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Ageing in Australia and the increased need for care

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Abstract

In this paper, we argue that the biggest challenge facing an Ageing Australia is care, specifically, the labour shortages in the care industry and the high demand for care, which exceeds the supply. We propose that this situation has arisen out of the extremely divergent discourses about the need for care, from feminist to neoliberal, managerialist responses. The aged care context in Australia is predominantly female, because women live longer than men, and 90% of formal and informal carers are women. We therefore see the continuing relevance of a gendered view of care and believe that the feminist ethics of care is a theory which offers much to our understanding of ageing in Australia. To illustrate key issues for older people and their families within the aged care system in Australia, a case study is presented and referred to throughout the paper

Key words: Ageing, Australia, care, ethics of care, gender, social work

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In this paper, we argue that the biggest challenge facing an Ageing Australia is care, specifically, labour shortages in the care industry and the high demand for care which exceeds the supply. We propose that this situation has arisen out of the extremely divergent discourses about the need for care, from feminist to neoliberal, managerialist responses. Postfeminists of the New Right argue that feminists have caused the problem by convincing women that unpaid care is not a valued activity and should be accounted for financially. The feminist movement has been accompanied by an increasing number of women entering the workforce, leaving a care vacuum. In contrast, the neoliberal postfeminist backlash and third wave feminism appeal for a return to traditional family values, where women care for their children, removing the need for paid care. This viewpoint feeds into Third Way policy, which according to McRobbie (2009), has mainstreamed feminist politics in the UK. The New Left third way language of freedom and choice, wherein the consumer voice is central is, however, hardly recognizable as feminist discourse in the hands of neoliberal politicians, though its mainstreaming has led some to question whether the need for feminism still exists at all. We believe that it does. In the discussion below, we outline what the feminist ethics of care brings to our understanding of ageing in Australia. Its philosophical limitations aside, it is a theory which has much to offer a context that is predominantly female, where women live longer than men, and 90% of formal and informal carers are women.

Case study

Elena is 42 years old and works as a welfare worker in a family support service. She is married. Her husband is a truck driver and is often away for several days at a time. Elena and her husband have two children, aged 7 and 13. Elena also contributes to the care of almost three generations of older people. She therefore works part time in order to care for her children and parents. Her parents are in their mid-60s, her husband's father is in his late 70s

and her grandparents are in their late 80s. Elena's parents live close by and are very independent. She visits them regularly and occasionally assists her mother with the shopping. At times, her mother also helps Elena by minding her young daughter. Her husband's father lives in a nursing home a few suburbs away. His doctor has told him that he must walk regularly to prevent muscle deterioration. However, the nursing home does not have the resources to assist him with this. Elena is also very close to her grandparents who live several hours drive away. Until recently they were managing fairly well at home with the assistance of various in-home services. However, Elena has observed that they are becoming increasingly frail. During her last visit she spoke with them about the possibility of residential aged care. They were interested, but very worried that they would not be able to remain living together. Elena has promised them that she will look into future accommodation options for them.

Care and gender

There are a range of issues for women as they age, which relate to the interrupted nature of their working life due to their caring roles – in raising children and looking after ageing parents. Some of these issues are evident in the case study. Elena works part time because she has a lot of responsibilities at home. This arrangement will impact on her savings and superannuation funds for her retirement. According to Quine and Carter (2006), 'women are ... less financially prepared for retirement than men, particularly if they prioritised family and childbearing responsibilities over work and earnings' (p. 6). Elena is married, which will be a source of security for her in her later years. Quine and Carter (2006) note that 'women are best prepared for retirement if married to a man earning an income' (p. 6). This is because women tend to earn less than men and are more likely than men to rely on government benefits (Australian Bureau of Statistics, 2008a). Elena also contributes to the care of almost

three generations of older people. She is, therefore, 'sandwiched' between caring for her children as well as her own ageing parents. With the ageing population caring becomes increasingly complex and demanding for the 'sandwich generations'. For instance, it is often necessary for both parents to work to support their families, it can be difficult to secure or afford child care, and the expectations of the baby boomer generation for their care in later life are generally higher. These issues also mean that many older people have intergenerational care obligations. For instance, Elena's mother's care of Elena's daughter referred to earlier. Almost a quarter of older Australians provide care and support for adult children or grandchildren (Australian Institute of Health and Welfare; AIHW, 2007a) and a third of over 50-year olds provide financial assistance to their adult children (Olsberg & Winters, 2005).

Feminist ethics of care

Philosophically, care is an ethical practice (see Gray, forthcoming) which feminists have been at pains to argue, is largely associated with the private, domestic sphere. Historically, the family has been seen as the main locus for care, with women the primary providers of care and nurturance alongside the male breadwinner. Thus, even though Elena works, she remains the primary provider of care for both her children and her ageing parents, particularly as her husband is frequently away working. This traditional view of the family has been the main focus of attack from feminists, especially those who have sought to politicize care (Sevenhuijsen, 1998, 2000, 2003; Tronto, 1993). Their argument is that care is marginalized and devalued in Western society precisely because it is mainly given by women. It is yet another diminution of women's role in society. It thus remains invisible and unaccounted for in public policy. It is undervalued and its real worth in the economy goes unmeasured. Not only does it keep women out of the labour force but it also constitutes a free good for

government. Thus, say feminists, care is a complex moral and political issue: It is not merely a private interpersonal or familial matter but a public concern. Furthermore, citizen-consumers have a democratic right to care and policy makers and care providers have a responsibility to respond to their care needs. Feminist care ethicists highlight that welfare or care recipients – now described as passive and dependent in neoliberal terms – are active care providers, or as Sevenhuijsen et al. (2006) claim, they are ‘normal citizens’ caring for themselves and others. Thus one cannot understand the complex nature of contemporary welfare transformation without grappling with the issue of care in the evolving pluralist or mixed economy of welfare (Daly & Lewis, 2003). In public policy, care constitutes ‘the activities and relations involved in meeting the physical and emotional requirements of dependent adults and children, and the normative, economic and social frameworks within which these are assigned and carried out’ (Daly & Lewis, 2003, p. 285). How the responsibility of social care is shared is the crucial question for feminists.

The shifting boundaries of care

Daly and Lewis (2003) observe that the boundaries of care are shifting to meet the increasing demand for care in contemporary welfare states, where the supply of care has decreased through more women entering the labour force, the ageing of the population, and changing norms about family. Elena’s ageing parents and grandparents will require more and more care over the years. However, because Elena needs to work to support her family she will not be able to provide this care on her own, and will be forced to rely more heavily on paid care. Also, not every child has the same sense of obligation which Elena shows in caring for her own and her husband’s parents, as well as for her grandparents. De Vaus (1996) noted that children in modern society frequently reject the idea that they are responsible for older family members. Also, many older people nowadays do not expect their children to provide care for

them. This has forced neoliberal governments to think of alternative ways of providing care in the public sphere. Daly and Lewis (2003) refute simplistic, neoliberal, managerialist, economic rationalist, and feminist arguments about welfare cutbacks. They identify expansions into new forms of care and welfare provision in various countries and show how these new arrangements rest on historical patterns of provision and shrinking family resources for caring. The image of family solidarity understood as 'readiness to care' (p. 290) which was prevalent in social policy in the 1950s and widely promoted by social workers, is being transformed by a more realistic, gendered understanding of family largely due to the input of feminists into debates about family and unpaid care. The movement of women into the labour force had already begun in the post-war years and feminists highlighted the dual role women were playing in society through work and motherhood. Whether the decreasing availability of private unpaid family-based care was due to inevitable social trends or to the direct influence of feminists remains debatable. Nevertheless, what followed was an expansion of care in the public welfare sector and, subsequently, due to growing demand, into the private market sector. The privatization, or marketization, of care has led to the 'increasing significance of care as a sphere of social policy and the merits of a social care-based analysis of the welfare state' (Daly & Lewis, 2003, p. 291) and, for our purposes, of ageing in Australia. This shift is thus not a mere function of ideological arguments between Left and Right – or between radical and liberal feminists – but a matter of necessity based on the supply of, and demand for, social care. Thus, when analyzing new policies, it is essential not to generalize but to acknowledge the inevitable diversity of care provision in increasingly pluralistic societies, where governments alone cannot meet the increased demand for care but have sought policies which share the burden across the various sectors of social service provision: public, private or voluntary, informal or family and community, and business or

market sectors. In this context, marketization has produced both positive and negative results: It has led to more accurate targeting of need and a larger professional role in deciding who receives care in the context of limited resources. It has provided greater individual choice, creating a new type of citizenship and raising questions about the 'limits of the market' (Daly & Lewis, 2003, p. 292). Thus, the movement of care out of the family into the market is not necessarily a bad thing and is what feminists have pressed for. In terms of the postfeminist backlash alluded to earlier, it appears feminists have precipitated the crisis in care (Faludi, 1992; McRobbie, 2009) and, following their intervention, 'paid care work is here to stay' (Martin, 2007, p. 184).

The growing demand for care

Several studies predict a shortage of carers in later life, due to a growing demand for care among the ageing population in both the formal and informal care sectors. Consequently, care will increasingly be outsourced by families as household structures change, expectations of family care provision decline, patterns of participation in paid work evolve and expectations, particularly those of the baby boomer generation, increase (Martin, 2007). This means that 'paid care work will offer significant and growing employment opportunities for many years to come' (Martin, 2007, p. 184). It is thus important to examine the nature of paid care *work* since aged care as an employment sector generates over 100,000 jobs annually, mainly for nurses and personal carers (Martin, 2007). Drawing on data from a study conducted in 2003 (see Richardson & Martin, 2004), Martin (2007) shows that paid care work compares favourably with work in other sectors though it is distinctive in terms of the emotional bond that develops between caregivers and receivers, which shows an ethic of care in operation. However, the level of debriefing that is done to support paid carers who lose their clients due to death or movement into residential care is questionable. According to the Australian

Nursing Federation (ANF, 2006a), workers in aged care 'are not being adequately supported or supervised because there are not enough nurses employed to do so'. Perhaps there is also an assumption that the bond between paid carers and clients is not strong enough to warrant this kind of support. Meagher (2007), in her examination of the community services care workforce based on 2001 ABS statistics, reports that professional nurses are leaving the residential aged care sector for jobs in health where wages and work conditions are better and professional recognition is more forthcoming. This gives rise to an increase in less skilled carers who require more managerial supervision. In short, two forces are shaping the aged care sector: (i) Deinstitutionalization which gives rise to a greater demand for community care and (ii) deprofessionalization with fewer professionals in those areas where they are most needed, such as nursing homes, at a time when there is greater need for professionally skilled care workers to deal with the complex tasks of community care work.

Personal carers, who are unlicensed and unregulated, now constitute the majority of the nursing workforce in aged care (ANF, 2009a; see Table 1). There is therefore a lot of pressure on these carers to do more than they are qualified for (ANF, 2009b). This can lead to inadequate care for older people. In contrast, safe staffing through the provision of adequate numbers of appropriately educated nurses leads to reduced morbidity, increased recovery times, reduced risk of falls, a decreased incidence of pressure areas, lower rates of urinary tract infections, pneumonia, cardiac arrest, gastrointestinal bleeding, and death (ANF, 2006b). In Australia, pressure on nursing homes has risen with an increase in the number of serious complaints to the Department of Health and Ageing's Complaints Investigation Scheme (CIS) (ANF, 2009c). The ANF (2009c) stated that 'without the right numbers and mix of skilled and educated assistants in nursing, enrolled and registered nurses in aged care we are concerned that nursing homes will remain under pressure'.

There appears to be a large proportion of migrant workers performing care work in aged care. Research suggests that this is because there are labour market niches in aged care as jobs in this area are low paid and low status, and are avoided by locals (Colic-Peisker & Tilbury). Other employment niches for refugees are cleaning services, taxi driving, meat processing, building, and security, which all require lower educational qualifications (Colic-Peisker & Tilbury). In contrast, the Australian Nursing Federation (2009a) reported that 76% of residents in aged care have high care needs. The complexity of caring for the aged therefore requires appropriately qualified workers with the skills and knowledge to provide care for this vulnerable population.

Table 1: Residential Aged Care: Distribution of direct care workforce (FTE) by occupation 2003 and 2007

Occupation	2003 Private and Public			2007 Private and Public			% change in FTE staffing levels	
	Distribution of Direct Care Workforce	% of direct care workforce	Private only	Distribution of Direct Care Workforce	% of direct care workforce	Private only	Public & Private	Private only
Registered Nurse	16, 265	21.5%	14, 720	13, 247	16.8%	12, 107	18.6% decrease	17.8% decrease
Enrolled Nurse	10, 945	14.4%	9, 905	9, 856	12.5%	9, 009	10.0% decrease	9.0% decrease
Personal Carer	42, 945	56.5%	38, 864	50, 542	64.1%	46, 196	18.9% increase	4.8% increase
Allied Health	5, 776	7.6%	5, 776	5, 204	6.6%	4, 757	9.9% increase	0.5% decrease
Total	76, 006	100.0%	Less 9.5% public – 7, 221 = 68, 785	78, 849	100.0%	Less 8.6% public – 6, 781 = 72, 068	3.7% increase	4.8% increase

Source: Australian Nursing Federation Federal Office (June, 2009)

Aged care policy in Australia

Aged care policy is built on the premise of independence and individualization and assumes that older people will remain in the community for as long as they are able to. There are four cornerstones to aged care policy flowing from this premise: The first is the old-age pension

system, which is well-established in Australia and is the social security program that has historically enjoyed the widest degree of public support. The second is independent living in the community with supportive services in pursuit of the dominant ageing-in-place policy. The third is self-funded services and supports, which have been brought about by a shift in government policy over the last twenty years to encourage self-responsibility among the ageing population. The fourth is residential and frail aged care as a last resort when all measures to maintain the older person in the community have been exhausted and independence is no longer an option. In the discussion which follows, we examine aged care policy and services in Australia more closely.

Aged pensions

Old-aged pensions were the first form of income support to be introduced in Australia soon after federation in 1901. Today nearly two-thirds of retirees rely on a means-tested government pension as their main income source (AIHW, 2007b). To encourage private savings (see below), in recent years there have been significant increases in the private income and assets older people can have yet still remain eligible for the old-age pension. Only 13% rely solely on the government pension with a further 28.2% earning a small private weekly income of \$20 (Rosenman & Scott, 2009). Aged pensions are not linked to previous contributions or earnings and constitute the largest portion of the welfare budget amounting to \$22.6 billion in 2006-2007 (ABS, 2008b). In July 2008 the annual pension was \$14,216.80 for singles and \$23,756 for couples. Pension payments continue to have a high degree of public support, and there are frequent calls for increases to the old-age pension. However, the number of older people relying on the aged pension is expected to decline in the future as government policy on compulsory superannuation and incentives for workers to remain in the workforce longer start to take effect (AIHW, 2007b).

Community care

The area of welfare or community service provision enjoys a great deal of public support in Australia. Large religious charities, such as Anglicare, UnitingCare, Benevolent Society, Salvation Army, and St Vincent de Paul, are key providers of formal, paid community care. In line with the Government's social inclusion agenda, one-off grants are provided to a range of national and state and territory organizations that provide services for frail, older, socially isolated people living in the community, such as emergency meals, shelter and clothing, and services that encourage and support social re-engagement. The increasing swing to community care has also led to the growth of informal, unpaid care, with family members or neighbourhood services providing help with shopping, cooking, cleaning, and laundry.

Swedish research has found that older people prefer help from public services rather than having to rely on family and friends (Gunnarsson, 2009; Szebehely & Trydegård, 2007). As Plath (2002) found, older people regard independence, i.e., having control over their lives, as crucial and are reluctant to think of themselves as dependent and in need of care. Remaining independent seems more important for women who stress the importance of working and supporting themselves, possibly because men are more accustomed to having a wife who takes care of them (Gunnarsson, 2009). Most old people do not want to be a burden, especially not on their children. They express a preference for government services over reliance on family and friends, especially where they have personal care needs with bathing and personal hygiene.

Unfortunately, due to limited funding, there remains a long wait time for community care assessments and services (Allen Consulting Group (ACG), 2007). While the 2007-2008 budget increased spending on aged care by 1.7 billion (Department of Health and Ageing (DHA), 2007), community care received only \$298 million (DHA, 2007). As a result, many

older people living at home are not receiving the services they need. The ACG (2007) estimated that the community care needs of over 400,000 older Australians residing at home are not being met. The 2008-2009 Budget has done nothing to improve this situation, as no extra funding for community care has been provided. Instead, the Government has allocated \$438 million to expanding residential care (DHA, 2008).

There are also many instances where ‘changes in eldercare services have ... been accompanied by reports of poor conditions and neglect’ (Gunnarsson, 2009, p. 253), and squalor (McDermott, Linahan, & Squires, 2009). In any case, the professionals and technologies necessary for providing care to people in their homes may compromise the very essence of what it means to be at home (Gott et al., 2004). This is supported by findings that receiving help while living at home results in a lower quality of life for older people (Hellstrom, Persson, & Hallberg, 2004). In addition, a number of studies have found that older people have a strong need for social support (Baltes & Smith, 2003; Victor et al., 2000), especially since many older people living at home are socially isolated (Findlay, 2003). The need for older people to be accompanied at the end of life may be so strong that it exceeds their desire to live at home (Lloyd, 2004). Ageing-in-place thus carries with it particular challenges, especially where older people with complex needs remain in the community despite diminishing capacities and increasing social isolation.

Care facilities are increasingly acknowledging individual needs, such as accommodation for couples, ethnicity specific services, food preferences, facilities for own pets, and high and low care on the same site to minimize disruption as care needs change. However, this acknowledgement remains largely ideological, with a gap between what is offered and what is actually provided. Elena’s grandparents may therefore need to find the

right facility that is suited to their specific needs, in which case they may prefer this to struggling at home.

There are currently several government-funded programs rendering community-based care, namely, the Aged Care Assessment Program (ACAP), Home and Community Care (HACC), Community Aged Care Package (CACP), and Extended Aged Care at Home (EACH).

Aged Care Assessment Program (ACAP)

With the advent of managed care, and the government contracting private providers to manage aged care packages, assessment becomes a major professional undertaking to establish those with legitimate needs for care. This role falls to Aged Care Assessment Teams (ACAT). The effect has been a shift to stigmatizing, targeted, selective care to those with the highest care needs, i.e., those who are unable to live independently or without help. As Gunnarsson (2009) notes, care is ‘connected to illness, dependence and the end of life ... in a society in which independence is valued highly, it can be more difficult to accept being in need of help and adapting to a new life situation’ (p. 258). Policy on independence in old age seems to suggest that older people appreciate services that prolong independence and willingly accept home help as health and mobility deteriorates so long as they can remain in their own homes, hence the importance of the Home and Community Care Program (HACC). However, many older people refuse help and this can lead to catastrophic events that might precipitate nursing home admission.

Home and Community Care (HACC)

A key element of the Australian Government’s aged-care policy, *The Home and Community Care (HACC) Program*, is a joint Federal, State and Territory Government initiative that

provides services to support older Australians and their carers to be more independent at home and in the community and to reduce the potential or inappropriate need for admission to residential care. These services include domestic assistance, personal care as well as professional allied health care and nursing services, meals and other food services, home modification and maintenance, transport, respite care, and counselling, support, information, and advocacy. The federal government provides approximately 60 per cent of funding for the program and maintains a broad strategic policy role while state and territory governments provide the remaining percentage of funding, are the primary point of contact for HACC service providers and consumers, and are also responsible for program management, including the approval and funding of individual HACC services in their jurisdictions. In 2008-2009, \$1.788 billion was provided for the HACC Program nationally, an increase of over 8% from 2007-2008. Of this, the Australian Government provided \$1.090 billion, and the remaining \$698 million was contributed by state and territory governments. However, HACC is not without its problems. It is underfunded and oversubscribed. There are tight limits on hours and dollars available per person, and long waiting lists. Services have developed in a somewhat piecemeal manner, in response to identified gaps in services. There is a lot of overlap and no centralized organization. Hence this is a very shaky cornerstone.

The *Veterans' Home Care* program for veterans and war widows and widowers is managed by the Department of Veterans' Affairs. It provides services similar to those offered by HACC.

Community Aged Care Packages (CACP)

In addition to the HACC program, three smaller government-funded community care programs provide assistance to people who have been identified as eligible for residential

aged care. One of these is the Community Aged Care Packages (CACP) program. This program provides community care for people with complex care needs who would require low-level residential care, but would like to remain living in their own home. It was introduced at a time when the government was experiencing difficulties attracting enough hostel providers. CACPs are therefore viewed as direct substitutes for residential facilities (Kendig & Duckett, 2001). In 2007, 61,740 people received care through the CACP program (Commonwealth of Australia, 2009). At this time, the majority of recipients (83%) of CACPs were aged 75 years and over and most (75%) were female (ABS, 2008c). The use of CACPs is also higher among Indigenous Australians (ABS, 2005). This is probably due to the flexible nature of the program as it can 'provide services for small populations without requiring the larger infrastructure associated with institutional care provision' (Kendig & Duckett, 2001, p. 22).

Extended Aged Care at Home (EACH) & EACH Dementia

CACPs provided under the Aged Care Act are complemented by the Extended Aged Care at Home (EACH) and the Extended Aged Care at Home Dementia (EACH Dementia) programs. These smaller government-funded programs deliver the equivalent of nursing-home level care in the home. In addition, the EACH Dementia program provides high level residential care in the home for frail older people with psychological symptoms and behaviours associated with dementia. Services offered by the EACH programs comprise personal care, including continence care, assistance with meals, support for people with cognitive deficits, 24-hour emergency assistance, specialist nursing care, and home maintenance and help (ABS, 2005). Although this program may be preferable for many older people it is not a cheap option, with costs averaging \$85 per day compared to \$29 for CACPs (Kendig & Duckett, 2001).

Self-funded options

The majority of Australia's older population has relied on the aged pension as their main income source. However, shifts in government policy have led to increasing insecurity for older people who are faced with the responsibility of planning for their retirement needs. This is intensified by employer-linked benefit schemes, compulsory superannuation introduced in 1992 and economic policies, which increasingly emphasize private savings and fees for services (Ozanne, 2009; Rosenman & Scott, 2009). Thus, aged-care policy in Australia links economic wellbeing or financial independence in later life to people's employment and earnings during their working life. These shifts require elderly people to have financial planning and management skills, especially those who opt for self-managed superannuation schemes.

Lusardi and Mitchell (2007) found that older people who plan for their retirement have higher wealth levels when they research retirement and also display higher financial literacy than non-planners. Glass and Kilpatrick (1998) observe that retiring women are generally poorer than men, and appear to prepare less for this period of their lives. They suggest that this is because (i) women feel that retirement planning is a male role, and that they will be taken care of; (ii) women find existing pre-retirement planning programs are generic, male or couple oriented, and do not address women's specific needs and situations; (iii) women are traditionally 'other-focused' and place their wellbeing behind nurturing others; and (iv) women may not feel they have a locus of control.

Declining confidence in public service provision makes it highly likely that retiring baby boomers, especially those who have achieved some measure of financial independence, are likely to want to purchase the services they need. This applies especially to private health care given the increasingly long waiting lists for medical procedures in the public healthcare

system. The net result of the neoliberal welfare reform, which ties targeted services to illness (as noted above) and generates the positive ageing discourse (see below), is that ageing baby boomers are more conscious about their health and better informed about their choices.

There appears to be a commercial arm alongside government-funded services which is providing care for people who can afford it. 'Pre-purchased funerals', home delivery frozen gourmet meals, and home delivered groceries are just some examples of the kinds of services available. This way, even people who cannot afford private accommodation can supplement their care with services they can afford. Thus Elena could pay someone to take her father-in-law for a walk a few times a week. Even her grandparents could benefit from purchasing some extra services while they are in low-level care residential accommodation.

Residential aged care

Residential aged care is divided into nursing homes, now referred to as 'residential aged care facilities' (RACFs), where nursing care is required and aged care accommodation, where it is not a major service. However, these are not distinct divides. While there are low and high care people or beds, they may reside in the same general 'place'. With the 'ageing-in-place' policy of government, which most directly relates to the aged-care sphere and not the community sphere, there has been a push for people to remain within the same institution, and sometimes this means the same room as they become increasingly frail. Thus while there used to be a hostel-nursing home divide, this is less apparent now where the main distinction is between high and low care as defined by the recipient, who may be situated anywhere within the facility. There can also be 'self-care' units within facilities, and people may migrate to securer parts of the facility as they deteriorate. This depends very much upon the aged-care facility. Hence the diversity of aged-care arrangements within aged-care facilities,

most of which – well over half – are run as for-profit businesses which are heavily subsidized by the government.

The most recent report from the Australian Institute for Health and Welfare (AIHW, 2009a) reveals that the Commonwealth Government's 2011 target of 88 operational residential aged care places for every 1,000 people aged 70 years or older is already close to fruition. The *Residential Aged Care in Australia 2007-08* report also shows that the trend towards fewer but larger aged care facilities is continuing, and that length of stay for permanent residents is constantly rising (AIHW, 2009b). At the end of June 2008, there were an estimated 175,500 aged care beds in Australia, an increase of 5,500 on the previous year. These 'beds' could be in nursing homes, hostels, or independent units within an aged care setting. Table 2 shows the number of residential aged care facilities and their auspices.

Table 2: Ownership of residential aged care facilities

As at 30 June 2007		
	Number of facilities	Percent
Private not-for-profit	1762	61.4
Religious	827	28.8
Community-based	504	17.5
Charitable	431	15.0
Private for-profit	773	26.9
Government	337	11.7
State/Territory	262	9.1
Local	75	2.6
Total	2872	100.0

Source: Parliament of Australia (2008)

During 2007–2008 there were over 105,000 admissions to residential aged care facilities, 1,800 more than the previous year. Almost half the admissions were for respite

care, with an average length of stay of just over three weeks. The average length of stay for permanent residents was 148 weeks, two weeks longer than the previous year, and 17 weeks more than 1998–1999. Essentially frail care is an end-of-life passage as shown by the Aged Care Funding Instrument (ACFI) introduced in March 2008 to measure residents' care needs, rather than the care provided, and thus collect data on health conditions affecting permanent residents. However, the ACFI is not very well liked in Residential Aged Care Facilities (RACF) circles as it is highly manipulable and does not encourage improvement in residents since it pays more when people are frail resulting in a disincentive to work towards increasing resident capacity. Mid-year 2008 just over three-quarters of the 47,000 aged care residents required high level care and almost half recorded a diagnosis of dementia. The increase in dementia among older people has direct implications for aged care provision, which policy makers and service providers have yet to grapple with, not least the need for highly skilled professionals to deal with these people with complex needs (see below). Other health conditions include circulatory diseases which affected 14,000 aged care residents and diseases of the musculoskeletal system and connective tissue which affected 8,200 older people. Interestingly, 'formal help ... is now more obviously connected with illness' (Gunnarsson, 2009, p. 257). As we shall see below, this creates a formal role for professionals tasked with assessing eligibility for care. The strong connection established between formal help and dependence increases the demand for trained, skilled carers as those in residential care increasingly tend to have complex care needs. Here we are looking at a workforce of approximately 110,000 paid carers working in nursing homes and hostels in Australia, most of whom are women (Meagher & Healy, 2005; Richardson & Martin, 2004). These paid carers range in level of professionalisation from registered nurses, to assistant nurses to personal care assistants. As we shall see below, as responsibility for aged care

provision has shifted from government to non-government community service providers, there has been a decrease in professionally trained nurses and an increase in unskilled personal care assistants. Furthermore, the main role of Registered Nurses (RNs) in RACFS is as managers and administrators. The majority of hands-on care is done by poorly skilled workers, who may only have undertaken a 10-week course, may be poorly educated and, while often well-intentioned, poorly equipped emotionally.

Social work and social care

Social work's caring role in society has long been acknowledged, yet, ironically, much of its critical discourse has sought to distance *professional* practice from its caring beginnings (Meagher & Parton, 2004). Social work has also long clung to a human rights and social justice agenda making the right to care essential and social justice an unquestioned social obligation extended to dependent populations, like the sick, aged, and mentally ill. Thus social workers have been critical of neoliberal social policy which robs these individuals of their status as rights-bearing subjects. They are particularly concerned that those who do not fit the active citizen, positive ageing, self-care, and self-responsibility neoliberal agenda are forced to 'rely on the discretion and benevolence of others who care for them' (Lloyd, 2006, p. 1173). Most social work clients have little choice, and this includes older clients, though there is some expectation that the retiring baby boomers will be quite vociferous about their needs and actively engage in policy issues, as well as carry some influence through their sheer voting power and economic advantage. However, to date there has been little direct research on the wants and interests of baby boomers in Australia specifically and most local commentators extrapolate from international studies. These commentators continue to make claims about social work's importance for an ageing population when there is no concrete data on the number of social workers who work in aged care and when research shows it is

the least favoured avenue for new social work graduates. The truth is that social work is itself an ageing profession and one that does not play a significant role in welfare generally, let alone in the field of aged care. International estimates suggest that about 7% of social workers work in aged care. The bulk of workers in this sector, as we have seen above, are health workers, especially in residential care, and informal carers, many of whom do not hold professional qualifications. Nevertheless, the majority of social workers who work in the health sector – an estimated 59%, are likely to come across issues relating to ageing, especially when older people are discharged back into the community following an illness for which they have been hospitalized. While contemporary social work literature on ageing suggests that older people are a diverse group, their needs are remarkably constant and include difficulties in accessing mainstream services and the need for advocacy to highlight the plight of older people as welfare reform becomes more deeply entrenched supported by a wider discourse on positive ageing, personal responsibility for one's own wellbeing, ageing well, a focus on healthy living, and so on. Social workers need to avoid becoming complicit in these strengths-based approaches, which laud older people as a source of social capital and talk about investment in a certain quality of life, as if this were a luxury available to all.

Feminist ethicists argue that the perception of individuals as autonomous, rational, and independent may lead to a blindness to dependency needs (Lloyd, 2006). This critique is particularly pertinent in relation to frail and dependent older people, who may be unable to maintain independence. Lloyd (2006) emphasizes that professionals should be aware of the influence of the independence discourse on older clients. Minichiello et al. (2000) found that older people were acutely aware of the risks associated with being viewed as 'decrepit' and went to significant lengths to prevent giving this impression. A preoccupation with individual autonomy may lead to inaccurate assessments as professionals overlook the care needs of

older people (Lloyd, 2004, 2006). This reluctance on the part of older people to admit to needing help alluded to earlier is a resistance to the stigma of dependency.

This positive ageing discourse glosses over structurally-induced needs and social inequalities, where government provision is unavoidable, especially for vulnerable and disadvantaged groups that have always been social work's main focus. The social inclusion and wellbeing agenda being promoted by many Western governments, including Australia, puts a positive spin on welfare and poverty. It serves to stigmatize those in need of welfare, i.e., those who are poor, ill, disabled, or mentally ill, who are unable to participate in the workforce and who require social support. These people are labelled passive welfare recipients juxtaposed against the active, engaged citizen who takes part in civic life, who volunteers and participates as a contributing member of society. Active citizens constitute social capital and buy into neoliberal agendas that reduce welfare to a safety net when all other measures have failed. Often social workers are at this end of welfare provision, assessing people for targeted and selective managed care packages and arranging resources for those in need of community or personal care. Most will be working in government or mainstream agencies providing formal care to groups at greatest risk: Older people on low incomes, women, non-Australian ethnic groups, Indigenous people, those in rural and remote areas, and those who are divorced or separated (Ozanne, 2009). But the bulk of aged care is provided, not by social workers, but by a mainly health-trained professional care workforce and the innumerable informal carers in families and neighbourhoods throughout Australia.

Conclusion

This paper has argued that the biggest challenge facing an Ageing Australia is care. It examined the dynamics contributing to labour shortages in the care industry and an excess of demand for care over supply proposing that this situation has arisen for a variety of reasons

originating in extremely divergent discourses from feminist to neoliberal, managerialist responses to the need for care. It has shown that the aged care context is predominantly female with women living longer than men and 90% of formal and informal carers being women, and argues for the continuing relevance of a gendered view of care and the insights offered by the feminist ethics of care. Australia is a society which cares and women in Australia, as elsewhere, will continue to be the backbone of the care industry.

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