

# Changing concepts in ageing: a social policy perspective

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## ABSTRACT

In this paper the changes in Australia's aged care policies in the context of demographic, economic, social and ideological factors are explored. Through the 20th century the policies of federal and state governments have resulted in a system of age pensions, residential and community-based long-term care. This system is supported by a wide range of services in both public and private sectors, which must respond to the diverse needs of older people in a multicultural and geographically dispersed society. Changes in government policies over the past 10 years have entailed responses both to international and local research evidence and to economic values, resulting in the rhetoric of 'self-help', privatisation and 'user-pays' principles. A three-tiered model of care, adopted by the Australian Government in 2004, was designed to provide consistent standards, equity of access, accountability, quality assurance and planning. Current issues in Australia's aged care policies for long-term care are discussed, specifically the funding and organisation of services, the health-aged care interface, and the skills and payment of the aged care workforce. It is concluded that community-based care will remain the preferred policy direction, requiring refinement in resource financing and allocation, training, service co-ordination and carer involvement in policy development, all based on research evidence. A broadening of the concept of 'community-based care' to include 'community-based death' is suggested, requiring a broadened scope for palliative care to service the range of terminal conditions affecting older people.

**Key words:** Aged; Australia; Health Services for the Aged; Policy making; Social support

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## CHANGING CONCEPTS IN AGEING: A SOCIAL POLICY PERSPECTIVE

Australia's policies for long-term care have long been of international interest. The policies have been developing over the past 50 years and are currently subject to changes resulting from demographic, financial, ideological and social factors.

### Australia's aged care policies in a nutshell

From colonial days, state governments in Australia provided subsidised care in charitable institutions

for people who were in need because of poverty, ill health or homelessness, and mainly these were dependent women, children, disabled and old people. With Federation of the States in 1901, the Australian Government took responsibility for cash payments to old, poor, dependent people, by way of the Age Pension, access to which was restricted by criteria of citizenship, moral character and a means test. Whenever possible, old people were expected to rely on their family for support. From the 1950s, a mix of residential care and help in the home developed. Residential care facilities now include nursing homes, hostels with a low level of care and self-care

housing. Early community programmes included home nursing and meal provision. A stronger direction towards community-based care emerged in 1985, with the Home and Community Care Scheme, which provided aged care assessment teams, and later on case management based integrated and individualised care (involving various programmes of service delivery in the community). Over the past 15 years there have been many innovations directed to providing appropriate care that avoids institutionalisation, but allows respite for the carers where the older person's needs are complex and demanding. These programmes include transition from hospital, transition to residential care and extended care in the community.

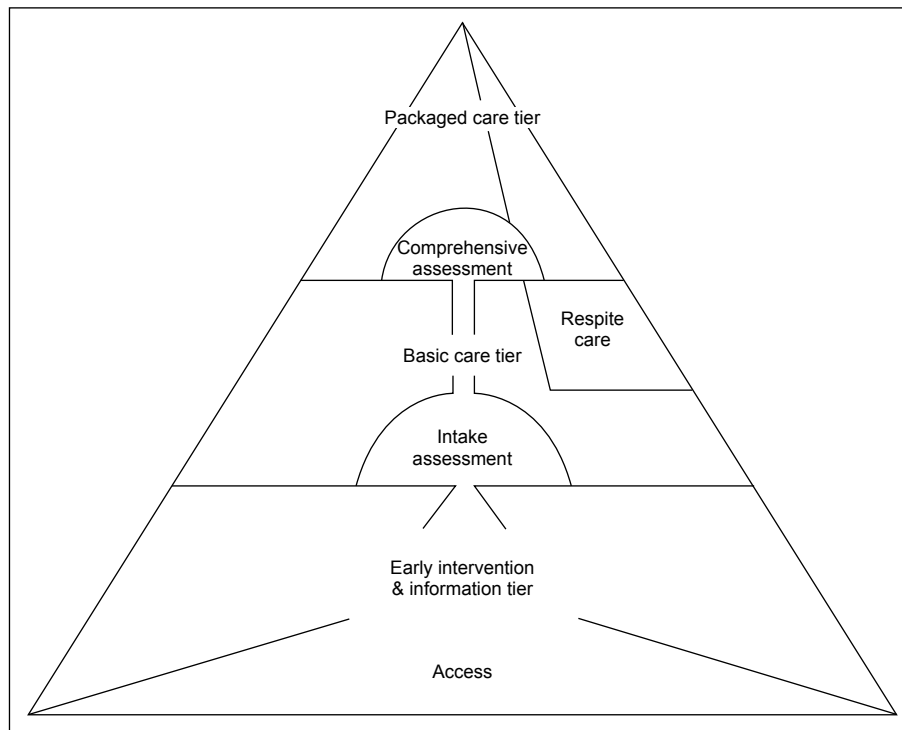
Underpinning the Australian system and the way it is changing are demographic, structural and economic factors. Demographically, Australia's population is ageing, not as extensively as in older European states, and not as rapidly as in many parts of Asia. Nevertheless, people aged 65 years and over make up over 13% of the population, and this is expected to grow to 26-28% by 2051. Importantly, those in the 'old-old' group (85+ years), will increase exponentially from 1.5% to 6-8% of the population by 2051.<sup>1,2</sup> Not only are the numbers of older persons growing and living longer, their composition is changing. As a result of Australia's immigration programme over the past 50 years, older people now include those from non-English-speaking countries, where cultural and social factors influence their attitudes to ageing and use of services. This diversity is both enriching and complicating. A third dimension of the demography in Australia is the geographic diversity by way of urban and rural populations, where distributional equity in service provision is difficult. Structurally, the layers of government involved affect Australia's ageing policy: the Australian Government funds a number of programmes and some are cost-shared with state governments. They include community care, carer support and dementia programmes. The effect of this division of responsibility and funding is a source of tension between the providers and the rhetoric of cost shifting between layers of government. Economically, Australia has pursued policies of economic rationalism since the early 1990s, and these have been strengthened during the past 10 years of conservative government. The effect of these factors on aged care has been to produce legislation directed

towards 'user-pays' (self-funding) for residential care and the promotion of community-based care, with a trend to privatisation of services.

### Changing concepts in ageing

'Changing concepts in ageing' can be interpreted variously. First, they may highlight the way values are influenced by research, publication and discussion. The United Nations' concern with ageing resulted in the policy directions of the World Assemblies in Vienna (1982), the International Year on Ageing (1999) and the Madrid Plan of Action (2002), geared towards mainstreaming old age and promoting a holistic approach. The discourse is changing, with emphasis on 'independence', rather than 'dependence', with questioning of the meanings of 'care'<sup>3</sup> and with the development of indicators of 'quality life strategies'.<sup>4</sup> With globalisation and a greater interest in comparative studies, the discourse is changing to highlight 'vulnerability' as a concept that allows for a positive approach to overcoming disabling problems in older age, rather than assuming inevitable deterioration.<sup>5</sup> In Australia, there has been substantial research in gerontology. Recently a research network involving university-based researchers and other stakeholders has been formed. While its effect may not be direct, there is an energy and level of debate involving care providers and clients and their families that is leading to improvements in line with the above-mentioned changing concepts.

Second, the idea of 'changing concepts' refers to the influence of governments, particularly the central government's role on what concepts predominate in policy planning. Fuelled by the fear of future costs of an ageing population, in recent years the Australian Government has promoted concepts such as 'independence', 'user-pays', 'self-responsibility', 'efficiency' and 'accountability'. Accompanying these have been steps to promote self-funded retirement income and to offer incentives for people working beyond the standard retirement and pensionable age of 65 years. These may reduce costs to government of the age pension scheme. With respect to long-term care, these concepts have influenced the cost-sharing for residential care, the promotion of community based care, and importantly, the development of accreditation and standards, management reporting and data collection. These developments have



**FIGURE. A tiered model of service provision as a framework in which all community care programmes are to operate**

Source: Australian Government (2004) p. 24

been accompanied by the funding of innovative programmes (falls prevention and exercise programmes) by both levels of government.

### **New directions: a tiered system of care**

With the release of the strategy paper 'The Way Forward' in 2004,<sup>6</sup> the Australian Government introduced a tiered model of service provision as a framework in which all community care programmes are to operate. This is shown in the **FIGURE**.

The model consisted of three tiers. The base level was one of information and early intervention services. At Carelink Centres, clients and families can obtain information about available services in their area. At the basic care level, an intake assessment is made to establish a person's need for basic care, including respite care. At the highest level, a comprehensive assessment determined a person's eligibility for packaged care, such as the Community Aged Care Packages and the Extended Aged Care at Home. These assessments were to be made by an interdisciplinary team, a model well tested over the past 15 years. The intention of the tiered national model is to provide consistent standards, equity of access, accountability, quality assurance and

planning.

The intention can be illustrated by a case study, that of Mrs L:

- Mrs L remained in the family house after the death of her husband (when she was 55 years old). She was not employed and did not recover well from her bereavement. A few years later she moved to an apartment close to where her daughter lived. A loner by nature, she did not make new social links and gradually developed paranoid ideas about her neighbours and family. At this point she entered what in the three-tier system is termed the Early Intervention Tier. Her general practitioner (GP) assessed her with the help of information from her family, and she was referred to the local psycho-geriatric team for assessment. Her GP felt she may have major depression with psychotic features. She also appeared to have early cognitive loss. Following assessment at the Basic Care Tier, she was started on a low dose of medication and monitored by the family, her GP and community outreach services. After a few quiet but stable years her daughters felt that she was quite 'flat' emotionally and had lost weight. They were unsure whether she was regularly taking her medications. She was therefore re-

referred to psychiatric services, and temporarily moved to her daughter's house. Before attending this psychiatric appointment she attempted suicide. A grandson found her in the process of cutting her throat. A lengthy hospital admission ensued (acute general hospitalisation followed by several months in a psychiatric facility). Whereupon the third tier of the model became relevant to her case. Discharge planning included an assessment of her living arrangements in view of both her depression and memory problems. At this stage, Aged Care Assessment Teams assessed her comprehensively. Her daughter felt she could not care for her in their home, due to the trauma to their children of Mrs L's suicide attempt. The family researched Residential Care Facility options and a 3-tiered Retirement Village was found. Mrs L was moved into the independent living stream (ie her own home with kitchen/bathroom facilities). She now has access to many group activities including trips, shopping, crafts and music etc. She has daily nursing supervision of her medications, community psychiatric team review when needed and is regularly reviewed by her GP, who coordinates her medical care; her family co-ordinates her overall care. When her memory deteriorates, she will be able to progress to a hostel and subsequent nursing home care.

### **Aged care policies in Australia: current issues**

There are a number of issues under debate, of which three of the major ones are highlighted for discussion herein, namely: (1) Funding and organisation, (2) The health-aged care interface, and (3) Workforce matters of skill and pay.

#### ***Funding and organisation of services***

The universal problem of who should pay for aged care services remains important.<sup>7,8</sup> Traditionally, the Australian Government has subsidised residential care in non-profit organisations and either funded or cost-shared community care with state governments. The pressures towards 'market choice' are leading to a 'user-pays' principle and to the development of private-for-profit residential care. As a result of the Aged Care Act 1997, older people entering residential care may be required to make a substantial lump sum payment towards their ongoing care. Users of community care services make a small co-payment linked to the age pension at 17.5% of the pension,

which most old people receive. It is anticipated that, as 'for-profit' home and community care in the private sector is now permitted, costs will increase and there may well be differences in quality depending on capacity to pay. The issue then becomes a matter of social justice and equitable access to quality care. Resources are not evenly distributed geographically and equitable access is not guaranteed for people who live in certain rural areas or those of non-English-speaking backgrounds who do not use the resources available to them. The latter include interpreter services that have been developed specific for certain ethnic groups. For example, in Sydney there are nursing homes specifically for Chinese, Italian and Russian people, to name but a few.

#### ***The health-aged care interface***

This refers to the relationship between health and welfare services, particularly with respect to co-ordination and transfers between hospital and community-based services. Older people are the major users of public hospitals and often require substantial care for short-term needs after discharge from acute care hospitals. With best practice, they are discharged with a package of care set in place.<sup>9</sup> However, patients are sometimes discharged at short notice, without support in place. It is not unusual for them to wait nine months for integrated services such as Community Aged Care Packages. Also, some aged care services do not link well with the health care systems. For example, at weekends, when GPs are not available and nursing home staff limited, frail and sick residents may be sent by ambulance to an accident and emergency unit. This places undue pressure on overburdened hospital services. Recent research<sup>10</sup> draws attention to the lack of knowledge about available services held by older people and their carers and their difficulties in negotiating a complex field of service provisions. The latter involve doctors, hospitals, respite, home supports, government, charitable and for-profit providers. Recommendations for policy development draw on a public health oriented strategy to inform and involve patients and carers from an early stage, and thus facilitate access to practical and emotional dimensions of long-term care, particularly with respect to dementia.

#### ***Workforce skills and pay***

The aged care sector is one that traditionally has provided low pay for its workers, who may be

registered nurses, lesser-trained enrolled nurses or nursing assistants, or minimally trained 'personal care assistants'. Steps are being taken to provide adequate training for all levels of carers. Employees of state governments are paid according to a set scale. For workers in the private sector, Australian Government legislation with respect to 'workplace relations' means workers must negotiate their pay. This may be to their disadvantage, especially when they work irregular hours and are required at weekends and public holidays, which previously attracted higher rates of pay. With a change of government in November 2007, this legislation is under review. Because of low pay and the nature of the work in caring for old people in residential care, workers are often migrants of non-English-speaking backgrounds and communication with the majority of mainly English-speaking residents may be a problem. Moreover, their culturally diverse backgrounds and experiences on approaches to care may also be relevant. Specific training in looking after older people is available for other health professionals as well. For example, since 2003 the Australian Government has funded Aged Care GP Panels, which provide education for relevant doctors and facilitate services (such as medication review) in residential care. Nevertheless, issues pertaining to recruitment of adequate numbers and the training of all types of staff in aged care institutions still persist.

As well as the interventions by formal organisations, family carers, neighbours and volunteer service organisations provide many informal services for the aged. Informal carers, who in 2003 comprised 2.6 million people,<sup>11</sup> are supported by non-government groups, such as Carers Australia, and by government financial and respite support.

### **Gazing into the crystal ball**

First, it is clear that community based care for older people will remain the preferred policy direction of the central government, and it is referred to as 'ageing in place'. With 20 years' experience and a high level of public support, it is now time to further refine the system to improve resources, training, service co-ordination, and carer involvement in policy development, which should all be based on evidence from research. Residential care will continue for those assessed as unable to live in the community because

of complex medical or mental health needs. Issues of funding are likely to entrench the private-for-profit sector in aged care, as well as engender further policy discussions about long-term care insurance.<sup>12,13</sup>

Another contentious aspect of the concept of 'community' that remains to be addressed is 'Community-based care', which is an accepted policy goal. 'Community-based death', on the other hand, is fraught with difficulties. Nursing homes, GPs and families generally expect their dying patient or relative to receive active interventions to keep them alive as long as possible. This sometimes requires multiple hospital admissions and the outcome is 'institution-based death'. Yet a model of community-based death exists in palliative care programmes, which relies on collaboration between medical, nursing and allied health professionals.<sup>14</sup> In Sydney at least, palliative care is generally restricted to people dying of cancer and not available to those dying of other conditions. As for Mrs J, who died recently, at the age of 100 years, the community-based ideal in aged care will be for old people to end their years as she did. She had been looked after at home by her daughter, and supported by her GP. In recent years, she had several episodes requiring hospital care, but each time she returned home and her daughter resumed care. At times she was placed into respite care to give her daughter a holiday. It became clear that further hospital intervention would not improve her quality of life and she was allowed to die at home, her daughter by her side. When the GP arrived to certify death, there lay Mrs J with a beautiful rose next to her on the pillow. This ending to life will not be the reality or even a possibility for many older people who live alone or cannot afford to pay for services in the private market. But such a death, at home, with supportive services and loving family, is surely an ideal goal for community-based care. Its realisation would require resolution of attitudinal and practical barriers and an element of luck. Important amongst these is the need to conceptualise and resource palliative care, to extend its scope beyond cancer to a wider range of terminal conditions affecting older people.

In conclusion, Australia's long-term care policies are developing and changing as interest in evidence-based policy grows, and as governments respond to evaluation research and the lobbying of interest groups. As well as non-government agencies, Aged

and Community Services Australia, Carers Australia, and the National Aged Care Alliance have for many years been a powerful voice for carers. Clinicians in medicine and allied health, academics and other researchers are stakeholders. Aged policy research is supported from all levels of government. Despite the difficulties in achieving appropriate, adequate and equitable care, these problems are matched by enthusiasm and a commitment to research and innovation that promises a healthy policy for the future care of older people in Australian communities.

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