THE PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA

IN A HOME OR AT HOME:

accommodation and home care for the aged

Report from the House of Representatives
Standing Committee on Expenditure

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1. Chairman of the Joint Committee of Public Accounts, who, in accordance with Clause (2) of the Resolution of Appointment, is a member of the Expenditure Committee.

Foreword

This report is the result of two years of hard work by members of an Expenditure Committee Sub-Committee, the Committee's Secretariat, specialist advisers and a number of others. The Committee thanks the 220 individuals and organisations that made submissions to the Inquiry and the witnesses who gave evidence. We are appreciative of the time and effort put into the Inquiry by the many Government departments and authorities involved in this area. We were most grateful for the assistance and co-operation of the Commonwealth Department of Health and in particular Mr Matt Carroll and Mr Peter Johnstone.

As Chairman, I would like to thank my fellow Committee members, Mr Ray Braithwaite, Mr John Hyde, Mr John Mountford and Mr Ross McLean. The Committee travelled throughout Australia to all capital cities and many provincial centres to take evidence and in many instances it was quite difficult for members to fit the work into their busy schedules. We were fortunate that the two expert advisors, Dr Bruce Ford and Ms Anna Howe, brought to the Committee a breath of knowledge of aged care which extended beyond the medical. Dr Don Stammer, the Expenditure Committee's General Adviser also made a valuable contribution to the work of the Sub-Committee.

The detailed work of the Inquiry was carried out by the Committee Secretariat. Our initial Secretary, Ken Bone, set the framework, Bob Harlow's organisational skill made it easier to bring the report together in the end and John Howard's drafting skill in writing the report made the task of the Committee that much easier.

Above all, I would like to pay tribute to my secretary, Mrs Albertha Williamson, whose long experience and continued interest in the field of the care of the aged sparked my interest and prompted this report. Her support, advice and encouragement throughout the Inquiry contributed greatly to this Report.

Leo McLeay
(Sub-Committee Chairman)

Contents

Overview

1. The Committee estimates that in 1982-83 the Commonwealth will spend approximately $963m on Accommodation and Home Care for the Aged. Of this, $886m will be spent on residential accommodation and care and $77m on home care and domiciliary services of which the aged are the major users. These estimates exclude Commonwealth income security payments of nearly $6000m for Age and Service pensions. Although Commonwealth payments for Accommodation and Home Care are small in relation to the cost of the Income Security System they nonetheless represent a significant proportion of Budget outlays.

2. Government policy is that social welfare expenditure should be allocated to those in need. The Committee draws attention to a recent statement by the Minister for Social Security:

> '. . . that unless we can devise tenable strategies for directing welfare to those in the greatest need then, given the desire, or perhaps the need, for some overall restraint on welfare expenditure, we shall begin to approach a position where we are failing to meet adequately the needs of the poorest groups in our community —those who are solely dependent for their income on the social security system. And this leaves aside the question of those for whom even the current provisions are inadequate.'

3. The stated rationale for many Commonwealth initiatives in the provision of Accommodation and Home Care for the Aged has been to supplement assistance provided under the Income Security System for those in special categories of need. For example, the Aged Persons' Home Scheme was originally introduced to assist those pensioners for whom a small increase in the pension would not solve their housing problems. Similarly, the introduction of Nursing Home Benefits was against the background that most nursing home patients were pensioners and therefore unable to pay either the direct or insurance costs of nursing home care. It is relevant to bear in mind that at the time these schemes were set up pensioners were, as a result of the then definition of eligibility, more likely to be the genuinely needy.

4. In this Inquiry the Committee sought to identify the reasons for the continued dominance of expenditure on institutional care and establish a framework which allows governments to make cost effective decisions on the provision of both Accommodation and Home Care for the Aged. The Committee also wished to establish what evaluation has been carried out on Commonwealth programs and identify the evidence that exists for changing the present balance of institutional and home care services. As it turned out however, a major part of the Committee's work involved investigating departures from stated policy and, as far as possible, reaching an understanding of the basis of present policy.

5. Members of Parliament must rely, first and foremost, on Ministerial Statements to the Parliament and Second Reading Speeches on legislation to discern expression of Government policy. The Parliament must expect that policies thus promulgated continue until informed otherwise. However, practice sometimes differs significantly from stated policy. In particular, the *Aged or Disabled Persons Homes Act 1954* and the *Nursing Homes Assistance Act 1974* provide conspicuous examples of a lack of coincidence between Ministerially expressed policy and administrative practice. The combined effect of these two schemes, involving a Budget outlay in the order of $270m in 1982-83, is to allocate a significant amount of public expenditure to the relatively well-off in the community. This contrasts with the expressed policy objective that the schemes were set up to assist the needy.

6. The Committee has found that policies do not stand still. They change through interpretation in response to pressures of changing times and circumstances. This is inevitable. However, in the interests of responsible government and public accountability, which involves effective monitoring and evaluation, the Parliament should have the opportunity to re-examine and re-endorse substantial new emphases in policies in the light of changed circumstances.

7. The Committee was convinced by the submissions and evidence that most elderly people wish to remain in their own homes. There are, however, a number of factors which prevent many aged people from being adequately cared for and housed in their own environments. These factors also work towards the drift of aged people towards high cost institutional care. The Committee received evidence that some people accommodated in institutions could be cared for at home if housing was adequate and support services were available.

8. The Committee identified the basic reason for the predominance of institutional care as the relatively generous financing provisions for the construction and operation of nursing homes compared to the resources available for alternative forms of community based care.

9. The machinery for determining and allocating public financial support to the various sectors of Accommodation and Home Care for the Aged is dispersed among Commonwealth, State and local government agencies, religious and charitable organisations, individuals and private commercial enterprises. There is, moreover, a lack of co-incidence between the responsibility for paying benefits and subsidies and the responsibility for the supervision, regulation and control of facilities and services.

10. The Committee has made a number of recommendations directed towards improving the standard of accommodation for the needy aged and to re-dress the balance between institutional and home care services. However, the Committee considers that major progress will only come with changes in financial procedures and Commonwealth-State Financial Arrangements.

Summary of Recommendations

The Committee's recommendations fall into two categories.

The first category concerns changes to programs on the premise that financial arrangements and functional responsibilities between the Commonwealth and the States will not alter, at least in the short term. These recommendations are directed towards removing major problems and anomalies in the administration and delivery of programs, shifting the imbalance between institutional and home care and directing Commonwealth Government assistance for health and welfare to those in greatest need, in accordance with stated Government policies. These recommendations are combined in the body of the Report and in particular, in Chapters 4 through to 9. They are also summarized below under Recommendations 1.1 to 4.17.

The second category of recommendations deals with the Committee's medium to long term strategy for transfer of responsibility for the administration, delivery and financing of accommodation and home care programs to the States. This strategy is to be implemented after, or in conjunction with the propoals in the body of the report, and set out in detail in Chapter 10. Recommendations 5.1 to 5.7 summarise this strategy.

CHANGES TO PRESENT ARRANGEMENTS

Major recommendations on general matters are:

1.1 A change to present arrangements to achieve: a reduction in the number of programs; responsibility to be brought under one Minister; modifications to financial arrangements so as to remove disincentives for the expansion of home care services; similar forms of control over all categories of program expenditure; and, a reallocation of resources between institutional and community care.

(Paragraph 10.2)

1.2 The number of programs should be reduced to an Extended Care Program and a Nursing Home Care Program, with subsidised housing provided under the *Housing Assistance Act 1981*.

(Paragraph 10.6)

1.3 All programs providing home care and accommodation for the aged be brought under the control of one Minister. On balance the Committee considers the appropriate Minister is Health. Housing assistance to remain with the Minister responsible for the *Housing Assistance Act 1981*.

(Paragraph 9.6)

Major recommendations on housing, extended care and nursing home care are:

Housing

2.1 Housing assistance be provided to those most in need and that all assistance for construction of aged persons' accommodation be directed through the Housing Agreements.

(Paragraph 4.35)

Extended Care

3.1 The following strategy be implemented:

- an Extended Care Program be introduced to replace the *States Grants (Home Care) Act 1969*, the *States Grants (Paramedical Services) Act 1969*, the Home Nursing Subsidy Scheme and the Delivered Meals Subsidy;

- the Extended Care Program include an Attendant Care Allowance to replace the Domiciliary Nursing Care Benefit and the Personal Care Subsidy;
- the range of services to be funded be decided in consultation with the States to encourage a diversity of services to meet local need;
- resources be distributed so as to achieve a basic provision in all areas rather than solely in response to submissions for funding; and,
- the Extended Care Program be funded through a grant without matching conditions.

(Paragraph 7.74)

Nursing Home Care

4.1 The Commonwealth establish a 'Nursing Care Program' to replace the current Nursing Home Benefits paid under the *National Health Act 1953* and the *Nursing Home Assistance Act 1974*.

(Paragraph 6.27)

Further recommendations on housing, extended care and nursing home care are:

Housing

2.2 No more approvals be granted under the *Aged or Disabled Persons Homes Act 1954*. Assistance in respect of disabled persons might be provided under a separate program.

(Paragraph 4.48)

2.3 Existing commitments under the *Aged or Disabled Persons Homes Act 1954* be honoured but that future assistance be provided under the *Housing Assistance Act 1981*.

(Paragraph 4.50)

2.4 Action is needed to ensure:

- the retention of an adequate supply of boarding-house accommodation at low cost, through spot-purchasing under the Housing Agreement;
- the construction or purchase of new and replacement boarding house accommodation to be run by religious and charitable organizations under the *Housing Assistance Act 1981*; and,
- the maintenance of adequate standards in regard to number of occupants per room, meals, bathroom facilities, safety and protection of residents' civil liberties.

(Paragraph 4.91)

2.5 In order to improve the housing situation of low income aged people:

- that a diversity of accommodation types continue to be fostered through innovative projects involving local government, voluntary organisations and self-help groups;
- that consideration be given to varying Supplementary Assistance in line with housing costs in different areas; and,
- provision for nursing home care and home care services be applied equally to aged people in all types of accommodation.

(Paragraph 4.109)

2.6 Provision for home maintenance and repair services be made in the proposed Extended Care Program.

(Paragraph 4.64)

Extended Care

3.2 The restriction applying to services 'in the home' be removed to facilitate the provision of a wider range of services under a new Extended Care Program, which will otherwise incorporate the provisions of the *States Grants (Home Care) Act 1969*.

(Paragraph 7.36)

3.3 Senior Citizens' Centres, or other community based centres, be a base for the development of community care services wherever possible, and that the proposed Extended Care Program include provision for staffing and services associated with Senior Citizens' Centres.

(Paragraph 7.45)

3.4 The Delivered Meals Subsidy be subsumed within the proposed Extended Care Program.

(Paragraph 7.52)

3.5 Categories of staff for whom salary subsidies are paid should be widened to allow for the employment of Home Health Aides.

(Paragraph 7.62)

3.6 The replacement of the Domiciliary Nursing Care Benefit and Personal Care Subsidy by an Attendant Care Allowance which would pay for unskilled assistance without which the assessment team considers an elderly person would require institutional care.

(Paragraph 7.70)

3.7 Alarm systems be seen as one of the elements of community care that be provided under the proposed Extended Care Program, on the advice of the assessment team.

(Paragraph 7.72)

3.8 State Governments should actively assist and support local government in organising the delivery and planning of health and welfare services for the aged.

(Paragraph 9.46)

3.9 Special attention be given to the training of staff for all levels of care of the aged as a basic input in the development of services and that appropriate training programs be part of the Extended Care Program.

(Paragraph 8.23)

3.10 Additional finance for assessment teams be made available in the proposed Extended Care Program, with the introduction of additional teams planned in consultation with the States.

(Paragraph 8.21)

3.11 The Commonwealth should provide additional funds to the States for assessment teams under the proposed Extended Care Program.

(Paragraph 8.28)

3.12 A mechanism for planning the distribution of community care services be developed in consultation with the States, and that allocation of financial assistance be made on a consideration of need rather than relying on local initiatives and submissions for funding.

(Paragraph 7.27)

3.13 The proposed Extended Care Program include specific provision for monitoring of expenditure distribution and service development.

(Paragraph 7.47)

Nursing Home Care

4.2 The Nursing Home Care Program to involve the following elements:

- payment to be made through a grant to the States on a per-capita basis, with the base amount for each State in the first year to be determined in relation to the aged population currently resident in nursing homes;
- the Commonwealth work towards the provision of grants based on the number of aged persons in each State;
- a 'phasing-in' period to permit orderly re-adjustment in State hospital/nursing home systems;
- no payments be made in respect of nursing home beds not currently approved; and,
- relativities between the States be examined by the Grants Commission at the time of its next review of Tax Sharing Relativities; and,
- a minimum patient contribution to be retained.

(Paragraph 6.29)

4.3 Pending the transfer of responsibility to the States, the Commonwealth should fund the number of nursing hours per patient to a uniform standard set by the Commonwealth.

(Paragraph 6.14)

4.4 Public subsidy to institutions should be provided in terms of the cost of delivery of services which entails financial assistance to the provider of the services, on the basis of an assessment of appropriate costs.

(Paragraph 5.114)

4.5 Health authorities explore prospects for contract nursing care in lieu of benefit arrangements to finance nursing homes.

(Paragraph 6.65)

4.6 The deficit finance arrangements be subsumed in the Nursing Home Care Program and that **all** nursing homes be subsidised on a uniform basis.

(Paragraph 6.73)

4.7 In any case where additional nursing home beds are sought there should be an evaluation as to whether the funds that would be allocated in recurrent subsidies would be better applied to community services.

(Paragraph 5.49)

4.8 Control over growth in nursing home beds reflect the requirements and procedures for expenditure control.

(Paragraph 5.55)

4.9 Further control of nursing home growth be applied so as to limit the number of occupied beds and contain expenditure on institutional care.

(Paragraph 5.57)

4.10 Until the administration and control of programs are transferred to the States, growth of nursing homes should be limited to areas of demonstrated scarcity.

(Paragraph 5.58)

4.11 In the identification of areas of demonstrated scarcity, bed to population ratios should not be used as an indication of need.

(Paragraph 5.60)

4.12 Pending the introduction of the Nursing Home Care Program, decisions giving rise to the approval of new nursing home beds or increasing nursing home benefits be subject to formal Government approval and that the decision be made in the annual Budget context reflecting overall expenditure priorities in Accommodation and Home Care for the Aged.

(Paragraph 9.35)

4.13 The Commonwealth should negotiate an arrangement with the States whereby the State Health Authorities approve admissions to participating private and deficit funded nursing homes as they currently approve admissions to their State nursing homes.

(Paragraph 8.26)

4.14 Assessment for admission to nursing home care be introduced as speedily as possible and that it be in place at the time when administration of Aged Care Programs are handed over to the States.

(Paragraph 8.30)

4.15 Provisions for the development of respite care be included in the Extended Care Program.

(Paragraph 5.77)

4.16 Each non-government nursing home be required to make publicly available and provide to potential patients the names, addresses and occupations of all substantial beneficial owners of the home and the proportion owned.

(Paragraph 6.92)

4.17 To overcome the lack of channels of complaint against low standard nursing homes, hostels and domiciliary services, an Aged Care Tribunal should be established in each State, to which aged people receiving care or their relatives can take complaints about services.

(Paragraph 6.45)

TRANSFER OF RESPONSIBILITY

The major recommendation on the transfer of responsibility for the restructured programs is:

5.1 Transfer of the restructured accommodation and home care programs to the States, over a five year period, initially through grants and moving towards eventual absorption in the tax sharing arrangements.

(Paragraph 10.2)

Specific recommendations on the tranfer of responsibility are:

5.2 Planning the organization and delivery of health and welfare services for the aged should be a matter for State and local government. Commonwealth involvement should be limited to the provision of finance for the broad, general purposes as outlined in previous recommendations, until such time as full responsibility is handed over to the States.

(Paragraph 9.52)

5.3 The planning and delivery of programs should be conducted at the regional level.

(Paragraph 10.26)

5.4 The Commonwealth negotiate an Agreement with each State to operate for five years to cover the transfer of responsibility. After a period of five years payments should be absorbed within the Tax Sharing Arrangements.

(Paragraph 10.35)

(Paragraph 10.35)

5.5 A special unit be established to provide the Government with policy advice on all initiatives and programs which provide facilities and services for the aged, and that this unit be given the title *Office of Care for the Aged*. The unit would advise on policy in respect of the aged among all Commonwealth agencies involved in providing assistance to the aged, namely the Departments of Health, Social Security, Veterans' Affairs, Aboriginal Affairs, and Immigration and Ethnic Affairs.

(Paragraph 10.37)

5.6 The Office of Care for the Aged should be located within the Prime Minister's Portfolio.

(Paragraph 10.41)

5.7 In addition to the traditional Governmental response within 6 months of the tabling of the Report of this Inquiry, the Government should present a review of the effectiveness of aged care programs to the Parliament five years after the Report is tabled. The paper should describe the Government's achievements to that time and its further plans.

(Paragraph 10.42)

CHAPTER 1

RESPONSIBILITY FOR HEALTH AND WELFARE SERVICES FOR THE AGED

1.1 This chapter outlines the differing functional and financial responsibilities of the Commonwealth and the States in the provision of Accommodation and Home Care Services. Major problems arise because the Commonwealth's role is limited to the payment of benefits and the provision of financial assistance whereas the States have responsibility for control, supervision, regulation and licensing, as well as direct provision of relevant facilities and services. Of particular importance is variation in the form of Commonwealth financial assistance and budgetary control between different programs providing alternative forms of assistance and care.

Division of Responsibilities

1.2 The referendum of 1945, which gave power to the Commonwealth to legislate over a wide range of income security matters, including hospital benefits, and thus nursing home benefits, did not provide it with the specific power to legislate in respect of health and welfare services. Authority for legislation in that area derives from Section 81 of the Constitution, the general Appropriation power, and from Section 96, the authority for making payments to the States.

1.3 Section 81 allows the Commonwealth to allocate funds from the Consolidated Revenue Fund 'for the purposes of the Commonwealth'. However, Section 83 of the Constitution provides that funds cannot be withdrawn from the Treasury 'except under appropriation made by law'. There has been much contention about the impact of these provisions. One view is that if there is no Constitutional power there can be no Commonwealth law: if there is no law there cannot be an appropriation. The alternative view, and on which much of the Commonwealth involvement in the provision of health and welfare services relies, is that the 'purposes of the Commonwealth' cover anything the Commonwealth Parliament has voted on.[1] The most recent High Court challenge on these provisions, in the case of the Australian Assistance Plan, was inconclusive.

1.4 Section 96 of the Constitution provides authority for the Commonwealth to allocate funds to the States on terms and conditions it deems fit. It provides the vehicle for nearly all Commonwealth specific purpose and general purpose funds to the States.

1.5 With a limited number of exceptions, responsibility for planning and delivery of health and welfare *services* in Australia is largely a matter for State and local governments and for the private sector. The private sector includes both private enterprise and religious and charitable organisations. Details of direct Public Expenditure on Health and Welfare are set out in Table 1 at Appendix I.

1.6 Commonwealth involvement in the planning and delivery of services is generally restricted to provision of 'financial assistance' to governments and organisations, which in turn set objectives and standards and arrange or supervise the delivery of services. Notable exceptions are the provision of health and welfare in the Australian Capital Territory, the Repatriation System, the Commonwealth Rehabilitation Service and certain services for aboriginals and migrants.

1.7 The Commonwealth, on the other hand, has accepted almost complete responsibility for *income maintenance.* This responsibility not only includes the minimum income support or income security system, which is ostensibly designed to alleviate poverty, but also the provision of cash assistance to persons for the purpose of offsetting increased expenditure in particular areas—notably health, education and employment training. The major forms of benefit in the health area are medical, hospital, pharmaceutical and nursing home benefits. Details of Income Maintenance payments are set out in Table 2 at Appendix I.

1.8 Estimates of total public sector outlays for health and welfare are set out in Table 3 at Appendix I. This table indicates that outlays on health and welfare amount to about 34 percent of total public sector outlays. Taken together, the tables at Appendix I indicate the Commonwealth is responsible for payment of approximately 98 percent of income maintenance payments for health and welfare purposes. On the other hand, the States and local government account for about 80 percent of direct expenditure on goods and services. However, while the States and local government may have direct responsibility and incur the greater proportion of expenditure, they rely in these areas on Commonwealth transfers in the form of Payments to or for the States for a significant proportion of the finance.

1.9 The influence of Commonwealth funding on States' and local authorities' expenditure is indicated in Table 1.1.

Table 1.1: States' and local authorities' outlays for health and welfare purposes and contribution by the Commonwealth
($m)

	1976–77	*1977–78*	*1978–79*	*1979–80*
States' and local authorities' outlays				
Health	2 594	2 861	3 151	3 421
Social security and welfare	283	349	414	478
	2 877	3 210	3 565	3 899
Commonwealth payments to the States and local authorities				
Health	853	1 107	1 132	1 241
Social security and welfare	54	69	69	71
	907	1 176	1 201	1 312
Proportion of States' and local authorities' outlays from Commonwealth sources	31.5	36.7	33.7	33.6

Source: Table 3, Appendix 1 and *Payments to or for the States, the Northern Territory and Local Government Authorities*, 1982–83.

1.10 A change in the pattern of Commonwealth payments occurred in 1981–82 with the termination of hospital cost sharing in four States and the Northern Territory and the transfer of the Community Health Program and School Dental Scheme to the States. Under the *States Grants (Tax Sharing and Health Grants) Act 1981* general purpose financial assistance is identified for health in lieu of specific purpose assistance previously provided for hospital operating costs, community health and school dental services. **The Commonwealth, through the payment of nursing home benefits, still remains the principal source of finance for nursing homes, which are, for all intents and purposes, an extension of States' hospital service systems.**

1.11 The Commonwealth may have some influence on the level and scope of services provided by State and local authorities and by the private sector through adjustment of

amounts of financial assistance and specifying terms and conditions. However, this turns out in practice to give rise to major problems in planning and determining the most efficient allocation and distribution of resources for health and welfare purposes. **The form of Commonwealth financial assistance and the extent of budgetary control varies significantly between programs which provide finance for alternative health and welfare services.**

1.12 Commonwealth nursing home benefits are a form of income maintenance payment designed to offset increased personal expenditure because of the need for nursing home care. While income maintenance payments, such as age pensions, do not specify terms and conditions for use[2], the payment of nursing home benefits by the Commonwealth direct to nursing homes, which are in turn subject to State controls and regulations, causes major difficulties in determining standards, costs and allocation of services and facilities. Similar considerations apply in respect of Commonwealth subsidies paid direct to religious and charitable organisations and grants for home care services to State authorities.

1.13 The division of functional and financial responsibilities between the Commonwealth and the States led the Commission of Inquiry into the Efficiency and Administration of Hospitals (Jamison) to observe that

> '. . . under existing arrangements the most significant constraint on State health authorities' ability effectively to allocate funds between different types of health services and to different areas is the extensive involvement of the Commonwealth not only in providing money, but also in regulating the way it is spent. *Separating the States' financial responsibility from managerial responsibility to the extent which has occurred is not conducive to a well run service*'.[3]

Delivery of Health and Welfare Services for the Aged

1.14 For some time now it has been alleged that there are serious weaknesses in the organisation and delivery of health and welfare services for the aged. In August 1975, the Social Welfare Commission reported that—

> 'The present basis of care for the aged and the handicapped is haphazard, expensive and inadequate. The lack of support given to large numbers of aged people and the limited alternatives of institutional care available to them may in fact contribute to the accelerated deterioration of their health.'[4]

In April 1975, the Poverty Inquiry noted—

> 'At least some of the deficiencies in the care of the elderly can be blamed on the complicated way in which the field is administered. In any State up to half a dozen government departments can be involved, divided between the centre and State. And even within one department affairs are by no means straight-forward.'[5]

In January 1977, the Committee on the Care of the Aged and Infirm referred to—

> '
> - the largely ad hoc way in which programs had been launched;
> - the lack of co-ordination between the efforts of various levels of government and between governments and the non-government sector;
> - past concentration on institutional accommodation rather than on the development of comprehensive domiciliary services;
> - failure to develop effective assessment and rehabilitation procedures which could improve the efficiency of programs by matching services to people's particular requirements.'[6]

1.15 In 1981, and referring specifically to nursing homes, the Jamison Commission observed that 'the machinery for administering the nursing home sector is something of a maze, the key to which gives various financial powers to the Commonwealth'.[7] The Commission also noted that the effectiveness of the sector had been criticized by all

parties involved and suggested that this criticism reflects the 'ineffectiveness of the profusion of machinery to produce effective policy'.[8] With a touch of irony it added—

> '. . . it was striking to observe how effective the Commonwealth financial machinery had been in shaping the nature of available services for the aged with its predominance of nursing homes.'[9]

and concluded by stating—

> 'In summary, nursing homes illustrate the ability of a maze of financial and administrative machinery to 'clog up' or obstruct the process of policy development.'[10]

In the *Report on an Efficiency Audit of Commonwealth Nursing Home Programs*, the Auditor-General made the more general comment that:

> 'Effective interaction between Commonwealth departments (Health, Social Security and Veterans' Affairs) in the planning and evaluation of related programs of care for the aged and the infirm is largely absent, although informal liaison occurs. Commonwealth administration is not adequately integrated. Better value for the Commonwealth's health and welfare expenditure on the aged and the infirm could be obtained if related services were planned for and evaluated jointly.'[11]

1.16 The Australian Council of the Ageing in its submission to the Committee echoed these views, arguing that:

> 'Once established, there appear to have been few attempts at systematic monitoring of services to establish levels of effectiveness and efficiency in relation to clearly defined goals. This has led to haphazard development that is patchy in coverage and often dictated by needs other than those of the intended beneficiaries, ie., the aged.'[12]

1.17 The South Australian Government informed the Committee that the system providing support for the aged is complex, depending on Commonwealth, State and local governments, voluntary agencies, private hospitals, nursing homes and rest homes, practitioners in several disciplines and multitudinous volunteers. The South Australian Government further claimed that a persistent thread which has run through previous inquiries has been the need to enhance formal communication between Commonwealth, State and local government agencies concerned with the health, welfare and housing of the aged. Many of the difficulties in providing co-ordinated programs were seen to derive from this longstanding issue.[13]

1.18 A further problem that arises in respect of accommodation and care for the aged is the difference in approach between the organisation and delivery of health services on the one hand and welfare services on the other. The nature of the welfare system is to focus on *assistance* to meet '*needs*'. Accordingly, Government policy is generally in terms of assisting *clients* who are suffering from social and economic hardship: policy objectives are identified with groups of clients whom the system is intended to benefit. The budget documents refer to Assistance to the 'Aged', the 'Handicapped', 'Widows and Single Parents', etc.[14]

1.19 By contrast, the Health system focuses on *treatment* with the result that Government policy is generally in terms of paying for the provision of facilities and services for *patients* assumed to be suffering from an illness. Thus, concern over the health status of the aged is subsumed within treatment available in the form of 'Hospital Services and Benefits', 'Medical Services and Benefits', 'Pharmaceutical Services and Benefits', 'Nursing Home and Domiciliary Care Services and Benefits', 'Community Health Facilities and Services', and so on.[15]

1.20 Although the aged as a group tend to be the heaviest users of the health care system, particularly nursing homes, they are not identified in the Commonwealth public expenditure documentation as a category of user with specific health needs—except to

the extent that they are eligible for 'pensioner health benefits'. But this is a 'welfare' criterion based on income, not health. The Jamison Commission reported a survey which found that in N.S.W. the aged, which in 1978 constituted 8.6 per cent of the population, occupied 30 per cent of acute hospital beds, consumed 40 per cent of prescribed drugs, used 70 per cent of community services and occupied 90 per cent of nursing home beds.[16]

1.21 The view put to the Committee in evidence by a senior officer in the Department of Health was that:

> '. . . it is dangerous, I think, to look upon the aged as some particular or peculiar group of clientele in the community. I have always looked upon the picture that we should integrate the services for the aged as much as a part of the total community services, but giving particular emphasis to their particular needs.'[17]

Programs and Policies

1.22 The Expenditure Committee, in a previous inquiry, concluded that there is no generally agreed definition of the term 'program'.[18] According to the Department of Finance the term can be defined in different ways and at different levels of aggregation, but is usually interpreted as covering a group of activities designed to achieve specific government objectives.[19] In this context the Expenditure Committee argued that a *program statement* should have four basic features. These are

- it identifies specific policy objectives laid down by government
- it specifies all the activities that contribute to the objective
- it identifies the resources and costs required to achieve the objectives, and
- it contains measurements or assessments of outputs.[20]

1.23 The conclusions from previous reports and the Committee's own inquiries indicate that these features are absent in respect of 'programs' relating to Accommodation and Home Care for the Aged. Indeed, the Auditor-General recommended the Government provide 'guidelines on program intentions clear enough to provide a firm base for program planning, evaluation and reporting as necessary'.[21]

1.24 Most references to 'programs' within the Health and Social Security portfolios are in fact to appropriations, or legislative authorisations to pay money to another organisation or institution, to offset —partly or totally —the cost of providing a particular service or facility. These appropriations are not integrated as part of a 'group of activities designed to achieve specific government objectives' in relation to Accommodation and Home Care for the Aged.

1.25 This issue should be seen against the background that administration within the Commonwealth bureaucracy is not so much concerned with the actual delivery of a service but with ensuring that funds are allocated and spent in accordance with legal and administrative requirements. The Commonwealth has very little formal involvement in the delivery of services or provision of facilities for the aged. Responsibility in this area is largely a matter for State and local governments and the private sector. These institutions have the authority to provide, administer, regulate and control health and welfare activities. The Commonwealth, in general, does not. The Commonwealth's responsibility is usually limited to providing some or all of the money.

1.26 Commonwealth appropriations constitute only one of the means towards achieving the objective of an efficient and effective provision of Accommodation and Home Care for the Aged. Other resources, provided by State and local governments, the private sector and voluntary organisations are also relevant in achieving this objective. The contribution made by aged individuals, families and other sources of informal support is by far the major source of support for the elderly. The personal resources which

confer access to other services, are also relevant. The extent to which all these resources are forthcoming and organised is of vital concern in considering program effectiveness.

1.27 The Committee found a tendency within the area of Accommodation and Home Care for the Aged to give attention to the 'means' of assistance rather than to the 'ends' or outcomes that programs or appropriations providing that assistance are attempting to achieve—either individually or in association with other programs or appropriations. This criticism is of course by no means confined to this area. It has been levelled at the health and welfare services in general.[22]

1.28 It is often suggested that one of the reasons for concentration on the 'means' of assistance is inadequate specification of policy goals and objectives. However, it does not always follow that once policy objectives have been specified the processes of program implementation will proceed unimpeded with success measured in terms of the extent to which those objectives have been achieved. It is now being appreciated that the criteria for determining policy success can not be as simple or as straightforward as the accomplishment of expressed objectives according to some empirical benchmark. Political considerations are also influential and sometimes paramount in determining whether policies follow their stated objectives.

1.29 Appropriations concerned with Accommodation and Home Care for the Aged are set out in Table 1.2. They are set out in accordance with the functional categories used in the *Budget Speech and Statements*. The purposes ascribed to these appropriations, provided in departmental submissions to the Committee, have also been listed. Details of expenditure under these items are set out at Appendix II.

Table 1.2: Commonwealth appropriations and purposes in relation to accommodation and care for the aged in terms of the functional classification of outlays used in the Budget Speech and Statements

Item	*Appropriations*	*Purpose*
Function: Health		
Sub-Function: Nursing Home and Domiciliary Care Services and Benefits		
Nursing Home Benefits	*National Health Act 1953* *National Welfare Fund Act 1947*	To assist persons requiring nursing home care by reason of infirmity, illness, disease, incapacity and disability in meeting the cost of such care as is appropriate to their needs, desirably within reasonable proximity to the general community in which they have lived. To monitor the care provided to patients in nursing homes and the standards and conditions on which that care is based (Evidence 2211).
Nursing Homes Assistance	*Nursing Homes Assistance Act 1974* *National Welfare Fund Act 1947*	To remove the uncertainty in financial budgeting for voluntary non-profit organisations conducting nursing homes. To remove the financial insecurity for patients in meeting the cost of their accommodation in nursing homes (Evidence 2214).
Domiciliary Nursing Care Benefits	*National Health Act 1953* *National Welfare Fund Act 1947*	To provide financial assistance to persons who choose to care for chronically ill or disabled relatives in their own homes as an alternative to admission to a nursing home. The benefit is directed towards enabling the caring persons to provide for the patient's needs and supportive care at home (Evidence 2216).
Home Nursing Services	*Home Nursing Subsidy Act 1957* *National Welfare Fund Act 1947*	To provide financial assistance to approved non-profit organisations providing home nursing services to the people of Australia (Evidence 2218).

Item	*Appropriations*	*Purpose*
Function: Social Security and Welfare		
Sub-Function: Assistance to the Aged		
Aged Persons Homes and Hostels	*Aged or Disabled Persons Homes Act 1954* *Appropriation Act No. 1*	*Aged Persons Homes:* To encourage and assist the provision of suitable homes for aged persons and in particular homes at which aged persons may reside in conditions approaching as nearly as possible normal domestic life and, in the case of married people, with regard to the companionship of husband and wife. The Department of Social Security, on the basis of agreements entered into by organisations, lists the objectives of the assistance as follows: • to facilitate the construction of accommodation for the aged or disabled; • to ensure that the subsidised accommodation is available in areas of greatest need; • to ensure that subsidised accommodation is available both to those who can and those who cannot contribute towards its capital cost; • to ensure that such accommodation is used by those people who are eligible for admission to it; • to ensure that subsidised accommodation continues to be used for its intended purpose (Evidence 2380).
	Aged or Disabled Persons Hostels Act 1972 *Appropriation Act No. 1*	*Aged Persons Hostels:* To quickly increase the supply of hostel type accommodation for the aged. The aim was to reduce the inappropriate use of expensive nursing home accommodation by people who had no real medical need for those services. The Act was to provide for: • the rapid expansion of beds of the type most needed; • the allocation of those beds to those most in need of them (taking into account the existing accommodation and the degree of frailty and the financial situation of the person); • the administration of those beds by the charitable organisations, which are best qualified in this field (Evidence 2383).
Home Care Services	*States Grants (Home Care) Act 1969* *Appropriation Act No. 2*	To provide financial assistance to the States in relation to certain home care and other welfare services by States, local government and community welfare organisations for the purposes of: • providing appropriate supportive service primarily to aged people to enable them to remain in their own homes as long as possible; • fostering co-operation between Governments and encouraging community effort in providing services for the aged; • providing opportunities for advice on and co-ordination of welfare services at the local level (Evidence 2385).
	States Grants (Paramedical Services) Act 1969 *Appropriation Act No. 2*	To assist the States to support the provision of approved paramedical services (such as chiropody, occupational therapy, physiotherapy and speech therapy for aged persons in their own homes) (Evidence 2219)

Item	*Appropriations*	*Purpose*
	Delivered Meals Subsidy Act 1970 *National Welfare Fund Act 1947*	To provide for assistance by the Commonwealth to voluntary organisations and local government bodies toward the provision of delivered meals for aged and invalid persons by: • providing assistance and occasional help to aged or invalid persons to help them to live independently in their own homes as a matter of choice; • expanding the Government's home care program complementing other Commonwealth programs which provide housekeeper, home nursing and other services, with a view to maintaining aged or invalid persons in their own homes, if they so desire, as long as possible; • mobilising community support through voluntary effort in assisting aged or invalid persons and provide them with daily contact with other members of the community (Evidence 2387)
Personal Care Subsidy	*Aged or Disabled Persons Homes Act 1954* *National Welfare Fund Act 1947*	To offset the costs of caring for the frail aged in hostels and self-contained facilities (Evidence 2382).
Function: Housing *Sub-Function:* Welfare Housing Assistance to the States and Northern Territory		
Grants—Pensioner Housing	*Housing Assistance Act 1981* *Appropriation No. 2*	The objectives of the Agreement are set out in the legislation. Housing assistance will: • facilitate home ownership for those able to afford it but not able to gain it through the private market; • provide adequate rental housing for those of the community who are deemed to be in need of government assistance at a price that is within their capacity to pay; and • provide assistance for home ownership and assistance with rental accommodation in the most efficient way and thus to exclude from eligibility those not in need, to minimise continued availability of assistance to those no longer in need and to accord benefits which are designed so that assistance being provided is related to the particular family's or individual's current economic and social circumstances (Evidence 2646).

1.30 Taken together these statements of purpose indicate a rather haphazard approach to the organisation and delivery of health and welfare services in respect of Accommodation and Home Care for the Aged. In particular—

- Nearly all 'purposes' give prominence to the provision of financial assistance.
- Except in one or two cases, the purposes are not related to objectives which can be used in evaluation exercises to assess policy achievement or program effectiveness.
- There is doubt that many 'purposes' would be universally accepted by Government as matters of policy.

1.31 Thus, while departments have provided the Committee with statement of purposes for individual programs, the Committee has not been able to elicit an overall philosophy or goal of Commonwealth programs providing Accommodation and Home Care for the Aged. It is apparent that while programs are directed at satisfying specific

needs of the aged they do not allow sufficiently for the clients' changing circumstances or attempt to cater for all needs or discriminate adequately between degrees of need.

1.32 The Committee identified a tendency to see Accommodation and Home Care for the Aged solely as a 'health' matter, reflecting an underlying value that the Aged are 'essentially people in stages of failing health'.[23] While failing health, engendering a need for a period of extended care does not characterise the majority of the aged population, it is nonetheless the major factor that brings the minority within the scope of needing assistance.

1.33 The 'Aged' cannot be unambiguously defined for policy purposes. Whilst the Government may have, or should be encouraged to have, a policy for the Aged it is noted that within the aged population there are a significant number of ex-servicemen who, for a variety of historical and contemporary reasons, are the subject of separate policy objectives and initiatives. Similarly, the Government has adopted specific policies and programs in respect of Aboriginals administered through the Aboriginal Affairs portfolio.

1.34 Attempts to rationalize and integrate a general policy for the Aged with the policies for Veterans and Aboriginals would be fraught with difficulty. It has therefore been decided to exclude Veterans and Aboriginals from the general consideration of programs in relation to Accommodation and Home Care Services for the Aged in this Report.

1.35 A major issue that is attracting increasing attention in Government and the community is the growth in the aged population, both absolutely and as a proportion of the total population. This development may not of itself call for additional public expenditure on health and welfare services, although substantial reallocation to the aged may be appropriate.

CHAPTER 2

THE EMERGENCE OF COMMONWEALTH INVOLVEMENT

2.1 Commonwealth involvement with Accommodation and Home Care Services for the Aged might be seen to have developed in a number of stages. The Committee has identified these stages as follows:

- The 'Voluntary Principle' 1954–62
- Expansion of Institutional Care 1963–69
- Cost Sharing 1969–72
- Public Intervention 1973–75
- New Federalism 1976–81
- Recent Initiatives.

These categories overlap and continue. However, they provide a useful framework for identifying significant policy developments in Accommodation and Home Care Services for the Aged.

The Voluntary Principle 1954–62

2.2 The Commonwealth-State Housing Agreement of 1945 was seen as a response to the shortage of residential accommodation that had arisen during the war. Although proposals were made at the time for the Commonwealth to assume some responsibility for accommodation of pensioners, these tended to become submerged in the wider demands for acceptance by governments of responsibility for improving the general standard of housing accommodation, especially for low income groups.[1]

2.3 The first specific Government policy initiative in respect of housing the aged emerged from the Prime Minister's 1954 election policy speech. Given the Commonwealth's limited responsibility for housing in general, and aged persons welfare in particular, the new policy initiatives were implemented placing reliance on the general appropriation power in the Constitution. The mechanism was, and remains, one of providing grants to religious and charitable organizations towards the capital costs of building homes for the aged.

2.4 According to the then Minister for Social Services, Mr McMahon, the Aged Persons Homes Bill broke new ground in Commonwealth social services for aged people. It was recognised that welfare services, other than rehabilitation and social care work had been left to the churches, the State Governments, voluntary organisations and 'other kindly groups'.[2] But, the Minister said:

> 'We march a little ahead of our times. New conditions demand new policies; new problems demand the breadth of novelty and new solutions. The Commonwealth is anxious to provide leadership in assisting to find a solution of what is a delicate human problem—the care and companionship of aged people'.[3]

It was recognised that churches and other voluntary organisations had done a 'splendid job' in providing care for the aged. They had with 'devotion and unselfishness' given time, energy and thought to the problem of raising funds for building homes for the

aged.[4] The Minister said that 'voluntary organisations are anxious to expand and take on new responsibilities if finance is available'.[5]

2.5 Prior to the introduction of the legislation, more than 50 organisations had applied for assistance under the new scheme. According to the Minister this amounted to 'evidence of a need and that the Commonwealth will be playing a leading part in providing assistance to those who are willing to give their time, money and attention to the aged'.[6] This attitude is still relevant to a large part of Commmonwealth social welfare policy. Government activity has been built around responding to 'expressed need', which may be more accurately described as 'demand'.

2.6 Unfortunately reliance on 'expressed need' may not identify needs in the community which are not articulated by a benevolent organisation. Needs may therefore continue to be unmet. The alternative approach is for Governments to provide facilities and services on the basis of 'assessed need'.[7] The 'assessment of need' for various forms of assistance and care is taken up in Chapter 8 of this Report.

2.7 It is also important to recognise that the Aged Persons Homes Scheme was not seen as a substitute for living at home. The Government placed a great deal of importance on the family unit and encouraging aged people to remain at home.

> 'All of us would like other people to be able to remain contentedly in their own homes, and to have the feeling of independence. The family remains the most important unit in our society . . . The basis of the Commonwealth's social services legislation has been the wish to strengthen the ties of the family and to strengthen its status and independence. It does so recognising that there are many outside factors which lead to weaken these ties and to break up the family as a unit'.[8]

The Aged Persons Homes Scheme was an expression of the Government's concern that many aged people do not have families 'with whom they can enjoy the comforts of life'.[9]

2.8 The *Aged Persons Homes Act 1954* provides an exception amongst Commonwealth legislation in actually setting out the purposes for which funds were to be provided—rather than simply detailing the mechanisms of payment and eligibility requirements. Section 3 of the Act provides that the purpose of Commonwealth assistance is:

> 'to encourage and assist the provision of suitable homes for aged persons, and in particular homes at which aged persons reside in conditions approaching as nearly as possible normal domestic life and, in the case of married people, with proper regard to the companionship of husband and wife.'[10]

This statement reflects the Government's desire to compensate for the ties of the family unit where these were unavailable, so that aged people can live with 'the associations we think of when we think of our home'.[11]

2.9 There was also a clear implication in the Minister's Second Reading Speech that the Scheme was for the needy aged. It was thought that giving money to religous and charitable organisations on a $1 for $1 basis towards the capital cost of housing would be sufficient to ensure that Commonwealth funds were directed towards those in need.[12] That is, there was an assumption that the voluntary organisations were concerned only with the needy. In this instance the needy were specifically identified by the Minister as 'pensioners for whom an increase in the pension would not solve their housing problems'.[13]

2.10 Had Commonwealth interest and involvement remained in accordance with the sentiments expressed in the second reading speech on the Aged Persons Homes Bill, present policy would be relatively straightforward and easy to comprehend. However, from this basis successive governments and administrations have significantly changed

the orientation and implementation of the scheme in response to changing circumstances and pressures brought to bear by interested sections of the community. These changes came about through deliberate policy initiatives or inconspicuous changes in interpretation and administration but few of them involved changes to the Act.[14]

2.11 It also needs to be recognised that the housing characteristics of aged pensioners in 1954 were somewhat different to those pertaining in 1982. The housing situation of the aged in 1954 reflected the general housing shortage that applied after the war and lay at the basis of the 1945 and subsequent Housing Agreements, and a continuous Government policy of encouraging home ownership. The progressive increase in home ownership among the Australian population may have contributed to the fact that the Aged Persons Home Scheme has developed from a means to house the needy aged to a 'rehousing' scheme which benefits the relatively well-off. The operation of founder-donation arrangements would have re-inforced this trend.

2.12 The 'donation' paid by an incoming resident to the organisation to secure accommodation has been a major source of funds for the religious or charitable organisations operating in this field. When accommodation is vacated by the original 'founder donor' some organisations require subsequent occupants to make donations. It is claimed that a 'consequence of this practice was that the Aged Persons Homes Scheme was probably more successful in increasing the supply of appropriate accommodation for the comfortably off aged than in housing the aged poor, who were perhaps more prominent in the minds of those who earlier advocated government assistance for the housing of aged people'.[15]

2.13 The Government's support for, and recognition of, the work of voluntary organisations and its belief in the desirability of providing nursing care in the home, gave rise to the introduction of a subsidy for Home Nursing Organisations.[16] The Home Nursing Subsidy Scheme commenced operation in 1957, to assist in the extension of home nursing activities. The subsidy arose mainly because of the shortage of hospital beds and the consequent need for 'adequate, properly equipped home nursing services'.[17] The Minister stated at the time that each of the 150 district nurses then employed by district nursing associations was saving the provision of six hospital beds —a total of 950 beds.[18] The Minister also said that 'many patients, particularly old people, will be much happier and perhaps much better if they can be nursed at home, and modern medical thought favours this practice'.[19]

2.14 The scheme was built around the provision of existing home nursing organisations with a subsidy equivalent to the salary paid to nursing sisters employed by them over and above the number employed during the year prior to the commencement of the Act. New organisations were to be assisted on the basis of half the salary of each nurse employed in home nursing duties. The other sources of funds for district nursing associations are State government subsidies and collections from the public and patients.

Expansion of Institutional Care: 1963–69

2.15 In 1962 the Government decided that a number of private hospitals were not in fact hospitals for hospital insurance purposes but were actually extended care hospitals—or nursing homes. They were taken out of the hospital insurance system and, from January 1963 became 'approved' to care for patients in receipt of a nursing home benefit of $2 per day.

According to the Minister,

> 'Because many patients in these homes are pensioners and because they very often remain in the homes for very long periods of time, the Government has decided that they should not be obliged to pay an insurance fee to qualify for Commonwealth benefits . . . patients in these

institutions will receive a Commonwealth benefit of £1 per day, which will be deducted from their accounts by the institution.'[20]

In 1968 an additional, supplementary benefit of $3 per day was instituted for patients requiring 'intensive' care.

2.16 It has been suggested that the new benefit 'encouraged a belief among certain investors that nursing homes were low risk, high profit financial ventures'.[21] Certainly, the growth in the number of nursing home beds would bear out this proposition. In the first five years following the introduction of the nursing home benefits scheme, the number of nursing home beds grew by 48 percent. The growth was mainly in the non-government sector and particularly in homes conducted for profit. At 30 June 1965, 22 percent of nursing home beds were administered by State Governments, 27 percent by voluntary non-profit organizations, and 51 percent by private enterprise.[22] By June 1972, the last full year before growth controls were implemented, the shares were State Governments, 17 percent, religious and charitable, 27 percent, and private enterprise, 56 percent.[23]

2.17 It was not only the attractiveness of the nursing home benefit to private operators that stimulated the growth in nursing home beds. According to the Department of Health there was during the 1960s

> 'concerted action by some States to move busloads of people out of their mental institutions and into big boarding houses. They immediately approved these as nursing homes before we got into the act. This added thousands to the nursing home field and nursing home beds had to be found for them . . . Perhaps in the long run it was the right sort of thing to do to get these people suffering from senile dementia out of the large mental institutions and into more community based environments. It was just the way it was done and the sort of accommodation into which they put them that caused concern. These are some of the factors that caused waves of people to go into nursing homes. This is basically because, as we have said here, the Commonwealth is meeting a high proportion of the total cost of operating nursing homes in Australia, which is part of total health care, and the States are meeting very little. The States have a concerted policy of not accepting these liabilities and getting their patients into these institutions'.[24]

The growth in the number of nursing beds since the inception of the scheme, together with ratios to the population in various age categories is set out in Table 2, Appendix III.

2.18 Prior to 1966, institutions subsidised under the *Aged Persons Homes Act 1954* providing care for sick aged people were not eligible for capital subsidy for nursing home beds although a grant could be made for an infirmary or sick bay subject to certain conditions. This constraint was to prevent subsidised homes from developing into nursing homes. However, residents in sick bays and infirmaries became eligible for nursing home benefits in 1963 when the Government amended the *National Health Act 1953* to provide benefits to patients in approved nursing homes.

2.19 In August 1966 the subsidy provisions under the *Aged Persons Homes Act 1954* were extended to the provision of nursing home beds, subject to a limit of half of the total number of residential beds provided by an organisation in any city or town. The object was to give encouragement to the inclusion of nursing accommodation in homes for the aged.[25] The pressure for nursing accommodation arose from the 'ageing' of residents who had entered homes at the inception of the scheme 12 years earlier and the ability of organisations to pay for their care through nursing home benefits.

2.20 In 1969, the Director-General of Social Services reported that further encouragement had been given to organisations to provide additional nursing accommodation. The 'incentive' was to further liberalise the basis on which nursing accommodation could be provided. From January 1969 subsidy became available on the basis of one

nursing home bed for every two residential beds conducted by the organisation in the same State. In addition, different organisations conducting aged persons homes in the same city, town or district were permitted to aggregate their nursing bed entitlement.[26] Furthermore, organizations which wished to concentrate more on nursing accommodation were permitted to arrange to take over the nursing bed entitlement of other organizations which did not wish to enter the field.[27]

2.21 The Department of Social Services actively encouraged the concept of 'continuity of care' or 'total care' in aged persons homes. Noting the effectiveness of the liberalised nursing accommodation policy in improving the balance between self-contained units, hostels and nursing homes for the aged, the Director-General reported in the 1969–70 *Annual Report* that there was 'still a backlog of demand for hostel and nursing accommodation; but the present trend is expected to continue to a point where the aged can receive a continuity of care as their health deteriorates'.[27]

2.22 The ageing of residents in homes for the aged and a reluctance to see their 'inappropriate' admission to nursing care gave rise to the institution of the Personal Care Subsidy under the *Aged Persons Homes Act 1954* for hostel residents aged 80 years and over. The subsidy is available in homes where residents are provided with all meals, and where staff are employed to assist those who need help with bathing, dressing, personal laundry and the cleaning of rooms and those who need help with medication. The purpose of the subsidy was to provide an adequate standard of personal care so that people could continue to live normal lives in hostel accommodation. It was claimed that following the introduction of the subsidy many organisations were placed in a better position to provide supporting services for their frail residents who have been able to remain longer in hostel accommodation before transferring to a nursing home.[28]

2.23 The subsidy was first introduced in 1969 at a rate of $5.00 per week. It was doubled in 1972 in order to increase the incentive to provide hostel accommodation and expand the care provided to infirm residents. The subsidy was increased from $15 per week to $20 per week in October 1980, and to $30 per week with effect from July 1982.

2.24 The changes to allow a greater proportion of capital subsidies under the *Aged Persons Homes Act 1954* to be applied to nursing home accommodation altered the character of the scheme and significantly changed the original purpose of the legislation. Of particular note is that the shift in emphasis to nursing accommodation, like many decisions affecting the operation of the *Aged Persons Homes Act 1954* came about from a policy decision —without an amendment to the Act.

2.25 The Committee is concerned that a major scheme, involving many millions of dollars can change direction to such a significant extent without the Parliament having the opportunity to reconsider and debate proposed initiatives in the same manner as when the legislation was introduced.

Cost Sharing: 1969–72

2.26 In 1969 the Commonwealth announced a series of measures 'directed to the development of a comprehensive programme for the care of the aged, particularly the frail aged in their homes'.[29] In informing the House of the Government's intentions, the Minister for Health stated:

> 'The overall welfare programme towards which the Government is working, has stemmed from the Government's belief, as expressed by the Prime Minister (Mr Gorton) that 'no nation can be great unless it seeks not only materially to progress but also to take care of the weaker within it'. In bringing such a welfare programme into effect we have been seeking to identify who are most in need so that we can provide them with the extra help they may require whether by way of direct financial assistance or by way of services.'[30]

The measures were contained in the *States Grants (Home Care) Act 1969*, the *States Grants (Paramedical Services) Act 1969* and the *States Grants (Nursing Homes) Act 1969*. All proposals involved cost sharing with the States.

2.27 In introducing the States Grants (Home Care) Bill, the then Minister for Social Services, in outlining the proposals for cost sharing said:

> 'The basic reasoning behind this provision stems from the desire to ensure that the recipient State, which will be administering the funds provided by the Commonwealth, will have a due sense of responsibility because its own funds are also involved.[31]

However, it proved to be anomalous that, whereas assistance for care in the home, including cottages, flats or home units, was to be cost shared with the States, the provision of assistance for care in hostels for the aged, in the form of the Personal Care Subsidy, was fully funded by the Commonwealth.

2.28 The *States Grants (Home Care) Act 1969* provided for the provision of housekeeper and home help services, the establishment and development of Senior Citizens' Centres and for the provision of welfare officers operating from those centres. Senior Citizens Centres were seen to be the central points in the community to which 'aged persons can turn not only for activities to relieve their loneliness and for services such as meals, laundry and chiropody but also as a centre for the co-ordination and in some cases the provision of a variety of domiciliary and other support services'. Welfare officers were seen to have the role of co-ordination and the continuing provision of these services and to stimulate and co-ordinate the services produced by other organizations.[32]

2.29 The *States Grants (Paramedical Services) Act 1969* made provision for services, such as chiropody, occupational therapy, physiotherapy and speech therapy. The *States Grants (Nursing Homes) Act 1969* made provision for $5m to be paid over 5 years on a $1 per $1 basis for additional State nursing home beds on the condition that 'the additional beds will be used only for the sick aged of little means in genuine need of nursing home care'. The States were also to help significantly with the problem of ensuring that nursing home beds in State and other institutions are allocated to the best advantage.[33]

2.30 The provision for delivered meals was not introduced as part of the Home Care package. It was a commitment made in the 1969 election. According to the Minister

> 'The introduction of this measure will mark an important expansion of the Government's home care programme, which is designed to provide housekeeping, home nursing and other services to the aged with a view to maintaining them in their own homes if they so desire for as long as possible.[34]

The Minister added that the scheme will 'provide another opportunity for the participation of voluntary organisations and other bodies in the programme of caring for people in need of community support'.[35]

2.31 The Delivered Meals Subsidy is payable to voluntary organisations and local government bodies providing 'Meals on Wheels' services. Assistance is given for meals served at Senior Citizens' Centres. Meals can be prepared at public hospitals but only collected from, not delivered by them. Subsidised meals generally are not available on weekends or public holidays.

2.32 In 1969 the Commonwealth agreed to provide special subsidies to the States for housing elderly people. The States were specifically excluded from the provision of the *Aged Persons Homes Act 1954* (although local government became eligible to receive subsidies in 1967). The *States Grants (Dwellings for Pensioners) Act 1969* provided $25m over a 5 year period to June 1974 for the purpose of providing self-contained

dwelling units at reasonable rentals for single people receiving an age or service pension and who were eligible for Supplementary Assistance.

Direct Intervention: 1973–75

2.33 The rapid growth in the number of nursing home beds which followed the introduction of the nursing home benefits scheme gave rise to a great deal of concern by the Commonwealth Government. Several policy initiatives were introduced to counter the pressure on nursing home accommodation. These were both direct, in the form of controls, and indirect in the form of alternatives. Controls over nursing homes came into effect in January 1973. They were exercised over three areas

- admission to nursing homes.
- growth in nursing home accommodation
- fee arrangements

The controls did not apply to State nursing homes. However, the controls were directed at containing the profits of private nursing homes, which were regarded by some at the time, as being excessive.

2.34 In addition to the formal controls, a benefit was introduced to assist people caring for potential nursing home patients in their home. (This benefit is detailed at Paragraph 2.41) This package of measures involving legislation to amend the *National Health Act 1953* was introduced in October 1972 and came into effect in early 1973.

2.35 The measures were regarded as a 'milestone in the development and extension of public responsibility, particularly at the Commonwealth level for the chronically ill, especially those whose financial circumstances are such that the cash burden of nursing care is often equal to or even greater than their whole income'. The new scheme was based on the fact that approximately 80 per cent of patients in nursing homes throughout Australia were pensioners enrolled in the Pensioner Medical Service.[36]

2.36 *Control over admissions* was to be achieved by the requirement that nursing home proprietors be obliged, as a condition of approval of the nursing home, not to admit new patients without the prior approval of the Commonwealth Department of Health. It was intended that the primary basis of admission would continue to be the certificate produced by the patient's own doctor, but it would need to be endorsed by a medical practitioner employed by the Department of Health. The NH5 and NH10 forms were introduced at this time. The matter of 'unnecessary' admission to nursing homes will be taken up later in this Report.

2.37 *Control over the growth of nursing home beds* was brought about by a requirement that before new nursing home accommodation was approved for the payment of nursing home benefits, the Director General of Social Services (now Director General of Health) had to be satisfied that existing accommodation did not exceed the requirement in a particular locality. Commonwealth-State Co-ordinating Committees were set up in each state to provide advice.

2.38 *Control over fees* was achieved by the imposition of a requirement that, as a condition of registration for payment of benefits, homes could not charge fees in excess of those approved by the Department from time to time. The formula adopted for determining nursing home benefits was that the benefit combined with the statutory patient contribution should not exceed the fee charged for more than about 70 per cent of the nursing home patients in the State.

2.39 It is of interest to note that the balance of nursing home beds between the public and private sector is almost the reverse of that pertaining to hospital beds. Compared to the limited encouragement of State Nursing Home Beds between 1969 to 1974, the

Commonwealth assisted in the rapid expansion and support of hospital beds from 1973 to 1976 under the Hospitals Development program, the Medibank arrangements, and from 1976 under the hospital cost sharing arrangements. The removal of nursing homes from the health insurance arrangements in 1963, the larger proportionate public subsidies available for hospital care and the absence of a requirement for a patient contribution provided different stimuli for the provision of public and private services.

2.40 This is not to underplay the importance of State governments in this sector. In general terms State geriatric hospitals provide for the more acute forms of geriatric care and sponsor research and training in geriatric medicine. The private sector on the other hand, has not had the incentive to provide significant opportunities for research into gerontology and teaching of geriatric medicine.

2.41 The legislation instituting controls over nursing homes also provided that:

> 'if a patient who is over 65 years of age needs such nursing care as would warrant his admission to a nursing home, but it can be provided in the private home of a relative then the relative may receive the new Domicillary Nursing Care Benefit of $14.00 per week.'[37]

At the time of introduction, the *Domiciliary Nursing Care Benefit* (DNCB) was equivalent to 40 per cent of Commonwealth nursing home benefits in N.S.W., Queensland and Tasmania.

2.42 In the 1970–71 and 1971–72 Annual Reports of the Director-General of Social Services reference was made to the shortage of hostel–type accommodation. This shortage was said to be forcing many elderly people who could adequately be looked after in hostel accommodation to enter nursing homes, where the cost of their maintenance was placing 'unnecessary burdens on their families and on the Commonwealth'.[38] The Government response was the introduction of the *Aged Persons Hostels Act 1972* to stimulate the provision of hostel type accommodation for needy aged people.[39] The new scheme was limited to a period of three years, to encourage organisations to move quickly in taking advantage of the benefits the scheme offers.[40]

2.43 An agreement between the Department of Social Security and a recipient organisation stipulated that accommodation under the *Aged Persons Hostels Act 1972* must be allocated without any 'donation' being required and strictly on the basis of need. Particular attention was to be given to:

- the applicant's frailty or medical condition;
- the applicant's existing accommodation situation, with preference to be given to the frail elderly living alone or whose families can no longer care for them; and
- the financial position of the applicant, with preference to be given to pensioners enrolled in the Pensioner Medical Service and in particular, those who cannot afford their present rent.[41]

2.44 From 1972, when the Act came into operation to June 1981, 12,184 units of accommodation had been provided under the Act. No evidence was presented concerning the impact of the hostels scheme on reducing 'unnecessary' admissions to nursing homes.

2.45 In September 1973 the Government moved to provide additional funds under the *States Grants (Home Care) Act 1969* to stimulate the provision of home care services. In his Second Reading Speech, the Minister referred to an editorial in the November 1972 issue of the *Medical Journal of Australia* which stated that 25 per cent of patients in nursing homes had no clinical reason for being there. The Minister said:

> 'Of course there are a number of reasons why this happens, and not the least of the reasons are those associated with certain commercial motives related to the supply of nursing home services. There are other reasons and I have often referred to them; viz the inadequacy and

often total absence of suitable domiciliary services which allow people to remain in their homes.'[42]

The main effect of the amending legislation was to increase the rate of cost sharing from $2 to $1 to $4 for $1 for both home care services and Senior Citizens' Centres.

2.46 In his second Reading Speech on the 1973 Home Care Bill, the Minister also referred to the fragmented arrangements for the organization and delivery of community welfare services. He envisaged the development of an integrated programme of welfare services, complementary to income support and the welfare related aspects of health, education, housing, employment, migration and other social policies. This function was to be the broad aim of the *Australian Assistance Plan.*[43] Some functions were also taken up in the *Community Health Program.*

2.47 The introduction of the Australian Assistance Plan and the Community Health Program (neither of which ever received legislative endorsement), added greatly to the scope of funding community based services for all categories of disadvantaged.

2.48 The Department of Health pointed out in evidence to the Committee[44] that after the Community Health Program was introduced, States which had not previously sought assistance under the welfare officers component of the *States Grants (Home Care) Act 1969* or the *States Grants (Paramedical Services) Act 1969*, which was provided on the basis of cost sharing, had no incentive to do so because of 100 per cent funding of Community Health Services.

2.49 In October 1973, the nexus between residential accommodation and nursing accommodation under the *Aged Persons Homes Act 1954* was broken. This meant that an organisation could seek subsidy for nursing home beds under the *Aged Persons Homes Act 1954* without providing residential accommodation.[45] In 1974 the provisions of the *Aged Persons Homes Act 1954* were extended to disabled persons and the subsidy increased from $2 for $1 to $4 for $1. The title of the Act was changed to the *Aged or Disabled Persons Homes Act.*

2.50 Another decision, announced in October 1973, made it possible for religious and charitable organizations to purchase existing private nursing homes, which were on the market, under the terms of the *Aged and Disabled Persons Homes Act 1954.* The decision was taken because of an apparent surplus of private nursing beds and a belief in the economic merit of transferring existing nursing accommodation from the private profit to the non-profit area. It might be recalled that during this time the Government was engaged in a major confrontation with nursing homes over fees and profitability.

2.51 In April 1975 approval was given for the normal maximum subsidy limits under the *Aged or Disabled Persons Homes Act 1954* to be extended in respect of the approved capital cost of day care facilities. The purpose of this move was to actively encourage aged persons homes to provide physiotherapy and occupational therapy not only for their own residents but also for other aged and disabled persons using the facilities on an outpatients basis.[46] These services are eligible for recurrent subsidy under the *Nursing Homes Assistance Act 1974.*

2.52 The 1973–74 *Annual Report* of the Director General of Social Services referred to the special role that religious and charitable nursing homes fulfil in accommodating a high proportion of the less affluent patients and at the same time providing a high level of nursing care. It was stated that as a result of this special role 'many such homes are operating in financial deficit and the organizations who operate them are therefore reluctant to expand their facility and services'.[47] In response to this position the Government introduced the deficit financing arrangements under the *Nursing Homes Assistance Act 1974.* The then Minister for Social Security (Mr Hayden) in referring the

charitable and benevolent organizations which were to be covered by the arrangements, stated:

> 'Their motivation stems from concern for their fellow man particularly the least affluent members of our society. This concern has resulted in many of the nursing homes incurring a deficit as a result of their operations notwithstanding the frequent generous increases in nursing home benefit rates . . . The Government feels that by providing a means of meeting the losses incurred they will be enccuraged to improve and expand the traditionally high standard of patient care that they provide.'[48]

2.53 The legislation provided that the Government would meet the deficits incurred by religious and charitable organisations, and local government authorities, not only for providing inpatient care but also approved services for visiting patients. These services include nursing, physiotherapy and occupational therapy. The provision of these additional services was seen to represent a major step towards the establishment of complete and integrated services. It was envisaged that the arrangements would enable the aged to be kept in the community as long as possible in the knowledge that the nursing and associated service they need will be available. The extended services under the deficit financing arrangements were to include the cost of transportation of patients to the clinics providing these services.[49]

2.54 Unfortunately, the vision embraced by the legislation did not reckon on the obstacles contained in legislation in some States which prevent nursing homes accepting outpatients. It appeared nonetheless that there was a presumption that the deficit financed homes would provide accommodation and nursing home care for the financially needy. This is in contrast to some evidence received by the Committee and will be taken up later in the Report.

2.55 The provision that the deficit funding arrangements had as their stated purposes providing 'complete and integrated services', *fully funded* by the Commonwealth, amounted to a marked shift away from earlier arrangements, instituted in 1969, for a 'comprehensive programme' of care for the aged based on *cost sharing* arrangements with the States.

2.56 In 1974 the provisions of the *States Grants (Dwellings for Pensioners) Act* 1969 were extended. New legislation provided $30m over a three year period and extended the eligibility to cover single invalid pensioners. A further $10m. was provided in 1977–78. In 1978 this assistance was subsumed under part III of the *Housing Assistance Act* 1978. A new *Housing Assistance Act* came into operation in July 1981.

New Federalism 1976–1981

2.57 The climate of fiscal restraint, which began with the 1975-76 Budget, involved decisions to cut public expenditure in attempts to achieve 'savings' in an effort to reduce the growth of the public sector. The new government, elected in December 1975, had a commitment to a policy of new Federalism, which involved shifting the balance in Commonwealth State responsibilities. It was in this context that a major review of policies and programs was undertaken by the Task Force on Co-ordination in Welfare and Health.[50]

2.58 The terms of reference of the Task Force were reasonably clear and, more importantly, contained a statement of the Government's concern:

> '1. Against the background of the Government's Federalism policy and its concern at the proliferation and overlap of Commonwealth services and programs in the health, welfare and community development fields, the Task Force shall examine and report on—

(a) the identification of particular services and programs, currently being undertaken by the Commonwealth, in the health, welfare and community development fields, which could be better delivered by a State, local government or voluntary agency and the adminstration of which could be transferred to the States;
(b) the possibilities for elimination of individual programs and consolidation into broader based programs . . . ;
(c) the possibility of achieving better co-ordination and avoiding overlap by more specific definitions of programs, eligible projects and eligible organisations, having in mind that co-ordination could be effected at the State and local government level without Commonwealth involvement; and
(d) the continuing machinery which should be established to co-ordinate social policy development at the Commonwealth level.

2.59 The Taskforce concluded that 'the most important functions for the Commonwealth are, as the national government, to establish and watch over national policy in the welfare/health field, to be the source of income maintenance payments, to be a funder of programs adminstered by the States or other bodies and to be an initiator'.[51]

2.60 The Task Force recommended that four new 'Program Grants' be developed in consultation with the States that would involve the bringing together of 26 programs at present operating separately.[52] These grants were to be as follows:

- Community Health and Care Program
- Sheltered Accommodation Program
- Community Assistance Program
- Welfare/Health Services Planning Grants

Whatever the merits of these amalgamation proposals, little ever came of them.

2.61 The Committee recognises that it is very difficult to group together appropriations which, on the face of it, have similar purposes and at the same time rationalize the services financed from those appropriations which are delivered by numerous different government and private agencies each with different objectives, criteria and methods for selecting and providing health and welfare services. Appropriation provisions may reflect vast differences in funding, organization, eligibility and voluntary activity. Further, organisations, whether public or private will not accept rationalization for its own sake —particularly if it makes them worse off —either in funding by changed cost sharing arrangements, or in the organization and delivery of services or in the selection of clients.

2.62 By way of example, it would be very difficult to integrate a scheme which pays benefits to individuals (e.g. the Domiciliary Nursing Care Benefit) with payments to the States (e.g. Home Care Services) without affecting the type and level of service provided. In particular, it would be hard to convince a person in receipt of the DNCB of the advantages of stopping a $21 per week cash payment in the interests of rationalization, in return for a houskeeping service which may or may not be to the value of $21 under a revamped Community Health and Care Program.

2.63 Commonwealth decisions which cut public expenditure on the provision of health and welfare services came about in successive budgets from 1975-76. Schemes were either wound up, handed over to the States, allowed to decline in real terms through non adjustment of benefits for inflation or non approval of new services. Other measures included a return to $2 for $1 funding under the *Aged or Disabled Persons Homes Act 1954* and the *States Grants (Home Care) Act 1969*. By contrast, the Commonwealth has maintained the real value of nursing home benefits.

2.64 Many of the restrictions applying to Commonwealth funded, community-based health and welfare programs were removed progressively from the 1981-82 Budget. The restriction on growth of home nursing organisations was removed in July 1981. At June, 1980 there were 192 organisations, employing 1653 nurses. The total number of visits made in 1979-80 was 5.5 million.[53] The 1982-83 Budget provided for a significant expansion in home care services, an increase in the rate of subsidy for delivered meals to 50c per meal (plus 5c for approved vitamin C supplement) and an increase of 50 per-cent in the Personal Care Subsidy to $30 per week. In 1981, the Commonwealth withdrew from the Community Health Program and from cost sharing hospital operating costs in four states as part of a package involving a shift to general revenue financing of health services.

2.65 In August 1975, funding for projects which had not been approved under the *Aged and Disabled Persons Homes Act 1954* at that time was suspended. The decision was taken because of the rapidly growing demand for financial assistance set against the background of financial restraint. It appeared that a large number of proposals were being made without any real effort to establish whether there was a need for a facility, but rather, on the conviction that people would come forward to take up the accommodation once the buildings were completed. This may have reflected the incentive provided by the $4:$1 subsidy which would have limited the contribution required by the relevant eligible organizations.

2.66 In May 1976, in an attempt to infuse some degree of rationality and priority into the Aged Persons Homes Scheme, a three year funding program was announced.[54] The amount allocated for the program was apportioned between the States taking into account the number of aged persons and accommodation available under other Acts, unsubsidised homes, the bed capacities of private nursing homes, State Housing Authority provisions and supportive services available or planned.

2.67 Details of the three year funding program were announced in September 1976. The Minister said that the main thrust of the three year program was on the provision of nursing accommodation and hostel accommodation for the aged and infirm. Also included was provision for day hospitals and day centres to provide treatment and services for residents of aged persons homes and aged or disabled persons who are living independently in the community. The three year program provided for 4098 nursing and 8033 hostel beds. The *ongoing* recurrent cost incurred in associated benefits was not disclosed.[55]

2.68 In the Statement announcing the three year program, the Minister stated:

> '. . . the government appreciates the need to recognise in policy development that old people or handicapped people often prefer to stay in their own homes among friends and familiar surroundings. The importance of developing adequate domiciliary care programs with support services to assist people who wish to live independently, will be recognised in future Government programs'.[56]

2.69 Since 1976–77 there has been a marked increase in the number of nursing home beds subsidised under the *Aged or Disabled Persons Homes Act 1954*. Up until that time, the proportion of nursing home beds which had been subsidised was 13.6 per cent of total beds approved. Since 1976-77 the proportion has exceeded 50 per cent. (These estimates are derived from Table 2 at Appendix III).

2.70 According to the Department of Social Security, greater priority in recent years has been given to hostel and nursing home construction because of:

(a) the development of equity funded projects for self-contained units;

(b) recognition that people most likely to use self-contained units were not usually in necessitous circumstances;

(c) the existence of a substantial stock of self-contained units partially funded by the Commonwealth; and

(d) the availability of 'pensioner units' from State housing authorities for aged people in need.[57]

2.71 It appears therefore that what started out as a housing scheme for the fit aged, based firmly on welfare criteria, has in effect become a program providing capital subsidies predominantly for nursing home care. This outcome sits uneasily with the Government objectives to limit the growth of nursing homes and work towards improving the balance between institutional and community care in accordance with patient's needs and requirements.

2.72 It does however appear that the controls over nursing home growth instituted in 1973 have had some overall effect in restraining the growth in the number of beds. The annual average growth rate between 1963 and 1972 was 8.1 percent whereas the increase between 1973 and 1981 was just over three percent. However, figures in Table 1 at Appendix III point to an acceleration in the growth rate in recent years. Much of this growth occurred in the religious and charitable sector where beds are approved for capital subsidy under the *Aged or Disabled Persons Homes Act 1954*, as is indicated in Table 3 at Appendix III. Thus, while the Commonwealth has been able to contain growth in the private 'for profit' sector, it has actually been contributing to the growth in the 'non-profit' sector by providing direct capital subsidies. The proportion of beds in the three sectors at 30 June 1981, was Government, 22 percent, religious and charitable, 30 percent and private, 48 percent.

2.73 The upsurge in approvals for nursing home beds under the *Aged and Disabled Persons Homes Act 1954* gave rise to a continued and increased Commonwealth liability for payment of nursing home benefits and subsidies. **The policy objective of fiscal restraint applied to the domiciliary care sector may have been self defeating**. Since 1976 6,800 new nursing home beds have been subsidized under the Act, giving rise to an additional 'ongoing' recurrent subsidy in excess of $80m in 1982-83. This compares with a *total* budget allocation of $77m. for alternative forms of domiciliary care provided in the 1982-83 Budget. (See Appendix II)

2.74 In 1979, changes to the *National Health Act 1953* and the *Health Insurance Act 1973* were made so as to correct an inequitable situation concerning nursing home patients accommodated in hospitals. The current provisions are now that after 60 days of hospitalization, a long-term nursing home type patient will make a contribution to his or her care unless a doctor certifies that he or she continues to require hospital treatment. The rate of contribution varies from State to State and equates with the rate charged in State controlled nursing homes. The maximum patient contribution in any State does not exceed 87.5 per cent of the single rate pension plus Supplementary Assistance.

Recent Initiatives

2.75 The *Housing Assistance Act 1981*, gives legislative authority to the 1981 Commonwealth State Housing Agreement. It replaced a similar agreement entered into for the three year period 1978-81. The aim of the Agreement is to facilitate home ownership for those not able to gain it through the private market and to provide adequate rental housing for those in the community in need of governmental assistance at a price which is within their capacity to pay.[58] The Agreement provides for grants to be earmarked for the provision of rental assistance for pensioners thus subsuming the provisions of the *State Grants (Dwellings for Pensioners) Act 1969*.

2.76 The States are guaranteed funds for rental assistance under Section 8(1) of the *Housing Assistance Act 1981*, which provides for $54 million a year in grants to the States for rental housing assistance to pensioners, aboriginals and other needy groups. The split up of funds between these groups has not been spelt out in the legislation. The then Department of Housing and Construction advised that it can be expected that the distribution which currently exists (i.e. pensioners $32 million, aboriginals $22 million) will continue for the five years of the Agreement. This allocation is part of a guarantee of $200 million a year to States for welfare housing under the Agreement. These provisions replace those under Part III of the *Housing Assistance Act 1978*. The scheme is directed at assisting poor pensioners who have been renting privately.[59]

2.77 Whereas the *States Grants (Dwellings for Pensioners) Act 1969* provided for the construction of self-contained accommodation for single aged pensioners and those who qualify for service pension by reason of age, the 1978 and 1981 welfare housing legislation gives States substantially more flexibility in the way they may use the grant funds. Eligibility for assistance was widened to include married as well as single pensioners and other categories of pensioners apart from the aged. The purposes for which funds are available under the 1981 Agreement are set out in Appendix IV.

2.78 The 1981 Agreement included for the first time a provision for Housing Authorities to provide rental subsidies to needy people renting private housing. Another important feature of the 1981 Agreement is that it provides an avenue for religious and charitable organizations to obtain the same type of assistance for accommodation as is available under the *Aged or Disabled Persons Homes Act 1954*. The extent to which the States are expanding their welfare housing activities in accordance with the provisions of the new agreement will be taken up in Chapter 4.

2.79 According to the then Department of Housing and Construction on the basis of a survey of State Housing Authorities conducted for the Committee, nearly all funds allocated to the States for pensioner housing are spent on the construction of units for the fit aged.[60] The department also pointed out that the ability of pensioners to live 'independently' in the units provided depended on—

- modification to units, or provision of units with easy access
- siting of aged persons accommodation within easy reach of shops, senior citizens, centres, and so on
- the role that caretakers can play in the provision of assistance to aged residents
- provision of home care services by outside agencies

2.80 It is too early to comment on the effect of the provisions of the *Housing Assistance Act 1981*. Nonetheless, the provisions indicate a shift in the balance of responsibility for the provision of the accommodation and care requirements for the needy aged from the Commonwealth to the States. Some of the initiatives being pursued by State Housing Authorities under the new Agreement are taken up in Chapter 4.

2.81 In general terms however, the emergence over the years of policies and programs for Accommodation and Care of the Aged points to a lack of concern with evaluation in relation to the stated purposes of schemes and programs. There is evidence of a lack of attention to considerations of cost-effectiveness and program effectiveness, particularly in relation to the development of strategies for alternative means of providing accommodation and care. These matters are explored in the remainder of this Report.

CHAPTER 3

POLICY ISSUES IN CARE FOR THE AGED

3.1 Some issues in care of the aged have only recently come to the fore in Australia while other perspectives in the current debate are longstanding themes. The adherence by different interest groups to predominantly health perspectives or welfare perspectives is reflected in evidence given to the Committee.

3.2 A central issue in current policy discussions is the development of community care, combining formal support services and informal systems, as an alternative to institutional care. However, the relationship between the formal services and informal support has not been made fully explicit in policy.

3.3 A major impetus to restructuring programs for care of the aged is the future growth of the aged population and especially the implications of substantial increases in the number of people aged 75 years and over. The lack of information on needs of the aged and lack of analysis of the effectiveness of different types of assistance is a major factor limiting policy development at present.

Perspectives on Dependency and Assistance

3.4 The Committee on Care of the Aged and Infirm stated that 'basic reason for Government involvement in the care of the aged and infirm is to assist those unable to fend for themselves'.[1] This view has been endorsed in recent statements of the Minister of Social Security (Senator Chaney), who has stressed the priority of meeting 'the pressing needs of that minority of older Australians who are homeless and destitute, and who, as such, live well below any standard that is acceptable to us as a civilized and responsible society'.[2]

3.5 The focus of this Inquiry is on physical and mental dependency, which relates to physical, social and psychological incapacity within the context of current Social Security policy on income support for the aged, and other forms of assistance.

3.6 Policies to assist the *dependent* aged combine both 'categorical' and 'generic' appproaches to policy development. In the former approach, the dependent aged are categorised on the basis of characteristics associated with the increased likelihood of disabilities associated with processes of ageing. This approach favours the development of administrative units that relate to client groups, for example, veterans or migrants.

3.7 In the 'generic' approach, the special nature of the problems of the aged and strategies to overcome them are seen in relation to more general policies addressing different areas of social concerns. The Dwellings for Pensioners provisions within general housing agreements, and the Pensioner Medical Service as part of the health care system, are example of this approach. The nature of assistance that the aged require from health and welfare services is special in that it will often be more prolonged, draw on a wider range of services and be delivered in more than one setting. The term 'Extended Care' has been used to describe this extension in time, space and scope of care for the aged.

3.8 In order to develop appropriate policies for the dependent elderly it is essential to identify the target groups to whom assistance measures are to apply and to distinguish

between different needs within the total aged population. Policy measures directed to the dependent aged are not based on a view of all aged people as dependent, but on a recognition of the loss of independence which brings some aged people within the scope of policy attention. Insofar as the broad aim of policy is to maintain the independence of the aged, it is the independent aged and not the dependent aged who provide models to this end.

3.9 In its evidence the Department of Health emphasized that most aged persons do not have significant functional impairments. The great majority of the aged remain relatively independent. While some decline in the physical and mental well-being of many aged people can be expected, it is argued that most of the problems of the aged are amenable to relief. Most aged persons prefer to live in their own homes and this is a good reason for providing support services to help them stay there.[3] It is also recognised that a great many aged people reach the end of their life without first entering a state of prolonged ill health. Policies for Extended Care are, by definition, concerned with the minority who do experience these problems.

3.10 A number of Government agencies and professional organisations concentrated on issues of health problems in their submissions. Responses to these problems are generally framed in a *health* perspective, with *assessment* and *treatment* as central elements in reducing dependency. The Department of Health summarized this approach, proposing that 'there is general consensus that the predominant element in any framework of service to aged persons is assessment. The primary aim of assessment is to match patients to the level of care which is most appropriate to their degree of dependency and to ensure that patients entering facilities catering for high levels of dependencies need the level of care provided.[4]

3.11 Many community groups and voluntary ogranisations adopted a more welfare oriented view in their submissions to the Committee, making statements of principles which guide their activities. The Australian Council on the Ageing presented this view to the Committee, stating that:

> 'A national policy on care of the ageing should be developed, within which there should be provision of care of the elderly in *'any kind' of setting*, the right to high quality care and the right of the elderly to decision-making in regard to their own care. The national policy on care of the ageing should be built on the fact that the aged are vital, dynamic persons.'[5]

3.12 The response to dependency associated with ageing advocated by several of these groups is based more on a *welfare* perspective. Here assistance, either in cash or kind, is provided with the aim of *avoiding* or *alleviating* hardship that might arise in situations of dependency. In particular, more attention was given to housing problems of low income aged people and the role of informal sources of support and community groups were more often raised.

3.13 A broad welfare view is also seen in government policies. The Government's expressed welfare objective is to protect people from economic hardships that might arise as a result of insufficiency of income in old age.[6] Present government policy is that assistance should be concentrated on those who need it most.[7]

3.14 Some of the confusion in respect of policy for accommodation and care for the aged arises from conflicts between the health and welfare perspectives. Whilst community care is commonly associated with the welfare concept, it is pertinent to note that community care and institutional care have common origins in the 'indoor' and 'outdoor' relief offered by the benevolent institutions of the last century. Modern practices in community care have developed overseas largely as an adjunct to geriatric medicine, and in Australia practitioners in geriatric services have been leading advocates of team approaches to care of the aged.

3.15 Geriatric medicine has also been the source of much criticism of custodial institutional care and has sought to advance rehabilitation. While shortcomings are recognised in medical perspectives applied to care of the aged, change is more likely to be achieved by an integration of acute care and extended care than by the development of separate systems of care. Many of the needs for long term care for the aged result from the residual disabilities of acute health problems. Changes in care requirement often arise when acute episodes are superimposed on chronic conditions.

Community Care

3.16 The Committee is aware 'community care' has a variety of meanings. A useful distinction can be made between care in the community and care by the community.[8] In the former view, policy measures involve giving public support to develop services in a variety of community settings. In the latter view, the responsibility for care shifts from public authorities to informal support and voluntary sector activity. Some policy analysts have argued that an ideology of voluntarism and self-help is associated with moves for greater privatisation of welfare services and to reduced dependence on the State.[9]

3.17 While recent government statements have reiterated the need for self-reliance and family inter-dependence, the voluntary principle is longstanding. On introducing the Aged Persons's Home Bill in 1954, the Minister for Social Services (Mr McMahon) said that 'the Commonwealth will be playing a leading part in providing assistance to those who are willing to give their time, money and attention to the aged'.[10]

3.18 A major factor in the development of policy for community care is the relationship between formal support services and informal care. While information in this area is incomplete, data that are available point to two main problem areas.

3.19 The first problem relates to the extent and strength of support that family and friends already give to the elderly. One study of the aged associated with the Commission of Inquiry into Poverty found that these informal sources were the main source of support for the elderly.[11] A number of other studies have since reported similar findings, with a detailed account being given in a report from the Ageing and Family Project of the Australian National University.[12]

3.20 In a large scale survey undertaken by the Ageing and Family Project information was sought on help with domestic and household tasks. Responses from handicapped and non-handicapped elderly are detailed in Table 3.1. The results of this study show that informal support from family, friends and neighbours is the overwhelming source of assistance. Formal services from Government and voluntary agencies were mentioned by less than three per cent, while privately purchased assistance was common for household repairs. Preliminary findings of the study, 'The Aged at Home',[13] being carried out by the Australian Council on the Ageing and the Department of Social Security, presents a similar picture of the extent of family and informal support and the very limited use made of formal services.

3.21 Different strategies are needed for community services intended as supplements to available family care, and those which are required to provide a substitute in the absence of family care. The presence of family support significantly reduces the likelihood of admission to an institution. An indicator of this effect is seen in the marital status of nursing home patients compared to the total aged population. Figures in Table 3.2 show the widowed and never married to be over-represented in the patient population. The option of community care based on family support is limited for these people.

Table 3.1: Persons Completing Common Household Tasks in the Households or Handicapped and Non-Handicapped Respondents

	Shopping		*Meals*		*Housework*		*Minor repairs*	
	Handi-capped	*Not handi-capped*	*Handi-capped*	*Not handi-capped*	*Handi-capped*	*Not handi-capped*	*Handi-capped*	*Not handi-capped*
	%	%	%	%	%	%	%	%
Self	17	58	41	65	27	62	10	43
Spouse	18	16	16	22	6	21	14	17
Self and spouse	4	16	2	5	15	7	1	1
Informal	58	11	31	6	39	8	62	26
Formal	2	..	10	1	9	1	1	..
Private	..	..	..	..	4	2	7	7
Other	..	..	..	..	..	..	7	4
(n)	(141)	(908)	(142)	(907)	(142)	(903)	(133)	(888)

Source: Survey data from A.N.U. Ageing and the Family Project, reported in D. M. Gibson and D. T. Rowland, Special Needs in Health Care The Aged and Handicapped, A.N.U. Public Affairs Conference on Health Policy, July, 1982.

Table 3.2: Comparison of marital status of nursing home patients and aged population

	Nursing home patients			*Population 65+ (Victoria 1976)*		
Marital status	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*
	%	%	%	%	%	%
Married	36.7	11.1	16.8	71.5	34.9	49.9
Widowed	38.5	69.3	62.4	16.9	51.3	37.2
Divorced/separated	5.6	1.4	2.4	3.7	2.8	3.2
Single	19.2	18.2	18.4	7.9	11.0	9.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Source: A. L. Howe, *Report of a Survey of Nursing Homes in Melbourne*, Department of Geography Monash University, Working Paper No. 10, October 1980, p.53.

3.22 Demographic and social factors both affect the availability of family support. Among the generation now aged 70-80 years (born between 1902 and 1912), relatively higher proportions are single or childless due to the effect of the Depression on marriage rates and childbearing. The group in the over 80 years age range in the next decade will thus have a reduced availablity of family support.

3.23 Changing female participation in the workforce is commonly seen to have an effect on the availability of carers. Generalised comparison between the small and selective group of women as carers and the much larger female workforce are however not particularly informative for policy development. By way of illustration, the number of women aged 30-60 years in the workforce at the 1976 census was 1,117,883 compared to a total population of 211,632 aged 80 years and over. If carers for 20 per cent of the aged group are to be drawn from the workforce group, only four per cent of working women would be affected. This estimate is reduced by the extent to which less than 20 per cent of the aged might need such care and by the number of those carers who are women not in the workforce, such as elderly wives or non-working middle-aged and younger women as well as those who combine caring and workforce roles. A different approach is required depending on whether assistance is to be seen as a reward for those who already provide care or whether it is intended as an incentive to others to take on such responsibilities.

3.24 Research findings and evidence indicate that community care at present relies on a major input of informal support and a minor contribution of formal services. If community care is to be developed as an effective alternative to institutional care, there needs to be a clearer recognition of differences within the aged population which affect the likelihood of admission to a nursing home. In some cases, community services can supplement available family care but in other cases where family support is limited, it is necessary to provide a substitute for informal support.

3.25 A prime impetus for developing community care stems from the imminent growth of the aged population and the implication of this growth if the present balance of institutional and community care remains unchanged.

3.26 Figures on past and projected aged population are given in Table 3.3. The total aged population increased by almost 90 per cent from 1964 to 1980 and is projected to increase by 66 per cent in the next 20 years. Of particular importance in considering policy for the welfare of aged people is the growth in the number of 'old old' people, those aged 75 years and over. In the 27 years from 1954 to 1981 the number in this group has increased from 232,200 to 497,700, an increase of 114 per cent. In the next 20 years a similar percentage increase will occur, bringing the number in the 'old old' population to 1,071,500.[14]

Table 3.3 Growth of Aged Population, 1954 to 2001

	Pop. aged 65+	*Pop. aged 75+*
	('000)	('000)
1954	746.0	232.2
1961	894.2	295.4
1966	986.4	327.1
1971	1 091.1	397.8
1976	1 236.1	439.8
1980	1 401.5	497.7
Projected		
1986	1 656.8	627.4
1991	1 925.2	764.7
1996	2 166.2	898.0
2001	2 338.7	1 071.5

Source: A.B.S., *Australia's Aged Population*, 1982.

3.27 While some 10 per cent of the total population is now aged, the concentration of aged population varies considerably from one locality to another. In older established suburbs of capital cities and in some coastal retirement areas, the proportion aged is as high as 15 to 20 per cent. The proportion aged in inner city areas is similar to the national average but the diversity of population structure here means that the aged may be competing with other groups for community resources.

3.28 The aged are a lower proportion of the population of outer suburban areas but absolute numbers in these areas are significant. Many rural areas are ageing, with local movement to larger towns apparent in some cases. As future increases in aged population will have more impact in some communities than others, there is a need for the service delivery system to be sufficiently flexible to meet varying local and regional needs.

3.29 It was suggested to the Committee on many occasions that the expected growth in the older age population will inevitably lead to greater pressure for increased services, with a consequent expansion in public expenditure. Since resources are limited there is

an urgent need to obtain a greater understanding of the issues associated with the care of the aged so that policies may be developed to guide a more effective use of funds.

Research and Policy Development

3.30 Despite the considerable expenditure on aged care and accommodation programs in the last 20 years there has been very little monitoring or evaluation of the effectiveness of outcomes. Applied research into community care was stimulated by the Community Health Program which incorporated specific provisions for evaluation in service development. Almost $740m is expected to be spent on nursing home benefits in 1982-83 with little provision for evaluation. The 'onus of proof' of effectiveness before receiving funding is imposed far more heavily on community care services.

3.31 The first inquiry objective of this Committee was to establish the scope of evaluation made of programs in home care and accommodation, and to review the evidence that existed for changing the balance of care. Most evaluations reported in submissions to the Committee were of a simple descriptive type and restricted to specific areas or services. Little evidence was presented from comparative evaluation studies, although some results were available from projects carried out under grants from the Health Service Research and Development Scheme. Although the National Health and Medical Research Council produced a document, *Health Problems of the Ageing in Australia*, in 1976,[15] there has been little support from that source for research into geriatric medicine and care of the aged.

3.32 Monitoring of activities might be expected of agencies receiving support from Commonwealth programs and by Commonwealth Departments themselves but this generally appears not to be the case. In some cases, programs have run for extended periods without any monitoring. Changes have been made on an *ad hoc* basis rather than on the basis of any sound evaluation. Pilot projects to assess the effects of changes are seldom used.

3.33 A number of comments have been made about the failure of government departments to use the information they collect in routine returns for evaluation purposes, and their reluctance to make such information available to others for research purposes. It is difficult to gain an overall view of what has been going on under different programs or where the money went to, let alone the effectiveness of expenditure channelled to any one agency for one service compared with another agency for another service.

3.34 Realisation of the need for better information on the nature and extent of the actual needs of the aged and the effectiveness of different responses to these needs has prompted a number of research projects in recent years. Commonwealth sponsored studies, inquiries and surveys dealing with social conditions and services of the aged are now under way in several areas and should define present needs and estimate likely trends in some future needs. These studies include:

- 'Survey of Older People at Home'—Australian Council on the Ageing and the Department of Social Security.
- 'Ageing and the Family' Project—Australian National University;
- 'Retirement Study'—National Research Institute on Gerontology and Geriatric Medicine and the Institute of Applied Economic and Social Research, University of Melbourne;
- Projects funded under Health Service Research and Development Grants—9 projects detailed by the Department of Health;[16]
- Study of Family Network—Institute of Family Studies;
- 'Care of the Aged'—Report on the Relations between Governments in Australia. Advisory Council for Inter-government Relations;

- An internal Committee of Review of aged persons welfare programs chaired by Mr John Hodges, M.P.
- The Senate Committee on Private Hospitals and Nursing Homes.

3.35 The Committee is concerned that future programs and policy development should be accompanied by the development of an adequate information base. It recognises that information will not automatically provide solutions but agrees with the comment made in evidence that:

> 'I do not see how people can formulate policy without information, so it is not a question of the problem solving itself if you have information. The policy makers have to solve the problem, but they are in no position to do so without the information.[17]

CHAPTER 4

HOUSING FOR THE AGED

4.1 Several Commonwealth programs for the aged include a housing component, with varying combinations of other care services. Independent housing with no other services is provided for low income aged pensioners under the *Housing Assistance Act 1981*; Supplementary Assistance, available under the *Social Services Act 1947*, is another form of housing assistance paid to low income pensioners renting accommodation in the private sector. Independent living units, and more so hostels, provided under the *Aged or Disabled Persons Homes Act 1954* and *Aged or Disabled Persons Hostels Act 1972*, combine housing with varying levels of support services.

4.2 While nursing homes do provide accommodation for aged people, the Committee considers that they should be properly regarded as health facilities providing care in an institutional setting. They are not therefore discussed in this Chapter. Capital funding for nursing homes has, however, come to absorb a large proportion of funds provided under the *Aged or Disabled Person's Homes Act 1954*.

Housing Characteristics of Aged Persons

4.3 The submission to the Committee prepared by the former Department of Housing and Construction (DHC) gives a useful background picture of the housing situation of the aged.[1] The Evidence tends to suggest that the majority of older Australians are in a generally favourable housing situation. However, the DHC Submission highlights the disadvantaged position of some groups, notably aged renters.[2] Unsuitable housing of some aged homeowners and the need to increase opportunities for them to adjust their housing, using their own resources, is also apparent. Given satisfactory accommodation, support services are able to maintain at home those elderly who have need for care.

4.4 While a variety of other forms of sheltered housing, combining some level of support with accommodation is required, the demand for such provision will depend on the initial housing situation of the aged. The Committee believes that movement from the aged person's own home often, of itself, engenders progression to higher levels of care. While a range of options is needed, the Committee is concerned that the forms in which care and accommodation are combined should not foster unnecessary movement.

4.5 Evidence from the former Department of Housing and Construction gives a summary of the housing characteristics of the aged population in terms of housing type and tenure, household composition and differences in occupancy patterns over the age range.[3] This is shown in Table 4.1.

4.6 The *Aged Persons Housing Survey, 1974* estimated that the majority of aged persons (79 per cent) who were living in private dwellings were in a detached house. The next most common form of private dwelling (11 per cent) was a low rise flat.[4]

4.7 Although the information in Table 4.1 indicates that 10.1 per cent of the aged population at the census were living in non-private dwellings there are difficulties in accurately describing and classifying the different types of non-private dwellings. The numbers in each category, such as nursing home, home for the aged should be regarded as indicative only.[5]

Table 4.1: Housing Type and Tenure for Individuals Aged 65 Years and Over, June 1976

Dwelling type	*Numbers*	*Percentage*
	('000)	
Private Dwellings (*a*)		
Home Owners	754.9	62.4
Home Buyers	86.0	7.1
Public Tenants	50.8	4.2
Private Tenants	103.2	8.6
Other tenure arrangements	92.3	7.6
Total:	**1 087.2**	**89.9**
Non-Private Dwellings		
Nursing Home	42.3	3.5
Hospital	26.8	2.2
Home for the Aged	20.5	1.7
Boarding House	5.3	0.5
Other	26.9	2.2
Total:	121.8	10.1
TOTAL:	**1 209.0**	**100.0**

(*a*) The census definition of private dwellings includes all houses, flats, home units etc., whether they are owned by individuals, business enterprises or governments.
Source: Estimates by DHC based on 1976 Census.

4.8 The composition of households in private dwellings where the head is aged 65 years and over is shown in Table 4.2.

Table 4.2: Composition of Households with Head Aged 65 Years and Over, June 1976

Composition	*Number*	*Percentage*
	('000)	
Head living alone	311.0	44.7
Head and spouse	262.0	37.6
Head and other adults	61.5	8.8
Head, spouse and other adults	50.6	7.3
Head, spouse and children	5.1	0.7
Head, spouse, other adults and children	3.3	0.5
Head, and children	2.1	0.3
Head, other adults and children	0.8	0.1
Total Households	**696.4**	**100.0**
Total population in private dwellings (From Table 4.1)	1 087.2	

Source: 1976 Census.

4.9 It should be noted that these are only households which have an aged person as the head. Information on the composition of other households which have a head aged less than 65 years and where an aged person is present is not available from census data. However, if it is assumed that the spouses of the aged household heads in the above table are themselves aged then the figures relate to the family composition of roughly 90 per cent of all aged persons living in private dwellings.[6]

4.10 Table 4.2 also indicates that approximately 40 per cent of all aged persons in private dwellings are living by themselves. The requirements of these persons for support services and for various forms of housing assistance may be greater than for other aged persons. It must be assumed that most are coping.

4.11 The household composition of aged persons differs also according to tenure. The *Aged Persons Housing Survey* showed that homeowners were much more likely to be living with a spouse than renters or boarders. Data in Table 4.3 show that nearly two-thirds of home owners were living with their spouse, while the figure was about 40 per cent for those who were renting and about 15 per cent for boarders.

Table 4.3: Marital Status and Tenure of Aged Persons, 1974

	Tenure			
Marital status	*Owner/Buyer*	*Renter*	*Boarder/ Lodger*	*Total*
Married	484 000	66 800	17 600	568 400
Not Now Married	305 000	90 100	111 000	506 100
Total	**789 000**	**156 900**	**128 600**	**1 074 500**

Source: Aged Persons Housing Survey, 1974.

4.12 It is anticipated that the Family Survey to be conducted by the Australian Bureau of Statistics and the study by the Australian National University of Ageing and the Family will provide more recent information on housing arrangements, household composition and family relationships of aged persons. The Department of Social Security and the Australian Council on the Ageing study 'Older People at Home' will also yield information in this area.

4.13 Cross-sectional data show differences in both tenure and household composition across the age range from 65 years to 95 years. These data give some indication of changes likely to occur on a longitudinal basis but considering that a 30 year time span is involved, differences in housing conditions between generations must be taken into account as well as adjustments due to ageing. The housing changes made by people in the 'young' old group will reflect their more satisfactory initial housing and the range of options available. The movement from private to non-private dwellings as people age can be illustrated by census figures showing the proportion of people in five yearly age groups who are living in the different kinds of dwellings. This information is contained in Table 4.4.

4.14 The proportion of aged persons in nursing homes and other non-private dwellings increases slowly from around five per cent of those aged 65-69 years to about 10 per cent at age 80-85 years and then expands to almost 60 per cent at age 95. While the latter proportions are high, the absolute numbers involved are small, with only 1.5 per cent of the total population aged 80 years and over at the 1976 Census. Future increases in this advanced age group however will have a considerable impact on provision if present patterns continue.

4.15 Changes in the composition of households occur as people age. This information is set out in Table 4.5.

Table 4.4: Housing Type and Tenure
('000)

Age	*Private dwellings*				*Non-private dwellings*									*Total all persons*
	Home owner	*Renter*	*Other*	*Total private*	*Acute hospital*	*Nursing home*	*Mental hospital*	*Homes for the aged*	*Hotel/ motel*	*Caravan park*	*Boarding house*	*Other*	*Total*	
65–69	346	60	19	424	5	4	1	2	4	5	2	3	25	449
70–74	242	44	17	303	5	5	1	3	2	2	1	2	22	326
75–79	148	29	21	198	6	9	1	5	1	1	1	1	24	223
80–84	72	15	18	106	5	10	1	5	..	..	1	..	24	129
85–89	27	5	11	43	4	9	..	4	..	..	..	..	18	61
90–94	5	1	4	10	2	4	..	1	..	..	..	..	7	17
95+	1	..	1	2	..	1	..	..	..	..	..	..	2	4
Total	**841**	**154**	**93**	**1 087**	**27**	**42**	**4**	**21**	**8**	**8**	**5**	**7**	**122**	**1 209**

Source: 1976 Census and DHC.

Table 4.5: Household composition of aged household heads over five-year age groups, June 1976

Household composition / *Age group*		*Head and spouse*	*Head only*	*Head and other adult(s)*	*Other persons*	*Total*
65–69	No.	116 680	93 337	18 680	35 261	263 958
	%	44.2	35.4	7.1	13.3	100.0
70–74	No.	79 814	86 422	15 130	16 061	197 427
	%	40.4	43.8	7.7	8.1	100.0
75–79	No.	42 665	69 880	12 839	6 973	132 357
	%	32.2	52.8	9.7	5.3	100.0
80–84	No.	16 971	41 518	8 917	2 510	69 916
	%	24.3	59.4	12.7	3.6	100.0
85–89	No.	5 130	16 157	4 485	932	26 704
	%	19.2	60.5	16.8	3.5	100.0
90–94	No.	757	3 171	1 273	133	5 334
	%	14.2	59.4	23.9	2.5	100.0
95+	No.	97	487	218	25	822
	%	11.8	59.2	26.5	2.4	100.0

Source: Department of Housing and Construction.

4.16 It is apparent that the most common arrangement on the death of a spouse is for the survivor to live alone. However the data also show that there is a steady rise, with increased age, in the proportion of aged household heads who share a household with another person (other than their spouse); about 20 per cent of those aged 65 to 70 years are in such households, but over 90, the figure rises to 30 per cent.

4.17 Another account of changes in accommodation and support services over the age range is apparent in an analysis of place of death of persons aged 50 years and over. Most aged people do *not* move through progressive levels of supportive accommodation, but rather, will either end their life at home or in an acute hospital. It is not until age 85 years that the likelihood of dying in a nursing home exceeds that of dying at home.[7] Table 4.6 provides information on places of death by age.

Table 46: Place of Death by Age, Victoria, 1980
(Per cent)

Age group years	*Place of death*									
	Domestic home	*Nursing home*	*Geriatric hospital*	*Metrop. public hospital*	*Metrop. private hospital*	*Rural base hospital*	*Rural other hospital*	*Other inst. N.P.**	*Other loc.*	*Total all places*
50–64	28.5	1.9	1.1	37.0	10.4	7.0	6.7	1.9	5.6	15.1
65–74	29.4	5.2	2.2	32.4	9.6	6.0	10.7	2.7	1.6	23.7
75–84	25.4	13.6	4.2	23.1	11.1	8.1	10.6	2.5	1.4	36.7
85+	22.3	31.8	7.3	14.1	7.7	5.5	9.5	1.8	0	24.5
Total all ages:	**26.7**	**11.9**	**3.5**	**27.1**	**9.9**	**6.8**	**9.6**	**2.3**	**2.1**	**100.0**

(*) Other institutions or non-private dwellings, e.g. psychiatric hospitals, hostels.
Source: A. L. Howe, Beginning at the End; Patterns of Death Among the Aged, Community Health Studies (1982):

4.18 The picture of aged person's housing indicates that aged renters and homeowners face different types of problems and have different resources with which to meet their changing housing needs. Different kinds of assistance are needed to overcome problems

of costs and suitability of accommodation and need for support with increasing dependency.

4.19 Because of major differences between the high level of home ownership in Australia and other countries, it is difficult to make international comparisons about provision of different types of accommodation. With the emergence of new forms of aged person's housing in recent years, it is likely that the housing of those now aged, say, 65-75 years will not in future follow exactly the pattern of those now 85-95 years. Increased home-ownership of the post war generation means that more of the aged population have some housing asset. Changing preferences and needs and a different range of accommodation and support services will to some extent change the accommodation choices of the aged in the future.

Housing Costs

4.20 For many aged persons housing costs are a significant proportion of total household outlays.[8] For aged persons who are on low incomes high housing costs can be of special concern and could result in:

- housing which is of low physical standard, badly located in relation to community services and transport; and
- a balance of income, after paying housing costs, which is inadequate for other essential outlays such as food, clothing, electricity and transport.[9]

4.21 The majority of aged persons are owner-occupiers and despite having a valuable asset in the form of their home, some may encounter financial difficulties if their only income is the Age Pension. Those aged people who were still buying a house were found by the Poverty Inquiry to be one of two groups suffering from high housing costs—the other group being private renters. Recent housing policy initiatives have not benefitted these people.

4.22 Lack of income and the reduced ability to undertake repairs means that many aged owner-occupiers are living in dwellings which are in a poor state of repair. Although this can result in their having a low standard of housing, aged persons have shown a high level of tolerance for poor housing conditions in their own home.[10]

4.23 The *Aged Persons Housing Survey* also collected detailed information on the physical aspects of dwellings. Some of the features of the housing standards of aged persons at that time were:

- 11 per cent lived in dwellings which were independently assessed as unsatisfactory and three per cent lived in dwellings which were beyond repair;
- unsatisfactory dwellings were more likely to be outside capital cities;
- twice as many of the single aged were in substandard accommodation as couples (14 per cent compared with seven per cent);
- housing standards varied according to tenure: 10 per cent of owner/buyers had unsatisfactory dwellings, the figure for renters was 16 per cent and boarder/lodgers 11 per cent;
- non-pensioners were less likely to be in unsatisfactory accommodation than pensioners;
- while an objective assessment found that 11 per cent of dwellings were substandard, only three per cent of all aged persons admitted to living in an unsatisfactory dwelling.[11]

4.24 The survey found that 52.2 per cent of aged people expressed no dislike for their dwelling or area, 34.6 per cent had some dislike but did not want to move; only 13.2 per cent were dissatisfied and wanted to move. Of the last group, one third wanted to relocate within their own immediate neighbourhood.[12] These figures indicate that many

aged people might benefit from assistance with home repairs and maintenance and that motivation to move might also be reduced. However, since only three per cent were concerned about the standard of their homes, such assistance is on the face of it, of low priority to aged people themselves.

4.25 Owner-occupiers who have paid off their homes have relatively small costs compared with other tenure groups. Costs of rates, insurance, repairs and maintenance for this group were obtained in the 1976 ABS *Household Expenditure Survey*. The average outlay of $8.11 was approximately 12 per cent of the average income of aged home owners of $65.26 at that time.[13]

4.26 Aged owner occupiers who are still making mortgage payments on their dwelling may have high housing costs in relation to their income. The 1976 census showed that the average weekly mortgage repayment of $13.68 amounted to 18.6 per cent of the average income of $73.48 for those aged persons still purchasing their home. When the estimated costs of rates, insurance and repairs and maintenance are also included, average housing costs could have amounted to nearly 30 per cent of income.[14]

4.27 Aged tenants renting from State Housing Authorities had the lowest income of any tenure group in private dwellings, $47.34. However, rents were also low, being generally less than 20 per cent of income.[15]

4.28 The average weekly rent for private tenants at the time of the 1976 census was $20.45. This amounted to 35.3 per cent of the average income of $58.00 of this group. Over a quarter of aged private tenants were paying more than half of their total income on rent at the 1976 census.[16] Further data are given in Table 4.7.

Table 4.7: Rent as a proportion of income in respect of privately renting household heads aged 65 years and over are as follows:

Rent as a proportion of income (percent)	*Percentage of household heads*
20 or less	31.1
20.1-25	4.4
25.1-30	16.7
30.1-40	5.5
40.1-50	16.1
50.1 or more	26.2
Total	**100.0**

Sources: 1976 Census.

4.29 No comprehensive data is available on rents or 'maintenance costs' paid by those occupying subsidised housing provided under the *Aged or Disabled Persons Homes Act 1954*. From evidence given by organisations operating subsidised retirement villages, these costs appear to be quite variable. Although allowance should be made for the cost of any in-going donation, it appears that rents are in some cases lower than those paid by aged tenants in State Housing Authority dwellings.[17]

4.30 For many aged persons, particularly private renters, their income, after housing costs, which is available to meet other basic needs of food, clothing, transport, electricity and gas will be small. According to the Society of St. Vincent de Paul:

> 'One of the regular concerns of our parochial branches is the financial difficulties of aged people. They are faced with the commitment to pay their electricity bills or their rates—not so much their rent, that seems to be the thing they have to pay first and foremost. Then we are faced with the problem of helping them on a regular basis with all their other financial

problems. When you analyse the difficulties and discuss the matter with them, it becomes evident that their difficulties stem from a rent increase. The problems are accentuated when one partner of an old couple living in rented premises dies and it then becomes impossible for one person to cope."[18]

4.31 All the indications are that single aged people receiving a pension have to commit a high proportion of their pension and supplementary assistance to rent a dwelling. A comparision between pension levels and rents for different dwelling types is available as at August 1980 and is set out in Table 4.8. As the aged, due to low relative income, are likely to look for dwellings at less than average market rental, rental costs are also shown for dwellings in the cheapest 20 per cent of the market as well as for dwellings of average market rent.[19]

Table 4.8: Rent as a proportion of income for dwellings of average rent and dwellings in cheapest 20 per cent of market, all capital cities, August 1980

Type of accommodation		*Single pensioner (pension plus supplementary assistance)*	*Pensioner couple (pension plus supplementary assistance)*	*Full-time employee (average weekly earnings $268.60)*
		%	%	%
Average Rent	1 Bedroom Flat	64.5	40.1	15.2
	2 Bedroom House	76.1	47.4	17.9
	2 Bedroom Flat	88.0	54.7	20.7
Cheapest 20%	1 Bedroom Flat	48.6	30.3	11.4
	2 Bedroom House	54.1	33.7	12.7
	2 Bedroom Flat	65.5	40.8	15.4

Source: ABS, August 1980 Survey of Housing Occupancy and Costs.

Assistance with Low Cost Housing

4.32 Access to accommodation provided under the States Grants *(Dwellings for Pensioners) Act 1969* and *1974* and Part III of the *Housing Assistance Act, 1981* is limited to pensioners. Units provided under the *Aged or Disabled Persons Homes Act 1954* are not restricted to pensioner occupants although there seemed to be an understanding when the scheme was introduced that age pensioners would be the main beneficiaries.

4.33 Eligibility for pensioner housing is generally determined on the basis of a means test. Although these tests vary between the State housing authorities the evidence suggests that access is restricted to the financially needy. In Victoria for instance, eligible pensioners must be entitled to receive Supplementary Assistance.[20]

4.34 Demand for public housing is well above available supply. Only one third of pensioner applicants in 1979–80 were accommodated in public housing in that year. Despite their greater need for housing assistance, only 13 per cent of people accommodated by State housing authorities in the same year were age pensioners, only marginally higher than the proportion of aged people in the total population.[21] Thus, rather than being overrepresented in public housing, many of the aged have to find accommodation in the private rental market.

4.35 The Committee recommends that:

Housing assistance be provided to those most in need and that all assistance for construction of aged persons accommodation be directed through the Housing Agreements.

4.36 The Committee became aware from submissions, hearings and inspections that aged persons housing financed under the *Aged or Disabled Persons Homes Act 1954*, is

primarily for people with assets or who have little difficulty in meeting the required 'donations'. To the Committee's knowledge very few homes for the aged do not require some sort of 'donation' or key money from incoming residents. While some organisations indicated admission favouring 'those in need', financial need was in no cases assessed by a formal means test.

4.37 It appears anomalous to the Committee that there is no distinction between assistance to the indigent aged and those with considerable means. The former group appear to be disadvantaged in gaining access to subsidised facilities while the latter gain entry without any means test.

4.38 During 1974–75 it was decided that organisations subsidised under the *Aged or Disabled Persons Homes Act 1954* would not be permitted to receive second and subsequent donations in return for accommodation except for the purpose of making ex-gratia refunds to founder donors.[22] The Committee's understanding is that the embargo was not enforced.

4.39 The Committee was advised by the Department of Social Security that present arrangements require all applicant organisations to fill in a 'fund certificate' which includes the number and the amount of ingoing donations to be received from prospective residents. The Department cannot exercise any control over how much an organization charges incoming donors.[23] It is however one of the factors that is taken into account in granting approvals.

4.40 The admissions policy of an applicant organization and the extent to which it is relying on ingoing residents to make donations are factors which are taken into account by State Offices of the Department of Social Security when assessing funding priorities over the range of applications they have received. All other factors being equal, it was stated that if there are two aged persons accommodation projects in similar areas, with one charging a substantial donation and the other charging nothing—preference would be given to the organisation which has a no-donation policy.[24] The outcome of this preferred action is not known, but does not appear to have resulted in many organisations providing accommodation free of donations.

4.41 There is no constraint or control placed on the organisations from 'selling' a unit a second time when someone moves out. The agreement signed with the organisation is that the Department does not interfere in its admissions policy. The clause in the agreement which deals with in-coming donations provides that organisations are expected to reach the position as soon as possible where at least 50 per cent of their residents have not made an ingoing donation.

4.42 The agreements also provide that if the organisation uses second and subsequent donations for the provision of additional hostel or nursing accommodation they are not regarded as donations for the purpose of the 50 per cent requirement. This means that an organization could continue to 'sell' the independent living unit that the Commonwealth Government has constructed, or paid a substantial amount towards the construction, time and time again so long as, in the terms of the agreement, these funds are used for the production of extra hostel or nursing accommodation.[25] The result of this situation is further demands for subsidies which benefit further people who are not financially needy.

4.43 The Department of Social Security stated in evidence that:

> 'We are somewhat concerned about our agreement with organisations and our powers under them and are reviewing them as quickly as we can but we need a degree of legal advice.'[26]

The Department also advised the Committee 'that successive Ministers have made it plain that the role and function of the Department is to ensure that the capital grants

are used for the purpose for which they are given, namely, for capital purposes. After that there should be no interference by the Department'.[27] However, the Committee was advised that some donations are absorbed by salaries of people who work for the organisation. It was pointed out that some hostel operators take the view: 'We know we are in breach of the agreement but we have to use some of these funds for ongoing costs'.[28] The Department of Social Security said that it receives 'infrequent requests from organisations to make use of ingoing funds for that purpose' and if it is considered essential for the survival of the home, that approval is given.[29] **The Committee is concerned by the situation revealed in this Evidence.**

4.44 *In relation to allowing 'huge suburbs' of retirement villages to be built it has also* been the policy of successive Ministers for many years to approve projects, to provide the funds and leave it largely to the organisation as to where these homes should be constructed. The view was put that huge suburbs of aged people are not good and that aged people should be in the community.[30] The Committee is however aware that projects have to be of a sufficient scale to support associated services, and that land costs and availability of suitable sites also affect the size of projects.

4.45 The Department of Social Security said that the approval procedures for subsidies to Aged Persons Homes was 'deficient inasmuch as it provides only for responding to applications and claims made by organisations'. The Department does not have the capacity to generate claims.[31] Applications for assistance reflect a demand for subsidized housing. Assistance is not based on the identification of 'assessed need' in terms of the usual welfare criterion of economic hardship, reflected in low income and insufficiency of assets. People suffering economic hardship associated with inadequate housing may not be represented by a religious and charitable organisation which could make applications on their behalf.

4.46 The option of resident funded schemes is increasingly being considered, and in some cases adopted, by organisations that wish to extend their provision for aged people with some capacity to pay for accommodation. The Committee saw a project which operated successfully on this basis, and was informed of others. Provisions in the Housing Agreements now also provide an alternative avenue for subsidising organisations.

4.47 The Committee formed the view that the arrangements for administering subsidies under the *Aged or Disabled Persons Homes Act 1954* were deficient. It appeared that administration gave little attention to the impact of the scheme in terms of the Government's wider social welfare objectives of assisting those in need. There also appears to be little regard for the effect of the scheme on other public sector policies in the area of welfare and health. The operation of the scheme is built around satisfying the *demand* for funding, rather than a concern with providing services and facilities for those who are required by their circumstances to seek Government support. As outlined in Chapter 2, the Scheme has become a government rehousing program for the well-off rather than a low cost accommodation scheme for those usually judged by society to be in need.

4.48 The Committee recommends that:

> **No more approvals be granted under the *Aged or Disabled Persons Homes Act 1954*. Assistance in respect of disabled persons might be provided under a separate program.**

4.49 The Committee takes the view that organizations seeking support to provide housing assistance for people in need should seek provision from State Housing Authorities under the terms of the *Housing Assistance Act 1981* provisions for pensioner Housing. The Act provides for the States to allocate funds to religious and

charitable organisations for housing purposes. The relevant provisions of the Act are set out in Appendix IV.

4.50 The Committee recommends that

Existing commitments under the *Aged or Disabled Persons Homes Act, 1954* be honoured but that future assistance be provided under the *Housing Assistance Act 1981*.

4.51 This procedure would bring the provision of Commonwealth housing assistance for pensioners back into line with the original objective of the *Aged Persons Homes Act 1954*. The Committee envisages other arrangements in relation to nursing home accommodation. Recommendations are contained in Chapters 5, 6 and 10.

Rental Assistance

4.52 Supplementary Assistance is paid by the Department of Social Security on an income tested basis to all types of pensioners who pay rent for their accommodation. The current maximum level of assistance is $8.00 per week, which will be increased to $10.00 per week from November 1982. Under current arrangements the income test provides that the level of assistance will reduce by 50 cents for each $1 of non-pension income received. For single pensioners, no Supplementary Assistance is payable if other income exceeds $20.00 per week. It is not payable where rent is less than $10.00 per week or if a pensioner is a resident of a public housing authority.

4.53 The number of aged pensioners receiving supplementary assistance at 30 June 1981 was 191 700. This represented 14.2 per cent of all aged pensioners. There were also 2400 wives of aged pensioners in receipt of supplementary assistance.[32]

4.54 The level of payment, even after the recent budget increases, is insufficient to subsidize private rents to the extent that housing authority rents are subsidized for people in similar circumstances. Supplementary Assistance has not overcome differences in the levels of rent and proportions of income paid in rent which have been referred to in Chapter 4.

4.55 The *Housing Assistance Act 1981* includes a specific provision allowing the use of Commonwealth funds to pay rental allowances to persons in private rental accommodation. South Australia currently has a proposal to pay a rental allowance to single aged pensioners renting privately who are on the waiting list for Housing Trust accommodation. New South Wales is currently considering a proposal to pay rental allowance to aged pensioners and Victoria is introducing a rental allowance system for single parents.

4.56 A potential problem associated with the payment of rental allowances is the possible reduction in pension payment and supplementary assistance when the allowances are treated as income. This issue was seen as a major barrier by the South Australian Housing Trust.[33] However, the Government announced in the 1982-83 Budget that from November 1982 all grants by way of rent subsidy provided to or for a private tenant by a housing authority will be excluded from the definition of income for the purposes of assessing entitlement for pensions benefits and Supplementary Assistance.[34] This move should help State housing authorities develop further policy initiatives for rental rebates.

4.57 The main advantage of rental subsidies is that they enable the tenant to choose a dwelling that meets his or her particular requirements rather than accept a usually limited choice offered by Housing Authorities. This may be of particular relevance to elderly persons who may wish to stay in an area with which they are familiar, or be near to family and friends.

4.58 It is difficult to determine the extent to which increased use of rental allowances would reduce the demand by pensioners on Housing Authorities for accommodation. Factors such as a desire for security of tenure as well as financial considerations influence a person's decision on the type of housing preferred. The relative importance of the various factors in relation to the preferences of aged persons is hard to estimate.

Assistance with Indirect Costs

4.59 The Commonwealth has only limited involvement in assistance with indirect housing costs. The *Housing Assistance Act 1981* does not contain any specific provisions for Commonwealth funds to be used for such a purpose. As the earmarked grants for pensioners are for rental assistance only, these grants could not be used for home renovations.

4.60 Victoria has commenced a pilot Home Renovations Service with funds from outside the Commonwealth-State Housing Agreement. This service is available for others apart from aged persons but the aged make up a signficiant proportion of those assisted. Loans of up to $10 000 are available for essential repairs or improvements. The average loan so far is $4000-$5000. Repairs, such as to roofs, are the most common renovations being carried out. Loans may also be used for modifications to make the dwelling suitable for a person with disabilities. Eligibility is restricted to owners with a gross income of less than $220 per week (April 1981). The loans attract a non-escalating interest rate of from 5.5 per cent to 10.5 per cent, set according to the recipient's income.[35]

4.61 So long as they are actually restricted to 'essential' repairs, such schemes offer an efficient method of helping aged persons remain in their own homes. The cost of such assistance is less than providing alternative housing. Such a scheme also meets the wishes of many aged persons who desire to remain in their homes. As they remain in their own homes, frail recipients of this assistance may also need other types of assistance, e.g. home care.

4.62 Some *handymen services* have been established as part of home help services under the *State Grants (Home Care) Act 1969*, but evidence from Local Government indicates that State Governments vary in their preparedness to recognise handymen services for subsidy.[36] Some Local Councils have provided their own handymen services, and evidence from voluntary groups shows this is a particularly suitable area for volunteer efforts.

4.63 The Volunteer Task Force, in Perth, had a paid co-ordinator and some volunteers, and over a year had assisted over 1000 aged people with household repairs, maintenance and gardening.[37] Some geriatric services are also able to carry out modifications and repairs, although these provisions are limited to frail and sick aged individuals. As well as the high cost of repairs, the aged are vulnerable to exploitation by shoddy tradesmen. Home handymen services are seen by the Committee as an integral part of comprehensive home care services.

4.64 The Committee recommends that:

Provision for home maintenance and repair services be made in the proposed Extended Care Program.

4.65 Rates rebates constitute a major form of assistance with indirect housing costs. A proportion of rebates given by local government are reimbursed by State Governments. While rebates are an important means of helping aged people remain in their homes, other forms of assistance are needed to give more flexibility to the aged who wish to adjust their housing.

Housing Adjustment—Market Factors

4.66 In 1978 the Committee of Inquiry into Housing Costs reported that the total housing market appeared to have substantially satisfied community housing requirements at most levels. The Committee said that 'the most important exception has been the lower income groups and here Commonwealth and State housing programs and monetary policies have provided support in varying degree'.[38] The Committee also noted that for older people the financial and social costs of moving from family homes to dwellings that are more appropriate to changing requirements will be an important influence on the demand for housing.[39]

4.67 The Committee of Inquiry into Housing Costs stated that the regulation of the housing industry is pre-occupied with satisfying the tastes of those already resident in existing suburbs. The requirements of potential new residents, or residents with specific needs receives little attention. 'This attitude has constrained choice, induced inefficiencies and increased the costs of housing.'[40]

4.68 In a paper commissioned for the Inquiry into Housing Costs it was claimed that:

> 'The building industry caters fairly well for established demands and standardized tastes, and badly for variants on the normal. It is suggested that the new dwelling industry will continue to cater for *mainstream* demand, while renovation of the existing stock will provide for the meeting of new tastes, lifestyles and consumption levels.'[41]

4.69 The study also noted that as the proportion of elderly people to the total population increases, and while the majority of ageing people remain close to their previous residential locations, there has been a trend towards long distance migration, or at least ex-urban migration upon retirement.[42] This trend is re-inforced by the development of retirement village facilities which, in general, cater for a large and increasing proportion of aged people with substantial means. These people have the ability to express effective demand for accommodation which suits their needs.

4.70 An option for an aged person or couple still able to live independently but finding their present accommodation too large is to '*trade down*'. This means selling their present dwelling in order to buy a smaller, more-acceptable flat or unit. This may be in an aged persons' property development, or a flat or home unit.

4.71 A problem which arises with 'trading down' is that, although many aged people wish to remain in the same area so that they can keep their social and other contacts, not all areas have suitable alternative dwellings at a reasonable price. Newer units also may be more expensive than established homes in the same area. Even if something suitable is available, the transaction costs which include stamp duty, estate agents' commission and legal costs, can mean there is a substantial decline in the value of the persons total assets. Table 4.9 shows the estimated transaction costs for selling an average house and buying an average unit in five of the capital cities. When removal costs are added the aged persons may well be deterred from making the change.

4.72 The development of retirement villages through *resident funding* or other financial arrangements present aged homeowners with an opportunity to 'trade down' to more suitable housing. A number of voluntary organisations have established resident funded villages, extending their provision beyond projects subsidised under the *Aged or Disabled Persons Homes Act 1954*. Private developers have also entered the field. Resident funded and similar schemes provide a means of financing retirement housing for those who wish to realise their present homes, and are seen by the Committee as an alternative to provision of subsidized housing under the *Aged or Disabled Person's Homes Act 1954* for people in a position to provide for themselves.

Table 4.9: Estimated Transactions Costs of 'Trading Down' from House to Unit, June 1981

Capital City	*Transaction Costs*
	$
Sydney	4 600
Melbourne	3 200
Brisbane	3 400
Adelaide	2 600
Perth	2 700

Source: Estimates by Department of Housing and Construction.

4.73 The State Government in New South Wales is to change the planning laws to allow motel style development on a wider classification of land zoning to encourage the construction of more resident funded group housing. Under present arrangements some local councils are insisting that nursing home accommodation be provided in these group projects as a condition for development approval. This practice not only inhibits market oriented rehousing schemes but also restricts access by people in the community to nursing care when such care is required.[43]

4.74 The Committee considers that retirement villages should be regarded as residential projects. It believes that the elderly who make these places their homes should have the same access to nursing home and domiciliary services as aged people in the community. Any attempt to require nursing home provision may conflict with controls of growth of nursing homes and State health authority planning.

4.75 Aged people tend to exhibit a higher incidence of poverty than the population at large. To the extent that the poor aged live in rented accommodation and rely for income support on government income maintenance payments, they may be unable to express demand for their specific housing needs through the market without additional assistance (such as rental allowances or Supplementary Assistance).

4.76 It has been observed that most of the lower quality dwelling stock in Australian cities has been destroyed by demolition and conversion of land use to industrial and commercial purposes, or construction of new flats to contemporary standards:

> 'Middle class elements of the 19th century building stock survived and adapted but the lower quality stock disappeared. The mansions and follies of the very rich of the late 19th century have largely gone to institutional uses, in many cases after a period of boarding and lodging houses.'[44]

4.77 Market responses to the housing needs of lower income groups, such as through the provision of new multi-unit housing, are inhibited by the combined effects of planning, environmental and building controls. A study on the effects of controls in Sydney and Melbourne for the Committee of Inquiry into Housing Costs concluded that:

- There was an unsatisfied demand for multi-unit housing in Sydney, although in Melbourne this is not so large.
- Land available for multi-unit housing is readily available in Melbourne but is much more difficult to obtain in Sydney.
- A variety of council standards and controls influence, at one extreme, and exclude, at the other extreme, the development of multi-unit accommodation in Sydney and, to a lesser extent, in Melbourne. Up to ten controls have a significant effect upon costs.

- In recent years the number of multi-unit dwellings produced in Sydney has decreased at a faster rate than the production of detached dwellings.
- The costs of multi-unit housing construction have risen substantially during the past decade, particularly in Melbourne, where increases have exceeded increases in an index of labour and material costs.
- Area specific controls introduced by individual councils often lead to anomalies between adjacent areas.
- In both cities there is a need to review and amend legislation, regulations and ordinances impacting upon the developer of multi-unit housing.[45]

4.78 Housing market forecasts of increasing rents in all cities due to an expected strengthening of demand for rental accommodation are likely to add to these difficulties. An effect of these higher costs is that many aged private renters on low incomes have no option but to live in sub-standard accommodation. This is but further incidence of the relatively poor treatment of renters by both tax and welfare systems. If the renter were more equally treated then the supply of rental accommodation may improve.

4.79 It could be expected that relatively few private renters who become frail would have dwelling modifications such as the installation of rails and ramps carried out by landlords. Inadequate heating and other physical limitations often impose further hardships. The alternative for many of these poor aged renters is not however a nursing home, but hardship. The only accommodation option to self-contained rental dwellings is often a boarding house.

4.80 *Boarding and lodging* has played an important role in the provisions of relatively cheap, well located housing for low income groups. Access costs, compared with bond and rent in advance requirements for self-contained private rental dwellings, are low and aged persons are one of the groups which have traditionally occupied the cheaper boarding and lodging house and private hotels which are concentrated in the inner city areas.

4.81 Conditions of tenure of boarders and lodgers are a matter of concern as there is little security of occupancy. A change in ownership of premises or an increase in rent can cause aged occupiers to have to find alternative accommodation at short notice. Inability to pay rent during even a short stay in hospital may mean forfeiting accommodation on admission, leaving the aged person with no home to return to on discharge.

4.82 Another set of problems arise where boarders who are unable to manage their own affairs find themselves without any freedom of movement. Responsibilities of boarding house proprietors towards their residents are poorly defined and some aged people find themselves reliant on persons who have no formal or legal responsibility for their welfare. An advocate or guardian system may be warranted to protect these individuals.

4.83 There is however a falling supply of boarding house accommodation in some areas which reduces the range of choices open to aged persons looking for this kind of accommodation. The supply is falling for the same kind of reasons described above for rental accommodation. However, there are additional reasons:

- the reduced overall demand for this type of accommodation with preferences being shown for sharing self-contained dwellings;
- the reduced viability of operating boarding houses, due to higher land values in inner city areas, increased interest rates and other cost factors;
- actions of some local councils to discourage the operation of boarding houses in their areas, such as by the progressive upgrading and vigorous enforcement of health and fire regulations.

4.84 Evidence from the City of Fitzroy pointed out that 'many elderly people who have traditionally rented rooms, flats and houses in Fitzroy are being forced out because of the changes in property values in the inner city. The number of rooms available has halved in the past five years'. It was also pointed out that 'many of the older, cheaper flats have been purchased and converted to own-your-own units, or renovated and relet at higher rates . . .'. It is not uncommon for 80 year olds to be faced with eviction and the need to find a new place with a week or two notice.[46] In Sydney, the situation has been even more extreme.

4.85 In evidence, the Uniting Church made the comment that, based on their experience, people prefer to stay where they are, 'in their own little rooms', rather than be moved to unfamiliar surroundings.[47] This point was also made by the St. Vincent de Paul Society when asked whether the Housing Commission, which provides accommodation away from where people have been used to living causes great disruption in these peoples lives. It was stated that they feel isolated and they just want to find somebody previously connnected with them to latch on to. The Society visits people at Parramattta, Rydalmere and other places who had previously lived in Bondi. 'They still want you to continue to visit—even contact by phone comforts them; they want to talk to you.'[48]

4.86 The Victorian Government has started a pilot program of buying boarding houses to enable those residents who prefer this style of accommodation to continue living there. The Committee feels that there is a need for more diverse provision under the *Housing Assistance Act 1981*.

4.87 A distinct type of boarding house is operated in Victoria under Government regulation. These are the Special Accommodation Houses which are privately financed and operated hostels and boarding houses accommodating six or more aged or handicapped persons. Many former psychiatric patients also live in this type of accommodation. As they provide full board as well as a level of supervision and care, charges in special accommodation houses are generally higher than for ordinary boarding houses.[49] Costs range from around pension levels to over $200 a week, with an equally wide range of standards.

4.88 Special Accommodation Houses are not permitted to advertise or to offer nursing care or accommodate incontinent patients. The Committee received evidence from the manager of one house that the operation and management of Special Accommodation House does not require any qualifications. Anyone can open special accommodation after a successful suitability interview with a Victorian Health Commission special accommodation inspector.[50]

4.89 Special Accommodation houses do not receive any government subsidy, although residents receive Supplementary Assistance. If these were to be closed, many residents would be returned to mental institutions and the remainder to hospitals or nursing homes. If, on the other hand, similar people were in hostels, many would receive the Personal Care Subsidy.

4.90 Private boarding houses in other States operate along similar lines to Special Accommodation Houses, with varying levels and types of Government regulation. The Committee sees that this form of accommodation caters for the group of aged people who have least choice in housing due to limited disposable income and who also need some supervision and provision of meals. While many shortcomings with this type of accommodation were recounted in evidence, it is also recognised that it represents a 'non-institutional' environment, and for this reason, is preferred by some people to hostels.[53]

4.91 The Committee recommends that:

Action is needed to ensure:

- **the retention of an adequate supply of boarding-house accommodation at low cost through spot-purchasing under the Housing Agreement and/or rental assistance;**
- **the construction of new and replacement boarding house accommodation to be run by religious and charitable organizations under the *Housing Assistance Act 1981*; and**
- **the maintenance of adequate standards in regard to number of occupants per room, meals, bathroom facilities, safety, and protection of residents' civil liberties.**

Housing Adjustment—Other Options

4.92 The Committee was advised of a number of schemes for *joint ventures* being undertaken on the initiative of State and local authorities. In Victoria there is a scheme whereby local government councils donate land to the Ministry of Housing for the construction of elderly persons independent units. In return for the construction of independent accommodation the municipalities continue to be involved by assisting in the allocation of such units generally to residents from within their municipality and the provision of support services to the independent units. This is an important role of local government.[54] A similar scheme is being developed in South Australia.[55]

4.93 The Committee supports these initiatives and would wish to see further developments in this area. Funds available under the *Housing Assistance Act 1981* can of course be allocated to these schemes.

4.94 *Dual occupancy* offers another option for housing adjustment. Many aged people live by themselves or with their spouse in a dwelling which once housed a large family. The amount of space and the grounds are no longer required and in fact may become a burden. One of the ways of achieving a better balance between housing needs and housing size is through division of a dwelling into two (or more) self-contained units, to provide for 'dual occupancy'.[56]

4.95 Many aged persons living alone in large houses who would like to live with families but in self-contained accommodation are prevented from doing so by local government restrictions on the dual occupancy of a dwelling. Many local councils will not permit 'granny' flats or division of a house in residential zones. In most cases there is no right of appeal against the council decision.[57]

4.96 In New South Wales, planning legislation has been recently amended to provide applicants who have been refused permission by local councils to convert their dwelling the right of appeal to the NSW Department of Environment and Planning. Despite the encouragement the State Government has been giving to dual occupancy, local councils generally remain opposed to the idea.

4.97 There are a number of problems to be overcome in successfully implementing a dual occupancy policy:

- resistance by local governments to dual occupancy on the grounds that it can reduce property values and add to demand for community services etc.;
- additional income received by an aged home owner from the letting of part of the dwelling may affect their pension and P.H.B. card entitlement; and
- many elderly people lack the confidence and financial and legal knowledge to undertake the conversion.[58]

4.98 The Victorian Housing Ministry provides '*granny flats*' as an alternative form of housing assistance for pensioners. 'Granny flats' provide independent, self-contained accommodation for a pensioner couple, or single person who receives a full Australian Government Age or Invalid Pension or Repatriation Services Pension. The family, or in some cases a friend, of the aged person can apply to have the demountable 'granny flat' erected in their back garden. The 'granny flat' may be purchased or rented, the rent being based on 20 per cent of the Australian Government Aged Pension. Such a scheme enables aged people to stay in a more familiar environment and receive some help from relatives, provided of course that they have relatives able and willing to do so.[59]

4.99 **The Committee supports initiatives taken in facilitating dual occupancy in private dwellings and would wish to see the implementation of policies to provide further development.**

4.100 *Group housing schemes* are operating though only on a small scale. The Committee visited one group house owned by the Municipality of Waverley, in Sydney, which accommodated six aged people. Support services were supplied to these people through council services, similar to provision to other aged residents in their own homes. According to the N.S.W. Department of Youth and Community Services the operation of the Waverley scheme involves an assessment by Council prior to the selection of the applicants. Other Councils have similar schemes but there are problems in more widespread development, as noted by the Department:

> 'The Council provides the house and the Welfare Officers support the occupants. If they need ongoing care, the Welfare Office will provide the links. But it is fairly difficult because there are not very many houses that are reasonably priced in Sydney. That is one of the main problems. In a number of local government areas, councils have adopted the idea in principle but they are not willing to stop selling their properties and there is a continual lack of available accommodation.'[60]

Relationship Between Accommodation and Care Services

4.101 The Committee believes that there is a need to distinguish more clearly between accommodation assistance for low income aged who are otherwise independent, and provision of care to the frail aged at all income levels and in all types of housing.

4.102 There is confusion whether the aim of hostels is to provide low cost shared accommodation with limited support and supervision, or whether higher levels of care are to be provided. Payment of the Personal Care Subsidy to all hostel residents aged over 80 years is seen to be inappropriate as these residents are not necessarily in need of extra assistance. The amount of the benefit is conversely seen to be too low for those who require a significant level of care of a non-nursing type. A further problem is that the Personal Care Subsidy is paid only to residents of approved hostels. Frail aged people in boarding houses or who are living alone are not eligible for the subsidy or the Domiciliary Nursing Care Benefit (D.N.C.B).

4.103 The replacement of the Personal Care Subsidy and the D.N.C.B. with an Attendant Care Allowance is seen by the Committee as a means of overcoming these

problems. The Allowance would be paid to the aged person on the basis of assessed need, irrespective of accommodation and living arrangements, to enable a carer to be engaged. The concept of the Attendant Care Allowance is discussed further in Chapter 8.

4.104 The Committee is aware of the need for a degree of flexibility in the level of care that can be provided in any residential setting so that aged people are not required to move with every change in their well-being. From the point of view of residents and staff, it is probably desirable to cater for a mix of well and frail aged in hostels and other shared accommodation. There are also difficulties in defining and applying criteria categorising people to fit into more specialised types of accommodation.

4.105 One means of providing care services, especially for short term episodes, is through bringing in community services, as occurs for aged people living in their own homes, instead of having additional staff attached to the accommodation. The main need is for a supervisor who calls in the necessary services. Warden-supervised housing in Britain operates in this way and caretakers in independent accommodation provided by State Housing Authorities perform this role.[61] Domiciliary nursing and home help are already used in this way in public housing. Development of Day Hospitals and Day Care Centres is preferred to tying these facilities to housing complexes or other institutions. In some cases however, it may be appropriate to locate facilities for wider community use in a residential setting.

4.106 When a move to nursing home care is required, the Committee holds that the same form of assessment should apply to all aged people and that occupancy of a particular type of accommodation should not give priority access. It appears that direct progress through 'on-going' levels of care comes about in some cases without acute treatment and rehabilitation which could return the person to independent living. Where nursing home beds are associated with other levels of accommodation, they are frequently blocked to outsiders. It is unreasonable that aged people who remain at home for as long as possible may find themselves disadvantaged should they eventually need nursing home care.

4.107 The provisions for institutional care in nursing homes and for home care services, as discussed in the remainder of this report, are seen to be applicable to aged people in all types of accommodation.

4.108 Artificial links have developed between some forms of accommodation and support services notably in 'ongoing' complexes. Residents in some other types of accommodation have had restricted access to community services; some local councils appear reluctant to provide services to boarding house residents, arguing that the services should be provided by the proprietor.

4.109 The Committee recommends that:

In order to improve the housing situation and choices of low income aged people:

- **that a diversity of accommodation types continue to be fostered through innovative projects involving local government, voluntary organisations and self-help groups;**
- **that consideration be given to varying Supplementary Assistance in line with housing costs; and,**
- **provision for nursing home care and home care services be applied equally to aged people in all types of accommodation.**

CHAPTER 5

THE DOMINANCE OF INSTITUTIONAL CARE

5.1 There are many reasons for the dominance of institutional care in the range of Accommodation and Home Care Services for the Aged. The issues involved and the forces at work are complex and interrelated. They reflect financial, bureaucratic and political considerations. This complexity will be apparent from the analysis in the following paragraphs. However, the complexity indicates how difficult the process of rationalisation might be. Nonetheless, the Committee sees this process commencing with a withdrawal by the Commonwealth from the provision of capital subsidies for nursing home accommodation.

5.2 Most discussions of the 'imbalance' between institutional care and home care refer to Commonwealth public expenditure data. For the purposes of illustration estimates of the allocation of public expenditure between Institutional and Home Care, are set out in Appendix II. Information relating to assistance for self-contained accommodation is also provided.

5.3 As with all aggregated statistical data there are some difficulties in making comparisons. Two matters are of considerable importance. First, not all expenditure relates to the aged. Secondly, there have been changes in the terms of, and eligiblity for, various schemes: since 1979-80, rental assistance for pensioners has been available for *all* pensioners, this change accounting for the marked increase in expenditure over the previous year. Since 1980-81, the Domiciliary Nursing Care Benefit has been available in respect of handicapped persons aged between 16 and 64. Both these changes significantly affect the figures and therefore, the comparisons of expenditure data over time.

The Expansion of Nursing Home Care

5.4 The Australian Council of Social Service made the point that

> '. . . the Commonwealth's assistance to aged care and accommodation services is directed through a plethora of programs, under several different pieces of legislation, each operating through different channels of funding, based on different units for funding with different matching conditions applying with the States or with the organization concerned or with local government and administration through different departments.'[1]

5.5 Although Commonwealth financial assistance for the aged does operate through a plethora of different funding mechanisms, the important point is that formal procedures have been set up for determining and providing financial assistance to the nursing homes sector (or industry as it has become known). There exist formal arrangements for government-industry consultation through advisory panels and committees. On the other hand, the arrangements for dealing with the sector providing domiciliary services are diffuse and informal.

5.6 The nursing home industry has become organized into powerful interest groups. It is represented by the Australian Affiliation of Voluntary Care Associations (AAVCA) and the Australian Nursing Homes Association which represents the private sector. These bodies do not however have common interests even within the nursing home sphere, and have differing interests in and relations to other areas of care.

5.7 Providers of domicilary services are not well organized. 'Umbrella' organisations that do exist tend to emphasise policy issues rather than being directly involved in service delivery. It became apparent during the Inquiry that the interests of organisations providing community based and home care services were unco-ordinated and in some cases duplicating services. Apart from some State Government Geriatric Services, there are no organisations that span a range of institutional and community care.

5.8 Contact between the nursing home bodies and the Commonwealth is centred in the Hospitals, Insurance and Nursing Homes Division of the Commonwealth Department of Health. Over the years clear procedures have come into being for the determination of benefits, review of fees and evaluation of the nursing homes sector in general.

5.9 The interests of providers of community and home care services are spread across departments depending firstly on the type of service provided and secondly on the particular type of client served. There is no one (or even two) national organization representing their interests and putting a co-ordinated case to government for their requirements. For example, home nursing organizations and home help services which provide complementary services for the aged in the home do not come together to put a case for government support. The diversity of groups making submissions to the Committee reflected a great deal of fragmentation.

5.10 The absence of integration of the nursing home and domiciliary sectors is reflected in the absence of pressure from lobbies to use nursing homes for community and home care services. The Committee received evidence that deficit financed nursing homes and to a lesser extent, private nursing homes could constitute a base for other services. There was however, little explicit indication of how such propositions could be realised.

5.11 The continued dominance of financial support for institutional care can possibly be attributed to the greater integration and formalization of Government procedures applying to the nursing home industry. It is able to push its case through to the political level with unity and strength. On the other hand, community based service providers compete for funds and overlap or duplicate in their jurisdictions. Translated into financial terms, this has meant that the institutional nursing home sector has been able to increase its level of public sector assistance whereas the community/home care sector has not been able to increase its assistance at the same rate.

5.12 Whilst it may be true to say that such an outcome misallocates those resources available for care and accommodation of the aged it must be accepted that Governments (and Oppositions) respond variously to pressures in the operation of the political system. It is one thing to argue that, on the basis of rational calculation and evaluation, the share of resources flowing to institutions should be less. It is quite another to infuse such conclusions into the policy formulation and political decision making processes.

5.13 It was put to the Committee, very persuasively, that:

> 'The problem is one of community attitude which is reflected by politicians. Votes are to be gained by opening buildings and having pictures taken while cutting cords, but no votes are to be gained by starting a domiciliary service. We see this time and time again; shining institutions are built for the wrong reasons and in the wrong place. The Launceston General Hospital has to be the shining example. If we had that money for community health services in Tasmania, this Committee would not need to meet.'[2]

5.14 The funding of institutional care by the Commonwealth provides a financial incentive to State and local governments and voluntary organisations to maintain the provision of nursing homes rather than expanding domiciliary care services. After the capital cost there is limited ongoing cost to them for the provision of institutional care.

The Commonwealth Department of Health estimated total State expenditure on institutional care to be $35m in 1979–80 compared to Commonwealth outlays in the same period of $314m.[3] Any increase in domiciliary care services, as proposed by the great majority of witnesses to the Inquiry and by recent reports on the subject, poses significant costs to them. Ultimately, the community pays in either case; but domiciliary services are more difficult for State Treasuries because unlike non-State nursing homes, they must meet portion of the cost.

5.15 Under present arrangements States have little direct control over the expansion of institutional care in the private and voluntary sectors. There are no financial incentives for them to seek this control because the Commonwealth is funding a substantial segment of health care for the aged, without State involvement. Funds not expended by the Commonwealth on institutional care are not available for other options.

5.16 According to the Department of Health the recent history of long term services for the aged person in Australia is one of custodial care in institutions. Nursing home care has now become the dominant form of long term care for the aged in terms of the allocation of public sector resources.[4] This outcome is not, however, the result of deliberate policy. It is the result of other largely separate factors, the consequences of which are only now fully evident.

5.17 The Commonwealth's funding of nursing homes arose out of the health insurance arrangements for hospitals. The payment by the Commonwealth of a subsidy to nursing homes, on account of patients approved for home nursing care, has resulted in the provision of large sums of money to nursing homes. The Nursing Home Benefit is a cash benefit paid by the Commonwealth to a nursing home on behalf of an individual.

5.18 Nursing Home Benefits are, in many respects, for many pensioners, an addition to the pension for the purposes of securing benefits in kind. With the payment of nursing home benefit being determined in the first instance by the eligibility of an *individual* (rather than as a subsidy to an organisation on the basis of the cost of providing a service) there was a financial incentive for the establishment of nursing homes to satisfy the potential demand created by large numbers of people eligible for a payment on condition they find a place to spend it. This is in fact what happened in the 1963–72 period.[5]

5.19 According to the Department of Health present Commonwealth policy in determining nursing home benefits has had to take account of the fact that the vast majority of nursing home patients are aged. In this respect there has been a requirement to make the cost of care relatively inexpensive to the patients.[6] Policy has been directed towards ensuring that the real value of benefits is maintained in order that patients or their families will not have to pay large amounts for the cost of nursing care.

5.20 The underlying presumption has been that patients in nursing homes are pensioners and therefore all in need. Nursing home benefits are increased annually so that the benefit and the minimum patient contribution together cover the whole of the approved fees charged for 70 per cent of the non-Government nursing home beds approved under the National Health Act in each State. This is meant to ensure that the real value of the benefit is maintained over time, although there is some erosion of cover between annual adjustments.

5.21 The expansion of nursing home care was in the past very much influenced by Commonwealth State financial arrangements. Presumably, changes in these arrangements will also exert an influence in the future. The Department of Health points out that while the States have been responsible for funding mental health

institutions, and responsibility for funding hospitals and home care services has been shared by the States and the Commonwealth, nursing home benefits have, except for a short period of partial involvement by health insurance funds, been paid exclusively by the Commonwealth. This has provided an incentive for the States to have people cared for in nursing homes rather than in alternative facilities such as State psychiatric and acute care hospitals.[7]

The Demand for Nursing Home Care

5.22 There has developed within the community, according to the Department of Health, the attitude that to have your aged relative admitted to a nursing home is the normal thing to do when that person ceases to be able to look after him or herself. It was suggested by the Department of Health that people feel that if their aged relatives are in a nursing home they will be well cared for by the people best qualified to undertake this task. There will no longer be the 'what will happen if . . . ' worry that exists if the aged relative is living alone or even with the family, and there will be the feeling that the family's sense of obligation has been discharged.[8]

5.23 There is however other evidence that suggests that 'the common view' in the community does not accord with the wishes of individuals faced with the prospect of nursing home admission. A medical officer from the Department of Health stated 'I have yet to meet a person who wants to go into a nursing home'.[9] A district nursing organisation similarly rejected the view that once parents reach a certain stage, most families prefer to institutionalise them, and stated that the experience of her organisation was rather that families do look after aged relatives.[10]

5.24 One individual witness gave the Committee a moving account of his efforts to bring his wife home from hospital instead of having her placed in a nursing home, and of their mutual happiness when this outcome was achieved. He said:

> 'I do admit that if I asked the Blue Nursing Service to, say, bathe my wife once a week, that could possibly be arranged. But it gets basically back to myself. I am the male nurse day and night. That is the way I want it. I do these things myself because I feel that no institution can take the place of a home environment. That has been proved most correct. My wife was given three days to live by Dr Powell, the head of the stroke department or whatever you call it—the rehabilitation area—at Princess Alexandra Hospital. She was basically clinically dead when she left my home and that was eight months ago. Her improvement since she came home four months ago has been outstanding. She is still chairfast and it is a seven day a week job . . .
>
> 'I receive $21 a week; my wife was costing $700 a week in hospital. You would be quite aware that $21 per week would not buy anything. It helps me pay for a little medication that otherwise I would obtain for nothing. Let us get down to the nitty-gritty. It has cost me $5000 give or take a dollar to re-equip my home. One cannot put a wheelchair patient in a shower room measuring 3 feet by 3 feet. It must be 10 feet by 10 feet because not only is there the person in the shower chair but there is also the person attending to it. Basins must be designed so that the wheelchair patient can get underneath —there must be no cupboards underneath. All those things had to be done. That cost about $5000. There is also a hospital bed with sides on so that the patient does not fall out and, as happens so often, break a hip or break a collar bone. The shower chair, wheelchair and so on all ran into that amount of money. That was the financial problem I had to meet and we met it. That is still much less than it costs the Government to supply that kind of facility at any institution. The next thing is to try to get some help. My age group has to deal with most of this. The younger age group also finds it most difficult to cope with an extra person. That is why there is the great use of institutions . . . .

'The Government social officer at Princess Alexandra Rehabilitation Centre advised me. They all helped me at the Centre. They gave me data on the type of facilities vital for chair-fast people. I had no idea that $21 a week was available for those providing home assistance. They helped me.'[11]

5.25 It was submitted by a staff member of the South Australian Regional Geratric Service that 'institutional care dominates for many historical reasons and this is now perpetuated by inadequate training of health professionals and a community ethos based on the myth of security'.[12] The Committee received a great deal of evidence concerning the inappropriate placing of patients in nursing care and how this could be overcome by appropriate patient assessment by assessment teams.

5.26 The reasons for inappropriate placement reflect lack of understanding or widespread community ignorance and a failure to appreciate that a patient may benefit from rehabilitation following treatment in an acute care hospital, or alternatively, a lack of awareness of community based home care services, or a lack of availability of the required services. But, as the Department of Health pointed out, it is useless having assessment teams unless there is something for which they can assess the patient. 'If they have only nursing homes to which to turn they may as well not assess them.'[13]

5.27 A Queensland survey suggested that a great percentage of the admissions to nursing homes arose out of the family environment and pressures by the family on the doctor to have that person admitted.[14] According to a matron-owner of a private nursing home a person is admitted to nursing care on the grounds of physical illness or disability, but the real determining factor is whether there are family and other social supports available.[15] It was argued that nursing homes fill a social demand not a medical need.

5.28 It should be recognised that admission to nursing home care may also involve significant costs to the individual and family. The patient's pension is lost as a component of a household's disposable income, additional payments will be involved where the fee is in excess of the standard fee, and charges for 'extras' are not uncommon.[16] Although, in some cases, the patient's former dwelling may be sold or rented, this income will only be obtained where the person was a home owner and lived alone.

5.29 Nevertheless, the Australian Council of the Ageing points out that 'in the absence of other alternative and frequently in the face of an imminent breakdown of the older person's caring family, the availability of a bed can be seized upon as a solution to an urgent and pressing problem'.[17]

5.30 The frequently cited statistic of 20-25 per cent of patients in nursing homes who have no need to be there[18] should be seen in the context of the demand for nursing care for *social reasons* as well as a *medical problem*. It was suggested to the Committee by a nursing home proprietor that there was a difficulty in defining need for nursing care. She pointed out that there was probably no-one in her nursing home who could not be adequately looked after at home. It was suggested that bathing, dressing, diversional therapy could be, and in fact are, done at home.[19]

5.31 It might be concluded therefore that to the extent that there is a socially generated demand for a range of institutional care then the provision of full recurrent subsidies for nursing care may amount to a significant misallocation of resources, particularly if the care required can be provided at a less intensive level and at lower unit cost. This issue will be taken up again under discussion of hostel accommodation.

5.32 An important source of demand for nursing care is that under the existing system there is no method of ensuring that people with the greatest need for nursing home care have the highest priority for admission. The Department of Health argues that someone

who waits until he really needs nursing home care before seeking admission may then have to wait some time before obtaining a bed. This constitutes an incentive for aged people to seek nursing home care *before* they really need it.[20]

5.33 For similar reasons there is an incentive for people to seek admission to an independent living unit or a hostel in an aged person's complex in which there is a nursing home although they are still capable of looking after themselves at home—to be sure of getting nursing home care when the need arises. Once a person enters a nursing home there is strong disincentive to his leaving, should his condition improve. He is aware for example of the problem he will face in seeking readmission at some later date.[21] This point is also taken up by the Australian Council on the Ageing. It is argued that:

> 'Because of poor coverage of community and domiciliary services many older people have been forced to seek admission to care as an insurance against future difficulties and frailty. If they are able to secure a place it is often accompanied by the dilemma of opting for security by acceptance of the vacancy or taking the risk of going to the bottom of the waiting list[22].'

5.34 Other evidence suggested that people offered places when their name come to the top of the list frequently declined the place, preferring to stay at home until they 'really needed care'.[23] The practice of admitting patients from a longstanding waiting list is now not common.

5.35 The Committee was interested in the results of research undertaken for the Nedlands Municipal Council, Perth.[24] The Council was concerned that there was an apparent demand for aged persons resident funded units to be built. The Aged Persons Trust had a long waiting list which would indicate that there was a need in the community. However, when a unit became available they usually had to go down to about number 50 on the waiting list before they could get any one to accept it. Before Council went ahead with building any more units they wanted to know what the reason for this was. Also, a home support scheme in a neighbouring suburb had been in operation and there was some demand from people within the area for a similar service.

5.36 The main finding of the Study was that people seemed to be putting their name down on the waiting list for units in case they ever needed nursing services. They felt that residing in such units could allow easier access to nursing services. Such services were fairly limited anyway because there was only a nurse resident mostly at night. Respondents felt they would have easier access to a nursing home in the area through residing in such a complex.

5.37 However, when vacancies arose in a retirement village complex it was found that people did not generally wish to move. They wanted to keep their names on the waiting list just in case. It was suggested that 'some of them did not know that extended care services existed in the community. They seemed to feel that the nursing home was going to be the ultimate place that they would be. There seemed to be a lack of awareness that a lot of people do not ever need nursing home accommodation. There seems to be a great fear at the back of their minds that such accommodation would be inevitable and that they must prepare for this'.[25]

5.38 The Tasmanian experience with waiting lists was also interesting. Commenting on the compilation of a combined waiting list for all nursing homes in Northern Tasmania, a witness stated:

> 'the paradox of this list was that those who had their names on a waiting list for a nursing home in general were not receiving any services. In my view if you are bad enough to need a nursing home place you need some help while you are waiting. Conversely, most of those who were receiving home nursing were not on the waiting list for nursing homes. But when it came to the crunch in northern Tasmania the sister whom we employed full time to solve

this problem could not maintain a list of 20 people in immediate need of beds. She still cannot maintain such a number. When I spoke to her a few weeks ago her list was not a waiting list but an assessment list. Most of the people on it do not want nursing home beds. The list had 1,200 names but she could not identify 100 people on it who needed beds immediately although many of them will need beds eventually. But if representatives from the nursing homes in Launceston were appearing before this Committee, and I am referring here to private homes, charitable homes and State homes, they would all agree that their admissions problem is well under control.[26]

5.39 A number of other factors also combine to make it unlikely that a nursing home patient will ever leave the home. The following situations were cited by the Department of Health.

- having moved from his previous accommodation it is likely that it will now be inhabited by others and he will not be able to go back to it;
- having been in the nursing home for a significant period it is likely that he will become more dependent and significantly less able to look after himself than he was before he entered the nursing home;
- for proprietors of nursing homes, particularly those operated for profit, there is no incentive to encourage a patient to leave if his condition improves, as the patient would be seen as requiring less care than his replacement.[27]

5.40 While rehabilitation services were introduced in deficit financed homes with the aim of achieving restoration of the patient to the community, no evidence was given to show that this has been achieved.

5.41 Premature admission to a nursing home results in a low turnover of patients. The less frail a patient is upon admission to a nursing home bed, the longer he or she is likely to occupy that bed. The N.S.W. Department of Youth and Community Services pointed out that the way in which subsidies are provided tends to reinforce the push towards increasing care and has militated against a flexible two way movement—

'Flexibility is discouraged, particularly with the extensive care subsidy. In fact what we are doing is encouraging people to provide more care to those who need it but at the same time providing a disincentive to the rehabilitation process because if a person is rehabilitated to a level where he requires less care then, of course, he/she loses the subsidy. The operation of the subsidy system discourages rehabilitation and stifles flexibility'.[28]

5.42 The classification of patients as extensive care is also affected by the cost structure of private nursing homes in some States. Unless patients receive the higher benefit, they will not be admitted to these homes.

5.43 The Australian Council on the Ageing argued that if it is recognised that institutional care is the preferred arrangement for some older people then efforts must be directed to achieving a 'revolving door' programme of intermittent care thereby maximizing the use of expensive residential facilities.[29]

The Supply of Nursing Home Beds

5.44 The arrangements for determining the provision of new nursing home accommodation is that the Director-General of Health consults with the relevant State Health Authority on the basis of existing provision of nursing care in a particular locality. The consultation takes place through the mechanism of Commonwealth-State Co-ordinating Committees in each State. The Department of Social Security is also represented on these Committees.

5.45 The guidelines followed by the Co-ordinating Committees are currently the subject of review by the Commonwealth Minister of Health. The present guidelines involve the use of a bed to population ratio of 50 beds per 1000 of the population aged 65

and over. While the current provision for Australia is close to this, there is considerable variation from State to State and between regions within any one State. The Department of Health told the Committee that the figure has no basis as an estimation of need —it is merely the average of provision that existed in 1972.

5.46 The Department of Health pointed out that it had been fairly common practice to place great weight on the 50 beds per 1000 ratio as a guideline 'pretty much as if it were the only basis on which nursing home beds were provided'.[30] The Department of Health stressed that the ratio was a mere guideline, not a target, and should be seen in the context of other guidelines which refer to a whole range of factors relevant to considering whether or not additional nursing home accommodation is needed in a particular area. These include alternative accommodation, the provision of domiciliary services and other health factors.[31] As far as the Committee is aware the guideline of 50 beds per 1000 has not at any time been endorsed by Government as a matter of policy.

5.47 Referring to an alternative guideline of 80 beds per 1000 for people aged 70 and over, the Department of Health explained that such a ratio usually equates with the ratio of 50 beds per 1000 for people aged 65 and over.[32] The Department of Health suggested that the 80 per 1000 ratio over 70 would be a more appropriate measure and indicated that age 75 could be argued for. The Department conceded that given a rise in the number of aged people, such a guideline would lead to a greater number of beds.[33] The Department stressed however, that the bed ratio is not the only guideline. As far as future policy is concerned the Department of Health stated:

> 'it is intended that the guidelines recognise in a more practical fashion that the beds should be related to the relevant age population but that co-ordinating committees and the delegates of the Minister will be expected to have much more regard to other factors in the community as to what the need is . . . . If more concentration were given to what the appropriate alternative forms of care of the aged were at the same time it would be easier for committees to recommend against additional nursing home accommodation'.[34]

5.48 According to the Department of Health there is government recognition that Co-ordinating Committees should look beyond nursing home accommodation in that it has decided that they should look at hostel accommodation approvals as well.[35] The Committee was informed that there was a Cabinet Decision in late 1979 to the effect that Commonwealth-State Co-ordinating Committees should extend their concern to other forms of aged care, including hostels. According to Health, 'the Department of Social Security is currently taking steps to implement that decision'.[36]

5.49 The Committee recommends that:

> **In any case where additional nursing home beds are sought there should be an evaluation as to whether the funds that would be allocated in recurrent subsidies would be better applied to community services.**

The Committee recognises that this position could only be reached through rationalization of the functional and financial responsibilities between the Commonwealth and the States.

5.50 The procedures followed for the approval of new nursing home beds are deficient. Although the Co-ordinating Committees may be able to direct the growth in the number of beds to areas of greatest need or least waste, they have had little success in controlling the growth, and in turn, the level of public expenditure. Expenditure on nursing home benefits in 1982-83 is estimated at $534m, an increase of $126.7m. or 31 per cent reflecting the effects of higher benefit levels and an estimated increase in bed-days of 11 per cent.[37]

5.51 In 1982-83 expenditure under the *Nursing Homes Assistance Act 1974* is expected to increase by 25.5 per cent to $205m, reflecting an allowance for cost increases and an estimated seven per cent increase in bed days.[38] According to the *Budget Statements*, the expected increase in bed days reflects the continuing assistance provided to organizations under the *Aged or Disabled Persons Homes Act 1954*. The number of beds funded by the deficit financing arrangements under the *Nursing Homes Assistance Act 1974* increased by 1300 in 1981-82 and is expected to increase by a further 950 in 1982-83.[39]

5.52 The Committee was concerned at the lack of co-ordination between the Departments of Social Security and Health in the development of procedures for control of the growth in bed numbers so that in turn public expenditure would be contained. Whereas the Department of Social Security approves beds for capital subsidy under the *Aged or Disabled Persons Homes Act 1954* and the Department of Health approves recurrent subsidies under either the *National Health Act 1953* or the *Nursing Homes Assistance Act 1974* there appears to be little concern with issues of financial control and fiscal restraint.

5.53 While this Inquiry was in progress, the Minister for Social Security announced additional capital subsidies under the *Aged and Disabled Person's Homes Act 1954*. The consequence of the construction of additional nursing home beds under these grants will be an ongoing commitment of several million dollars annually in the form of nursing home benefits or deficit finance payments.

5.54 The Committee believes that increases in the number of nursing home beds of this magnitude, together with the public expenditure liability that follows is not in any way control over growth. The Committee takes the view that the Co-ordinating Committees are, in effect, operating as a means to formally 'approve' nursing home beds, which are subsidized under other Commonwealth legislation, rather than exercising control over growth as envisaged when controls were implemented in 1972.

5.55 The Committee recommends that:

Control over growth in nursing home beds reflect the requirements and procedures for expenditure control.

5.56 The Committee expects that effective assessment, outlined in Chapter 8, is a necessary complement to reduce apparent demand for nursing home beds. Not only will aged clients not requiring the high level of care provided in nursing homes be screened out, but those who currently add their names to waiting lists as insurance against possible future incapacity will no longer feel the need to do so. If the assessment procedures result in fewer admissions then control will be automatic. However, the outcome of assessment should not be prejudged.

5.57 The Committee recommends that:

Further control of nursing home growth be applied so as to limit the number of occupied beds receiving subsidy and contain expenditure on institutional care.

This restraint would allow for expansion of expenditure on domiciliary care services, day care centres and day hospitals.

5.58 The Committee further recommends that:

Until the administration and control of programs are transferred to the States, growth of nursing homes should be limited to areas and types of demonstrated scarcity.

5.59 The Department of Health in consultation with State Health Authorities should determine the extent of scarcity with particular attention to scarcity of nursing home

beds and community services for special patient groups. In the evaluation of scarcity, reliance should be placed on assessment of need rather than proxy indicators, such as bed ratios.

5.60 The Committee recommends that:

In the identification of types of demonstrated scarcity, bed to population ratios should not be used as an indication of need.

5.61 The three groups most commonly identified as having special needs are the confused elderly, migrants and aboriginals. It is recognised that there are already substantial numbers of elderly patients with chronic brain syndromes in nursing homes. The creation of additional beds in a separate category would have the effect of segregating this group, with their many attendant problems.

5.62 The creation of a separate category might, moreover, precipitate an 'epidemic' of dementia if funding was seen to be more readily available for care of this group. It is quite apparent that while there are shortcomings in nursing home care of confused patients the provision of community psychogeriatric services is virtually non-existent. Any consideration of special nursing homes for these patients should be weighed against the alternative use of funds for the development of community services.

5.63 Migrant groups giving evidence to the Committee have demonstrated the diversity and complexity of problems with which they are confronted. But the needs of migrants who will be aged in the future will be different to those who are now aged. Nursing homes as institutions are unknown in the home countries of some ethnic groups, and there is a need for special community services for these groups as much as nursing homes. Again, the alternative use of funds for such services instead of nursing homes should be canvassed. The Galbally Report has recommended attention to this area be directed through migrant services.[40]

5.64 The need for staff with similar cultural backgrounds and language is recognised. With reference to staff for nursing homes some problems have been identified as some ethnic groups do not regard nursing as an acceptable profession for young women.[41] Education and training programs carried out by ethnic welfare agencies were proposed as a solution to this problem.

5.65 It was pointed out to the Committee that certain anomolies arose due to the limitations of the Maintenance Guarantee. Aged migrants, ineligible for the aged pension on residence grounds and with no other means of support place great strain on families with limited resources. However, because there is no residence requirement for nursing home benefit there may be pressure to place aged relatives in nursing homes.

5.66 The problems in care of aged aboriginals were observed by the Committee in Alice Springs. The development of services through Aboriginal health programs was seen as the preferred approach of aboriginal groups to meet specific needs of local communities. The area is complex and would require separate consideration in relation to services available through the Aboriginal Medical Service.

Short-term Respite Care

5.67 A feature of the nursing home benefit system is that it subsidizes *bed occupancy* and not nursing home services *per se*. There is an incentive for nursing home proprietors to keep beds full in order to achieve the maximum profitability. This reduces flexibility in the provision of nursing home care. Thus, the system of nursing home care does not encourage the admission of patients from the community for respite care or for short-term convalescence.

5.68 Aged and infirm people may be adequately cared for in the community but families or relatives do not have recourse to nursing home care when the usual caring arrangement is temporarily suspended—for example by the caring family wishing to take holidays or the carer herself (or himself) suffering temporary illness. However, given that aged persons and families using respite care are likely to be receiving other services, respite admissions must be seen as an element of community care and cannot be organised in isolation from other services. On discharge from respite, the patient may also need to be provided with additional supports in order to maintain and strengthen care at home.

5.69 Examples of relative relief schemes presented to the Committee were based in State geriatric institutions, where other services could readily be engaged for ongoing care at home. Extension and consolidation of these schemes is probably a forerunner to use of private and deficit financed nursing home beds for short term admissions.

5.70 The South Australian Health Commission also argued that the private nursing home sector operates on the basis that as soon as a bed becomes emptied economic pressures drive the proprietor to attempt to fill it without delay. For this reason the private nursing home sector makes minimal contribution to respite services.

5.71 The need to involve private nursing homes in respite activity would not justify expanding the stock of private nursing home beds: within the existing bed stock a quota of nursing home beds could be designated for respite purposes with a fixed time beyond which they could not be occupied by the same patient. A period of six weeks would be a reasonable working maximum and in most settings 3 or 4 weeks would be all that would be required.[42]

5.72 Regulations in some States do not appear to permit nursing home beds to be occupied on a 'respite' basis that would allow families to book aged relatives into nursing homes for short periods. For aged people with private health insurance, respite admission can be and is often secured in an acute private hospital. This is, however, a far more expensive option to Governments. Provision for short term admissions to nursing home beds, properly administered, would allow proprietors to keep beds occupied, and of course receive benefit.

5.73 Respite beds would provide a supplement to assist home based care that might not otherwise be forthcoming. That is, if the choice was between full year nursing home care or no nursing care, families might opt for nursing care; if on the other hand the choice was 4 week nursing home care and 48 week home care, the choice might go the other way. The benefits scheme should allow more flexibility in terms of meeting the occasional care requirements of the aged.

5.74 The Department of Health argued that the availability of a range of accommodation options could be an incentive to people, otherwise unwilling, to assume full time responsibility for an elderly relative. The Department argued that there is a need for nursing home care to be flexible enough to allow short term occupancy. Flexibility in rules governing movement in and out of nursing homes could have beneficial outcomes for aged persons in terms of activity and rehabilitation strategies, improved functioning and overall quality of life, and should be encouraged. However, per diem benefits do not readily facilitate such arrangements.[43]

5.75 The South Australian Health Commission has developed a State-wide domiciliary care policy, under which patients and their carers have an entitlement to ask for, but not to demand, what is called programmed domiciliary respite. This involves an arrangement whereby the domiciliary care services, subject to the availability of funds and subject to the compatibility of the personalities involved, are given the authority to

mount additional services, including the payment of overtime, so that people can be maintained at home and not go into an institution when the caring relative is away.[44]

5.76 Respite care permits an increasing number of frail old people to be supported at home. When breakdown does occur, either because of a failing health of the individual concerned, or by withdrawal of caring relatives, eventual admission to hospital or nursing home is required. Before this stage there is very often a phase of considerable vulnerability and this is the setting in which guaranteed programmed respite is an important component.

5.77 The Committee recommends that:

Provisions for the development of respite care be included in the Extended Care Program.

Procedures for Admissions to Nursing Homes

5.78 People who seek admission to nursing homes are required to have their application for benefit approved. This procedure provides that a doctor, usually patient's general practitioner, certifies that the patient needs nursing home care. This opinion is then checked by a Commonwealth Medical Officer (CMO) before the application is approved, except in the case of admissions to Government nursing homes, where admission procedures are the responsibility of the State health authorities. Virtually no applications for nursing home admission are rejected by the CMO's.

5.79 For entry to a nursing home the current requirement is for a Form NH5 to be signed by the patient and completed by the patient's general practitioner. Medical opinions required by the form cover patient mobility, continence, care needs and treatment needs together with a diagnosis and an opinion on the need for extensive care.

5.80 While the review by the CMO may have some cautionary value, the interpretation of the *National Health Act 1953* until quite recently was that the CMO is not permitted to examine the patient and may refuse admission to a nursing home only if alternative accommodation is available. This means that virtually no applications for nursing home admissions were rejected by CMO's.

5.81 The Department of Health advised the Committee in June 1982 that an opinion from the Attorney-General's Department indicated that a CMO did have the authority to refuse admission if a patient's condition does not warrant nursing care, irrespective of alternative accommodation.[45]

5.82 The present procedure does not provide for assessment of factors such as home and family environment, financial circumstances and psychological condition. It has been put to the Committee in many submissions that these social factors are as important as medical condition in determining whether or not an old person should enter a nursing home.

5.83 The condition that admission could only be refused if other suitable accommodation is available appeared to preclude the search for other care options, such as remaining at home with home nursing and meals delivered, or attending a day care centre. Nursing homes, at a cost of $10 000 to $15 000 per patient per year are expensive forms of accommodation.

5.84 Effectively, the decision on nursing home admission has been left to the general practitioner. The general practitioner is properly the agent of the patient or his relatives and quite naturally feels no particular obligation to the general interest of the taxpayers. He is not therefore in a position to have to assess the options and to draw

upon alternative resources as required. Under these circumstances it would not be surprising if a significant number of people who do not need nursing home care entered nursing homes.

5.85 An officer from the Tasmanian Department of Health Services argued that:

> 'The pressures brought upon the GP are unreal. First of all he does not know what the general situation is . . . he just knows that he has 14 relatives jumping up and down on his doorstep demanding a signature. He gives in; of course he does.'[46]

5.86 This situation results in people who do need nursing home care not being able to obtain it, and creates pressure for the establishment of more nursing homes. Health points out that although final approval for admission is given by a CMO there have been claims that limitations put upon him and the Department which stem from the doctor-patient relationship mean that it is possible for patients who do not need nursing home care to obtain entry to a nursing home.[47]

5.87 The Department of Health pointed out in evidence that the procedure by which a person gains approval by the Commonwealth to enter a nursing home is not an approval for entry, but an approval for payment of a benefit. It was intended to be an application for entry but ended up as an application for approval for benefit largely because of the influence and the requirements, or the requests, of the organised medical profession.[48]

5.88 The steps of obtaining approval for benefit, recognising need for nursing care, and actual admission to a nursing home are commonly one and the same. A factor contributing to this situation is that a nursing home willing to accept the patient must be nominated on the NH5 form. In effect, a bed has to be found before recognition of need for nursing care is granted. Once a bed is found, approval for benefit tends to become a rubber stamping rather than a screening process. In many cases patients have been admitted before the NH5 is approved. To mix metaphors, this procedure puts the cart before the horse and then fails to close the door after the horse has bolted!

5.89 According to the Department of Health, the major problem with all forms of assessment for nursing home admission relates to the provision of suitable alternatives with which to meet those people's needs, if, in fact, they are going to be prevented from going into a nursing home. The degree of distinction between someone who is a nursing home type patient and one who is not but gets into a nursing home is not a clear one. The ones who should not be there by whoever's judgement are people who could in fact be cared for elsewhere. Normally it would be accepted that they are people in some sort of need, and that raises the problem of what alternative forms of accommodation are available.[49]

5.90 The Department of Health did however argue that the procedure whereby CMO's look at admission proposals and certificates by doctors is a discouragement to doctors to admit people to nursing homes too readily. The Department of Health said that there is no doubt, although general practioners are not generally overridden, there are circumstances in which CMO's telephone the doctors concerned or look very carefully at particular cases or find out more detail about them.[50]

5.91 The Department of Health also made the point that it was questionable whether or not physical examinations would in fact solve the problem of unnecessary admissions. Whether the difference in diagnosis of a patient by a CMO would be sufficient for him to be able to say 'despite your GP saying this, I say conclusively you should not go into a nursing home' is open to question.[51]

The 'On-going Care' Concept

5.92 It was suggested to the Committee that the growth of subsidised funding for aged care in Australia has concentrated on entry into aged persons homes and therefore 'staying in the system' and progressing through self contained unit living, via hostel accommodation to an eventual nursing bed situation.[52] The Queensland Voluntary Care Association suggested that people get into retirement villages to assure themselves of nursing home care when it is required.

5.93 The South Australian Health Commission submitted that within the voluntary sector nursing home admissions are dominated by admissions from hostels and independent living units conducted by the parent organisation and that only a few admissions take place directly from the community.[53] The Committee understands that this is contrary to government policy which is built around the provision of beds on a regional basis, by reference to the whole community, not the complex.

5.94 The South Australian Health Commission also pointed out in evidence that when people are selected to go into independent living units, and to some extent into hostels, those who are undertaking the selection process will reject people whose health is obviously vulnerable. What then happens is they age and fail as a group. This becomes a major focus for demand for more nursing home accommodation.[54] It also appears that the opportunity to 'resell' a unit encourages movement of residents into nursing home care rather than taking an outsider in at this higher level, foregoing the ingoing donation.

5.95 The services provided and the sources of funds in one 'ongoing care' or 'three tier' complex were provided by an organisation in a submission to the Committee. These are set out in Table 5.1. While the range of services is comprehensive within the 'ongoing' system, it is apparent that many voluntary organisations offer aged people approaching them an 'all or nothing' package. Not all organisations offer even the Day Therapy Centres as shown in this example, and hence there is no alternative form of support available to those seeking help.

Table 5.1: Services and fund sources: Aged Cottage Homes Inc.
(Evidence, p. 693-4)

	Funding		
Services provided	*Type of funds*	*Sources*	*Method*
1 Independent living units	1. Capital	1. Donor	
		2. Aged and Disabled Persons Homes Act	
		3. Organisation's reserves	
Maintenance costs include:	2. Maintenance costs	Tenants	Monthly rental
Rates and taxes			
Building insurance			
Building and equipment maintenance			
Gardening			
Equipment replacement and administration			
Welfare Service	3. Cost recoupment	Tenants	Included in monthly rental

	Funding		
Services provided	*Type of funds*	*Sources*	*Method*
2 Hostels—including full support according to criteria for Personal Care Subsidy	1. Capital	1. Donors	
		2. Aged and Disabled Persons Homes Act	Building subsidy
		3. Aged Persons Hostels Act	
		4. S.A. Health Commission	Furniture and equipment subsidy
		5. Organisation's reserves	
	2. Running costs	Tenants	Fortnightly tariff
3 Nursing homes	1. Capital	1. Aged and Disabled Persons Homes Act	Subsidy
		2. S.A. Health Commission	Furniture and equipment subsidy
		3. Organisation's reserves	
	2. Running costs	1. Patient fees	Set by Department of Health
		2. Hospital benefit funds	
		3. Department of Health	Deficit finance
4 Day therapy centres Approved services: Transport Medical Physiotherapy Occupational therapy Podiatry Meals	1. Cost of approved services	Department of Health	Deficit finance
Other services: Craft activities Social activities Hairdressing Holiday trips Day trips Co-ordination of community services	2. Other services	1. Volunteer help 2. Aged persons payments 3. Service clubs 4. State Government Community Welfare Grant (1980-81) 5. Donations	

5.96 The Department of Health stated in evidence that the deficit funded nursing homes were more likely to be part of a retirement village complex and that they were likely to give preference to people from within their complex.[55] It is not known to what extent this is done or whether they do it to an extent where they admit people who should still be in the hostel or independent living unit part of the complex.

5.97 It was pointed out that part of the principles of having these complexes is that people will not be admitted to nursing homes until they really need to be admitted. There is however a higher rate of movement to nursing homes in these complexes than in the community at large; it may also be that this move is sometimes made without consideration of acute treatment and rehabilitation services outside the complex.[56]

5.98 There are also other suggestions that some deficit funded homes would tend to give preference to people connected with the particular charitable and benevolent organisation that runs the deficit funded home. When it was suggested that it would be pretty hard for an atheistic alcoholic to obtain admission to such a nursing home, the

Department of Health responded that they could always consider a proposal from an association of atheistic alcoholics for a special purpose nursing home but that none has been put forward yet.

5.99 This hypothetical case demonstrates, in a rather inverted fashion, two things. First the provision of nursing homes relies on application from community interests rather than assessment of community requirements. Secondly, it demonstrates that nursing homes accessible to the community as a whole tend to be privately or government owned. State geriatric hospitals and public hospitals report that they are rarely able to discharge a patient needing nursing home care to a deficit-financed home.[57]

Hostels

5.100 Hostel accommodation provided under the *Aged or Disabled Persons Homes Act 1954* or the *Aged or Disabled Persons Hostels Act 1972* relates to care for those who are unable to care for themselves fully and who are provided with three meals a day, assistance with room cleaning, bathing and dressing where necessary.

5.101 Hostel care fits rather uneasily between 'nursing care' and 'independent living'. The movement towards nursing care can possibly be traced to the origins of Commonwealth support for hostel accommodation. The purpose was to relieve the pressure on nursing homes by providing a facility for less intensive care for those who did not require nursing care.

5.102 The bias towards 'health care' in hostel accommodation was criticised in evidence to the Committee as was the policy role of the Department of Social Security. A witness made the point that 'hostels are not primarily a health matter. They are an accommodation matter'. He went on:

> 'Once you license them under a health Act you start getting all the hospital regulations applied to something which is really a home and not a hospital. There should be more involvement by the Department of Social Security, or whichever body is appropriate, with the way in which the hostel is being used. Some hostels are running excellent programs but there is no incentive for the promotion of such programs and there is no obligations on an organisation to follow any leadership that is being given'.[58]

5.103 In the same vein, the N.S.W. Department of Youth and Community Services suggested that 'the Commonwealth should also clarify its definition of hostels and force hostels to conform to it.'[59] Given that hostels meet a diversity of needs from low cost accommodation with minimal care, to quite significant levels of care for frail elderly, the definition adopted would need to allow for this range. The Department said that

> 'At the moment hostel operators advertise and charge for domiciliary support services which they may not necessarily provide. In cases where such services are not provided, this may become a burden on the community even when residents have already paid for such service. Perhaps the Commonwealth could also encourage residents in hostels to join management committees, as they have the right to. Also, there should be stricter control of design, to make sure that accommodation is suitable for aged persons'.[60]

5.104 It is the problem of supportive care that causes most problems to operators of hostels. It could be provided in the form of domiciliary services provided by the community, or in the form of additional subsidy for personal care. The St. Vincent de Paul Society argued that

> 'we or any other organisation that are conscientiously looking after the indigent aged must get a better subsidy for hostel care, which I consider is the vital care, to be able to carry on with this work. I am not talking about large expensive projects.'[61]

5.105 The Society argued that to build a 40-bed hostel, considered to be the viable operating size, costs over a million dollars. Under the two for one subsidy arrangements, an amount of $330,000 has to be found which means that many poor people out

in the world would not be assisted in some other way.[62] The Society also made the point that

> 'whilst there is great necessity for nursing homes, a lot of people can be kept out of them by better care in the hostels. I saw evidence of this in Europe and particularly in Japan recently where the hostel is extended into a semi-nursing home. With proper care and activities, which is the great problem area, activities of people, even when they show some degree of senile dementia, you can still retain them there in the hostels. I think that is an extension of what is really needed here to keep back the cost of operating nursing homes.'[63]

5.106 People tend to go into hostels, which then becomes home. They live in it as a home and as a community. The Society envisaged the development of the hostel establishment as an overall economic measure with financial assistance to incorporate a small infirmary for the temporarily ill residents. This would serve to keep people in their environment, give their co-residents an opportunity to visit and drastically cut costs of transfer or even temporary movement as well as giving a little more time for the administration to arrange a nursing home bed if that situation was required.[64]

5.107 The Committee is however aware of the dangers inherent in this type of development. It points to the experience of the *Aged Person's Homes Act 1954* since nursing home beds were permitted—where small 'sick bays' became large nursing homes, absorbing a major part of capital funding under the Act, and incurred enormous on-going costs. The association of nursing home beds with other kinds of accommodation also appears to block access to those beds for outsiders. **The Committee's view is that the need for on-going care of residents of independent living units and hostels should not be treated in any way different to the needs of those who have remained in their own home.** That is, home is home, whether it be a suburban house or flat, a public housing unit, a retirement village or a hostel.

5.108 At the present time, the Personal Care Subsidy is only available for eligible residents of hostel accommodation provided by the voluntary sector. It was put to the Committee that the subsidy should be made available to people of equivalent dependency in private accommodation. Moreover, it was suggested also that should it ever happen then the whole of the Personal Care Subsidy criteria would have to be reviewed.[65]

5.109 It was submitted that some hostels are making a profit when occupied by *fit* people over 80 in receipt of the Personal Care Subsidy of $20 per week. The rate of subsidy was increased by 50 per cent to $30 per week in the 1982-83 Budget, backdated to July 1982. One study carried out under a Department of Health Research Grant found that hostel residents had a much lower level of disability than a group of aged people living at home and receiving services from a domiciliary service in Adelaide.[66]

5.110 Hostels can provide accommodation for people who previously were assessed as light nursing cases, and in receipt of the very much higher nursing home benefits.[67] The South Australian Health Commmission argued that there should be something analogous to the Personal Care Subsidy as an inducement to the private sector in order that the private development need not be confined to the high cost nursing home area.[68]

5.111 On the other hand, evidence was put to the Committee that hostel accommodation in many 'on-going care' complexes were running at a loss and required cross subsidization from the independent living unit sections. Findings of a report on hostels prepared by the Voluntary Care Association indicate that the costs and returns of hostels are highly variable, and further investigation of these marked differences appears warranted to determine the relative influence of factors such as size, location, date of establishment, type of residents accommodated and services provided.[69] It was put to the

Committee that revenue received from 'donations' by incoming residents of necessity was being used to subside the costs involved in hostel care.[70]

5.112 Many submissions and evidence pointed to the very large gap in the level of payment between the Personal Care Subsidy and the nursing home benefit and argued for a level of financial support relevant to a person's requirements rather than the catagorization as 'hostel' or 'nursing home'. In evidence, the Q.V.C.A. argued that the personal care subsidy of $20p.w. compared with the nursing home benefits of $157.95 placed a great strain on hostels.[71]

5.113 The Committee does not see the solution to these problems as simply an increase in the personal care subsidy. Such a move would no doubt replicate the boom in nursing home accommodation when the Commonwealth moved into the payment of nursing home benefits in 1963.

5.114 The Committee recommends that

> **Public subsidy to institutions should be be provided in terms of the cost of delivery of services which entails financial assistance to the provider of the services on the basis of an assessment of appropriate costs.**

A less rigid approach would also allow a mix of residents which is preferable to categorising and segregating groups into different types of hostels.