



**Australian Health Policy Institute
at the University of Sydney**

***Australian directions in aged care:
the generation of policies for
generations of older people***

Hal Kendig
The University of Sydney

Stephen Duckett
La Trobe University

Australian Health Policy Institute
Commissioned Paper Series 2001/05

Published by

The Australian Health Policy Institute at the University of Sydney
Victor Coppleson Building (D02)
University of Sydney, NSW 2006
Australia

ISBN 1 86487 432 5

© The Australian Health Policy Institute at the University of Sydney 2001

For further information regarding The Australian Health Policy Institute or this publication, please contact:

Associate Professor Michael Frommer
Academic Co-ordinator
The Australian Health Policy Institute
Victor Coppleson Building (D02)
University of Sydney, NSW 2006
Australia

Telephone: +61 2 9351 4394
Facsimile: +61 2 9351 7218
Email: mfrommer@med.usyd.edu.au
URL: <http://www.usyd.edu.au/chs/ahpi>

ABOUT THE AUTHORS

Hal Kendig, AB *Calif*, MPL, PhD *S. Calif*, FASSA

Professor Hal Kendig serves as Dean of the Faculty of Health Sciences at the University of Sydney. He formerly directed the Australian Research Council's Key Centre in Gerontology at La Trobe University. His earlier appointments at the Australian National University were in the Research School of Social Sciences and the National Centre for Epidemiology and Population Health. He is a member of the Academy of Social Sciences in Australia, Honorary Life Member of the Council on the Ageing (Australia), and co-chair of Planning and Research for the International Association of Gerontology Asia-Oceania.

His research includes longitudinal surveys and evaluations on the health of older people, community care, housing, retirement, and international studies. His most recent book, *Who Should Care for the Elderly? East-West* (co-edited with Professor William Liu) won the Outstanding Book Award for the Australasia Journal on Ageing in 2000. Other books include *The Sociology of Ageing* (1996), *Towards Healthy Ageing* (1994), *It's My Place* (1993), *Family Support to the Elderly* (1992), and *Grey Policy* (1990).

Stephen Duckett, BEc *ANU*, MHA PhD *UNSW*, DipEd (Tert) *Darling Downs*, DipLegStuds, FCHSE

Professor Stephen Duckett is Professor of Health Policy, Dean of the Faculty of Health Sciences and Pro Vice-Chancellor (Health Developments) at La Trobe University. From 1994 to March 1996 he was Secretary of the then Commonwealth Department of Human Services and Health. From 1983 to 1993, Professor Duckett held various operational and policy positions in the Victorian Department of Health and Community Services and its predecessors, including Regional Director of the Western Metropolitan Region and Director of Acute Health Services.

Professor Duckett is an economist with a Masters degree and PhD in Health Administration from the University of New South Wales. He is a Fellow of the Australian College of Health Service Executives.

In 1999-2000 he was Chair of the Victorian Ministerial Review of Health Care Networks. He is currently Chair of the Board of Directors of Bayside Health (the metropolitan health service responsible for The Alfred, Caulfield and Sandringham hospitals) and Chair of the Board of Directors of the Brotherhood of St Laurence.

His research principally concentrates on the economics of hospital care including development and use of casemix measures and methods of financing hospital care.

Contents

Introduction	1
Social and policy legacies	4
The Menzies era.....	5
The Whitlam and Fraser Governments	8
The Hawke-Keating Government.....	9
Howard-Costello Government.....	12
The aged care system today.....	16
Community care for older people and people with disabilities.....	18
Current policy issues in community care	23
Residential care.....	24
Government care subsidies.....	25
Resident's payments	26
Assessment	28
Quality of residential aged care	32
Current policy issues in residential care.....	34
Carers' payments and benefits.....	35
Interface with the health system	36
What is wrong with the current system?	41
The contemporary policy environment	42
The future social and economic base for aged care	47
Consumer viewpoints.....	47
Population dimensions	51
Cohort momentum	54
Towards an affordable 'choice-based' aged care system for 2020.....	60
A constructive approach to ageing and support.....	61
Funding approaches	63
Commonwealth-State reorganisation of functional responsibilities.....	67
Regional fund pooling.....	69
Unbundling housing and aged care.....	71
Directions: towards evidence-based aged care policy	74
Acknowledgements.....	79
References	80
Commentaries - Mr Denys Correll	88
- Dr Diane Gibson.....	96
- Mr Greg Mundy.....	101

List of figures

Figure 1	Government health and welfare expenditure on older Australians, 1995-96	17
Figure 2	Australia: Home and Community Care expenditure, by type of service, 1997/98.....	19
Figure 3	Australia: cumulative number of separate Home and Community Care organisations providing services to a client, November 1997	20
Figure 4	Australia: service provision per 1000 population over 70, by state or territory, November 1997.....	21
Figure 5	Community aged care packages per 1000 population 70+, 30 June 2000 by geographic area.....	23
Figure 6	Australia: number of persons in residential aged care facilities per 1000 population, by age and gender, 30 June 2000	30
Figure 7	Lifetime probability of permanently residing in aged care facility, 1999-2000.....	31
Figure 8	Australia: duration of stay of permanent residents in nursing homes, by mode of separation, 1 July 1999 to 30 June 2000	32
Figure 9	Australia: hospital utilisation rate (separations per 1000 population; patient days per 100 population) by age group and gender 1999/2000.....	38
Figure 10	Distribution of population and benefits paid by health insurance funds.....	38

List of tables

Table 1	Percentage of residents and basic residential aged care facility subsidy per resident per day (from 1 July 2001).....	26
Table 2	Residential places per 1000 people aged 70 and over, state/territory by geographic area, as at 30 June 2000	30
Table 3	Projections of total health costs as percent of GDP under various assumptions	43
Table 4	Options for development of aged care funding.....	66
Table 5	Current funder/purchaser roles for aged and disability services	68

Introduction

Over recent years aged care has emerged as a significant public issue in the popular media and in the rhetoric of politicians anticipating elections. The prominence of nursing home scandals reflects a deep and longstanding public concern for vulnerable older people. The major issues of aged care, however, have recently been attracting wider public attention, emerging from their place on the 'back burner' of politics in the 1980s (Kendig, 1990). This increasing public recognition arises partly from the dominant baby boom cohort's involvement with their ageing parents and anticipation of their own old age. Governmental responsiveness to ageing also reflects the problematic politics of appealing to older voters in times of fiscal restraint, economic uncertainty and population ageing.

This essay is written for a wide public audience to interpret longer-term socioeconomic and political changes influencing aged care in order to better assess directions and options for aged care in the future. While politics and programs are understandably preoccupied by the present, major improvements require diagnosis of reasons behind difficulties in the current system and a feasible vision for new directions. The past needs to be understood because present policies, with all their flaws, are difficult to change given the interest groups that benefit from them and the way in which current provision structures public expectations. The future needs to be anticipated far in advance because long lead times are required for considering individual and societal investments and redistribution over the life span. In our view, academic commentators can effectively contribute to policy development through conceptualising problems - and possible solutions - for policymakers who may draw on them when opportunities or challenges arise.

Policy development is not 'a conveyor belt in which agenda-setting takes place at one end of the line and implementation and evaluation occurs at the other' (Parsons, 1995, p. 79). Rather, there are many influences on policy development and many opportunities for contribution to the policy process. A key part of policy development is ensuring that one's favourite issue is on the 'policy agenda'. Academic analysis may contribute here, but a traditional role of academics has been and continues to be that of the 'independent critic', contributing to the policy debate through analysis. Academics can bring to policy debates expertise not beholden to the government of the day or

particular interest groups. This essay is cast in that tradition through analysis of the factors that have led to contemporary policies and descriptions of the current aged care environment. We also identify possible options for responding to contemporary and emerging needs.

Understanding longer-term development of age-related policies requires attention to the complex ways in which individual and population ageing relate to needs, resources, and social and economic change:

1. *Individual ageing* needs to be appreciated in terms of lifelong development of expectations, resources, and vulnerabilities. Experiences in old age reflect the great variation of individuals over the life course. Older people as a category for government consideration reflects a clustering of issues concerning the opportunities and risks of retirement and child launching; health, income and social vulnerabilities; and wider public expectations and stereotypes for old age and old people.
2. The *generational* dimension of age policy reflects the interdependence between age groups and their changing places as they grow older, relate to each other, and eventually succeed each other from birth to death. Families are central to understanding economic and informal support over lifetimes, and beyond through inheritance.
3. The *cohort* dimension recognises that each of the successive groups entering old age bring with them a legacy arising from the historical circumstances of their childhoods, when they formed core values and orientations, and the economic and social opportunities and constraints faced in the course of their adult lives.
4. Finally, experiences of ageing are heavily influenced by the *period of history* in which people live their later years. Major influences on policy are economic growth (or not), the economic prospects of other age groups, public attitudes towards ageing and older people, and of course the ideologies and constituencies of parties in power and the policymakers who implement their policies.

Within the broad framework of age policy, aged care is a relatively new concept that has been widely understood only over recent decades. While virtually everybody will provide and/or receive aged care sometime in their life, less than one out of five older people require any assistance with the household tasks or activities of daily living that are central to aged care. Older people who require care present distinctive policy challenges because they typically are also rendered vulnerable by poor health, low income, and limited informal support. Their capacities as consumers can be limited and assistance may be required with carers as well as older people themselves. Indeed, a major historical change has been the increasing recognition of the importance of caregivers, notably spouses of older people and middle-aged daughters. These features of aged care present complex challenges in designing and delivering services that meet needs effectively.

The next section of the paper reviews the past generations of older people and the policies and the interest groups that led to the formation of the current system of aged care. The paper then turns to features and issues concerning the current system of aged care and the processes by which policies are developed. The longer-term directions for aged care need to anticipate changes in the older population, notably the rising expectations of the large baby boom cohort, and available information for gauging these changes is reviewed in the next major section. The final major section begins with key criteria for policy and perspectives of older consumer groups and it then turns to what we believe are the two major domains in which aged care policies will unfold: firstly, a constructive approach to ageing and, secondly, alternative ways of financing aged care. The paper concludes with suggestions for ways in which information and analysis could better inform policy debates on aged care.

Our broad and long-term view of aged care inevitably means that the paper has a number of limitations that must be acknowledged. Our emphasis is on directions for national policies, with only some illustrations from the States (NSW and Victoria) and regional levels where aged care is actually delivered. We regret that this scope has not allowed for sufficient attention to the great diversity among older people, overseas policy experiences, and theoretical perspectives. Fortunately, comprehensive and scholarly treatment of policies concerning older people are found in significant books - including Borowski, Encel and Ozanne (1997) Gibson (1998), McCallum and

Geiselhart (1996), and Sax (1993) - and there also are many valuable consultancy reports, aged care statistics, and policy and position papers. Finally, while our own views inevitably pervade the paper, we have aimed to restrain explicit presentation of personal values and to work within values already expressed by older people and public policies.

Social and policy legacies

The present aged care system and the forces on it can be traced directly back to social and policy developments since World War II. It is useful to review key features of these developments because their legacies are found in the expectations and actions of both providers and consumers of aged care. People in the seventies age group today typically would have seen the support of their then older parents back in the 1970s and their grandparents back in the 1940s and 1950s. Many senior managers in the aged care industry today would have entered the workforce back in the 1960s and 1970s. Further accounts of the changes of the older population over these times can be found in Rowland (1992) and Borowski and Hugo (1997), and early policy accounts include Kewley (1973), and Kendig and McCallum (1990).

As outlined below, the postwar aged care developments have been transformed by the following long-term trends:

- Increasing involvement by government in the care and support of older people;
- A shift of leadership and power in structuring the aged care industry from providers, first voluntary and later more private for profit, to government funders.
- The rising expectations and financial resources of increasingly significant proportions of older people anticipating and requiring care.
- Political and program recognition of carers as central to aged care, and the centrality of caring to crucial issues concerning gender relations and equity.
- A reversal of two fundamental expectations for the distribution of financial resources: (1) the vast majority of older people can no longer be assumed to be economically disadvantaged by their cohort of birth and their stage of life; and (2) it is no longer the fact that real incomes will continue to rise

and the public share of resources will increase (evidently untrue over the last decade).

- Closely related to the above trends are the increasing expectations of older cohorts and their personal capacities and resources for achieving them.
- Not until the 1990s did population ageing begin to have an appreciable impact on policies and programs and to date these effects have been confined largely to the growth of the very old population aged 80 years and over (Rowland, 1992).

The Menzies era

The origins of present aged care policy can be traced directly back to the early postwar developments in the era of family responsibility, voluntarism in welfare, and optimism for a making a better world - particularly for returned servicemen and their families (Kewley, 1973). At that time most people did not reach old age let alone live very far into retirement. National policy specifically for older people was limited basically to either the meagre pension available to less than a third of older people, and hospital-based services funded under the 1951 Pensioner Medical Service. With their childhoods in the 19th Century, older people at the time had low expectations and there was little question that care responsibilities rested with self-provision or family support. Few older women at the time would have experienced the widening of employment opportunities afforded to younger women (at least temporarily) by the war.

In the early postwar era the national response to the needs of older people was limited given States' responsibilities for health and welfare and the conservatism of the early Menzies era. However, prototypes of later aged care systems were found in *homes* for independent older couples provided by Churches to their members (Dargavel and Kendig, 1986). (It was virtually unquestioned that single people would live with their families, and 'sick' older people would go to hospital). As compared to benevolence homes for the sick, poor and neglected, the church homes were convincing models for the support in the community of well older people. They took the lead in demonstrating to the public and governments the potential value of aged welfare accommodation and services.

Government involvement began in the form of the *Aged Persons Homes Act* (1954) that provided grants to the politically popular and vocal voluntary sector, most visibly in the lead-up to difficult elections. These small beginnings, after quick political decisions that could not anticipate the consequences, set in train the massive public expenditure on care that provides major benefits to vulnerable older people. However, in considering directions for aged care, it also is important to appreciate how the early developments established structural flaws that vexed aged care for decades:

- The expectation that the direction of aged care naturally rests in the religious, non-profit sectors; no government at the time would have the financial means nor make the political presumption of interfering with churches or their experts.
- A legacy of structural inequality in access to aged care, where people who could afford to pay part of the costs themselves had privileged use of public subsidies that were not available to those without financial means.
- The provision of funds, and hence power, directly to the voluntary providers rather than older people themselves.
- The provision of federal money for service delivery bypassing the State governments that retained responsibility for the health, housing and other basic services that are integral to the provision of integrated aged care.
- The development of separate welfare and health policy streams, each with their own entrenched constituencies and different public expectations, notwithstanding the need to integrate them as the base for aged care.

Over the 1950s and 1960s population ageing was not a major social policy issue, given the massive baby boom and migration, and Australia maintained its historical preoccupation as a ‘young’ country (Davison, 1993). Further, the Menzies era of economic growth and political conservatism was not conducive to health or welfare policy development. While older people continued to be viewed as the ‘deserving poor’ (implicitly in contrast to the younger less deserving poor), policy expression of this sentiment consisted largely of modest increases to the real rate of the pension and the widening of eligibility. Towards the late 1960s, at the end of the Coalition’s long regime, this trend had advanced to the point where the terms ‘elderly’ and ‘pensioners’ were becoming increasingly perceived as synonymous.

The major development in aged care during this era was the emergence of substantial public funding that defined and sustained a nursing home industry comprised increasingly of private providers (Howe, 1990). During the early 1960s - an unsettled economic and political time for the Menzies government - private insurance firms and State governments were concerned by the rising costs of long-stay older patients in hospitals. Under pressure from insurance interests concerned with costs and an electorate concerned about gaps in hospital care, the Commonwealth government amended the *National Health Act* in 1963 to provide substantial nursing home benefits to private as well as voluntary and government providers virtually on demand. Nursing home policy was divided between the Health department that administered the nursing home benefits and the Social Security Department that provided capital subsidies to voluntary organisations, increasingly for nursing homes rather than housing.

The consequent 'laissez-faire' period of nursing home 'policy', as Howe (1990) accurately termed it, inevitably led to persistent problems in the burgeoning industry. While more care certainly became available, it was nearly all concentrated in the residential sector to the neglect of the community sector, thus entrenching the provider interest groups and public expectations for nursing homes as the solution to care needs. The disparate histories of institutions across States and regions led to equally wide disparities in quality, costs and availability. There was rapid escalation of costs to government but availability remained limited for people with few financial resources and for those in areas with low resources. The neglect of policy coordination with State governments ensured little coordination with community or acute care and 'buck passing' on gaps in quality regulation between the levels of government.

There was relatively little development of housing or community services over Menzies' time as Prime Minister but there was a quickening of policy development after his departure (Healy, 1990). Legislation for home nursing (1956) was not followed further until a politically harried Coalition government passed legislation for home care (1969), paramedical services (1969), and meals services (1970). Although home care and paramedical services were funded through the States, these grants continued the 'voluntary' era's fragmented service development by providing small supplementary funding to individual organisations virtually without program directions and controls. These fledgling organisations had neither political strength nor many

allies. The different health and welfare approaches continued under separate legislative strands from the Commonwealth. The public debate on community services, to the extent there was one, centred around whether or not government had any useful part to play in what was assumed to be family responsibility for care of older people.

The *Dwellings for Pensioners Act* (1969) provided funding for much more public housing for single older tenants on low incomes. Older people were recognised on the national public housing agenda several decades after the postwar housing shortage had been relieved for families. In this same year the Government introduced modest personal care subsidies for hostel residents aged 80 years and over. These subsidies recognised that supportive housing for vulnerable older people was increasingly becoming a base for the ongoing care of residents who become frail. Housing Authorities, however, generally did not allow entrance or continued residence for frail older people (Kendig, 1990). Moreover, housing and hostel programs continued implicitly under a welfare framework with little relation to the nursing homes provider under a health framework.

The Whitlam and Fraser Governments

During the brief Whitlam era there was relatively modest policy development specifically for older people. There were funding increases and more equitable access for residential care particularly through more capital funding and needs-based allocations for residents in hostels, and deficit funding and more capital funding for nursing home providers in the voluntary sector. The Commonwealth faced substantial obstacles in trying to negotiate funding programs with the States. The emphasis was on national policy development - including pension increases, Medibank and public housing - that benefited all age groups. Since the introduction of Medibank the Australian electorate has consistently expressed its expectation that good quality health care should be available without cost to all who need it. On the welfare side, government recognised the increasing needs of single parents and younger unemployed people by widening eligibility in the re-named *Aged or Disabled Persons Homes Act* and funding for pensioners in public housing.

The Fraser government's philosophy of 'small government' accompanied by a 'new federalism' rhetoric, ushered in a quiescent period of social policy. Economic goals (such as the size of the budget deficit or CPI increase) were predominant. Health

policy became an instrument to achieve these economic objectives (Duckett, 1986) and for aged care policy, was a period of consolidation rather than innovation.

Another notable trend, as noted in Correll's commentary, was the increasing separation of the disability movement for younger people into rights-focused approaches that increasingly diverged from more traditional aged care.

The Hawke–Keating Government

It was not until the return of Labor in 1983 that national government began to take aged care reform seriously. At that time the concept of integrated aged care was developing among frustrated professionals as an aspiration against which the existing health and community services were clearly inadequate. Aged care took on wider political significance as the women's movement began to recognise family carers and older women after many years of neglecting them. The carers and dementia movements formed advocacy organisations that joined with traditional welfare lobby groups in exerting increasing political influence on a government relatively receptive to their claims. The Combined Pensioners Association (CPA) and the Australian Council on the Ageing (COTA) enunciated strong universal principles for aged care provision and developed policy capacities, and COTA began to shift its constituency base by ensuring that older people themselves made up a majority on the national and state councils. Academic researchers were conducting research and writing papers that supported their case. The social context for care policies had been changed by the rising work participation and political activity of Australian women, and the emergence of community care along with income and health on the political agenda of older people.

Within government the main precipitants for change were the rapid blow-out of residential care costs (exceeding 20 per cent annually through the 1980s), scandals on patient mistreatment, and evidence of inappropriate entry to nursing homes. Urged on by a succession of reports and enquiries - notably the persuasive McLeay report: *In a Home or At Home* (House of Representatives Standing Committee on Expenditure Inquiry, 1982) - Commonwealth health and welfare departments shared with the central portfolios an interest in, and commitment to, aged care reform. Howe (1990) lists applied studies, funded by governments, which substantiated the case for change. There was a broad view at the time that the growth of community care could be financed by (and make politically acceptable) necessary restraints on the residential

care sector. In its efforts to overcome opposition from provider groups and to appeal to public opinion, the Labor government drew on consumer ideology to legitimise its actions and support the 'rights' of older people (Gibson, 1998).

The tension in aged care between rising consumer need and fiscal restraint was a microcosm of the broader dilemma faced by the Labor government with its claims to social justice and economic management. The government's Social Justice Strategy argued that the provision of social wages limited wage growth and hence inflationary pressure, thus enhancing economic growth that could fund further social dividends (Keating and Howe, 1995). Universal Medicare provided a popular foundation for the social wage. A policy regime of strong program controls would deliver social wages efficiently and target resources to those most in need. In aged care the action was led by a championing Minister, Don Grimes, who oversaw a consolidated Department of Community Services that brought together welfare and health aspects of aged care formerly divided between the departments of Health and Social Security.

This consolidation allowed consideration of community and residential care for the aged within a single bureaucratic structure. However, nursing homes (transferred from the Health portfolio) and hostels (from Social Security) continued to be subject to separate funding regimes and policy settings. Aged care policy still has vestiges of these two cultures and the departmental consolidation has not succeeded in creating similar provisions of aged care services. Although community care transferred from Social Security and became more targetted toward 'preventing institutionalisation', it too stemmed from a different culture and orientation from aged residential care with different lobby groups, systems and expectations.

The integrated community service department was subsequently merged with the Health portfolio in the departmental consolidation and creation of super ministries in 1987 (Nethercote, 1996).

The Labor government's ten-year reform of aged care had two primary strands. The 1985 Home and Community Care (HACC) Program brought together bits and pieces of existing service funding into a joint Commonwealth-State effort (Healy, 1990). HACC established the objective of preventing inappropriate and premature entry to residential care and to maintaining quality of life for both frail older people and their carers. The

target groups included younger people with disabilities as well as older people, the range of 'service types' was widened to provide more comprehensive services and planning aimed to allocate funds to the areas of greatest need. Over the next decade the HACC program developed with specialised services for those with intensive and/or complex needs (Community Options), carer and respite support, and dementia-specific services. Notwithstanding the difficulties of managing and funding the program jointly by the States and the Commonwealth, the growing capacities of HACC has demonstrated that community services are the mainstay of aged care for most frail older people.

The creation of the HACC program, replacing the relatively uncoordinated multiple funding streams, provided the platform for a significant service expansion of community-based care. The policy was seen to be economically rational, as cheaper care in the community might prevent unnecessary institutionalisation, and was supported by a philosophy promoting independence to older people.

Although residential care may be the only realistic option for older persons with particular needs, a shift from the family home is a difficult decision for the potential resident and carers alike. The move to residential care certainly symbolises a loss of autonomy, control and independence. The potential resident may be unsure of the level of care they will actually receive and fearful of the new social environment and the potential loss of contact with their carers. Despite these concerns and the HACC services expansion, demand for residential care remains high.

The 1986 Nursing Homes and Hostel Review provided the basis to restructure and rationalise the residential care program that continued to be led and funded entirely by the Commonwealth government. It included in one program the formerly separate hostels operating as a welfare program and nursing homes operating as a health program. Funding disparities and disincentives were reduced by shifting the basis of funding to providing fixed unit costs for accommodation and related services, and nursing and care costs varying according to each resident's level of dependency. Approval by a Geriatric Assessment Team (GAT) was required for entry to nursing homes, thus restricting inappropriate admission and enhancing referrals to community services (Howe, 1990). Nursing home places were allocated on the basis of needs-based planning, and capital funding was reduced and directed to special needs groups.

The implementation of rights-based outcome standards, monitoring and quality improvement were found to substantially improve the quality of accommodation for vulnerable residents (Gibson, 1998).

In her review of the 10-year Aged Care Reform Strategy, Howe (1997) argues convincingly that the reforms have been substantially successful in achieving their objectives including more extensive and integrated services, improved access and social equity, and shifting the balance of aged care towards the community. From 1985 to 1995 the main changes in the balance of aged care funds were a relative decline from 80 to 64 per cent for nursing homes, and relative increases from 5 to 12 per cent for hostels, and from 10 to over 20 per cent for community care. Further, from 1985 to 1994, aged care funding increased by more than 50 per cent in real terms (Australian Institute of Health and Welfare, 1995). This balance was changed primarily through the addition of funds for community care. Overall, the level of need rose for people in all settings of care. Among Howe's areas of continuing concern were the interface between the aged and acute sectors, the availability of basic community services, reform fatigue and the slow movement of reform through the many agencies that deliver aged care services.

Further, as noted later by Howe (2000) and documented by the Government's own Gregory report (1993), a precipitous cut to the government's capital funding program aggravated already severe problems of a deteriorating physical infrastructure. After listening carefully to the industry, Gregory provided some unwelcome recommendations on the need for market-based reforms.

Howard-Costello Government

In its early days in office the Howard-Costello Government National Commission of Audit (1996) quickly moved to present population ageing as a looming national crisis. By projecting some worst-case assumptions on the public costs of older people and economic growth, the Audit strengthened the government's case for massive cuts to the public sector, and it presented specific and immediate recommendations for program changes said to be needed in order to address a macro fiscal problem 20 years ahead. Further, the new government undertook to implement the radical Council of Australian Government's (COAG) proposal to pool Commonwealth and State funding for aged

care and to devolve service delivery to the States within a broad framework of national guidelines (Duckett, Hogan and Southgate, 1995).

The Hawke-Keating COAG proposal would have addressed many of the cost-shifting difficulties that continue to confound aged care. Such devolution was entirely consistent with Coalition policy and it remained for some time as an avowed goal of the new government. However, it was undermined by opposition from both provider and consumer groups fearful of State government control, and inconsistencies as well as deep suspicions between the Commonwealth and States concerning which government would ultimately bear the financial and political costs of change.

The National Commission of Audit and the COAG proposals provided the framework for the new Howard Government's 'Recognising Older Australians' Budget statement, which heralded further politicisation of aged care policy (see Angus, 2000 for analysis in historical context). Its 'Ageing in Place' theme appealed directly to older voters and a broad sweep of income support and aged care reforms promised to increase security, widen choice and improve quality. To sustain a viable industry, provider groups were offered the twin prospects of additional revenues for capital upgrading and less restrictive regulation, together addressing the aged care problems identified fulsomely in the 1993 Gregory report. More market-based provisions, more user payments and more industry self-regulation were proposed as the necessary means.

Within a year of presenting its first Budget, the Government enacted its *Aged Care Act 1997* as the centrepiece for its Aged Care Structural Reform Strategy. Central amongst these reforms was further integration of hostels and nursing homes as residential care facilities and development of a common funding instrument. An accommodation bond provision was proposed on a means-tested basis for incoming residents in nursing homes (formerly only possible for hostels). This policy initiative can be seen as the extension to the health (nursing homes) sector of the means testing and user charges that had previously applied only to 'welfare' services. Finally, the outcome standards of the Labor government were to be replaced by a new accreditation system, with accreditation required for facilities to charge accommodation bonds as well as to receive Residential Care benefits.

The public and political response to the reforms was overwhelming. Overall, provider groups strongly supported the changes on the basis that they would provide more revenue and fewer restrictions, although significant parts of the charitable sector decried the inequalities in the new bond arrangements. Although consumer groups and the media initially were decidedly negative, their concerns were largely assuaged by the eventual switch to a daily fee rather than a bond for capital and the provision of a modest \$A5 per day subsidy on behalf of residents who could not pay the fee. Bitter opposition centred around two concerns which lie at the heart of Australian values: first, to the extent that nursing homes are considered as health care rather than welfare accommodation, user charges (especially capital charges) are not deemed appropriate; and second, the family home is broadly perceived as inviolate and to require its sale to pay for a nursing home is perceived as an unfair attack on older people and their families. The debate harkened back to the 1984 introduction of the assets test on the pension and the failed attempt to include the value of the family home.

In 1998, while still in the midst of the controversy on the residential care reforms, the government launched its four-year Staying at Home package, providing additional support for special community care needs in the areas of dementia and carers. While this increased expenditure on community care, the balance of aged care expenditure again tipped towards residential care as a result of the reforms (Howe, 2000). This outcome was quite different from the government's initial stated intention of saving half a billion dollars by shifting costs to users.

The Howard Government's Two Year Review of Aged Care Reforms - promised during the initial controversy and conducted by Professor Len Gray (2001) - concluded that the reforms have '... delivered substantial improvements to the aged care system (pxxxix)'. With regard to his specific terms of reference, he concluded as follows:

1. The reforms improved access to aged care particularly for people with high levels of dependency and for people who wished to stay in their own homes.
2. Affordability was maintained while bonds and charges increased to allowable limits for high-care (formerly nursing home) residents who pay them.

3. It was too early to comment definitively on the new quality assurance arrangements but the industry had accepted them, building activity had increased, and more public information was available on the quality of care.
4. Savings to government were less than expected and the savings/outlays balance for governments was sustainable.
5. Overall the industry remains viable, returning an average 12 per cent return even if substantial rebuilding was required.
6. The data was not adequate to comment on impacts on State and Territory programs.
7. While the reforms aimed to increase choice and appropriateness, consumer and family awareness was low and more research was needed into communicating the needs of consumers.

Overall, notwithstanding the changed rhetoric, it would appear that the structural reforms have re-shaped Labor's era of program controls more than proposed fundamental options to increase choice and resources in aged care.

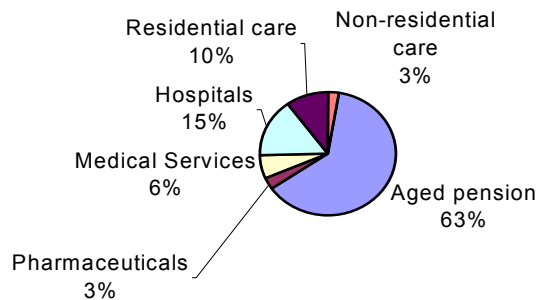
The National Strategy for an Ageing Australia, launched by the government in 1998, aimed to chart long-term directions for policy. One of the four discussion papers, *World Class Care* (Bishop, 2000a), aimed to inform the community and key stakeholders about emerging issues and possible directions. The document consolidated sound information already available on the implications of population ageing and it elicited a good deal of response, but the government has yet to formulate its further directions. Related discussion papers were completed on *Independence and Self Provision* (Bishop, 1999a), *Healthy Ageing* (Bishop, 1999b), and *Attitude, Lifestyle and Community Support* (Bishop, 2000b). The response to these papers by various bodies, notably the Council on the Ageing (Australia) and Aged and Community Care Services Association (Australia), has provided critical debate on the issues broadly reviewed in the next section. The Strategy had not been released when this paper was completed soon after the election.

The aged care system today

Public resources for aged care indicate that it is a substantial government commitment. In 1995-96 governments spent \$22 billion on health and welfare services for the aged, about 5.1 per cent of GDP and 13.4 per cent of government outlays (Choi, 1998). Australia's population is ageing and doomsayers regularly produce projections showing dire consequences for government or economic-wide spending. Such projections are accompanied by favoured nostrums to rein in expenditure. However, independent analyses from the Australian Institute of Health and Welfare (Choi, 1998) showed that the GDP share of health and welfare expenditure on the aged increased from 4.8 per cent in 1975-76 to 5.1 per cent 20 years over 20 years, hardly a startling increase. Further, expenditure on the aged did not increase as percentage of government outlays over this period and declined as a percentage of government health, social services and welfare outlays (40.1 per cent to 32.8 per cent).

Figure 1 shows that aged care amounts to a relatively small share of the government health and welfare expenditure for the aged for 1995-96. Almost two-thirds of government expenditure is for aged pensions with the next largest component being expenditure on aged persons in hospitals. Residential aged care comprises 10 per cent of total government health and welfare expenditure. Growth rates of these expenditures from 1990-91 to 1995-96 vary however, with residential care showing relatively low real annual growth (2.9 per cent) relative to pharmaceuticals (13.1 per cent), medical services (8.5 per cent). Non-residential care grew 7.8 per cent and there was a moderate growth rate of 3.5 per cent for pensions. Assuming these patterns continue, expenditure on pensions will dominate aged health and welfare expenditure for the foreseeable future. Specific aged services will be less than 15 per cent of total government health and welfare expenditure on older people.

Figure 1 Government health and welfare expenditure on older Australians, 1995-96



Notwithstanding policy directions towards better integration, the aged care service system is not well coordinated. While the Commonwealth government is clearly accountable for policy about residential aged care, community-based services, particularly home and community care programs, are a joint responsibility of Commonwealth, State and local government. The Commonwealth is pre-eminent in terms of program design, while the States and local government are more active in determining service delivery arrangements for home and community care. As a result of differences in history and program choices, there are significant differences in the mix of home and community care services between the States.

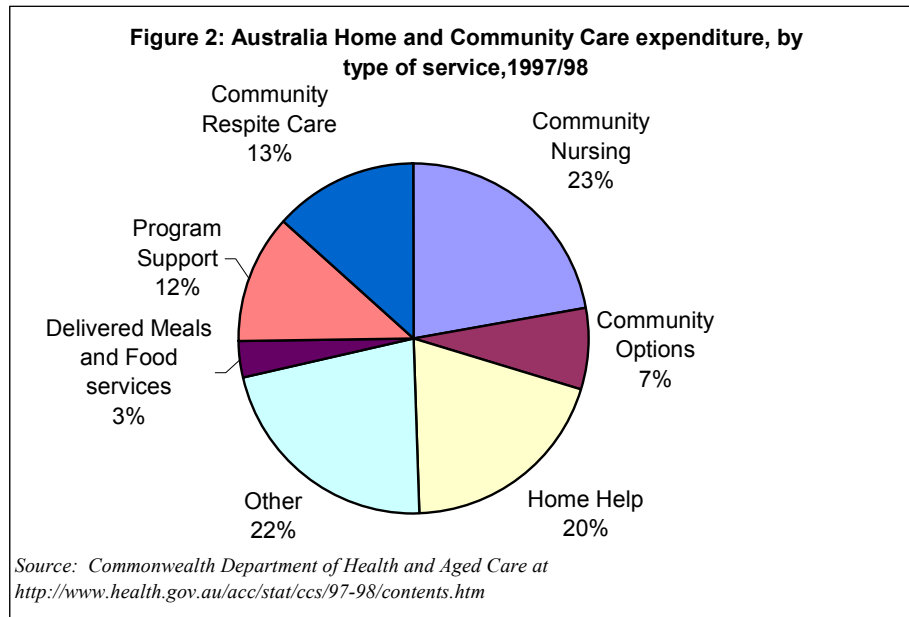
The interface between the aged care sector and the health sector is also problematic. Older people account for a significant proportion of hospital use, with public hospitals essentially the policy preserve of State governments. These different patterns of program leadership across sectors and within the aged care sector inevitably lead to difficulties at the interface between the territories of the program leaders.

Delivery of aged care services also involves a mix of public and private, the latter involving both for-profit and not-for-profit providers. The private sector has a dominant role in residential aged care, the public sector and not-for-profit organisations dominate in most areas of community-based care, and the provision of hospital care is a mixed responsibility. In this section we will briefly review the current service provision arrangements in the health and aged care service systems.

Community care for older people and people with disabilities

The main vehicle for provision of community care for the aged and disabled is the Commonwealth-State Home and Community Care program (HACC). This program provides a range of services including community nursing, meals on wheels (delivered meals) and home help. In 1997-98 (the latest year for which HACC statistics are available), a total of \$786 million was spent on HACC, approximately 60 per cent of which was sourced from the Commonwealth government. Howe (2000) states that 20 per cent of the program is now funded by user charges, although there are still no official statistics showing the amount of money raised from user-charges and whether these funds are used to augment service delivery or reduce the State government contribution. Howe also estimates that approximately one-third of frail older people, and fewer younger people with disabilities use the program. Bridge et al. (2001) provide similar findings and points out that the greater access by older people persists after taking into account other factors including living arrangements, level of disability and income.

Figure 2 shows the major areas of HACC expenditure. About a quarter of the HACC program is spent on community nursing with about a fifth on home help. Nearly 70 per cent of HACC users are female and their average age is 74 years (median 78 years). The average age of males was slightly younger at 69.9 years (median 75 years). Although younger people with disabilities are also eligible for the program, the average age for the total HACC population was 72.4 years (median 77 years).

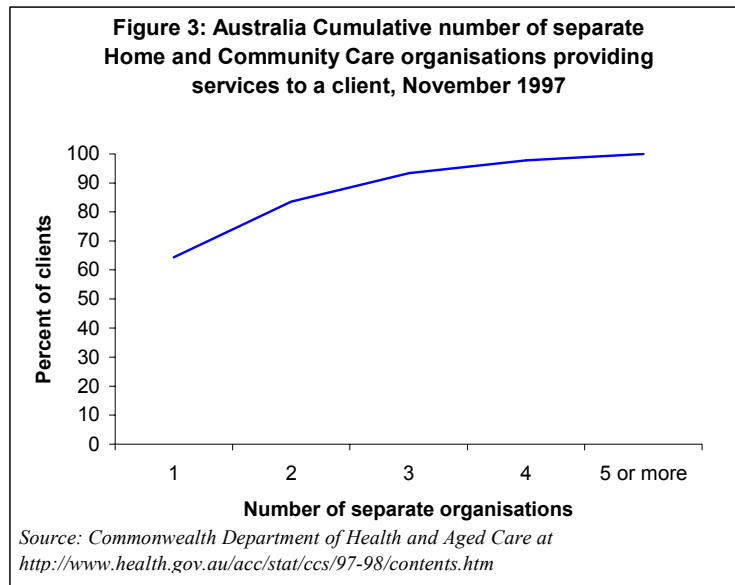


The community care sector is characterised by a large range of very small organisations. For example, in 1997-98 there were 2,367 organisations in receipt of funding under the HACC. Although 11 organisations each received more than \$5 million funding in that year, 963 organisations received less than \$50,000 with a further 425 organisations receiving between \$50,000 and \$100,000. This means that almost 60 per cent of all HACC-funded organisations were able to employ fewer than three staff for HACC-related activities. These figures reflect the voluntary agency heritage of most services and suggest some of the complications experienced in ensuring consistency of service delivery and organisation of the sector relative to the residential care sector.

Figure 3 shows the cumulative distribution of the number of separate organisations involved with a client. Although 64 per cent of clients have their service needs met by one organisation, almost one-sixth of all clients are seen by three or more separate organisations. These figures suggest that concerns for coordination among services may apply primarily to only a minority of service users who have relatively intense needs.

The different service types provide quite different patterns of service to HACC clients. Overall, the most prevalent service type is home help, involving about 116 clients per 1,000 population over 70. The typical home-help client receives 4.1 hours of service

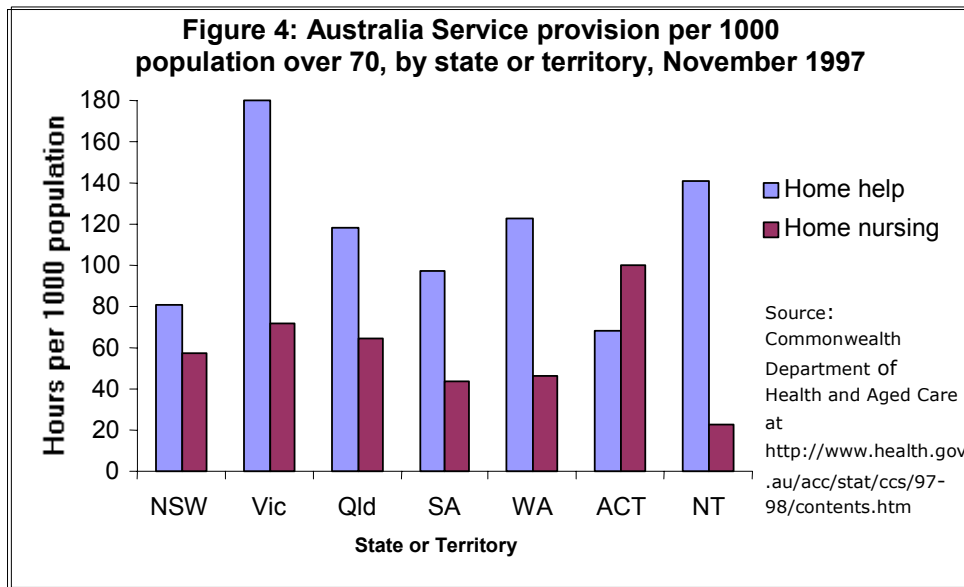
per month (see Figure 3). This pattern of broad availability and low intensity can be contrasted with the availability of day centre care which is provided to an average of 40 clients per 1,000 population over 70, each of whom receives on average 17.9 hours per month, a much higher level of intensity. Meals on wheels provision is available to 62 clients per 1,000 population over 70, on average providing 15.4 meals per month.



With the growth in resources for the HACC program, increasingly there has been questioning as to the appropriateness of the ‘targetting’ of the program: on the one hand no formal assessment is required and on the other hand there has been increasing demand for high levels of support for small numbers of highly frail people. The latter has emerged partly because the Community Options model demonstrated the considerable capacities of case management and individually targeted service packages in maintaining people with intense needs in the community with adequate quality of life. Howe (2000) reports that between half to two-thirds of HACC clients receive only 20 to 30 per cent of the resources, while 5 to 10 per cent of clients absorb up to half of the resources.

HACC funding is allocated to areas on a planned basis (in contrast to the market-based development of primary medical services). The program aims to achieve an equitable provision of HACC services across Australia, and since 1995 has established service provision targets or ‘benchmarks’ for evaluating allocation of resources (see Alt Statis and Associates, 1994). Although the Commonwealth Department of Health and Aged

Care now reports on the agreed performance indicators in terms of service availability (for example, hours of service available per 1,000 population over 70 and service intensity by State and region), there is considerable variation between and within States for many of these benchmarks. Figure 4, for example, shows the State variation in home help and home nursing hours per 1,000 population over 70.

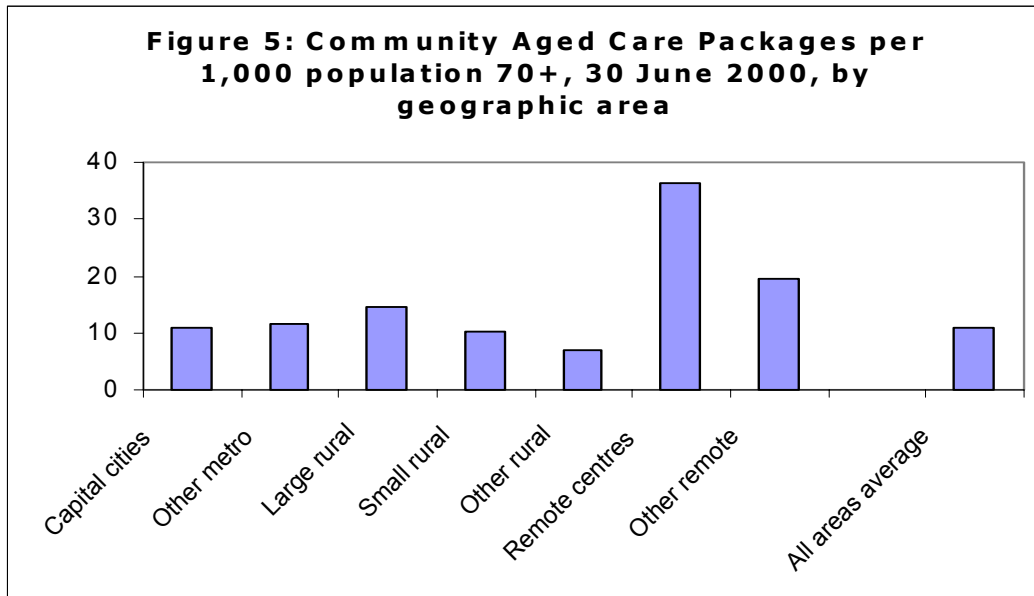


It can be seen that rates of provision for home help vary from 68 hours per 1,000 population over 70 in the Australian Capital Territory to 180 in Victoria. The range in rates of provision of home nursing is almost as great: from 44 in South Australia to 100 in the Australian Capital Territory (setting aside the rate of 23 home nursing hours per 1,000 population in the Northern Territory). The two services are not substitutes: Victoria has high rates of provision in both areas, South Australia low rates in both. It is unlikely these data could be said to reflect differences in need: they probably reflect differences in current or past State commitment to these services. The differences between New South Wales and Victoria in home help provision - where the average elderly Victorian receives twice the amount of home help compared to a resident of New South Wales - is striking. Victoria's local government base for home help provision may well have exposed decision-makers to a greater level of consumer pressure for more provision compared to the more centralised New South Wales decision-making structure.

Community Aged Care Packages (CACPs), introduced as a Commonwealth program in 1992, provide a second strand of community care that parallels the HACC program. CACPs provide funding for clients who have been assessed as needing (low level) residential care but who, with a package of community services, are able to remain in the community. CACPs are thus seen administratively as direct substitutes for residential facilities and they were introduced when the government found it difficult to attract enough hostel providers. Since 1995 CACPs have counted in residential provision ratios for planning and funding purposes with a target of 10 CACPs per 1,000 population over 70. Gibson and Mathur (1999) concluded that in 1996 the CACPs served a less dependent clientele than did either hostels in the residential care program or Community Options clients in the HACC program.

As at 30 June 2000 there were 18,149 CACPs in Australia. There has been a rapid increase in the number of CACPs with a growth of 64 per cent in 1997-98 financial year, 37 per cent in 1998-1999 and 32 per cent in 1999-2000. Through CACPs the Commonwealth's residential care program provides full funding for intensive community care. The program has enabled the Commonwealth to provide alternative care to areas where there were insufficient applicants to manage hostels. The cost has also been lower, given that care in the home does not involve the provision of any capital component by either government or the service provider.

All States have now reached the target of 10 CACPs per 1,000 persons aged 70 and over. There is a substantially higher rate in the Northern Territory (46.1 CACPs per 1,000 persons aged 70 and over). Figure 5 shows the distribution of CACPs by geographical area. It can be seen that there is a high level of provision in remote centres and areas. This distribution probably reflects the flexible nature of CACPs in that they are very suitable to provide services for small populations without requiring the larger infrastructure associated with institutional care provision.



Current policy issues in community care

Community-based care for people who require ‘high level’ residential aged care is expensive (as, of course, is care for those clients in a residential care facility). Despite Community Aged Care Packages counting as part of residential aged care ratios (see below), they do not appear to have reduced demand for this type of care.

Community care for the aged has dramatically expanded since the creation of the consolidated Home and Community Care program in the mid-1980s. Together with the creation of more direct (and targeted) community-based substitutions for residential care (Community Aged Care Packages), HACC provides a significant level of support for elderly people who wish to remain in their own home environment. These community-based services have proved effective substitutes (or have reduced demand) for low level residential aged care. There seems to be no public pressure to expand the provision of ‘hostel level’ care and, to the extent that waiting lists for hostel care exist, they do not seem to have the same political salience as waiting lists for ‘nursing home’ care.

The most significant and ongoing issue for HACC is the expansion of real resources to meet more of the substantial unmet demand. Real increases of budgets over the years, and new programs such as the Veterans Home Care Program, have helped considerably. However, the now more mature HACC system has demonstrated its

effectiveness and popularity, with the result that demand grows all the faster, notwithstanding the application of user charges for those who can afford them. Another approach is to ration and direct resources: the HACC Targeting report (Howe, 2000) recommends different policy treatment for Basic HACC users (broadly continuing present HACC services for 80 per cent of clients), HACC 'Plus' (approximately 15 per cent referred to more resources after assessment), and HACC 'Exceptional Clients' (two per cent with funds pooling on a case-by-case basis).

'Outcome standards' have long been featured in HACC to focus attention on meeting client need. Feasible instruments and procedures for implementing and monitoring them have been developed (Jenkins, Butkus and Gibson, 1998) and are now in the early stages of implementation. Quality control is becoming increasingly important with the rising numbers of very vulnerable older people in the community and the difficulty of monitoring the interaction of workers with clients in their own homes. These difficulties are particularly acute for those having dementia.

The Commonwealth is further testing the capacities of community care in the pilot Extended Aged Care at Home (EACH) program for older people requiring nursing-home level care. Evaluation findings suggest that the costs (\$85 per day) are much more than CACPs (\$29 per day), comparable to residential care (see below), and generally require a co-resident carer. While the program is likely to be preferred by many older people, it is not necessarily cheap, even in terms of government outlays, and the total costs are higher when one takes account of private housing costs and carer efforts.

Residential care

Residential aged care facilities (until 1997 distinguished as 'nursing homes' and 'hostels') are designed to meet the needs of frail elderly people who can no longer stay at home, even with access to the community support services described above. As reviewed above, residential care today reflects the funding restructuring and integration of the mid-1980s, and further restructuring and the increase of consumer co-payments (Howe 1998; Gibson 1998). These changes have also been accompanied by strategies to improve the quality of care and strengthen residents' rights (Gibson et al. 1993).

As at 30 June 2000, there were 3,005 residential aged care facilities approved by the Commonwealth Department of Health and Aged Care providing a total of 141,162 places (an average of 47 places per facility)¹.

There are two major sources of funding to support people in residential facilities. The Commonwealth subsidy varies with the resident's dependency and need for care, thus aiming to provide adequate resources and to encourage providers to accept individuals across the full range of needs. The patient contribution in part recognises that residential facilities provide food and shelter that residents would need to pay for wherever they lived.

Government care subsidies

The resident's need for care is measured using the Resident Classification Scale (RCS), an eight-point scale which provides the basis for the differential daily payments to the residential care facility (see Table 1). The scale value is determined by a scoring system of 20 questions that take into account the resident's communication, mobility, personal hygiene, toileting, bowel management, whether they are physically aggressive, and medication requirements. Specific points are allocated to each type of answer, and a resident with more than 81.0 points is assigned to classification level 1, 69.61 to 81.0 points classification level 2, and so on. Residents with less than 10.6 points are assigned to classification level 8; these residents are not eligible for a care subsidy from the Commonwealth. Categories 1-4 represent high care (formerly restricted to nursing homes) and categories 5-8 represent low care (hostels).

¹ The data in this section are drawn from the Australian Institute of Health and Welfare, 2000, and Commonwealth Department of Health and Aged Care, 2001.

Table 1: Percentage of residents and basic residential aged care facility subsidy per resident per day (from 1 July 2001)

RCS level	Commonwealth subsidy (\$)	Percentage distribution of residents as at 31 March 2001
RCS1*	103.78-115.00	16.9
RCS2*	93.96-104.12	25.8
RCS3*	80.89-89.87	15.8
RCS4*	57.22-64.21	4.6
RCS5	36.63	9.5
RCS6	30.35	10.5
RCS7	23.30	15.1
RCS8	0	1.8

*Notes for levels 1 to 4:

1. Rate depends on State/Territory; Queensland is the lowest rate, Tasmania is the highest.
2. Supplements are paid to facilities where ‘concessional’ residents are up to 40 per cent of bed days (\$7.52 per day) or over 40 per cent of bed days (\$12.89 per day).
3. Resident-related supplements are also paid for oxygen treatment (\$7.70 per day), enteral feeding (\$12.19-\$13.66 per day) and respite care (\$12.35-\$28.99 per day depending on whether ‘low level’ or ‘high level’).
4. Facility-related supplements are also paid (eg. for facilities in isolated or remote areas).

Supplements are paid on the basis of resident need and facility location. Where ‘concessional’ residents are up to 40 per cent of bed days the supplement is \$7.52 per resident day; the supplement rises to \$12.89 per resident day where facilities have over 40 per cent concessional residents. Resident-related supplements are also paid for oxygen treatment (\$7.70 per day), and enteral feeding. Facility-related supplements are paid, for example, for facilities in isolated or remote areas.

Resident’s payments

The resident’s payment consists of two major components, a basic daily care charge, and a contribution to the capital costs of the facility. Maximum resident payments are specified by the Commonwealth and depend on the resident’s income (for daily

charges) and assets (for capital-related payments). A very limited number of facilities that provide a higher level of amenity are exempt from the specification of maximum resident contributions. The vast majority of places in residential care facilities are subject to Commonwealth-specified fee maxima, which are updated annually (the amounts quoted here applied from 20 March 2001). These maximum fees differentiate between:

- full pensioners face a maximum daily care fee of \$23.46;
- part pensioners who face an ordinary daily care fee of \$23.46 and a further income-tested fee of up to \$18.20 per day; and
- non-pensioners ('self-funded retirees') who face an ordinary daily care fee of up to \$29.30 and an income-tested fee of up to \$41.08 per day.

There are some transitional provisions for people who were receiving hostel level care (RCS levels 5-7) prior to 1 October 1997. Of the total, 65 per cent of residents are full pensioners and thus do not pay the additional income-tested fees.

In addition to the contribution to the day-to-day costs of a residential facility, residents may also be required, subject to an assets test, to contribute an accommodation charge (for high-level care, RCS 1-4) or 'bond' (lower-level care). The accommodation charge/bond effectively provides additional working capital to the residential facility proprietor and is thus analogous to a contribution to the capital costs of the facility. Residents of residential care facilities who require high-level care and who have assets in excess of \$25 000 may be asked to pay a capital-related accommodation charge. The maximum accommodation charge is set on a sliding scale and for residents with assets in excess of \$48 900 is \$13.07 per day. The accommodation charge can be levied for a maximum of five years.

In low-level care facilities (formerly hostels), residents with assets in excess of \$25,000 can be asked to pay an accommodation bond, the balance of which is refunded if the resident dies in a residential facility. The provider can take a maximum of \$13.07 per day for the first five years out of this capital amount but may also retain the interest earned on the full amount for the full period of care.

The limits for asset tests are based on the basic age pension (eg. the minimum permissible asset value that a resident may maintain after paying an accommodation bond) is set at 2.5 times the basic annual pension per annum. A resident's home is not included in the asset test if the resident's spouse or dependent child is living there or in other special circumstances (eg. another close relative lives there).

Residential aged care facilities with a higher proportion of low-income residents (over 40 per cent), and hence a reduced ability to receive bond or accommodation charges, receive a higher level of supplementation from the government toward capital costs (see above).

Assessment

All proposed residents of aged care facilities must be approved by an Aged Care Assessment Team (a multidisciplinary team funded by the Commonwealth Department of Health and Aged Care), which assesses applicants to determine their needs, and to consider appropriate services and treatment. The assessment process takes into account whether the person could be maintained in his or her own home with other forms of support. While ACAT assessment is required in order to be eligible for entry to subsidised residential care, ACAT approval does not directly ensure access to care nor does it set the level of government subsidy as reviewed above.

Even though Aged Care Assessment Teams (ACATs) have been set up with funding from the Commonwealth to undertake similar tasks, there is considerable variation in the pattern of decision making of the teams. In particular, ACATs in different States have different rates of assessment (in terms of the percentage of older people population assessed) and place of assessment (assessing clients in their home vs. in residential care). There are also significant differences in the rates of recommendations for residential care versus community services (Kung, 1996). To some extent these differences may reflect differences in the environment. For example, Victorian Aged Care Assessment Teams have significantly higher rates of referral to community services than New South Wales teams, which may be a result of better availability of services and Victoria's stronger culture of community-based aged care services.

Commonwealth policy for more than 15 years has been to discourage residents with low-level care needs being accommodated in funded facilities. The ACATs have

played a critical part in reducing inappropriate entry to residential care: in the early 1980s, before they were introduced, up to a third of nursing home residents were estimated to not have sufficient dependency to warrant their living there. This trend has continued over recent years; for example, there has been a decline in residents classified as category 8 and equivalent from 16 per cent in 1994 to 4.5 per cent in 1998.

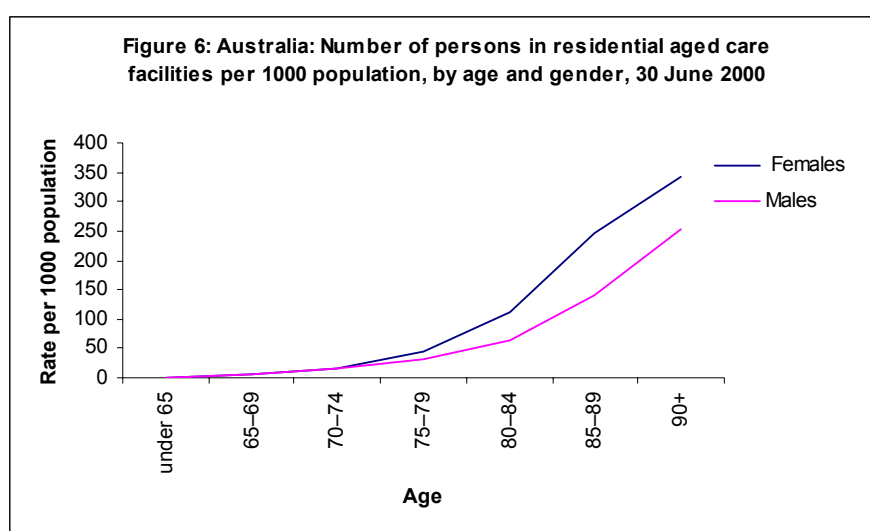
Because all residents in residential care facilities attract a Commonwealth benefit, the Commonwealth has established planning guidelines for approving new facilities. The guidelines are designed to limit the number of funded places to no more than 100 places per 1,000 population over 70. At 30 June 2000 there were 83.8 places per 1,000 aged 70 and over, a decline from the ratio of 89.2 as at 30 June 1997. The last few months has seen considerable political activity about the adequacy of contemporary levels of provision. In Victoria for example, Aged Care Minister Bronwyn Pike attacked her former Commonwealth counterpart, Bronwyn Bishop, for under-provision of residential care. This is claimed to result in a knock-on effect of patients staying in public hospitals while awaiting a nursing home place, thus reducing availability of beds for other purposes and causing access problems to both emergency care ('ambulance bypass') and elective surgery ('waiting lists'). Research commentators have previously drawn attention to these trends and the potential difficulties consumers might face in gaining access to needed residential care (Gibson and Liu, 1995).

Although the Commonwealth planning guidelines aim to ensure a relatively even distribution of provision across States and by geographic area, Table 2 shows that the provision ratio varies; for example, there are 87.2 places per 1,000 people aged 70 and over in capital cities compared with 77.2 per 1,000 in small rural areas. There is also a variation between States with Victoria having 79.7 beds per 1,000 aged 70 and over, relative to the New South Wales ratio of 83.9 and the Queensland ratio of 88.3. The residential care planning process was reviewed by the Commonwealth Auditor-General (1998) who recommended a number of changes including stronger links with non-residential (HACC) provision for aged care.

Table 2: Residential places per 1000 people aged 70 and over, State/territory by geographic area, as at 30 June 2000

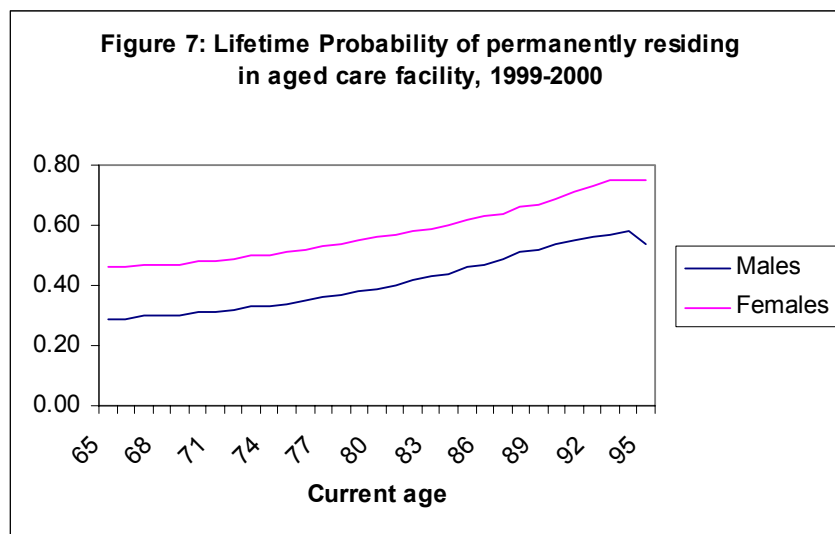
	State/ Capital cities	Other metropolitan centres	Large rural centres	Small rural centres	Other rural areas	Remote centres	Other remote areas	Total
NSW	101.7	85.6	100.6	81.5	79.2	..	76.0	94.5
Vic	90.6	98.6	114.5	91.6	78.1	..	22.1	90.0
Qld	99.6	94.8	104.4	91.5	100.3	114.0	96.9	99.2
WA	99.8	..	..	95.5	63.5	159.3	48.0	95.5
SA	102.1	..	78.2	85.6	78.7	..	8.5	95.4
Tas	99.4	..	103.5	92.4	85.2	..	81.0	95.7
ACT	101.1	..	..	..	..	..	..	101.0
NT	100.9	..	..	..	..	375.6	72.2	135.3
Australia	98.1	89.8	104.9	87.6	81.7	153.6	64.6	94.5

The likelihood of an older person being accommodated in a residential aged care facility increases sharply with advanced age (see Figure 6). Although the average is 84 places per 1,000 population, less than seven persons per 1,000 population aged 65–69 reside in residential aged care facilities compared with 343 per 1,000 women 90 years plus and 252 per 1,000 men over 90 years. It is important to note that even for 90-year-olds, most people in this age group are not currently living in sheltered accommodation, i.e., most people aged 90 and over are living in the community.

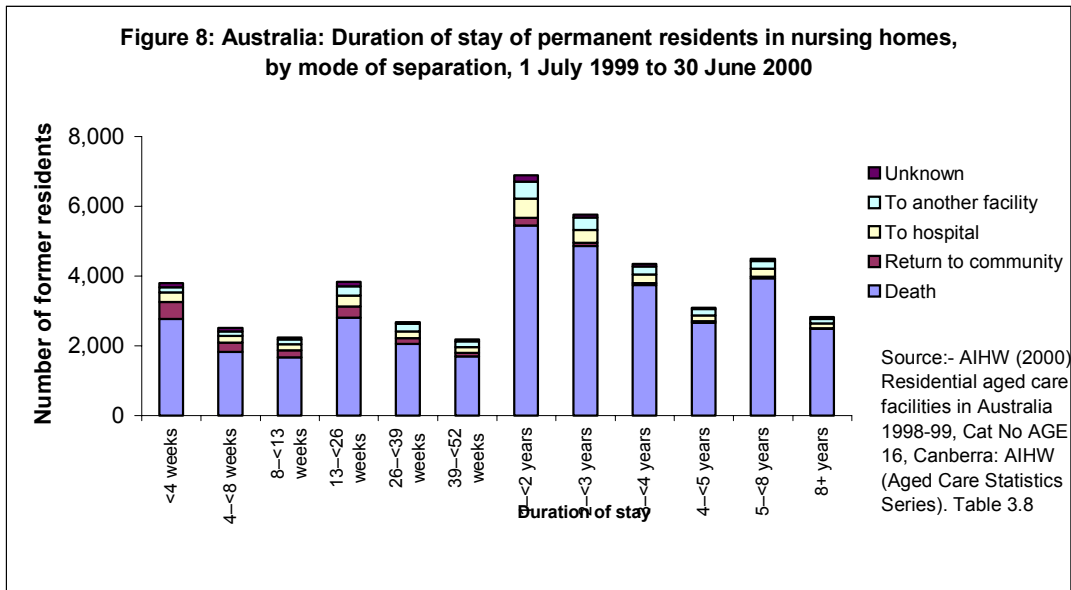


Source: AIHW (2000) *Residential aged care facilities in Australia 1998–99, Cat No AGE 16*, Canberra: AIHW (Aged Care Statistics Series). Table 1.1 and 2.1

The data on current residence arrangements need to be complemented by data about past experiences and the future (Liu et al, 2001). Figure 7 shows the probability of ever entering a residential care facility. At age 65 years less than half of women and a third of men are likely to ever enter a nursing home. Women over 73 years of age in 1999–2000 are more likely than not to enter permanent residential care in their remaining lifetime. The likelihood of a male entering a facility is greater than not after turning 87. Contrary to many common beliefs, only a minority of the people who reach old age are ever likely to need residential care.



For those who do enter a nursing home the average length of stay is between one and two years (Figure 8). The duration of stay has fallen considerably over recent years, as people have tended to enter care with higher levels of dependency closer to the end of their life. Figure 8 also shows that for short stays, about one sixth of residents return to the community. However, for the majority of residents, especially those with longer stays, the common reason for leaving a residential care facility is death. These results suggest that, while residential care experiences are highly variable, nursing homes now serve mainly those older people who have serious illnesses and are in the last stages of their life.



Quality of residential aged care

The quality of residential aged care facilities is supervised by the Aged Care Standards and Accreditation Agency (established under the *Aged Care Act 1997*) with responsibility for managing accreditation for all Commonwealth-funded residential aged care services including monitoring of standards of care for services which are not accredited. This is a relatively new approach to accreditation and standards monitoring with the aim of ensuring that all residential aged care services were to be accredited by 1 January 2001. The accreditation process in aged care is somewhat similar to that used in hospitals and includes a self-assessment program together with a visit by assessors appointed by the agency.

The current quality management framework includes four main elements:

- accreditation standards;
- certification of the quality of buildings;
- concessional and assistant-resident ratios;
- prudential arrangements.

The four accreditation standards, as specified by the government, include:

1. management systems, staffing and organisational development;
2. health and personal care;
3. residential lifestyle; and
4. physical environment and safe systems.

In all there are 44 'expected standards' for these areas (nine outcomes in management, 17 in health, 10 in lifestyle, and eight in environment) with explicit criteria specified for each outcome. A four-level rating system is applied (commendable, satisfactory, unacceptable and critical) with a set of decision rules published to identify criteria for awarding each level. This information is available on each residential care facility, thus providing possible residents with some guide to quality. The extent to which these people can be considered 'informed consumers' is limited, however, by the restricted availability of residential care for most people during the typically stressful time when they seek residency.

Quality standards are another area that has attracted considerable political attention over the last year. Well-publicised incidents (such as the Victorian kerosene baths) have called into question the adequacy of current quality assurance and regulatory mechanisms generally.

Regulation of residential aged care is subject to comprehensive appeal processes under administrative law. As a result, decisions to sanction residential facilities can be contested through judicial review processes. The perceived requirements of evidence for judicial review mean that professional judgements about areas to improve the quality of care and relative weaknesses are transformed into numerical scales and narrative descriptions. For good providers, who welcome opportunities to improve, the reports from the accreditation processes still provide a basis for improvement. However, for providers keen to minimise expenditure and maximise profits, commentary is contested and challenged through litigation. It is important that appeal processes be maintained to ensure fairness and allow opportunities to correct mistakes. Staffs of administrative agencies are fallible humans who can make mistakes, and enforcing the letter of regulation at times may be inimical to the delivery of flexible, client-centred care. However, it also must be recognised that the current decision making processes slow administrative responses to weaknesses in care delivery.

The existing residential care funding system replaced an earlier one where funding for care provision was determined separately from housing and infrastructure (through a system known as CAM/SAM - the Care Aggregate Module and Services Aggregate Module). Under the previous funding arrangement, if residential care facilities did not

incur expenditure for direct care staff (such as nurses and allied health staff), they were not able to claim subsidies for this element of expenditure. The financial incentive on the residential care provider was thus to provide, as a minimum, care expenditure up to that which would be reimbursed under the CAM arrangement.

The current funding arrangements do not distinguish between care, hostel and infrastructure expenditure and so the minimum level of care provision is only regulated through what is necessary to meet accreditation requirements rather than through direct financial incentives. Partly as a result of the appeal framework, it is often difficult to define clearly whether care provision is inadequate. Financial incentives are not acting to ensure minimum care provision and the regulatory arrangements are cumbersome. Aged care lobby groups have also argued that the funding level for residential care is inadequate, especially for residential care facilities catering primarily for low-income residents without the ability to obtain supplemental funding from the residents. These arguments were successful and both political parties promised increased funding per resident at the recent election. Inadequate funding might also force proprietors to skimp on care provision. The combination of these factors has led to quality of care problems and the continuing public concerns about the quality of residential care.

Current policy issues in residential care

The Commonwealth's 'Aged Care Reform' program, as reviewed earlier in this paper, was in part designed to increase capital funding for residential facilities through increased consumer co-payments; the original proposal to charge accommodation bonds was later made more palatable in the form of daily charges. The underlying problem the program was designed to fix was the poor capital stock of nursing homes. Industry groups had stated the problem to be government under-funding and this was implicitly assumed by government as the basis of its policy. However, it is notable that transfer prices for nursing home licences were high both before and after the reforms. Given the strong public reaction against the changes, government is unlikely to attempt a similar strategy for some time.

The current funding arrangements for residential care are probably unsustainable over the medium term. Despite the adoption of nomenclature suggesting continuity of policy and funding arrangements (eg. 'high care' and 'low care' rather than 'nursing homes' and 'hostels', 'ageing in place'), there are significant discontinuities within the

residential aged care sector (most notably relating to capital funding) and between the health sector and residential aged care. Addressing these discontinuities will be difficult, and addressing problems of adequacy of capital funding will probably be expensive for taxpayers if entirely funded by government.

Overall, Australia's long-term care policy has been relatively stable since the mid-1980s: an emphasis on expanding HACC and reining in the growth of residential care. This policy has been remarkably successful and Australia is not facing an unsustainable increase in its population of older people in institutional care (see Howe, 1999). The most notable change is that high-level community care has provided a substitute for low-level residential care. Although there is some evidence that access to residential care is now falling, and some increase in high-level care may need to occur, the main priority remains the need for further expansion of community care and funding policy for residential care.

Carers' payments and benefits

In recognition of the opportunity costs experienced by informal carers, an income and asset-tested Carer Payment (equivalent to the Age Pension) has been introduced. The carer payment is paid in circumstances, for example, where a carer provides full-time care to an adult who has a long-term and severe disability who would otherwise need full-time professional care; similarly, the benefit is paid where a carer looks after a dependent child with a profound disability or medical condition. In 1999, 40,070 people received the Carer Payment, an increase of 60 per cent over 1996 levels. Most recipients (53 per cent) were caring for a relatively younger adult with a disability, 33 per cent for aged persons, and the remainder for children.

Carers also may receive a Carer Allowance designed to assist parents and guardians to care for a disabled child or adult at home. The Allowance is not asset or income-tested. The current rate is set at a relatively low level of \$75.60 per fortnight (indexed annually) and 152,253 persons received it in July 1999: 66 per cent were caring for a child or children. Carers also are assisted by respite services in residential care facilities (see Department of Human Services and Health, Aged Care and Community Services Division, 1996). It is notable that these allowances, unlike other aged care policies, place the resources and choice directly in the hands of the carers themselves.

There is probably a large amount of care provided for short-term needs after a person is discharged from an acute hospital. Unfortunately, this type of caring is often taken for granted by the health system even when the person does not have the family and informal network that is assumed by discharge policies of many hospitals. Post-acute care was once termed a HACC 'no growth' area, leaving a legacy that such community care was to be restricted to ensure that HACC resources were not used to minimise hospital costs.

Interface with the health system

The problematic interface between the aged care sector and the health sector is exacerbated by changes in acute health delivery. Technological change is significantly affecting delivery arrangements in the acute health sector. New pharmaceutical and treatment technologies are changing the demands on acute health services. An increasing number of interventions can now be performed at home or on a same-day basis. More than half of all acute health services are delivered on a same-day basis and this is changing the nature of the interface between the acute health system, home care and families.

Although the average length of stay for those who stay overnight is roughly the same in 1999-2000 as it was five years ago, the average acuity (complexity) of those who are in hospital overnight is increasing. As the intensity of the use of acute health beds increases, there is a corresponding increased pressure for older patients to be moved to settings where the longer recovery periods often required by these patients are able to be met more appropriately. This requires improved coordination with rehabilitation services and other sub-acute facilities and with residential aged care services. While such services can improve quality of life and reduce overall health care costs, State governments may limit their expenditure in these areas when the alternative is nursing homes funded solely by the Commonwealth government.

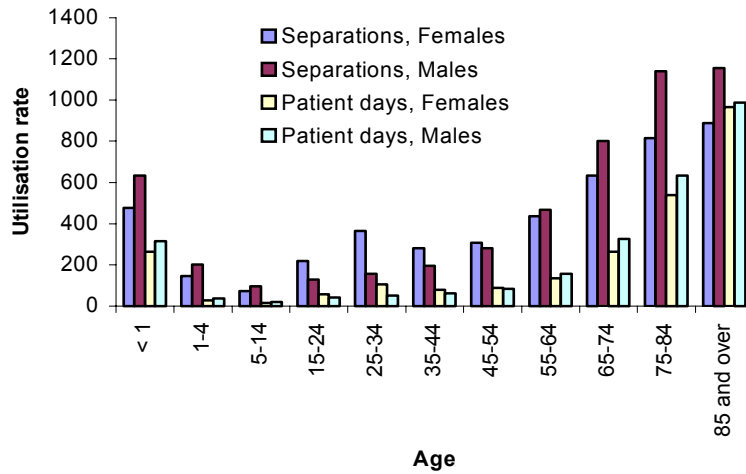
Often the interface between acute and rehabilitation services involves a dysjunction in care as an older patient is transferred from one treatment team to another. The interface with residential aged care involves a greater disjunction especially where the older person did not come from that setting into the acute health service. An acute event might precipitate a requirement for a different care setting post-discharge with families having to make quick decisions about an appropriate nursing home or other facility,

and so on. In the current environment where there has been a decline in residential care provision and so suitable residential care facilities in appropriate locations may be in short supply, this exacerbates pressure on families and acute facilities. Acuity is likely to continue to increase in acute health services, which will place greater demands on the sub-acute and residential care facilities in the future.

Rehabilitation services have evolved differently in different States. In New South Wales, for example, rehabilitation services are generally co-located with major hospitals (Dorevitch et al, 1993). In Victoria, historically separate aged and rehabilitation facilities have continued to exist, with new free-standing 'extended care centres' being developed in the last 20 years. The Victorian model of care provision has facilitated the development of geriatric medicine and rehabilitation medicine as specialties, but this strength, of separation from acute care, is also a weakness in terms of seamless care paths. Similar dilemmas arise in terms of the NSW CADE (dementia-specific) units that are being phased out of the State mental health system on the basis of their high costs, notwithstanding their demonstrated effectiveness.

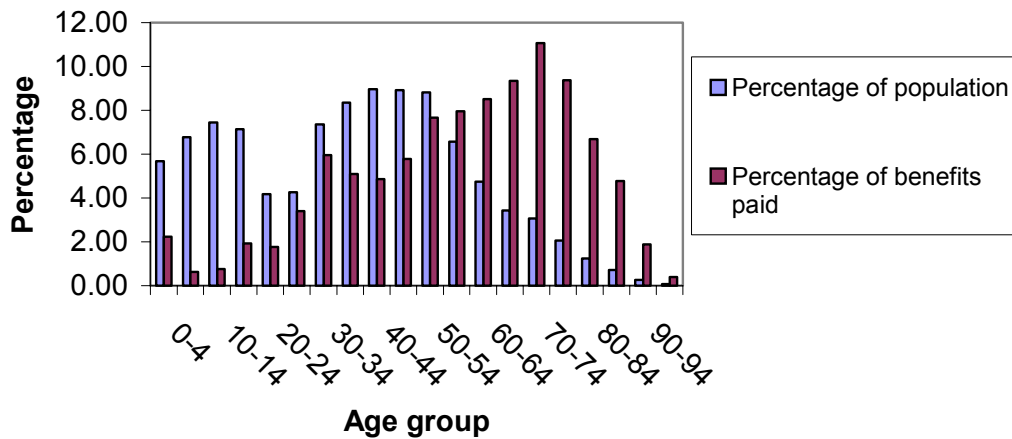
Even though older people are only a relatively small proportion of the population, Figure 9 shows that their very high rates of utilisation also translate into high proportions of hospital activity. The over 65-year-old population represents over 30 per cent of all hospital separations for females, and over 35 per cent for males (32 per cent of total separations). This population also represents around 47 per cent of bed days for both females and males. These very high proportions emphasise the critical role hospitals play in the care of older people and the importance of standardising for age and gender in hospital planning. However, the data do not support the argument of McKie et al. (1996, p 50) that older people's use of hospitals is 'disproportionately large'. Their use may indeed be proportional to need.

Figure 9: Australia: Hospital utilisation rate (separations per 1000 population; patient days per 100 population) by age group and gender 1999/2000



The distribution of overall health expenditure is also skewed to people of older ages. For example, Figure 10 shows the distribution of persons with health insurance by age group compared with the distribution of expenditure by health insurance funds. The difference in the two distributions is quite stark. About 30 per cent of expenditure by health insurance funds is on the 5 per cent of the membership of funds who are over 70 years of age.

Figure 10: Distribution of population and benefits paid by health insurance funds



The various health components of the aged care system are not integrated in a seamless way. Responsibility for Medicare and Pharmaceutical Benefits rests with the Commonwealth government, though decisions about hospital services are taken by State governments and the decisions about the mix of Home and Community Care services are in part a responsibility of State government, in part the Commonwealth government, and in part local government decisions. As we have shown earlier, an aged person in New South Wales or Victoria may have different access to Home and Community Care services, even if they have the same level of need. Even where services are the responsibility of a single level of government, there may be significant differences in rules about access, service eligibility and costs. The Pharmaceutical Benefit Scheme, for example, has rules about eligibility for differential levels of co-payment whereas decisions about co-payments under Medicare - whether to bulk-bill or not - are taken by individual doctors.

The ideologies and approaches of the health and aged care systems are quite different. Consider a person who has a stroke and ends up requiring ongoing care. Ignoring the different funders (and the Commonwealth, State and local governments, as well as health insurance funds, might all get a guernsey here), the consumer faces a bewildering array of different financial policies. If admitted to a public hospital as a public patient, the patient is not expected to make any financial contribution. The same is true for his or her episode of acute rehabilitation (if any). If the patient is deemed to require residential care the transition from the 'health' sector to 'aged care' is not seamless. Capital and recurrent contributions may be required from day one in residential care. If community care is required, there may be different expectations of financial contributions depending on the service auspice: hospital-in-the-home generally do not require a patient/client contribution in contrast to home and community care requirements.

During the mid-1990s there was increasing recognition by governments about this poor integration of services. Services were recognised to be deficient in terms of availability, funding complexity and organisation. The governmental response was to experiment with a new form of pooling funds from a number of different funding sources. The experiment, known as the Australian Coordinated Care Trials, were planned during a time of considerable State dissatisfaction with Commonwealth-State

relations in health, most trenchantly expressed by Paterson (1996) who argued that there were 60 separate Commonwealth funding programs with little coordination, resulting in wasted money and unmet needs. The political argument was that the rigid Commonwealth program boundaries were leading to waste and were inhibiting effective service coordination at local level. The Coordinated Care Trials offered the prospect of sweeping away all Commonwealth program boundaries at local level, including allowing pooling of funds which would otherwise have been expended under the Medicare Benefit Scheme (MBS) and the Pharmaceutical Benefit Scheme (PBS).

The Trials involved an explicit process of planning the provision of services, pooling of funds within a resource cap, and service provision based on agreed individual care plans. Unlike many public sector reform processes in Australia, the development of coordinated care was specifically designed to provide empirical evidence for evaluation of the new policy (Fine, 1999). The evaluation of the Trials is one of the largest health service research projects undertaken in Australia to date.

The interim findings of the national evaluation of the Coordinated Care Trials (Silagy et al, 1999) are somewhat equivocal. Across the nine funded generalist trials, the outcome after the first year of the trial suggests that in only two of them were there improvements in the health status and wellbeing of participants in the intervention group, as measured by the SF-36 questionnaire, and in only one trial was there a reduction in hospital readmission rates. The cost structures of the different trials also suggest mixed results in terms of long-term financial viability. Six trials are likely to be financially sustainable in the long term, two trials are unlikely to be financially viable and in one, the results are too early to say.

Despite these equivocal results, the Coordinated Care Trials are addressing an important system issue and they may contribute to the design of new forms of organisation and funding to meet the needs of the chronically ill. Certainly, the flexibility shown by the Commonwealth in allowing funds pooling of MBS and PBS funding is an encouraging sign that Commonwealth–State barriers to high quality service delivery can be dismantled.

What is wrong with the current system?

The above review of aged care services might convey the impression that all aged care needs are met through comprehensive government provision. This is not the case. The current system has a number of weaknesses from a consumer point of view. First, there are consistent reports of access problems to residential aged care both in terms of people remaining in acute hospitals when they no longer require acute care but cannot access a residential aged care place, and also in terms of people living in the community facing a similar problem.

Second, public provision of Home and Community Care services is capped and there are long waiting lists for many community-based services. Care professionals also report that the services that are provided are not as extensive or professionally desirable as might be the case. To some extent, wealthier people are able to bypass these public sector constraints through purchasing additional support from private agencies, resulting in inequity in access to care. This private provision is only accessible to those who have current means of paying for it.

As with many other aspects of social provision, especially health care, public aged care services provided with relatively low co-payments may be subject to moral hazard to provide greater levels of services than are 'needed'. This moral hazard may apply to both public and private provision, depending on the nature of insurance arrangements. However, the equity risk with sizeable co-payments is that only those with sufficient private means may have full access to public subsidies. Community care practitioners also report that many older people have to be actively persuaded to accept the level of support they require.

A major concern of aged care providers in both community and residential care is that levels of funding do not enable them to pay sufficient salaries to attract and retain good staff (Aged and Community Services NSW and ACT, 2001). They argue that quality of care depends on having the resources to support a skilled and dedicated workforce.

Aged care services also suffer from the responsibility disjunctions with the Commonwealth responsible for residential aged care policy, the Commonwealth and State's sharing responsibility for the Home and Community Care program, and other primary care services, including allied health services provided in Community Health

Centres, which are the sole responsibility of the States. This mixed responsibility to some extent handicaps consistent planning and leads to attempts to shift responsibility and costs from Commonwealth to State and vice-versa. In turn, divided responsibilities lead to weaknesses in accountability, service delivery and continuity of care.

The interface between the various service systems is disjointed. This is in part because of different ideologies at work between the acute health sector, residential aged care, Home and Community Care services, etc, and in part because of different funding rules. The interface between hospitals and residential aged care is a matter of public debate, with vociferous exchanges between State and Federal ministers about who is responsible for inadequate provision in residential care that delays discharges from public hospitals when people no longer require the extensive mix of services available in that latter setting. Similarly, in October the then Minister for Aged Care launched a strongly worded attack on State governments for not providing enough rehabilitation services. Other interface issues abound.

Finally, a major gap in integrated aged care concerns the crucial nexus between housing and care (Bridge et al, 2001). Both consumer and provider bodies have argued strongly for increased government support for public housing and other forms of housing assistance particularly for those who are not homeowners. However, funding for public housing has fallen sharply over the last decade and successful pilot programs linking housing and care have not expanded into mainstream policies. A home is required as a base for community care. Appropriate funding of supportive housing is required, particularly for those who do not have adequate housing wealth. Very little has been done to advance barrier-free design of housing and neighbourhoods.

The contemporary policy environment

The service system outlined above has shaped and is shaped by the policy environment in which decisions about aged care are taken. Fundamental to this decision making is the divided interests and difficulties in coordination due to Commonwealth-State divisions of responsibility across residential care (Commonwealth), community care (Commonwealth and States), and other aged care and health programs as reviewed above. States also play a major role in health promotion programs for older people (eg. the Healthy Ageing program). Local government is also a significant provider of community care for older people in a number of States.

The divided responsibility for aged care between the Commonwealth and the States means that the policy options of both governments are constrained in that neither level has all the policy levers in their hands. As a result, governmental policy development is characterised by shadow boxing and gridlock. Both the Commonwealth and the States attempt to guess what future policy options other levels of government will propose or support and it is rare that unanimity can be obtained across all States and Territories to proceed in a particular policy direction. Further, policies that are designed in Canberra for implementation in Cremorne, Coburg and Caboolture are bound to fail in at least one of those locations.

The Commonwealth should not be seen as a unified entity. There is significant divergence of interest within the Commonwealth with spending departments such as the Commonwealth Department of Health and Aged Care and the Commonwealth Department of Family and Community Services often acting as advocates for the sector against the guardian or custodian departments such as Treasury and Finance. Treasury especially is concerned at perceived impacts of an ageing population on government revenues. For example, the Retirement and Incomes Modelling Unit, reproduced in the recent OECD report on Australia, incorporated the following table:

Table 3: Projections of total health costs as percentage of GDP under various assumptions

Productivity growth, per cent per annum	Real annual growth rate in age-adjusted per capita health expenditure			
	2031		2041	
	1 per cent	2 per cent	1 per cent	2 per cent
1.00	10.7	15.9	11.7	19.1
1.25	9.8	14.5	10.4	17.0
1.50	8.9	13.2	9.3	15.1

Source: RIM Unit, Commonwealth Treasury of Australia

This table purports to show the potential impact on health expenditure in Australia due to the ageing population with the health share of GDP forecast to be up to 19.1 per cent compared to the current level of 8.6 per cent. Although the higher productivity assumption (1.5 per cent) is consistent with past experience, some newspaper commentators have already quoted the higher forecasts based on the lower productivity

assumption. The table is presumably designed to frighten Commonwealth policy makers into developing and accepting policies designed to reduce future expenditures significantly.

Providers of services are another important interest in the aged care policy ferment. Providers do not speak with a single voice and there may be significant differences of interest between for-profit providers and not-for-profit providers of residential care. Increasingly, the for-profit residential care industry is moving from 'cottage' providers (family businesses, small companies owning one or two residential facilities), to large nursing home chains that achieve both economies of scale and significant industry clout and influence over policy. The former Aged Care Australia, representing voluntary residential care providers, has expanded its scope to become the Australian Aged and Community Services Association (ACSA), attempting to bring into a larger coalition the largely fragmented industry of community care agencies. In the lead-up to the 2001 election, ACSA advanced a wide range of policy papers available on its website <http://www.agedcare.org.au>

Consumers are also able to influence policy directions, with a number of organisations advocating consumer interests with differing emphases and ideologies. The Council on the Ageing (Australia) has since the 1980s shifted from a largely provider organisation to one that constitutionally has a majority of older people on its boards. Over recent years it has aimed to extend its scope by including members aged 50 years and over. The Combined Pensioners and Superannuants Association, once a significant policy advocacy force, has seen its influence wane since the Commonwealth withdrew its funding after public policy disagreements with the Government. The Older Women's network provides grassroots advocacy while most other organisations representing older people are concerned more with income support than with care.

In the lead-up to the November 2001 election, a wide range of peak bodies formed the National Aged Care Alliance. The Alliance included a diverse range of 18 organisations including consumer groups, unions, employer organisations, and professional associations (Council on the Ageing Australia, 2001). The Alliance organised itself effectively to lobby not only for overall increases in aged care funding, but also for increasing funds for capital shortfalls and quality staffing, revamped complaints mechanisms, more residential care places and increased medical input. The

Alliance commissioned applied university research that very effectively brought to public attention the shortfalls of aged care funding over recent years (Australian Institute of Privacy Care, 2001). Similarly, the NSW Aged Care Alliance (2001), convened by the Council of Social Services of NSW, produced a Federal Election Kit that also reflects a broader constituency of consumer, employer, and professional groups.

Older people are an increasingly articulate voting group and may be prepared to shift political allegiance, depending on perceived responsiveness of political parties to the interests of older people. Unpublished polling suggests that the government was deeply concerned by a downturn of older Coalition voters in the 1998 election. The government's post-GST actions to increase the real incomes of older people, particularly for those on the margin of a pension, suggests that care issues were not perceived to be as critical to the older vote in this lead-up to the next election. The aged care component of the Labor platform 2000 emphasised the nursing home scandals that have embarrassed the government and concentrated overwhelmingly on improved regulation of residential care (ALP, 2000). According to COTA (1998) the government and opposition had broadly similar aged care policies in the lead-up to the 1998 election.

The major political parties have been responsive to the aged care industry and advocates in their election platforms. The Liberal's 'Our Future Action Plan: Better Care for Older Australians' defended government policy and stated that '...the Coalition will continue its reform and funding growth for aged care homes and community care'. Major parts of the Plan (costed over the next four years) were increases of 30,000 aged care places (including Community Aged Care Practices) by 2006 (\$68 m), capital assistance for aged care homes in rural and remote areas (\$100 m), increases of residential care subsidies (\$200 m), more aged care nurses (\$28 m), and aged care training for small homes (\$20 m). The Plan summarised the government's achievements as 'The Coalition has provided more places, more money, and better care in a more transparent system of aged care.' It stated that aged care funding increased by 41 per cent to six billion dollars from 1997-98 to 2001-02.

As for ALP policy, Kim Beazley's Plan for Aged Care carried the banner 'Putting the "Care" Back into Aged Care', referring back to nursing home scandals and Bronwyn

Bishop as the responsible minister. Its list of ‘top ten failures’ for the government, to be redressed by the ALP, included shortfalls of aged care beds (and the ‘phantom’ of approved but unbuilt homes), funding cuts, inadequate quality controls on aged care, and difficulties for nurses and other aged care workers. It matched government plans for community care expenditure but the main focus was on residential care, including \$200 million for interest-free capital loans, \$109 million for improving wages and conditions in aged (residential) care, benchmark of care (quality measures), and more respite care (\$37 m). Other initiatives included ‘getting younger people out of nursing homes’, funding catch-up for Victoria and Tasmania, ‘cutting red tape’, and building the aged care workforce.

Several observations can be made about these election debates. For virtually the first time aged care emerged as a central issue, notably as part of Labor’s trilogy of social issues that also included health and education. Aged care was a focal point for a broader challenge to the government with its minister depicted as uncaring and unresponsive to vulnerable older people and the workforce. A ‘bidding’ contest emerged between the parties, with the aged care industries and nursing unions adding to the pressure on government. The debate on ‘unopened’ nursing home beds, funding and quality, centred on immediate ‘problems’ with scant attention to longer-term plans or new directions. The limits of the debate underscore Diane Gibson’s point in her commentary that the nursing home bed is a known unit measure of merit for the public assessment of government resource commitments.

Finally, it is important to note that superannuation funds are significant players in policy on older people but not necessarily with respect to aged care because their focus is primarily on income protection rather than service delivery. Contributors to superannuation funds are of working age but the recipients of superannuation are retired. Following the introduction of the Superannuation Guarantee there is now significant funding held by superannuation funds and they are significant contributors to the retirement incomes of older people in Australia to provide financial independence in old age. In addition to providing the financial means to buy care, superannuation funds could provide enhanced advisory services to assist older people in their choices after retirement when additional care needs emerge. Superannuation

funds potentially could also take a more active role as service coordinators or care managers on behalf of superannuants.

In summary, the size of government investment in aged care means that aged care policy will be a significant factor in shaping Commonwealth budgets and it will regularly attract the attention of the central departments of Treasury, Finance and Prime Minister and Cabinet. In turn, aged care policy will be shaped by the prevailing economic conditions as governments balance fiscal responsibility with generosity to older people. Because older people form a significant proportion of the Australian population, small changes in levels of funding (eg. increasing the pension by \$10 per week) have significant expenditure consequences. Accordingly, expenditure on older people is to some extent determined by the prevailing views of Cabinet about the expansion or contraction of overall government expenditure.

The future social and economic base for aged care

Public policy for older people is increasingly shaped by older people's own expectations as well as broad public views of old age. The National Strategy for an Ageing Society and the breadth of its scope adds recognition to old age as a time of opportunity and capacity rather than inevitable decline and dependency. The vast majority of people can look forward to several decades of relatively independent life after retirement - a great contrast to the short and restricted retirement experiences typical of the early postwar era. Varying life experiences is increasing diversity of the older population and challenging cultural stereotypes of older people as a homogeneous group. McCallum and Geiselhart (1996) write of the era ahead for 'Australia's New Aged'.

Consumer viewpoints

While policies are directly largely towards populations, they need to deliver services that enable older individuals to achieve their own goals and to facilitate service providers in meeting individuals' preferences, needs and situations. The imperative to appreciate older people's own views has been increasingly recognised by governments over recent decades, notably the emphasis on quality of life in the 1985 Home and Community Care Program, outcome-based measures for assessing quality of residential care, and the 'Planning for the Individual' theme in the Community Options program.

It is, however, inherently difficult for services to achieve such high ideals given the strength of entrenched interest groups, power relations and resource constraints. Nonetheless, a civic and humane society must strive to keep the views of older people themselves central to the objectives and accountability of programs for them.

There are a number of ways to involve advocacy organisations in policymaking (Correll and Bourke, 1992) and consultations are seen as essential to identifying older people's needs (Sax, 1993). However, as Gibson (1998) and other commentators point out, consultations and 'proxy voices' do not work very well in representing the views of consumers who are rendered highly vulnerable people by physical and mental impairments and their dependency on service providers. In a paper 'Social Policy and Research for Elderly Citizens', Russell and Kendig (1999) drew on Australian evidence to argue that applied research can have a constructive part in shaping ideas on policy directions. Government agencies with reform agendas have funded research that elucidates the views of vulnerable older people and explores the implications for service delivery.

Research can contribute in normalising public understandings of old age. Attitudinal research conducted for the National Strategy for an Ageing Australia (Worthington di Marzio, 1999, p4) points out that 'Younger people tend to characterise old age by physical descriptors ... in generally a stereotypical and narrow focus'. Further, '... "baby boomers" are largely in denial about the prospects of growing older', suggesting some of the obstacles in individual and collective planning for growing older. In sharp contrast to this negativity, 'Older Australians are very definite about their perception of being only as old as they feel'. The 'ageist' impositions of younger people (notably health professionals) can leave older people with the decidedly negative and limiting experience of 'feeling old' in contrast with the experience of 'normal ageing' with its opportunities as well as its limitations (Minichello, Brown and Kendig, 2000).

The starting point for planning for future aged care is to understand older people who presently experience frailty. Qualitative research shows that very old women have a strong sense of themselves as survivors and they maintain their identity notwithstanding the many changes in their lives (Walker-Birckhead, 1996). Even when experiencing life-threatening illness and pain, older people maintain generally high levels of wellbeing as long as they can maintain their activity and independence and

have social support (Kendig, Browning and Young, 2000). Adaptation through the life transitions of old age is enhanced considerably by a sense of control along with personal and social resources (Browning and Stacey, 1999). There is substantial research evidence that older people generally take active measures to maintain their health (Kendig, 1996).

Staying at home can be central to older people's sense of identity and to their independence (Davison, Kendig, Stevens and Merrill, 1993). While the single family home can be difficult to maintain, older people can evince remarkable inventiveness in adapting and using their home environments to render them supportive and to overcome physical limitations. If they are no longer able to remain independent, they overwhelmingly prefer to remain at home with outside help rather than to move to a relative's household or to cared accommodation. However, those who choose to move to retirement villages (Gardner, 1994) or public housing (Brooke et al, 1998) by and large benefit from the adjustment. Only in the case of nursing homes are older people overwhelmingly resistant, with one study recently reporting that most would prefer to die (Salkeld et al, 2000). These intense views are shaped by a fear of dependency as well conditions in some nursing homes. However, it is equally true that the strong demand for residential care rises partly because of the shortages of high levels of support in the community.

In her intensive qualitative study of very frail older people receiving community care, Brooke (1995) reports that older people's views of dependency and care depend on earlier life experiences that continue to shape expectations and interpretations of caring experiences. The difficult interpersonal negotiations centre around accepting enough support to maintain adequate care at home and, if necessary, resisting the efforts of family and service providers if they urge moves to residential care. Caregiving typically begins when a long-term relationship between an older person and a close relative, usually a spouse or a daughter, is changed by dependency and reduced mutuality. The demands of caregiving can generate considerable stress, particularly in situations of co-residency, and community care depends as much on the capacities of caregivers as it does on the needs of frail older people (Schofield et al, 1994). In many cases, entry to residential care reflects difficult decisions by caregivers more than by older people themselves.

Within this broad framework of issues there is great variation among older people in many respects that can only be briefly mentioned in this paper but which are central to the delivery of quality of care. Chapters in Borowski et al, (1997) provide analyses of most of the groups and issues understanding diversity. The following are some of the main sources of variation in addition to the kinds and levels of disability that need to be appreciated in designing and delivering aged care services that provide integrated, client-directed aged care:

- *Gender* with the different 'his' and 'her' worlds, and the reality that women make up the vast majority of aged care recipients as well as informal carers.
- *Family situations* with spouses, then daughters as the frontline support in most instances; services generally reinforce family support when available and provide alternatives when it is not.
- *Financial means* including the income capacity to purchase services privately and/or the assets to buy into more supportive accommodation.
- *Dementia* and its effects in undermining self-care and increasing demands on caregivers.
- *Health status* including any specialised treatment requirements.
- *Ethnicity and migration* including cultural variation of care expectations, language barriers, as well as potentially reduced family availability. (Benham, Gibson et al, 2000).
- *Aboriginality* with very few indigenous people reaching old age by conventional definitions, given health profiles more typical of those for people in developing countries.
- *Local area* including the vast disparities between urban and rural areas and between regions in their social, economic and service infrastructures.
- *Social deprivation* including homelessness, insecure housing and unemployment. (Russell et al, 2001)

Population dimensions

Almost all of the objective commentators conclude that Australia does not face a crisis concerning population ageing but there is a clear requirement for long-term planning (Australian Institute of Health and Welfare, 2000; Gibson and Goss, 1999; McCallum, 1999a; Productivity Commission 1999). To put the future into the context of recent history, the proportion of the population aged 60 years and over increased only modestly from 9 per cent in 1976 to 12 per cent in 1997, notwithstanding substantial increases in life expectancy in old age. The explanation lies in the small inter-war birth cohorts, along with the presence of the large baby boom war cohort in middle age and continuing high levels of immigration. As the baby boom ages the older population is projected to rise substantially from the 2.3 million in 1998 to 4.0 million (18 per cent) in 2021 when Australia will reach the extent of population ageing that Sweden and other northern European countries have already have experienced for a decade. There is substantial time, however, before the older population is projected to eventually reach 5.7 million (23 per cent of the population).

A better indication of the population needing aged care is the proportion aged 80 years and over. Gibson and Goss (1999) show that by this measure Australia's old-old population was growing reasonably quickly at 5 per cent annually from 1985 to 1995. This rate of growth will be slowing to 3.3 per cent per year over the next decade and may slow further until the baby boomers begin to reach this age in numbers in 2030. Moreover, most of the health costs of older people occur in the last few years of life, and this fact may prevail even if people live longer.

Similar trends may prevail in the case of disability, the best indicator of care needs. Using the latest measures of Disability Adjusted Life Years (DALYs) from the World Health Organisation, Australian women at age 60 years can expect another 25 years of life including only 4.5 years with disability and men at 60 years can expect another 17 years with 4 years of disability (McCallum, 2001). Moreover, there is increasing evidence that healthy lifestyles and the use of aids can potentially reduce the levels of disability at given ages (Browning and Kendig, 1997; Simons, McCallum, Friedlander and Simons, 2000). There is less indication, at least on the basis of present knowledge, that the age-specific incidence of dementia will be declining, and individuals with

dementia have particularly great difficulties in managing their own care or in being cared for by others.

A major trend that has yet to be widely appreciated is the rapidly growing number of people who are reaching late middle age with lifelong disabilities or disabilities acquired earlier in life. This trend partly reflects the baby boom bulge and also the increasing survival rates of people with long-term disabilities. Between 2000 and 2006, the numbers of people with severe or profound disabilities are expected to increase by 137,000 including nearly 60,000 more in the 45 to 64 year age bracket and 76,000 in the 65 and over group (AIHW, 2000). These developments underscore the increasing service needs of relatively younger adults and children as well as older people with disabilities and the increasing difficulty of distinguishing needs on the basis of age. People growing older with disabilities tend to bring a 'rights' perspective that is likely to increase consumer expectations in old age.

Overall, only 20 per cent of Australians aged 65 years and over in 1998 were reported to have a substantial disability defined as causing difficulties with the core activities of self-care, mobility, and/or communication (AIHW, 1999). Another 8 per cent have mild levels of disability in which they find the core activities difficult but do not need assistance. While only those with substantial needs require personal care, the majority of those with mild disabilities also have needs with household and property-related responsibilities.

In 1998, 91 per cent of older people lived in private households, 7 per cent lived in cared accommodation such as nursing homes or hostels, and 9 per cent in non-private dwellings such as boarding houses. However, among those who have a substantial disability, the vast majority resided in some form of 'cared' accommodation including hospitals, nursing homes and hostels, and related parts of retirement villages. The proportions in residential care are especially high for those who are widows and never-married men, reflecting the important influence of informal care. Overall, as shown earlier in the paper, less than half of the people entering old age are projected to ever live in a nursing home or a hostel.

Among older people who have substantial disabilities and live in private households, more than half are married and a third live alone, again indicating the importance of

informal support (Bridge et al, 2001). Fully three-fourths of them own their homes and 10 per cent live in public housing. However, only one out of five has a personal income greater than \$12,000 a year, thus fitting the 'asset-rich but income poor' profile. They have extensive needs for assistance ranging from property maintenance (60 per cent), housework (46 per cent), health care (44 per cent), and transport (42 per cent) through to self-care (29 per cent) and meal preparation (18 per cent). Across these areas 54 per cent report that all of their needs are met, 30 per cent that needs are partially met, and 12 per cent that none of their needs are met.

The Disability, Ageing and Carer Survey (DACS) confirms that informal support is the primary source of assistance for older people who live with substantial disabilities in the community. Fully 77 per cent of them have some informal support and a third of them receive assistance only from these sources. Just over half (53 per cent) receive some formal support from community services and/or privately purchased assistance, and 9 per cent have only formal assistance. The single most common arrangement is the combination of both formal and informal assistance received by 44 per cent of them. Only 12 per cent of these people report that they do not need any assistance and 2 per cent say they do not have any support. Nearly half a million people were primary carers of younger or older people with disabilities in 1998 (AIH, 2000) and more than a third of them spent 40 or more hours a week on caregiving. The monetary value of this work was estimated at \$16.6 billion in 1995-96.

There is great controversy concerning the sustainability of informal support. Notwithstanding popular concern for the erosion of family ties, the available research does not suggest any attenuation in the availability of close family over recent decades or in the motivation to assist older relatives when necessary (Kendig, 2000a). The increasing numbers of baby boomers, children of the marriage boom, are potentially available to support their very old parents (Rowland, 1997). Paid employment of middle-aged women in the labour force, one of the most significant factors influencing carer availability, has remained at the high levels of nearly 70 per cent for a decade and there are no clear reasons to expect changes either way. Not until the late baby boom cohort reaches old age are many people likely to be ageing without having ever married and/or ever having had children.

Cohort momentum

The key features of future groups of older people can be anticipated by understanding each birth cohort as it moves into and through old age (Rowland, 1992). People's orientations, resources, and vulnerabilities reflect their entire life histories and the lasting influence of the periods of history in which they have lived their lives. The people who are now in advanced old age were born in 1920 and earlier, living their formative teen and young adult years in the Depression and World War II. Their lives have followed very different contours from those of their children's' cohort, the early baby boomers born after the World War II, who will be entering advanced old age in numbers from 2030.

The life experiences of successive cohorts of older women have been mapped by Gibson, Benham and Grey (1999). As compared to the small cohort of the present 80-year-olds born in the World War I years, the massive baby boom cohort will begin reaching 80 years old in the 2020s. The baby boomers have had a defining influence on each subsequent period of Australian society from the child-focused 1950s, the youth era of the 1960s, through to the discovery of middle age in the 1990s. Approximately nine out of ten of the women in both of these cohorts have had children, with the notable family difference being that only 7 per cent of the now elderly group were separated or divorced on entry to old age as compared to the 27 per cent anticipated for their counterparts in 2020. Among women reaching old age, the proportions living to 85 years and over was estimated at 54 per cent for the next cohort of older women, 41 per cent for the current one, and only 28 per cent for older women as recently as 1985.

Educational and work experiences have been massively different for the two cohorts. In contrast to those who came a generation before them, the early baby boom women are much better educated (half through full high school and a third with further qualifications) compared to the typical age of 13 or 14- years-old for school leaving of the older cohort. While the older women typically worked a few years before marriage and then returned for a time after their children grew older, half of the baby boom women were working full-time in their late 20s and almost 70 per cent were working during their late 40s and early 50s. As workers (and some non-working spouses) the future cohort of older women will be receiving at least some superannuation and they

may stay in the workforce longer. While very old women today were pioneers of feminism, the women's movement has been accepted widely mainly by young women from the 1970s onwards and this influence too can be expected to carry through to old age.

As compared to the current cohort of older people, the baby boom cohort of men and women will probably bring different attitudes to old age (see also McKay, 1997). They are unlikely to evince the stoic acceptance, low expectations and predispositions to save that are typical of the Depression cohort. Their expectations have been built by their centre-stage position in Australian society throughout their lives and their observation of the rapid growth of aged care services for their parents' cohort. Older women can be expected to have much more of the organisational skills necessary for negotiating advantage in bureaucratic systems. Having paid taxes for widespread pensions and nursing homes throughout their working lives, it is unlikely that they would view very favourably any reduction of these government benefits. A major question, however, will be the extent to which the quality of publicly available aged care services will meet expectations, particularly for the more privileged social classes when they reach old age.

It seems likely that there will be some increases of income but also increasing disparity of income among people reaching retirement over the coming decades. On the positive side, increasing proportions of older people will have superannuation benefits accumulating since the 3 per cent mid-1980s Accord and the 1992 Superannuation Guarantee, and there are increasing voluntary contributions (Bishop, 1999a). By 2020 a significant minority of people will be retiring with 30 or more years of tax-advantaged superannuation, together with other investments accumulated particularly since the share and property booms of the 1980s. It is also possible that older workers will stay in the labour force longer as a result of concerns over retirement income adequacy, increasing opportunities in likely labour shortages, and government incentives to keep working. Present policies suggest that taxation and means-testing may become more favourable for those who are eligible for a partial pension. Overall, Australia has a robust income support system - with the three pillars of pensions, compulsory superannuation and private savings - including high levels of home

ownership - with the main questions for the next cohort concerning likely gaps between rising incomes and even greater rises in expectations.

The OECD and other authorities provide reassuring evidence that Australia can easily afford to maintain its current age pension into the middle of next century, notwithstanding massive population ageing. The continued payment of 25 per cent of average earnings, with increasing top-up from private superannuation, is likely to lift the present low floor to a somewhat higher standard of living for the vast majority of older people who own their homes. However, the one out of five older people who do not own their own home are highly vulnerable not only in terms of current income but also in having minimal assets to buy into improved accommodation and care. The National Strategy on an Ageing Australia (Bishop, 1999a) recognises that groups with low retirement savings include women, migrants with low English proficiency, women, Indigenous Australians, people in rural areas, farmers and people with disabilities.

The financial capacities of older people in the future are likely to be heavily influenced by their position relative to younger people and the consequences on political perceptions of relative need and power. Changes of real income are difficult to predict but most forecasters do not expect major rises or falls in real standards of living for those currently employed. There is little doubt, however, that many older people of the future will have been advantaged by the income gains and wealth accumulation during the 1970s and 1980s that are unlikely to return. Long-term trends have been to maintain tax advantages to older people while reducing them for families, notwithstanding rising concern for massive falls in birth rates. The National Strategy on Ageing also suggests that the historic growth of the Australian labour force – and hence tax receipts – is projected to end by 2020.

Housing is already one of the major economic divides between social groups and the disparities are expected to increase in the future (Kendig and Neutze, 1999). Three-fourths of older people today are outright homeowners, leaving them with low housing costs that permit a reasonable standard of living on the pension. The home is also a substantial asset that can be used to buy into aged care facilities and/or left as inheritance. By contrast, most private tenants are heavily pressured by high rents as well as low incomes and neither public nor private tenants have housing assets. These inequalities have been accentuated by massive subsidies to buy homes and they have

been sustained by the tax-free position of owner-occupied housing in terms of use value (imputed rent), property appreciation and eventual inheritance that perpetuate financial gain down lineages (Baekgaard, 1998).

As for the future, the baby boom cohort will be bringing to old age high levels of home ownership and they are likely to own much of the most valuable housing. While very old people today tend to live in smaller homes in suburbs designed for public transport, the baby-boomers are presently concentrated in low-density postwar suburbs having relatively less variety of housing and poor access to public transport. Home ownership rates have been falling for recent cohorts and, if this trend continues, it will greatly increase inequalities (within as well as between cohorts). Overall, in terms of housing wealth as well as lifetime incomes, it can no longer be assumed that older people are disadvantaged relative to younger people by their cohort of birth.

It is difficult to anticipate the effects of social change but the attempt to do so can sharpen the choices ahead and heighten awareness of the long-term consequences of current decisions. Uniting Care (2001), the largest voluntary provider in the field, recently completed a report on 'Alternative Futures for Aged Care in Australia'. On the basis of 34 interviews with specialists in aged care and related fields, the report identified a number of trends, including most of those reviewed above, and draws several conclusions of considerable significance:

- Aged care is 'solvable' because a doubling of expenditure would meet demand (unlike the field of health where a doubling of expenditure would be expected to increase demand.)
- Information technology is likely to have a major impact, including greater access by older consumers to medical information that could greatly increase consumer power.
- The growth of the numbers of older people '... is very likely to make older Australians a potent political force when combined with the Baby Boomers' propensity to speak up for themselves' (p.6); and
- The political cycle works against long-term thinking and planning.

The report builds three scenarios that crystallise 'critical uncertainties' concerning the crucial areas of economics and technology as well as other social, environmental and

political developments. For example, they do not rule out possible technological developments such as a dramatic extension of life or a cure for dementia. Economic growth is seen as the critical factor for enabling 'good times' for all rather than social divides and tensions. One of their three scenarios is the 'Brave New World' led by massive technological advance and the rapid accumulation of wealth. Another is 'Blade Runner' in which economic, social and environmental life deteriorates with a consequent divide between the haves and the have-nots.

The Uniting Church's 'She'll Be Right, Mate' Scenario, largely a continuation of present trends, anticipates that government will still be the major source of aged care funds but there will be greater emphasis on the user-pays principle and mutual obligation, and the introduction of some form of long-term care insurance. They suggest that there will be increased emphasis on community care but residential care will remain the dominant paradigm and there will be more specialised facilities for palliative care and people with particular health conditions. This scenario anticipates that the aged care industry will consolidate into fewer but larger providers precipitated by the absence of government capital funding and higher building standards. It is expected that the 'staffing crisis' will continue, as will 'image' problems for aged care.

Other views of the future were provided by Bridge et al, (2001) who explored with policy-makers, service providers and advocates their views on middle and long-term trends concerning the accommodation and care of younger and older people with disabilities. The first was the trend towards 'deinstitutionalisation', particularly for younger people, and difficulties in marshalling the necessary resources. The second was 'ageing in place' for older people and the inappropriateness of present housing, land use and transport policies in responding to this trend. The third was the increasing expectations of the carers on whom the first two trends are so heavily dependent. Fourth was the trend towards increased 'consumer rights', as furthered by disability discrimination legislation and its implications over the last decade. Fifth was a trend towards more 'user-pays' as a result of fiscal pressures on governments combined with rising consumer expectations.

In 1999 the (then) Aged Care Australia and Association of Gerontology convened four 'think tanks' to consider long-term (to 2025) strategies to deliver quality of life to older people (<http://www.agedcare.org.au>).

1. *Paradigms or models of services* with a desired future involving a genuine client focus, community interaction with residential care closely connected to community care, and residential care support modelled on community rather than institutional norms. Key requirements were for services that enhanced empowerment of older individuals and carers (paid and unpaid), holistic approaches, and flexibility at the strategic level and in daily provision.
2. *Finance implications* focused on the perception that most people would need to pay more for their own services and that the care system would need to facilitate self-contributions as part of a 'resilient financing mechanism which spreads risk'. There was to be less emphasis on physical infrastructure and more on enhanced cost-effectiveness gains.
3. *Infrastructure issues* comprising physical infrastructure, including the importance of adaptable housing, community design to handle isolation, and better use of technology to enhance capacities; and staffing developments to make the industry a more attractive workplace including the breakdown of professional, union and State demarcations, as well as training that enhances multiskilling and an increased retention and return of skilled workers to the field.
4. *Technology* has the promise to assist in efficiency, monitoring and communication, but there needs to be a balance with 'hands-on' care and access by all income groups.

Overall, it is clear that the need for aged care services will be rising appreciably over the next three decades. In reviewing AIHW projections for residential care to 2021, Howe (1999a) concluded that a continuation of current planning ratios would lead to some shortfall of nursing homes but that these would be offset by an excess of hostel places and community aged care packages. Gibson et al, (1999) noted that among selected European and comparable countries in the early 1990s, there was no clear relationship between the availability of aged care and the size of the very elderly population; nor was there any indication of countries with relatively high levels of community care having lower levels of residential care. These coarse figures underscore the fact that levels of aged care provision are matters for negotiation within each country's own traditions, expectations and means: there is no definitive way to clearly benchmark ideal or necessary levels of provision.

Towards an affordable ‘choice-based’ aged care system for 2020

In our estimation, the social and policy trends suggest that a new vision is developing to guide aged care development in the future. Over the last 50 years the locus of power in aged care has turned from providers to funders and, increasingly, to consumers in designing and delivering care systems. In addition to concerns for the adequacy and quality of care there will be increasing concern for enabling choice of care. There also will be concern for funding approaches that are equitable, not only between groups of older people of different needs and means but also between younger and older people of equivalent needs. It can no longer be assumed that younger taxpayers will have more capacity to pay than older retirees.

A new aged care system is thus required to integrate public and private funding and Commonwealth and State responsibilities. We have argued earlier that the next generation of elderly will expect greater choice in service design. There will be a number of elements in which choice could be exercised. Consumers will expect to have choice in terms of providers and also choice in ensuring that the mix of services is the most appropriate to their needs, that is, consumers will expect flexibility in terms of service provision. An appropriate service response, then, will require significant reshaping of existing aged care services to ensure that they are flexible and that they can be tailor-made to the needs of the consumer.

Services must recognise that different consumers will have different ability to pay for services. The service system will thus need to be designed to ensure that all consumers have access to a care level of service that ensures appropriate residential care and community-based care. The care level of service should not be ‘second rate’.

The new aged care system must also provide for consumers to be able to top-up care where they want to purchase additional amenities. These top-up arrangements must be structured so that they do not undermine the public system but facilitate aspects of choice in areas where it is appropriate for financial leverage to be exercised rather than providing only for the wealthy get access to necessary care services.

While there are many ways of addressing long-term policy developments, we develop below the following as a focus on the choices ahead for Australian government and society:

1. a constructive approach;
2. improved funding approaches;
3. regional development and delivery of aged care services; and
4. ‘unbundling’ accommodation and care services.

A constructive approach to ageing and support

Academics, advocates and government planners have already envisaged a tidal change in the way in which government social defines old age and treats older people. This new constructive approach recognises reality as it is felt by older people themselves; that is, they take a positive approach in which they build on their strengths and independence rather than concentrate on disability related deficits. ‘The Life Style’ and other background papers for the National Strategy for an Ageing Australia set a good grounding for this approach. While governments are at only the early stages of acting on many aspects of this vision, the ideas are sound and likely to eventually find a place in policy when an opportune time arrives.

A cornerstone of a constructive approach to old age is adequate – and ideally more than adequate – income. Virtually all of the advocacy groups including carers have policy priorities for income in hand, preferably from employment where possible. People entering old age with long-term disabilities are likely to demand ‘rights and benefits’ in the community rather than ‘dependence and services’ in residential care. As Sidney Sax (1990) has argued, the provision of government subsidies directly to clients rather than to providers can radically redefine power relationships and enable older people to better meet their preferences. There are a variety of ways in which family or case managers can act on older people’s behalf when they are too vulnerable to act for themselves. Allocation of resources directly to older people or their agents is possible across the range of funding proposals outlined below.

This approach to maximizing choice reinforces the importance of superannuation and income-support policies that provide older people with sufficient resources to pay for assistance in forms that they prefer. Resources also can be maximised by financial instruments such as Home Equity Conversion that enables people to draw on their housing wealth for care and other needs (Storey et al, 1994). Reinstatement of government support for this scheme, discontinued recently, would facilitate this choice, enabling more older people to finance themselves for the costs of care.

The Commonwealth, State and Territory Strategy on Healthy Ageing (2000) presented concepts on ways in which governments could proactively enhance the wellbeing and health of older people, including actions that can delay the onset of frailty and dependency. While the strategy foundered in unfortunate competition between Commonwealth and State governments, it has outlined a realistic vision that could be implemented through commitments and partnerships among governments. Action does not appear to be likely soon, given that the government and opposition share health-promotion policies that focus on specific diseases rather than lifestyle and community influences that could more comprehensively address health in a constructive way.

A particularly important feature of the healthy-ageing approach concerns the promulgation of positive community attitudes towards ageing, dispelling the harm of negative stereotypes and age discrimination that unnecessarily restricts the aspirations and lives of older people. The Australian Council on the Ageing, in its response to the National Strategy for an Ageing Australia, places leadership responsibilities clearly on the national government for presenting a realistic view of older people rather than one-sided arguments about their dependencies and costs.

Another important recognition is that disability – technically the gap between an individual's capacities and his or her environmental demands – can be obviated by actions that ensure appropriately supportive environments (Bridge et al, 2001). This approach can involve the provision of aids in everyday living, adaptable housing, and accessible and safe local areas. However, the interests that influence the built environment are focused overwhelmingly on the short-term cost considerations of developers rather than the long-term benefits for all people, but especially those rendered vulnerable somewhere in their full life span (Kendig, 2000b). While there are potentially effective actions to address these complex issues (AURDR, 1994), they require 'whole of government' approaches that do not have natural constituencies of much influence.

Funding approaches

A number of aged care analysts have in recent years developed various recommendations for new ways in which to fund aged care. Part of the concern is that the need for aged care is an uncertain, expensive risk that is naturally suited to some form of insurance. Another concern is to ensure adequate resources for the care of the large baby boom cohort. Even now there are insufficient funds, particularly in accommodation and community care components of the system. Further, insurance approaches provide an alternative to the imposition of high public costs on a younger generation of taxpayers who could be hard pressed to afford them or may even be unwilling to pay them. While there is little reason to fear a financial doomsday ahead, it is clear that both older and younger people could be advantaged by having better financial mechanisms to enable older people to pay in advance for their aged care should they require it.

The next generation of policies of health and aged care could evolve along three distinct paths, each based on different funding options. First, there could be an incremental change option that continues to rely primarily on taxpayer revenue and user charges on entry and during care. The assumption with this option is that policy settings for health and aged care policies and the interfaces between the two are correct. Advocates of this option would argue that there is a good institutional framework for community and residential care and that incremental change to policy settings is either all that is required to ensure that the policies are responsive to future need or that, given interest groups at play in the sector, incremental change is all that could be achieved.

The two other paths involve more fundamental changes to the service framework. Radical options could be developed, with either primarily public or primarily private financing. In common between the two paths would be that the sector needs to decrease the emphasis on a tax-based, pay-as-you-go system of financing for residential and community-based care to a system where consumers provide for their own future care needs with the tax-based system continuing only as a residual safety net.

The publicly oriented variant of this option is common in those European countries with a Bismarckian tradition of social insurance. Under social insurance, consumers (and/or employers) are required to contribute to a social insurance fund that is drawn down by contributors for future needs. The scope of the social insurance fund can be

quite broad, including provision for possible unemployment or retirement income, or the scope could be restricted to more narrow care needs. The design of social insurance arrangements could provide for unexpended balances in a social insurance account to be inherited or for these balances to revert to the fund. Social insurance arrangements can also provide for a greater level of care management by the social insurance fund or can allow the consumer to make independent choices about the appropriate service response to care needs.

Concern for the adequacy of taxpayer and user-funded long-term care has led Howe (1999b) and others to argue for social insurance as a necessary third 'pillar' of aged care funding. Fine and Chalmers (2000), after reviewing a variety of international user-pays approaches to long-term care, also recommend the social insurance approach for advantages in terms of social equity and development of integrated aged care systems. However, Smith (1999), in her review of another social insurance model advanced by McCallum (1999a), points out that aged care costs and their anticipated increases are relatively small compared to the income support and health costs that are higher priorities for superannuation and insurance approaches. A social insurance model of financing aged care would need to incorporate provision for people who leave the workforce for child-rearing (primarily women) or who have intermittent work histories. The 'safety net' provision needs to be incorporated into general aged care provision to maintain universality and not lead to stigmatised ghetto services for the poor. Further, while social insurance has many advantages it is unlikely to be popular among older people who have already paid taxes for the care of their parents' cohort of older people. Even the advocates for social insurance do not think it likely to be adopted in the near future.

A third path would place a greater emphasis on private insurers. The National Commission of Audit (1996) recommended the promulgation of private long-term care insurance. As with social insurance such an approach certainly would ease the pressure on younger people who would otherwise meet more of the costs of aged care through the tax system. However, while private long-term care insurance may well increase in future, it is likely to benefit only the more affluent older people and undercut support for public funding for others on low incomes. Moreover, those with more resources would be understandably reluctant to self-insure if it meant that they themselves would

be paying for services that are expected to be a government responsibility. The Australian view that long-term care is part of the health system underscores the expectation that government should pay for its provision at a good quality level irrespective of people's financial resources.

In Australia, likely providers of private long-term care insurance are most obviously represented by superannuation funds. The minimum level of contributions to superannuation funds under the Superannuation Guarantee provisions is currently 8 per cent of taxable income. This minimum could be increased and superannuation funds given the responsibility not only for income security in old age but also associated care needs for older people. Under existing superannuation rights, if a lump sum is taken residual amounts can be inherited. The three different paths are summarised in Table 4.

Whatever policy path is followed, there will be differential impacts on different consumers and classes of consumers. The policy options will therefore need to be evaluated in terms of standard criteria of equity, efficiency and quality. If a transformational option is adopted, *equity* would need to be assessed both in the short term (eg. transitional arrangements) as well as in the longer term in respect of the adequacy of safety net provision for all consumers.

Table 4: Options for development of aged care funding

	Publicly funded	Public contributory	Private contributory
Basis of the system	<ul style="list-style-type: none"> • Tax funded, pay-as-you-go. 	<ul style="list-style-type: none"> • Compulsory contributions to publicly managed ‘Social insurance account’, eventually fully funded. • Contributions offset by reduced income tax or payroll tax rates. 	<ul style="list-style-type: none"> • Compulsory contribution to privately managed fund(s), eventually fully funded. • Contributions offset by reduced income tax or payroll tax rates.
Community care	<ul style="list-style-type: none"> • Current Commonwealth-State joint responsibility for Home and Community Care. Could evolve to regional funds pool model to enhance flexibility. 	<ul style="list-style-type: none"> • Integrated funding. Consumers could purchase from any public provider. 	<ul style="list-style-type: none"> • Integrated funding. Consumers could purchase from any public or private provider.
Residential care assessment	<ul style="list-style-type: none"> • Current Commonwealth-funded Aged Care Assessment Service. 	<ul style="list-style-type: none"> • Responsibility of social insurance fund 	<ul style="list-style-type: none"> • Responsibility of each privately managed fund.
Residential care	<ul style="list-style-type: none"> • Commonwealth responsibility. National payment rates; nationally consistent consumer contribution. • Payment rates could evolve to protect quality of care better. 	<ul style="list-style-type: none"> • Probably as current. Consumers can use social insurance account to top up for amenity. 	<ul style="list-style-type: none"> • Privately managed fund may set different rates for different providers; different levels of consumer contributions. Consumers could use fund to top up for amenity.

Efficiency should be broadly defined to ensure that the new arrangements promote both allocative and technical efficiency. Allocative efficiency is designed to ensure that the mix of services is optimised. Thus, allocative efficiency would be promoted if the service mix is the most appropriate to meet the care needs of a consumer; that is, if a consumer does not require residential care they should not be forced into such an option because of the unavailability of cheaper home-based alternatives.

The efficiency criterion also incorporates technical efficiency: policies should minimise waste in service provision, and thus be efficient in the ordinary meaning of the term.

The third criterion for evaluating policy responses is *quality*. Quality should be broadly defined to incorporate both clinical quality of services and also responsiveness to the needs of consumers and consumer satisfaction with the care choices available to them. Consumers now expect to be consulted in terms of their satisfaction with service provision; ensuring consumer responsiveness and satisfaction is going to be an increasingly important component of the next generation of aged care policy.

In summary, the more radical public and private contributory schemes could provide the resources necessary to ensure the greater consumer choice and flexibility that the baby boom cohort may demand. As Diane Gibson argues in her commentary, this approach does run the risk of widening inequalities and ‘residualising’ care for those who cannot contribute to long-term care insurance. However, in our estimation, the greater risk could be to attempt to maintain a universal system funded almost entirely by taxpayers, notwithstanding the financial capacities of many older people.

The experience with aged care policy is that incremental and evolutionary program change is more likely than a fundamental funding change. Although some aspects of the current system have significant choice, there are significant rigidities in the system both within States and certainly there is no equity in provision between States. Later in the paper we will outline some of the priorities for evolutionary change over the next five to ten years for the service system. This time period should also see evaluation of the two contributory paths as well as a review of the current funding and decision making arrangements for public aged care programs.

Commonwealth-State re-organisation of functional responsibilities

Within an aged care system funded as currently by annual government revenue, there have been continuing calls for reforms to realign the responsibilities of governments, notably the COAG reform effort of several years ago as reviewed above. For example, Aged and Community Service Australia has recently published a discussion paper (National Community Care Advisory Committee, 2001) that outlines four options for community care programs for the future, including sub-options based on clarifying the responsibility of roles for aged and disability services between the Commonwealth and the States. (The proposal we develop below is similar to option 4, the ‘community of interest’ option, in the Aged and Community Services Australia paper.)

There are two fundamental roles in aged care, that of funder/purchaser on the one hand, and provider/owner on the other. Table 5 shows the significant differences between aged care and disability services with the State having an almost exclusive role in residential and community care for disability services but the responsibility for aged care being in some cases a Commonwealth-only responsibility (eg. residential care), sometimes a joint responsibility and sometimes the responsibility of the State or the individual consumer through using private services. The disability system is not quite as neatly divided as outlined in the table, as the Commonwealth has the responsibility for employment services for people with a disability.

Table 5: Current funder/purchaser roles for aged and disability services

	Aged care	Disability services
Assessment	Commonwealth	State
Residential	Commonwealth	State
Specific Community Care	Joint Commonwealth-State	State
Primary medical care	Commonwealth	State
General community services	Private and/or State	State

The Commonwealth is the dominant funder/purchaser in residential aged care; State responsibility in this area is primarily as provider/owners of services and thus can be seen to be on the same footing as private sector providers. The dividing line between residential and community care, however, is not straightforward. For example, the Commonwealth counts Community Aged Care Packages as part of residential care provision even though they are delivered in home settings. As shown earlier, the provision of Community Aged Care Packages has increased dramatically in recent years and this development is one of the frictional problems that need to be addressed in any future planning for community-based care for the aged.

Given the community aged care package developments, it would be more sensible to assign full responsibility for specific community care for older people to the Commonwealth. This, of course, would address the intergovernmental divide between residential care and community care. However, it would create frictional problems with general community services such as community health centres and it would

exacerbate the already considerable boundaries between acute services and aged care services generally.

Fundamental solutions to the aged care divides would require more radical changes with either the Commonwealth or the States comprehensively assuming funding and planning responsibility for health and aged care services. However, as the COAG experience has demonstrated, such an outcome is not on the political agenda because neither level of government can be expected to cede funds and control to the other across this broad spectrum of services. Not until GST revenue is provided fully to the States in 2007 is there likely to be a fiscal climate in which aged and health care could be considered basically as the responsibility of one level of government. Even then, it is difficult to imagine the political motivations that would enable such massive but beneficial change.

The mixed responsibilities in aged and community care could continue in a regional funds pool, as outlined below, or they could be assigned to either level of government.

Regional fund pooling

It is proposed that all Commonwealth and State funds for aged care services be pooled into a single fund to be managed at regional level. The funds pool would incorporate residential aged care, Home and Community Care and community aged care packages, and relevant State-funded community health activities. One of the advantages of this approach is that the supply of care can be tailored to local circumstances, such as those in rural and remote areas, and that additional supply can be carefully gauged to meet priority gaps in provision. Another advantage is that the funder/s of services are close to the providers of care and this will enhance coordination and accountability, including quality of care. A single point or consistent points of assessment can allocate resources (and case manage where necessary) on the basis of comparative need. All of these approaches should increase the appropriateness, and hence cost-effectiveness, of provision.

A funds pool could be managed regionally but with an advisory board of all stakeholders: Commonwealth, State and local officials, and local providers and consumers. The Commonwealth and State governments should jointly determine how much additional funding should be allocated to the pool each year on the basis of a

planning needs formula which should include provision for increases in line with the ageing of the population and the increases in the proportion of the population with severe disabilities. In the medium to longer term, contributions to the pool could become the responsibility of a single level of government, although this is not a necessary consequence of our proposal. The scope of the pool could also be broadened to include other related services (eg. sub-acute hospital care for older people) as experience with pool management is gained. Increased responsibilities for pool managers should lead to reduced responsibilities at other levels of the system and, hopefully, a reduction in system overheads.

Priority for drawings from the pool should be determined locally (without necessary referral to Commonwealth and State ministers), and managers of the pool should have the flexibility to reallocate funds across portfolios. With respect to residential care, the pool managers would need to focus on individuals who meet assessed-needs requirements and payments would remain funded according to national fee schedules. However, they would have autonomy over the number and mix of residential services including Community Aged Care Packages.

These regional pools would provide significant additional flexibility to respond to different needs. The involvement of local providers and consumers would help in identifying local needs and determine local priorities. These priorities may differ significantly within States as well as between States. However, it is expected that over time there will be common set of core services that will be available to all Australians wherever they live. The main point is that the shape and mix of services will be determined more by people who directly observe and experience the consequences. Regional Boards will also be well placed to advocate for older people and their needs on a broader whole-of-government basis including articulation with mainstream health services (including regrettable cutbacks of rehabilitation programs) and encouragement of housing developments, land use planning, and other positive approaches to ageing as considered above in the paper.

The funds pool proposal advanced here involves major changes to bureaucratic and political decisionmaking. Ideally, it would be accompanied by governments moving to common regions that aggregate whole local government areas and bring health, welfare and disability planning regions to have common boundaries. The size of the regions

would have to be determined such that they would encompass the full range of services but be small enough to have a clear understanding of each of them and their inter-relationships. While traditionally ‘welfare’ groups might fear being swamped by health interests, it is important to recognise the rising strength and support for community care and the need to integrate the delivery of all forms of aged care. Government’s political decision making would primarily be about the size and growth rate of the funds pool; allocative decisions would be devolved to the regional pool managers.

The inclusion of residential aged care in the pool adds considerable complexity, primarily because of the possibility of residents of an area moving to other areas for residential care that would require some form of inter-regional charging. Ideally, the pools would develop their own dynamics to ensure local responsiveness and flexibility. This would need a parallel increase in monitoring and evaluation to ensure local managers are responsive to expressed community needs (as measured by satisfaction) and that services are provided efficiently and are of high quality.

A major advantage of the regional pools model is that it can be pursued initially through incremental developments. For example, some States such as Victoria and New South Wales are already working towards regional re-organisations of their own services, consolidating and inter-relating their own programs and articulating them better with Commonwealth and local programs. Joint governmental planning arrangements with residential and community care are important steps in this direction, as are State and local efforts to better articulate health and welfare systems at the local level. This regional model could be extended to include additional services for younger adults and children with disabilities, with HACC of course already covering older and younger populations.

Unbundling housing and aged care

A second major reform would be to change the current funding system for residential aged care and other forms of high-level support. At present, people’s choices are starkly limited to a few forms of either community care or residential care. For many there is little way to add their own funds to those publicly available, while others are virtually forced to enter residential care in order to get an accommodation subsidy. Large government subsidies for care are rationed, partly by their being provided only

by the nursing homes that are unacceptable to most older people unless there are no other options.

The divide between residential care and community care is already being blurred, as older people seek alternatives to these stark contrasts. For example, the rapid development of private retirement villages providing supportive accommodation similar to some hostels (Howe, 1999a). While the residents pay entirely for their own housing, typically trading in on the wealth in their former homes, they are gaining increasing access to community services. They have the advantages of supportive housing paid for by themselves combined with care services paid for largely by governments. Further, they do not have to go through the painful process of leaving their home at a vulnerable time of life.

While there are more private options for supportive accommodation, high levels of care are increasingly being provided by government in community settings. The Community Care Packages have successfully substituted for low-level residential care, meeting older people's needs in a more preferable way and saving the capital costs of residential care. However, for people with very high levels of need it is more efficient to provide care in a common setting having economies of scale and minimal access costs. Hard choices are emerging as the provision of high-level care at home, such as alternatives to nursing homes, can be three times the cost even without the capital component or informal carers' time included in costs. However, even when the total costs of care are higher at home, it needs to be recognised that many older people and their carers would be willing to pay much of the additional cost (if not the whole cost) particularly given that the last stages of high dependency are often for limited durations of a year or so.

Another consideration is that there are two main sources of residential aged care funding, the Commonwealth subsidy and the consumer contribution. The Commonwealth subsidy is devoted to the infrastructure of care (including the housing and living costs component) as well as the care needs component. We have previously suggested that one of the weaknesses of the current system is that the integration of these two components into a single funding stream weakens the incentives for residential care providers to ensure adequate employment of care professionals within the residential care facility.

We propose the re-introduction of separate funding streams for housing and living costs and care needs. The housing and living costs component should recognise that these costs need to be met by people wherever they live (in their own homes versus residential aged care facilities). Commonwealth assistance for housing and living costs should thus be means-tested and there should be a significant consumer contribution. Savings from means-testing on more affluent older people (usually house owners) can provide the means to pay for more subsidies for the accommodation component of care for older people with lower financial means (usually long-term tenants). For example, community accommodation for people with dementia, such as the NSW CADE units being closed down by State mental health authorities, could have the accommodation costs of care met by a more flexible accommodation component to Commonwealth residential care programs. Notwithstanding separation of funding streams, residential care facilities would of course remain available with the accommodation subsidies remaining for those who need it.

In contrast, care service provision should be based on personal needs and this payment should therefore be needs-tested along the lines of the Resident Classification System. ACASS teams could have expanded responsibilities in this regard. Work is already underway on a community care classification and it may be that a classification of needs could be developed specifically for the delivery of high-level care irrespective of whether the individual is in residential and community care. In line with Australian expectations for universal health care, the care component of funding should not be means-tested, and it should be portable between types of private residences and aged care facilities.

This unbundling of care is similar to proposals recommended by the British Long-Term Care review (1999). It could provide more choice for older people by enabling them to more specifically purchase (or find) care services that would build more naturally on their own circumstances and preferences. Consistent with public expectations for welfare, the proposal would conserve public resources to provide more accommodation support for those who with financial needs. It also enables people with financial means to have basic care services and still choose whatever accommodation they can afford. They could

also pay for ‘top-up’ care beyond a good basic quality available for all people in need.

Directions: towards evidence-based aged care policy

This review has aimed to inform the development of national aged care policies that would better meet the needs of older individuals and an ageing society. It began by explaining the historical developments that led to existing programs along with the industry and government interests that support them. The discussion then turned to the substantial aged care system now available in Australia and its notable strengths as well as its weaknesses. In considering the design of new directions for aged care policy needs, it is essential to recognise the long-term trend from provider-led to consumer-led care policies and the rising expectations and more diverse means of the baby boom cohort when they reach old age. Overall, Australian society must undergo major attitudinal change with policies comprehensively embracing a positive approach to older people and ageing.

The paper recommends that priority attention be given to reform of financial incentives to shape the evolution of the aged care service system in desirable directions. Our first major recommendation is for regional funds pooling that would allow local communities to make judgments about where the gaps are to ensure that the services better meet consumer needs. Funds pooling would also help to overcome the current disjunction between Commonwealth and State responsibilities. Our second major recommendation is for the redesign of residential care subsidies into separate payments for mean-tested accommodation support and needs-tested care components. This recommendation would improve consumer choice and equity and enable older people to contribute more to their own support.

Underpinning these two changes should be a substantial investment in monitoring and evaluation. The performance of regional funds pool managers should be evaluated in terms of the comparative mix of services, their efficiency and quality. Regions should also be assessed in terms of the extent to which needs are clearly met including the extent to which consumers seek services outside the funds pool (especially residential care services). The Commonwealth should substantially expand the use of data to monitor care provision (both residential care and community care) and to inform

policy. The additional data, including linking of community, residential and health care datasets, should be a hallmark of any evolutionary policy.

However, the proposals here have not addressed the overall funding of the system. As we have indicated above, the current system is funded on a tax funded pay-as-you-go approach rather than a contributory scheme which would move to full funding. On the one hand, there is therefore a risk that it will de-emphasise inter-generational equity or face funding shortfalls as existing aged care services are funded by the non-aged population. On the other hand, the improved efficiency of the system through funds pooling and improved high-level care funding arrangements will help to ensure the continued viability of aged care. While social insurance approaches have significant advantages over the longer term for equitably meeting funding shortfalls, they are unlikely to be politically feasible in the near term and require more critical analysis and public debate.

Our proposals outlining fundamental, middle-term developments require sound knowledge and debate to sharpen policy choices and consider their implications. The process of continual policy development, review and revision benefits greatly from ongoing communication between governments, consumers and industry constituencies. Information is the key to ensuring more transparency in government and to identifying ways to increase the appropriateness, cost-effectiveness and equity of aged care services and related policies. Understanding the many influences on older people's health and wellbeing will point the way towards priority policy areas where there are opportunities to improve ageing experiences.

The potential value of applied research on ageing has been underscored by research agenda reports for government (eg. Kendig et al, 2001) and by consumer advocate and industry groups including the Council on the Ageing (Australia) and Aged and Community Services Australia. While there have been major advances over the last decade, program development and delivery in Australia continue to be informed primarily by a limited range of short-term consultancies, broad-brushed aggregate statistics and by-products of academic efforts. Australian governments, contrary to their counterparts overseas, have not recognised very well the value of applied research. Politicians and policymakers appear reluctant to have their programs subjected to critical scrutiny and the public gaze.

Policy development has increasingly become the preserve of bureaucracies and government, with interest groups having only occasional successes in shifting bureaucratic or government opinion. Over the last 50 years, Commonwealth and State bureaucracies have increased their knowledge and skills about the aged care sector, partly through experience but partly also because of recruitment from the sector. This increased competence in the bureaucracy has contributed to clearer directions, planning frameworks and targetting criteria, and sophisticated funding formulae to relate funding to need and the other technologies of program direction. Bureaucracies and bureaucrats are not, of course, disinterested players. They have their own interests which unfortunately can occasionally be about bureaucratic comfort or aggrandisement rather than the interests of consumers or taxpayers. Dysfunctional bureaucracies lead to overly bureaucratic rules, overly rigid eligibility criteria, cost- and blame-shifting between Commonwealth and State governments and to policy silos that militate against integrated solutions to need. Policy advocates outside bureaucracies would be able to cite aged care policy examples of all of these problems.

A stronger role for evidence in policy development, such as is advanced here, may help to rebalance power or, at least, highlight problems and potential solutions. It should allow independent validation of the insights of providers and consumers and perhaps provide a speedier path from local innovation into widespread policy innovation.

A truly well-informed aged care policy would have institutional and funding arrangements that would deliver the following kinds of information:

1. *Population-based information* on the capacities, needs, situations, independence, wellbeing and service use of older people in their homes and communities as well as cared accommodation. Important resources here are the national DACS by the Australian Bureau of Statistics and the Older Persons Health Survey (OPHS) by the NSW Health Department. Particularly important features of these sources are the capacities of the DACS to show consequences of State differences of care systems, the OPHS to show regional differences, and both surveys to compare users and non-users of services.

2. *Program-based data systems* that integrate administrative records in ways that better identify the characteristics of various services and their recipients. A particularly important priority is to provide information on individuals (including multiple service use) and tracking them through health and aged care service systems. Promising developments here include the Minimum Data Set for the Aged Care Assessment teams and other initiatives being led by the Australian Institute of Health and Welfare. This data capacity is essential to understand how access to and costs of provision for older people vary between areas with different mixes of services.
3. *Program and service evaluations* showing the cost-effectiveness of existing provision, testing innovative pilot programs, and disseminating national and State ‘intelligence’ necessary for policy development.
4. *Social and economic studies* that improve the broader understanding of diverse experiences of ageing and broader impacts of population ageing on Australian society and the economy.

A concerted effort to address these information needs calls for attention to funding programs, the skill and institutional base for research, and close collaborative arrangements between researchers and policymakers, including service providers and older people themselves.

Education provides a crucial link between sound, research-based knowledge and its translation into more cost-effective and equitable policies, programs and practice. It is essential that professional education pay special attention to ageing and older people as central to the health and welfare professions. Postgraduate education – notably in gerontic nursing, geriatric medicine, and multidisciplinary gerontology – strengthens the information base and reflective learning capacities that are critical to practise-based advancement of the field. Sadly, the provision of effective education gauged to the range of workers in the field has lagged far behind the growth of the aged care industry. To overcome this shortfall is a major responsibility for universities, professional bodies, employers, peak bodies and government funders.

In summary, there is no better authority than Dr Sidney Sax, whose leadership as a geriatrician, health planner and policy advisor was grounded in a strong empathy with

and commitment to older people themselves. His *Ageing and Public Policy in Australia* (Sax, 1994), published when he was aged seventy-four, was ‘... designed to raise awareness and stimulate critical debate about the circumstances of older Australians and the policies that affect their well-being, particularly as we move into a phase of rapid demographic ageing’ (p.xi). We cannot improve on his optimistic vision of directions for an ageing Australia and the value of information and analysis in widening public choice in determining desirable futures:

‘In reworking our social obligations to each other and assessing what entitlements society is prepared to offer the older generation, consultation with and involvement of the affected parties have become essential parts of the process of policy development. In fields of work, retirement, and material welfare this principle is highlighted by the reduced acceptability of social disadvantage, and the improved education and assertiveness of older people. In service fields, the client is no longer a passive recipient of what providers choose to make available. Services are tending to be tailored to match individual needs, and are coordinated in a cooperative system involving the public sector, voluntary agencies, and carers. The rights of service recipients are subject to regulation, the quality of services is protected by prescribed standards, and benchmarks are being developed as guidelines to the level of service required.

It is essential that a platform of information should be available to those who plan or request new arrangements that affect the welfare of older people.’ (p.xii)

Acknowledgements

This review paper draws on the rapidly expanding literature on policies and programs for older people published over the last ten years. We are pleased to acknowledge the valuable information cited throughout the paper from the Australian Institute of Health and Welfare, the Department of Health and Aged Care, and the *Australasian Journal on Ageing*. The commentators – Denys Correll, Diane Gibson and Greg Mundy – have suggested ways to improve the paper as well as offering welcome cautions and alternatives to our recommendations. We wish to thank Warwick Bruen for information and other suggestions, and other Commonwealth and State policymakers with whom we have worked over the years. Kim Wilson and Stephanie Chard provided support in preparing the references and text and Amanda Parsons who assisted with information collection. Notwithstanding this support, we of course accept responsibility for any remaining errors and interpretations.

References

- Aged and Community Services Association of NSW & ACT (2001), Staffing and Quality in Aged Care Services, Seminar Report, Sydney AIHW (1995)
- Aged and Community Services Australia (2001), Community Care Programs: ‘The Future’, Discussion Paper 1.
- AIHW (Australian Institute of Health and Welfare) (1999) Australia’s Welfare 1999 Services and Assistance, Canberra.
- AIHW (Australian Institute of Health and Welfare) and National Disability Administrators (2000), Disability and Ageing: Australian population patterns and implications, Canberra.
- ALP Policy (2001) Kim Beazley’s Plan for Aged Care: Election 2001.
- Alt Statis and Associates (1994), Service provision targets: A report for the Home and Community Care Program, Aged and Community Care Service Development and Evaluation Report No. 15, Canberra, AGPS.
- Angus, J.M. (2000), Possibilities for Resistance: A Critical Discourse Analysis of Nursing Home Admission in Australia, PhD Thesis, La Trobe University.
- Australian Bureau of Statistics (1999), Australia Now: A statistical Profile, ‘Who’ll be Home Alone in 2021?’ Australian Demographic Statistics.
- Australian Bureau of Statistics (1999), Disability, ageing and carers, Australia: Summary of findings. Cat no. 4430.0 Canberra, Ausinfo.
- Australian Labour Party (ALP) (2000), Labor’s Plan For Quality Aged Care: Putting the care back into aged care, <http://www.alp.org.au/policy/agedcare120201.html>
- AURDR (Australian Urban and Regional Development Review) (1994), ‘New Homes for the Old: Workshop Papers’, Canberra.
- Baekgaard, H. (1998), ‘The impact of increasing house and share prices on the distribution of household wealth in Australia’, Paper presented at the 27th Annual Conference of Economists, Sydney, 28 September–1 October.
- Benham, C., Gibson, D., Holmes, B. and Rowland, D. (2000), ‘Independence in Ageing: The social and financial circumstances for older overseas-born Australians’, A report prepared for the Department of Immigration and Multicultural Affairs by the Australian Institute of Health and Welfare.
- Bishop, B. (1999a), The National Strategy for an Ageing Australia, Independence and Self Provision Discussion Paper, Canberra.
- Bishop, B. (1999b), The National Strategy for an Ageing Australia, Healthy Ageing Discussion Paper, Canberra.

- Bishop, The Hon. B, Minister for Aged Care. (2000a), *The National Strategy for an Ageing Australia, World Class Care Discussion Paper*, Canberra.
- Bishop, The Hon. B, Minister for Aged Care. (2000b) *The National Strategy for an Ageing Australia, Attitude, Lifestyle and Community Support, Discussion Paper*, Canberra.
- Blewett, N. (1999), *A cabinet diary: A personal record of the first Keating government*, Kent Town, SA, Wakefield Press.
- Borowski, A., Encel, S. and Ozanne, E. (1997) (eds), *Ageing and Social Policy in Australia*, Cambridge University Press, Melbourne.
- Borowski, A., and Hugo, G. (1997), 'Demographic Trends and Policy Implications' in A. Borowski, S. Encel, and E. Ozanne (eds), *Ageing and Social Policy in Australia*, Cambridge University Press, Melbourne.
- Bridge, C., Kendig, H., Quine, S. and Parsons, A. (2001) *Housing and care for younger and older adults with disabilities: Final Report*, for AHURI (Australian Housing and Urban Research Institute).
- Brooke, E. M. (1995), *Identity and Practice: Case Studies in Community Care in Australia*, unpublished PhD thesis, La Trobe University, Melbourne.
- Brooke, L, Davison, S., Kendig, H. and Reynolds, A. (1998) *The Support Needs of Older People in High Rise Public Housing, Aged, Community and Mental Health*, Human Services Victoria.
- Browning, C. and Kendig, H. (1997), *Positive Ageing: Facts and opportunities*, *Medical Journal of Australia*, 67, 409-410.
- Browning, C. and Stacey, B. (1999) 'Psychology and Ageing in Australia', *Australian Psychologist*, 34, 79-81,
- Choi, C. (1998), *Government health and welfare expenditure on older Australians*, Canberra, Australian Institute of Health and Welfare, (Welfare Division Working Paper No. 20).
- Commonwealth Department of Health and Aged Care. (1999), *The National Strategy for an Ageing Australia, Healthy ageing discussion paper*, Commonwealth of Australia, Canberra
- Commonwealth Department of Health, Housing and Community Services (1991), *Aged Care Reform Strategy Mid-Term Review 1990-91, Report*, Australian Government Publishing Service, Canberra.
- Commonwealth, State, and Territory Strategy on Health Ageing (2000), Commonwealth Department of Health and Aged Care, Canberra

- Correll, D, and Bourke K. (1992) Reviewing strategies for involving the non-government sector in policy development. In: Lefroy RB, ed, *The Ageing Adventure: Options for the Future, Proceedings* of the 27th Annual Conference of the Australian Association of Gerontology, Melbourne: Australian Association of Gerontology, 1992: 66-69.
- Council on the Ageing (Australia) (CAA) (1998), Inventory of Major Political Party Policies for Older Australians. <http://www.cota.org.au/election.html>
- Council on the Ageing (Australia) (2000), Older Australians: An Agenda for the New Millennium in Health and Aged Care, Victoria. Prepared by Veronica Sheen.
- Dargavel, R., and Kendig, H. (1986), 'Political rhetoric and program drift: House and Senate debates on the *Aged and Disabled Persons' Homes Act*' in *Australian Journal on Ageing*, 5: 23-31
- Davison, B., Kendig, H., Stephens, F. and Merrill, V. (1993), 'It's Our Place': Older People Talk about Their Homes, AGPS, Canberra.
- Davison, G. (1993) 'Old People in a Young Society: Towards a History of Ageing in Australia', Lincoln Papers in Gerontology, No. 22, La Trobe University, Melbourne.
- Dorevitch, M. L., Gray, J., Robbins, C., Madigan, S. Farish and Emmett, D (1993). *National survey of hospital geriatric services*. Aged and Community Care Service Development and Evaluation Reports No. 9, Canberra, Australian Government Publishing Services.
- Duckett, S.J. (2000), *The Australian Health Care System*, Oxford University Press, Melbourne.
- Duckett, S.J., T. Hogan and J. Southgate (1995). 'The COAG Reforms and community health services', *Australian Journal of Primary Health Interchange* 1(1): 3-10).
- Duckett, S.J. and Swerissen, H. (1996). 'Specific purpose programs in Human Services and Health: Moving from an input to an output and outcome focus', *Australian Journal of Public Administration*, 55(3): 7-17.
- Fine, M.D. (1999), 'Coordinating Health, Extended Care, and Community Support Services: Reforming Aged Care in Australia', *Journal of Aging and Social Policy*, 11: 67-90.
- Fine, M., and Chalmers, J. (2000), 'User pays' and other approaches to the funding of long-term care for older people in Australia', *Ageing and Society*, 20: 5-32.
- Gardner, I. (1994) 'Why people move to retirement villages', *Australian Journal on Ageing*, 13(1): 36-44.
- Gibson, D. (1998), *Aged Care: Old policies, new problems*, Cambridge University Press, Cambridge.

Gibson, Benham and Grey (1999), 'Older Women in Australia' in *Women in Australia*, Office of the Status of Women, Canberra, pp 105-159.

Gibson, D., and Goss, J. (1999), 'The Coming Crisis of Australian Aged Care: Fact or Fiction?', *Australasian Journal on Ageing*, 18: 19-25.

Gibson, D. and Z. Liu (1995), 'Planning ratios and population growth: Will there be a shortfall in residential aged care by 2021?' *Australian Journal on Ageing*, 14(2): 57-62.

Gibson, D., and Mathur, S. (1999), Australian Innovations in Home-based Care: a Comparison of Community Aged Care Packages, Community Options Projects and Hostel Care, *Australasian Journal on Ageing*, 18 (2) 72-78.

Gibson, D., G. Turrell and A. Jenkins (1993). 'Regulation and Reform: Promoting residents' rights in Australian nursing homes' *ANZJS*, 29(1): 73-91.

Gray, L. (2001), *Two Year Review Of Aged Care Reforms*, Canberra.

Gregory Report (1993) *Reform of the Structure of Nursing Home Funding Arrangements: Stage 2, Aged and Community Service Development and Evaluation Reports*, 11, Canberra, AGPS.

Healy, J. (1990), 'Community Services: long-term care at home?' in H.L.Kendig and J.McCallum (eds), *Grey Policy: Australian policies for an ageing society*, Allen & Unwin, Sydney.

House of Representatives Standing Committee on Expenditure (1982), *In a Home or at Home: accommodation and home care for the aged*, Parliament of the Commonwealth of Australia.

Howe, A. (1990), 'Nursing home care policy: from laissez faire to restructuring', in H.L.Kendig and J.McCallum (eds), *Grey Policy: Australian policies for an ageing society*, Allen & Unwin, Sydney.

Howe, A.L. (1992), 'Housing for Older Australians: Affordability, Adjustments, and Care, National Housing Strategy', Background Paper no. 8, Canberra.

Howe, A.L. (1997), 'From States of Confusion to a National Action Plan for Dementia Care: The Development of Policies for Dementia care in Australia, *International Journal of Geriatric Psychiatry*, 12: 165-171.

Howe, A. (1998). 'The Economics of Aged Care: achieving quality and containing costs'. In G. Mooney and R. Scotton (eds) *Economics and Australian health policy*, Sydney, Allen & Unwin: 137-53.

Howe, A. (1999a), 'Future Directions for Residential Care', *Australasian Journal on Ageing*, 18: 12-18.

Howe, A.L. (1999b), 'Extending the Pillars of Social Policy Financing to Aged Care', *Social Policy & Administration*, 33: 534-551.

Howe, A.L. (2000), 'Rearranging the compartments: The financing and delivery of care for Australia's elderly', *Health Affairs*, 19: 57-71.

Jenkins, A., Butkus, E. and Gibson (1998), Developing quality measures for home and community care. AIHW cat. No. AGE 8. Canberra: Australian Institute of Health and Welfare (Aged Care Series no.4)

Keating, P. and Howe, B. (1995), Social Justice Statement, 1995–96, AGPS, Canberra.

Kendig, H. (1990), 'Ageing, policies and politics' in H.L.Kendig and J.McCallum (eds), *Grey Policy: Australian policies for an ageing society*, Allen & Unwin, Sydney.

Kendig, H. (1996), 'Understanding Health Promotion for Older People: Sociological Contributions', in V. Minichello, N. Chappell, H. Kendig, and A. Walker. (eds), *The Sociology of Ageing*, International Sociological Association, Melbourne, 362–377.

Kendig, H. (2000a) 'Family Change and Family Bonding in Australia', in W. Liu and H. Kendig (eds) *Elderly Care, the Family, and Human Values: East Meets West*, Singapore University Press, 107-125.

Kendig, H. (2000b), 'Ageing and the Built Environment', in P.Troy (ed.), *Equity, Environment, Efficiency: Ethics and economics in urban Australia*, Melbourne University Press, Melbourne.

Kendig, H., Andrews, G., Browning, C., Quine, S., and Parsons, A. (2001) 'A Review of Healthy Ageing Research in Australia', Report Prepared for the Community Services Ministers' Advisory Council, Commonwealth Department of Health and Aged Care.

Kendig, H., and Brooke, L. (1999), 'Social Perspectives on Community Nursing Practice' in R. Nay, and S. Garratt (eds), *Nursing Older People: Issues and innovations*, McLennan and Petty, Sydney.

Kendig, H., Browning, C.J., and Young, A.E. (2000), 'Impacts of Illness and Disability on the Wellbeing of Older People', *Disability and Rehabilitation*, 22: (1/2) 15–22.

Kendig, H. and McCallum, J. (1990), (eds), *Grey Power: Australian policies for an ageing society*, Allen & Unwin, Sydney.

Kendig, H. and Neutze, M. (1999), 'Housing implications of population ageing in Australia', in Productivity Commission and Melbourne Institute of Applied Economic Research, Policy Implications of the Ageing of Australia's Population, Conference Proceedings, Canberra: Ausinfo, 435–450.

Kewley, T.H. (1973), *Social Security in Australia 1900–1972*, Sydney University Press, Sydney.

Kung, F.T.Y. (1996). Variation in performance of Aged Care Assessment Teams. Health Systems Research Reports No. 2, Melbourne, La Trobe University.

- Leutz, W.N. (1999), 'Five Laws for Integrating Medical and Social Services: Lessons from the United States and the United Kingdom', *Millbank Quarterly*, 17:77–110.
- Liu et al (2001), The probability of using residential aged care services over a long time. Australian Institute of Health and Welfare No. 36, Canberra.
- Liu, Z. (1998), The probability of nursing home use over a lifetime, Welfare Division Working Paper no.16, Australian Institute of Health and Welfare, Canberra
- McCallum, J. (1999a), 'Financing Aged Care Services: 1999 and Beyond', *Australasian Journal on Ageing*, 18 (2) 54–55.
- McCallum, J. (1999b), Policy Implications of Australian Ageing: The Greying of a Young Society, *Journal of Sociology and Social Welfare*, 16: 87-106.
- McCallum, J. (2001), 'Health in the "grey" millennium: Romanticism versus complexity?' *International Journal of Law and Psychiatry*, 24: 135-148.
- McCallum, J. and Geiselhart, K. (1996), *Australia's New Aged: Issues for young and old*, Allen & Unwin, Sydney.
- McKay, H. (1997), *Generations: Baby boomers, their parents and their children*, Pan Macmillan, Sydney
- McKie, J., H. Kuhse, J. Richardson and P. Singer (1996). 'Allocating healthcare by QALYs: The relevance of age', *Cambridge Quarterly of Healthcare Ethics*, 5(4): 534–45.
- Minichello, V., Brown, J., and Kendig, H.L. (2000), Perceptions and Consequences of Ageism: Views from Older Persons, *Ageing and Society*, 20: 253–278.
- National Aged Care Alliance (2001) Residential Aged Care Funding: Second Report
- National Commission of Audit, (1996) Report to the Commonwealth Government. Canberra: AGPS, 123–140.
- National Community Care Advisory Committee (2001), Community Care Programs: The Future, Discussion Paper Number 1, Aged and Community Services Australia.
- Nethercote, J. (2000) Departmental machinery of government since 1987. *Australian Journal of Public Administration* 59(3): 94–110.
- Parliament of Victoria, Family and Community Development Committee (1997), Inquiry into Planning for Positive Ageing. Melbourne
- Parsons, W. (1995), *Public Policy: An introduction to the theory and practice of policy analysis*. Aldershot, UK, Edward Elgar Publishing.

Paterson, J. (1996), *National healthcare reform: The last picture show*. Melbourne, Department of Human Services.

Productivity Commission and Melbourne Institute of Applied Economic and Social Research (1999), Policy Implication of the Ageing of Australia's Population, Conference Proceedings 18–19 March.

Rowland, D.T. (1992), *Ageing in Australia: Population trends and social issues*, Longman Cheshire, Melbourne.

Rowland, D.T. (1997), The demography of ageing and families in Australia, *Australian Journal on Ageing*, 16: 99–109.

Russell, C., Touchard, D., Kendig, H., & Quine, S. (2001) 'Foodways of disadvantaged men growing old in the inner city: Policy issues from ethnographic research.' In *Ageing: Culture, Health and Social Change*, D.N Weisstub, D.C. Thomasma, S.Gauthier & G.F. Tomossy, (eds), Dordrecht: Kluwer Academic Publishers, 191–215 [Volume 10 of the International Library of Ethics, Law, and the New Medicine.

Russell, C. and Kendig, H. (1999) 'Social Policy and Research for Older Citizens', *Australasian Journal on Ageing - Supplement*, 18(3), 44–49

Salkeld G., Cameron I., Cumming R., Seymour J., Kurrle S., Quine S. (2000), Quality of life related to fear of falling and hip fracture in older women: a time trade-off study *British Medical Journal*, 320: 341–345.

Sax, S. (1984), *A Strife of Interests: Politics and policies in Australian health services*, Allen & Unwin, Sydney.

Sax, S. (1990), 'Development of public policy for the aged', in H.L.Kendig and J.McCallum (eds), *Grey Policy: Australian policies for an ageing society*, Allen & Unwin, Sydney.

Sax, S. (1993), *Ageing and public policy in Australia*, Allen & Unwin, Sydney.

Schofield, H., Bloch, S., Herrman, H., Murphy, B., Nankervis, J. and Singh, B. (1994) (eds), *Family Caregivers: Disability, illness and ageing*, Allen & Unwin, Sydney.

Silagy, C., Pekarsky, B., Leigh, J., Fagg, B., Quigley, R., Masters, G., Southwell, C., King, J., Tyler, P., Church, A., Esterman, A. and Pradham, M. (1999). *The Australian Coordinated Care Trials: Interim national evaluation summary*. Canberra, Department of Health and Aged Care.

Simons, A., McCallum, J., Friedlander, Y., and Simons (2000), Healthy Ageing is associated with reduced and delayed disability, *Age and Ageing*, 29: 143–148.

Smith, P. (1999). 'Financing Incomes and Services for the Aged: Problems with the EQOLL Model', *Australasian Journal on Ageing*, 18: 55–57.

Storey, L., Wilson, P. and Kendig, H. (1994), Home Equity Conversion in Australia, Australian Housing Research Council, Canberra.

The Howard Government (2001). Better Care for Older Australians: Putting Australia's Interests First, Election 2001.

Uniting Care NSW.ACT Ageing and Disability Service, (2001), Alternative Futures for Aged Care in Australia, Sydney.

Walker-Birckhead, W. (1996) 'Meaning and Old Age: Time, Survival and the End of Life', *Lincoln Papers in Gerontology*, No. 35, Lincoln Gerontology Centre, La Trobe University, Melbourne.

World Health Organisation (2000), The World Health Report 2000, WHO, Geneva.

Worthington di Marzio (1999) Ageing, Community Attitudes, and Older Australians, report produced for the National Strategy for an Ageing Society, Canberra.