Submission No. 132

SUBMISSION TO THE INQUIRY INTO LONG-TERM STRATEGIES TO ADDRESS THE AGEING OF THE AUSTRALIAN POPULATION OVER THE NEXT 40 YEARS.

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I have been involved in research on ageing since receiving a University of Queensland Scholarship to Oxford University in 1996 where I undertook research on 'retirement among British Leyland car workers and UK Civil Servants'. Most recently I have spent considerable time in longitudinal research on ageing in Dubbo, since 1987, and in Western Sydney since 1995.

In this time I have created and advocated a vision to address ageing over the next 40 years, which is driven by my research and derived from the data that I have collected. In general I am far less concerned about demography than about the extensive adjustments that need to be made throughout Australian institutions in order to make them 'age friendly'. I argue that the most important strategies to deliver this result would need to cover:

1. Improving employment rates of older workers;
2. Managing 'asset and health dynamics' for older Australians, <u>not</u> costs of ageing;
3. Rebuilding community aged care;
4. Intervening to promote healthy ageing; and
5. Exporting aged care services.

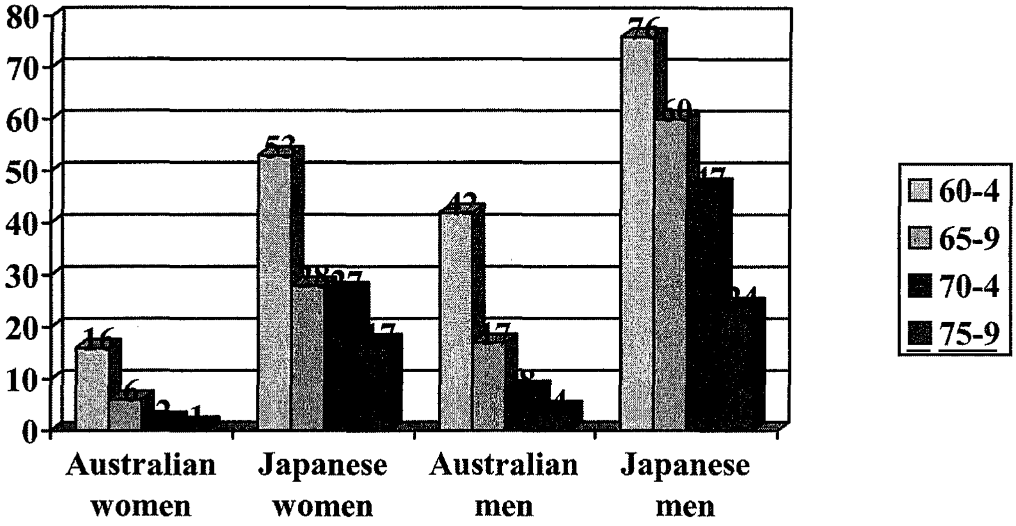
I will now comment on these long-term strategies in detail.

1. OLDER WORKERS

An Access Economics report to Minister Bishop in 2001, the *National Strategy for an Ageing Australia* (2002), a House of Representatives Inquiry and the *Intergenerational Report* (2002) have all addressed this issue. They have examined in detail Australia's ageing workforce and the initiatives being either explored or implemented by the public and private sectors to remove the barriers to continuing employment beyond the traditional retirement age. The Prime Minister made a commitment to work to increase the participation of older workers aged 55 to 64 years by 10 to 15 percent (*The Age*, 30 July 2002). The current participation is around 49 per cent and the Prime Minister proposed a target of 59 to 63 per cent to match international levels. This is achievable given rates in Scandinavian countries and in Japan.

The Japanese example
While Australia struggles with the older worker issue, our Pacific neighbour, Japan, has maintained high levels of work participation of older workers. This is under current threat with the declining Japanese economy but remains high despite this. Japanese participation rates are approximately double for those aged 60 to 64 years, treble for those aged 65 to 69, and even higher for those aged 70 years and over. The figure shows a comparison of older workers' participation in Australia and Japan.

Figure: A comparison of older workers' participation in Australia and Japan



The high Japanese participation rates are based on a number of features of their employment practices and pension policies. Japanese talk about work in old age as part of '*ikigai*', the 'meaning of life'. They have age related job change, called '*teinen,*' which means 'job change from seniority wage positions not completely stopping work'. Japanese workers who have been through *teinen* job change can get the pension and still work because of large steps in the means test. In Australia, after a free limit, there is 40 cents withdrawn for every $1 earned. Most older Japanese do low income, menial jobs but some high level managers experience *'amakudari'*, which literally means 'descent from heaven'. This means that a senior national bureaucrat will move to a related smaller company. An Australian example would be Bernie Fraser's move from the head of Treasury to an independent pension fund. These are reforms that need to be put 'on the table' in Australian policy debates.

There is another innovative development in Japan in their Silver Human Resource Centres. The centres provide, not paid employment for older Japanese, but something new, a transition from work/corporation to community centred life. This allows a choice of type of work and hours. These attract a low pay rate with part of the earnings going to maintain the centre. In 2001 Japan had 769 centres with 460,000 members and the whole system has been proven successful over 10 to 20 years of experience. For example, the Shinagawa Centre in the suburbs of Tokyo has 1,865 members, two aged 97 years, out of a local government population in the suburb of 72,000 people aged 60 years and over. It recruited 300 new members in the previous three years and receives Y109,000,000 from governments with a turnover of Y800,000,000 plus per year. While there are a few examples of such organisations here, this is a potential area for new developments.

The issues for older workers

The Australian older worker problem is: workforce participation at older ages continues to decline for men, and older women are not increasing their participation.

Most older Australians retire to live on the age pension not on their savings or superannuation, although in the future many retirees will have their age pension supplemented by their superannuation and other savings. About eight out of 10 older Australians are severe handicap free after their 65th birthday. And yet, on the other hand, physical inactivity and social isolation – often experienced during retirement – are risk factors for disease and disability. The public interest in maintaining older people in work needs to be matched by employer interest.

There are positive signs of change in employment practices. A 71-year old advisor has been employed by Centrelink and changes are evident in multinational corporations after major crises:

- Bertelsmann, a German media giant, has replaced its Chief Executive Officer with a 60-year old;
- Vivendi, the French media company, replaced theirs with a 63-year old;
- Xerox has taken on a 59 year old Chief Executive Officer; and
- EDS, a major US service provider, has brought in a grandfather, Jim Daley, as its new Chief Financial Officer.

A number of other cases have been documented (Access Economics 2001). In Australia, for example, Westpac is looking to realign its workforce to match the demographic profile of its customer base and the labour market. It appears to be reacting to the fact that half of its customers are aged 46 years and over but only two percent of its staff is over age 56.

Research conducted by Westpac suggests that their customers want to be served by people of similar characteristics to themselves, who have similar knowledge of their experiences and the issues they are facing[1]. The over 55 years population is growing and an increasingly large group of baby boomers is looking towards retirement and wealth creation services. In order for Westpac to provide the desired customer experience, it is looking to attract more mature age people to its workforce, who can share their experiences with customers. It is currently developing a range of career options, and supporting tools and processes, to encourage existing employees to continue working beyond the age of 55 years, and to attract a more diverse range of external clients to work in Westpac, including older workers.

The change agenda required to promote participation of older workers in Australia requires reform at the level of the worker, the employer and the work organisation, as well as with national policies. In this later area Japan provides a successful model for change. There is substantial work done internationally on workers and employers, and of particular note are the 28 recommendations that were made by the Finnish Institute of Occupational Health (1999), which were adopted by the European Union. The focus needs to be upon the '*work ability*' of older workers namely 'the result of the interaction between individual resources and work' (Ilmarinen 1999: 46). Individual resources include health, functional capacity, education and various kinds of work know-how. The important message is that good resources do not transform into good *work ability* unless the content of the work, the work community and the work environment provide the proper conditions for the older worker.

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[1] Westpac brochure (in print). Westpac thanks you for your interest.

Some priority issues for Australia are:

(i) Occupational health and safety:
There is significant increase in incidence of diseases, for example arthritis and cardiovascular disease, in the last 15 years of working life. Such prevalent diseases need prevention, treatment and changed work methods and practices, which allow people with chronic diseases to continue to work without disadvantage caused by the work environment. It is estimated that workplace changes are needed for about a third of workers aged 55 years and over to prevent them leaving work because of preventable, health-related diseases.

(ii) Insurance of older workers:
There is an increased insurance risk and cost associated with older workers but it is not as large as might be expected. While older workers do face increased health risks they tend to be more careful and more reliable than younger workers. It is important that particularly sensitive groups of older workers are protected against the predictable risks that they face by continuing to work. There is a danger of generalisation about the abilities and needs of older workers. Any individual older worker may need quite specific support to cope with increasing job demands arising from new technologies and organisational practices.

(iii) Changes to superannuation, age pensions and other forms of income support:
An immediate risk to the increase of the participation of older workers in the labour force is the access they have to superannuation at age 55 years. Measures such as gradually increasing the pension age for women so that it is the same as for men, and gradually increasing the superannuation preservation age to 60 (for those born after June 1964) will ease the burden of future pension outlays. Increased rates of superannuation coverage, via the superannuation guarantee scheme, will also assist in this regard.

The Commonwealth Government has recently introduced the pension bonus scheme, which enables eligible people of age pension age to accrue a bonus if they choose to defer claiming the age pension while continuing to work. However the take-up rates for this are currently low.

(iv) The identification of age as a *bona fide occupational qualification:*
Age can be relevant for exclusion from some occupations. While airline pilots of jumbo jets may be considered too great a risk at older ages where a catastrophic health event will put many others at risk, university academics would harm no one if they suffered the same fate. However, the advances in work technologies and health monitoring and maintenance begin to challenge conventional assumptions about *work ability* related to age.

(v) Age discrimination in employment:
The *Workplace Relation Act 1996* provides that an employer must not terminate a person's employment because of age unless it can be proven that maximum age retirement is an 'inherent' requirement' of the job. The Commonwealth Government has abolished the compulsory retirement age of

65 years for Commonwealth statutory office holders and for other public servants. A number of state governments have also introduced anti-discrimination legislation and the abolition of compulsory retirement age. The evidence is that such changes, of themselves, have no impact on participation rates.

The age discrimination that many mature age workers encounter in the work force also needs to be addressed via awareness and education campaigns. The media has a role to play here, and some of the programs offered by state governments – such as the provision of training and education services that provide information to employers and advocacy groups on age discrimination and compulsory retirement matters and the offering of best practice awards promoting mature age employment – could be evaluated with a view to expanding them to other states.

(vi) Complex patterns of employment, part-time, casual, shared jobs etc:
The Commonwealth Government has introduced flexibility into the *Workplace Relations Act 1996*, which can be accessed by employees and employers to develop phased retirement approaches and other flexible arrangements to meet the needs of older workers. This will enable mature age workers to combine aspects of their employment and income earning with family involvement and caring responsibilities. If the participation of older women is to increase, more flexible work patterns will need to be developed, which fit better with the family commitments of older women.

(vii) Government incentives:
In order to overcome the difficulties that older people experience in re-entering the workforce, the government needs to provide incentives and offer programs to remove some of the barriers. An example of one program is the initiative introduced in 1991 by the Commonwealth Government entitled *A Fair Go for Older Workers*. The program is designed to assist older jobless people by providing additional places in employment, disability, education, training and transitional programs. Some state governments also provide funding for computer equipment and programs to assist unemployed people to upgrade skills or obtain new skills, and to motivate disadvantaged job seekers, including older people, by boosting self confidence and self esteem so as to increase employment prospects.

There are market forces that will assist the growth in employment of older workers. Hence, with attention to the above reform agenda, the increase promoted by the Prime Minister will most likely be achieved. However there are two issues of 'collateral damage' which will need consideration, namely:

The first issue is that those who need work can't get it and those who don't can! Unskilled males and some divorced women who need to work tend not to have the skills that are in demand in an older workforce. They will be the people who will want to work. On the other hand tradespersons and professionals will be in demand but will not have strong financial incentives to continue employment. They will have substantial savings, real estate assets and superannuation and a taste for leisure.

Specific programs will need to be directed to those workers who are already disadvantaged and who are seeking work.

The second issue will be older workers versus younger worker trade-offs. While the general case for substitution is not supportable in economic argument, there is already some anecdotal evidence from Sydney recruitment firms that they can sell the older worker as an option in comparison to relatively poorly skilled younger workers from areas like Western Sydney, Wollongong and the near North Coast. The possibility that we solve one issue of access by creating another needs attention early in this process. There are options for special programs for disadvantaged younger workers as well as programs like that run by Golden Circle, which matches younger workers with experienced older workers so that both groups are advantaged. Other examples, like older GPs maintaining services to older clients within a much reduced workload would be neutral in its impacts on younger workers and, therefore, need to be encouraged.

In conclusion the key age group shaping the future of the workforce for the next few decades are not younger people, but the baby boomers. An ageing Australia has a problem with work at older ages but Japan doesn't, so we can learn from international best practice in this area. There are policy reforms that need to be considered to improve motivation to work and to remove disincentives to remaining at work. As well work place practices need to be developed to enhance the 'work ability' of older workers, such as those already being considered by the European Union. The key issue is employment growth for all ages, which will generate increased economic growth and prosperity. We will need to deal with at least two possible negative consequences related to this. If Australia is successful in continuing to reduce its unemployment rate for all age groups, and particularly unemployment and involuntary retirement for the older age groups, this will impact positively on the community's capacity to finance Australia's ageing population.

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2. ASSET AND HEALTH DYNAMICS IN THE OLDER POPULATION

I argue that we need to re-think the debate over funding of our ageing population by examining it in a new context namely the asset and health dynamics of ageing. Our new, longitudinal study of the health and economic behaviour of very old people (AHEAD - *A*sset & ***Hea***lth ***D***ynamics among the 'old' old 70+) has collected longitudinal data about resources of three types: economic, public programs and families. *Economic resources* are those from past and present employment, consumption and saving decisions of individuals and households including housing equity, superannuation and consumer durables. *Public programs* cover individual claims on age and veterans' pensions, health and aged care (particularly Medicare and Pharmaceutical Benefits funded services), and other government programs. *Family resources* are the combined stocks of time, skills and financial reserves held by the older person's extended family. For many older Australians the combination of public program entitlements like age pensions, Medicare and PBS along with their informal care resources will be much more valuable than their actual financial assets.

In AHEAD we have measured current amounts and sources of income, assets, housing, and employment; use of health and aged care services, out-of-pocket expenses, health and long-term care insurance; and age pension, primary health care and other program use through linkage to administrative data (subject to privacy constraints), from the Health Insurance Commission (HIC) and the Department of Health and Ageing (DHA), Department of Family and Community Services (DFaCS) and Department of Veterans' Affairs (DVA). We are also examining data from the Probate Registry for people in the study who have died since it began in 1988.

In AHEAD we test the general hypothesis that the *course* of age-related changes in health can be *offset* by three broad types of "resources": economic resources which result from past employment, consumption, and savings; claims on structured programs such as Age Pensions, Medicare, and publicly funded aged care programs; and family resources of time and money which can be made available to an older relative for caregiving or the purchase of services. AHEAD provides data to address a broad range of scientific questions focused on the interplay of resources and late life health transitions. These include: the costs of illness borne by the family; differences in how resources are used to offset cognitive, physical, and functional losses; the effectiveness of various care arrangements in preserving function and delaying institutionalisation; the extent to which transfers from family buffer the assets of older persons and slow transitions to late life impoverishment; and the pattern of income flows and the extent and mechanisms for dissaving and 'spend down'.

A major feature of this project is the extensive collaboration between the University of Western Sydney, four major Universities **(UNSW, ANU, Michigan and Tokyo)** and four public and private industry stakeholders. The strategic importance of the project to the partners indicates they will benefit from early access to survey data i.e. it is not just an academic exercise. Briefly, the linkage of survey data with their administrative datasets will enhance the capabilities of the **Department of Health and Ageing** and the **Department of Family and Community Services** to formulate effective policies for the ageing Australian population; and **Southern Cross Homes** are committed to ensuring their facilities and services are responsive to the needs and expectations of older Australians.

The AHEAD Study

We have conducted Australia's first major longitudinal study of the aged since late 1987. It covers everyone in the town of Dubbo born before the year 1930, 2805 individuals. The first Wave of the AHEAD-Australia Study was completed in 2001 and Wave 2 will be complete in April-May 2003. In Wave 1 we interviewed the 1490 residents (out of a possible 1,794) of whom about 400 completed short interviews. Of these, 1086 gave consent to a range of record linkages to Medicare/PBS and pension data.

Our early results show some of the dynamics of assets/income and health and the importance of this level of detail for planning aged care services. For example, less than 10% received income from superannuation while a quarter had some asset incomes. Generally the group had a high dependency on the age pension:

- 55% of people received money only from the age pension;
- 6.3% of people received some income from current superannuation;
- 24.9% of people received some income from savings and assets, mostly small amounts; and
- 2.2% of people received some income from their business(es).

Despite relatively low income most people agree that they are able to manage on their current income. This frugality may not continue for new generations of older people.

Question: *"I would like to ask you about managing your money."*

I can manage my money so I do not have problems living day to day		No.	%
	Strongly agree	234	22.4
	Agree	774	74.1
	Neither agree or disagree	4	0.4
	Disagree	22	2.1
	Strongly disagree	3	0.3
	Don't know	3	0.3
	TOTAL	1040	100
I can decide on the amount of money I spend over and above daily living expenses		No.	%
	Strongly agree	233	22.3
	Agree	751	71.9
	Neither agree or disagree	12	1.1
	Disagree	32	3.1
	Strongly disagree	4	0.4
	Don't know	8	0.8
	TOTAL	1040	100
I am financially prepared for caring and medical expenses		No.	%
	Strongly agree	201	19.2
	Agree	737	70.5
	Neither agree or disagree	27	2.6
	Disagree	56	5.4
	Strongly disagree	5	0.5
	Don't Know	14	1.3
	TOTAL	1040	100

While nearly all people seem to be able to manage on the age pension we found that people who have income other than the pension are more likely to score 'strongly agree' 33% of all people with pension plus other income compared to just above 10% for people who have only the pension income. However about 90% of both groups agree that they are coping on their current income. This was quite often reported with resignation e.g. 'you just have to, don't you'. A few people did express considerable financial distress.

We can get a sense of the dynamics of assets and health from the results to questions about life changes across the 12 years of the study.

Question: ***"We're interested in some of the things that may have happened to you since 1988. Have you …"***

Question	Yes/ No			Were you worse off financially because of it?			Did you need to spend savings or assets?		
a. moved house?		N.	%		N.	%		N.	%
	Yes	320	30.6	Yes	37	11.6	Yes	51	15.9
	No	725	69.4	No	282	88.1	No	268	83.8
				-7	1	0.3	-7	1	0.3
	Total	1045	100	Total	320	100	Total	320	100
b. had a major health change?		No.	%		No.	%		No.	%
	Yes	590	56.5	Yes	79	13.4	Yes	66	11.2
	No	455	43.5	No	510	86.4	No	523	88.6
				-7	1	0.2	-7	1	0.2
	Total	1045	100	Total	590	100	Total	590	100
c. had a spouse go into care?		No.	%		No.	%		No.	%
	Yes	27	2.6	Yes	6	22.2	Yes	4	14.8
	No	1017	97.3	No	21	77.8	No	23	85.2
	-8	1	0.1						
	Total	1045	100	Total	27	100	Total	27	100
d. had a major family crisis excluding widowed?		No.	%	see	data	below			
	Yes	318	30.4						
	No	727	69.6						
	Total	1045	100						
e. moved to live with our family?		No.	%		No.	%		No.	%
	Yes	24		Yes	2	8.3	Yes	2	8.3
	No	1021		No	22	91.7	No	22	91.7
	Total	1045	100	Total	24	100	Total	24	100
f. had family move in with you?		No.	%		No.	%		No.	%
	Yes	60	5.7	Yes	8	13.3	Yes	10	16.7
	No	985	94.3	No	52	86.7	No	50	83.3
	Total	1045	100	Total	60	100	Total	60	100

Comparing the results of survivors in the two surveys 1988 and 2001 we have documented major health and sensory changes in addition to these life changes. For example, the worst self-rated health ratings 'fair' and 'poor' are up by 30%; disability rates increase by 75%; urinary incontinence rates double; self-reported fracture rates increase 30-50%; hearing aid rates treble but hearing is worse. So health changes are on average negative and major sensory losses occur for hearing which are not corrected by hearing aids.

As well widowhood and living alone rates more than double between 1988 and 2001. However contrast to these risks we found strong evidence that social support buffers social losses for many people. We found that frequency of club visits, contact with children, supportiveness of family all increased for the survivors. As well, contact with friends, feeling loved, visits remain relatively stable. In summary some types of support increase, some remain stable in the face of isolating life events like ill-health and widowhood. This is a very important new finding if we can confirm it in more detailed analyses.

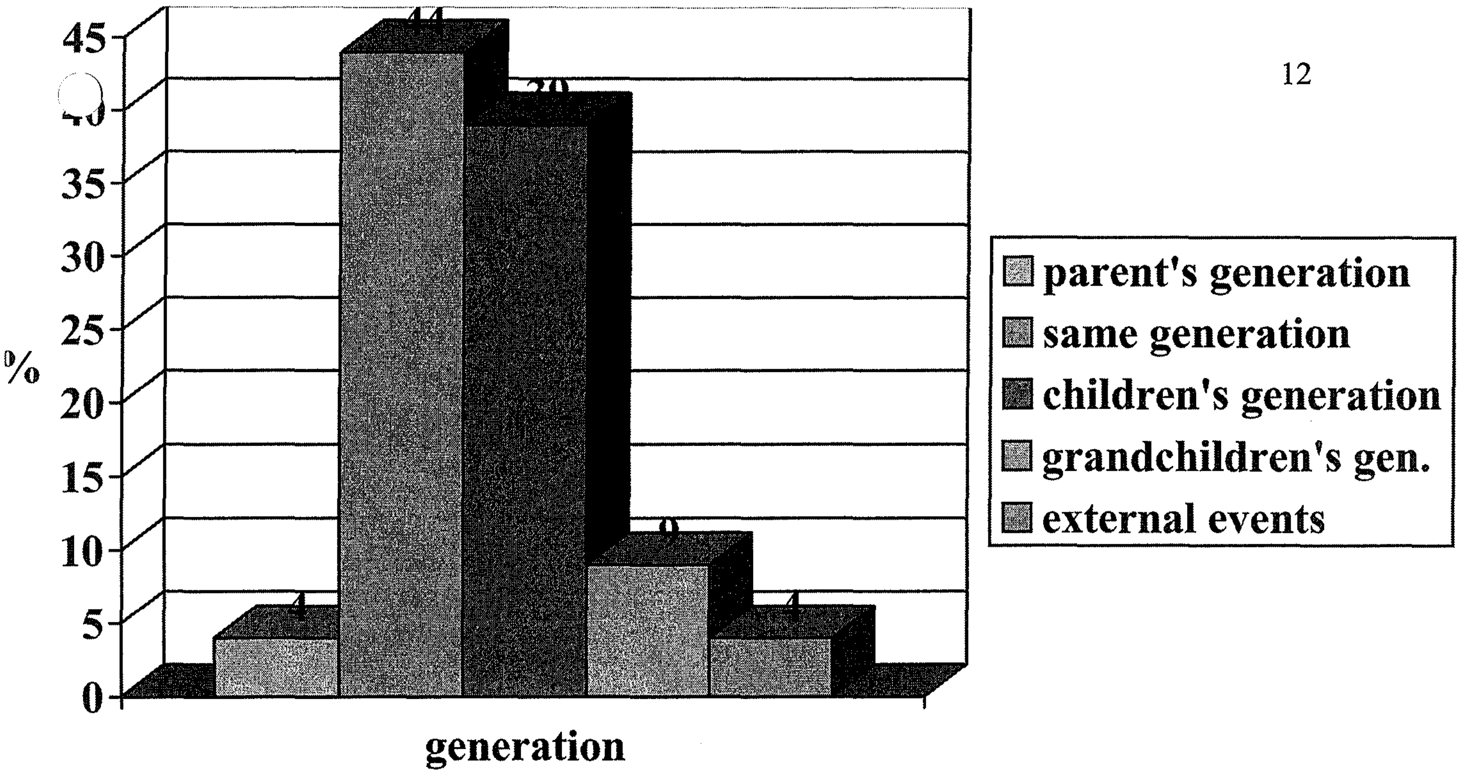
As was expected from PBS data, self prescribed pain and laxative medications increased but sleep medication and antacids declined. Prescribed medication increases generally with only prescribed sleep medicine being stable. There are substantial increases in cardiovascular medication use and other major drug categories. Arthritis medication remains stable but there have been changes in the medications used without increasing rates of use, unlike cholesterol lowering medication which has increased from a very low base. General increases are at least in part due to greater need, but new drugs increase use with only moderating effects from changed prescribing behaviour around sleeping pills and arthritis medication.

Symptoms of psychological distress ratings also increased by a small degree on average, probably due to illness and frequency of distressing life events. While life satisfaction scores also declined, this was almost entirely due to decreases in reporting of 'these are the best years of my life'. 'Expecting an interesting future' and 'general satisfaction with life' were relatively stable so we can say that survivors' well-being is relatively stable despite some dramatic and risky changes associated with age.

There are a wide variety of other family changes, not just health and widowhood changes, occurring across 4 generations of family, for example:

- Divorced husband after 52 years of marriage, brother murdered, husband dementia, lost mother+sister+brothers in same year;
- Daughter died from breast cancer, communication breakdown with father and daughter, son's suicide;
- Grandson depression, grand daughter's custody case, grandson killed in a car accident, granddaughter died 5 days old; and
- all savings lost in business failure, property sale caused spouses nervous breakdown, home invasion and assault, family farm passed to son with much upset.

Figure Family Event Rates by Generation



You can retire from work but not from life! As well as the table above indicated, these events have financial implications for older people who spend down their assets to deal with them.

We also have new evidence of current expectations in the expressed preferences of older people born before 70+ for care with a comparison between Australia and Japan.

Table Australia-Japan Comparison of Care Preferences: *Age group by preferred care option (Japan 'J', Australia 'A')*
Question*: "What would you prefer to happen if you were unable to care for yourself? Your answer does not need to reflect what would actually happen."*

	Age group (years)				
Preferred option	70 - 74	75 - 79	80 - 84	85+	Total
Don't know[J]	10.9%	10.9%	12.1%	9.6%	11%
[A]	6.4%	6.0%	6.2%	4.7%	5.9%
Family at home[J]	16.7%	19%	13.6%	30.1%	17.7%
[A]	5.5%	5%	8.5%	4.7%	5.1%
Formal Home Care [J]	21.3%	21.6%	19.7%	20.5%	21.1%
[A]	58.3%	63.3%	58.0%	51.5%	59.0%
Hospital[J]	32.4%	33.3%	35.9%	31.5%	33.1%
[A]	.5%		.4%		.2%
Residential Care [J]	17.8%	14.8%	17.7%	8.2%	16.4%

[A]	28.4%	22.9%	26.8%	38.6%	27.6%
Other[J]	.8%	.5%	1%	0	0.7%
[A]	.9%	2.5%	2.7%	.6%	1.9%
Japan [No.]	713	421	198	73	1405
Australia[No.]	218	397	256	171	1042

Note options provided were:

1. *I would like to be taken care of by my family in my own home**
2. *I would like my family to care for me in their home**
3. *I would like to be taken care of at home with outside help for housework and personal care services*
4. *I would like to be admitted to a hospital*
5. *I would like to reside in a nursing home/hostel**
6. *Other*
7. *Don't know*

The sources as well as the AHEAD Study were the parallel Tokyo Metropolitan Institute of Gerontology data from Japan produced here with permission of Professor Hide Sugisawa and the research group.

Older Japanese prefer informal family and hospital services ahead of formal aged care services in contrast to older Australians who prefer formal home delivered services and to a much lesser extent, residential care. Such preferences are strongly predicated on family structures, such as 3 and 4 generation co-resident families in Japan where the potential for support is greater than in single generation households in Australia, and values such as the shameful, 'poor law' associations of formal aged care services in Japan. We might expect the proportions of older Australians preferring flexible services delivered to home to increase as new generations enter old age. Regardless of these directions a professional aged care service industry will be much more closely focused on consumer needs and tastes.

The early results from our AHEAD study indicate that 64% of people born before 1930 survived 13 years, their health gets worse and hearing is a major issue but that informal support becomes a buffer for isolating life events and psychological well-being remains fairly stable. Medication use increases with some small signs of better prescribing behaviour e.g. sleeping pills and assets and savings are spent on 4 generations of families to manage prevalent family crises. In short people 70+ manage well through life changes across 12 years rich with social and health changes. This work provides essential data for the current generations of people 70+ which will allow us to model future experiences for babyboomers. It is also desirable now to survey the babyboom generation as it passes through to retirement ages. This would allow real time monitoring of changes in behaviour from the patterns previously established in the AHEAD work. It is the dynamics of the three types of resources that we need to understand if we are to manage the costs of an ageing population.

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3. REBUILDING COMMUNITY AGED CARE

I have been a strong public advocate of re-organising and expanding our community aged care services. Despite the policy emphasis on community care, since 1993 residential care funding relative to 'need' has stayed stable around 74% of the total long-term care per capita budget while Home and Community Care has declined slightly in share from 23% to 21% (Table below). Residential care has maintained its proportion but with an internal shift towards low intensity care. The fastest growth has been in community packages which have increased in funding, from a low base, by 9.8 times over only 4 years. However they still constitute an almost negligible fraction of the total long-term care budget. If there has been a shift in relative shares it appears to be from HACC to CACPs. On the other hand the growth of CACPs demonstrates the potential for change if residential care share can be shifted or new funds found.

Table: Aged care recurrent aged care expenditure per person aged 65+ with a profound or severe core activity restriction, in constant prices 1993-4 to 1997-8

	1993-4	1994-5	1995-6	1996-7	1997-8
HACC	1,481(*22.7%*)	1,551(*22.8%*)	1,601(*21.9%*)	1,654(*21.4%*)	1,700(*21.1%*)
CACPs	18(*.003%*)	41(*.006%*)	74(*.010%*)	112(*.015%*)	176(*.022%*)
Residential	4,807(*73.9%*)	5,008(*73.6%*)	5,406(*74.1%*)	5,732(*74.3%*)	5,971(*74.0%*)
TOTAL	6,507	6,805	7,293	7,717	8,074

Note from Australian Institute of Health and Welfare and note that smaller expenditure items are not included in the list.

Similarly recent expenditure analysis by the Productivity Commission shows that average real HACC expenditure per recipient per month declined from $254 in 1993-4 to $224 in 1999-2000. HACC services appear to have reached a growing proportion of the target population but this has led to a decline in expenditure per client. By contrast real average hostel expenditure increased 67% over the period 1989/90 to 1996/7 while nursing home expenditures were relatively stable. These patterns suggest that without policy emphasis on community care the residential care share could have been higher. It is surprising, nonetheless, that the public perception of greater share for the community care sector, which has been part of the policy rhetoric around policies such as 'ageing in place' is not yet apparent in the evidence of expenditures relative to need.

Table 1: Average Real Expenditure per person in $1996/7

	Nursing Home	Hostel	HACC
1989/90	32,843	4,750	
1990/1	34,032	5,318	
1991/2	32,650	5,846	
1992/3	32,009	6,158	
1993/4	31,000	6,381	254
1994/5	31,014	6,923	252
1995/6	32,342	7,366	244
1996/7	33,853	7,956	244
1997/8			243
1998/9			233
1999/2000			224

Madge, A. (2000). Long-term aged care: Expenditure trends and projections. (Productivity Commission Staff Research Paper). Canberra: Productivity Commission

Australian policy separates funding arrangements for long-term care from acute care and community care. Planning and funding residential aged-care services has traditionally been the responsibility and prerogative of the Commonwealth Government. Community care services, from 1985, have been jointly funded with State Governments, within a national policy framework. State governments are the principal funders of acute health services for older people, largely with resources provided through the Australian Health Care Agreement, derived from both a tax-based national health insurance payment and partly from general revenue. Separate Commonwealth Government programs fund general practitioner and specialist medical services and provide subsidized pharmaceutical services.

Table 2: Australian Expenditure on Older People 1996/7

	$m1996/7	**%LTC**	**%GDP**
Nursing Homes	$3,149	53.92%	0.59%
Hostels	$1,225	20.97%	0.23%
HACC	$ 927	15.87%	0.17%
CACPs	$ 57	0.97%	0.01%
Carers Support	$ 130	2.23%	0.02%

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The residential care sector accounts for 75% of the expenditures on long-term care, compared to 16% for HACC and very minor amounts on CACPs and carer support. All expenditures account for just over 1 percentage point of GDP. Moreover the projected increase in long-term aged care costs is relatively modest from 1.1% of GDP in 1996/7 to 1.38% in 2031. By contrast aged pensions are expected to grow from 3% of GDP in1999 to 4% in 2031. Nursing homes are about half the costs of hospital care for older people and total health care costs are approximately double the long-term care proportion of GDP (Madge, 2000).

The scale of health services relative to long-term care, approximately two times larger, is creating new issues for long-term and community care as acute and sub-acute medical care is shifted from hospitals into the home. There is a rapidly emerging need to reorganise the relationships between health and community aged care. On the other hand the residential care component has remained stable in its long-term care share continuing to capture more than 3/4 of the long-term care budget. This scale creates a dilemma for change: intensive residential care is the obvious area to target for cost cutting but it is so large that the political rationale tends to move from servicing clients with aged care needs to servicing powerful service providers. The key problem is that residential care has been established, since the 1950s, as the central point of the provision of aged care services and home and community care has not gained status as the focus for long-term care provision.

The most recent reforms, arising from the implementation of the Aged Care Act 1997, have continued the focus on residential care in the provision of long term care to Australia's frail and disabled older people whilst beginning an important redefinition of the role of the accommodation setting. "Ageing in place" has described the policy shift to enable care provision to match the needs of older residents without requiring residents to relocate to access the level of care appropriate to their emerging needs. Both the residential and community care service systems now have the capacity to respond to increasing illness, frailty or disability within a person's own home or within the residential setting in which they reside. Changes to the boundaries of these programs have also enabled the provision of services to support increasing need without always requiring persons to relocate to access the level of care that is appropriate.

However, the reforms have not removed the access barriers created by the remaining program boundaries. Implementation of the "ageing in place" policy has been based on a classification scale that estimates the care needs of persons seeking or requiring residential care. The ascribed classification then determines the entitlement to funding of the individual within residential care and the residential setting of care is able to be determined on the basis of availability. The classification scale does not, however, embrace the care needs of clients who choose or prefer to continue to live in a non-institutional environment: their own home, that of a relative or carer, or other community environment. As a result, individuals with the same level of care need have access to differential levels of funding entitlement and of service provision, depending on the environment in which they receive care. "Ageing in place" unintentionally retains the presumption that residential environments are those most appropriate to the provision of high dependency care. Community care remains a separate service system, supporting the needs of people with limited care needs or high levels of family support.

Other reforms implemented in 1997 and policy initiatives announced in 1999, the International Year of Older People, tended to continue the pre-eminence of residential care within the Australian aged care system. More generally, these most recent reforms drive a significant structural change present in aged care services from government driven health and welfare benefits to the construction of a substantial service industry, through the shift to higher user payments, self-regulation, and government regulated standards.

In Australian long-term care, we now have parallel service systems providing residential service provision and community care services, with access determined largely by the level of dependency and often the availability and capacity of familial carers. Consumers are faced with restricted choices of care options, based on their care needs. If the consumer requires or chooses high-care residential facilities they will have all their accommodation and care needs met. Alternatively if the consumer prefers to or chooses to live at home with family support even with high levels of dependency, they do not receive support for accommodation and may not have all their care needs met in a pressured Home and Community Care system.

The 1997 reforms recognised the need and potential to provide support services for older people with high dependency care needs within the community rather than in institutions. The reforms also introduced some recognition of the changing health status of older people, particularly in respect of the increasing incidence of dementia in advanced older age and of the incidence of chronic illness in older people seeking low dependency care in residential environments. These reforms, however, have *added* to the existing complexity and overlap within the Australian long term care service system - older people with similar care needs are now offered an expanded range of care options; but, those care options provide significantly different levels and mixes of care services.

As Australia has focused on improvements in residential care, we have simultaneously entrenched aged care policy debates within the narrow framework of the supply of those services. The number of beds becomes, as we have seen in recent times, a critical policy focus - rather than the number of older people receiving support, the number of carers receiving support, and the quality and quantity of that support. Rethinking aged care requires the recognition that almost all older people will, as they experience advancing age, seek support with living at home, whereas only 5.5% of older people, at any point in time, will seek or require residential care. It has proved difficult however to fund community care relative to its actual importance in the aged care system.

What can be done about this situation? A key characteristic of an ageing society is the co-existence of many diseases in the one person and the realistic expectation of other diseases as death approaches. Hence I argue that we have entered a new, complex phase of the epidemiological transition, the age of comorbid and substitute disease. When we prevent one disease or death, other diseases are in place ready to reduce the quality of life gained or can be expected to be real risks in the near future.

Four key principles underpin a proposal for a restructuring proposal for health and aged care proposed in McCallum et al (2001) to deal with this new situation:

1. Subsidies follow the client based on assessed needs;
2. Clear distinction between care and accommodation costs in aged care;
3. Flexibility and greater choice of care location for the client; and
4. Recommended care setting and care package determined through universal assessment.

The model proposes a shift away from Australia's historical (current) system for purchasing health and residential care where funding is tied to the buildings. Care would be packaged according to assessed need, the location of care would, subsequently, be determined on a needs basis, and the quality of care provided would be transparent and competitive.

In this approach, a funding pool for a large local area would be established and drawn from collaborating health and aged care services such as:

- the Commonwealth Residential Care Program (for residential care and CACPs);
- income tested fees & resident contributions applicable in residential care;
- Commonwealth funding for residential respite care.
-

And the pool would be augmented by funding drawn and pooled from:

- State subsidy payments funding to public sector residential care beds;
- State payments for Nursing Home Type Patients (NHTP) in acute or sub-acute facilities;
- State funding for predominantly aged care services provided in hospitals such as sub-acute centres; and
- State funding for Community Care Packages.

There is a need to recognise the benefits of a new community focused care paradigm in the face of an ageing population with increasing life span, and increasing expectations. We propose the establishment of a *Continuous Care Restructuring Program (CCRP)* to test and implement these ideas and would be happy to work with any new government initiatives in this area. The benefits of a changed focus will be cost effective services with emphasis on quality of care driven by increased self-determination, autonomy and choice for older people and other people with chronic disease.

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4. HEALTHY AGEING

There is a large and growing literature on promoting healthy ageing. In our Dubbo work since 1988 we have provided some of fundamental data which can provide the basis for new initiatives. I will briefly review some of this evidence and a full set of publications from this long running study is attached.

The Dubbo Longitudinal Study is a major health and social study of 2805 people, 1236 men and 1569 women living at home, born before 1930. We surveyed them in 1988 and it is continuing in 2003 with our AHEAD study added on. There have been four core team members over 12 years: Professor John McCallum UWS (originally ANU), A/Professor Leon Simons and Ms Judy Simons St Vincents/UNSW, and Professor Yechiel Friedlander Hebrew University, Jerusalem.

Are older people in Dubbo representative of Australian ageing? Dubbo is better described as non-metropolitan than rural and the population is representative of Australians with only one major exception, namely it has 5% migrants rather than 30% for the whole of NSW. As a consequence we found, for example, that Dubbo residents had high CVD rates but lower rates of treated hypertension than the Honolulu Heart Study. This had a very simple response namely to treat the hypertension. Hence there are a number of healthy ageing issues which our peer-reviewed, published work has addressed. I will briefly review factors which predict death, hospitalization, residential care admission and disability.

What predicts earlier death? In a survival analysis of mortality the predictors of survival were: age, marriage, smoking, alcohol, prior CHD, use of anti-hypertensive medications, poor self-rated health (women only), level of disability(men only) and moderate alcohol consumption. Moderate alcohol is associated with significantly longer survival (cardiovascular and all cause), so we estimate that we can gain extra year for men at $5700 for men 60-74 and some pleasure into the bargain! It is important that we work with the modifiable risk factors that our analyses identified to promote healthy ageing.

Do respondents go to hospital because they are sicker or are there inequalities in hospital access? Hospital admission rates are similar for men and women at around 90% over 12 years. An analysis of hospital admissions shows that the predictors were: age, smoking, prior CHD, poor self-rated health, level of disability and other health factors. Higher education, the best measure of social class difference, was not significant, due to the accessibility of publicly funded hospital services and effective assessment in primary health and aged care services.

Next we asked was there differential access to residential care? Men have a relatively flat rate of institutionalisation by education level but women's rates of institutionalization were lower at higher education levels. Age was the dominant predictor of residential care use and there was little significance of other factors after we took account of it. There have been historic changes across the period of study in hostels and aged care.

We took particular interest in discovering what delays disability? We looked at disability 1988 i.e. 2 or more Activities of Daily Living that people 'can't do'. By gender and education, primary educated women have more disability than men but tertiary women have less than men. Looking at disease and disability after 8 years, we found that people with 3+ admissions (normal levels) have disability 5 years earlier than those with less admissions. That is we can work on lowering the reasons for hospital admissions and at the same time delay the onset of disability! Other factors which predicted onset of disability included: baseline age, disability, Body Mass Index, poor Peak Expiratory Flow, Blood Pressure medication, depression, stroke predict 8 year disability. Excess cumulative disability was evident for all major health risks e.g. depression, stroke, so a healthy ageing disease prevention program is also a disability prevention program. These synergies are important although the task is a challenging one.

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5. EXPORTING AGED CARE SERVICES

Finally I have been a long-term promoter of the opportunity for Australia in exporting aged care services. I started this initiative with an article in the Department of Foreign Affairs and Trade Journal in 1992 and I then was a major player in a large consultancy on the issue. Most recently I headed up the Australia-Japan Partnership in Community Care.

My argument is very simple. Ageing societies all around the world require new kinds of expertise, services and products. Moreover we need to maintain levels of economic growth so commerce and trade in these areas is essential. For example the establishment of the new long-term care insurance system in Japan created major new opportunities for Australians with expertise to sell there. My visit recently identified a new agenda particularly around education and training exchanges improving quality of care. This needs to be focused on care planning and care workers, and around community care. There is also much to be learned from Japan about older workers as indicated above. Many other countries also provide opportunities for mutual exchanges of expertise, services and products that are required in elderly populations. We have an opportunity to become a leader in this area of trade which will need some further nurturance and support by governments at all levels.

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A FINAL NOTE:

I am happy to expand on any of these views and to speak to the committee if required.

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