality aged care. These taxpayers on average indicated that they would be willing to pay an additional 1.4% per year in income tax to ensure that all Australians have access to what they would consider to be a satisfactory level of quality aged care. Furthermore, 55% of current taxpayers indicated that they would be willing to pay a further 1.7% beyond that already specified for a satisfactory level of quality aged care (equating to 3.1% additional income tax in total) to ensure equal access to a high level of aged care.

In conclusion, this report highlights the strong significance that Australians place on the care of our most vulnerable citizens and that quality in aged care is highly valued. It shows the general public recognise the current deficiencies of Australia's aged care system and believe significantly more government funding should be allocated to achieve higher quality aged care, in addition to using co-contributions based on care recipient's capacity to contribute. It shows a majority of current income taxpayers would be willing to pay more income tax to ensure a high-quality aged care system is achieved. These findings provide an important and timely societal perspective with which to inform aged care policy and practice in Australia and in other countries which share similar values, aspirations and circumstances.

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6. Sample survey

Screener

MR- ask all

ASK ALL- Terminate if code f- Aged care selected

S1 Which, if any, of the following do you personally have or use for yourself?

a. Medicare card
b. Private Health insurance
c. Childcare services
d. Health care card
e. Student card
f. Aged care services
g. None of the above

OE NUM: ASK ALL- QUOTA: AGE

S2 What is your age?

……(years)

SR: ASK ALL- QUOTA: GENDER

S3 Are you?

Female	○
Male	○

OE NUM: ASK ALL- QUOTA: LOCATION-
PLEASE USE THE AP POSTCODE WITH SUBURBS (FOR GEOTRIBE)

S4 What is your post code?

……

SR: ASK ALL

S5 What **type of dwelling** do you live/reside in?

Separate house (detached)	1
Semi-detached / duplex	2
Unit / Apartment	3
Row / Terrace	4
Townhouse / Villa	5
Other	6

Aged care — We need to know your views

Introduction

INTRO/SHOW ALL HOLD PAGE =15 secs

Australia's Royal Commission into Aged Care Quality and Safety wants to know your views about aged care and the extent to which the current Australian aged care system meets the unique preferences, values and needs of older people who are receiving care and the funding of aged care in the future.

As you age, you may need some form of aged care service in the future. In 2018, more than a quarter of a million people (282,000) were using residential care and high level home support services, and more than three quarter million people (783,000 people) were using basic home support services.

We are asking you and others, of many ages, to undertake this survey to give us that information. Your opinions will enrich our understanding of the diversity and needs of the Australian community and guide our work.

The survey should take around -15 minutes to complete. Your responses will remain confidential and will be analysed anonymously as part of the total pool of respondents.

Section A: Your attitudes towards aged care in Australia

SR PER ROW - ASK ALL

Q1- We would like you to read through each statement and indicate how important each statement is, in your opinion, to ensuring quality of care in home and residential care. *Click on the button that best represents your views*.

STATEMENT	NOT IMPORTANT	SLIGHTLY IMPORTANT	MODERATELY IMPORTANT	IMPORTANT	VERY IMPORTANT
Older people should be treated with respect and dignity					
Aged Care Staff should have the skills and training needed to provide appropriate care and support					
Older people and their families should be supported to raise any concerns they have with the aged care service they are receiving from organisation(s) providing their care					
Older people should be supported to make informed choices about the care and services that they receive					
Older people should be supported to live the life they choose					
The care and services provided to older people should meet their needs, goals and preferences.					
Older people should be supported to maintain their social relationships and connections with the community					
The identity, culture and personal history of the older person should be known and valued by staff					
Older people should feel safe and comfortable receiving aged care services whether in a nursing home or in their own home					
Older people should have a trusting and supportive relationship with the staff providing their care					

SR: ASK ALL

Q2- How well do you think you understand Australia's current aged care system?
Click on the relevant button.

NOT AT ALL	SLIGHTLY	SOMEWHAT	FAIRLY WELL	VERY WELL	DON'T KNOW
○	○	○	○	○	○

If Respondent indicates Somewhat, Fairly Well or Very Well

MR: ASK IF Q2= 3,4,5

PROGRAMMER: PLEASE PIPE IN THE 9 STATEMENTS FROM Q1 FOR THIS QUESTION ONLY ALLOW MIN. AND MAX. OF 3 RESPONSES

Q3- Please review the list of statements above (**re-present the statements in the on-line programming**) and pick out the three that, in your opinion, reflect the most important elements of quality aged care for older Australians.

Statement 1 _____
Statement 2 _____
Statement 3 _____

SR PER ROW - ASK ALL
PROGRAMMER: PLEASE PIPE IN 3 STATEMENTS SELECTED AT Q3

Q4- Thinking about each of these three statements, please rate how successful you think the aged care system in Australia is in achieving them currently.
Click on the relevant button.

STATEMENT	NOT AT ALL SUCCESSFUL	RARELY SUCCESSFUL	SOMETIMES SUCCESSFUL	VERY OFTEN SUCCESSFUL	ALWAYS SUCCESSFUL	DON'T KNOW
1: (**insert relevant statement**)	●	●	●	●	●	●
2: (**insert relevant statement**)	●	●	●	●	●	●
3: (**insert relevant statement**)	●	●	●	●	●	●

Section B: How would you choose?

INTRO/SHOW ALL HOLD PAGE = 5 secs

We need to gain an understanding of how you would choose an aged care provider for yourself or someone close to you. We have posed six different scenarios. Please respond to each scenario, choosing the provider you would prefer in each.

Although some of the scenarios may appear similar please note that the descriptions do differ in each scenario so please read each question carefully before making your choices

You should also assume that the two providers are the same in all other characteristics other than those described.

Scenario 1 *(*randomise order of provider A and B labels in on-line programming*)*

CHARACTERISTIC	PROVIDER A	PROVIDER B
I am treated with respect and dignity	**Never**	**Always**
I am supported to make my own decisions about the care and services I receive	**Never**	**Always**
I receive care and support from aged care staff who have the appropriate skills and training	**Never**	**Always**
I receive services and support for daily living that are important for my health and wellbeing	**Never**	**Always**
I am supported to maintain my social relationships and connections with the community	**Never**	**Always**
I am comfortable lodging complaints, with confidence that appropriate action will be taken	**Never**	**Always**

SR: ASK ALL

If you had to make a choice between these two providers based on these characteristics which one would you choose? ***Select one***

Provider A ○ Provider B ○

SR: ASK ALL

Quality rating

Think about the provider you have chosen and the quality characteristics associated with it. How would you rate the overall quality of their care? ***Select one***

○	○	○	○	○
Unacceptable	Poor	Satisfactory	High	Very High

*(*randomise order of presented characteristics for each scenario 2-6*)*

Scenario 2

CHARACTERISTIC	PROVIDER A	PROVIDER B
I am treated with respect and dignity	Sometimes	Sometimes
I am supported to make my own decisions about the care and services I receive	**Sometimes**	**Always**
I receive care and support from aged care staff who have the appropriate skills and training	**Rarely**	**Sometimes**
I receive services and support for daily living that are important for my health and wellbeing	Mostly	Mostly
I am supported to maintain my social relationships and connections with the community	**Rarely**	**Mostly**
I am comfortable lodging complaints, with confidence that appropriate action will be taken	Always	Always

SR: ASK ALL

If you had to make a choice between these two providers based on these characteristics which one would you choose? ***Select one***

Provider A ○ Provider B ○

SR: ASK ALL

Quality rating

Think about the provider you have chosen and the quality characteristics associated with it. How would you rate the overall quality of their care? ***Select one***.

○	○	○	○	○
Unacceptable	Poor	Satisfactory	High	Very High

Scenario 3

CHARACTERISTIC	PROVIDER A	PROVIDER B
I am treated with respect and dignity	**Always**	**Rarely**
I am supported to make my own decisions about the care and services I receive	Sometimes	Sometimes
I receive care and support from aged care staff who have the appropriate skills and training	**Mostly**	**Rarely**
I receive services and support for daily living that are important for my health and wellbeing	Mostly	Mostly
I am supported to maintain my social relationships and connections with the community	Sometimes	Sometimes
I am comfortable lodging complaints, with confidence that appropriate action will be taken	**Sometimes**	**Always**

SR: ASK ALL

If you had to make a choice between these two providers based on these characteristics which one would you choose? ***Select one***

Provider A ○ Provider B ○

SR: ASK ALL

Quality rating

Think about the provider you have chosen and the quality characteristics associated with it. How would you rate the overall quality of their care? ***Select one***

○	○	○	○	○
Unacceptable	Poor	Satisfactory	High	Very High

Scenario 4

CHARACTERISTIC	PROVIDER A	PROVIDER B
I am treated with respect and dignity	Sometimes	Sometimes
I am supported to make my own decisions about the care and services I receive	Rarely	Rarely
I receive care and support from aged care staff who have the appropriate skills and training	Rarely	Rarely
I receive services and support for daily living that are important for my health and wellbeing	**Rarely**	**Always**
I am supported to maintain my social relationships and connections with the community	**Sometimes**	**Rarely**
I am comfortable lodging complaints, with confidence that appropriate action will be taken	**Always**	**Sometimes**

SR: ASK ALL

If you had to make a choice between these two providers based on these characteristics which one would you choose? ***Select one***

Provider A ○ Provider B ○

SR: ASK ALL

Quality rating

Think about the provider you have chosen and the quality characteristics associated with it. How would you rate the overall quality of their care? ***Select one***

○	○	○	○	○
Unacceptable	Poor	Satisfactory	High	Very High

Scenario 5

CHARACTERISTIC	PROVIDER A	PROVIDER B
I am treated with respect and dignity	Sometimes	Sometimes
I am supported to make my own decisions about the care and services I receive	**Sometimes**	**Mostly**
I receive care and support from aged care staff who have the appropriate skills and training	**Mostly**	**Rarely**
I receive services and support for daily living that are important for my health and wellbeing	Always	Always
I am supported to maintain my social relationships and connections with the community	Mostly	Mostly
I am comfortable lodging complaints, with confidence that appropriate action will be taken	**Mostly**	**Never**

SR: ASK ALL

If you had to make a choice between these two providers based on these characteristics which one would you choose? ***Select one***

Provider A ○ Provider B ○

SR: ASK ALL

Quality rating

Think about the provider you have chosen and the quality characteristics associated with it. How would you rate the overall quality of their care? ***Select one***

○	○	○	○	○
Unacceptable	Poor	Satisfactory	High	Very High

Scenario 6

CHARACTERISTIC	PROVIDER A	PROVIDER B
I am treated with respect and dignity	**Mostly**	**Rarely**
I am supported to make my own decisions about the care and services I receive	Always	Always
I receive care and support from aged care staff who have the appropriate skills and training	Sometimes	Sometimes
I receive services and support for daily living that are important for my health and wellbeing	**Sometimes**	**Never**
I am supported to maintain my social relationships and connections with the community	Always	Always
I am comfortable lodging complaints, with confidence that appropriate action will be taken	**Never**	**Always**

SR: ASK ALL

If you had to make a choice between these two providers based on these characteristics which one would you choose? ***Select one***

Provider A ○ Provider B ○

SR: ASK ALL

Quality rating

Now thinking only about the provider you have chosen and the quality characteristics described relating to that provider, how would you rate the overall quality of their care? ***Select one***

○	○	○	○	○
Unacceptable	Poor	Satisfactory	High	Very High

Section C: Your attitudes to funding aged care

HOLD PAGE =10 secs

Currently Australians receiving aged care pay on average around ¼ of the cost themselves, and the rest is paid by taxpayers.

Home care is support that enables an older person to remain living independently in their own home. It typically involves help with activities like gardening, shopping, cooking and cleaning. It may also include help with personal care, such as showering, dressing, access to allied health professionals (e.g. physiotherapists, podiatrists) and nursing care.

Residential care is support provided in a residential care facility over a 24-hour period, seven-days-a-week. It typically involves nursing care and services that support someone with deteriorating health.

We would now like you to imagine a future where you need aged care services. When answering the following questions, please consider your expected level of income and expenses at that time.

SR: ASK ALL

Satisfactory level of quality home care

C3- In order to continue living in your home independently, you need to access **home care** services. Thinking about the ratings of quality of care you gave in the previous section of this survey, would you be willing to pay a fee to ensure that you have access to what you consider to be a **satisfactory level** of quality in **home care**

YES ● NO ●

***If Respondent indicates* YES SR: ASK IF C3= YES**

C4 How much would you be willing to pay **per week** to guarantee that you have access to what you consider to be a **satisfactory level** of quality **home care**?

Click on the relevant button

$75	$150	$225	$300	$375	$450	More than $450
●	●	●	●	●	●	●

If you would be willing to pay more than $450 per week please specify the amount here …….

SR: ASK ALL

High level of quality home care

C5- Would you be willing to pay a higher $ amount **per week** to guarantee that you have access to what you consider to be a **high level** of quality **home care**?

YES ○ NO ○

If Respondent indicates **YES SR: ASK IF C5= YES**

C6- How much would you be willing to pay **per week** to ensure that you have access to what you consider to be a **high level** of quality in **home care**?

Click on the relevant button (**re-present payment scale with chosen amount from previous as the lowest amount and higher amounts presented in the on-line programming**)

$75	$150	$225	$300	$375	$450	More than $450
○	○	○	○	○	○	○

If you would be willing to pay more than $450 per week please specify the amount here…….

SR: ASK ALL

Staying in your own home

C1- You now find that your health has deteriorated to the extent that you can no longer live at home independently and you require a lot of support and care provided on a daily basis. If your aged care provider could provide you with an intensive home care package that would give you the care and support you need on a daily basis, would you choose to remain at home or would you choose to move into a residential care facility?

Select one

A. I would choose to remain at home ●
B. I would choose to move into residential care ●

If Respondent indicates A.

SR: ASK IF C1= A

C2- How much would you be willing to pay per week to guarantee that you could stay in your own home, receiving the support you need, instead of going into residential care

Select one

$0	$75	$150	$225	$300	$375	$450	More than $450
●	●	●	●	●	●	●	●

If you would be willing to pay more than $450 per week please specify the amount here…….

Now please imagine that because of your health and wellbeing needs you are no longer able to remain at home and you need to access a higher level of care provided in a residential care facility. Residential care fees cover living expenses, accommodation costs and care services. Residential care fees are means tested:

- full pensioners with no income or assets pay $360 per week,
- pensioners with some income or assets pay between $360 and $760 per week
- self-funded retirees with a large amount of income and assets typically pay between $760 and $1290 per week

SR: ASK ALL

Satisfactory level of quality residential care

C7- Thinking about the ratings of quality of care you gave in the previous section of this survey, would you be willing to pay a fee to ensure that you have access to what you consider to be a **satisfactory level** of quality in **residential care**?

YES ○ NO ○

***If Respondent indicates* YES SR: ASK IF C7= YES**

C8- How much would you be willing to pay **per week** to guarantee that you have access to what you consider to be a **satisfactory level** of quality in **residential care**?

Click on the relevant button

$400	$600	$800	$1000	$1200	$1400	More than $1400
○	○	○	○	○	○	○

If you would be willing to pay more than $1400 per week please specify the amount here……

SR: ASK ALL

High level of quality residential care

C9- Would you be willing to pay a higher $ amount **per week** to guarantee that you have access to what you consider to be a **high level** of quality in **residential care**?

YES ○ NO ○

If Respondent indicates **YES SR: ASK IF C8= YES**

C10- How much would you be willing to pay **per week** to ensure that you have access to what you consider to be a **high level** of quality and in **residential care**?

Click on the relevant button (**re-present payment scale with chosen amount from previous as the lowest amount and higher amounts presented in the on-line programming**)

$400	$600	$800	$1000	$1200	$1400	More than $1400
○	○	○	○	○	○	○

If you would be willing to pay more than $1400 per week please specify the amount here…….

SR PER ROW: ASK ALL

C11- Below are a series of statements about funding for Australia's aged care system. Click on the button that best represents your views.

Statement	Strongly Agree	Agree	Neither agree nor Disagree	Disagree	Strongly Disagree
The Government should provide more funding for aged care	●	●	●	●	●
I would be willing to pay more tax to ensure Australians are able to access aged care services when they need them	●	●	●	●	●
Australians should contribute towards the funding for the aged care services that they receive in line with their ability to pay	●	●	●	●	●
I would be willing to pay more tax to improve the quality of the aged care services being provided to older Australians	●	●	●	●	●

SR: ASK ALL

C12- Currently the Australian government spends 4% of tax collected from each taxpayer annually in Australia on aged care. Do you think the Australian government should allocate a greater proportion of taxpayer's $ on aged care and less on other public services?

YES ● NO ● UNCERTAIN ●

If Respondent indicates YES

OE NUM- ASK IF C12= YES OE NUM RANGE 0-100

C12A- What percentage of tax collected do you think should be spent on aged care annually?

….%

SR: ASK ALL

C13- Do you currently pay income tax?

YES ● NO ●

If Respondent indicates YES sequence through the next four income tax questions

SR: ASK IF C13= YES

Satisfactory level of quality aged care

C14- Would you be willing to pay an additional amount in income tax to ensure that all Australians have access to what you consider to be a **satisfactory level** of quality aged care

YES ● NO ●

If Respondent indicates YES

SR: ASK IF C14= YES

Satisfactory level of quality aged care

C15- What percentage of additional income tax per year would you be willing to pay to ensure that all Australians have access to what you consider to be a **satisfactory level** of quality aged care? Please click on the relevant amount

0.5% 1% 1.5% 2% 2.5% More than this (Please specify) ……%

SR: ASK IF C13= YES

High level of quality aged care

C16- Would you be willing to pay a higher amount in income tax to ensure that all Australians have access to what you consider to be a **high** level of quality aged care?

YES ● NO ●

If Respondent indicates YES

SR: ASK IF C16= YES

High level of quality aged care

C17- How much more would you be willing to pay in additional income tax per year to ensure that all Australians have access to what you consider to be a **high level** of quality aged care? Please click on the relevant amount (**re-present payment scale with chosen amount from previous as the lowest amount and higher amounts presented in the on-line programming**)

0.5% 1% 1.5% 2% 2.5% More than this (Please specify) ……%

Section D: Your socio-demographic characteristics

INTRO/SHOW ALL

We would be grateful if you could provide a few details about yourself.
All of the information you provide will be treated in complete confidence and used for research purposes only.

SR: ASK ALL

D1- Do you live?

On your own	○
With spouse / partner	○
With family	○
With others – not relatives	○

SR: ASK ALL

D2- What is the highest educational qualification you have?

Primary school	○
Some secondary school	○
Completed high school	○
Some additional training (eg TAFE, apprenticeship)	○
Undergraduate university	○
Postgraduate university	○

SR: ASK ALL

D3- Were you born in Australia?

YES ○ NO ○

OE: ASK IF D3=NO

D4- What country you were born in?

●	England
●	New Zealand
●	China
●	India
●	Philippines
●	Vietnam
●	Italy
●	South Africa
●	Malaysia
●	Scotland
●	Other, please specify_

SR: ASK ALL

D7- Do you have a close family member who is currently receiving aged care services?

YES ● NO ●

SR: ASK IF D7= YES

D8- are they receiving?

Home care	●
Residential care	●

OE: ASK if code 2-4 at D1 Auto code 1 if D1=1

D9- How many people currently live in your household (including yourself)?

●	1
●	2
●	3
●	4
●	5
●	More than 5

SR: ASK ALL

D10- What is your current employment status?

Please Click on the relevant button

○	Employed full-time
○	Employed part-time
○	Undergraduate or post-graduate university student
○	Retired
○	Unemployed
○	Other (please specify)

SR: ASK ALL EXCEPT UNEMPLOYED(D10=5) AT D10

AUTOCODE THIS QUESTION AS "NOT IN THE WORKFORCE" IF D10=UNEMPLOYED

D11- Please click on the category below that best describes your occupation. If you are retired please click on the category that best describes your most recent occupation

○	Manager
○	Professional
○	Technicians & Trade Workers
○	Community & Personal Service Worker
○	Clerical & Administrative Worker
○	Sales Worker
○	Machinery Operators & Drivers
○	Labourer
○	Not in the workforce (e.g. student, homeworker)

SR: ASK ALL

D12- Please can you estimate the annual income of your household before deducting tax? (If you receive any benefits or pensions please include them as income).
Click on the relevant button

○	Negative or zero Income
○	$ 1 - $9,999 per year ($1 - $189 per week)
○	$ 10,000 - $19,999 per year ($190 - $379 per week)
○	$ 20,000 - $29,999 per year ($380 - $579 per week)
○	$30,000 - $39,999 per year ($580 - $769 per week)
○	$ 40,000 - $49,999 per year ($770 - $959 per week)
○	$ 50,000 - $59,999 per year ($960 - $1149 per week)
○	$60,000 - $79,999 per year ($1150 - $1529 per week)
○	$ 80,000 - $99,999 per year ($1530 - $1919 per week)
○	$100,000 - $124,999 per year ($1920 - $2399 per week)
○	$ 125,000 - $149,999 per year ($2400 - $2879 per week)
○	$ 150,000 - $199,999 per year ($2880 - $3839 per week)
○	$ 200,000 or more per year ($3840 or more per week)
○	Prefer not to say

SR: ASK ALL

D13- Which of these statements best describes your situation with regards to money? Click on the relevant button

○	I normally have enough money for everything I want
○	I have enough money, so long as I plan my spending carefully
○	I have enough money for basic things, but I can't afford anything unnecessary
○	Sometimes it is hard for me to afford even the basic things I need