Aged care policy and programs: a literature review

Review of services for older people

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INTRODUCTION

This paper draws on the literature from Australia and other OECD countries, to examine five key issues about directions in aged care policy and program development:

- in policy and program development — shifts to community care;
- development of needs-based care packages;
- moves to higher user contributions;
- involvement of service users; and
- changing definitions of dependency and entitlement.

This last is perhaps the most difficult issue to deal with in a short paper because it has a broad array of dimensions and intermeshed factors — changes in needs and expectations; in family and social structures; economic, social and political conditions; personal and public resources and priorities. The final summary links the implications of the trends to the main focus of the Brotherhood’s work — low-income older Australians.

This paper was the first of two background papers produced for the Brotherhood’s Review of Services for Older People in 1994.
THE AUSTRALIAN POLICY CONTEXT

The aged care reform strategy

Australia is nearing the end of a decade of centrally planned and staged reform of national aged care policy. Whilst the impetus to act has been economic, particularly the need to rein in growth at the high cost, Commonwealth-funded residential care end, the reforms are based on widely recognised dissatisfactions with both residential and community care provisions articulated in numerous reports and studies from the mid 1970s and the realities of rapidly expanding numbers of older people, particularly the very old who are most likely to require care. The foundations of the reform strategy were set out in the Nursing Homes and Hostels Review (Commonwealth of Australia Department of Community Services 1968), and the Home and Community Care Act, 1985, and implementation has been subject to formal monitoring through the First Triennial Review of the Home and Community Care Program (Saunders 1988) and a Mid-Term Review process, utilising background papers and consultations and culminating in two reports published in September, 1991 and October, 1993 (Commonwealth of Australia DHH&CS 1991, 1993).

There have also been numerous commissioned and departmental reports related to specific aspects of policy and program implementation and evaluation.

Long-term care

Whilst this policy direction is referred to as aged care policy, its primary concern is with the long-term care arrangements of those older people who through chronic ill health, frailty and/or disability, require assistance with the tasks of daily living. Although there have also been major reforms in income security policy to reduce the reliance on taxation-based pensions in the future, health promotion initiatives and increasing concern with the intersection of long-term care with health and housing policies, Ozanne (1992, p.118) argues that the Australian aged care policy direction to date has been relatively narrow and not based on a broader view of the shifts occurring in both the economic and social circumstances of the demographic transition from a young to an ageing society. An increased level of interest and debate about ageing and an ageing society is however apparent in recent government inquiries, seminars and professional publications (Commonwealth of Australia, House of Representatives Standing Committee on Community Affairs, 1990 and Standing Committee for Long Term Care Strategies, 1992; Economic Planning Advisory Council, December, 1992 and January, 1994; Sanders, 1994).

This paper is primarily concerned with current long-term care policies affecting frail and disabled older people and their carers. However, the broader contexts of and shifts in ageing policy as discussed by authors such as Guillemard (1989) and Minkler and Estes (1984) illustrate the degree to which ageing is a social construct, and how social vulnerability can be created by the policy environment encountered prior to and during later life. Thus the
economic and social conditions now will impact on the opportunities, vulnerabilities and expectations of future older Australians — changes which need to be anticipated and understood in planning the development of appropriate services.
SHIFTS FROM RESIDENTIAL TO COMMUNITY CARE

Reduction in supply and demand of residential care

A hallmark of the recent changes in Australia's aged care reform strategy has been the reduction in both supply and demand for nursing home care. This has been addressed through national planning mechanisms which set an upper limit on funded provision levels — 40 beds per thousand aged 70 plus; the establishment of geriatric assessment teams across the country to gatekeep access on the basis of both specified levels of care need, and relative need; additional funding for the expansion of community-based care service types and levels; and specific recognition and support to maintain and extend the care-giving capacity of family caregivers.

This shift reflects an international trend that has been occurring since the 1960s, starting with the de-institutionalisation processes of relocating residents with psychiatric and then intellectual disabilities from large segregated state residential care institutions to smaller more home-like facilities, private sector nursing homes, boarding houses and family care. This process has been both supported and critiqued on ideological and economic grounds. Wolfensberger's views on ‘normalisation’ of devalued groups and the concept of ‘ageing in place’ utilised by Lawton (1985) and others have provided potent normative frameworks for the policy shifts.

The debate about the shift from residential to community care is less dichotomised in the 1990s, with more concern about the appropriate ‘balance of care’ (Commonwealth of Australia DHH&CS 1993); the extent to which different types of services can substitute for one another (Pijl 1991), and what sorts of care needs can be best met in group rather than individual accommodation (Johannson 1991; Dalley 1988) — Denmark seems to be one of the few countries aspiring to an ideal of no residential care provision. Nonetheless, the shift from residential to community care has generally sought to substitute cheaper for more expensive services and less professional for more professionalised forms of care (Ballock in Taylor-Gooby and Lawson 1993).

Restructuring of providers and provision in aged care

There have been major changes in the provision and providers of both residential and community care. In Australia, both non-profit organisations (mainly church-based) and private for profit businesses have been the substantial providers of residential care. Over the last decade, many of the traditional non-profit residential care providers have also become involved in community care, as have new organisations such as Aboriginal, ethnic and other community groups and private businesses. Particularly in Victoria, more local governments — major suppliers of community care — have built hostels and nursing homes, or supported local community organisations to do so. Although Australia’s residential care sector has not been as dominated by public sector provision as Sweden and Britain, there is clearly also a trend to increased plurality. In Victoria there has been quite a large state government
role — about one-third of nursing home beds — but recently announced policy changes seek to reduce that to about 10 per cent (Victorian Government DH&CS 1993).

Other changes here in residential care have occurred as part of the staged aged care reform strategy and have been concerned with reducing nursing home beds and increasing hostel beds, setting uniform national standards for funding and staffing, quality of care requirements and user rights' issues. There has been an emphasis in particular on programs for people with dementia, providing respite care and meeting cultural and regional diversity (Commonwealth of Australia DHH&CS 1991).

Critiques of the shift to community care

The major critiques of the shift from residential to community care are concerned with:

1. The associated **reduction in state financial responsibility** in that the same level of capital, administrative, housekeeping and care resources required to provide an individual with residential care are generally not transferred to either individuals or the community care sector — this is argued as both an abrogation of State responsibility and also as an economic efficiency shift to more cost-effective service types.

2. **Regional or locational inequities**, based on differing social and economic capacities to provide community care have not been adequately addressed by central governments in the move to care ‘by’ the community rather than care ‘in’ the community (Walker 1991).

3. The devolving of at least some of these responsibilities on to non-government organisations and families. **Family care** has been exposed as meaning care predominantly by women, and often disproportionally by one member of the family (Braithewaite 1990; Qureshi and Walker 1989; Kendig 1986).

There is now substantial literature, from a range of perspectives, addressing issues of concern in this new policy recognition of family care and reliance on it as the foundation of community care.

Patterns of paid and unpaid care

Johannson (1991) suggests that the role of informal care is understudied in Sweden, but that informal care is at least twice as extensive in giving help to the elderly as formal care. In Australia and other countries the proportion of unpaid help to paid help is estimated at more like 80 per cent to 20 per cent (Kendig 1986). Family care remains the mainstay of most long-term care systems and there is little evidence to suggest that the provision of formal services reduces the involvement of family, but rather that they do different things. Where formal services replica the things that family do, it is to substitute for family in the short-term (e.g. to provide respite) or for people
who have no informal care available. The flexibility and individuality of family care have become important standards for formal services to aspire to.

The inter-weaving of formal and informal services

Julia Twigg (1991) proposes a model describing how public sector agencies conceptualise their relationship to carers as resources, co-workers, co-clients or as superseded — the latter category is seen more in disability than aged services, linked to arguments of independence and normalisation — attendant care being one service response example; although in Israel, home care entitlements are made on disability criteria alone and provided regardless of whether or not there is a family carer (Morginstin et al. 1992). From both a feminist and disability critique, only in the superseded model is their choice for the person needing care and their family about who provides the care, and some separation between ‘caring for’ (instrumental) and ‘caring about’ (expressive) which Dalley (1988) argues are so intrinsically linked in the role of motherhood, that our society expects both aspects to be present in women’s caring role for other dependent groups.

Carer burden

There are a growing number of studies describing and measuring the disbenefits — and some benefits — in the carer's role, ranging from physical and psychological health problems; social and economic costs; sources of the subjective experience of burden; and the gender, class and relationship differences in the caring experience (Braithewaite 1990; Hooyman 1990; Qureshi and Walker 1989).

Gender justice

The Nordic, North American, Australian and British feminist writings on care highlight the failure of social and economic policy to adequately address the gender inequities and contradictions between policy areas. Most focus on the lost opportunities of paid work for women carers and the failure of the employment/industrial systems to accommodate all workers' care responsibilities. At one extreme the argument denounces community care as unable to deliver justice to women and advocates for residential care or collectivist forms of care (Dalley 1988), whilst others argue that strategies for institutional reform which both integrate women into the public sphere and those that extend the imperative of caring to men are necessary (Hooyman 1990). Braithwaite suggests that the quality of life of caregivers is an outcome worthy of equal attention in any evaluation of community care and there is no social justice in a system which ignores this issue:

Community care continues to function as a system in which the needs of one powerless group, the aged, are being met by sacrificing the needs of another powerless group, caregivers, predominantly women, the demands for whose unpaid labour drives them out of the remunerative work force. (Braithwaite 1990, p.137)
**Demographic and cultural change implications**

Changing compositions of families, their availability and willingness to provide care has also received attention in overseas and local literature. Rowlands (1991) asserts that although forthcoming generations of older people in Australia will have fewer children than in the past, more of them will survive into mid and late-life and therefore the actual numbers available are not substantially less than in earlier periods. Also the care role is generally performed primarily by one person, even when more are available. Kendig (1986, p.179) states that a dominant theme in the literature is the way in which major changes in marital patterns will shift the balance of family relationships towards voluntaristic rather than obligatory bonds and to expressive rather than instrumental support. He states that there are mixed prospects for the provision of substantial instrumental support from adult children. On one hand there will be increased numbers of children without competing family or employment responsibilities (support from one generation of older people to another) but a decrease in the numbers of middle-aged daughters prepared or able to leave the work force. Even so:

... women are at high risk of bearing the brunt of providing care in mid life, thus limiting their independence and social advancement, and of being left without community support in old age. (Kendig 1986, p.184)

**Emerging themes across OECD countries**

Walker (1990) identifies five themes showing the common trends within the European community.

1. **State preference for community care** as opposed to residential or hospital care, although the motivations for such a policy vary, as does the pace and extent of change.

2. **Considerable territorial variations**, both within and between countries, in the coverage of community care services.

3. **The ‘care gap’** — even in the leading EC countries, the levels of home care services are not sufficient to keep pace with the rising need created by socio-economic change — in Australia, an ABS 1988 survey showed significant levels of unmet need for community care from disabled people aged 70 plus (Victorian Government DH&CS 1993, p.15).

4. **Fragmentation of community care policies and providers** and the separation of health and social services, requiring a range of attempts to improve co-ordination and integration.

5. **The community care services are in a state of purposive development** with ‘considerable evidence of innovatory zeal’. These are not universal and the dominant model of home help remains the traditional one and the experience of the majority of older people is one or two hours of home help a week (Walker 1990, p.6).
Based on a review of a number of recent comparative studies of community care, Ozanne (1992, p.118) concludes that there is surprising similarity in the trends across quite different social and political systems. From a comparative study of innovations in aged care in Sweden, the Netherlands and the United Kingdom, Baldock and Evers (1991) assert that these changes have been at the forefront of the restructuring of European welfare states.

The major features of innovation and change in relation to the frail aged have been the shifts:

1. from standardised to flexible services

2. from implicit to explicit interaction between the formal and informal (family) care systems.

The changes in larger welfare systems have been from:

1. bureaucratic centralism to regulated pluralism

2. separate to integrated social and economic criteria (Baldock and Evers 1991, p.9).

Baldock suggests that it has been the pressure of demand for social care of older people that has justified strikingly similar changes in the financing and management of services across European welfare systems:

The key features are: the devolution of responsibility to the lowest levels of government; financial arrangements whereby local authorities and municipalities are effectively contracted to deliver services in return for cash — limited funds paid by the health sector or central government; the increased purchase with public funds for private and voluntary support services; greater efforts to stimulate or even buy and manage informal care; and a much greater emphasis on targeting and charging for social services. The effect of these changes is to emphasise financial and contractual relationships between various parts of the care system, to expand greatly the range of possible care sources and to make explicit the need for managerialist rather than a welfare approach to service allocation. (in Taylor-Gooby and Lawson 1993, p.28)
DEVELOPMENT OF NEEDS-BASED CARE PACKAGES

The place of care packages in long-term care systems

Needs-based care packages represent an individualised and co-ordinated approach to provide community care services in the most appropriate and cost-effective forms and ways to meet the needs of highly dependent people for the purpose of delaying or substituting for institutional care. They generally involve case management and the capacity to organise and purchase services up to set financial limits. The intention is to improve choice, flexibility and availability in care services. They have been utilised most in countries where the basic home care services:

- are not well developed,
- are inaccessible due to regional inequities or costs,
- are fragmented across a large array of providers,
- are unable to always meet high levels of service need (because demand is generally greater than supply due to factors such as population ageing, higher dependencies and reluctance to exclude larger numbers of people from smaller amounts of timely but less critical assistance)
- are inflexible or unresponsive.

For example, they have been less common in the Nordic countries where there has been clear entitlement and responsibility with a strong publicly provided and accepted range of home care services, than in the USA, with poor public sector provision, a strong private sector for those who can afford it and a plurality of eligibilities and providers leading to fragmentation and difficulties in accessing a range of services across sectors or care systems.

Whilst care packages have featured in recent home care developments in many countries, they have generally been small scale and utilised either as pilot schemes to test out cost comparisons of home and residential care and the potential of ‘substitution’, or as innovations to demonstrate changed ways of organising the general community care service system to make it more responsive, efficient and effective.

In Britain, the new Community Care legislation adopts the elements of individual assessment, case management and care packaging, separated from service provision, as cornerstones of achieving change in the social services.

Development of care packages in Australia

Australia has clearly been influenced by these overseas trends and has incorporated the use of care packages into its reform strategies in a number of ways.
Aged Cottage Homes in Adelaide piloted the first care package project in July 1984, motivated by dissatisfactions from staff and elderly people about its own residential services and the examples of the Wisconsin Community Options Program in the USA and the Kent Community Care Project in England (Rungie in Howe et al. 1990). The Wisconsin program was an attempt to reform the state's long-term care system, characterised by a bias to residential provision, fragmentation of limited community services, and a practice of fitting people to available services rather than fitting services to people, in face of skyrocketing costs of nursing home care, and a rapidly increasing older population (McDowell in Howe et al. 1990). In contrast, the Kent project was begun in the mid-1970s as a small scale experimental partnership between the Social Services Department and the University of Kent, in designing arrangements for matching resources to the needs of individuals by using case management and brokerage, with a well defined and documented cost effectiveness evaluation process (Davies in Howe et al. 1990).

Both schemes were concerned with providing individually tailored packages of services to enable people to live at home rather than in institutions, for no more, or less than the costs of providing residential care. The Kent scheme and other variations of it have been very influential on policy reforms in Britain and parts of Europe.

**Community Options**

Through the example of the above programs, in 1986-87, the Commonwealth Department of Community Services proposed a four-year pilot Community Options Program — the Victorian part of the program was called Linkages, reflecting the concerns of established home care service providers to avoid further fragmentation and focus on increased provision and service co-ordination. Using Commonwealth monies, 150 projects were funded across Australia. Since 1992, these have been absorbed into the HACC programs in each state without significant expansion beyond the pilot areas or levels. The national evaluation concluded that because of the diversity in these programs, Community Options is better suited to some environments than others and cannot resolve all the issues in community care (Commonwealth of Australia DHH&CS 1992, p.10). It identified three unique features required for the case-management approach to reach its full potential:

1. Designated case manager's role with the resources to fully consolidate all tasks
2. Additional funds to purchase services not otherwise available

Overall, the Community Options approach was found to be a cost-effective alternative to residential care; clients and carers were very satisfied; it worked best where HACC was working best and there was the capacity ‘to manage case management’. It has been a catalyst for achieving change to a more client focused service delivery system in the areas it has operated (Commonwealth of Australia DHH&CS 1992, pp.96-101). In Victoria, features such as reaching a
higher dependency group, providing additional resources into expanding the mainstream community care services, the large project sizes and the close inter-agency networks were viewed as particularly valuable. The costs of providing Community Options to people eligible for hostel care were higher than the government hostel subsidy in Victoria (Boldy et al. 1993, p.152).

Despite these successes, because of other changes in the aged care system — such as Aged Care Assessment Teams and the benchmark planning guides for residential care — Community Options is not now seen as essential in preventing inappropriate admission to residential care. There has been some debate about the degree to which the HACC services should now be able to respond flexibly and with priority to those with the greatest needs and dependencies.

The community care system needs to develop the capacity to identify the highest need people and allocate resources accordingly. (Commonwealth of Australia DHH&CS April 1992, p.96)

Community Aged Care Packages

Other pilot projects funded with the Commonwealth's unmatched monies, but under the *Aged or Disabled Persons Care Act 1954* were Hostel Options Care Packages and Assistance with Care and Housing for the Aged (ACHA), designed to provide increased support from hostels and to public housing tenants respectively. These became subsumed by the Community Aged Care Packages (CACPs) in early 1992, funded from the recurrent savings of reduced hostel development.

*The Aged Care Reform Strategy, Mid-Term Review 1990-91 Report* (Commonwealth of Australia DHH&CS 1991) identified that some areas continued to have difficulty in organising the necessary infrastructure to build nursing homes and hostels, and that it may be more effective to provide increased access to community services. It also recommended that the hostel benchmark be adjusted down five places to 55 per 1000 aged 70 years and over and that resources equivalent to the capital and recurrent funding of five hostel places per 1000 70 years plus, be transferred to community care (Commonwealth of Australia DHH&CS 1991, p.21). In the 1993 Federal Budget, the hostel benchmark was further reduced to 52.5 per 1000 70 years plus, and the CACPs increased to 7.5 per 1000 70 years plus, to be achieved over a three-year time frame. These packages combine the elements of case management and tailored services to assist people who would be eligible for hostel care, with the capacity to purchase additional services to the level of the lowest personal care subsidy rate paid to hostels (currently $24 per day).

Whereas Community Options projects focused on providing case management and brokerage, usually with close links to and usage of the mainstream home care services, the Hostel Options projects mostly became alternative small scale home care providers (Commonwealth of Australia DHH&CS November 1992).

Although in some cases Hostel Options Care Packages were used to transfer people out of hostels and back to community living, the majority were not
people who had considered moving into hostel care, though others around
them may have recommended it and co-ordinators estimated that 60 per cent
would have moved to residential care or hospitals within a short time without
the assistance of the program. Because of the considerable overlap between the
types of people supported by Community Options and aged care packages and
part of the HACC population, the relationship between services and the exact
types of needs newer projects seek to meet will require adjustment over time

The planned expansion of CACP projects will increase the resources
available for the provision of community care services and potentially
increase the diversity and range of services available in a local area.
However it also has the potential to add to the complexity of funding and
program boundary problems already existing in the community care field.
(Commonwealth of Australia DHH&CS 1992, p.124)

Aged Care Assessment Team Transition Care Projects

These are another four-year pilot of case management and purchasing
additional services, with Aged Care Assessment Teams (ACATs) as budget
holders, targeted at frail older people being discharged from acute hospital
care. The Kingston Geriatric Centre is one of six federally-funded schemes in
Australia, the only one in Victoria.

Summary of trends

Needs-based care packages, combining case management, individualised care
plans and the purchase of additional services for people with high needs, seem
to be well entrenched in principle in Australia’s aged care system at this stage.
They are still small but growing in number and being used discretionally by
the Commonwealth to achieve quite specific goals in a very dynamic aged care
system. There is some expectation that HACC services will become more
equitably distributed, flexible and targeted to those with high needs through
greater use of ACAT assessment, benchmarks and client outcome focus, but
the growing evidence that demand is overtaking supply in many areas and the
failure to enhance or expand the case management capacity of the geriatric or
community care services in a comprehensive way would suggest that the more
selective approach of individual care packages to top up the mainstream
services and develop cheaper or more targeted alternatives will prevail for
some time.

The trend towards an increasing diversity of providers seems to be borne out
in the latest funding round for CACPs in Victoria where health and residential
care providers have been the major beneficiaries alongside a number of
organisations who have not traditionally been involved in community care.
Some of the learning from the Community Options program — Linkages in
particular — does not appear to be applied in CACPs, for example, the
advantages of a larger scale and inter-agency co-ordination. CACPs may work
well for individuals and areas where adequate housing choice is not a problem,
but they don’t contribute financially to obtaining supportive housing for those
without it, in the way that hostels can do. The separation of housing and care choices seems to be a trend in both disability and aged services.

Case-management approaches are not without their critics. Interestingly one of these is Mike Rungie, the initiator of the first Community Options project here. Following a recent trip to America he writes:

The hopes for case management as independent brokerage able to meet the needs of individual elderly people has not been realised. This has not stopped its widespread establishment in community based long term care for relatively minor gains at high cost, but with a belief that it is doing much more. Australians are likely to embrace case management for the same reasons as Americans and will be just as disappointed. Despite this lack of real effectiveness of case management, a highly individualised response to elderly people's needs is still required but, this experience indicates, will only be achieved with a much broader strategy. (Rungie 1993, p.37)
POSSIBLE SHIFTS TO USERS PAYING A HIGHER PROPORTION OF SERVICE COSTS

Long-term care financing

The literature available to date suggests that any policy changes in financing Australian aged care services would not include significantly higher user contributions in the short term. There is interest however in increasing contributions from working life to care costs in later life.

The first report of the Mid-Term Review of the Aged Care Reform Strategy stated that the restructuring of retirement income arrangements in recent years suggests opportunities for linking funding of aged care to superannuation, as this has the potential to generate far more substantial revenue for aged care than from user charges. It is expected that the superannuation funds will hold about $600 billion by the year 2000 when aged care expenditure would be about $3.5 billion (Commonwealth of Australia DHH&CS 1991, p.148). The second Mid-Term Review report addresses methods of financing long-term care (LTC) as one of its specific terms of reference and refers to a current OECD study by Weiner (1992) on private sector funding such as long-term care insurance and home equity conversion schemes (Commonwealth of Australia DHH&CS 1993, p.95). It concludes that:

... the current evidence from overseas does not suggest a strong role for private long term care insurance. The demand — and supply — side barriers are considerable and development has been very limited even in countries that do not have the universal provisions of the kind available in Australia. (Commonwealth of Australia DHH&CS 1993, p.97)

Australia has one private LTC insurance scheme — GIO Personal Care Insurance commenced in 1992. A number of countries are now including long-term care in their social insurance schemes — the Netherlands (Kraan et al. 1991); Israel (Morginstin et al. 1992) and Germany has just introduced compulsory care insurance based on employer and employee contributions (Correll et al. 1993). The recommendation of the Mid-Term Review team is that a social insurance-based system drawn from superannuation contributions would contain public outlays but protect equity and the capacity of older Australians to meet user contributions (Commonwealth of Australia DHH&CS 1993, p.97). To date there has been no government response to implementing such a recommendation and the recent EPAC report suggests that such changes are not likely in the near future (Clare and Tulpule 1994, p.vii).

Fees and user charges

There has always been a tension about fee policies for aged care and it has remained a largely unresolved area, especially within community care and between community and residential care, despite other major changes and shifts to national uniformity over the past decade. Baldwin (1992) comments
that the whole issue of charging is yet to be confronted in the changes to community care in Britain.

Releasing capital to pay for care

On one hand there is acknowledgment that the resource base of many older Australians is improving, much of it in the capital investment of their homes which is generally passed on tax free as inheritance. The 1990 estimate was that over $140 billion is held by Australians over 65 years of age which will lead to a substantial inter-generational transfer of wealth early next century. (Barber 1992, p.135). Politically and practically it has been difficult for governments to access capital as service fees. Kendig (1986, p.181) suggests that the growth in retirement housing illustrates one way older people are choosing to convert assets into instrumental support and annuity and home equity programs also have this potential.

Low-income status of most current service users

On the other hand most older people requiring care services now are reliant on government pensions and thus have low incomes. Seventy-seven per cent of those over 70 years have Health Care cards — as do 83 per cent of HACC service users over 80 (Commonwealth of Australia DHH&CS 1993, p.91).

Variation in charging principles and practice

Although there are national guidelines restricting fees to 87.5 per cent of pension income in all but a few exempt-funded nursing homes, there is no such uniformity across other care services. Entry into many hostels requires user contributions of between $4,000 and $150,000, with fewer numbers of places available for financially disadvantaged people who can't make such contributions. Community care charges vary both between services, areas and states. In some services there has been a disincentive for providers to charge fees because subsidy has reduced proportionately to this income and is seen to be another form of cost shifting. There is some contest over how fee income should be distributed between funding partners and retained within the HACC program. There is also the view that given that charges in nursing homes and hostels are for the ‘hotel’ costs of food, rent, and usual living costs, then full rate pensioners meeting those costs in their own home should not be charged for care services (Commonwealth of Australia DHH&CS 1993, p.90).

In November 1993, a draft national policy on charging in the HACC program was finalised by the Department of Health, Housing and Community Services and has been circulated to peak bodies for comment. It states that the policy aims to protect clients' rights, to encourage equity within the program and ensure that fee revenue is used to enhance and expand HACC services. It proposes that flat rate fees should apply and fees for multiple services not exceed 17.5 per cent of after-tax income. It proposes 12 principles on which providers should base their charging practices. A means-related fee scale will probably be developed over the next few years.
Paying for private services

Melbourne, and the eastern and southern suburbs in particular, already has a range of private hostels — Special Accommodation Houses, many of which charge fees higher than pension rates. There is also a growing provision of private home care services. Those who can afford to pay from their own or family resources and live in the well serviced areas clearly have a wider choice of care options. Some of the home care services appear to be meeting gaps in the subsidised provision levels or times of availability and are utilised in conjunction with the public services. In Sweden, growing numbers of well-off elderly are utilising a responding private home care market (Johansson and Thorslund in Kraan et al. 1991). In Britain there has been a substantial growth in self-financed retirement housing as in Australia and the United States, much of which provides and charges for on-site care.

Those with lower needs in the context of tighter targeting and prioritising are being increasingly excluded from subsidised services and will either have to pay commercial rates, do without, or rely on the availability and willingness of unpaid help from families and friends. Those with low income and without the resources of their own housing and family will continue to be most disadvantaged in relation to choice and access to care.

Charging families

There doesn't appear to be much emphasis in the literature on the inter-generational issues of children's willingness and capacity to pay for their parent's care as charges. In the new Commonwealth funding for respite programs the issue of who is the client and to be charged is not explicitly addressed — the assumptions of the high rate of spouse carers, low-income status of most carers and that supporting family care is cost effective seems to override interest in collecting small proportions of that cost in means-tested user charges.

Summary

Whilst increased user charges is not yet an explicit policy direction in Australian aged care services, it is a direct outcome of tighter targeting and the inability of subsidised services to expand to meet increased demand in many areas. Attempts to increase equity in fee setting both within and across service types is evident although not yet achieved. A strong commitment to low fees for pensioners and utilisation of the Department of Social Security means testing has remained a fairly firm principle in the decade of Labor Party control of federal policy, but as we have seen in New Zealand and with state services in Victoria, a change of government could alter the view on user charges, with higher expectations of individual and family contributions. Clearer division of responsibilities is apparent in disability services in Victoria with the individual meeting their own housing and living costs and the state providing fixed amounts of care according to assessed need.
ROLE OF SERVICE USERS IN POLICY AND PROGRAM DEVELOPMENT

The literature on aged policy and long-term care addresses the role of users in two main ways. Firstly, the place of older people and carers as organised interest groups in pluralist democracies and their influence on the broad political agenda or in actions around specific pieces of legislation (Minkler and Estes 1984, 1991; Kendig and McCallum 1990; Sax 1993). In Australia at least it is apparent that much of this action has been relatively narrow and focused on income security issues with a growing constituency amongst the better-off elderly. Secondly, the way in which recent policy and program changes have responded to and connected with the concerns of users.

Increased policy recognition of service users' rights

The mainstream government documents emphasise the commitment to quality outcomes for service users and user rights including accountability practices such as complaints procedures (Commonwealth of Australia DHH&CS 1991; Victorian Government H&CS July 1993; British Parliamentary White Paper 1989). There is support for the potential benefits of these outcome-oriented policy approaches which purport to ‘put older people first’ and ‘increase consumer choice’. The introduction of arms' length audit and inspection units in Britain looking at service quality, complaints' procedures and involvement of service users should increase consumer power (Baldwin 1992, p.38). The growing recognition that consumers' views need to be taken into account is reflected in the increased focus on outcomes in social and health policies (Barber 1992).

Australia's aged care reforms have also included major changes ‘in the relationships between interest groups participating in the policy process’ (Howe in Kendig and McCallum 1990, p.168). Increased access to both the bureaucracy and ministers has been given to consumer groups and selected individual older people as ‘representatives’ of some of the diversity of interests amongst the older population, through formal advisory committees and wide consultations around particular aspects of policy development and review. The Commonwealth government established consumer forums for the aged in each state and territory, co-ordinated by its Office on Ageing.

Through the Community Organisation and Support Program advocacy bodies such as the COTAs, Australian Pensioners and Superannuants Association, Alzheimer's Association and the Carers' Associations have received funding. This clear commitment to creating and supporting an organised consumer sector with which to consult has also drawn criticism over the degree of control of the agenda and limited autonomy the processes allow. Changes in the Commonwealth's consumer forums are foreshadowed and in Victoria, the state government has abandoned both the consumer forum and Older Persons Planning Office, raising concerns that the period of commitment to and resourcing the channels for hearing the views of older people will now decline.
Contradictions in the consumer and empowerment discourse

There is quite a strong critique, particularly from Britain, which is less optimistic about current policy directions having an empowering effect on service users. The following points are made:

‘Upward Pressure’

Pijl (1991, p.40) in a review of policies in the Netherlands, comments that the increased intensity of policy making and the many reorganisations to increase effectiveness have seen a growing number of policy makers and managers so that the care sector becomes top heavy with an increasing interest in the system rather than the elderly. Beresford and Croft make similar observations about broader restructures in the British Social Services (admittedly prior to the new Community Care legislation):

The dominant voices have been those of white male academics and managers. Service users have not been involved. Most service workers and voluntary and community organisations have had little or no part to play in the initiation and discussion of new policies. (Beresford and Croft 1986, p.289)

Alan Walker also expresses concern that older people have not been at the forefront of pressure for change in Britain and Europe and, in relation to the case management/brokerage projects, that:

... these sorts of innovations were not sought by older people, nor did they have an equal voice to that of service providers in the process of innovation. (Walker 1991, p.23)

Two different models of user involvement

Walker points out that there are two distinct models of user involvement operating within the social discourse and social service practice; consumerism, based on an analogy with the market and assumptions that if there is a choice, consumers will have the power to exit and that direct payment confers power; and user empowerment, based on clearly defined rights which would seek to involve users in the development, management and operation of services as well as assessment of need (Walker 1991, p.16). In practice the two models are often confused, a factor which probably inhibits progress towards empowering users. Baldwin also comments on the conflicting objectives and tension created by the inclusion of both a rights and market approach in the British Community Care legislation:

The loss of clear entitlement to a benefit for residential care leaves poorer clients entirely at the discretion of service providers. This is hard to square with the notion that we are creating a care market with the specific aim of challenging the hegemony of professionals and increasing the self-determination of service-users. (Baldwin 1992, p.39)
**Strategies to increase empowerment**

Walker (1991) believes that there are formidable institutional barriers to user involvement and power:

1. Organisational principles and structures such as professionalism based on training which encourages an expert and autonomous view as well as power differentials with clients based on knowledge, control over resources and social class;

2. Resistance to change based on self interest, uncertainty, lack of skill and insufficient resources — a reluctance to ‘put the pain back into the system’; and

3. Major practical and personal barriers facing older users themselves.

A strategy to increase user involvement must be built into the structure and operations of agencies and not just ‘bolted on’, and take positive action to provide users and potential users with support, skills training, advocacy and resources (Walker 1991, pp.18-19). Neysmith (1992) and Beresford and Crofts (1986) also propose approaches necessary to involving service users in an empowering way, incorporating the above elements. It is clear however that user involvement is not cheap, and there will always be contradictions in achieving equal partnerships.

In Australia there has been an attempt to take service users along with the major aged care reforms and incorporate their views in the fine-tuning of policy and practice. There is very little evidence in the literature that users are gaining more institutional power or becoming more involved in the running or management of services. Statements or charters of rights seem fairly common in countries where there has been a high degree of administrative reform, but their role in achieving better outcomes is not discussed and they appear to be tools in clarifying expectations and standard setting. In Britain there have been some legal challenges about service outcomes not meeting assessed need.
Dependency is commonly discussed in functional or financial terms and in relation to the providers of the required support — the state, the taxpayers, the family. There have been many changes which have both increased and reduced physical causes of functional dependency. For example, the increased prevalence of Alzheimer’s disease is related to longevity — as more people reach very old age, the greater the numbers with Alzheimer’s. Fractured hips and cataracts, common causes of poor mobility in the elderly can be reduced by better known preventive strategies and technical advances in surgery which decrease disability. The costs of applying resources to reduce disability in old age is part of the broad policy debate about affordability and priorities in the health sector. McCallum argues that the debate needs to be about desired outcomes for consumers and warns that the pushing of technological solutions by powerful lobbies may improve the health of the elderly in a limited way but reduce their autonomy. Maintaining function to prevent dependency should be the goal rather than the pursuit of endless marginal extensions to life (in Sanders 1993, p.76).

The issue of dependency in policy is framed in demographic and inter-generational terms, expressed as a ratio of the costs of supporting those not in the work force by those in the work force. This type of measurement tends to perpetuate some of the myths about dependency, ignoring the substantial economic, emotional and practical contributions made by older people towards younger generations (Kendig 1986).

The social construction of dependency

Townsend (1979) wrote of the ‘structured dependency of the elderly’ and many authors since have exposed the way that dependency in old age is influenced by social policy. Townsend pointed to state policies of fixed retirement age and low pensions as contributing to poverty and, with the lack of community services, institutionalisation — the deliberate marginalisation and forced dependency of the elderly. More recently, Anne Marie Guillemard, the French political economist (1989); Minkler and Estes in the USA (1984) and Laczko and Phillipson (1991) in Britain have argued that the extrusion of older people from the labour force — at earlier and earlier ages — has created an ambiguous status for the long-term unemployed as ‘strangers’ in a capitalist economy. There are increasing numbers who are neither workers nor retired with increasing segregation and decreasing ‘rights’ to employment. In Australia, retrenchment with poor access to re-skilling has been the major route to long-term unemployment amongst older workers over the past decade. In Victoria, 150,000 people were retrenched in 1991, many of them older workers (Crookes in Sanders, 1993). The impact of reduced financial and personal resources with which to enter ‘old age’ will be a significant source of socially induced dependency for large numbers of people.

Ozanne (1992, p.116) discusses the work of Judith Mattras which argues that definitions of dependency, the nature of social obligations to each other and what entitlements societies are prepared to sanction are undergoing a major
reworking. The major changes are those of population ageing, changes in material production, employment and income distribution mechanisms as well as the enhancement of knowledge and information. Some of the consequences of these changes are that parenting takes up less time in the life course and that the old patterns of age-related social roles are becoming obsolete, for example expectations of the appropriate times for education, family functions, employment etc. (Ozanne 1992, p.117).

Kendig (1986, p.5) also emphasises that the experience of ageing is strongly conditioned by the period of history in which one becomes old, as well as a lifetime’s accumulation of orientations, resources and vulnerabilities. He sees the major social changes of population ageing leading to more time spent in retirement than in childrearing; and the changes in material production, employment and income distribution; and enhancement of knowledge and information translating into higher expectations and demands which will impact on the status of forthcoming generations of older people. His is an essentially optimistic view that sees many (middle class?) older Australians as benefiting from better education and inter-personal skills, higher incomes and early retirement and becoming more socially capable with extensive ties particularly with age peers. This view fits with Laslett’s (1989) account of how increases in longevity have created a ‘third age’ — a time of personal fulfilment between the responsibilities of mid-life and the decline in later life. The main obstacles to the achievement of the benefits of the ‘third age’ are described as the poor economic position of many older people and the demeaning way in which society views and treats the aged.

Recent policy awareness of the need to confront ageism in attitudes and structural discrimination, promote exercise, encourage education and other self-fulfilling and engaging activities amongst older people seems in stark contrast to the lack of political action on the disadvantages experienced by those prematurely removed from the workforce.

**Targeting**

Targeting has been a central feature in the Australian aged care reform strategy and has substantially changed entitlements. There has been a shift in emphasis from extensive to intensive provision of assistance (Fine and Graham 1992, p.11). Davis and Challis (1986) argue that from a government viewpoint it is efficient to use limited resources to achieve given goals, but that problems of equity arise when such policies are pursued too vigorously. Access to services is based on need not right, and needs are assessed by professionals, acting as gatekeepers and responsible for matching scarce resources to needs. Neysmith (1992) argues that this is quite a political act, but that professionals generally depolitisise it by translating political issues into legal, administrative or therapeutic matters. There are hair raising anecdotes about people with very high care needs being told on the phone that they can't have home care assistance because they are part of the ‘no growth’ group. With pragmatic awareness, Beryl Jamieson (1992, p.14) from the NSW Home Care service recently told a conference that ‘less need is the place where the money runs out’ and spoke of the difficulties services are facing in determining
relative need when demand exceeds supply. The increasing use of assessment tools and attempts to distribute care resources more equitably have meant in practice a shift to a more health and functional orientation to need and neglect of needs that are linked to social skills and disadvantage.
SUMMARY OF MAJOR TRENDS AND THEIR IMPLICATIONS FOR
LOW-INCOME AUSTRALIANS

Aged care has always been and remains reliant on family care. Those without family support will continue to be the major users of formal services. Despite the rhetoric of choice, access to all types of publicly-funded care services is restricted by a professional assessment of needs against program eligibility and priority. For community care and hostel services, low income restricts choice to the subsidised services, because private services can be purchased on the basis of felt need rather than assessed need. User fee policies are unlikely to significantly reduce access to the subsidised services for low-income people in the short term. However, an implication of targeting and the shift of eligibility for aged care programs to those with the highest functional needs, is the reduced capacity of low-income people with many disadvantages to get timely socially-oriented support to improve their living skills and status.

Community care is reliant on individuals having a home in which their care needs can be adequately provided. The balance of care approach of Australian policy still doesn't include a large enough range of supported housing options likely to be necessary for those who don't own their own home, and whose housing is unstable or unsuited to their needs. The CACPs offer some flexibility to provide services to meet individual needs, but not enough to compensate for inadequate housing, so in that sense they are poor alternatives to hostel provision in low-income areas.

Whilst Australian policy changes, as in most other OECD countries, have been driven by forces other than consumer demand for them, at the macro level, there has been a fair commitment here to involve older people and consumers in their development. This commitment has not really extended to resourcing serious attempts at user involvement in the management of either residential or community care services. At the more local level of service planning and provision both here and in countries such as Sweden and Britain, the literature refers to the importance of and barriers to consumer involvement, but there don't appear to be case studies with detailed accounts of how better consumer involvement has been achieved. This may be indicative of a gap in the type of literature accessed.

Whilst the numbers of older Australians solely reliant on the pension is declining, over the next decade the majority of the very old and those who enter old age with social and health disadvantages from earlier life, will be pensioners and thus be on low income. Vulnerability increases when there is no home ownership nor the social resources of family and friends, thus the accommodation component of care will be critical to provide. This paper has not specifically addressed the additional needs of the growing number of Australians from non-English speaking backgrounds, but clearly immigrants who are not eligible for government financial assistance in their own right, but whose families can't support them with accommodation and care are exceptionally vulnerable.
NOTES


2. For example; Chris Ronalds (1989) *Residents' Rights in Nursing Homes and Hostels; Final Report*, AGPS, Canberra; Richard Rosewarne, et al. (1990) *Hostel Dementia Care; Survey of Programs and Participants*, DCS&H, AGPS, Canberra.
REFERENCES


Commonwealth of Australia, Department of Community Services (1986) Nursing Homes and Hostels Review, AGPS, Canberra.


Commonwealth of Australia, Department of Health, Housing and Community Services (DHH&CS) (November, 1992) Evaluation of Hostel Options Care Packages, Aged and Community Care Services Development and Evaluation Reports, Number 8, AGPS, Canberra.

Commonwealth of Australia, Department of Health, Housing and Community Services (DHH&CS) (March 1993) *Home and Community Care Unit Costs Study*, Aged and Community Care Service Development and Evaluation Reports, Number 7, AGPS, Canberra.


Victorian Government, Department of Health and Community Services (DH&CS) (July 1993) Everyone’s Future: Directions for Aged Care Services in the 1990’s, Aged Care Services Publication, Melbourne.

FURTHER READING


Commonwealth of Australia, Department of Health, Housing and Community Services (June 1990) A Summary of HACC Consumer Rights Measures (Planned and in Place), HACC Program, Canberra.


