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Australian population ageing is moderate by Western country standards but there are major issues emerging in national policy debates. The proportions 65+ will double and the proportions 85+ will more than quadruple by 2050. The first concern is the long-term trend to earlier retirement from work along with a nearly universal dependency on publicly funded age pensions rather than on private savings and superannuation. New mandatory superannuation guarantee scheme will ease some of the financial pressure from income dependency. Secondly heart, musculoskeletal, cancers, mental illness and digestive diseases are high cost conditions but musculoskeletal and mental conditions are a higher cost for women than for men. About two thirds of health expenditures are spent on the tenth of the population 65+ which indicates an issue of control of health costs through appropriate servicing. Third severe handicap rates reported in national surveys have stabilised over time to cover the last 3 or 4 years of life. Over two thirds of the remaining years of life at age 65 are currently spent free of handicap. Aged care services have shifted in focus from intensive options like nursing homes to less intensive options like hostel care and home and community care. There is about a two thirds risk of ever entering a nursing home or hostel at age 65. Consequently long-term care financing is one of the most urgent issues in Australian aged care policy.

Introduction

Population ageing first became popular in public debates in the mid-1970s when it was discovered that older Australians were living longer than expected. Because of increased concerns on July 2, 1998, the Australian Government announced a decision

to hold consultations to develop a National Strategy for an Ageing Australia. Australians have generally viewed themselves as members of a youthful society and have high expectations of government support. This presents some unique challenges of ageing. Over time the role of government has increased both as a direct provider of services and as a funder of non-government agencies providing aged care services. Government is, as well, a regulator in all these areas. For various reasons, future governments are likely to find it less easy to increase social spending in the same way as they have in the past. This report explores three policy issues arising from demography: retirement and pensions, disability and health, and aged care services.

Demographic Ageing

While aged activists regard much of the discussion of demography of ageing as overly negative, it is a topic of perennial interest to the general public. There are several important points from the most recent projections for people 65 and older (ABS, 1996). First, the number of Australians 65 and older will increase by 8% from 1996 to year 2001, 35% to 2011, 82% to year 2021, 227% to 2031, 259% to 2041 and 274% to 2051. Second, the proportion of the total population 65 and older doubles, between 1996 and 2051, from 12 percent to 23 percent. Third, the proportion of population 65 and older increases rapidly between 2006 and 2011, when the "front end" of the babyboom cohort reaches age 65 years. Fourth, the rate of growth of the population 65 and older will be at its maximum around 2016.

These rates of population ageing are of most interest if the working years continue to end at around ages 60 to 65 years. Should this assumption hold, then around 2006–2010 there will be great demands on retirement income support, for housing, leisure, and other activities suitable for older adults.

Although the absolute numbers are relatively small, the rate of increase of the population 85 and older—the "old old"—is exceptional. The main points of the most recent projections for people 85 and older are that the number of Australians 85 and older will increase by 29% from 1996 to year 2001, 94% to 2011, 233% to 2021, 325% to 2031, 485% to 2041 and 603% to 2051. As a proportion of the total population, people 85 and older move

from 1.1 percent to 4.6 percent between 1996 and 2051 and, as a proportion of the population 65 and older, from 9 percent in 1996 to 20 percent in 2051. The proportions of population 85 and older increase rapidly to 2001 when the front end of the post World War I babyboom—supplemented by adult migrants arriving in the 1940s and 1950s—reaches age 85 years and again from 2031 when the Initial World War II babyboom cohort reaches age 85 years. The rate of growth of the population 85 and older is double-peaked at its maximum at 2001 then declining and peaking again around 2036 (ABS, 1996).

If rates of "old old" age health and dependency continue to follow the same patterns, then around 2001 (and more so in 2030) there will be greater demands on health care and long-term care for very old people. The demands will be even more substantial if, as in countries like Sweden, there is the growing tendency for very old people, predominantly women, to live apart from their families. This is to suggest that people living alone are likely to need more, and earlier, services than people co-residing with their social supporters.

Retirement

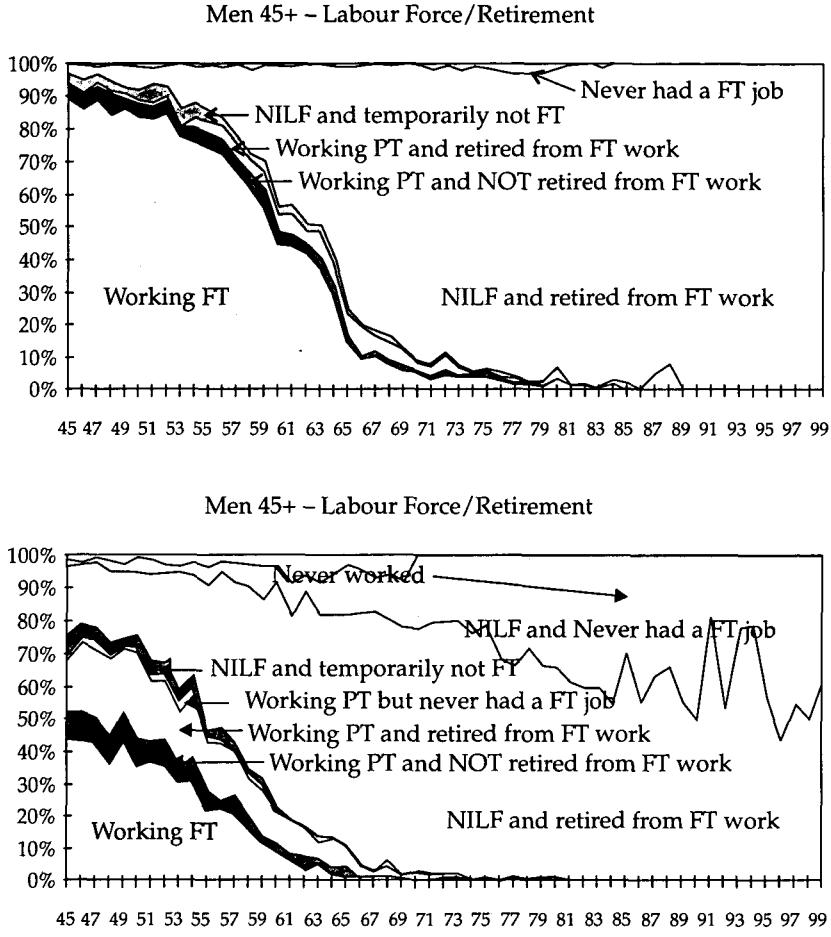
The existing patterns of work and retirement of an industrial society are evident in the differing patterns of labour force status for men and women (Figures 1 & 2).

Current retirement behaviour is problematic in an ageing society. At ages 60–4 years, the participation rate for men drops below 50 percent and for women below 20 percent. There are 'retirement' rate peaks at ages 55, 60 and the highest at age 65 years for men and the largest at 60 years for women, with smaller peaks at ages 55 and 65 years (Figure 2). Given the absence of compulsory retirement, these single year peaks reveal strong effects of eligibility for age pensions and superannuation preservation rules, along with persistent cultural patterns, set by historical mandatory retirement ages. This early retirement is a concern for the future viability of retirement income support.

Retirement Age

As Australia moves away from an industrial society to being one with more flexible work patterns, there has been a slow

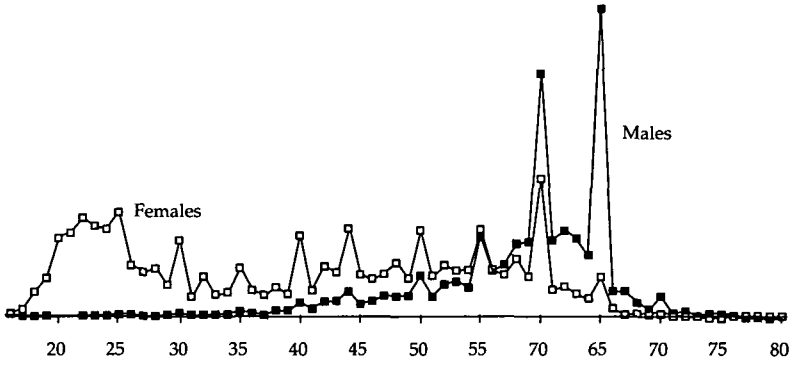
Figure 1
Labour Force Status Men and Women 45+.



Source: Bacon 1996.

convergence between the labour market experiences of women and men (Bacon, 1996). This indicates that there has been a gender shift, with relatively more women employed and fewer men. Further, there is an increase in part-time and casual employment,

Figure 2
Age of Retirement from Full-time Work, Persons Over 45, November 1994



Source: Bacon 1996.

as well as new cohorts retiring before pension eligibility of age 65. A final trend is that more women are re-entering the work force after having children. Yet, unless government produces more incentives to longer working lives, early retirement trends will not slow down.

Pensions

There are two main parts to the Australian pension system: government means-tested age pension and mandatory superannuation for employed persons. There are about 1.7 million aged and wives pension recipients and estimated outlays of $13.6 billion in 1997–8. This accounts for 32 percent of total social security pension outlays. About half of men and women 65 and older receive the full pension, while about 20 percent of men and 30 percent of women receive part pensions due to means-testing. Pensions make up two-thirds of the income of people 60 and older compared to about one-fifth for interest earnings, and 8.5 percent for superannuation. There is, then, no evidence that the current generations of older people retired to live on the benefits of superannuation or private savings. Three quarters of pensioners own

their own homes which are estimated to account for two-thirds of the total assets of people of pension age. Older Australians hold most of their wealth as equity in their own homes and live on publicly funded age pensions.

The major policy development in anticipation of population ageing in the last 10 years has been the introduction of compulsory contributions to the Superannuation Guarantee (SG) scheme by employers and employees. The expected impact of the SG can be seen in Retirement Income Modelling Unit estimates for years 1996/7 to 2015/6 (Table 1).

Some key issues can be seen in these numbers. Superannuation payouts, as a consequence of increased contributions from the late 1980s, begin to outweigh the value of other assets excluding housing around the year 2000. The interaction of the superannuation payouts with the age pension means test causes gains in superannuation to be reduced by means testing on the age pension. The combination of both means testing and tax almost halves the extra income to the older person by the year 2015/6.

Table 1

Average Impacts of SG on Individual Retirees

Year	*Average Super Payout A$*	*Payout to Average Financial Assets**	*Estimated Extra Annual Income A$*	*Extra Income after Pension Reductions A$*	*Extra Income after Pension and Tax Reductions A$*
1997/8	52,241	0.9	2,012	2,012	2,012
2000/1	69,484	1.2	2,874	2,737	2,737
2005/6	93,083	1.3	4,054	3,327	3,191
2010/1	115,051	1.3	5,153	3,876	3,662
2015/6	216,281	1.9	10,214	6,407	5,504

* Financial assets exclude the value of homes.

Source: Retirement Income Modelling Unit (unpublished data)

* A$1= US 60c approx in Sept. 1998

Retirement and pensions are a major policy issue for an ageing Australia. The Organization for Economic Cooperation and Development (OECD), in 1995, considered a number of pension scenarios in 20 countries between 1995 and 2030, using World Bank data. A "later retirement" scenario modelled the gradual lifting of retirement ages to age 70 years whereupon people were working and paying tax and other contributions. This change allowed upward pressures on pension costs to be offset by longer participation and periods of contribution. A 'targeted pensions' scenario held the ratio of pension benefits to wages constant from 2010 and gradually reduced the proportion of older people qualifying for the pension to 30 percent. This dramatically reduced pension costs. For Australia, the pension expenditure as a percent of Gross Domestic Product (GDP) in 2030 was simulated to be 2.4 percent under the 'later retirement' scenario, 1.7 percent under the 'targeted' scenario, and 3.8 percent if policies did not change. In 1995 the actual ratio was 2.6 percent.

Disability

Being able to function independently is the desired state for older people but this is threatened by increasing risk with age of accidents and illnesses. The most prevalent cause of disability among people 65 years of age and older is arthritis and other musculoskeletal disorders which have a prevalence rate of 17.3 percent for all people over 65, but 19.6 percent among women 65+. The next most prevalent are diseases of the ear (8.1 percent) and circulatory diseases (8.0 percent). Diseases of the ear are much higher among older men (11.5 percent) than women (5.5 percent) and circulatory disease is slightly higher among men. By comparison to these prevalent causes of disability, only 1.7 percent of older Australians had psychiatric conditions. Whilst organic disorders like Alzheimers disease are low in prevalence they are high in impact, accounting for around 8 out of 10 persons in nursing homes.

Using the most recent disability survey evidence, the expected years that a person aged 65 has in different disability states can be calculated (Table 2). Handicap is more severe than disability since it is defined by costs associated with loss of function.

Table 2

Health Expectancies (HE) and proportions of Life Expectancy (LE) for men and women at age 65 in 1993

Expectations at age 65 with—	*HE in years*		*HE/LE percent*	
	men	*women*	*men*	*women*
Profound handicap	1.72	3.72	12.7	19.1
Severe handicap	0.64	0.94	4.1	4.8
Moderate handicap	1.62	1.64	10.3	8.4
Mild handicap	3.34	2.90	21.2	14.9
Disability only	1.90	1.19	12.1	6.1
Disability free	6.51	9.09	41.4	46.7
Life expectancy at age 65	15.73	19.48	100	100

Note: Disability is less than full function and handicap is disability with a social, economic or cultural cost.

Source: Mathers (forthcoming)

Thus, we expect men and women to spend more than half of their years remaining after age 65 years free of handicap. On the negative side, of the 16 years men have remaining at age 65 they will have almost 2 years, or an eighth, with profound handicap and women will have almost 4, or a fifth, of their remaining 19.5 years with profound handicap. Without wanting to emphasize the negatives, it is these more severe conditions that will be explored because of their personal and policy importance.

The Australian Bureau of Statistics (ABS) measure of disability is complex and relatively "soft" or inclusive, so it is better to concentrate on severe (and profound) handicap as indicator measures for morbidity. The ABS disability surveys indicate that rates of severe handicap increased between 1981 and 1988 but returned to 1981 levels in 1993 (Table 3). Womens' rates were almost double those for men. This is due to the fact that there are many more older women at advanced ages than men and they have greater risk of severe handicap than men, due to a less active lifestyle and possibly a greater underlying vulnerability than men to disabling disease.

Table 3

Trends in Rates of Severe Handicap (percent) 65+.

	Severe Handicap		
	Men	*Women*	*Persons*
1981	12.3	20.4	17.0
1988	13.1	22.6	18.6
1993	12.4	20.3	16.9

Source: Wen, Madden & Black (1995) and various ABS Disability Surveys.

On average, 20 percent of women and 12 percent of men 65+ suffer severe handicap but there are higher rates of severe handicap at older ages, growing to half of men and almost two thirds of women aged 85 years and over (Table 3). A fourth in the series of national disability surveys will be released early in 1999. Analysis by Wen, Madden and Black (1995) shows only a few percent are due to increased age-specific rates (ie sicker people at older ages), with most being simply due to increases in numbers of older people. Evidence is even more positive from recent U.S. work (Crimmins, Saito, & Ingegneri, 1997) where disability-free life expectancy increased from 1980 to 1990 for people 65 and older. The improvements in the 1980s were evident in declines in levels of disability in people living in the community. In the previous decade, 1970 to 1980, the trend was in the opposite direction; namely, disability-free life expectancy decreased. The authors point to improved experiences in education, the labour market and socio-economic circumstances, as well as health advances to explain the change. These factors could operate in Australia in the future to produce improvements in disability-free life expectation.

Health

In Australia, national health insurance began life in 1976 as Medibank, then it was weakened under a changed government only to be given new life by a new Labor government in 1984 as Medicare. The Medicare system exists alongside voluntary

private health insurance—the latter covers about a third of the population and slightly less of older people. Medicare is a social insurance system with a levy on pre-tax salary of 1.5% for those with incomes above the specified minimum. For this, all Australians were provided with 85% of the scheduled fee for GP consultations, 85% rebate of the scheduled fee for specialist consultations out of hospital; a bulk billing option from private providers if they did not require consumer copayments and make no charges to the consumer: 100% of specialist services scheduled fees for in-hospital services; and 100% of public hospital and other medical services provided in hospital.

Most older people have incomes that fall below the level at which they are required to pay contributions, but all are provided with high quality services when they need them. Rationing occurs only according to health need and, *de facto*, through waiting lists. No funds are accumulated and the government pays its share of costs on a pay-as-you-go basis. That cost is increasing. Total expenditure on health care services in Australia amounted to $41.7 billion in 1995–6. 8.5% of gross domestic product. Total health expenditure rose by 5.3% in real terms between 1994/5 and 1995/6 while population grew by only 1.3%. Government health expenditure increased by 6.4% over the same period, double the rate for non-government expenditure. Approximately 37% is spent on public hospitals, 25% on medical services and 9% on pharmaceuticals. Government expenditures on the last two areas are uncapped.

Health costs of an ageing society are hotly debated in Australia (EPAC 1994; National Commission of Audit 1996). A key issue is whether to project *pro rata* on historic evidence of use and costs on years from birth versus years from death. The later method is preferred on the historical evidence that a low percent of health cost increase is attributable to population ageing. While even under appropriate projections costs increase, the traditional methodology over-estimates health expenditure per aged person by 4–8 percent by 2030 (Eckerman, 1992). The OECD (1996) modelled health costs for ageing in 20 countries. A first scenario assumed that as people grew older they consumed more health care so current per person health care expenditure was multiplied by the total number of older people. Under this model, public

health care costs in Australia grew from 5.8 percent of GDP in 1995 to 7.6 percent in 2030, assuming health expenditure grew at the same rate as GDP. The second scenario modelled consumption of health care in the period immediately before death so current per person expenditure was multiplied by the number of deaths in the elderly population. Under this scenario, health care costs rose to 6.2 percent of GDP, again assuming health costs grew at the same rate as GDP. For most countries, as for Australia, the first assumption yielded higher health costs than the second.

People 65 and older constitute 11.8 percent of the Australian population, 10.3 percent of men and 13.3 percent of women, but they account for 33.6 percent of health costs for men and 35.5 percent for women. People 65 and over receive three times the expenditure in health costs compared to their population representation, slightly more for men and slightly less for women (Mathers, Penm, Carter, & Stevenson, forthcoming). The breakdown by type of disease shows, however, that older people have less than their average costs on some of the most costly diseases (Table 4).

Digestive and respiratory disease costs for older men and women, in the range of 20 to 25 percent of all age costs, are lower than the proportion of costs for all diseases. By constrast the costs for circulatory disease are much higher, at 60 percent for men and 71 percent for women—almost double for all diseases. To complicate the picture, musculoskeletal and mental diseases are higher only for women, at about 50 percent, whereas cancers are higher only for men, at 55 percent. Injury costs are lower for men but about on par for all diseases for women. The composition of these costs in terms of the sectors also varies by type of disease. It is important, then, to look at high cost diseases for older people to identify just where costs arise for the population 65+ and, further, to look at the contributions of different sectors.

On the basis of this evidence, a major area of interest will be changes in circulatory disease rates, and other high cost, high prevalence conditions, among older people. For example, if all age trends continue, then circulatory disease might be expected to become a low prevalence condition by 2020. If this were achieved it would require massive reallocations of the medical and community workforce and reorientation of resources in the health system.

Table 4

Total Health System Costs Persons 65+ by sex for Diseases by Health Sector and ICD-9 Chapter 1993–4 ($ million)

ICD-9 Chapter	*All Hospital*	*Nursing Homes*	*Medical Services*	*Pharmaceuticals*	*Dental & Allied*	*Total Costs**	*65+% of All Ages*
All Diseases							
men 65+	2351.6	646.1	598.8	486.4	178.8	4595.2	33.6%
women 65+	2532.4	1620.7	757.4	766.1	274.1	6340.8	35.5%
Digestive							
men	165.0	13.6	38.3	41.0	80.3	357.8	22.6%
women	175.4	17.7	40.2	53.8	119.7	430.3	20.2%
Circulatory							
men	553.8	189.1	123.8	158.4	12.0	1102.0	60.0%
women	481.7	318.0	147.5	155.9	13.1	1292.4	70.5%
Musculoskeletal							
men	170.6	78.7	59.9	6.0	28.8	394.3	31.3%
women	273.3	316.8	93.3	73.5	50.2	850.7	50.0%
Mental							
men	102.6	149.7	23.2	23.0	1.4	318.2	28.3%
women	147.5	453.3	47.2	50.5	2.7	743.4	49.3%
Injury							
men	185.5	33.2	18.4	6.9	9.7	268.8	18.8%
women	297.6	59.0	37.0	12.5	13.8	445.0	37.8%

continued

Table 4

Continued

ICD-9 Chapter	*All Hospital*	*Nursing Homes*	*Medical Services*	*Pharmaceuticals*	*Dental & Allied*	*Total Costs**	*65+% of All Ages*
Respiratory							
men	162.9	31.1	50.5	61.9	2.5	326.4	26.3%
women	134.6	58.8	50.0	65.8	4.3	331.4	26.1%
Neoplasms							
men	368.8	11.2	47.4	15.2	4.6	487.9	54.5%
women	265.0	18.1	34.1	17.9	3.4	376.9	37.3%

* Total costs include research and other categories not listed above.

Source: Mathers. (Forthcoming)

Around 80 percent of coronary artery disease deaths are now among older people. There has been a decreasing reduction in chronic heart disease (CHD) mortality with age between 1950 and 1994 with decreases of nearly 65 percent in the 45 to 54 age group and 40 percent in the 75 and older age group. So CHD deaths are down in all age groups but less among older people. There is also increasing prevalence of coronary artery disease with age from 9.4 percent at age 55 to 64 years to 18.1 percent at ages 75 and above. As a consequence there is a projected doubling of numbers of patients who need treatment for hypertension between 1996 and 2026. It is this issue that is being highlighted by writers who resist the claim that there are too many physicians and cardiologists in the community, and who put a note of caution on the good news about heart disease declines (Kelly, 1997).

Achieving continuing reductions in CHD, especially at older ages, is uncertain but possible. Trends are down in smoking and hypertension, but trends in other major risk factors are either flat or. in the case of obesity, getting worse. These factors operate in different ways at very old ages compared to younger ages. There may be greater expenditures on pharmaceuticals, such as antihypertensives and cholesterol-lowering drugs. There will also be investments in public programs to help people become more active and fit. On the other hand, continuation of current downward trends would reduce costs for that illness. The problem for older people is competing risks (i.e., saving someone from heart attack will keep them alive a little longer to die from a pre-existing cancer or to develop dementia). We can actually see this in the declining rates of death attributed to cardiovascular disease compared to increase rates due to cancers.

Australia has developed a Draft National Healthy Ageing Strategy which was approved by the Health and Community Services Ministerial Council in 1997. While having a broad focus, it seeks to "improve health and well-being for all older Australians." A broad set of strategies are provided to prevent illness and disability, and to promote well-being and participation. However, the potential impacts of shifting epidemiology also need to be explored.

Aged Care Services

Most care of older people is delivered on an informal basis by family members, neighbours and charities—crude estimates suggest about two thirds of care service events. Thus, putting residential care in its proper place, government or formal services are really supplementary to services provided informally in the community. As well, the bulk of formal services for older people are provided by generic service providers such as GPs, hospitals, and community health services. The effectiveness of the connections between generic services and specific aged care services, such as residential aged care, home and community care, respite and assessment services, is currently being investigated in a series of coordinated care trials. There has been as well a major attempt to shift the balance of care from more intensive to less intensive residential care and from residential to community-based care.

Nursing homes were the dominant form of residential care in the late 1970s, but since the mid-1980s the less intensive hostel accommodation has grown at the expense of nursing homes. While expenditure on nursing homes has grown most because of high unit costs, the number of places in hostels and the availability of community-based care services such as community aged care packages (CACPs) (which provide hostel level care in the community) and home and community care programs (HACCs) (which cover the full range of community services received by older people) have grown at a greater rate than nursing homes. Between 1985 to 1997, residential care places per 1000 persons 70 years of age and older decreased from 67.2 to 47.8, while for hostels there was an increase from 32.3 to 41.7 (Steering Committee for the Review of Commonweath/State Service Provision, 1988).

In June, 1997, there were about 132,500 residents (permanent and respite) in residential care facilities, 72,500 in nursing homes and 60,000 in nursing homes. The growth in persons in residential care between 1992 and 1997 was 12.7 percent. Places in nursing homes increased by 0.1 percent and hostels by 31.7 percent while, overall, the proportion of the older population in residential care declined over the period. Less than 10 percent of the population 65 to 69 are profoundly or severely handicapped and less than

1 percent are in nursing homes or hostels. Of those 85 and older over half are severely or profoundly handicapped and 31 percent are in nursing homes or hostels.

Commonwealth funding for long-term residential care was around $2.7 billion in 1996–7, $2.2 billion for nursing homes and $0.5 billion for hostels. (Note, as of September, 1998, the Australian $1.00 equaled $0.60 U.S.) Client contributions to nursing home costs was $685 million in 1996–7. On the more complex issue of contributions to hostels, data is not available. Nursing home costs were around $24000 per place a year which is about four times the cost of hostels. Among OECD countries, Australia has made exceptional progress towards informal and community based care. The critical decision is when the shift to home based care reaches a natural limit. The OECD (1996) argued that the development of home based care in member countries had failed to keep pace with growth in numbers of people 80 years of age and older.

Between 1 and 4 percent of the aged population are assessed by multi-disciplinary aged care assessment teams (ACATs) in standardised procedures which is mandatory for admission to aged care residential facilities. Among people 80 and over, around 12 percent were assessed and women were more likely to be assessed than men. Of the assessed men, 26 percent were recommended for nursing home and 19 percent hostel care. For women the comparable figures were 23 and 24 percent, respectively. ACATs are one of the effective rationing mechanisms for expensive residential care services which allow them to be received by those who need them most. There is some concern that the current practice of setting provision levels as proportions of persons 70 and older will be unworkable with the rapid increases in numbers at very old ages. This has provided a rational basis for setting supply, but the increasing number of very old at risk people suggest that 70 and over ratios may create under-supply in the future. Levels are also dependent on the health status, levels of independence, and care support technologies that may be available in the future.

About 6 percent of people 65 years and over are in residential care facilities. The rates increase rapidly with age, from 1 percent at ages 65 to 69, to 31 percent at ages 85 and older This first raises

the question of the focus for a national aged care strategy: What about the other 90 percent? From a public sector cost point of view the focus is nursing homes, but from the general public point of view the focus is on the majority of non-institutionalised elderly. What is not well understood by the public is that the probability of ever using a nursing home is considerably higher than the proportion of older people currently in residential care (Table 5) This can be explained by analogy to hospitalisation. Most people will not be in hospital in any one year but the lifetime expectation of hospitalisation will be nearly 100 percent.

On the current evidence, women have a 35 percent chance of ever entering a nursing home and a 28 percent chance of entering a hostel. Men have a 21 percent chance of entering a nursing home and a 13 percent chance of entering a hostel. These probabilities, with respect to nursing homes, increase with age to half of all persons at age 80 and two-thirds at age 85.

Roughly a third of people 65 and older are living in family settings at home, but 4 percent of these are sole parents even at this advanced age. About a quarter live alone and another 10 percent are in some form of care, for example in residential care or acute care facilities.

Prior to age 60, women predominate as carers and those cared for are predominantly children and parents. At ages 60 and above,

Table 5

Probability of Future Residential Care Use at Various Ages 1994–5

At Age	*0*	*65*	*70*	*75*	*80*	*85*	*90*	*95*
Nursing Homes								
Men	0.21	0.27	0.30	0.34	0.40	0.49	0.57	0.61
Women	0.35	0.41	0.44	0.50	0.61	0.78	0.97	0.95
Persons	0.28	0.34	0.37	0.43	0.53	0.67	0.85	0.86
Hostels								
Men	0.13	0.17	0.19	0.22	0.27	0.36	0.44	0.41
Women	0.28	0.33	0.35	0.41	0.51	0.63	0.65	0.45
Persons	0.21	0.25	0.28	0.33	0.42	0.53	0.58	0.44

Source: Steering Committee for the Review of Commonwealth/State Service Provision (1998)

partners become the major recipients of care and men become the majority of care providers. Spouses are 90 percent of carers 60–69 and 72 percent of carers of those 70 and older. Many older women do not have spouses to care for them. Daughters are about a third of carers and sons are about 5 percent. On the other hand, a third of Australian children under 12 years are cared for by grandparents or other older relatives. Over half of older people living alone have adult children living within half an hour travelling time.

The OECD (1992) had indicated a number of policy initiatives aimed at informal care: day and longer term respite care providing relief for carers; home monitoring and security systems with 24 hour triage, for which installation and monitoring costs may be subsidised; home and community care services delivered to the home; partnerships with non-profit and voluntary organisations providing contracted out and complementary services; and financial support for informal carers.

Australia has programs in all these policy areas. HACC expenditure increased at 8.3% annually in real terms over the last 10 years to reach $763 million in 1997. The future issue is how to fund the growing needs.

Conclusion

Recent Australian policy initiatives dealing with ageing issues (see Budget Papers 1996 a,b) have been (a) to require workers to save for their own income needs in retirement during working life; (b) to make older people pay towards the costs of their care (user pays) in residential aged care and home and community care; (c) encouraging people of retirement age to continue working by allowing people 65–70 to continue contributing to improving a superannuation fund if they are in the paid workforce at least 10 hours a week or more; (d) improving the coordination of the range of care services by innovations, such as community options, community aged care packages, and coordinated care trials; (e) increasing support for carers in the carers package amounting to A$36.7 million over 4 years; and (f) targeting health promotion programs on the elderly.

More policy development is needed and new options will need to cross sectoral and Commonwealth/State boundaries.

There is international interest in various forms of long-term care insurance as a way of ensuring adequate coverage of care needs and of limiting public outlays. The U.S. has some experience in private long-term care insurance and has reviewed performance of the product. On the demand side there has been a disappointing 3 percent take-up of insurance by older people. Public long-term care insurance has just been introduced in Japan and already exists in Israel, Holland and Germany. A variety of options exist for examination in Australia. We could have schemes that operate like Medicare, the Superannuation Guarantee or private health insurance. Equally as important is the need for public acceptance and understanding of any new financing system.

A number of countries allow older people to access their housing equity to finance long-term care. Housing finance initiatives have been taken up by few people and has had little impact on public expenditure (OECD 1996). France has experimented with partial recovery from inheritances of its dependency allowances. On the basis of this evidence, the OECD (1996) concluded that public sources are likely to continue to bear the major part of the risk of long-term care.

While examining the range of experiences with policies in other countries, Australians must avoid learning lessons that come from situations that existed in the past rather than the present. Discussion is needed to deal with this gap since most policy demands from the public will typically come from models that already exist in other countries. Some changes have been that older peoples expectations of quality of life and social participation have dramatically improved; fewer men work in full-time career based jobs and most retire before age 65; more women are well educated, work until retirement and others prefer flexible but permanent working arrangements; and family ties and living arrangements are changing. Informed but guided debate around a national strategy is as likely to reveal options for dealing with Australian ageing as is review of international options. However, both processes will be important.

By any standards Australia has created a world class aged care service system across all areas. It is a system that has been built on strong public funding which is unlikely to be maintained at the same rate and which will be put at risk by demographically

driven cost growth. The future challenge will be to contain public expenditure without affecting the quality of care.

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