Chelsea, Quebec, Canada
November 17, 2002

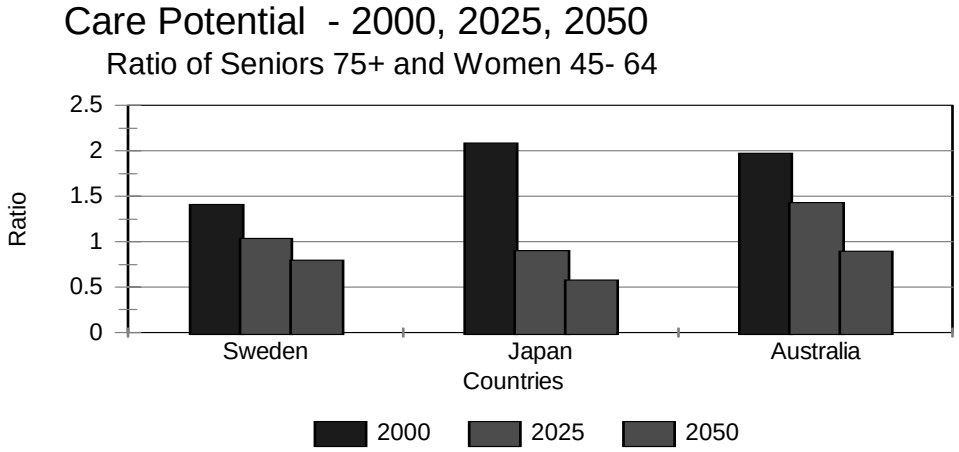
I would like to respectfully submit the following to the Australian Parliamentary Inquiry into Aging. I made a presentation (available for viewing at the following website: http://www.agedcare.org.au/conferences/speakers%20papers.htm) to the Aged and Community Services Australia conference in Adelaide last September after which I was encouraged to provide input to the inquiry.

THE AGING POPULATION CHALLENGE FOR POLICY MAKERS

Aging policy for the 21st century constitutes an unprecedented challenge in most developed countries with established policy infrastructure. The issues are no longer merely insufficient funding, increased clientele or program adaptation. Focusing on a single policy, such as pensions, at a time is inadequate. Traditional incremental policy making will no longer work and parliamentarians are challenged to take not only a comprehensive view but a long term perspective in designing aging policy for the future. The risks of failure to do so are high. Once the baby boomers start to age, if appropriate public policy decisions for the future are not taken existing policies will be unsustainable, and countries may be forced to cut expenditures for existing programs with serious consequences to both the working and the elderly population. Now is a window of opportunity to make structural policy changes that take an intergenerational and life course view of aging.

In most industrialized countries, aging policies, including those for housing, care and health services were designed in the nineteen sixties, almost two generations ago. They were based on biological, social, economic and environmental factors that were appropriate for that time, but which have changed considerably in the forty years since then. The entire system of care for older citizens has undergone major changes and therefore policy makers have to reconsider the division of responsibilities between the individual, families and the state as well as the relative importance of the policies in the mix. For instance, the high share of informal care was possible because of the size of the baby boomer generation. Following generations will not be as large. As the baby boomer generation reaches old age, the dependency ratio between the working population and the elderly will rise. With more highly educated women and more of them working, the potential for informal care will fall and the caring professions will be starved for workers, since care is largely provided by women (See chart 1). Furthermore, as people live longer, the pattern of service consumption and the costs associated with them between the ages 80 and 90, are very different from between 70 to 80.

Chart 1



Note: The care potential ratio is a crude but telling measure. It is recognized that men and spouses provide care as well.

LEARNING FROM INTERNATIONAL EXPERIENCE

Though aging is a universal human phenomenon, depending on country-specific factors, each country has developed an approach for the care of its older citizens. However, all countries share some features: Older persons have primary responsibilities for themselves and they wish to live independently, generally drawing on help from family. A small proportion lives in special settings for the elderly, relying on public or private health and support services. But on closer examination, countries appear to cluster into three phases according to their responses to population aging and societal changes. The rate at which countries move through a phase is dependent on their national context. This provides the opportunity to learn from international experience and to customize the approach for national conditions.

THREE PHASES OF RESPONSES TO POPULATION AGING

Phase 1: These countries experience growing life expectancy and the proportion of their elderly population is around 7-10%. The co-residence of two generations is in decline and they engage in the construction of institutions and the training of specialists such as geriatricians which they did not need as much before.

Phase 2: The pressures experienced by these countries arise from the higher proportion of older people, from about 11 to 14%, in their population. Since there are few other options, the demand is high for nursing home care and the skyrocketing costs incite the reduction of their use to 5-6% of the elderly. Policies for aging-in-place stimulate the development of many forms of residential care. Home care grows rapidly. Problems emerge, as older persons with the same assessment level in the community, in residential care and in nursing homes, receive different services and pay differing costs.

Phase 3: When the proportion of the elderly population is over 15% of the population, the aging care system is examined as a whole. An integrated system results in the blurring

of forms and levels, with an emphasis on better quality and equal treatment. Older people require varied types of care at different times of their lives and it is difficult to ration and administer the allocation of nursing homes and residential care facilities. The costs of housing and housekeeping services tend to remain with the individual and the latter is often purchased from the private sector. Home care is provided according to need regardless of type of residence or facility. Nation-wide lower level care (community care) is the best strategy for reducing the numbers of clients, delaying their entry and minimizing the time spent in higher levels of care. The amount of time spent in collective institutions declines as people move in, mostly at the end of life. Policies are based on life cycle needs and not only on prevalence.

Chart 2 provides a graphic picture of how services are used in the three phases. In the first, the inverted triangle shows that most of the aging policy dollars go to nursing home and hospital care of older people. In the second, the diamond shows that nursing home care is reduced, that there is growth of residential care but that home care is still serves few seniors. In Phase three, the integrated triangle, shows that most elderly people benefit from some home care and that the integrated system allows them to move in and out of more expensive forms of care. This enables the delay of more expensive forms of care and also shortens the time spent in such care.

Chart 2

THE PATTERN OF SERVICE PROVISION IN THE 3 PHASES

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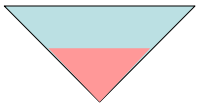
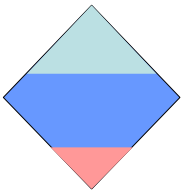


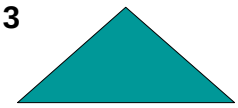
7-10% of 65+ in the population. Most older people (7-9%) requiring care live in nursing homes. There are few services available for those living at home.

2



11- 14% 65+ in the population. High cost of nursing home care stimulates reduction of its use (5-6%). Policies for aging-in-place results in many forms of residential care. Low use of home care.

3



Over 15% 65+ in the population. An integrated system where the care provided is dependent on the need of the older persons. Blurring of forms. Most people receiving home care. Housing quality maintained. Few people in nursing homes, mostly at the end of life.

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TWO MODELS FOR ENSURING SERVICES TO THE OLDER POPULATION

In the first model, generally associated with Phase 2, housing is attached to care, with staff on site to provide the services to the residents. The United States is a leading example. Residents have a package of barrier-free housing (generally a room), and

"hotel services", such as meals, laundry and emergency call system and sometimes, a minimum amount of personal and nursing care. There are many types (for example, Assisted Living, Abbeyfield, Sheltered Housing, Retirement Villages, etc) which vary mostly in the way they deliver services and charge for them.

In most countries using this model, there is already sufficient housing stock and most people move to these facilities primarily to ensure the availability of services. These residential care facilities are expensive to construct and hard to distribute so that older persons living in any part of the country have equal access to such housing. Allocation is specially challenging because most seniors do not want to leave their community or lose their established social networks. Though attempts are made to keep the scale small, service delivery is more economic at larger concentrations of older people.

In the second model, usually associated with Phase 3, housing is de-linked from services, so that elderly people can access health and social services according to their need at a specific time, regardless of their type of housing. The Scandinavian countries and Holland rely on this model. With almost one in five in the population being elderly, it becomes essential to provide older persons with the same needs with the same array of services. Increasing numbers of older people age in place. Most older households move once, about the time of retirement, mostly to downsize while independent. The majority of older households own their homes, mortgage free and if modifications are made, they tend to be minor. Generally, they prefer to add services to their existing home. Because the needs of persons 80 years and over are very diverse, customization of services and the ability to vary them is more effective than a fixed package. The services required by older persons 80 years and over requires a variety of trained professionals, providing services at different rates, and delivery cannot be accommodated either by a single home helper or by staff in a residential facility, unless it is very large. If they move to housing with care at all, it is generally late in life and for a relatively short period of time. High levels of care can be provided at home for a few and for a short time, particularly if it is better for the older person to remain at home rather than be moved.

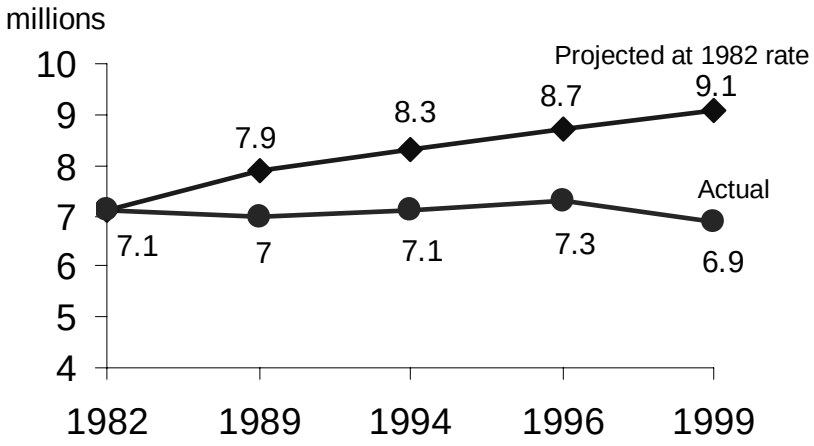
LEARNING FROM OTHER COUNTRIES

Japan, the fastest aging country: By 2015, one in four Japanese will be 65 and over. Japan launched the Gold Plan in order to develop sufficient home based care, residential care and community based services but issued a drastically revised New Gold Plan in 1995. In particular, the target for "care housing" was unrealistic, when only 6,853 were built of the planned 100,000. Home care also fell far short, with only a third of the planned capacity achieved. The New Gold Plan has a major emphasis on aging-in-place. Regulations require that all new housing, about 1 million units, should be built for 30 years of "liveability" to universal design standards. By 2015, the target is to have forty per cent of the housing stock supportive of aging-in-place – half from new construction and half through renovation. Because of the major savings to the health and social services budget, the Ministry of Health and Welfare provides second mortgages at 1% lower rate for construction of barrier-free housing.

The United States recognizes that more years will be spent in community care: The United States first identified the increase in disability-free years and falling rates of disability among people 65 and over. (See Chart 3. Regardless of the current situation, if one country is able to achieve such a growth in disability free years, there will be pressure every where to achieve the same goal.). About 5 to 7 per cent of older persons live in institutions at any one time, but between 25 to 30 per cent may move to nursing homes at the end of life. They move into nursing homes at an average age of 85 and the average stay has fallen from 34 months in 1985 to 28 months in 1995. In comparison, the average age for moving into assisted living is 83 years and the average stay is 24 months. There is not a large difference between the two clientele. Many older people, who desire special housing, cannot find spaces or cannot afford it unless subsidized.

Chart 3

Disability rates are declining among Americans 65 years and older



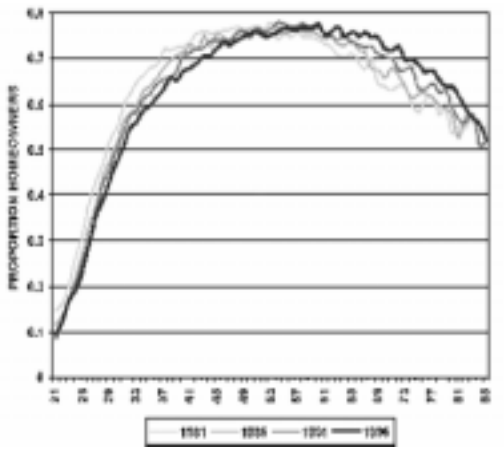
Source: Manton and Gu, 2001. Long Term Care Surveys. Age standardized rates.

The elderly in Canada live longer independently in their own homes compared to 20 years ago: Older households move around the time of retirement in order to trade down in size and trade up in quality. Patterns of home ownership show that though the young delay purchase of housing, even at the age of 85 over 50% continue to own. (See Chart 4) Though there is a 20% drop from the peak, it is occurring later compared to 20 years ago. The remaining renter households are likely to have low income, and because they have higher rates of illness and disability, they are likely to benefit the most from residential care, but are least able to afford it.

Chart 4

LEARNING FROM CANADA

The market for residential care housing will not grow as fast expected.



Canadians live longer independently in their owned homes compared to 20 years ago. Renter households are likely to have low incomes and higher rates of disability but are least able to afford residential care.

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The Netherlands leads in client control and customization: The Netherlands has benefited from the SEV Substitution Project, which supported experiments for housing with care services that would cost less than institutions. It was estimated that 22% of all clients in nursing homes could live in residential care facilities and about 60% of those living in residential care facilities could live more independently, provided that home care was available. To support aging-in-place, services were de-linked from housing. Therefore, the housing decision was separate from care decisions and individuals were responsible for their own housing, with the attendant security and rights of tenure. The "Senior Citizen Label" is a quality standard with a list of 31 basic requirements for new life time housing. The Netherlands also pioneered the "care to measure" concept, shifting from the "facility and supplier oriented approach" to the "demand and function oriented approach". In 1995, the "client linked budget" was introduced which allows the older person to customize services according to need. Older persons chose to buy private house keeping services, and used the budget for public specialized services according to need.

Scandinavia has a high proportion of citizens 80 and over:
Almost all Swedish municipalities provide 24 hour home care and a variety of mandatory services according to need. In Denmark, housing for older people meets the same minimum standard for space and amenities as general housing - an independent self contained unit, with living room, bedroom, kitchen, bathroom; up to 67 m2. The older residents have a rental lease and secure tenure. Residents receive services independent of

their housing and do not have to move out if their condition worsens. Norway has a Life Span Standard for housing, supported by supplement to loans from the Norwegian State Housing Bank.

AUSTRALIA - A GOOD PLACE TO AGE?

The National Strategy for An Aging Australia and the Intergenerational Report have stimulated debate. Australia will be a good place to age if a systemic and a lifecycle approach is taken rather than considering older persons as sole beneficiaries of aging policy. When one in five, or even four in the population is 65 and over, they will have voter and consumer power to demand that their needs are met effectively and equitably. Wise policy decisions will ensure that Australia is a good place to age.

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