

Integrated housing, support and care for people in later life

authored by

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ACRONYMS

AARC	Active adult retirement community
ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ACHA	Assistance with Care and Housing for the Aged
ADL	Activities of daily living
AGPS	Australian Government Publishing Service
ALF	Assisted living facilities
AHURI	Australian Housing and Urban Research Institute
AIHW	Australian Institute of Health and Welfare
AARP	American Association of Retired Persons
ASPE	Office of the Assistant Secretary for Planning and Evaluation
AURDR	Australian Urban and Regional Development Review
CACP	Community aged care package
CCRC	Continuing care retirement communities
CSH	Congregate seniors housing
CSHA	Commonwealth-State Housing Agreement
DHS	Department of Human Services
DOHA	Department of Health and Ageing
EACH	Extended Aged Care in the Home
HACC	Home and Community Care
HSAP	Housing Support for the Aged Program
IADL	Instrumental activities of daily living
IAHSA	International Association of Homes and Services for the Aged
ILF	Independent living facility
ILU	Independent living unit
ILRC	Independent living retirement community
LORC	Leisure-oriented retirement community
LTC	Long-term care
NCAL	National Centre for Assisted Living
NHPI	National Health Provider Inventory
NORC	Naturally occurring retirement community
RACH	Residential aged care homes
RCS	Resident Classification Scale
SEH	Service-enriched housing
SHA	State and Territory Housing Authority
SNF	Skilled nursing facility
SRS	Supported residential service

EXECUTIVE SUMMARY

Aim and questions

As the period of later life for many Australians lengthens, and as the overall number of older Australians grows, there is a need for greater attention to be given to the range of housing and choices available to older Australians, and in particular the availability of forms of housing that are integrated with support and care.

The term 'integrated housing, support and care' refers in this project to all forms of housing for older people that make deliberate provision for one or more types of support and care as part of the housing complex or development. The main forms of support and care services are classified in Table 1 and include assistance relating to the physical environment (property maintenance and modification), household tasks (meal preparation, domestic work, transport), sociability (social activities and recreation), and personal and health care (self-care, health care, respite care, and life planning and management).

The policy question that the project seeks to inform is:

In addition to providing aged care services (community care and residential care), should the Australian community be developing a wide range of integrated housing, support and care options for people in later life? If so, what forms should these options take?

The project provides an evidence base to address this policy issue by addressing six questions:

1. What factors (historical, policy, market, etc.) are shaping the development of integrated housing, support and care options for people in later life in Australia?
2. What models of integrated housing, support and care have already been developed in Australia, and what is their longer-term relevance?
3. What are the main international models of integrated housing, support and care for older people that might have relevance in Australia?
4. How can these models (Australian and international) best be conceptualised and classified in order to identify choices, opportunities and implications for policy makers, program and project developers in the public, community and market sectors, and consumers?
5. What key issues should be considered in appraising the relevance and suitability of the range of models of integrated housing, support and care?
6. What are the implications for policies aimed at expanding integrated housing, support and care options for older Australians, and for further research?

The research approach

The research project is divided into two stages.

Stage 1 comprises an analysis of the Australian policy context, identification of the main forms of integrated housing, support and care products and services currently available and emerging in Australia, and identification and analysis of the main forms that have developed in the United States, the United Kingdom and selected other countries. This is based on analysis of policy documents and the international academic, professional and industry literature. Stage 1 addresses research questions 1–3. The main findings of stage 1 are reported in the positioning paper and are summarised below.

Stage 2 comprises a series of seventeen brief case studies of specific Australian integrated housing, support and care services and products. The purpose of these case studies is to portray in some detail the diversity of services and products that have emerged, or that are emerging, in the Australian context. Stage 2 provides greater depth with respect to research question 2, and an empirical foundation for addressing research questions 4–6. The research plan for stage 2 is outlined in chapter 4 of the positioning paper and is summarised below.

Findings of stage 1

The positioning paper reports on three sets of findings:

- The policy context
- Australian models
- International models.

The policy context

The cornerstones of the Australian aged care system are a community care system designed to maximise older people's capacity to remain in their home despite the onset of frailty, disability or ill-health, and a residential aged care system to provide high quality nursing and health care for those no longer able to live at home. Since the 1980s an extensive aged care system combining these elements has been put in place by the Australian Government in combination with state and territory governments.

By contrast, little attention has been paid to the development of integrated housing, support and care options for older Australians. The market and community sectors, and to a lesser extent the public sector, have been developing a range of such options in Australia during the past two decades. But this has occurred without clear policy direction. The question is: what (if any) should be the role of public policy in guiding, facilitating, supporting and/or regulating the further development of these options?

Australian models

Australian models of integrated housing, support and care derive from four main contexts.

The main context is the retirement village industry which comprises both community and market sector organisations. While most retirement villages in Australia are designed for older people able to live 'independently', part of their attraction is that they provide a range of services on-site, including some of the support and care services identified in Table 1. One conventional model of integrated housing, support and care in Australian retirement villages is the 'continuum of care' model. However, extensive diversification of Australian retirement villages is occurring both in the range and depth of services provided (serviced apartments, flexi-services, assisted living) and in the development of 'affordable' villages offering a mix of services and rental accommodation.

The second context is the community housing sector. The sector first became involved in this field via the development between 1954 and 1986 of independent living units with capital funding from the Aged Persons Homes Act of 1954. Some independent living units became part of the retirement village sector. Others evolved into small-scale integrated housing, support and care services. The community and cooperative housing sector has also developed other products such as Abbeyfield housing, and has other innovative services in the pipeline.

The third context is a small housing sector focused on older people with high needs, including people who are living in insecure accommodation.

Finally, the public housing sector in association with community partners has developed a number of projects designed to address the support and care needs of people 'ageing in place' in public housing.

The number and diversity of integrated housing, support and care services will continue to grow as the number of households requiring assistance expands. It is for this reason that better understanding of service types, management and service issues, and policy implications and options are required.

International models

All developed countries in North America and Europe, and an increasing number of Asian countries, have a range of integrated housing, support and care services for older people which take many different forms and are subject to widely varying funding and regulatory policies. While all approaches to housing and care of older people are embedded in particular national contexts, international experience is of considerable relevance both as a source of innovative ideas about products and services, and as a comparative vantage point from which to observe and review the Australian policy approach.

The experience of the United States is of particular significance to Australia. In the United States, a wide diversity of integrated housing, support and care services has been developed during the last thirty years in a context dominated by the market sector within a weak public policy framework. A number of models of potential relevance to Australia have been developed including naturally occurring retirement communities (NORCs), leisure-oriented retirement communities (LORCs), various forms of service-enriched housing, group or shared housing models, assisted living facilities (ALFs), and continuing care retirement communities (CCRCs). Some of these models have parallels in Australia, and some new services in Australia are based on or have similarities with these American models. Analysis of the United States policy and research literature on these models is highly relevant to the Australian context, which is currently experiencing diversification that has similarities to what has already occurred in the United States.

The United Kingdom experience of integrated housing, support and care services provides a sharp contrast to the United States experience. In the United Kingdom, the state has been the main driving force behind the development of integrated housing, support and care arrangements for older people. Local councils and housing associations developed sheltered housing and then very sheltered housing, also known as extra care housing, as part of their general housing responsibilities. This has created a far more uniform and widespread approach to integrated housing, support and care arrangements than in both Australia and the United States, with much of the impetus for innovation coming from the social rather than the market sector.

The relevance to Australia is twofold. Firstly, the United Kingdom shows how such arrangements can be part of the mainstream policy debate concerning housing and care for older people, alongside consideration of the role of community care and residential care. As in Australia, only a small minority of older people in the United Kingdom live in integrated housing with care settings. However, these are viewed as part of the mainstream housing spectrum for older people, and are given far more policy attention than has been the case in Australia. Secondly, the specific forms of integrated housing, support and care that have developed in the United Kingdom are interesting as models in their own right. Of particular interest are the new forms of

extra care housing that have developed in the United Kingdom during the past decade. They suggest that there is a strong case for more systematic definition and development of extra care housing as a distinguishable housing type in Australia.

Models of integrated housing, support and care that have developed in a number of other countries are also pertinent to the Australian context. The diversity of models of housing, support and care in Europe and elsewhere provides a source of information to underpin innovation and diversification of the service and product range in Australia. These include a range of approaches to service-enriched and extra care housing, the concept of 'apartment for life', co-housing models for older people, and multigenerational models. Some of these may be unlikely to become mainstream approaches in the Australian structural and cultural context, but they have considerable potential for expanding the overall product mix. The experiences of many countries also demonstrate how state institutions can take a more proactive policy approach to integrated housing, support and care options than has been the case in Australia.

The research plan for stage 2

Chapter 4 of the positioning paper provides a detailed plan for stage 2 of the project. The main empirical component of stage 2 is the set of case examples of existing and emerging forms of integrated housing, support and care in Australia. The methodology for these cases is outlined, and a brief description of each proposed case is provided. These are shown in Table 3. The full descriptions of the cases will be included in the final report.

Drawing on the materials reported in the positioning paper and the case studies, the final report will also address the following:

- Nomenclature and categorisation of models
- Identification of key issues
- Discussion of policy implications

Nomenclature and categorisation of models

Within Australia the lack of clear and agreed terminology to describe and analyse the main models of integrated housing, support and care is an impediment to policy and service development. The disorder of terminology impedes clear policy development as well as creating difficulty for consumers. If the state sector wished to take a proactive stance towards the provision of integrated housing, support and care, greater clarity of nomenclature and classification of service types is required.

In the final report a Glossary of Terms and Translation of Terminology will be presented. The Glossary that appears at the end of this positioning paper is a first draft of this exercise. The final report will also contain a proposed classification of types of integrated housing, support and care services, and consideration of how this classification can underpin a more systematic policy approach.

Identification of key issues

The development of integrated housing, support and care services in Australia is taking place with only minimal and patchy reference to the now extensive international literature on the issues that should be considered in the design and management of this form of housing. The final report will provide an overview of the main research findings of this literature under the following headings:

- Physical environment issues

- Support and care provision issues
- Quality of life issues
- Management issues
- Access and distribution issues.

Policy implications

The final report will present an argument for a more pro-active, systematic, evidence-based policy approach to the provision of integrated housing, support and care for Australians in later life. It will suggest some of the roles that the public sector might play in funding, supporting, monitoring, regulating and generally enabling the development of a wider range of integrated housing, support and care services. It will consider the roles of the state, community and market sectors, and propose principles to underpin service provision. In this way the report will provide the foundation for policy consideration of a 'third way', alongside residential care and community care, to meet the housing and care needs of older Australians.

1 INTRODUCTION

1.1 Objectives and research questions

The central purposes of this study are: to describe the development of 'integrated housing, support and care' services in Australia; to analyse the nature and diversity of types of 'integrated housing, support and care' services that exist in Australia and internationally; to define and classify these services so as to provide a sound foundation for policy analysis and public debate; and to consider the implications for Australian public policies concerning the housing and care of the older population. The term 'integrated housing, support and care' refers to all forms of housing for older people in which the housing provider or another agency makes deliberate provision for one or more types of support and care as part of the housing complex or development.

In broad terms, interest in this topic derives from the anticipated acceleration in the rate of ageing of the Australian population in the early decades of the twenty-first century. There is increasing recognition that as the period of later life for many Australians lengthens, and as the overall number of older Australians grows, there is a need for greater consideration to be given to the range of housing and care choices available to older Australians. Aged care policy in Australia has received extensive attention, the main focus since the early 1980s being the development of a two-pronged approach comprising the provision of residential aged care homes (RACH) and home-based provision of care and support services (Gibson, 1997; Howe, 1997). By contrast, the development of 'integrated housing, support and care' services has received very little policy attention, despite the considerable growth and development of such services.

This research project seeks to broaden the policy debate to include consideration of the expansion of integrated housing, support and care options, alongside the provision of residential aged care and home-based community care services. It raises the question of whether the provision of residential aged care and home-based community care is a sufficiently wide policy frame to address the support and care needs of older Australians. In addition to providing aged care services, as conventionally defined, should the Australian community be developing a wide range of integrated housing, support and care options for people in later life? If so, what forms should these options take? The market and community sectors, and to a lesser extent the public sector, are already developing a wide range of such options in Australia, and the development of new products and programs has outstripped the development of public policy. The policy question is, therefore, not about whether integrated housing, support and care options should be developed. Rather, it is about the role of public policy in guiding, facilitating, supporting and regulating the development of a service sector that is already well established and expanding.

The project contributes to an evidence base to address these questions in three main ways. Firstly, the project provides an overview of policy and related developments pertaining to integrated housing, support and care for older people in the Australian context. It argues that the dominant policy emphasis on aged care has tended to crowd out attention to the issue of integrated, housing, support and care options for older people. Despite this inattention, during the past three decades a large number of programs providing some degree of integrated housing, support and care have been developed, most notably in the form of retirement villages. Other models such as Abbeyfield housing have also been developed on a smaller scale. There have also been other examples of integrated housing and support provided through the community and public sector for older people who are homeless or living in insecure

housing. During the past decade the market sector has expanded its range of services including rental retirement villages, and various forms of assisted living services. The project will provide an overview of these developments in order to provide a picture of the 'state of play' in Australia.

Secondly, the project will identify and document some of the major integrated housing, support and care programs and products that have been developed in various parts of the world during the past two decades. All such programs reflect policy and funding structures that pertain to particular countries, as well as social and cultural particularities. Nevertheless, the view that there may be program and product ideas that could be transplanted to the Australian context is widespread. There is a level of international investment in the Australian housing market for older people, and international companies involved in financing and developing older persons' housing are a conduit for new program ideas. Furthermore, interest in international models is channeled through international networks of housing and community care providers in the public, community and market sectors, such as the International Association of Homes and Services for the Aged (IAHSA). This project will take stock of these developments in order to further awareness of choices, opportunities, and implications of established and emerging programs and products. With respect to each of the major programs or products identified, it will appraise their relevance to the Australian context, and examine available evidence relating to consumer need and preference, and service delivery and outcome issues. This literature review will include consideration of the wider issues and principles involved in provision of integrated housing, support and care to older people.

Particular attention will be given to programs that have been developed in the United Kingdom and the United States, although a range of developments in other countries is also included. There is a large body of English-language literature relating to these two countries, and the contrast in approach to the provision of integrated housing, support and care provision is instructive. The United States exemplifies an approach dominated by the private sector, which provides most services and is responsible for most of the innovation. In the United Kingdom, by contrast, the public sector has been the dominant provider, although this is now changing. An examination of the models developed in these two countries, supplemented by review of models developed in a number of (mainly) European countries, provides a comprehensive picture of the range of possible models that might be considered in the Australian context.

The third contribution that the project will make to the evidence base is the development of case examples indicating the types of integrated housing, support and care products that are now emerging in the Australian context. These case examples are drawn from the retirement village industry, the community and public housing sectors, and the sectors providing integrated housing, care and support to older people who are at risk of homelessness. With respect to each case example, data have been gathered on location, housing form and scale, the mix and level of support and care, the nature and level of integration of housing and support, sector and management arrangements, financing, form of tenure, and target population. These case examples will be used in the final report to provide a picture of the kinds of models of integrated housing, support and care that are being developed in Australia, and to identify emerging issues.

Based on this data, the project aims to address three key issues that are fundamental to the consideration of integrated housing, support and care provision in the Australian context. Firstly, the project aims to address the issue of conceptualisation and classification of approaches. This will be achieved in the report in two ways. Firstly, a glossary and 'translation of terminology' will be provided to clarify the meanings of the

many terms used in this field, and to facilitate 'translation' from one country to another. The first stage of this in the form of a glossary is provided at the end of this positioning paper. Secondly, a classification system distinguishing the various types of 'integrated housing, support and care' services will be developed. This will serve a number of purposes. It will assist policy makers in the public sector to monitor the field, and develop appropriate approaches to support and regulation. It will assist developers in all sectors to understand the diversity of potential products and to target their projects accordingly. It will assist consumers and potential consumers to understand their options and make informed choices. An initial classification of international models is provided in the positioning paper, as a prelude to a more detailed classification in the final report.

Secondly, the project aims to identify key issues that should be considered in appraising the relevance and suitability of the range of models of integrated housing, support and care. This will be achieved through examination of international models and experience, review of the international literature, and analysis of the Australian case studies. This will assist in the development of principles to underpin the further development of integrated housing, support and care services and products.

Finally, the project will consider the implications for policies aimed at expanding integrated housing, support and care options for older Australians, and for further research. The current Australian context can be characterised as one of programs without policies. There is increasing interest in all sectors in exploring ways of developing integrated housing, support and care, but this interest is occurring in a policy vacuum. The project aims to identify some of the issues that will need to be addressed in order to develop a systematic and pro-active approach to developing integrated, housing, support and care programs and products.

While the project aims to be broad in scope, providing an analysis of a wide range of issues and programs, it has been necessary to impose some limitations on the range of issues examined. Generally speaking, the project focuses on service provision and consumer issues, rather than issues more broadly related to the demand for and supply of services by the community and private sectors. Thus, issues such as the impact of taxation systems and equity release arrangements on both demand and supply are not addressed. However, it is recognised that such issues are an integral part of policies designed to increase the supply of new forms of services, and they will be referred to in the consideration of policy recommendations.

The research objectives of the study can be expressed in the form of specific research questions that are addressed in the project. These are:

1. What factors (historical, policy, market, etc.) are shaping the development of integrated housing, support and care options for people in later life in Australia?
2. What models of integrated housing, support and care in Australia have been developed in Australia, and what is their longer term relevance?
3. What are the main models of integrated housing, support and care for older people based on international experience that might have relevance in Australia?
4. How can these models (Australian and international) best be conceptualised and classified in order to identify choices, opportunities and implications for policy makers; program and project developers in the public, community and market sectors; and consumers?
5. What key issues should be considered in appraising the relevance and suitability of the range of models of integrated housing, support and care?

6. What are the implications for policies aimed at expanding integrated housing, support and care options for older Australians, and for further research?

1.2 Approach, definitions and scope

Australian public policies concerning the relations between housing, care and support of older people have tended to be dominated by the discourse on aged care policy. Aged care policy has been focused on the needs of those older people whose frailty, disability or chronic illness require high levels of support and care. A central distinction in aged care policy has been between living 'in a home or at home' (Australia, Parliament, 1982). The aged care system distinguishes between community care provision through such programs as the Home and Community Care (HACC) program, Community Aged Care Packages (CACP) and Extended Aged Care at Home (EACH), and residential aged care provision funded through the Commonwealth Aged Care Act, 1997. During the late 1980s and early 1990s these distinctions became somewhat blurred as organisations providing 'low care' hostels (the major not-for-profit organisations) took on the role of providers of community care services to residents living in the local area (Howe, 1995, pp. 222–223). A further important development in the late 1990s was the formal abolition of the distinction between 'low care' hostels and 'high care' nursing homes and their integration into a unified residential care system in which residents are classified according to their level of dependency (AIHW, 2002). Aged Care Assessment Teams (ACATs) play key roles in rationing access and offering choice to clients across the full spectrum of aged care services.

The strong focus on aged care policy has tended to overshadow policy interest in the provision of housing options for older people, and the role of housing in enhancing the wellbeing of older Australians. All people in later life require housing and many require a range of care and support services, and these twin requirements can be provided in many forms and combinations. The role of public policy, from this perspective, is to expand the range of housing, support and care choices available to all Australians in later life, in order to enable them to enhance their safety, independence and lifestyle. The conceptual starting point for this approach is to identify the range of possible housing forms and types; the range of care and support services that may be desired or required; and the possible ways of combining each of these elements. The provision of support and care services to frail older people in their homes will continue to be a key component of policies to provide housing, support and care options. But this can be complemented by a purposive approach to expanding the range of other options.

This is the approach explored in this paper. The paper begins by defining and disaggregating the key terms 'housing' and 'support and care', and specifying what 'integration' means in this context. Each of these terms has a common, 'taken-for-granted' meaning and usage both in everyday life and in dominant policy discourses. Unpacking these terms enables us to begin to explore and evaluate the full range of possibilities opened up by the concept of 'integrated housing, support and care'.

1.2.1 Housing

The concept of 'housing' is at first glance unproblematic. A house is a physical structure for human habitation, i.e. a dwelling. In the Australian context, the main forms of housing are free-standing houses, apartments, and terrace housing and duplexes, as well as less common forms such as caravans, mobile homes, boats, and informal structures. Dwellings can be located in various types of settings. They may be set in their own separate land and grounds, in cluster housing or a 'village' where there is land in common, or in a shared building such as a block of units or

apartments. Households residing in all of these types of structures may do so under a range of tenure arrangements including private ownership, communal ownership, public rental, private rental, or leasing arrangements. Settings involving shared land or buildings may or may not have common amenities, may be open or 'gated', and vary widely in scale. They may have management structures such as a body corporate or a cooperative, or they may be managed by public, community or market sector organisations. They may be open to all individuals or to residents who have certain specific characteristics, such as belonging to a particular age-group.

In general this identification of housing with dwellings is clear and unambiguous. The one area of ambiguity arises from the commonly made distinction between housing as described above and other arrangements involving communal or 'institutional' living. For example, the Australian Bureau of Statistics (ABS) makes a distinction in the Census between 'private dwellings' encompassing the types of housing discussed above and 'non-private dwellings' described as 'establishments which provide communal or transitory type accommodation' (ABS, 2003, p. 31). This distinction raises particular issues with respect to the definition and delineation of older persons' housing. For example, independent living units in retirement villages are classified by the Census as 'private dwellings' if the occupants provide their own meals and are regarded as being self-sufficient. However, an older person living in a serviced apartment within a retirement complex or in a unit in a complex where meals are provided centrally may be classified as a resident of a non-private dwelling, and thus not living in a 'house' (ABS, 2003, pp. 31–33; Jones, Bell, Tilse and Earl, 2007, pp. 19–21). The distinction between living in a 'house' and living in a 'residential facility' is not precise, and the development of a greater diversity of linked housing, support and care options is likely to blur this further.

Classification of the diversity of possible housing forms, settings, tenures and management structures is a necessary part of identifying the various possible forms of integrated housing, support and care for people in later life. However, the identification of housing with 'physical structure' is no more than a starting point. For most people their house is also their 'home', and the dwelling that they share with their self-selected 'household'. It can also be viewed as a living environment that may or may not be supportive of an individual's independence and lifestyle. Each of these dimensions of housing will be briefly introduced prior to considering the integration of housing, support and care.

The distinction between 'house' and 'home' is well established in the housing literature (Clapham, 2005, pp. 117–154), including the literature on the housing of older people (Heywood, Oldman and Means, 2002). For most people, a house is not simply a physical structure providing shelter. It is also the place where many of the basic human activities of eating, sleeping, self-care, storage of possessions, social contact, recreation, support and care are experienced (Heywood, Oldman and Means, 2002, p. 3). It is also the focal point for many of the services required by the individuals who reside in the house. Most importantly, home is a place of emotional attachments:

'... home is best conceived of as a kind of relationship between people and their environment. It is an emotionally based and meaningful relationship between dwellers and their dwelling places' (Dovey, in Clapham, 2005, p. 118).

This relationship between people and their places of living has numerous dimensions, and there is great diversity in the salience attached to these dimensions amongst the population. To varying degrees, people view their homes as places of security and control, as representations of their identity and preferred lifestyle, as indications of their status, and as statements of their accomplishments (Clough, Leamy, Miller and

Bright, 2004, pp. 87–88; Heywood, Oldman and Means, 2002, pp. 3–4). Homes are the settings for family life, and for many intimate relationships and feelings. These dimensions of the meaning of home are deeply embedded in the experiences of many people. However, it is important not to romanticise the concept of home or to assume that the meanings associated with home are uniform or unchanging. For some, home has negative connotations of worry, debt, hard work, and loneliness, and for others it is the scene of violence and emotional trauma (Clapham, 2005, pp. 140–141). There are also cultural differences in the meaning of home, and differences over time as housing acquires different uses such as the increased incidence of working from home.

Home may also acquire changing meanings at different life stages. Studies of the meaning of home in later life have emphasised such factors as home as a repository of personal or family history, as a reflection of lifelong achievement, as a familiar space for daily activities, as a place of privacy, and as a place that provides confidence and a sense of control for older people (Clough, et al., 2004, pp. 87–108; Davison, Kendig, Stephens and Merrill, 1993). The attributes of housing valued by older people have been extensively studied, and include privacy, autonomy, affordability, adaptability, location, opportunities for sociability, and space for activities and possessions (for a summary see Jones, Bell, Tilse and Earl, 2007, pp. 42–45). Many older people spend more time at home once they have left the labour market, and this is particularly true for older people with mobility problems. It is often assumed that home in later life is experienced positively, but the empirical evidence suggests significant diversity (Heywood, Oldman and Means, 2002, pp. 30–32). Certainly some older people experience isolation, loneliness and worry in their homes, and for some older people their house is experienced as ‘a cage rather than a castle’ (Clapham, 2005, p. 229). Furthermore, there is an emphasis in aged care policy on the importance of making residential care as home-like as possible (Gibson, 1997, pp. 90 and 107), although this objective is often elusive (Clapham, 2005, p. 228).

Understanding housing as both ‘house’ and ‘home’ is of central importance to consideration of new approaches to integrated housing, support and care for people in later life. New approaches need to be based on a critical understanding of the diversity of meanings of home for older people. For example, much public policy is based on the belief that most people in later life wish to ‘age in place’, i.e. remain living in the familiar surroundings of their family home. This may be true for many older people. But it is also important to explore the diversity of housing values and preferences of older people, the ways that these may be changing, the forms of housing adaptation of households at different stages of later life, and the potential impact of widening availability of later-life housing choices (Olsberg and Winters, 2005).

The concept of ‘housing’ is also intertwined with the concept of ‘household’. Housing is consumed by individuals as members of households, and when we are considering approaches to integrated housing, support and care, it is essential to pay attention to the size and form of older-person households. Of Australians aged 65 and over living in private dwellings, 47.1 per cent live with their partner only; a further 10.1 per cent live with their partner and other household members; 7.7 per cent live with children but not a partner; 3.7 per cent have other living arrangements; and 29.1 per cent live alone (ABS, 2003). Housing forms both reflect and shape these household arrangements.

While many older-person households are stable over long periods, household change is a major factor resulting in changing housing need and demand. Major household changes such as children leaving home (or returning), loss of a partner or the onset of

disability for one or both members of a household are often the factors that precipitate housing moves. Major changes in household structure over time, notably the steady rise in the proportion of lone-person households in the older population (ABS, 2003, p. 39), have direct implications for housing demand. Furthermore, it should be noted that the concept of household has some inherent ambiguities (Kemeny, 1992). In some older-person households children or grandchildren may be temporary household members, and some older people living in the same dwelling as their children may have quasi-independent arrangements that suggest they should be viewed as constituting a separate household.

Most importantly, housing must also be viewed as a form of environmental support (Howe, 1992, pp. 93–94). With respect to all households, but particularly older-person households, this refers to the extent to which the physical environment is designed to maximize independence and support lifestyle. However, it also refers to the extent to which housing arrangements balance requirements for privacy and sociability and provide features that facilitate access to support and care services. In this sense housing can be viewed as ‘the foundation on which care services are built’ (Howe, 1992, p. 93).

In summary, the term ‘housing’, while essentially straightforward, encompasses a diversity of factors that must be taken into account in the linking of housing, support and care. The diversity of possible housing forms, settings, tenures and management structures opens up a range of possibilities. But it must be borne in mind that a house is not simply a physical structure. It is also a home that carries meaning for the individuals who live in it. Furthermore, houses and households are also interlinked, with changing household structures bearing heavily on housing need and demand. Most importantly of all, housing provides the environmental support foundation for the provision of support and care services.

1.2.2 Support and care

At various points and stages of life everyone needs support and care. This is most clearly the case for infants and young children and for those experiencing chronic illness or disability. However, all individuals lack the capacity to support themselves at some points in their life-course:

‘Care may, therefore, be regarded as a fundamental condition of human existence. Because it is not something we can always do for ourselves, but must rely on others, care is ... an inherently social activity’ (Fine, 2004, p. 218).

In the broadest terms, support and care are associated with the ideas of ‘sustaining’, ‘maintaining’, and ‘looking after’ others. The extensive literature on care and caring suggests that there are two key elements involved in support and care. Firstly, caring is a form of work, a service or an activity involving personal maintenance, assistance or support, as in the phrase ‘caring for’ someone. Secondly, caring involves a ‘mental disposition, an emotional engagement with, and concern about, the wellbeing of others’ (Fine, 2004, p. 224), as in the phrase ‘caring about’ someone. This latter element sometimes involves an ongoing interpersonal relationship: ‘the development of a personal relationship of care involves recognition of a mutual sensitivity, the recognition of forms of personal intimacy and the building of mutual trust’ (Fine, 2004, p. 225).

The ways in which support and care are provided and received vary widely in particular societies, at different historical periods, and for specific social groups. Hence, while the term ‘support and care’ carries broad meanings, within particular policy and service system contexts they acquire specific meanings. With respect to

older people in Australian society in the early twenty-first century these meanings have been shaped by the community care policies and programs of the past four decades. Since the 1960s the Australian Government has been involved in the subsidy of 'home care' services (Australia, Parliament, 1982, pp. 82–93), and since the passage of the Home and Community Care Act 1985 the provision of support and care services to older people living in their own homes has been a cornerstone of aged care policy.

HACC and similar programs in other countries raise a number of key questions concerning the nature and scope of support and care for older people. These are:

1. What are the sources (and potential sources) of provision of support and care for people in later life?
2. Who are (and potentially could be) the recipients of support and care services?
3. In what locations should support and care be provided?
4. On whose terms should support and care be provided?
5. What are the purposes of support and care provision?
6. What are the main types or categories of support and care services?

A brief examination of each of these issues will provide the foundations for a working definition of support and care for this study.

In broad terms there are two main groups of providers of support and care. 'Informal' care is care provided by family and friends. 'Formal' care is provided through state, community or market-based organisations, often involving care providers who have professional or occupational training. Many Australians aged 65 and over receive both informal and formal support and care services with personal activities (self-care, mobility, communication and health care) and activities to maintain living at home (transport, paperwork, housework, property maintenance and meal preparation). In an AIHW survey, approximately 42 per cent indicated that they received assistance in activities to maintain living at home, and 15 per cent with self-care activities. The main source of assistance was family and friends, with approximately 83 per cent of older people in receipt of assistance receiving it from this source. Assistance from formal service providers was received by approximately 59 per cent, and approximately 42 per cent of those receiving assistance were helped by both formal and informal providers (AIHW, 2002a, pp. 40-41).

Of particular note are the diverse patterns of support provision across both types of providers and types of services. While close family (partners, daughters and sons) are the main source of informal assistance for those older people who have a family, friends and other relatives are also significant sources of help. In terms of formal services, those provided by the private sector are numerically of greater importance as sources of assistance than state and community sector services combined. Formal services are particularly important in areas such as health care and property maintenance, while informal provision is predominant in areas such as self-care, mobility, communication, transport, and meal preparation (AIHW, 2002a, p. 41). These patterns are significant for the design of policies, programs and facilities linking housing, support and care. They suggest, for example, the importance of arrangements that facilitate informal care by both families and friends, as well as the need to acknowledge and enhance the role of all three formal sectors: state, community and market.

The dominant approach to defining the clients of support and care services in Australian community care programs is to focus on those older people judged to be

the frailest, most disabled, most chronically ill and most lacking in informal support and care. This approach stems from the perceived need to ration services to those most in need and at risk of admission to residential care. Estimates of the need for support and care services are based on the incidence of disability amongst the older population. While most (61 per cent) older people aged 65 and over do not have a disability for which they require assistance, the incidence of disability does rise sharply with age. One in five older people in Australia report a profound or severe core activity restriction. For those aged 80 or over, approximately 54 per cent report that they need assistance with core activities, and 77 per cent indicate that they require assistance with at least one type of activity required to maintain living at home. There is clear evidence that the number (although not necessarily the proportion) of older Australians with a disability will rise sharply in coming decades as the older population increases (AIHW, 2002a, pp. 30–43).

While it may be argued that scarce community care resources should be directed at those judged to be in greatest need, measured in terms of incapacity, this should not necessarily lead to a narrow conceptualisation of the need for support and care in later life. An exclusive policy focus on ‘problems associated with a failing body’ (Clapham, 2005, p. 214) reflects and is encapsulated within a negative image of old age. An alternative approach is to view the provision of support and care services as a means of assisting a wide range of people in later life to ‘make their own lives choosing their own identities and lifestyles’ (Clapham, 2005, p. 221). The provision or availability of particular support and care services may play a key role in enabling an older person to maintain a valued lifestyle, and maximise quality of life on their terms, whether or not they are categorised as having a ‘high need’ for support and care services.

The issue of the location of support and care services also needs to be elucidated. Prevailing approaches to support and care provision in Australia have emphasised the importance of provision in an older person’s home, and the desirability of restricting the number of older people inappropriately or prematurely admitted to residential care. Most services provided through HACC are located in the older person’s home, although some, such as day care, respite care, nursing care and allied health services may be provided in local community facilities. However, there is no particular reason why support and care services for older people should be exclusively home-based. Services that are concerned with social support and sociability are typically provided in community locations. Many other services may be more efficiently and effectively provided in congregate locations such as cluster housing, apartments and retirement villages than in typical suburban housing settings.

A further issue is the terms of provision of support and care, and the fundamental question of who controls service provision. In a context of limited resources, assessment of eligibility and priority for community care services tends to be based on professional and provider assessment of need, although consumers and their carers are also involved (Australia, Department of Health and Ageing, 2004). The issue of the relative weight that should be given to professional assessment and consumer preferences in defining the nature of provision needs to be considered. It has been argued that when older people talk about what they want from services it is couched in terms not of ‘care’ but of ‘help’:

‘The word ‘help’ implied that the older person remains the prime mover, remains in control and actually wants the minimum possible, covering only the things that they cannot do for themselves or cannot do easily, or the times when they cannot do things’ (Heywood, Oldman and Means, 2002, p. 57).

The issue of whether services reflect consumer preferences related to their life choices and preferences or professional assessments of need is a fundamental concern. Similar issues arise with respect to informal care where the views and preferences of an older person and their family members may differ.

This issue is closely linked to the question of the purposes of support and care services for older people. Most commonly these purposes are couched in terms of maintaining the 'independence' of older people, although the issue of what this means is disputed (Plath, 2002). In many community care policy statements independence is equated with avoidance of inappropriate or premature admission to residential care (e.g. Australia, 2002), and it is certainly the case that remaining in a private dwelling may allow a control of surroundings and services that is difficult to achieve in residential care (Gibson, 1997, p. 213). However, living at home may involve other forms of dependency, including dependence on family or formal service providers. Independence may be too narrow a concept to underpin the provision of support and care services. Rather, the provision of support and care services may need to be related to the wider goals of enabling older people as far as possible to enhance their quality of life and achieve or maintain a valued lifestyle.

Finally, the meaning of support and care for older people can be clarified by identifying the main types of support and care that can be provided for people in later life. These are listed in Table 1. This list categorises the main service types in terms of core life activities. It is based on the service categories listed for the HACC program (Australia, 2002, pp. 38–41), supplemented by other service types provided in settings such as retirement villages. It proposes four broad categories of support and care services: those relating to the physical environment; those relating to household tasks; those relating to sociability; and those relating to personal and health care.

In summary, the term 'support and care' in this context refers to services and activities that involve sustaining, maintaining, assisting and helping older people with daily life activities. These services and activities may in some cases involve emotional engagement and interpersonal relationships between those providing and those receiving support and care. These services and activities may be provided by state, community, and market sector organisations as well as by family and friends. Support and care services and activities can enhance the lives of many older people, not only those with high levels of need. Support and care services and activities can be located in private homes, in community facilities, and in congregate locations such as cluster housing, apartments and retirement villages. The terms of provision may be based on professional definitions of need or on consumer choices about what they would find most helpful. While the purposes of support and care services are often couched in terms of independence, this may be too narrow a concept to encompass the range of purposes involved. A broader view is to define the overall purpose of support and care services as being to enable older people as far as possible to enhance their quality of life and achieve or maintain a valued lifestyle (National Ageing Research Institute, 1999). Support and care services can be grouped according to their relations to nine types of life activities as shown in Table 1. These are property maintenance and modification, meal preparation, domestic work, transport, social activity and recreation, self-care, health care, caring, and life planning and management.

Table 1: Types of support and care services categorised by life activities

<i>Life activities</i>	<i>Support and care services</i>
<i>Relating to the physical environment</i>	
Property maintenance and modification	<ul style="list-style-type: none"> → Household repairs → Grounds and garden maintenance → Minor modifications (e.g. grab rails, shower rails) → Major modifications (lifts, ramps, widening doorways)
<i>Relating to household tasks</i>	
Meal preparation	<ul style="list-style-type: none"> → Delivered meals → Cooking in person's home → Nutrition, food preparation and storage advice
Domestic work	<ul style="list-style-type: none"> → Restaurant → House cleaning → Washing and ironing → Shopping → Linen service → Household management, e.g. paying bills, making telephone calls, etc.
Transport	<ul style="list-style-type: none"> → Individual transport to and from appointments (medical, banking, etc.), shopping → Group transport for recreation, shopping, etc.
<i>Relating to sociability</i>	
Social activity and recreation	<ul style="list-style-type: none"> → Friendly visiting and companionship → Centre-based social activity (day care) → Provision and maintenance of recreational facilities, e.g. swimming pools, sporting facilities, recreational areas → Organised activities, outings, trips, holidays
<i>Relating to personal and health care</i>	
Self-care	<ul style="list-style-type: none"> → Bathing/showering → Toileting → Dressing → Eating → Personal grooming, e.g. shaving, hairdressing, make-up
Health care	<ul style="list-style-type: none"> → Home nursing in person's home, including post-hospital → Domiciliary nursing in community centre → Allied health, i.e. physiotherapy, podiatry, dietitian, speech therapy, occupational therapy → Provision of goods and equipment, e.g. dressings, wheelchairs → Medication assistance → On-call nursing care (call button)
Caring	<ul style="list-style-type: none"> → Substitute carer in home or home of relief carer (respite) → Support for carers → Specialised dementia and Alzheimer's care
Life planning and management	<ul style="list-style-type: none"> → Service coordination and case management → Counselling, support, information, advocacy

1.2.3 Integrated housing, support and care

As stated in the introduction to this chapter, the term 'integrated housing, support and care' refers to all forms of housing for older people in which the housing provider or another agency make deliberate provision for one or more types of support and care as part of the housing complex or development. It can be distinguished from both home-based care, where the older person receives support and care services from an organisation that has no involvement with the provision of the older person's housing, and from residential care where the element of private housing has been removed. In the Australian context, 'integrated' housing, support and care includes such housing forms as retirement villages, Abbeyfield housing, some forms of public housing for older people that include the provision of services, and the assisted living rental villages that have been developed by the market sector during the past decade (these forms are briefly described in Jones, Bell, Tilse and Earl, 2007).

The definitions of housing and support and care provided in previous sections indicate the wide diversity of integrated housing, care and support options that are theoretically possible. Integrated housing can involve the diversity of housing forms, settings, tenures and management structures identified in section 1.2.1, linked with any number of combinations of types of support and care identified in Table 1. Support and care can be provided as part of a housing, support and care package, or can be made available as a series of optional 'unpacked' services. In developing such integrated services attention must be paid to the meanings that older people associate with their housing, and to the diversity of older-person households. Attention must also be paid to the range of support and care issues identified in section 1.2.2, in particular the central goal of enabling older people to enhance their quality of life and achieve or maintain a valued lifestyle.

The main rationale for the development of integrated housing, support and care models is that they expand the range of housing choice available to people in later life. Significant numbers of older people are attracted to the idea of linked or 'on-site' support and care services incorporating many of those listed in Table 1. Furthermore, many of these housing models may have other features designed to attract older people. These models may also have community benefits. Their scale, location and design may result in efficiencies that reduce the costs and increase the effectiveness of community care and health service provision. With appropriate design and management they may play a role in reducing demand for more expensive residential care facilities. The opportunities that they provide for downsizing in later life may have positive impacts on the overall efficiency of use of housing stock.

Nevertheless, these integrated models are subject to a number of criticisms. A strong emphasis in the provision of services to people with disabilities in recent years has been the need to clearly separate the provision of housing and the provision of support services in order to avoid excessive dependency on one provider. These ideas have also been used to argue for the separation of control of housing and support services for older people, especially for those older people who are vulnerable due to poor health, low income, and/or lack of housing options. Furthermore, the lack of flexibility of some integrated models pose issues of capacity to adapt to the changing requirements of older people as their dependency increases as they age. Other criticisms relate to other typical features of many integrated models such as their age-specificity, with some arguing that it is preferable for older people to be fully integrated into the wider community.

A further issue is that of 'untying' or 'unpacking' components of housing, support and care that are tied together in particular housing arrangements. Housing models that tightly integrate housing, support and care run the risk of providing residents with 'all

or nothing', i.e. providing residents with services that they may not want or need or that are overly supportive for residents who wish to maximise their independence and autonomy (Howe, 1992, p. 91). The issue of choice of support and care services within housing arrangements and the ability to tailor services to individual needs is a key issue to be considered.

The purpose of this project is to examine these and related arguments through a detailed analysis of the international and Australian experience of particular service types, and theoretical consideration of the many possible ways of bringing together housing, support and care for older people.

1.3 Overview of the positioning paper

This positioning paper details the context and framework for the study. This is achieved in four ways, corresponding to the four chapters of the positioning paper.

In this first chapter, the research objectives, questions and approach have been stated and explained, and the key terms defined.

In chapter 2 the Australian policy and program context is examined. This chapter seeks to explain why the development of integrated housing, support and care has not emerged to this point as a central policy theme, and why it is now becoming a focus of policy interest. This is achieved through an analysis of the two major policy and service systems impacting on this issue: housing policies for older people, and aged care. In the course of this analysis the major forms of integrated housing, support and care that have emerged in Australia are identified and described, and the current 'state of play' is assessed. As well as providing the context for the study, this chapter addresses research question 1.

In chapter 3 the focus shifts to the international situation. The main models of integrated housing, support and care in the United States, the United Kingdom, and selected other countries are reviewed. The emphasis is on identifying the characteristics of key models and summarising some of the main issues relating to them in the academic literature. The chapter concludes by considering the relevance of some of these models to the Australian context. The discussion in this chapter will be at a general level, and it is anticipated that more detailed analysis will be provided in the final report. This chapter addresses research question 2.

Chapter 4 sets out the framework for the remainder of the study. It provisionally identifies the case examples that will be developed in order to address research question 3. It also indicates the type of analysis to be undertaken in the remainder of the study to address research questions 4, 5 and 6. It concludes by summarising the main findings of the positioning paper, and the relationship of the positioning paper to the final report.

2 THE AUSTRALIAN POLICY CONTEXT

2.1 Introduction

The importance of linking housing, support and care has been a recurring theme in the Australian ageing policy debate of the past two decades. It was, for example, a central theme in the last comprehensive review of housing for older people conducted in the early 1990s (Howe, 1992), and it has been a repeated topic in most subsequent reviews of housing and ageing issues (e.g. Kendig and Neutze, 1999; Howe, 2003). The saliency of this topic arises from the effects of frailty and disability on the capacity of individuals and households to manage the tasks of daily life in the domestic housing environment (Howe, 1992, p. 87). Most Australians aged over 65 with a moderate or severe disability live in private dwellings, as do more than half of those with a profound disability (Myer Foundation, 2002, p. 18). A central public policy emphasis has been on maximising older people's capacity to remain in their homes and reducing the number of admissions to residential aged care. Hence, as the population ages and the number of older people in Australia requiring assistance with daily living grows, policy attention has increasingly focused on ways of providing care and support in the home environment.

As indicated in chapter 1, and as discussed in greater detail later in this chapter, the main response to this issue in Australia has been the expansion of home and community care services within the aged care system. Less attention has been paid to the development of 'integrated' housing, care and support services as defined in section 1.2.3, i.e. forms of housing that make deliberate provision for care and support as part of the housing service. The development of integrated housing, support and care facilities for older people has rarely been an explicit goal of Australian public policy, and program guidelines have generally not encouraged innovative approaches outside the aged care sector (Howe, 1992, p. 91-93). Such development of integrated housing, support and care services as has occurred has mainly been initiated by the community and market sectors without strong direction from governments. While there have been a number of innovative approaches since the early 1990s in integrated housing, care and support, few have met what Anna Howe has referred to as 'the "sliced bread" test of successful innovation – they have not caught on widely' (Howe, 2003, p. 3).

The purpose of this chapter is to sketch the policy and program background to this relative neglect of the development of integrated housing, support and care options, while at the same time indicating the areas where forms of housing, support and care have emerged despite the absence of clear policy sponsorship. This will be done by examining, firstly, the housing policy context and, secondly, the aged care policy context. The chapter concludes with a summary of the 'state of play' at both the policy and program/product levels, and an assessment of the emerging challenges.

2.2 Housing policies and older people

Several commentators have pointed to the lack of an integrated policy approach to the housing of older Australians. Writing in the late 1990s, Kendig and Gardner stated that 'Government policy has major impacts on the housing of older people, but there is no comprehensive housing policy expressly designed for them' (Kendig and Gardner, 1997, p. 174). A similar view was expressed by Anna Howe in 2003: 'policy for housing in an ageing Australia may be emerging as a subject of interest to the whole of government, but it has yet to be addressed in an integrated manner across different areas of government' (Howe, 2003, p. 3). While there are many policies that are concerned both directly and indirectly with housing for Australians in later life, there

has been little attempt during the past decade to draw these together into a strategic framework. The last time these issues were addressed in a comprehensive manner by governments was in the early 1990s in special reports commissioned for the National Housing Strategy (Howe, 1992) and the Australian Urban and Regional Development Review (AURDR, 1994).

The absence of a clear or comprehensive policy approach reflects the strong reliance on the market and household sectors to address the issue of housing supply for older people, underpinned by the historically strong state support for home ownership during the second half of the twentieth century. While there have been important shifts over time in the level and form of support for home ownership (Winter, 1999), and in the effectiveness of home ownership policies (Yates, 2007), home ownership has long been viewed as part of the Australian 'social contract' and a cornerstone of the Australian welfare state (Winter, 1999, p. 9). During the decades immediately following World War Two, home ownership was strongly supported through sales of public housing, other direct government lending, and the regulation of home lending interest rates. Support continued in the late twentieth century through favorable tax and pension treatment for home owners, notably through exemption of capital gains from owner-occupied housing and exemption of the family home from the age pension asset test, as well as first home owner grant schemes (Yates, 2007; Winter, 1999).

These policies have resulted in high rates of home ownership amongst older Australians. In 2001, it is estimated that 74.3 per cent of all individuals aged 65 and over were home owners or purchasers, as were 79.8 per cent of individuals living in private dwellings (Jones, Bell, Tilse and Earl, 2007, p. 19). Most of these owned their homes outright (Howe, 2003, p. 8). This historically high rate of home ownership has resulted in low housing costs for many older Australians, and strong cultural attachment to home ownership (Winter, 1999, p. 10). There appears to have been a strong assumption in public policy that further, extensive intervention in housing provision for older people is not warranted, as housing affordability and quality have been largely achieved for most through support for household investment in home purchase and market sector supply.

The only other large-scale and sustained intervention in housing supply for older Australians has been through social (mainly public) housing provision for the minority of older people who have not achieved home ownership. In the period from the late 1960s until the early 1990s, older people were treated as one of the priority groups for the provision of public rental housing through the Commonwealth–State Housing Agreement (CSHA). All states and territories built up significant stocks of housing designed for older people during this period and the number of older people accommodated in public housing rose significantly. While older people have not been as clearly identified as a priority group in public housing since the mid 1990s, they continue to be one of the main public housing population groups. In 2006 it is estimated that over 116,000 people aged 65 and over occupied public housing, comprising 17.1 per cent of all public housing residents (Jones, Bell, Tilse and Earl, 2007, pp. 78–102). However, public housing tenants comprise only a small and declining proportion of older Australians, constituting 4.4 per cent of those aged 65 and over in 2001, down from 5.3 per cent in 1991 (Howe, 2003, p. 8).

These twin policies of support for home ownership and public rental housing provision for older people who have not attained home ownership constitute the mainstream of state intervention in housing for older people in Australia in recent decades. In the context of this report, it is important to note that neither of these sets of interventions has been significantly concerned with the issue of linking housing, support and care. In terms of the home ownership sector, matters of housing form have been seen to be

matters of predominantly private concern. The provision of care and support services to older home owners (and indeed to private renters) has been approached as an aged care issue, regardless of issues of housing form, type and location. With respect to public renters, the main focus of public policy has been on housing availability and affordability. Public housing has historically been viewed as targeted on those deemed able to live independently, and support and care services provided by the housing agency have been mainly limited to the areas of property maintenance and modification (Jones, De Jonge and Phillips, 2008). While there has been growing interest in linking public housing tenants to support and care services (e.g. Purdon Associates, 1997), state and territory housing authorities (SHAs) historically have not viewed it as their responsibility to provide support and care services to their older tenants (Jones, Bell, Tilse and Earl, 2007, pp. 102–103). However, this may now be changing as SHAs increasingly orient their activities to focus on complex needs groups, and the development of linkages with organisations that provide care and support. As will be shown in chapter 4, public housing may now be emerging as one of the contexts for the development of initiatives in integrated housing, support and care.

Insofar as the issue of integrating housing, support and care has been addressed in housing policies relating to older people, it has been mainly in areas outside the mainstream. Three areas of public intervention pertaining to integrated housing, support and care for older people can be identified. These are:

1. Support (and subsequent policy neglect) for the provision of independent living units by community organisations.
2. General support and regulation (but not sponsorship and promotion) of the retirement village industry.
3. Support for integrated housing, support and care services for older people with high needs.

State activity (and inactivity) in each of these areas has had a significant impact on the development of integrated housing, support and care services in Australia, and each of these areas is briefly introduced below.

2.2.1 Independent living units

The first involvement of the Australian Government in support of the provision of housing of older people was the passage of the Aged Persons Homes Act (APHA) in 1954. This measure provided matching capital grants to churches and other non-profit organisations to build homes for older people. The legislation imposed few conditions on management and operational matters including the types of housing to be provided and the rules governing allocation of housing to older people. Between 1954 and 1986 the Australian Government subsidised over 30,000 independent living units (ILUs) through the APHA (McNelis, 2004, p. 7).

The original intention of the APHA was to provide affordable, independent housing for lower-income older people. However, during the first two decades of the operation of the program its goals were deflected. Firstly, housing provided under the program became targeted, not solely on low-income households, but also on those able to provide a non-returnable 'donation' to the community organisation on entry. Secondly, as it became apparent that many older people required a combination of housing, support and care, changes were made to the program to allow for the funding of hostels and nursing homes providing care for older people, as well as ILUs. These processes of 'subversion' (Howe, 1982) of the APHA, particularly the trend towards

the provision of aged care facilities, had significant consequences for the subsequent development of housing, support and care services for older people in Australia.

The first consequence was the division of 'aged care' and 'housing' into distinct policy fields. By the mid-1980s the APHA had been superseded, on the one hand by new policy and funding arrangements that sought to rationalise an 'aged care' system comprising both residential and community care services, and on the other hand by new arrangements for the funding through the CSHA of more targeted affordable rental housing for low-income older people (for a more detailed discussion see Jones, Bell, Tilse and Earl, 2007, pp. 79–80). This policy and program divide between 'aged care' and 'housing' provision resulted in lack of policy focus on the development of integrated housing, support and care models.

As well as this policy legacy, the APHA left a services legacy of some 34,700 purpose-built dwellings for older people owned and operated by community sector organisations. These dwellings are predominantly cottage-type dwellings located on mainly small-scale (less than fifty units) congregate sites, primarily housing households with limited means and low incomes. These dwellings have been described as 'the forgotten housing sector' (McNelis, 2004). They operate outside the social housing system funded through the CSHA, and outside the aged care system, and for many years have not been linked to any wider policy goals or systems. Much of the existing housing stock is ageing and is in need of renovation or upgrading, and the social purpose of this housing stock in the contemporary social and policy context has become somewhat unclear. In a major review conducted for AHURI, McNelis argues that 'the primary challenge for ILU organisations is to reaffirm or revise their vision and mission in the light of their changing situation' (McNelis, 2004, p. v).

While ILUs are intended as dwellings for older people able to live independently, and are clearly distinguishable from aged care facilities, it is nevertheless the case that many residents have a significant need for support and care services. McNelis found that over 40 per cent of organisations providing ILUs estimated that over 35 per cent of their residents require assistance such as formal or informal support, practical assistance, personal care or home nursing. Approximately one-third of all organisations providing ILUs are also providers of support and care services to many of their residents, and others have formal arrangements for care to be provided by other organisations. Many organisations providing ILUs are large providers of HACC and CACPs, and some 80 per cent are also providers of residential care, sometimes on the same site as the ILU or on a contiguous site. Outreach community care programs run by the organisations operating 'low care' hostels have been a significant source of support and care for ILU residents (Howe, 1995, p. 223). Thus, many ILUs are in effect a form of integrated housing, support and care, although this is not widely or formally recognised at the policy or program level (McNelis, 2004, pp. 49–52).

It could be argued that ILUs represent a potential platform for the development of an explicit program of integrated housing, support and care services. This could be instigated by housing authorities, by the community sector providers of ILUs, or both. Many of these providers are also major suppliers of residential aged care, community care, and retirement villages, and have extensive capacity and experience as providers of services to older people. The development of ILUs as an explicit form (or a range of forms) of integrated housing, support and care would provide this 'forgotten social housing sector' with an explicit vision as proposed by McNelis (2004).

One consequence of the development of the ILU sector has been the engagement of community sector organisations with the area of housing for lower income older people. In addition to the provision of ILUs, community organisations have been involved in the development of the retirement village industry and in the development

of a number of innovative approaches to linking housing, support and care. Community organisations funded under the Community Housing Program of the CSHA have also been involved in provision of linked housing, support and care of older people (Jones, Bell, Tilse and Earl, 2007, pp. 104–105). As shown in chapter 4, the community sector is emerging as one of the key contexts for the development of initiatives in integrated housing, support and care.

2.2.2 The retirement village industry

The main form of integrated housing, support and care for older people in Australia is the retirement village. In the Australian context, the term ‘retirement village’ broadly refers to a housing complex comprising multiple dwellings primarily designed for people in later life, and involving the provision of communal facilities and services. Residents are usually deemed to be ‘independent’, meaning that they do not require the level of care and support associated with residential aged care facilities. Their units are often referred to as ‘independent living units’ or ‘self-care’ units. During the past three decades, retirement villages have been the fastest growing type of housing oriented to the needs of older people in Australia (Stimson, 2002, p. 6). The retirement village industry first emerged in the mid-1970s when the Australian Government began to phase out subsidies for ILUs. Not-for-profit organisations began to develop ‘resident funded’ retirement housing, and private sector operators soon joined them in developing this new market. By the late 1990s there were approximately 1,500 retirement villages in Australia, with an estimated 100,000 residents (Stimson, 2002, p. 19). Precise information on the current number of retirement villages is difficult to obtain due in part to definitional problems. A recent industry estimate puts the figure at over 1,650 complexes with a total resident population of over 150,000 (www.villages.com.au accessed 5 August 2007).

The growth in the number of retirement villages has been accompanied by increasing diversity and product differentiation. A typology of Australian retirement villages developed in 2002 suggested three broad types of villages: resort style, modest, and affordable. These types are differentiated by the socio-economic characteristics of residents, the range and quality of services and facilities, the level of care, the size of residential units, tenure and contract arrangements, and other factors (Stimson, 2002, pp. 31–33 and 202). There appears to have been further differentiation of retirement villages over the past five years including expansion of both the affordable and the luxury village sectors, and diversification of the physical form of villages, tenure arrangements, and the range and types of services.

While most retirement villages are designed for older people able to live ‘independently’, part of their attraction is that they provide a range of services on-site, including some of the support and care services identified in Table 1. All retirement villages provide on-site management and property maintenance services, and most provide various forms of social activities and recreational facilities. In higher-cost, ‘resort-style’ villages the range of recreational facilities is often extensive including a community building, swimming pool, spa, gym, tennis court, bowling and putting greens, workshop, café/restaurant and so forth (Stimson, 2002, p. 33). Most villages provide some form of transport service (usually a village bus), and some provide a meal service and assistance with domestic work (e.g. a linen service). Many provide a 24-hour emergency call service and medical rooms that are used by visiting doctors or health specialists.

A growing number of Australian retirement villages also provide ‘serviced apartments’. A serviced apartment, sometimes called an ‘assisted living unit’, is a one or two-bedroom apartment located within a retirement village that provides supported accommodation for residents who require some assistance with daily living. Services

such as cleaning, laundry and assistance with self-care activities are usually provided. Meals are often provided in a dining room setting, and a small kitchenette may also be included within the apartment.

A significant number of Australian retirement villages have historically been co-located with residential aged care services, and based on the concept of 'on-going care' (Australia, House of Representatives, 1982, pp. 63–65) or the 'continuum of care' (Stimson, 2002, pp. 211–212). This model, particularly prevalent in older retirement villages operated by not-for-profit sector operators, is based on the concept that residents can move from independent living to residential aged care while remaining within the one complex. While admission to an aged care facility is dependent on independent, professional assessment of need and is not guaranteed (Buys, 2000), the concept of jointly sited independent living units, hostels and nursing homes does seem to have considerable and continuing attraction (Buys, 2000; Stimson, 2002, pp. 55 and 211).

The perception that retirement villages provide access to integrated housing, support and care appears to be of great importance in many people's decisions to move to a retirement village. Declining health and mobility, difficulties in maintaining a home and garden, and loneliness and social isolation, have been identified as key factors precipitating the move of many to a retirement village, although for others lifestyle factors may be of most importance (Stimson, 2002, pp. 60-62). Support services such as 24-hour emergency support systems rate highly as desirable attributes of retirement villages (Stimson, 2002, p. 73). There is some evidence that there can be a gap between residents' perceptions of care and support availability and the reality of the availability of services in retirement villages (Buys, 2000). However, other studies have found that many residents of retirement villages report improved quality of life, particularly linked to the social environment of the village, the more manageable dwelling and garden, the health support, and the quality of the physical environment (Gardner, Browning and Kendig, 2005).

The growth of retirement villages is unquestionably the most large-scale and diverse development of linked housing, support and care services for older people in Australia during the last decade. However, it is important to emphasise that this development has occurred largely without intentional state support. Howe refers to the development of retirement villages as 'an outstanding example of policy by default' (Howe, 2003, p. 4). While public policies have certainly impacted on the growth of retirement villages, there have been no explicit policies to promote their growth or shape their character, other than urban planning requirements in some states, notably NSW. The retirement village legislation that has been passed in all states and territories during the past two decades is primarily concerned with consumer protection for those residing in retirement villages under a range of complex tenure arrangements (Stimson, 2002, pp. 25–28 and 37–43).

There has been no major study of the retirement village industry since 2002. Stimson's detailed analysis in that year predicted significant expansion of the industry in response to the increase in demand stemming from population ageing; likely increase in market penetration; blurring of the differences between profit and not-for-profit providers as each become more corporatized; increasing differentiation of product as suppliers respond to different market segments; new village forms including high-rise and more compact medium-density designs; greater concentration of ownership and management; and generally a maturing of the industry (Stimson, 2002, pp. 201–216). One important development has been the emergence of 'affordable' rental retirement villages targeted at older people wholly or partially dependent on the aged pension (Jones, Bell, Tilse and Earl, 2007, pp. 114–124).

There also appears to have been an expansion of villages targeting high-income individuals and households, and of villages providing a wider range of care and support services. Examples of some of the emerging types of retirement villages providing integrated housing, support and care are identified in chapter 4.

2.2.3 Housing, support and care for older people with high needs

Paralleling the development of the retirement village industry, there has been a growth of a far smaller housing sector that is focused on the needs of older people who are homeless or living in insecure accommodation. Wintringham, a housing and aged care organisation established in Melbourne in 1989, pioneered the development of services providing linked housing, care and support services to this population group. Wintringham's approach has been to provide integrated housing, support and care to older people at risk of homelessness drawing on funding available through the aged care system and the SHA, as well as other philanthropic sources. The organisation provides a range of services including residential aged care facilities, independent housing with associated care and support, and outreach care and support to older people living in boarding houses and the private rental market (Lippman, 2003; Lippman, 2006).

The development of linked housing, support and care services for older people in insecure housing was advanced by the establishment by the Australian Government of the Assistance with Care and Housing for the Aged (ACHA) program in 1993 (Roberts, 1997). Some forty-six projects have been funded under this program to assist frail older people in insecure accommodation to access, and be maintained in, secure and affordable housing with support (Alt Statis and Associates, 1996; Rusconi, 2003). The program is explicitly based on a concern that low-income frail aged people in insecure housing are at greater risk of premature entry to aged care facilities due to their reduced ability to access housing and community care services (Alt Statis and Associates, 1996, p. ix). The ACHA program is mainly focused on assisting older people in insecure accommodation to make the transition to secure and supported housing. A recent AHURI report examining the views and experiences of ACHA service providers and consumers emphasised the need for an expansion of suitable housing and support options for this population group (Judd, Kavanagh, Morris and Naidoo, 2004).

Integrated housing, support and care programs have also been developed for other high-need groups. Supported residential services, known in some states as supported residential facilities, licensed residential centres or supported accommodation, provide accommodation, social support and (most commonly) low-level care for people with disabilities who need support in daily living, including frail, older people (Jones, Bell, Tilse and Earl, 2007, pp. 148–149). The provision of housing, support and care for older adults with disabilities has been examined in an earlier AHURI report (Bridge, Kendig, Quine and Parsons, 2002). There are also some specialised housing and care services for older people with developmental disabilities (Milne and De Mellow, 1996).

2.2.4 Summary

The development of linked housing, support and care services has not been an explicit goal of Australian housing policies for older people. Since the 1980s, the housing of older people and aged care provision have developed as largely separate and distinct policy fields. The provision of care and support services has been primarily viewed as an aged care rather than a housing issue. Nevertheless, a number of forms of integrated housing, support and care have emerged, driven more by initiatives taken in the community and market sectors than by explicit public policy.

The main location of emerging forms of linked housing, support and care is the retirement village industry. This growing industry is rapidly diversifying and providing an increasing number of new forms of linked housing, support and care services targeted at different populations of older people. Other sites for the emergence of new approaches are community organisations either through the continuing provision of ILUs that incorporate care and support services or through the development of other innovative approaches. Organisations working with older people who are at risk of homelessness constitute another setting for innovative approaches to linking housing, support and care. There has also been increasing interest and activity by SHAs in developing support and care services for older public housing tenants. These are the locations for the case examples of established and emerging forms of linked housing, support and care that are proposed in chapter 4.

2.3 Aged care policy

As discussed in section 2.2.1, the origins of the Australian residential aged care system can be traced back to the passage of the *Aged Persons Homes Act* (APHA) in 1954. The initial focus of this legislation on housing, primarily in the form of both self-contained and hostel-type accommodation, was gradually displaced by an emphasis on nursing home beds. From the 1960s, nursing home beds provided by either the voluntary or the private sector attracted a recurrent subsidy, and this stimulated a rapid increase in the size of the nursing homes sector. By the late 1970s over half of the accommodation units being funded through the APHA were nursing home beds, and the number of nursing home beds in Australia grew rapidly during the 1960s and 1970s (Gibson, 1998, pp. 29–30). From the late 1960s, the growth of hostel-type accommodation was also stimulated through extension of capital and recurrent subsidies. Hostels were increasingly encouraged (and funded through the Personal Care Subsidy) to cater for frail older people with significant levels of dependency, rather than operating as originally conceived as low-cost, shared accommodation with limited support and supervision (Australia, Parliament, 1982, p. 48). By the 1970s, hostels were increasingly viewed as providers of care for frail older people with ‘low’ levels of dependency alongside nursing homes catering for older people needing a higher level of care (Baldwin, 1982, pp. 18–19).

During the 1950s and 1960s, alongside this gradual development of a two-tier residential aged care system, home-based care services for older people also began to be developed, albeit in a rather piecemeal and poorly coordinated fashion. The first Commonwealth Government program was the introduction of a subsidy for home nursing in the 1950s, followed a decade or so later by financial support for senior citizen centres, community-based paramedical services, and delivered meals (Gibson, 1998, pp. 31–33). However, prior to the 1980s home care services were small-scale both absolutely and in comparison to the rapidly growing residential age care system. The imbalance between home care and residential care services had emerged as a matter of public concern by the early 1980s, and there was increasing consideration of the possibility that many older people being admitted to nursing homes could be cared for more effectively and efficiently in their own homes (Australia, Parliament, 1982).

The complexity and lack of coherence in aged care services, together with concerns about the increasing cost of nursing homes and perceptions of likely increased demand stemming from the ageing of the population, led to a period of review and change in the early and mid-1980s that came to be referred to as the Aged Care Reform Strategy (Gibson, 1998, pp. 33–48; Howe, 1997). During the mid-1980s, the residential care system was restructured, an integrated national system of home and community care services was established, and the current approach of providing aged care through a combination of residential care and community care was established.

Key developments in the aged care system during the 1980s and early 1990s were the expansion of community care relative to residential care, and a reduction in the total level of provision of residential care services relative to the size of the population (Gibson, 1988, pp. 35–37). Access to residential care services was controlled by the introduction of aged care assessment teams (ACATs) which determined eligibility based on nationally consistent measures of dependency.

The expansion of community care was brought about through the creation of the Home and Community Care (HACC) program in 1984. HACC brought together under one umbrella a wide range of pre-existing services that had been funded through the Australian Government, the states and territories, as well as developing new service types. HACC provides services to younger people with a moderate or severe level of disability, as well as the older population group. The HACC program grew steadily during its first two decades of operation, both in the levels of funding and services provided. Australian Government funding of HACC is predicted to increase to over \$1 billion by 2007–2008, and much of this expenditure is matched by the states (Australia, DOHA, 2004, p. 14). HACC services are used by approximately 210 of every 1000 people aged 65 or over (AIHW, 2005, p. 163). Service types now include domestic assistance, social support, personal care, nursing care, meals, centre-based recreational activities, respite care, transport, allied health services, home maintenance and modification, assessment, counseling and support, and case management (Australia, HACC, 2002, pp. 38-41).

Throughout its history, the aims of the HACC program have been expressed in terms both of enhancing the independence and lifestyle of frail aged people and avoiding premature admission to long-term residential care (Australia, Parliament, 1994; Australia, 2002). Translating these goals into consistent eligibility and priority guidelines has proved complex (NARI, 1999). The *New Strategy for Community Care*, announced in 2004, signified the development of a more streamlined approach to community care services, drawing together HACC and a range of other community care programs developed since 1990. This strategy proposed a new, tiered model of service provision, and a more consistent approach to assessment of need and eligibility, access to services, setting of fees, accountability, quality assurance, information management, program boundary issues and planning (Australia, DOHA, 2004). The new tiered model of service provision envisaged three levels of service: an early intervention and information tier, a basic care tier, and a packaged care tier (Australia, DOHA, 2004).

The last of these three tiers referred to the development since the late 1980s of programs designed to make home care services more feasible options for highly dependent clients, who would otherwise in all likelihood require access to residential care (Gibson, 1988, pp. 37–38). Community options projects, first introduced in 1987, are based on the concept of a brokerage model involving a case manager who arranges an integrated package of care services that respond to the assessed needs of the individual. In the early 1990s, community aged care packages (CACPs) were introduced as an alternative to residential care for frail, elderly people assessed by ACATs as eligible for residential care (Gibson, 1988, pp. 62–64). CACPs provide the equivalent of low level residential aged care in the older person's home. Many CACPs were delivered as outreach programs from hostels (Howe, 1995, p. 223). CACPs have grown rapidly in number from less than 5,000 in 1995-96 to around 28,000 in 2003 (Australia, DOHA, 2004, p. 17). In 1998, the Australian Government also introduced extended aged care at home (EACH) packages to provide high-level care to people living at home, beyond the level of assistance provided through CACP (Australia, DOHA, 2004, p. 18). Further growth of both CACP and EACH is envisaged. These

programs, together with community options, represent a significant shift in the balance of community care resources towards older people with high levels of dependency.

The provision of HACC, CACP and EACH has largely taken place without particular reference to the type of dwelling occupied by an older person, and tenure groups including older people who are owner-occupiers, public and private renters appear to be represented amongst users of HACC services in rough proportion to their distribution in the older population (Victoria, DHS, 2004, p. 14). In the 1990s some HACC providers were unwilling to provide services to residents of boarding houses and retirement villages, and there was some ambiguity as to the eligibility of residents of housing complexes providing some support services (Australia, Parliament, 1994, pp. 101–102). However, this has been clarified and residents of retirement villages and independent living units are eligible for HACC services except when a resident's contract includes these services (Australia, HACC, 2002, p. 9). On-site managers and 'care coordinators' in some not-for-profit housing agencies play important roles in linking residents to HACC and other services. Residents of supported residential services and boarding houses also receive HACC services.

Indeed, there has been increased interest in and experimentation with linking of community care services with particular forms of housing. The Retirement Villages Care Pilot, announced in the 2002–2004 Australian Government budget, provides CACP and EACH packages to operators of retirement villages to enable residents to remain at home and prevent or defer the need to move to a residential aged care facility. The aim of the pilot is to build on care services already available to residents, and to take advantage of the structured environment of retirement villages (<http://www.health.gov.au/internet/wcms/publishing.nsf/content>). There has also been experimentation with the use of CACP and other community care funding to provide care services to public housing tenants (Kendig and Gardner, 1997, p. 189), and the development of closer links between community care and public housing providers (Jones, Bell, Tilse and Earl, 2007, pp. 102–103).

An important change in residential aged care occurred in 1997 with the combining of the two-tiered system of hostels and nursing homes into a unified residential aged care system. The *Commonwealth Aged Care Act*, 1997 also introduced an eight-category Resident Classification Scale (RCS) to measure resident dependency and determine the funding service providers would be paid for each resident. The rationale for this change was to enable residents to 'age in place' in the same facility as their level of dependency changed, as well as to remove perceived inequities in funding between hostels and nursing homes (AIHW, 2002). The change also benefited the not-for-profit sector, as the main provider of hostel care, relative to the private sector. The change also resulted in considerable increases in the number and proportion of residents classified as higher-dependency residents living in former hostels, and an overall increase in the proportion of residents in the residential aged care system assessed as requiring high levels of care (AIHW, 2002, pp. 3–8). In 2004, 62 per cent of all residential care places were used for high-level residential care (Bishop, 2004, p. 17). As a corollary, access to residential aged care homes became much more difficult for lower-dependency older people.

The development of a unified residential aged care system has been criticised on a number of grounds, including the capacity of small-scale hostels to provide a wide range of care services within the one facility and the reduction of differentiation and choice within the system (Howe, 1999, pp. 12–13). Howe has characterised the integration of nursing homes and hostels as a case of 'inwards and upwards' thinking, i.e. a focus on residential aged care as a system providing high-level care with clear demarcation from other forms of accommodation and care. She argues instead for

'downwards and outwards' thinking that minimizes the distinction between residential care and other forms of integrated housing, support and care, arguing that there are 'several trends that suggest that care and accommodation are already fanning downwards and outwards' (Howe, 1999, p. 16). These trends include the developments in integrated housing, support and care that are the central concern of our study.

In summary, during the past two decades the Australian aged care system has been transformed from a piecemeal and poorly coordinated set of disparate services into a mature service system. The system comprises a tightly defined residential care system with entry regulated through aged care assessment teams applying eligibility criteria based on national measures of dependency. These teams also regulate eligibility for intensive packages of home-based aged care services – CACP and EACH – that provide an alternative to residential aged care delivered in a person's home. Alongside this system is a network of home and community care services – HACC – that is also subject to increasingly formalised processes of need and eligibility assessment based on levels of dependency. The size of the residential aged care sector is highly regulated, and a major aim of the community care programs is to avoid unnecessary admission to residential care. There has been some experimentation of linking community care provision with specific forms of housing, but this is not a major emphasis in the system as a whole. While there is ongoing debate concerning the funding levels and processes of a system that will become increasingly costly as the population ages (Allen Consulting Group, 2002), the broad structures and components of the system appear to be, for the time being, settled. Nevertheless the links and tensions between this system and the developments in linking housing, support and care discussed earlier in this chapter may provide one impetus for change.

2.4 Conclusion

The fundamental feature of the Australian policy context shaping development of integrated housing, support and care is the divide between housing policies for older people and aged care policies. The Australian aged care system has developed over the past twenty years as one characterised by sharp boundaries, relatively clear elements, and a focus on older people with high levels of dependency. The sub-systems of residential aged care and community care are clearly delineated, although many providers are involved in both and a fundamental goal of community care services is to reduce demand on residential care. The community care system is increasingly focused on care packages for high-dependency individuals (CACP and EACH), as well as the more widely targeted Home and Community Care program (HACC). The system tends to be more focused on its internal arrangements and linkages rather than on relations with contiguous policy fields such as the housing of older people. By contrast, housing policies for older people lack coherence and shape. The important issue of linking housing, support and care is addressed only in a piecemeal way, and innovative practices, programs and products in the community and market sectors lack a policy framework. There appears to be a growth of new initiatives in linked housing, support and care, emanating from the retirement village industry, the community sector, public housing providers and organisations working with high-need populations of older people. Many of these initiatives are using HACC, CACPs and related services to provide the care and support elements. But the links between these initiatives and wider housing and aged care policies are not well articulated at this stage.

3 INTERNATIONAL MODELS

3.1 Introduction

The provision of housing and care for people in later life varies considerably from country to country, and the Australian approach differs in important respects from prevailing approaches in other countries. All developed countries in North America and Europe have a range of integrated housing and care services for older people, but these take many different forms and are subject to widely varying funding and regulatory policies. As in all areas of public policy and social provision, the singularity of national history, culture and institutions has resulted in great variation. Approaches to housing and care of older people are embedded in particular national contexts, and caution must therefore be exercised when considering the applicability of models and service types that have emerged elsewhere. Furthermore, differences of terminology can cause confusion, particularly when similar terms refer to different types of service. Nevertheless, ideas and models do exert influence across national boundaries, and examining the experience of other countries has long been a source of innovation and learning in social policy. The purpose of this chapter is to examine the experiences of the United States, the United Kingdom, and selected other countries as potential sources of new approaches to integrated housing, support and care in Australia.

The approach taken is necessarily highly selective. There is great diversity in the approach to these issues taken in other countries, terminology is not standard and is often imprecise, and the impacts of policy and social contexts are often highly nuanced. The aims of this chapter are therefore modest, and should be viewed primarily as an attempt to lay the foundations for more detailed comparative analysis. The specific objectives of the chapter are:

1. To describe the main forms of integrated housing, support and care that have developed in the United States, and the broad features of the national context in which these forms have developed.
2. To describe the main forms of integrated housing, support and care that have developed in the United Kingdom, and the broad features of the national context in which these forms have developed.
3. To describe a selection of other forms of integrated housing, support and care that have developed in other countries, particularly those that have received a degree of attention in the Australian context.
4. To consider the relevance of these international approaches to the Australian context.

The methods used in the literature review on which this analysis is based are described in Appendix 1. Almost all of the literature is drawn from the past fifteen years. It has not been possible within the confines of the project to ensure that all information relating to all the countries reviewed is up-to-date, and where non-contemporary sources have been used the historical context is indicated. The chapter is intended as an overview of the kinds of developments that have occurred during the past two decades, and as such it provides a foundation for considering the relevance of other countries' experiences for Australia.

3.2 United States

3.2.1 Overview

The range of integrated housing, support and care options available in the United States is sometimes portrayed as a continuum, based on the level of support and care

provided (e.g. Sexton, 1998, pp. 21–23). At one end of the continuum is housing available to older people who live independently in the community, with or without the assistance of home care and home health care services. The provision of such services may be facilitated by the location of older people in so-called naturally occurring retirement communities (NORCs). Some older people with a high capacity to live independently may choose to live in active adult retirement communities (AARCs), sometimes referred to as leisure-oriented retirement communities (LORCs) which have a strong orientation to lifestyle and recreational activities. Those with a need for some degree of support and care may have the option of supported or service-enriched housing, sometimes referred to as independent living facilities (ILFs) or congregate seniors housing (CSH). However, the level of support and care provided in these facilities is significantly less than that provided in assisted living facilities (ALFs), designed for older people with relatively high levels of frailty and disability. Beyond these services are skilled nursing facilities (SNFs), also known as nursing homes, which provides support and care for those requiring high-level nursing care. Continuing care retirement communities (CCRC) span several of these categories, and are designed to provide a continuum of living accommodation and care – from independent living through to skilled nursing – for an older person within a single setting.

The orderliness of this categorisation belies the complex and somewhat chaotic reality of housing, support and care provision in the United States. These categories of service types in reality describe a great diversity of arrangements that have emerged through complex historical processes involving an assorted mix of public, community and market sector initiatives, with significant variations from state to state. A plethora of terms are used to describe housing for older people, reflecting different state regulatory arrangements, the involvement of different professions, the hybrid nature of many products, and the rapidly evolving nature of the industry (Benjamin and Anikeeff, 1998, p. 15; Scribner and Dalkowski, 1998, pp. 73–74). The categorisation of types of services and products set out above is a helpful framework for beginning to understand this complex service system. However, it decidedly does not imply the existence of an orderly, purposive and integrated service system.

A brief historical overview provides a starting-point for understanding the character and complexity of this service system. The origins of specialised housing for older people in the United States can be traced to the nineteenth century and the provision by religious and fraternal organisations of ‘turnover of assets’ homes, whereby a resident would bequeath all of their assets in exchange for lifelong housing and care (Benjamin and Anikeeff, 1998, p. 17). Many of these facilities did not survive the Great Depression of the 1930s, but not-for-profit organisations continued to be the main providers of specialised housing for older people until well into the post-World War Two period (Sexton, 1998, p. 26).

In the late 1950s, lower-income older people became eligible for federally funded public housing. At this time the emphasis was on ILFs, and housing and services were viewed as separate domains (Pynoos and Nishita, 2005, pp. 244–245). In 1959, another housing program for older people was created through Section 202 of the National Housing Act, providing funding for housing for older people provided by non-profit organisations. These housing services also focused predominantly on older people able to live independently, although some support services were also provided. The growth of public housing and Section 202 housing has lagged far behind demand. By the late 1990s, approximately 1 million people received housing through these and related programs out of a total population of 35 million older people (Pynoos and Nishita, 2005, pp. 245–247; United States Census Bureau, 2004, p. 1).

During the 1980s, the private sector for the first time became involved in specialised housing for older people on a large scale (Fairchild, Higgins and Folts, 1991), and during the past two decades it has become the largest provider. Much of the early development was in the form of congregate seniors housing with a strong leisure orientation and only limited support and care services. However, the industry experienced considerable financial difficulty during the 1980s attributed by some to its overestimation of the market for congregate housing for younger, independent-living seniors and lack of awareness of the increasing need for care and support as people age (Sexton, 1998, p. 26). In the 1990s, the industry refocused on older people requiring higher levels of support and care, and assisted living facilities became the fastest growing sector in seniors housing (Benjamin and Anikeeff, 1998, p. 15; Scriber and Dalkowski 1998, p. 83). Most residents in ALFs pay privately for their accommodation, and as a consequence it has mainly been the more affluent population that has been targeted by the industry (Benjamin and Anikeeff, 1998, p. 16). The growing demand for ALFs has been stimulated in part by the growing numbers of older people in the population of the United States, which rose from 31.2 million in 1990 to 35.0 million in 2000 (United States Census Bureau, 2004, p. 1).

During the past decade there have been numerous initiatives by public, non-profit and market organisations designed to extend access to enriched housing, including ALFs, to lower income groups (Pynoos, Liebig, Alley and Nishita, 2004). This has been part of a wider emphasis on developing integrated housing, support and care services for lower income, older Americans, stimulated in part by the ageing and increasing frailty of residents living in public housing and Section 202 housing residents (Pynoos and Nishita, 2005, pp. 252–255). Many programs and projects aiming to link housing, care and support have had to work within the complexities of Medicare and Medicaid eligibility requirements, state licensing and regulation regimes, and subsidised housing arrangements. Developing such arrangements in the United States context has required public–private partnerships, the crossing of administrative boundaries between housing and service agencies, creativity with funding sources, and strong local leadership (Pynoos, Feldman and Ahrens, 2004).

In summary, the complexity, diversity and size of the United States seniors housing sector has resulted in a system that now includes many examples of integrated housing, support and care models. These have developed in an incremental fashion as a consequence of numerous public programs that have impinged both directly and indirectly on the service system, market and community sector initiatives, and many attempts to expand the range of enriched housing options through integrating funding sources and programs resources at state and local levels. The main forms of integrated support and care services are described below under six broad headings: home care services; leisure-oriented retirement communities; supportive or service-enriched housing; group and shared housing; assisted living services; and continuing care retirement communities.

3.2.2 Home care services

Support and care services provided to people in their own homes do not fall within this report's definition of integrated housing, support and care services. However, an understanding of the home care service system in the United States is needed to provide context for the later discussion of integrated service forms. Furthermore, some models of provision of support and care services in localities characterised by high densities of older people – often referred to in the United States as Naturally Occurring Retirement Communities (NORCs) – can be considered as integrated models that fall within our definition.

As in Australia, a high proportion of older people in the United States reside in private housing that does not involve the direct provision of care or services. Of all Americans aged 65 and over, 94.3 per cent live in private households and only 5.7 per cent in some form of residential care. The proportion living in residential care rises to 21.9 per cent for those aged 85 and over. Across the nation, 78 per cent of householders aged 65 and over owned their homes compared to 66 per cent for the American population as a whole (United States Census Bureau, 2004, pp. 3 and 9).

Support and care services to older people living in private households in the United States are variously referred to as home care services, in-home care, home health care or long-term care. The range of services provided is similar to those listed as support and care services in Table 1, although the terminology used to refer to particular service types often differs from that commonly used in Australia (see Kane, 1999). Policy and funding arrangements for the provision of home care services are complex, and there is no integrated national program equivalent to Australia's Home and Community Care program (HACC). The general picture is one of a fragmented service system with multiple funding streams and administrative agencies (Stupp, 2000). Generally, home care services are provided through a mix of programs including Medicaid, Medicare, the *Older Americans Act* and Social Services Block Grants, and the availability and cost of services varies widely between states and locations (Pynoos, Liebig, Alley and Nishita, 2004, pp. 20–22).

Medicare and Medicaid are jointly responsible for some 60 per cent of funding of long-term care, including home care and nursing home care, in the United States (Feder, Komisar and Niefeld, 2000, p. 44). Medicare, the federal government's health insurance program, finances medical care for nearly all elderly Americans. However, its role in the financing of home care is largely restricted to the period immediately following a hospital stay and is linked to short-term rehabilitative goals. The funding of longer-term care at home (as well as in nursing homes) for low income elderly Americans is largely the responsibility of Medicaid, the federal–state program that provides health insurance for low income families. Elderly (and disabled) people can receive Medicaid benefits for home care services subject to income and assets tests that vary significantly from state to state. Many states fund a wider range of home care services through 'Medicaid waivers' that enable them to provide particular types of services to specific population groups or localities outside usual federal guidelines (Stupp, 2000, p. 57). These arrangements result in large variations among states in expenditure on home care and nursing home care. The tight eligibility requirements and limited coverage of Medicaid-funded services mean that user charges and (to a lesser extent) private health insurance account for more than one-third of expenditure on both home care and nursing home care services (Feder, Komisar and Niefeld, 2000, pp. 44–45).

Interest in community-based care of older people is being driven by demographic trends, the relatively high cost of nursing home care, and awareness of the limitations of existing levels of provision (Pynoos and Nishita, 2005, p. 256; Feder, Komisar and Niefeld, 2000). Momentum has been provided by the Olmstead Decision issued by the Supreme Court in 1999 requiring states to administer services and programs to people with disabilities in 'the most integrated setting appropriate' to their needs (Pynoos and Nishita, 2005, p. 256). In many parts of the country there have been sustained initiatives designed to build more comprehensive and integrated service systems, particularly through the mechanisms of Area Agencies of Ageing (Stupp, 2000) and other approaches to integrated service provision (Balinsky and LaPolla, 1993). There is also increasing focus on other 'ageing in place' initiatives such as visitability (accessible design), universal design and creation of elder-friendly communities (Pynoos and Nishita, 2005, pp. 257–259).

Considerable attention has been directed in the United States to the provision of home care services in so-called naturally occurring retirement communities (NORCs). This term was originally coined in the mid-1980s to refer to buildings, apartment complexes, neighbourhoods or towns with a high concentration of older people as a consequence of the 'ageing in place' of the local population, or other factors (Hunt and Hunt, 1985). These localities were not originally planned or designed for older people and are not age-restricted, but they are, it is suggested, 'the most common form of retirement community in the United States' (Bassuk, 1999, p. 133). There is no universally accepted precise definition of a NORC. A New York legislative program designed to support service provision in NORCs required that a building have 50 per cent of households with one person aged 60 or over or more than 2,500 elderly residents in order to qualify as a NORC. Others have suggested a NORC be defined more widely as a community in which the proportion of older people exceeds twice the national average of those aged 65 or more (Bassuk, 1999, p. 133; Ormond, Black, Tilly and Thomas, 2004).

In the United States, a number of non-government organisations, often with various forms of public sector funding, have developed supportive service programs designed to enable older people living in NORCs to successfully 'age in place'. For example, in the mid-1990s New York State passed legislation to support NORCs to enhance quality of life, assist residents to maintain their independence through access to services, and minimise hospital stays and nursing home admissions. A total of fourteen NORC projects were funded in various parts of the state, providing a wide range of services and community activities. Similar programs are now available in a number of communities around the United States. NORC supportive services programs have been promoted as a cost-effective approach to enable significant numbers of older people to 'age in place' (Bassuk, 1999; Pine and Pine, 2002). An evaluation of NORCs conducted by the Urban Institute in 2004 concluded that while the NORC supportive services concept was intuitively appealing and should be developed further, implementation of the model raised a number of issues. It suggested that the capacity of NORCs to achieve 'ageing in place' was unproven, that outcome measures needed to be refined, that programs should respond more effectively to the changing nature of communities, and that funding should reflect the mix of public and private benefits conferred by the programs (Ormond, Black, Tilly and Thomas, 2004).

3.2.3 Leisure-oriented retirement communities

The term 'leisure-oriented retirement community' (LORC) refers to housing models that provide opportunities for older households to live in co-located settings oriented towards leisure and lifestyle goals. It may be argued that these housing models are not, strictly speaking, forms of integrated housing, support and care as they are not primarily oriented toward support and care activities. These settings primarily provide community and recreational activities and facilities, but may also provide services such as laundry, linen, building and grounds maintenance, and transportation. LORCs are also known as active adult retirement communities (AARCs). They range widely in scale including retirement resorts or retirement new towns that may have several thousand residents. The built form may take the form of cluster housing, gated communities, or apartment complexes. LORCs tend to focus on young retirees who are active, fully independent, and financially secure or affluent. Some are targeted as special interest or affinity groups such as retired military officers or retired university staff (Benjamin and Anikeeff, 1998, pp. 14-15).

The first LORCs were built in the early 1960s with the development of communities such as Leisure World in California and Sun City in Arizona. The model initially

involved small, relatively inexpensive dwellings located in an environment that offered a wide range of recreational facilities such as swimming pools, clubhouses, golf courses and organised leisure activities. While some early developments were organised as cooperatives, the dominant model by the late 1960s involved home ownership combined with collective ownership of grounds and facilities. Some of the early LORCs have developed into large communities, with Sun City, Arizona now having a population of 40,000 residents and Leisure World, California a population of approximately 9,000. During the 1970s and 1980s, as a consequence of competition amongst developers, many LORCs became increasingly luxurious and expensive (Folts and Muir, 2002, pp. 20–21). Many offer resort style amenities, wide choice of architectural styles, master-planned communities, and security gating.

In the 1980s, a new phase of development of LORCs emerged involving age-restricted luxury rental apartments with a large number of amenities, targeted at healthy, upper-income couples in the 65–74 age range. These have been described as ‘urban adaptations of the LORC model’ (Folts and Muir, 2002, p. 21). These facilities often offered dining, housekeeping and transportation services, as well as entertainment and activity programs. There was little or no emphasis on the provision of health or social services. Early estimates of demand for this type of housing proved overoptimistic, and initial projections of the number of facilities to be built were scaled back. By the late 1980s, it had come to be recognised that congregate facilities not offering health services appealed to only a small segment of the older persons’ housing market, and the focus of the industry began to shift to assisted living and similar products (Fairchild, Higgins and Folts, 1991). However, a recent study of LORCs has suggested that many LORCs have adapted well to the social and economic changes of recent decades, and continue to provide a good quality of life for the small sector of the older population that live in them (Streib, Folts and Peacock, 2007).

3.2.4 Supportive or service-enriched housing

‘Service-enriched’ housing has been defined as ‘living arrangements that include health and/or social services in an accessible, supportive environment’ (Pynoos, Liebig, Alley and Nishita, 2004, p. 5). In the United States the term encompasses a wide range of types of living arrangements for older people. These include independent living facilities (ILFs) which provide a supportive environment for older people, but with minimal on-site care and health services, and congregate seniors housing (CSH) which generally provide a somewhat higher level of services, mainly within the subsidised housing sector. Board and care housing, assisted living facilities (ALFs) and continuing care retirement communities (CCRCs) are also forms of supportive or service-enriched housing, but as they have special significance as models for older people requiring higher levels of care, they are considered separately.

Independent living facilities are retirement communities that provide a supportive living environment for older people who are able to maintain their residence and lifestyle without regular nursing or personal care assistance (Anikeeff and Mueller, 1998, p. 97). Many terms are used to describe ILFs, including retirement communities, retirement homes, senior apartments, senior housing and independent living communities, and they are similar in form and character to many Australian ‘self-care’ or ‘independent living’ retirement villages. Typically, ILFs provide a range of community activities, and some services such as building and grounds maintenance, and often meals, laundry and cleaning services. However, they do not provide personal care and health services, and residents are reliant on outside providers if they require these forms of assistance. The typical age of residents tends to be late

70s and early 80s, although some may be oriented toward younger residents. They do not have as high a level of emphasis on leisure activities as LORCs. Typically, residents pay a monthly rental charge to cover their accommodation and services. ILFs are predominantly provided by the private sector and, while the costs vary, are generally accessible only to older people with significant assets.

The term 'congregate seniors housing' refers to housing provided in a residential setting for older people who can no longer independently manage all the tasks of everyday living, but who do not require continuous nursing care or full-time personal care (Monk and Kaye, 1991, pp. 8-9). Most facilities referred to as congregate housing have separate apartments for each resident plus common shared areas for meals and recreation. Congregate housing is sometimes known as 'supported housing', 'sheltered housing', or 'enriched housing' (Moore, 1992). Most congregate housing facilities offer on-site management, at least one shared meal per day, housekeeping and maintenance, transportation, organised activities, and some assistance with activities of daily living. Some of these services are provided on an optional basis. In some instances, residents may have some home health care services provided to them by an outside agency (Heumann, 1991, p. 76; Anikeeff and Mueller, 1998a, pp. 96-97; Howe, 1999).

The origins of congregate housing lay in concerns about the increasing frailty and dependency of older residents in public and community housing apartments, which until the 1970s, emphasised housing construction rather than service provision (Sheehan, 1987). In the early 1970s large numbers of older public housing tenants were facing eviction due to their inability to continue to live independently, and this directed attention to the need to develop housing options that provided support services for lower-income, older people. Federal funding for the Congregate Housing Services Program (CHSP) was provided on a demonstration project basis in the 1970s and upgraded to a permanent program in the 1980s (Monk and Kaye, 1991). These programs operated in both public housing and Section 202 projects. The program expanded during the 1990s, but with requirements that funding of services be diversified, including a small proportion of costs met from user charges (Pynoos and Nishita, 2005, p. 253).

Meanwhile many other federally assisted housing projects introduced support services in ways that brought them very close to the prevailing definition of congregate housing (Monk and Kaye, 1991, pp. 9-11; Moore, 1992; Warach, 1991). Many publicly funded housing projects for older people now include on-site management, congregate dining, housekeeping and social work services (Pynoos and Nishita, 2005, p. 252; Cleak and Howe, 2003). It has been argued that the cost-effectiveness of congregate care compared with long-term care in nursing homes is one factor that has favoured their development (Heumann, 1991). During the past two decades a significant number of non-subsidised housing projects have been developed such that 'congregate seniors housing' can now be viewed as a generic housing type as well as housing that is subsidised under a particular program. Congregate housing that is provided through the private sector can be significantly more expensive than publicly subsidised congregate housing, and price and quality range widely.

An alternative approach to the conversion of publicly funded seniors housing into congregate housing was the development of the service coordinator program in the early 1990s. This federally funded program provided for the employment of service coordinators in older persons housing projects to facilitate linkages between residents and home care and home health care services. The program has grown rapidly, such that there were over 3,000 service coordinators employed in publicly funded housing complexes for older people in 2003 (Pynoos and Nishita, 2005, p. 253). Service

coordinators assess the needs of residents, provide information and linkages to locally available support and care services, and work with residents to determine needs and services. They may also take on wider roles including community organisation within the housing project, counselling, education and advocacy (Holland, Ganz, Higgins and Antonelli, 1995).

An evaluation of the service coordination project found that they resulted in earlier identification of frail and at-risk residents, more timely provision of support services, and closer links between housing and support services (Schulman, 1996). It has also been argued that they may have wider benefits, including decreased management costs due to lower turnover and vacancy rates, increased resident satisfaction and morale, avoidance of unnecessary or premature nursing home placement, and improved marketability of housing units (Sheehan, 1996; Sheehan, 1999). The involvement of service coordinators has resulted in a broadening of the focus of seniors' housing developments, and has been accompanied by significant levels of tension between housing managers and social service professionals (Sheehan, 1996). The services coordination model supports the proposition that housing facilities not purposely designed to house and support frail older people may find it more advantageous to assist in linking residents with community-based services rather than providing services from within (Cox, 2001, p. 108).

3.2.5 Group and shared housing

Living arrangements providing small-scale group or shared housing have a long history in the United States. Shared housing has been defined broadly as 'a situation in which at least two unrelated persons live together in a dwelling unit, each having ... private space and sharing other common areas, such as kitchen, living and dining room' (Schreter, 1985, p. 122). Three broad types of shared housing arrangements relating to older people in the United States have been distinguished. Self-initiated share housing is essentially a private arrangement involving older people (and sometimes younger people) who choose to live together to reduce costs and for mutual support and companionship. Agency-assisted shared housing involves a matching service that brings together a provider of housing, typically an elderly homeowner, and someone seeking housing, typically a younger person wishing to minimise housing costs. Agency-sponsored shared housing involves a social agency or private sector organisation providing small-scale housing and services for particular groups of older people (Schreter, 1985, pp. 123–124). Each of these types is briefly considered below.

Self-initiated home sharing has long been viewed as a means for older people to reduce housing costs and maintain independence (Folts and Muir, 2002, p. 17). Apartment sharing has been permitted in public housing in the United States since the 1970s, and several states encouraged this approach to older persons' housing during the 1980s (Muller, 1987). The Share-a-Home concept, developed in the 1970s and 1980s, involved small groups of older people renting or purchasing a large home, hiring a house manager to provide shopping, cooking and cleaning services, and living independently of state regulation and social services. Intended by its founders as a widely available franchised living arrangement, Share-a-Home was never widely adopted due to difficulties in recruitment of suitable managers and legal difficulties involving neighbours who objected to the establishment of 'group homes' in their neighbourhoods (Folts and Muir, 2002, pp. 17–18).

Attempts to form model intergenerational households, based on concepts of mutual support and (sometimes) the Danish co-housing model, also have had mixed outcomes in the United States. A study of intentional intergenerational households in the 1980s found that instrumental goals such as reduced rent were of greater

significance to most participants than idealistic concepts of group participation and mutual benefit. It was concluded that housing models based on notions of shared community tested the boundaries of cultural acceptability in the United States context (Folts and Muir, 2002, pp. 19–20).

The second broad type of shared housing for older people, agency-assisted shared housing, emerged as a significant service type in the United States in the 1980s in the public, community and market sectors. In addition to matching older home owners seeking support and younger people seeking accommodation, many homeshare agencies also monitor the arrangement and provide ongoing education, conflict resolution and negotiation if required (Rahder, Farge and Todres, 1992). Evaluations of home share arrangements from the perspective of the older people participating in the programs have emphasised the benefits of greater sense of security, higher level of companionship, and provision of assistance with home maintenance and household tasks (Pranschke, 1987). Disadvantages included personality conflicts, privacy issues and the short duration of many arrangements (Schreter, 1985). One study found that those deciding to share their home had often experienced a recent undesirable life event such as onset of a health condition, or loss of a partner or housemate, and many had low incomes (Schreter, 1985). While this form of home sharing represents another housing option for older people, its appeal may be limited to quite specific groups of older people in quite particular circumstances.

The most established form of agency-sponsored shared housing for older people in the United States is the board and care home, also known as 'adult care homes', 'sheltered care homes', or 'small group homes' (Oltman, 1982). Board and care homes are housing facilities for older people or people with disabilities who wish or need to be in a group-living situation, and who may need assistance with personal care and daily living activities. In this sense they are a form of supportive housing. Historically, many board and care homes have been informal, unlicensed facilities (Benjamin and Newcomer, 1986), and although many are now licensed, standards of care are not uniform. Often a board and care home is a converted single-family home with just a few residents, but there are also larger facilities. Residents have their own or shared rooms, and there are common recreational and dining areas. The range of services varies but usually includes meals, assistance with self-care, housekeeping and laundry, but not nursing or medical services. Board and care homes are primarily used by older people on low incomes, and residents often rely on government subsidies to help defray housing costs (Kalymun, 1990, p. 99).

Until the 1990s, there was a lack of national data on the prevalence of board and care homes. The 1991 National Health Provider Inventory (NHPI) estimated that there were about 30,000 licensed board and care homes in 1991 serving over half a million people, nearly two-thirds aged over 65. The number of unlicensed board and care homes was unknown (ASPE, 1993). While there is general acknowledgement that standards of care vary, it has been argued that many board and care homes provide good quality care in relatively informal contexts, thus providing an important alternative to more institutionalised settings (Eckert, Namazi and Kahana, 1987). The larger board and care homes, which were often called retirement homes, are sometimes viewed as the precursors of the assisted living facilities that have developed as a major form of supported housing for older people since the 1980s.

3.2.6 Assisted living facilities

The term 'assisted living' is widely used in the United States to refer to residences designed for frail older people who need significant levels of assistance with activities of daily living, but who do not require continuous nursing care and who wish to remain as independent as possible (Benjamin and Newcomer, 1986; Benjamin and Anikeeff,

1998, p. 14). Assisted living facilities (ALFs) have been distinguished from other forms of housing, support and care on three criteria (Kalymun, 1990):

- a residential rather than a medical or institutional physical form and operational culture;
- provision of a wide range of services including meals, personal care, medical assistance, housekeeping, social activities, transportation and security;
- residents who are characterised as 'semi-independent' in the sense that 'with assistance they can complete daily routines in a residential environment without requiring skilled care' (Kalymun, 1990, p. 129).

Many assisted living facilities are also characterised by barrier-free, purpose-designed environments to promote independence and reduce reliance on and use of services.

Assisted living facilities have historically also been distinguished from other housing forms, such as board and care homes, on the basis of the socio-economic status of their residents. Most ALFs have been 'user-pay' and hence have drawn their residents from the relatively affluent, although there are numerous initiatives underway to extend the availability of ALFs to lower-income households (Pynoos, Liebig, Alley and Nishita, 2004).

Many definitions of ALFs seek to distinguish them from nursing homes (also called skilled nursing facilities in the United States) on the basis of these three criteria. For example, a recent definition proposes that:

Assisted living is a housing option that involves the delivery of professionally managed supportive services and, depending on state regulations, nursing services, in a group setting that is residential in character and appearance. The intent of assisted living is to accommodate physically and mentally frail older adults without imposing a heavily regulated institutional environment on them (Pynoos and Nishita, 2005, p. 254).

Assisted living facilities are sometimes referred to as 'intermediate care facilities', offering a middle ground between independent living and nursing homes (Anikeeff and Mueller, 1998a, p. 97). The range of services that they provide may include some health services such as assistance with medications and emergency call systems, but they do not provide the level of nursing and medical care available in a nursing home. Some observers have expressed concern that increasing regulation of the ALF sector may blur their distinction from nursing homes and 'shift assisted living away from a social model to a "medicalised" approach' (Pynoos and Nishita, 2005, p. 255).

The distinction drawn between assisted living and nursing homes reflects in part the philosophical basis that is increasingly emphasised by the assisted living industry as the hallmark of their product (NCAL, 2007). There appears to be wide agreement within the industry that the key characteristics of assisted living include barrier-free design; services and oversight available 24 hours of the day; services to meet scheduled and unscheduled needs and facilitate 'ageing in place'; care and services provided or arranged so as to promote independence; an emphasis on consumer dignity, autonomy, and choice; and an emphasis on privacy and a homelike environment (Hawes, Phillips, Rose, Holan and Sherman, 2003, p. 875). The extent to which the current industry embodies these principles is a matter of debate (Frank, 2001; Hawes, Phillips, Rose, Holan and Sherman, 2003).

Assisted living facilities began to emerge as a distinct service type in the late 1980s. During the 1990s assisted living was the fastest growing sector in seniors housing (Benjamin and Anikeeff, 1998, p. 15). A national survey undertaken in 1998 estimated

that there were 11,459 ALFs nationwide, with 611,300 beds and 521,500 residents (Hawes, Phillips, Rose, Holan and Sherman, 2003). Industry estimates indicate that the rapid rate of growth during the 1990s is continuing. Figures from the National Centre for Assisted Living indicate that in 2004 there were approximately 36,000 assisted living residences in the United States housing more than 900,000 people (NCAL, 2007a). It is estimated that assisted living communities accounted for 75 per cent of all new senior housing in the late 1990s (Spitzer, Neuman, and Holden 2004, p. 29). The growth of the 'old-old' population in the United States suggests that the demand for assisted living will continue to rise during the next two decades.

Most of the growth in assisted living has been initiated by the private sector, rather than the not-for-profit sector. Over one-third of ALFs were operated by companies having only one facility in 1999 (Spitzer, Neuman and Holden, 2004, p. 28). However, a number of companies operating a large number of ALFs have emerged during the past decade, the largest being Sunrise Senior Living with 397 facilities in 38 states. The top 25 companies operate a total of 2209 facilities (NCAL, 2007a).

While assisted living has emerged as a distinctive housing type during the past two decades, there is significant diversity within this housing category. The 1998 national survey found that the average size of an ALF was 53 beds, with 67 per cent with 11–50 beds, 21 per cent with 51–100 beds, and 12 per cent with over 100 beds. Residential units were evenly divided between single rooms (52 per cent) and apartments (48 per cent). In terms of type of room, 73 per cent of residential units were private and 25 per cent shared by unrelated persons, with 2 per cent being 'ward-type' rooms. More than one-third (38 per cent) of all ALF units required the resident to share a bathroom. The survey classified ALFs in terms of level of privacy and level of services. Only 10.9 per cent scored high on both criteria, with a further 11.6 per cent classified as high service/low privacy and 18.4 per cent low service/high privacy (Hawes, Phillips, Rose, Holan and Sherman, 2003). These figures suggest that for many ALFs there is a significant gap between the industry ideals and practice realities (Frank, 2001).

One response to the rapid growth of ALFs has been the emergence of a significant body of research addressing key issues of concern. These issues relate in particular to the physical environment, the quality of life of residents, 'ageing in place', and affordability. The main research themes relating to these issues are reviewed below.

The physical environment of ALFs has been a central focus of research. Assisted living is based on a residential rather than a medical model of housing, with associated values of autonomy, privacy, and opportunities for social interaction. This is reflected in the architecture of many ALFs which is based around private rooms and common areas which are non-institutional in appearance, rather than features such as centralised floor plans and nursing stations that characterise some nursing homes (Benjamin and Anikeeff, 1998, p. 15; Spitzer, Neuman, and Holden 2004, p. 27). Many ALFs have incorporated architectural features that emphasise themes such as 'supportive protection', 'human scale', and 'naturalness' that are of central importance to a sense of home (Marsden, 2001). ALFs have been shown to achieve higher levels of satisfaction with quality of life than comparable nursing homes, and the physical environment has been identified as a key factor (Brandi, Kelley-Gillespie, Liese and Farley, 2004). However, as noted above, the physical environment of some ALFs limits their capacity to provide a residential setting with high levels of privacy and autonomy.

The social environmental factors impacting on quality of life in ALFs are also a focus of research. Facilitating individual choice and control, an individualised approach to care, and goodness of fit between the resident and the facility's social environment

have been identified as key factors impacting on perceived quality of life (Ball, Whittington, Perkins, Patterson, Hollingsworth, King and Combs, 2000; Dobbs, 2004; Kim, 2002). The quality of social support has also been linked to psychological wellbeing, suggesting that enhancing relations amongst residents and between residents and staff should be a key strategy in management of ALFs (Cummings, 2002; Dobbs, 2004).

The question of whether ALFs provide opportunities for people in later life to 'age in place' has been identified as an important policy and research issue (Frank, 2001). Clearly, most assisted living residences enable older people to remain in the same facility as their circumstances change from relative independence (requiring only meal preparation, housekeeping and emergency assistance) to reliance on assistance with a range of self-care activities. However, most ALFs do not offer ongoing care irrespective of changes in health and limitations in physical and cognitive functioning (Hawes, Phillips, Rose, Holan and Sherman, 2003, p. 880–881). Despite increasing interest in assisted living as an alternative to nursing home care, in part due to its lower cost structure (Cummings, 2002, p. 294), it is not likely to substitute for nursing home care (Pynoss and Nishita, 2005, p. 254–255). The main reason for residents leaving assisted living is their need for a higher level of care (Spitzer, Neuman, and Holden, 2004, p. 29; Wright, 2004). Industry research indicates that the average length of stay in assisted living is about 27 months (NCAL, 2007a). It has been argued that assisted living facilities provide 'prolonged residence' rather than the security of 'ageing in place' (Frank, 2001). This may result in residents feeling a high sense of insecurity, unable to view their assisted living residence as a permanent home (Frank, 2001).

The affordability of assisted living, and consideration of ways to extend assisted living to lower income households, has also been a research focus. Most ALFs operate on a monthly rental/service fee that may be a single, flat rate, or more commonly, a tiered price depending on the services purchased. The fees charged by ALFs vary considerably with a range of \$800 to \$3,000 per month charged in one state in 2001 (Brandi, Kelley-Gillespie, Liese and Farley, 2004, pp. 76–77). The industry reported an average fee of \$2,627 per month for private units in 2006 (ALFP, 2007a). Most residents in assisted living pay for their care from their own personal resources, which may include disposal of their existing housing assets. Long-term care insurance currently plays only a small role in funding of assisted living (Wright, 2004), although there are signs that long-term care insurance offering coverage for assisted living is growing and that some insurers are embracing assisted living as a means of avoiding more expensive nursing home alternatives (Spitzer, Neuman and Holden, 2004, p. 28). Overall, assisted living is largely unaffordable for moderate and low-income households, who do not have significant housing or other assets (Hawes, Phillips, Rose, Holan and Sherman, 2003, p. 882; Pynoos, Liebig, Alley and Nishita, 2004, p. 15). Furthermore, there is evidence that racial and ethnic minorities are significantly under-represented in ALFs (Dietz and Wright, 2002).

Finding ways of extending availability of assisted living to lower-income households has become a focus of a considerable number of housing and social service agencies at state and local levels in recent years (Pynoos, Liebig, Alley, Nishita, 2004; Golant, 2003). These initiatives have included incorporating assisted living services into existing public and community housing, converting existing multi-unit housing into assisted living, and using funding sources including Medicaid to enable frail, low-income older people to enter private ALFs. The large number of entities and funding programs involved in the funding of housing and services in the United States has led to a wide range of initiatives involving state and local agencies as brokers and

planners drawing resources together to expand assisted living for low-income households (Pynoos, Liebig, Alley, Nishita, 2004).

3.2.7 Continuing care retirement communities

A Continuing Care Retirement Community (CCRC) is 'a seniors living complex designed to provide a continuum of living accommodation and care – from independent living through skilled nursing – within a single community' (Sexton, 1998, p. 23). It offers 'ageing in place' with flexible accommodation designed to meet health and housing needs as these change over time. CCRCs may be apartment buildings or comprise individual dwellings located on common grounds. They may range from 100 residents to as many as 1,000. Often a CCRC will include common areas for administration, dining and activities, and a co-located health centre with nursing beds (Anikeeff and Mueller, 1998a, p. 97). Residents enter into a long-term contract that provides for housing, services and nursing care, usually in the same location although not necessarily the same building. The contracts usually involve a sizeable entry fee as well as monthly rents/charges.

The origins of CCRCs are found in the nineteenth century 'turnover of assets' homes, whereby a resident would bequeath all of their assets in exchange for lifelong housing and care (Benjamin and Anikeeff, 1998, p. 17). They were first known as life care communities, and this term is still used. CCRCs were pioneered by the non-profit sector, but during the 1980s the market sector became increasingly involved. In 1990 there were approximately 800 CCRCs in the United States (Netting and Wilson, 1991). However, expectations that their number would continue to grow rapidly (Williams, 1985), and that they would play a central role in addressing the problem of funding of long-term care (Somers, 1993), do not appear to have been realised. One factor is that CCRCs have encountered financial problems that have tended to make them risky business propositions, and CCRC business failures have been relatively common. They have encountered difficulty in accurately predicting the risk of high proportions of residents requiring relatively high levels of care (Folts and Muir, 2002, pp. 21–22; Nyman, 2000, pp. 95–96; Williams, 1985). There has also been considerable tightening of state regulations of services offering 'life care' in order to provide greater consumer protection (Netting, Wilson, Stearns and Branch, 1990).

A consequence of these developments is that many CCRCs offer less than the extensive 'life care' that commits them to provide care services to residents for the rest of their lives, including nursing home care (Nyman, 2000, p. 96; Alperin and Richie, 1990). Three broad types of contracts offered by CCRCs have been identified: life care contracts that include long-term nursing care for little or no additional cost; modified contracts that provide nursing care for a limited period, after which costs are borne by the resident; and fee-for-service arrangements where nursing care and other services incur a fee that is additional to the base package of accommodation and services (Netting, Wilson, Stearns and Branch, 1990, p. 140). In this sense many CCRCs in the United States should be viewed as offering continuous care within the one facility, but not necessarily on terms that guarantee 'life care'.

The CCRC has attracted considerable interest from economists exploring the most efficient ways of financing long-term care, including nursing care, in the United States (Nyman, 2000; Sloan, Shayne, and Conover, 1995). Because people typically sell their houses before entering a CCRC they are effectively using these resources to fund their long-term care requirements, and the demand on programs such as Medicaid is correspondingly reduced. Furthermore, there are economies of scale in delivering home care and home health care services to people living on the one site. However, the entry costs and ongoing fees charged by most CCRCs restrict entry to households with above-average income and assets. In order for CCRCs to be made

available to lower-income households, significant levels of public subsidy would be required (Sloan, Shayne and Conover, 1995).

3.2.8 Significance to Australia

Analysis of the experience of the United States with integrated housing, support and care arrangements has considerable relevance for Australian policy-makers. It must be borne in mind that the cultural, social and policy context is significantly different, most particularly with respect to funding arrangements for long-term care of people in later life. Nevertheless, the American experience is instructive in four key respects.

Firstly, the United States is illustrative of the great diversity of forms of provision of integrated housing, support and care that is likely to emerge in a context dominated by the market within a relatively weak public policy framework. The United States market for older persons' housing is much larger than Australia's and the public policy framework with respect to key issues such as long-term care of people in later life is less clearly defined. Nevertheless there are broad parallels between the two countries. In both countries public policies with respect to the housing of older people are not well articulated, and innovation with respect to new forms of housing is largely viewed as an issue to be left to the market sector, and to a lesser extent the community sector. In such a context, given the demand pressures created by the ageing of the population, Australia can expect to see a similar proliferation of forms of housing, support and care, albeit on a smaller scale. The case examples that will be examined in this study (see chapter 4) suggest that this diversification of products and services is well underway. It can be argued that the public sector has a key role in monitoring these developments, and setting a broad framework of objectives to guide market and community sector activities.

Secondly, the United States experience is informative with respect to the classification of emerging forms of integrated housing, support and care in Australia. Currently, the diversification occurring in the Australian service system is occurring in a somewhat haphazard manner, and the industry and policy community require a new lexicon to accurately describe emerging products and services. Developing such a classification system is one of the research objectives of this study. While the terminology used to describe services in the United States is messy and far from standardised, the broad categories of services identified in this chapter suggest a classification scheme that may be useful to the Australian policy discourse.

Thirdly, the United States experience of diverse forms of integrated housing, support and care has resulted in a body of policy and research literature that can be drawn upon when considering service and product design and evaluation in the Australian context. All of the emerging forms of services in Australia have parallels in the United States, and the American literature, while uneven in coverage and quality, provides some guidance to Australian product and policy developers and researchers. For example, there is a significant body of research on assisted living facilities, continuing care retirement communities, and provision of support and care in social housing for older people which has relevance to parallel Australian developments. Some of this research has been reviewed in this chapter, and it will be examined in greater detail in the final report.

Finally, the United States situation is instructive in demonstrating the importance of creative approaches by community sector and public officials at state and local levels toward developing integrated housing, support and care services for low-income households. The United States system of funding both housing and support and care services for lower-income groups is immensely complex, and many of the innovative services developed during the past decade have required inventive approaches to

linking funding sources in a variety of policy and regulatory contexts. The Australian system is less complex, but several of the case examples proposed in chapter 4 similarly involve the imaginative use at the local level of funds drawn from diverse housing and aged-care sources.

3.3 United Kingdom

3.3.1 Overview

The history of integrated housing, support and care in the United Kingdom differs markedly from that in the United States. Firstly, it has been characterised by an underlying ambivalence concerning communal living arrangements for older people associated with the theoretical critique of institutions developed by Goffman and others (Heywood, Oldman and Means, 2002, pp. 118–119). This has led to extensive debate concerning the merits of sheltered housing, the main form of integrated housing and care for older people that developed in the post-WW2 period, and only limited experimentation with other approaches until the past decade. Secondly, by contrast with the United States, state and other non-market agencies have played the dominant role in the direction and development of housing, support and care options, although the market sector has more recently become a significant provider (Croucher, Hicks and Jackson, 2006, p. 19). As a consequence of these two factors, there has been somewhat less diversity of integrated housing and care options, although this situation is now changing. In broad terms, the main models of integrated housing, support and care in the United Kingdom models can be described and analysed using three headings: sheltered housing, very sheltered or extra-care housing, and retirement communities.

3.3.2 Sheltered housing

Sheltered housing has been concisely defined as ‘groups of flats or bungalows with a warden service, designed for older people’ (Dickinson and Whitting, 2002, p. 39). More expansively, Clapham and Munro propose that the term sheltered housing be understood as a form of accommodation that:

‘... consists of a unique, and largely fixed, combination of housing and social support. It combines the provision of a ‘small warm home’ with communal facilities such as a common room and communal laundry. There is also a resident warden whose job is to act as a ‘good neighbour’, and who is linked to the residents’ houses by an alarm call system’ (Clapham and Munro, 1990, pp. 27–28).

This definition draws attention to the key defining features of sheltered housing: designed on a small scale; based on self-contained accommodation; providing shared facilities; and involving the support of a warden. Early in the history of supported housing a formal distinction was drawn between two main forms of sheltered housing. ‘Category 1’ was conceived as self-contained dwellings such as bungalows for the ‘more active’ elderly with limited communal facilities and usually a warden. ‘Category 2’ was designed for less active older people comprising grouped flatlets with a higher level of communal facilities and a warden (Peace and Holland, 2001a, p. 15). This distinction still influences design and language, although it is Category 2 that is most commonly thought of as ‘conventional sheltered housing’ (Appleton and Porteus, 2003, p. 4). However, there is now wide variation within sheltered housing in size, design, accommodation, range of facilities, and level of support provided (Dickinson and Whitting, 2002, p. 39).

Sheltered housing first emerged as an approach to housing provision for older people in the 1950s and 1960s in response to two main factors. Ideologically, it was viewed

as an alternative to residential care which had been highly criticised in studies such as Townsend's *The Last Refuge* (1962) as often demeaning and sometimes abusive of older people (Nocon and Pleace, 1999). In practical terms, it was seen as a way of releasing 'under-occupied' council housing for family housing by providing a new form of purpose-built accommodation for older people. In the 1970s sheltered housing was given further impetus as concerns developed over the costs of residential care. It was viewed as a less expensive option for many older people who did not need the level of support and care provided in residential care and nursing homes (Heywood, Oldman and Means, 2002, pp. 124–125). Central government encouraged the development of sheltered housing throughout the 1960s and 1970s, and numerous sheltered housing schemes were developed by local authorities and housing associations. The changing focus of public housing policy from general needs to special needs provision provided further impetus in the 1980s, with the number of sheltered housing units rising by 69 per cent from 1979 to 1989 (Peace and Holland, 2001a, p. 15). By the turn of the century, it was estimated that 598,000 persons aged 65 and over resided in sheltered housing, approximately 5 per cent of the older population (Appleton and Porteus, 2003, p. 5; Heywood, Oldman and Means, 2002, p. 119). These units were provided by local authorities (56 per cent), housing associations (31 per cent) and the private sector (13 per cent) (Appleton and Porteus, 2003, p. 5).

From its inception in the 1950s until the early 1980s, sheltered housing was widely perceived as a relatively inexpensive form of housing representing an important housing choice for older people. One respected academic observer in 1981 described the United Kingdom as a 'world leader in the development of A.I.L. (Assisted Independent Living) accommodation under the title of 'sheltered housing' (Heumann, 1981, p. 164). A key claim was that sheltered housing was the antithesis of the total institution as 'its goal is to let the elderly residents live as independently as their functional abilities will allow, providing very personal assistance at the margin of individual support needs' (Heumann, 1981, p. 176). Sheltered housing was seen to provide companionship, access to emergency help, and an environment in which older people could sustain an active community life. It was linked to the concept of the continuum of care and the goal of extending the period of time that an individual could live independently in the community before moving to residential care (Peace and Holland, 2001a, p. 15). Demand for sheltered housing was high during the 1970s, and attention focused on ensuring that a diversity of types of sheltered housing was provided to reflect the differing needs of older people (Heumann, 1981, p. 179).

However, during the 1980s academic and policy opinion turned against sheltered housing, and many criticisms were raised in both academic studies and official reports (Heywood, Oldman and Means, 2002, pp. 124–127). At the heart of these criticisms was the depiction of sheltered housing as a thinly disguised form of institutional care with the negative connotations of limited privacy, restricted choice and personal freedom, lack of familiarity, and communal living (e.g. Higgins, 1989). Later commentators argued that this depiction overstated the case and that sheltered housing was better understood as having features of both 'institution' and 'home' (Oldman and Quilgars, 1999, p. 368; Heywood, Oldman and Means, 2002, pp. 121). However, the growing emphasis on community care in the late 1980s and 1990s, driven in part by perceptions of the high cost of all forms of institutional care, led to sheltered housing dropping out of favour at the policy level. Policy-makers' attitudes to sheltered housing came to resemble their views of residential care. Increasingly, sheltered housing was viewed as both expensive and stigmatising, and not in harmony with dominant themes of independent living and personal autonomy (Oldman and Quilgars, 1999, pp. 368–369).

One outcome was a dramatic fall during the 1990s in the number of new sheltered housing dwellings being constructed (Heywood, Oldman and Means, 2002, pp. 94–95; Appleton and Porteus, 2003, p. 6). In its 1998 review of the role of housing in community care, the Audit Commission argued that sheltered housing had lost its way and that the current pattern of sheltered housing was 'entirely historical and not related to any identifiable levels of need or demand' (quoted in Appleton and Porteus, 2003, p. 7). It proposed that sheltered housing reinvent itself as a form of provision for people who prefer the presence of a supportive community. 'If it does not it will face serious questions about its relevance in a system which can deliver high levels of support in ordinary housing' (quoted in Heywood, Oldman and Means, 2002, p. 126).

This change in sentiment concerning sheltered housing was also related to consumer demand. A study commissioned for the Department of the Environment in 1994 concluded that there was a potential overprovision of sheltered housing (Appleton and Porteus, 2003, p. 6). The strong demand for sheltered housing experienced during the 1970s and 1980s fell away in the 1990s and a number of sheltered housing schemes became difficult to let. In some schemes the housing was old, unattractive, comprising small bed-sitter accommodation with shared facilities, and located in areas that had lost local services including shops and accessible transport. There was a perception that they no longer offered value for money. Moreover, the lack of lifts and other accessibility features made some sheltered housing less accessible to potential tenants considering sheltered housing at a later life-stage than was the case in earlier decades (Appleton and Porteus, 2003, p. 6). Furthermore, the design of some sheltered housing made remodelling and upgrading difficult and expensive (Dickinson and Whitting, 2002, pp. 41–42).

Other difficulties related to aspects of the housing model itself. One feature of the model emphasised in policy statements dating back to the 1960s was the idea of a 'balanced population' of tenants including both the 'fit' and the 'frail'. The rationale was that the fit would provide help to the frail, thus reducing the overall level of support and care to be provided by the warden service (Appleton and Porteus, 2003, p. 4). It was also argued that this would avoid a concentration of frail people leading to schemes becoming institutionalised and stigmatised (Clapham and Munro, 1990, p. 31). However, this approach was strongly criticised in the 1990s as leading to a fundamental lack of clarity concerning the role of sheltered housing: 'there is a contradiction at the heart of the traditional model of sheltered housing: it can only work when a sizeable proportion of people in it do not particularly need its special facilities' (Clapham and Munro, 1990, p. 42). It appears this concept of a balanced community has now been abandoned, with sheltered housing now focused on older people requiring some degree of support in order to live independently (Appleton and Porteus, 2003, p. 4).

The other central issue relating to the sheltered housing model is the much discussed issue of the role of the 'warden'. The presence of an on-site warden has been a defining feature of supported housing since its inception. Historically, the roles of the warden have included dealing with emergencies, providing friendship and advice, and liaising with agencies providing services to residents. However, the role has been interpreted in many different ways and has often also included the provision of direct services to residents, resulting in significant pressure and role confusion (Clapham and Munro, 1990, pp. 35–36). The term itself has strong institutional connotations and seems inappropriate for a housing service emphasising independent living. In recent years the role appears to have shifted to one of care management, linking residents to community care services (Heywood, Oldman and Means, 2002, p. 127). The conflicting expectations and lack of clarity regarding the warden's role reflect fundamental ambiguities about the nature of sheltered housing.

Despite these important criticisms, there is considerable evidence that for some older people sheltered housing continues to represent a desirable housing option, even in a context of expanded home and community care provision. The attraction of sheltered housing for many residents appears to lie in both its housing and support and care dimensions. The housing-related attractions are related to elimination of concerns about maintenance and repairs, social isolation, and security. The support, monitoring and service coordination provided by wardens is also valued, with overall satisfaction closely linked to the availability and perceived quality of the warden service (Nocon and Pleace, 1999).

From this perspective, it has been argued that the key issue is the need for careful planning to determine what types of sheltered housing are needed, and differentiation of the roles of particular schemes. Some sheltered housing schemes may be oriented to older people looking for some element of communality and minimal support. Others may require the warden service for personal support, regular contact and the coordination of services. For both groups, sheltered housing schemes can represent a positive housing option in later life (Nocon and Pleace, 1999; Heywood, Oldman and Means, 2002, pp. 131–132).

3.3.3 *Very sheltered or 'extra care' housing*

Beginning in the late 1970s, a number of local authorities and housing associations began to provide sheltered housing that included a higher level of support and care than that available in conventional sheltered housing schemes (Tinker, 1997). Initially, these new forms of integrated housing, support and care were collectively known, rather unimaginatively, as 'very sheltered housing'. By 1985, 17 per cent of local authorities and 11 per cent of housing associations in the United Kingdom were involved in provision of very sheltered housing (Tinker, 1997, p.15). During the 1990s interest in such housing arrangements grew rapidly, and there was a great diversification of both terminology and forms of provision. Housing arrangements in the United Kingdom focused on housing with care for later life also became known as 'supported housing', 'integrated care', 'extra care', 'close care', 'flexi-care' and 'assisted living' (Croucher, Hicks and Jackson, 2006, p. 8). All of these terms referred to grouped housing schemes for older people involving significant levels of support and care.

The initial impetus for the development of very sheltered housing was recognition that the needs of many tenants in sheltered housing could not be met simply through the provision of a warden service. This reflected in part the ageing population profile of residents of sheltered housing. Providers experimented with provision of meals, specialised facilities, and higher levels of staffing, and there was great variation in the type and level of care provided (Appleton and Porteus, 2003, p.8). Official support at the national level for the development of very sheltered housing came in 1994 in the Department of Environment-sponsored report on the housing needs of elderly and disabled people entitled *Living Independently* (Peace and Holland, 2001a, p. 15). It argued that sheltered housing was oversupplied but that there was a need for expansion of very sheltered housing. Further support came from the Royal Commission on Long Term Care, which argued in its 1999 report for a strategy of replacing residential home provision with very sheltered housing, on both cost-effectiveness and quality of care grounds. The number of units of very sheltered housing grew steadily through the 1990s, partly through conversion of sheltered housing schemes and residential care facilities, and partly through the building of new housing. However, the sector was still small compared with sheltered housing. It was estimated that in 1998 there were approximately 23,000 units of very sheltered

housing compared with well over 400,000 units of sheltered housing (Appleton and Porteus, 2003, p.9).

The gradual evolution of extra care housing (as it will be called from this point), and the diversity of forms of provision, means that it has proven difficult to provide a precise or widely applicable definition (Appleton and Porteus, 2003, pp.19–24; Croucher, Hicks and Jackson, 2006, pp. 8–29). Some have defined it in terms of its place in the repertoire of housing and care services:

A style of housing and care for older people that falls somewhere between established patterns of sheltered housing and the accommodation and care provided in traditional residential care homes (Appleton and Porteus, 2003, p. 2)

Somewhat more useful are definitions that specify the range of services provided. Typically extra care housing is based on self-contained accommodation (usually flats or bungalows) incorporating accessible design features and assistive technologies. It also provides many of the following features: care staff, probably including 24-hour coverage, and care packages for individual tenants; catering facilities including the provision of at least one meal per day; communal facilities such as restaurant, lounge, activity rooms or library; help with domestic tasks and shopping; and provision of other specialised equipment and facilities (Croucher, Hicks and Jackson, 2006, pp. 10–12). Not all extra care housing schemes necessarily include all of these elements, but a constellation involving most of these is the distinguishing mark of extra care housing.

Extra care housing can also be defined in terms of its aims. Based on a comprehensive review of definitions of extra care housing, Croucher, Hicks and Jackson suggest five common and related aims (2006, pp. 13–14):

- To promote independence, achieved via individual accommodation or ‘your own front door’, residents being tenants or owners, barrier-free environments, use of assistive technologies and a culture of independence;
- To reduce social isolation, by allowing opportunities for social contact, neighbourliness and mutual support;
- To be an alternative to residential models of care, by placing an emphasis on housing and autonomy, even though there are common features with residential care settings;
- To provide, where possible, a home for life, by providing care tailored to individual needs;
- To improve quality of life, both relative to living in the community (via opportunities for social contact, barrier-free environments, and care provision) and relative to residential settings (via greater independence and autonomy).

The predominant physical form of extra care housing is a small housing development, either a block of flats or a group of bungalows, combined with a resource centre. Some are purpose-built and others are remodelled buildings. Most accommodation is one-bedroom, but some may be two-bedroom. Other congregate facilities may include a residents’ laundry (or apartments may have their own laundry facilities), a guest suite, a large lounge, meeting and/or recreation rooms, a restaurant, and spaces for health care and administrative staff (Riseborough and Porteus, 2003).

The diversity of extra care housing developments can be illustrated through a small number of examples. Basilier Court, Nottingham, is a remodelled development with twenty-four rental flats and bungalows, owned and managed by a housing association providing housing and services for black and minority ethnic groups (Riseborough and

Porteus, 2003). Blake Court is a purpose-built extra care development in London with seventy-three apartments available to older people on leasehold. Residents have a management committee which controls the service contracts for building management and housekeeping and a basic support service is available as part of the service charge. Residents purchase support and care, or obtain them via state domiciliary services if they qualify (Riseborough and Porteus, 2003). Runnymede Court is a block of thirty-eight extra care flats opened in 2001, located on a large housing estate in Plymouth. On-site facilities include a common room/dining room, office and facilities for care staff, assisted bathing rooms, and a hairdressing room. Hanover Housing group is responsible for housing management, and care services are provided by separate organisations (Croucher, Hicks and Jackson, 2006, p. 86). Hanover Housing also has other extra care schemes ranging in size from twenty-five to forty flats. In these schemes the facilities include dining room (serving one hot meal per day), assisted bathroom, hairdressing/chiropractic salon, activities room, lounge, guest room, laundry, and small shop. A community care assessment is carried out by the social services department at the time of entry, and care is provided by social services and external contractors (Croucher, Hicks and Jackson, 2006, pp. 86–87).

As well as these forms, some extra care housing has been developed in the form of retirement communities, drawing on North American and European models and resembling Australian retirement villages in physical form. As these represent a somewhat different housing tradition, they are considered separately in section 3.3.4.

The emergence of extra care housing during the past decade or so is the most significant and widespread innovation in integrated housing, support and care in the United Kingdom since the advent of sheltered housing in the 1950s. As such it has been widely debated, and a significant body of writing and research is now available. A comprehensive literature review was published in 2006, including summaries of eleven evaluations of particular schemes that have been published since 1999 (Croucher, Hicks and Jackson, 2006). Several key issues have been highlighted in this and other research. Broadly, these can be divided into ‘consumer-focused’ issues and ‘policy and management’ issues.

Consumer-focused issues are defined as those that relate directly to consumer outcomes. Do extra care housing services achieve their goals of independence and choice, quality of life, and social integration? With respect to independence and choice the findings of evaluation studies are generally positive. Self-contained accommodation is viewed as critically important, with ‘your own front door’ enabling privacy as well as autonomy, a sense of being at home, and continuation of family relationships. In some cases more accessible, warm and purpose-built environments than in people’s previous housing also facilitates independence and people’s capacity to be self-sufficient. The security of knowing that help is on hand is also valued, as is a sense of feeling safe from crime and intruders. The ability to exercise choice with respect to social activities is viewed as a key ingredient of independence, as is the ability to choose between cooking meals for oneself or taking meals in the dining room (Croucher, Hicks and Jackson, 2006, pp. 56–60).

With respect to quality of life, including improved health status, the evidence is also positive, although generally not based on highly robust research. Several evaluations recorded that many staff and residents believe that the sense of security, availability of health and care services, and high levels of peer support all impact positively on health and wellbeing of residents. No studies have applied quality of life measures to those living in extra care communities. However, there is consistent evidence of positive accounts from residents of their experiences in these settings. Independence, security, and reduction in social isolation are the key factors mentioned. Satisfaction

levels are higher amongst residents who are fitter and more socially active. Generally, the perception of many residents is that their lives have greatly improved as a consequence of moving to extra care settings (Croucher, Hicks and Jackson, 2006, pp. 60–66).

Research findings with respect to social integration are somewhat more mixed and complex. There is evidence that many residents enjoy the companionship and social activities associated with extra care communities, and there is much evidence of good neighbourliness and mutual support. However, residents value privacy as well as sociability and seek to maximise both values. There is a strong feeling of not wishing to be 'corralled' into organised entertainment. Some residents with sensory, physical or cognitive impairments experience loneliness and find it difficult to 'join in'. Generational differences can cause conflict, as can tensions between the 'fit' and the 'frail'. There are mixed feelings about living in age-segregated settings with some appreciating the security that they associate with aged-only communities and others missing the presence of younger people and children (Croucher, Hicks and Jackson, 2006, pp. 66–69).

Resident outcomes with respect to independence and choice, quality of life, social integration and other values are closely linked to policy context and management practices. Policy and management issues that have been identified as impinging on the success of extra care housing include 'institutional drift', the separation of housing and support provision, capacity for continuing care, and cost-effectiveness and affordability.

The term 'institutional drift' refers to the tendency for settings such as extra care services to gradually take on the character of institutions and lose their commitment to independence, choice and autonomy of residents. This issue has particular salience in the United Kingdom as some extra care services have been required to become registered under the Residential Homes Act and are subject to its regulatory regime (Heywood, Oldman and Means, 2002, pp. 128–129). This issue is linked to the resident profile of extra care housing. It has been argued that a concentration of very frail older people in a scheme, irrespective of its physical environment and philosophy, will create the culture of a residential care home (Appleton and Porteus, 2003, p. 23). This argument is reminiscent of the concept of a 'balanced community' that was propounded in the early years of sheltered housing. It raises issues of admissions policy, as well as ensuring that management structures and cultures continue to reflect the aims and philosophy of extra care housing.

One such issue of management structure is the separation of housing management and care provision. There is a strong view in the field of supportive housing that housing and care should be provided by separate organisations in order to minimise the risk of institutionalisation (Heywood, Oldman and Means, 2002, pp. 129–130). Some extra care housing developments in the United Kingdom appear to have adopted this approach with housing managed through a housing association and care through the local authority social service department and/or private contractors. Nevertheless, there is little indication that residents in extra care housing have significant choice with respect to their care agency or carer (Croucher, Hicks and Jackson, 2006, p. 60). It has also been argued that there is a need for an integrated management approach that ensures that housing and care are delivered in a coordinated fashion, and that the quality and commitment of management, including their experience in housing and/or service provision, is the key issue rather than separation per se (Appleton and Porteus, 2003, pp. 22 and 37–38).

One of the most contentious management issues in extra care housing is that of continuing care. Do residents have a home for life, irrespective of their health

circumstances, or are there limits, in principle or in practice, to the commitment to 'a home for life' (Heywood, Oldman and Means, 2002, p. 130)? The evidence is that many extra care housing schemes aspire to offer a home for life, but that in many cases this is problematic. The ability to provide housing and care to residents with high needs varies from scheme to scheme. Significant numbers of residents move on to residential care or nursing care. Factors that lead to moves include challenging behaviours associated with dementia, difficulties in providing flexibility of care, problems of providing care when there are a high proportion of people with high-level needs, funding issues, and the preferences of residents and their families. Most residents have assured tenancies in extra care housing, and most schemes do not have explicit exit criteria. It appears that in most cases the issue is dealt with through negotiation involving the housing provider, health professionals, the older person and family members. Therefore, the evidence suggests that extra care housing is an alternative to, but is not likely to be a replacement for, residential care and nursing home care (Croucher, Hicks and Jackson, 2006, pp. 70–80).

A key issue for the future of extra care housing is its cost-effectiveness relative to residential care and care provided in a private dwelling. The review of this issue conducted by Croucher and colleagues stresses the complexities of comparing costs across these different types of services. However, their general conclusion is that there is no evidence to demonstrate the relative cost-effectiveness of extra care housing. There is evidence suggesting that the costs of care provision in extra care housing, for a given level of need, may be less than in ordinary housing. But if housing costs are taken into account, these cost advantages diminish considerably. The proportion of housing and care costs borne by residents clearly has a major bearing on this issue as well as on the issue of affordability (Croucher, Hicks and Jackson, 2006, pp. 80–85).

3.3.4 Retirement communities

Sheltered housing and extra care housing are the mainstream forms of integrated housing, support and care in the United Kingdom. Other forms of communal living arrangements in later life, such as the retirement communities that are prominent in the United States and retirement villages in Australia, have not been part of the British experience until quite recently. Several factors may account for this including the much larger scale of provision of public or council housing in which many older people have lived all or most of their lives. Some retirement communities have been provided in the past by employers and occupational groups (Phillips, Bernard, Biggs and Kingston, 2001, pp. 192–193), but it is only in the last decade that a small number of retirement communities have been developed. These reflect in part the growing interest in extra care housing, but also the influence of international models, particularly continuing care retirement communities in the United States. In recent years, retirement communities have been enthusiastically promoted by policy-makers in the United Kingdom (Bernard, Bartlam, Sim and Biggs, 2007, p. 556). Two developments in particular have been viewed as important pioneering approaches to retirement community provision in the United Kingdom: Hartrigg Oaks located on the outskirts of York, and Berryhill Retirement Village in the North Midlands.

Hartrigg Oaks is an initiative of the Joseph Rowntree Housing Trust which opened in 1999. It is widely described as the first example in the United Kingdom of a continuing care retirement community (Rugg, 2000). It comprises 152 bungalows on a 21-acre site spread around a central building. The main building comprises a 42-bed residential care home together with a range of communal facilities including restaurant, library, fitness centre, recreational room and crèche. A wide range of services are available including domestic help, personal care and short or long-term

care in the on-site care home (King, 2003). Homes, gardens and grounds are fully maintained, and security systems for the site are provided.

The underlying philosophy is that residents will be housed, supported and cared for throughout their lives, whatever their care needs may be. There is an emphasis on positive lifestyle as well as on provision of support and care. Residents pay an initial fee which is essentially the lease on the bungalow, and a monthly fee which covers services and the costs of care if required. Effectively this is an insurance scheme that depends on achieving a balance of residents between those that need care and support and those that are fully independent. Admission policies reflect this requirement by favouring the young-old and those in relatively good health (King, 2003). It has been suggested that for those residents who are in good health, Hartrigg Oaks is an expensive way to live until the level of support that is available is actually needed. It is a way for moderately wealthy older people to relieve their anxieties about coping with increasing frailty (Hanson, 2001, p. 43).

An evaluation of residents' perceptions of living in Hartrigg Oaks found high overall levels of satisfaction, and positive appraisal of the accommodation, community design, facilities, services and social activities (key findings are found in Croucher, Hicks and Jackson, 2006, pp. 560–85). The most satisfied residents were those who were the fitter and more socially active residents. A major reason for residents moving to Hartrigg Oaks was their desire to live independently and not be reliant on their families. Most residents were retired professional people able to afford the substantial fees involved. In the course of a year, 30 per cent of residents used home help services, 7 per cent personal care services, and 10 per cent the friendly visiting service. Over the same period there were ten permanent admissions to the care centre, and thirty short-term admissions. In many cases the availability of the care centre allowed early discharge from hospital or prevented hospital admission. The only health conditions that could not be provided for were dementia-type illnesses. In short, Hartrigg Oaks exemplifies a high-quality continuous care retirement community catering to older people who enter the facility in relatively good health and with sufficient means to provide for their long-term care needs through an insurance-style arrangement.

Berryhill Retirement Village was opened in Stoke-on-Trent, Staffordshire in 1998 by the ExtraCare Charitable Trust and Touchstone Housing Association. It is the first of a series of villages that the Trust is building in England. It is a purpose-built retirement facility comprising a single, three-storey, T-shaped building with 148 rented flats. There is an extensive program of social activities, and on-site facilities include a gym, library, activity rooms, shop, hairdressing salon, restaurant and bar. The residents are predominantly working-class and the village is located in a working-class suburb. All residents are from the surrounding area and many formerly lived in accommodation rented from the council in local housing estates. Many receive financial help with both housing and care costs through social security benefits. Most residents live independently while some 30 per cent receive one of four different levels of packages of support. Residents receiving support at levels 3 and 4 were assessed as having care and support needs similar to people admitted to long-term residential care. Regardless of whether they were receiving a support package, residents could opt to purchase help with housekeeping, shopping, pension collecting and laundry (Bernard, Bartlam, Sim and Biggs, 2007).

An independent evaluation of Berryhill conducted in 2004 found high levels of resident satisfaction both with their flats and the village as a whole. The village was perceived as a safe and secure environment, especially when compared with the surrounding areas, and the on-site amenities and communal spaces provided opportunities for

social interaction. The on-site hairdressing salon, restaurant, shop and bar were used consistently by a majority of residents, but other facilities such as the gym and activity rooms were less well-used. Residents expressed high satisfaction with the formal care and support provided in the village, and levels of informal support from friends in the village and relatives living nearby were high. However, some residents expressed concerns that the village would not be able to provide sufficient support if they became highly disabled. Some tensions between the 'fit' and the 'frail' were observed, and some residents experienced loneliness despite living in a 'village' environment. However, the evaluation concluded that:

'Despite certain drawbacks and limitations, Berryhill suits many of its residents and has helped them overcome illnesses, bereavements and loneliness, and to enjoy a good quality of life – especially in comparison with their previous circumstances and experience.' (Bernard, Bartlam, Sim and Biggs, 2007, p. 573)

The United Kingdom's experience of retirement communities is recent and not extensive. Nevertheless, the models that are now emerging are distinguished by their conscious intent to provide innovative ways of linking housing, support and care for different segments of the older population. Hartrigg Oaks and Berryhill are targeted at quite different social groups and differ markedly in physical design, type of care provision, and financial arrangement. However, they both include features that have wide applicability to the development of integrated housing, support and care in other national contexts.

3.3.5 All age communities

A different approach to the provision of integrated housing, support and care for older people is based on the concept of 'all age communities', i.e. housing with care arrangements for older people that are included within the wider community and not particularly earmarked or set aside as housing for the elderly.

This approach is exemplified by the Holly Street Comprehensive Estate Initiative in the London Borough of Hackney (Hanson, 2001, pp. 46–49). This large housing regeneration project undertaken in the 1990s involved the demolition of a 1960s-built housing estate that contained many tenants who had moved into the estate with young families and then 'aged in place'. One aim of the new estate was to provide a range of combinations of housing and care to meet the needs of older residents within the locality. This was achieved by offering the older residents a wide choice of housing options in the new Holly Street estate. Choices included smaller dwellings within the new mainstream housing incorporating: accessible design; a residential tower block for residents aged over 50 including a concierge service, CCTV surveillance, and accessibility features; a sheltered housing scheme incorporating a resource centre providing a day centre, lunch club and other personal services for local residents; and an extra care scheme of forty apartments for frail older people. It is argued that this approach to provision of an integrated range of housing and care options at the neighbourhood level:

'... holds out the potential to provide a seamless service in which each and every resident can choose the package which most accurately reflects their current and future needs. It can be conceived of as a dispersed or 'virtual' assisted living community that is fully incorporated into its surroundings.' (Hanson, 2001, p. 47)

Another approach involving enhancement of housing and care options without the creation of a discernible service for older people is the redevelopment of tower blocks housing significant numbers of older people via upgraded concierge services and

application of new electronic technologies (McGrail, Percival and Foster, 2001, pp. 148–153). The concierges perform similar roles to wardens in sheltered housing including handyman jobs, keeping an eye on residents, and providing friendship. New technologies are used to enhance safety and security. It is argued that, 'with their mature populations and concierges, these ... blocks fall between existing concepts of sheltered housing and "normal" flats' (McGrail, Percival and Foster, 2001, p. 150).

3.3.6 Significance to Australia

In the United Kingdom, unlike Australia, the state has been the main driving force behind the development of integrated housing, support and care arrangements for older people. This reflects the more central role that the state has played overall in housing in the United Kingdom. Local councils and housing associations developed sheltered housing and then very sheltered housing as part of their general housing responsibilities. This created a far more uniform and widespread approach to integrated housing, support and care arrangements. Unlike Australia and the United States, much of the impetus for innovation in the United Kingdom has come from the social rather than the market sector.

This point of difference is of considerable significance for Australia. In Australia integrated housing, support and care arrangements have received very little policy attention (chapter 2). The United Kingdom shows how such arrangements can be part of the mainstream policy debate concerning housing and care for older people, alongside consideration of the role of community care and residential care. As in Australia, only a small minority of older people in the United Kingdom live in integrated housing with care settings. However, these are viewed as part of the housing spectrum for older people, and are given far more policy attention than has been the case in Australia.

Each of the three main forms of integrated housing, support and care in the United Kingdom has relevance to Australia. The terms 'sheltered housing' and 'warden' sound somewhat paternalistic in the Australian context. However, the concept of small-scale, grouped housing with some shared facilities and the support of a service coordinator may have applicability in Australia, particularly for older people with limited means and low to moderate care needs. Elements of the sheltered housing model may have applicability to the redevelopment of independent living units as proposed by McNelis (2004). A service coordinator (warden) could play a key role in linking residents to community care services as well as providing other forms of social support. The sheltered housing model may also suggest ways that public housing authorities can respond to their population of increasingly dependent older people. The North American term 'service-enriched housing' is likely to be more acceptable in the Australian context than 'sheltered housing'. The United Kingdom debate on sheltered housing, particularly relating to the need to foster independence and the crucial role of the warden, may be instructive with respect to some of the more recent forms of service-enhanced housing that have developed in Australia in recent years.

The models of extra care housing that have developed in the United Kingdom during the past decade are of considerable relevance to Australia. Like assisted living facilities in the United States, they provide a model that combines an emphasis on independent living with significant levels of support and care. In the Australian context, this model sits between independent living retirement communities and low-level residential care facilities (formerly hostels). As will be shown through our report, significant numbers of Australian retirement villages are now offering housing with care that is akin to extra care housing. In some cases this is being achieved through 'in-house' care provision and in other cases through accessing the services available through the community care system. There is a case for more systematic definition

and development of extra care housing as a distinguishable housing type in Australia, for the benefit of both consumers and providers of services.

The emergence of retirement communities in the United Kingdom is also instructive. Each of the retirement communities discussed in this report has been developed according to an explicit model, one as a continuing care retirement community targeted at the middle class, the other designed to fit with a working class community providing a range of levels of care. While these particular models reflect the local social cultural context, there is a general point that Australian retirement villages may need to develop housing models that are more explicit in their philosophies and intentions, and that are designed specifically to meet local housing needs.

Finally, the level of research to underpin policy and service development in the United Kingdom is considerably greater than in Australia. For example, there is no equivalent in Australia to the eleven evaluations of extra care housing schemes undertaken in the United Kingdom during the past eight years (Croucher, Hicks and Jackson, 2006). There is a need for far greater attention to be paid to research and evaluation of current and emerging Australian models of housing, support and care for older people.

3.4 Models from other countries

It is not possible within the constraints of this report to provide a level of description and analysis of other countries' models of housing, support and care as detailed as that provided for the United States and the United Kingdom. The intent of this section is rather to identify the range of models that have been developed in other countries, and draw attention to those that have unusual features or particular salience to the contemporary debate. In broad terms, many countries in Europe developed specialised housing services for older people in the 1960s–1980s, but these tended to drop out of favour to some degree as home and community-based care become the dominant approach from the late 1980s onwards. The specialised housing forms that developed in the mid to late twentieth century in these countries continue to be an important and generally valued part of the service repertoire, and have adapted to changing circumstances, including the higher proportion of very old people requiring higher levels of care (Pastalan, 1997). Some European countries have developed distinctive approaches to housing with care provision and these are documented in this section. Asian countries have generally relied less on specialised housing provision for older people, relying more on family-based intergenerational models of housing and care for older people. However, in some of these countries there is increasing experimentation with Western models of service provision (e.g. Harrison, 1997).

3.4.1 Service-enriched and extra care models

During the second half of the twentieth century, many countries, particularly Northern European countries, developed forms of service-enriched and extra care housing similar to the comparable models already described in the United States and United Kingdom (Butler, 1986). The broad shape and nature of the types of housing services that were developed are described below on a country-by-country basis.

From the 1960s, Sweden developed service houses [providing high-standard, non-institutional housing with care for older people. These provided independent accommodation within housing blocks, and access to a range of services including restaurants, hairdresser, chiropody, activity rooms and occupational therapy. Originally designed for active older people, as their residents aged they increasingly catered to an older, frailer population. The more intensive care required was provided

in-house or by home care services (Phillips, Means, Russell and Sykes, 1998, p. 1). Service houses were owned and operated by municipal governments and typically ranged in size from forty to one hundred apartments. While they were designed as an alternative to institutional care, a criticism has been that the needs of residents often exceeded the range of services available on the premises (Monk and Cox, 1995, p. 262).

Finland also built service housing since the 1980s as part of a more general policy to decrease the level of residential care for older people. Service housing was intended for people needing care as well as accommodation but not requiring residential care. Service housing in Finland was built according to accessible design principles, and included an alarm system, as well as communal facilities such as kitchen, dining room and laundry. Meals were also provided. There was access to 24-hour care and home care services were arranged. Most service housing was rented, and residents were able to pay for extra services. If they had high needs, packages of care could be provided by the state. Not-for-profit organisations played a central role in provision. For individuals needing higher levels of care 'heavy service housing' was available with higher staff/resident ratios (Phillips, Means, Russell and Sykes, 1998, pp. 3–4).

In the Netherlands, 'sheltered housing' comprised enriched forms of independent living, usually in an apartment complex, including an electronic alarm system and links to nearby service centres. There is a great diversity of models within sheltered housing, and the Netherlands has been described as 'a hotbed for experimentation' in intermediate living arrangements such as sheltered housing (Van Vliet, 1995, p. 106). One example based on a 1995 description, is the Gooyer House of Amsterdam which comprises a multi-storey building without distinguishing institutional features within a residential area. Studio apartments are located in clusters of four to six with common recreational space. The clusters provide a context for social activities and mutual aid, and services can be brought into the housing as required. The clusters are monitored by a central administrative unit that assists in access to services (Monk and Cox, 1995, pp. 259–260). Some sheltered housing in the Netherlands is up-market and is provided by the market sector on either a rental or ownership basis. Meals and housekeeping services are available, and care is provided from a nearby care home or nursing home (van Egdom, 1997, pp.178–179).

In Denmark, 'sheltered housing' for frail elderly people was developed from 1976 to 1988. Sheltered housing consisted of a number of two-room flats, along with common rooms, alarm systems, and quite high levels of care staffing. After 1988 all sheltered housing was reorganised in line with wider policies to deinstitutionalise all forms of housing for older people. Residents in sheltered housing were provided with normal tenancy agreements, and care services were provided by the same staff that provided home and community care to all residents within a locality. The designation of these dwellings as 'sheltered housing' was removed in 1995. Denmark also has 'service flats' for frail older people that are served by the local home and community care services (Gottschalk, 1995, pp. 30–31).

Germany also has limited provision of sheltered housing for the elderly comprising purpose-built apartments, together with assistance in utilising locally available services. There has also been considerable experimentation with service houses for the elderly, which provide a range of in-house support and care services (Dieck, 1995, pp. 125–126).

Sheltered housing is also available on a limited scale in Israel and is provided primarily by state and non-government organisations, with a small level of involvement of the private sector. Individuals have self-contained dwellings, and facilities include public areas for social activities, a warden service (known as the 'housemother'),

home help and limited health services (Katan and Werczberger, 1997, pp. 59–60). Much of the development of sheltered housing occurred in the 1980s, and was largely modelled on the British program (Heumann, 1995, pp. 142–149). During the 1980s and 1990s Israel has experienced a rapid growth of assisted living facilities similar to that which has taken place in the United States, with extensive involvement of the market sector (Doron and Lightman, 2003, pp. 785–789).

In Canada a wide range of approaches to sheltered housing has developed reflecting both United Kingdom and United States influences. Housing alternatives have included sheltered housing on the British model, congregate housing based on similar developments in the United States, Abbeyfield housing, and cooperative housing arrangements (Wister and Gutman, 1997; Hallman and Joseph, 1997). The overall level of provision of various forms of supported housing has continued to be quite limited and there has been pressure for further expansion (NACA, 2002).

Service enriched housing has also been developed to a limited degree in Asian countries, as a residual service for elderly people who do not have family support available to them, but who are deemed able to live independently. For example, Singapore has a number of 'sheltered homes' located within apartment buildings which combine self-contained units and collective facilities (Harrison, 1997, p.p. 45–46). Japan has had 'silver housing projects' which provide specially designed dwellings, social support and 'life support advisors', based on the United Kingdom sheltered housing model (Kose, 1997, p. 156).

3.4.2 Small group housing

Small group housing for older people requiring a supportive living environment can be found in a number of countries. An example of a small group housing arrangement for older people from rural communities, designed to enable them to live independently is the French MARPA project (Maison d'Accueil Rural pour Personages Agees). This approach comprises a complex of up to twenty flats arranged around a service axis containing common living areas including living room and dining room. Each flat is independent, but home help, meals and recreational services are available. The service is designed for older people who are able to live independently with the provision of this level of support, and is designed to be accessible to those on low incomes (Australia, 1996, p. 15).

There are also examples of small group housing for people with high support needs. Sweden has developed 'group dwellings' as a variation on its service houses for frail elderly people, which are also targeted at older people with dementia. These are smaller housing complexes in which individuals have a small apartment as well as communal spaces. Staff provide intensive care and round-the-clock supervision. These group houses have been described as 'a kind of hybrid that combines features of both institutional and community care' (Monk and Cox, 1995, p. 263).

3.4.3 Apartment for life

The concept of 'apartment for life' is that all types of care for older people, including intensive nursing home care, should be provided in a person's home. The term 'apartment for life' was coined by the Humanitas Housing Foundation based in Rotterdam, The Netherlands. There are a number of apartment for life complexes operated by the Humanitas Foundation in Rotterdam and Amsterdam. These consist of apartment buildings comprising 100–250 self-contained apartments and a range of services including restaurant, bar, lounge, internet café, and health care services. There is a strong philosophy of older and severely ill people managing their own lives and retaining their independence (<http://www.woonzinnig.nl/>). Apartments can be

purchased or rented. Services based on the principles of 'apartment for life' are now emerging in a number of countries including Australia.

The idea of developing home-based care rather than nursing homes for very frail older people has been a focus of public policy in Denmark since the late 1980s (Cates, 1994). In contrast to most other countries, Denmark took the approach that rather than older people having to fit into static levels of care, services ought to adapt to the recipient, wherever he or she may reside. Thus, if a disabled older person needs intensive care, the nursing care should be brought to his or her home, rather than the other way around. These changes were introduced by legislation in 1987 which replaced the building of new nursing homes with the building of special housing for old and frail older people located close to service centres that provide and coordinate the provision of nursing and community care services in the older person's home. Allocation of special housing is based on assessment of needs. The level of care provided is similar to that provided in some nursing homes. In response to criticisms that older people felt too isolated in special housing, more common spaces and service facilities were introduced (Lindstrom, 1997, pp. 115–124). This approach effectively does away with the commonly used dichotomy between institutional and community-based care. It has been argued that widespread introduction of the Denmark model would involve fundamental reorganisation of the long-term care systems of most Western industrialised countries (Monk and Cox, 1995, p. 263). However, developments such as the expansion of CACPs and EACH packages in Australia can be viewed as paralleling those that have occurred in Denmark over the past two decades.

3.4.4 Co-housing

The concept of co-housing involves small groups of 10–50 individual dwellings with common facilities that provide opportunities for residents to share daily activities and mutual support without loss of privacy. Co-housing can be co-owned by residents or provided through non-profit housing organisations. Co-housing can be intergenerational or exclusively for older people. It has been described as 'the re-creation of a small-scale familiar neighbourhood plus an extra element of group solidarity, mutuality, and optional community activities' (Brenton, 2001, p. 170). Key features of co-housing include common facilities, private dwellings, resident-structured routines, resident management, design for social contact, and resident participation in the development process (Brenton, 2001, p. 171).

The model is most prevalent in a number of European countries including Denmark, The Netherlands and Germany. It is reported that in the late 1990s there were some 200 co-housing communities in The Netherlands, and the co-housing movement has spread to both the United Kingdom and the United States, although on a very small scale (Brenton, 2001; Lindstrom, 1997, pp. 126–127). In The Netherlands older people's co-housing has been encouraged and assisted by central and local governments and housing associations as a means of encouraging self-help and independence. It is argued that the social involvement and interaction offered by co-housing will help to keep people happier and healthier, and that mutual support will ease demand on health and social services. For residents the attractions are the social activities, avoidance of loneliness, safety and security, the prospect of prolonging independence, and participation in an innovative and experimental form of living. Issues include the demands of participatory management, the need for careful planning of age structure so that cohorts do not reach higher levels of dependency at the same time, and the balancing of sociability and personal privacy (Brenton, 2001). Co-housing has so far received only limited attention in the Australian context (Bamford, 2002).

3.4.5 *Multigenerational models*

The multigenerational extended family is the cornerstone of housing policy and housing provision for older people in many countries of Asia (Ara, 1997; Chi and Chow, 1997; Hwang, 1997), although the tradition of supporting elderly parents is waning in some countries (Kim, 1997). In countries such as Singapore housing polices provide strong incentives for ageing people to live with, or close by, their families (Harrison, 1997). In Japan, public rental housing authorities have had policies of 'paired apartment units' to enable elderly people and their children's families to live next door to one another, or in the same apartment complex (Kose, 1997, pp. 153–154).

A number of attempts to build multigenerational housing, support and care arrangements in other contexts can be identified. For example, in Jerusalem, Israel a multigenerational housing project provided ground floor units for elderly people in a number of residential blocks, with the upper floors occupied by families with children. A number of facilities for the older residents are provided including oversight by a 'house mother'. The aim was to provide older people with a supportive environment, and to encourage intergenerational relationships. An evaluation found that many older residents viewed these arrangements favourably (Katan and Werczberger, 1997, p. 61; Bendel and King, 1988; Heumann, 1995, pp. 149–151). The kibbutz movement in Israel also provides an example of older people with care needs being supported within a communal settlement, including if necessary care within a nursing centre located within the kibbutz premises (Heumann, 1995, pp. 152–154; Katan and Werczberger, 1997, p. 61).

The Supportive Home Living program in Nova Scotia, Canada is a somewhat different approach to multigenerational housing, support and care. This program, which operated during the 1990s, comprises duplexes which are linked by a connecting door, with a younger family living in one house and an older person or couple in the other. The non-government organisation managing the scheme contracted with the families to provide care services at various levels. It is reported that there was a high level of demand for the scheme from older people and that close relationships developed between the younger families and the older residents (Australia, 1996, pp. 21–22).

3.4.6 *Collective home care*

The term collective home care is used to refer to arrangements in which an organisation provides a range of home care services to a designated group of older persons living in their own homes in close proximity to one another. It differs from general home care provision in that residents are identified as members of the home care scheme and receive a range of services by virtue of this membership. In this sense they are similar to the supportive services provided in Naturally Occurring Retirement Communities (NORCs) in the United States or the concept of the 'virtual assisted living community' in the United Kingdom.

An example of collective home care is the 'supportive communities' scheme that has operated in Israel since the 1990s. In 2004 there were about eighty-eight such communities in Israel each providing support and care for about 200 members who remain living in their own home. The supportive community organisation coordinates the provision of support services, and there is a 24-hour emergency call service available. A range of services are coordinated, ranging from medical services to minor home repairs. They are mainly located in areas that are densely populated by older people (Billig, 2004).

3.4.7 Significance to Australia

This brief review of models of integrated housing, support and care in a number of countries provides a useful vantage point from which to reflect on the Australian experience. Public policies in many countries, particularly in Northern Europe, have placed considerable emphasis on the development of forms of service-enriched housing, particularly service housing and sheltered housing. Hostels in Australia used to resemble these housing forms. However, Australian public policy has increasingly viewed hostels as part of the residential care system rather than as a form of housing with support and care. As shown in chapter 2, service-enriched housing forms are now emerging in Australia, mainly in the context of retirement villages. However, the growth of these alternatives, which are central to housing and care provision in many countries, has so far eluded policy attention in Australia. Other international models such as co-housing and multigenerational housing seem unlikely to have widespread appeal in the Australian cultural context, although they may be attractive to small minorities. Small group housing may have a role as part of the range of housing alternatives, and may also have relevance for some older people with high support needs. The various models of collective home care suggest interesting alternatives for the delivery of home care services, especially in localities characterised by high concentrations of older people living in their own homes. They also illustrate the need to define the territory of integrated housing, support and care flexibly, and to recognise that housing, and support and care can be linked in many different ways.

3.5 The relevance of international programs

From the perspective of Australian public policy and service provision, there are five broad conclusions to be drawn from this review of integrated housing, support and care programs in the United States, the United Kingdom and selected other countries.

Firstly, in all countries examined, integrated forms of housing, support and care have been recognised as an important part of the repertoire of housing choices for people in later life. While in all countries these housing forms cater to only a small proportion of the population, they are important options for older people requiring some degree of formal support and care in order to be able to live independently. The range of similar options that already exist in Australia should be more fully recognised as a 'third way' of providing housing, support and care, along with home and community care, and residential care.

Secondly, across the range of countries examined, there is a wide diversity of forms of integrated housing, support and care in terms of housing forms, types and levels of support and care, tenure and management arrangements, and funding and regulatory arrangements. Even within defined categories such as 'sheltered housing' there is a great diversity of service types. It is important that there is widespread awareness in the state, community and market sectors in Australia of the range of possible services and products, and of the research evidence relating to their suitability as housing forms for people in later life.

Thirdly, this diversity indicates the need for careful definition of housing types, and for terminology and classification systems that can be used to ensure that policy-makers, service-providers and consumers share a common understanding of this field. Terms such as 'sheltered housing', 'assisted living' and 'retirement village' carry multiple meanings and this presents difficulties for policy and service development, particularly given the increasing influence of international models. In Table 2, an initial attempt to define and classify overseas service types is provided. This can be used as a foundation for mapping overseas models and considering their relevance to the Australian context.

Fourthly, it is clear that with the ageing of the population, and in particular the growth in numbers of the 'old-old', there will be a growing demand for products that provide high levels of support and care in housing rather than institutional settings. Demand for services such as 'assisted living' in the United States and 'extra care housing' in the United Kingdom seems likely to increase. As this service sector expands, issues relating to public support and regulation of the sector will arise, and existing distinctions between 'residential care' and other forms of accommodation and care may be blurred. There is likely to be a need for greater policy recognition of integrated housing, support and care services.

Finally, this international review assists to clarify the policy options for a country such as Australia with respect to integrated housing, support and care. The United Kingdom, and some European countries, exemplifies an approach in which the state (and more recently the community sector) has taken the lead in the development of housing, support and care services. By contrast, the United States is illustrative of a context where the public policy framework is relatively weak, and the market and community sectors have played central roles in product development and innovation. These models frame the choices facing Australia with respect to integrated housing, support and care provision for its older population.

Table 2: Categories for classifying overseas models of integrated housing, support and care

<i>Service type</i>	<i>Definition</i>	<i>United States</i>	<i>United Kingdom</i>	<i>Other countries</i>
Collective home care	Arrangements in which an organisation provides a range of home care services to a designated group of older persons living in their own homes in close proximity to one another.	Naturally occurring retirement community	Virtual assisted living community	Supportive community (Israel)
Group or shared housing	Living arrangements for older people where at least two, and usually no more than fifteen, related persons live together in a dwelling unit with a mix of shared and private facilities with the aim of providing a supportive and caring environment.	Share-a-home Home share Group or shared housing Board and care home	Abbeyfield housing	Home share Group dwellings (Sweden) MARPA (France) Abbeyfield housing (Canada)
Retirement community	Congregate living arrangements for older persons able to live independently, focused on provision of a secure, supportive, community environment and/or leisure and social activities	Leisure-oriented retirement community Active adult retirement community Retirement resort or town	Retirement community (independent) All age communities	Co-housing (Denmark) Multigenerational models

<i>Service type</i>	<i>Definition</i>	<i>United States</i>	<i>United Kingdom</i>	<i>Other countries</i>
Service enriched housing	Congregate living arrangements for older persons deemed able to live independently, but involving the provision of on-site management, services such as meals and/or domestic assistance, and/or low-level self-care and health assistance.	Independent living facility Congregate seniors housing Service coordinator program Service-enriched housing	Sheltered housing Retirement community (low support)	Sheltered housing (Netherlands) Supportive housing (Canada, Singapore, etc) Service housing (Finland, Sweden)
Extra care housing	Congregate living arrangements for older persons requiring a significant level of assistance with activities of daily living including self-care and ongoing health care assistance.	Assisted living facility	Very sheltered housing Extra care housing Retirement community (high support)	Assisted living (Israel) Heavy service housing (Finland)
Continuing care retirement community	Congregate living arrangements for older persons characterised by continuity of care within the same facility or location ranging from independent living through to high-level nursing care.	Continuing care retirement community Lifecare community	Continuing care retirement community	Apartments for life (Netherlands)
Residential aged care	Congregate living arrangement for older persons requiring high-level of nursing care and support.	Nursing home Skilled nursing facility	Residential care Nursing home	Retirement home or old-age home (many countries) Nursing home (many countries)

4 RESEARCH PLAN

4.1 Introduction

The purpose of this final chapter is to outline the methods and processes that will be used to address the six research questions listed in section 1.1. This positioning paper has so far provided the foundation for the research in three ways.

1. Statement of research significance, research approach, research questions, and the meaning of key terms (chapter 1).
2. Analysis of policy context and the current 'state of play', which also addresses research question 1 (chapter 2).
3. Identification and discussion of international models of integrated housing, support and care, which also addresses research question 3 (chapter 3).

Building on this foundation, the research plan involves the following further stages.

1. The development of a set of case examples indicating the types of integrated housing, support and care services that are now emerging in the Australian context. These will be used to illustrate features of the types of developments that are now occurring in Australia. This will address research question 2 and inform several of the other research questions.
2. The development of a 'Glossary of Terms and Translation Guide' and a classification framework of approaches to integrated housing, support and care, drawing on the international and Australian models. This will address research question 4.
3. The identification of key issues to be considered in the development of integrated housing, support and care services in the Australian context, drawing on the international literature review, and the Australian case studies. This will address research question 5.
4. An examination of the implications for housing and care policies for older Australians, and for further research. This will link back to the issues raised in analysis of policy context in chapter 2 of the positioning paper. This will address research question 6.

The final report will provide a comprehensive analysis of the six research questions listed in section 1.1. It will therefore include material drawn from chapters 1–3 of the positioning paper, as well as further chapters reporting the Australian case study findings and addressing research questions 3–6.

This final chapter of the positioning paper is divided into two main sections: the proposed method for the Australian case studies, including an initial listing of the proposed case examples; and the broad approach that will be taken to provide analysis of research questions 4, 5 and 6.

4.2 The case studies

4.2.1 Purpose

The central purpose of the case examples is to present a portrait of the types of developments that are taking place in Australia in integrated housing care and support products, programs and projects. Chapter 2 indicated that while the development of integrated housing, support and care services has not been an explicit goal of public policy, there is nevertheless a considerable level of growth and development of such services. Through the development of a series of case examples, the nature and

diversity of emerging forms of integrated housing, support and care can be better understood. This will provide a basis for comparing and contrasting Australian developments with the international models identified and described in chapter 3. The cases will also provide a foundation for the classification of approaches, issue identification and policy analysis discussed in section 4.3 and elaborated in the final report.

It is stressed that the case studies are not evaluations of the services that have been selected. It is not intended to collect evidence concerning the quality or outcomes of individual services. Rather the case studies are designed to illustrate the nature and diversity of current developments, and to stimulate consideration of the issues that might be addressed by those developing policies, services and products. The cases will not be presented as individual case studies. Rather, they will be used to illustrate the emerging range of concepts, proponents, housing forms, approaches to provision of support and care, consumers, and terms of provision in the Australian context.

4.2.2 Framework of analysis

In chapter 1, integrated housing, support and care was defined as all forms of housing for older people that make deliberate provision for one or more types of support and care as part of the housing complex or development. As the purpose of the case examples is to portray the nature and diversity of types of such housing developments that are emerging in Australia, it is necessary to develop a set of descriptive categories that can provide a basis for case selection, data collection and analysis. In broad terms, types of integrated housing, support and care can be described under six main headings:

1. The concept
2. The proponent
3. The housing form
4. The provision of support and care
5. The consumers or market
6. The terms of provision of housing and/or care, including fees and charges.

The concept

All forms of integrated housing, support and care are based on a broad 'concept' or set of ideas that underpins the service, product or program. This concept may have been developed by the proponent, it may have been borrowed or adapted from other established services either local or international, or it may have evolved from a previous service. The concept may have a philosophical base, i.e. it may be based on values and beliefs about the kinds of housing, support and care services that should be provided to older people. Alternatively, or additionally, it may be based on a perception of need or demand, i.e. a view that there is a gap in existing services or an actual or emerging market opportunity. The concept can be thought of as the rationale for the service. It is the fundamental reason for the development of the service or product, as perceived by its proponent.

Specific questions relating to the concept underlying any integrated housing, support and care service or product are:

1. What concept or set of ideas underpins the service or product?
 - What values and beliefs (philosophy) underpin the service or product?
 - What perception of need or demand underpins the service or product?

- What is the evidence or basis for this perception of need or demand?
- 2. Where does the concept underlying the service or product come from?
 - Is it based on other Australian services or products?
 - Is it based on international models?
 - Has it evolved or been adapted from other services or models?
- 3. In summary, what is the rationale for the service or product? Why is it being provided or developed?
- 4. Does experience thus far justify or raise questions concerning this rationale?

The proponent

The term 'proponent' refers to the organisation, company or individuals responsible for the development and provision of the service, or the combination of such groups. Proponents may be located in the public, community, private or informal sectors, or in a combination of these. Proponents may include those involved in initiation, concept development, project development, financing, marketing and selling (or recruitment and selection), and managing the product or service.

Specific questions relating to the proponents of integrated housing, support and care services or products are:

1. Who was responsible for initiating the product or service?
2. Who is or was responsible for the development of the product or service?
3. Who is or will be responsible for the management of the product or service?
4. Who is responsible for the funding or financing of the service, and what is the funding or financing structure?

The housing form and location

The 'housing form' is the physical form of the integrated housing, care and support service. It comprises the location, the built form of the development as a whole, and the form of individual dwellings. The range of potential options is considered in section 1.2.1. Location refers to the actual geographic location (state or territory, and locality), the type of location (inner city, middle or outer ring suburb, provincial city, rural, coastal, etc.), and the proximate environment (location in relation to services and facilities, population centres, characteristics of the local environment). The overall built form may be concentrated or dispersed; high rise, low rise or single storey; one building or many; open or 'gated'; large or small in scale; and including or not including shared facilities. Individual dwellings may be free-standing in their own grounds, they may be duplexes, or they may be apartments within larger buildings. They may be fully or partially self-contained, may vary in size, and may range from bed-sitters to multi-room dwellings.

Specific questions relating to these aspects of housing form are:

1. What is the actual geographic location of the dwelling, and type of location?
2. What is the nature of the proximate environment?
3. What are the characteristics of the overall built form?
4. What are the characteristics of individual dwellings?
5. What is the rationale for the location, overall built form, and characteristics of individual dwellings, and how do these relate to the underlying concept?

6. To what extent and in what ways does the housing address issues of environmental support, i.e. how is the physical environment designed to maximize independence and support lifestyle?
7. Does experience thus far justify or raise questions concerning the chosen housing forms and locations?

The provision of support and care

‘Provision of support and care’ refers to the types of support and care provided as part of the integrated housing, support and care development; the terms on which support and care are provided; the stated purposes of support and care provision; the location of care and support; and the support and care providers. These dimensions of support and care are introduced in section 1.2.2. The main types of support and care, as listed in Table 1, include those related to the following life activities: self-care, meal preparation, domestic work, property maintenance and modification, transport, social activity and recreation, health care, support for carers, and life planning and management. These forms of support and care can be provided as part of a standard package linked to tenure in the development, or they can be available on an optional, paid basis. They may be provided in order to enhance lifestyle, or may be linked to concepts of independence. The type of service may reflect consumer goals and preferences or may be tied to professional definitions of need. Services may be provided in the older person’s home, on the main site, or in other locations. Services may be provided by paid workers, by volunteers, or on the basis on mutual aid. There may be clear separation between the housing provider and the care and support provider, or these roles may be administratively combined.

Specific questions relating to the provision of care and support are:

1. What range and intensity of care and support services are provided (see Table 1)?
2. Are care and support services included in a standard service package or can services be obtained or purchased on an optional basis as needs and preferences change?
3. What are the stated purposes of care and support provision?
4. To what extent do consumers control the nature of services provided and to what extent do services reflect professional definitions of need?
5. Are services provided in the older person’s home, elsewhere on-site, or in other locations?
6. Are services provided by paid workers, by volunteers, or on the basis of mutual aid?
7. Are services provided in-house or from external sources? Does the housing provider play a role in the coordination of services and case management?
8. Is there or is there not clear separation between the housing provider and the support and care provider?
9. What is the rationale for the support and care arrangements, and how do these relate to the underlying concept?
10. Does experience thus far justify or raise questions concerning the chosen provision of support and care?

The consumers or market

There is great variation in the target group or market for the various emerging forms of integrated housing, support and care. These services and products may be intended

for older people with low, medium or high levels of support and care needs, and they may be directed toward groups of older people with complex needs, e.g. older people with a history of insecure housing. They may also be directed at different segments of the market in terms of capacity to pay, ranging from luxury developments to those directed at older people whose sole or main form of income is the pension. Developments may also be targeted at particular age groups, i.e. those older people in their 50s, 60s, 70s or older.

Specific questions relating to the target group for integrated housing, support and care services are:

1. Is the service or product aimed at older people with low, medium or high need for support and care (both at entry and over time as needs change)? Are any types of older people given priority, or are any excluded?
2. Is the service or product aimed at older people with other complex needs? Are any types of older people given priority, or are any excluded?
3. Is the service or product aimed at older people in the high, medium or low-income and wealth group?
4. Is the service or product aimed at older people in particular age groups, or other market segments?
5. Does experience thus far justify or raise questions concerning the chosen consumer group or market?

The terms of provision

The 'terms of provision' refers to the conditions laid down for the use of the product or service. This includes both the wider regulatory environment in which the service operates, and the specific terms under which the service is provided. The wider regulatory environment may include a direct and indirect element. Directly, the development may be subject to the requirements of retirement village legislation, other forms of housing regulation, and/or planning regulations relating to the provision of older persons' housing. It may also be subject to conditions relating to any public funding received. Less directly, taxation and income security policies and provisions may impact on the operation and financial viability of the development. Requirements or agreements relating to accessible, adaptable or universal housing design may also have an impact on the development. With respect to the specific terms of provision the main issues are the management structure and tenure arrangements. Management structures may make provision for input and feedback from residents, and residents may have a role in decision-making through body corporate or other mechanisms. Tenure may be based on ownership, various forms of leasing, or rental, and there may be a range of mandatory or optional service charges.

Specific questions relating to the terms of provision are:

1. Does the service or product operate under the provisions of retirement village or other housing legislation? With what impacts?
2. What other regulatory requirements, funding conditions, or other public policy settings impact on the operational or financial viability of the development?
3. What requirements or agreements relating to accessible, adaptable or universal housing design have impacted on the development?
4. What are the management structures for the development, and what opportunities are there for resident input, feedback or decision-making?
5. What is the form of tenure under which residents occupy the housing?

6. Does experience thus far justify or raise questions concerning the terms of provision?

In summary, this framework of analysis provides a foundation for describing, comparing and contrasting the types of services and products integrating housing, support and care that are currently emerging in Australia. It identifies the concepts that are driving innovation in this area, and identifies the kinds of organisations that are proponents of these developments. It also identifies the types of housing form, and types of support and care services that are being developed, and the ways that these are being 'integrated'. It indicates the diversity of markets and consumers being targeted, the forms of management and tenure being adopted, and the legislative and policy contexts impinging on these developments. It is intended to apply this framework to the specific cases identified and briefly described below.

4.2.3 Case selection

Choosing a set of cases to portray the diversity of types of developments that are taking place in Australia in integrated housing, support and care is necessarily a somewhat imprecise process. There is no clearly defined population or listing of such organisations from which to make a selection, and the context is dynamic with new services and products in varying stages of development. The processes followed in order to develop the list of potential cases presented in section 4.2.4 were as follows:

1. 'Integrated' housing, support and care services were defined, as in section 1.2.3, as forms of housing for older people that make deliberate provision for one or more types of support and care as part of the housing complex, development or project. This may include arrangements where support and care services are systematically sourced from outside. All cases included had to fall within this definition.
2. Services primarily funded as part of the mainstream aged care system in Australia, i.e. services defined as residential aged care homes (formerly hostels and nursing homes) were excluded from consideration. Previous compilations of case studies of innovations in housing for older people included low-care hostels (Forsyth, 1992), and as hostels as a class have their origins as 'housing' services, there may have been a case in the past for their inclusion in a study of this kind. However, as hostels are now viewed unambiguously in Commonwealth funding arrangements as aged care facilities, they are excluded from this study.
3. Supported residential services (known in some states as supported accommodation, licensed residential centres, or supported residential facilities) are included in the study, even though they provide accommodation and services to people of all ages. The case example chosen has a strong orientation to the provision of services to older people.
4. Based on the analysis presented in chapter 2, the four main groups of organisations involved in the development of integrated housing, support and care services in Australia were identified as:
 - The retirement village industry, including market and community sector (not-for-profit) providers.
 - Community sector housing providers, including providers of independent living units.
 - Public housing providers, sometimes in association with other organisations.
 - Organisations involved in providing services to older people with complex needs.

Examples from each of these four major categories were sought. In some instances cases were selected because they were representative of a wider group of similar services. In others the selection was based on the distinctive or innovative nature of the case.

5. Case examples were identified on the basis of analysis of secondary literature, use of key informants, web search, personal knowledge of study team members, and verification by means of direct contact with the organisations concerned.
 - A survey of the secondary literature on housing and older people in Australia was conducted and all references to specific examples of integrated housing, support and care identified. Particular reference was made to previous AHURI studies addressing housing and care issues for older people (especially Jones, Bell, Tilse and Earl, 2007).
 - Key informants with knowledge of housing and care issues for older people in each of the state and territory housing departments were asked to nominate examples of integrated housing, care and support services within their jurisdictions. Key informants were also contacted for knowledge of specific areas of the industry, e.g. independent living units, retirement villages, supported residential services.
 - A selected web search was undertaken to follow up leads provided through the secondary literature and within key categories of services including retirement villages and public housing.
 - All organisations identified through these processes were contacted to ensure that they fit within the parameters of the study.
6. Choice of cases was also influenced by the following considerations:
 - Where possible a geographic spread of cases was sought in terms of representation of as many states as possible and a mix of metropolitan and non-metropolitan locations.
 - In some cases, services that are still in the process of development were included if it was determined that they illustrated important emerging trends.
 - Inclusion of cases is dependent on agreement by the owners and/or managers to participate in the study.

Through these processes, the seventeen organisations listed in section 4.2.4 as proposed cases were identified. Key, distinctive characteristics of each case and particular reasons for their selection are identified in the brief descriptions provided. The list of cases analysed in the final report may vary slightly from the list provided below.

4.2.4 The proposed cases

Each of the proposed cases is briefly described below. The cases are introduced and grouped according to the four categories identified in chapter 2.

The retirement village case studies

The retirement village industry is the main location for the development of emerging forms of integrated housing, support and care in Australia. All retirement villages provide some of the forms of housing, support and care listed in Table 1, and many offer high levels of support and care through serviced apartments, flexi-care arrangements and forms of assisted living. Examples of retirement villages providing various levels and types of support and care are included below, selected from many possible cases. These include a retirement village providing independent living, hostel

and nursing home care on the one site; and a private sector village providing a range of support and care options. Examples are also provided of the diversification of the retirement village industry, including developments catering to the luxury, middle and affordable seniors housing markets, and developments offering new forms of tenure including high-cost and low-cost rental.

Aveo The Braes, Adelaide, South Australia

This retirement village has been selected as an example of a private sector retirement village offering a range of support and care options including independent living units (individual private residence), assisted living units (serviced apartments providing assistance with daily living activities including meals and domestic services); and flexi-units (independent living with additional services including personal care services available for purchase).

Grande Pacific Broadwater, Gold Coast, Queensland

This has been selected as an example of a market sector response to perceived demand for high-quality hotel living with a range of support and care services provided. It is a recently developed, up-market, high-rise apartment building designed for older people aged 60 and over. It includes a number of studio apartments for older people requiring extra care.

Harbour Quays, Gold Coast, Queensland

This project, described by the developers as 'a fresh take on the traditional retirement village', is scheduled for completion by 2009. It is a 133-apartment complex in a waterside location in which residents will pay a monthly rental fee of approximately \$3,500, which will include all services and facilities including meals, cleaning, and a linen service.

Wishart Village, Brisbane, Queensland

Wishart Village is included as an example of an established retirement village providing independent living units, hostel and nursing home facilities on the one site. It is located in the outer southern suburbs of Brisbane and is operated by Queensland Baptist Care.

Oxford Crest, Eagleby, Brisbane

This is an example of a housing development located in the outer, southern suburbs of Brisbane offering affordable rental accommodation for older people linked to a range of support and care services. The total cost of rent, food and services is set so as not to exceed 85 per cent of the rate of the single pension. A linen service is provided, there is an optional meals service, there is an on-site manager, and a range of social activities are provided.

Tall Trees, Rochdale, Queensland

This is a self-styled 'supported living community' located in the southern suburbs of Brisbane. It is included as an example of a middle-priced retirement village offering a diversity of care and support options that can be adjusted to the needs and preferences of residents. It provides self-contained units in a campus setting and levels of health care and household support that can vary according to the needs and preferences of residents.

The community sector case studies

The community sector has been responsible for significant innovation in integrated housing, support and care services. The long tradition of providing independent living units has led to numerous developments that provide a degree of support and care as

part of the housing complex. Community housing providers, including cooperatives, have also developed housing services for older people that provide a level of support and care. Abbeyfield housing has developed a small market niche for its model of integrated housing, care and support. A number of community sector organisations are also experimenting with innovative approaches to these issues.

Abbeyfield House, Burnie, Tasmania

The Abbeyfield housing model for low-income older people is a communal house consisting of approximately ten individual bed-sit style rooms with shared dining, living, and laundry facilities. The communal environment is designed to encourage a sense of community and mutual aid. Main meal preparation and cleaning of shared areas is provided by a housekeeper, with residents maintaining their own rooms and doing their own laundry. HACCC services may be arranged for residents unable to manage these tasks. A number of Abbeyfield houses have been developed in several Australian states and they are examples of group housing for older people able to live independently with some support.

Broadview House, Adelaide, South Australia

Broadview House is an example of rental group housing for lower-income older people who are able to live independently with some support, provided through a housing cooperative. The house consists of ten rooms and services include two meals per day, 24-hour personal alarm; and laundry assistance.

Irving Benson Court, Melbourne, Victoria

This complex of thirty-five independent living units operated by Wesley Aged Care Housing Services is an example of a low-rent facility providing a range of support services. Residents requiring higher levels of care may be able to move from this facility to low-care residential aged care services operated by the same organisation, and the housing provider may also be involved in organising or providing community aged care packages (CACPs) for residents with high-support needs.

Ocean Street Project, Sydney, NSW

Still in the development stages, this is an initiative of the Benevolent Society of NSW based on the Dutch concept of 'apartments for Life'. The intent is that residents are able to remain in the same apartment for the rest of their lives, through the provision of purpose-built apartments and access to support services and appropriate technologies. The main service provided on-site is meal preparation, with health and support provided through HACCC, CACP, and EACH. Rent levels will be based on the individual financial circumstances of clients. This exemplifies an innovative approach based on the concepts of continuity of care and ageing in place.

Wesley Homeshare, Melbourne, Victoria

This program operated by Wesley Mission in Melbourne is based on similar models that have been operating successfully in several other countries for many years. The model matches older home owners who require help and companionship with younger people who can provide assistance in exchange for affordable accommodation. A fee is charged by Homeshare for the matching service. This is an example of a small-scale, innovative approach to the provision of support in the home of the older person.

The public housing case studies

The third main location for the development of integrated housing, support and care is the public housing sector, where there has been increasing awareness of the need to develop models that provide support and care services to public housing tenants as they age. The Dougherty Apartments in NSW are well known as an established

example of a joint development involving the state housing authority, the local authority and community organisations in providing a range of housing, support and care options for older people including public housing tenants. More recent examples of models providing support and care to public housing tenants are the Matavia Ageing in Place Initiative in NSW and the Older Persons' High Rise Support Program in Victoria.

Dougherty Apartments, Sydney, NSW

Dougherty Apartments were constructed in 1989 as a joint venture between the Willoughby City Council, the NSW Department of Housing and the Uniting Church. The 138 residential apartments consist of fifty-five public-funded (Department of Housing) self-care units, forty-three resident-funded units, and forty low-level care hostel units. Services to residents include 24-hour emergency care services and call system, short-term emergency care, household maintenance, and affordable meals. This is an example of a housing initiative that involves inter-sector collaboration, and a mix of housing options including public housing and private ownership in the one development.

Matavia Ageing in Place Initiative, Sydney, NSW

This joint initiative of NSW Department of Housing and Mercy Arms provides 'ageing in place' for seven frail older people on one floor of a public housing high-rise building in Sydney, NSW. A number of long-term residents of the building requiring high levels of care and support were co-located on one floor of the building, in order to facilitate the efficient provision of high-level support services funded through pooling of Community Aged Care Packages (CACPs) provided by Mercy Arms. This is an example of an approach to meeting the care and support needs of older people in a public housing facility by combining community care entitlements.

Older Persons' High Rise Support Program, Footscray, Melbourne, Victoria

This program managed by the Victorian Department of Human Services provides on-site support to tenants of eleven inner-city older persons' public housing high-rise buildings. The program is targeted at vulnerable and isolated older tenants, particularly those who are frail or who have disabilities. Support workers provide social support, low-level monitoring, practical assistance, and links to health and community services. A pool of flexible care funds is available to assist tenants, especially those with complex needs. This is an example of direct public provision of support and care by a public sector organisation that also has responsibility for public housing provision.

The complex needs case studies

The fourth tradition of integrated housing, support and care has emerged in the area of services for older people with complex needs, including older people with a history of insecure housing. Wintringham, based in Melbourne, has pioneered services to older people at risk of homelessness. Victoria's Housing Support for the Aged Program (HSAP) provides support and care services to homeless people who are entering public housing. Supported residential services also provide support and care to older people with complex needs and are represented in the case studies.

Housing Support for the Aged Program, Victoria

This program of the Victorian Department of Human Services provides case-managed packages of support and services to people aged 50 years and over entering public housing with a history of homelessness or insecure housing. The aim is to assist people with complex needs including age-related frailty, serious mental health,

psychiatric disability, alcohol and substance abuse and similar problems, to maintain a stable public housing tenancy. The service includes case management and care coordination, low-level monitoring, practical assistance, social support, and a pool of flexible care funds. There are twelve equivalent full-time HSAP workers across Victoria.

Highgrove Supported Residential Service, Melbourne, Victoria

Supported residential services (also known as supported residential facilities, licensed residential centres and supported accommodation) are licensed, for-profit facilities providing accommodation and care for people who need support on a day-to-day basis including the frail aged and people with a disability. The service chosen to exemplify this form of service is Highgrove SRS, located in Kew, Melbourne. It provides housing for fifty frail older people in a purpose-built facility. Highgrove offers specialised personal care, physical assistance, and other nursing care. Residents are also able to access, where eligible, allied health, mental health, disability services, home nursing, and social support.

Wintringham, Melbourne, Victoria

Wintringham is a community organisation that provides a variety of housing and care services for older people who are homeless or at risk of homelessness. The aim is to provide access to appropriate housing, care and support services in order to prevent premature or inappropriate institutionalisation. A broad range of housing is provided, from inner-city apartments, to self-care apartments and units in “village”-like settings. The emphasis is on independent living, with flexible care services tailored to the individual needs of each resident, and the option of receiving additional services if needed.

Summary

The main characteristics of the proposed case examples, organised in terms of the framework of analysis presented in section 4.2.2 are summarised in Table 3. The table illustrates the diversity of approaches to integrated housing, support and care in the current Australian context, and the dynamic nature of this field with new services and products being developed by a diversity of proponents. The final report of this project will provide more detail on each of these cases, thus presenting a portrait of the diversity and extent of innovation in this field.

4.2.5 Data collection and case construction

Data will be obtained on each of the selected cases following the framework of analysis set out in section 4.2.2. Data will be obtained and analysed through the following processes:

1. Examination of the web-sites of each of the case organisations.
2. Examination of any other service information including references in the secondary literature, reports, organisational documents, information brochures, etc.
3. Semi-structured key informant interviews with a representative of each of the case organisations. These will be conducted face-to-face where feasible, and by telephone where face-to-face interviews are not possible. Interviews will be recorded. The interview schedule is included in Appendix 2.
4. Findings from each case example will be written up following the framework of analysis set out in section 4.2.2. This data will then be used in the final report to present a portrait of the nature and diversity of current and emerging integrated housing, support and care provision in Australia.

Table 3: Proposed case studies of integrated housing, support and care

<i>Case</i>	<i>Concept</i>	<i>Proponent</i>	<i>Housing form</i>	<i>Provision of support and care</i>	<i>Consumer or market</i>	<i>Terms of provision</i>
<i>Retirement villages</i>						
Aveo The Braes, SA	Retirement village offering a variety of options including independent living, assisted living and flexi-care	Aveo – a private company part of FKP Property Group’s retirement division	Complex of self-contained units	Residents can pay for a variety of care packages, with meals, linen and general maintenance provided in assisted living apartments	Middle range income, must be aged 55 years and older	Mainly leasehold, but also offers loan/loan-licence arrangements and freehold/strata title tenure
Grande Pacific Broadwater, Qld	Up-market, high rise apartment building providing a range of hotel facilities and support services	Private company Grande Pacific, a subsidiary of City Pacific	High-rise complex with luxury self-contained apartments	On-site 24-hour emergency call system and nursing, doctor’s clinic, chemist and meals service	High-income older people aged 60 years and over	Private purchase
Harbour Quays, Qld	Up-market apartment complex providing a wide range of support services	Australian company Petrac in association with US-based Harvest Development	High-rise complex with luxury self-contained apartments	Inclusive package providing meals, cleaning and linen service	High- income aged 75 years and over	High-cost rental (approx. \$3,500 per month)
Wishart Village, Qld	Continuum of care for older people with independent living, hostel and nursing home on same site	Amana Living (formerly Anglican Homes)	Complex of self-contained units, nursing home and hostel	On-site 24-hour emergency call system and adjacent aged care facilities	Low to middle income	Private purchase
Oxford Crest, Eagleby, Qld	Rental accommodation with some optional services	Private Qld-based company Oxford Crest Ltd	Complex of self-contained units	Optional meal and linen service, and assistance with access to HACC, CACP, etc.	Lower-income people 60–80 years of age.	Rental
Tall Trees, Qld	Self-styled ‘supported living community’ providing independent living units and added support services when needed	Private company – Tall Trees Group	Complex of self-contained units	24-hour emergency response, assistance can be provided with personal care, household help.	Average-income older people	99-year lease

<i>Case</i>	<i>Concept</i>	<i>Proponent</i>	<i>Housing form</i>	<i>Provision of support and care</i>	<i>Consumer or market</i>	<i>Terms of provision</i>
<i>Community sector</i>						
Abbeyfield House, Burnie, Tas	Supportive communal housing providing basic support and care for older people	Abbeyfield Society (Australia) Limited part of the charitable network Abbeyfield International	Self-furnished, private bed-sitting room and bathroom, with communal kitchen and living facilities	Meals and household maintenance provided by housekeeper; HACC arranged as required	Lower-income older people 50–90 years of age	Rental
Broadview House, SA	Housing co-operative providing group housing to older people with low income	Northern Suburbs Housing Co-operative	Private rooms with ensuite bathroom and air-conditioning, with communal kitchen and living facilities.	Main meals, 24-hour emergency care, laundry assistance	Lower-income older people aged 55 years and over	Low-cost rental
Irving Benson Court, Vic	ILU complex providing support including CACPs	Wesley Aged Care Housing Services, a community housing organisation	Complex of self-contained units	24-hour alarm, home maintenance, and HACC and CACPs arranged where required	Lower-income older people, including some with complex needs	Mainly rental with some private purchase
The Ocean Street Project, NSW	Apartments for life, allowing residents permanency for the rest of their lives through provision of support services	The Benevolent Society of NSW, a not-for-profit organisation	Complex of self-contained apartments	Meals provided, and HACC, CACP, and EACH provided when required	Lower-income older people with modest property assets, or lower-income older renters on the pension	Low-cost rental
Wesley Homeshare, Vic	Intergenerational housing matching older home owners with younger people who provide assistance and companionship in exchange for accommodation	Wesley Mission, Melbourne	Intergenerational home-sharing in private dwellings	Services vary depending upon the needs of the householder and are negotiated at commencement of the homeshare	Older homeowners with modest incomes	Householder pays small registration and matching fees Home-sharer receives accommodation in return for support provided

<i>Case</i>	<i>Concept</i>	<i>Proponent</i>	<i>Housing form</i>	<i>Provision of support and care</i>	<i>Consumer or market</i>	<i>Terms of provision</i>
Public sector						
Dougherty Apartments, NSW	Public funding and resident-funded apartment-style housing for socially and financially disadvantage older people.	Joint venture between Willoughby City Council, the NSW Department of Housing, and the Uniting Church	Complex of self-contained apartments	24-hour emergency care services and call system, short-term emergency care, household maintenance and meals	Socially and financially disadvantaged older people aged 50–97 years	Public housing rental and private purchase
Matavia Ageing in Place Initiative, NSW	‘Ageing in place’ on one floor of a public housing high-rise, providing support and CACPs	NSW Department of Housing and Mercy Arms	One bedroom self-contained units with additional units converted to communal kitchen and living areas	Mercy Arms supply pooled CACPS including personal care, shopping, laundry, emergency call system. Meals provided at an extra cost	Frail older people living in a pre-existing public housing high-rise	Public rental housing
Older Persons High Rise Support Program, Vic	A public housing high-rise providing on-site support for older residents who are frail or have a disability	Victorian Department of Human Services	Complex of self-contained high-rise units	Social support, low-level monitoring, practical assistance and links with community services	Low-income older people with complex needs	Public housing rental
Complex needs						
Housing Support for the Aged Program, Vic	Case-managed packages of support and services for older people entering public housing with a history of homelessness or insecure housing	Victorian Department of Human Services	Varies – high-rise, or complex of self-contained units	Case management and individualised support packages	Older people with complex needs who have a history of homelessness or insecure housing	Public housing rental
Highgrove Supported Residential Service, Vic	Accommodation and care for people needing support on a daily basis including frail aged	Highgrove, a private company	Purpose-built facility	Specialised personal care, nursing care, assistance in accessing other services	Frail older people with moderate/low income	Service charge
Wintringham, Vic	Affordable housing and support services for elderly men and women with history of insecure housing	Private non-profit company Wintringham in association with the Victorian State Government	Partly furnished units/studios in either village or apartment-style environments	Care services tailored to the individual, and access to HACC services arranged as required	Older people with a history of insecure housing or at risk of homelessness.	Rental equivalent to public housing rents

4.3 Program and policy analysis

The project findings relating to research questions 4–6 will be presented in detail in the final report. The discussion of these issues in the final report will draw together the findings from the case studies, the review of international models, and the international literature. A preliminary identification of the types of issues to be examined is provided below, based on an initial review of the international literature and the Australian context.

4.3.1 *Nomenclature and classification*

It is clear from the review of Australian and international models of integrated housing, support and care presented in this positioning paper that the terminology used to describe these models is complex, imprecise and confusing. This is the case both within countries, best exemplified by the plethora of terminology used in the United States, and internationally, where there is little or no standardisation of terminology. The terms used to describe particular products and services derive from public sector funding and regulatory programs, and the marketing endeavours of private sector and community providers. Efforts to standardise terminology have had to address the great diversity of product and the dynamic nature of the service field (Anikeeff and Mueller, 1998; Scriber and Dalkowski 1998; Sexton 1998). The lack of clear terminology presents obvious difficulties for prospective consumers and there is a case for greater standardisation of terminology based solely on grounds of consumer protection. However, the disorder of terminology also impedes clear policy development and may also have implications for housing supply. If the state sector wished to take a proactive stance towards the provision of integrated housing, support and care, greater clarity concerning the range of types of services to be supported is required. If community and market sector providers are to be encouraged to develop integrated housing, support and care services, the issues of product categorisation and classification are unavoidable.

Within Australia the lack of clear and agreed terminology to describe and analyse the main models of integrated housing, support and care is a major impediment to policy and service development. Within the aged care system the terms ‘nursing home’ and ‘hostel’ are giving way to the generic term ‘residential aged care home’, as part of the adoption of the residential care classification system based on consumer characteristics. However, outside the clearly delineated aged care system, terminology is highly imprecise and often confusing. The term ‘retirement village’ covers a great diversity of forms of integrated housing, support and care, and there is a clear need to find better ways of classifying retirement villages to reflect their differing objectives and services (Stimson, 2002). The term ‘independent living units’ can be used to refer to those dwellings funded by the Australian Government and community organisations from the 1950s to the 1980s (McNelis, 2004), but this is by no means a universal usage and in any case refers to a funding source rather than a carefully defined service type. There is no precise or widely accepted term to refer to the housing arrangements developed by companies such as Village Life over the past decade. Terms such as ‘serviced apartments’, ‘assisted living’ and ‘flexi-units’ have entered the lexicon of the seniors housing industry, but they lack clear and shared meaning. In this context, providers experiment with terms such as ‘apartments for life’ and ‘supported living communities’ in order to stress the distinctiveness of their product or to gain market advantage.

In order to address these issues of terminology, a Glossary of Terms and a Translation of Terminology will be developed and presented in the final report. The Glossary that appears at the end of this positioning paper is a first draft of this

exercise. In the final report all of the terms introduced in the positioning paper and final report which refer to forms of housing and care services for older people will be defined, and terms from different countries that have equivalent or near-equivalent meanings will be identified. The Glossary and Translation is designed to facilitate more precise and accurate policy discussions and international knowledge transfer.

As well as a need for clarification of terminology, there is a need for classification of the many types of initiatives in integrated housing, support and care. There has been a number of previous approaches to the classification of housing, support and care models (Lawton, 1981; Lawton, 1981a; Heumann and Boldy, 1982; Folts, Yeatts and Dwyer, 1991; Heumann and Boldy, 1993; Giarchi, 2002), and these will be examined in greater detail in the final report. A schema identifying different forms of integrated housing, support and care in the Australian context was developed by Howe in her report for the National Housing Strategy (1992, p. 92). Howe provided a three-dimension schema for showing the range of possible variations of housing, support and care combinations. The dimensions were the environmental support dimension, the service dimension, and the scale dimension. This showed 'the range of possible permutations and combinations for providing care services and environmental support in housing settings of varying scales' (Howe, 1992, p. 93). Howe's schema, adapted from an earlier version devised by Heumann and Boldy (1982), has the advantage of demonstrating the great diversity of possible housing, support and care models without reference to particular service types. It continues to have considerable utility as a framework for distinguishing existing approaches and suggesting new possibilities.

The approach to classification taken in this study will be to identify categories of service types that will provide a means of distinguishing the increasingly diverse range of service types that are coming onto the Australian market. This approach will build on the international literature review (chapter 3 and table 2), existing and emerging forms identified in the policy review (chapter 2) and the case studies (section 4.2). Further discussion of the approach to classification and a proposed classification built around a number of defining characteristics of services will be provided in the final report.

4.3.2 Issue analysis

The development of integrated housing, support and care services in Australia is taking place with only minimal and patchy reference to the now extensive international research and policy literature on the issues associated with the design and management of this form of housing. In the final report key issues and research findings will be identified, and implications for the Australian context (including the types of developments illustrated by the case studies) will be considered.

Key issues that have been identified through the literature review and which will be reviewed systematically in the final report include:

Physical environment

- The role of the physical environment and design in fostering independence as well as a supportive environment;
- The impact of scale;
- The impact of assistive technologies.

Support and care provision

- Provision of choice and control for residents and adaptability of housing and care arrangements to individual circumstances;

- The provision of continuing care as care and support needs change;
- The role of care management and brokering.

Quality of life

- Impact on health and quality of life;
- Attachment to home in congregate living arrangements;
- Sociability and mutual aid in congregate living arrangements;
- The institutionalisation of housing arrangements, especially those that provide higher levels of care.

Management issues

- The separation of the provision of housing, on the one hand, and support and care, on the other;
- The principle of age segregation;
- The relative cost-effectiveness of forms of integrated housing, support and care;
- The nature and quality of housing management.

Access issues

- Eligibility and social mix;
- The impact of tenure;
- Consumer demand for integrated housing, support and care arrangements;
- The affordability of housing, support and care arrangements;
- Choice and diversity in housing arrangements.

4.3.3 Policy implications

The final report of the project will consider the policy implications relating to the development of integrated housing, support and care options for older Australians, and possibilities for further research. It will present an argument for a more pro-active, systematic, evidence-based policy approach to the provision of integrated housing, support and care for Australians in later life. It will suggest the roles that the public sector might play in funding, supporting, monitoring, regulating and generally enabling the development of a wider range of integrated housing, support and care services. It will consider the roles of the state, community and market sectors, and propose principles to underpin service provision. In this way the report will provide the foundation for policy consideration of a 'third way', alongside residential care and community care, to meet the housing and care needs of older Australians.

The policy issues to be considered include:

1. Should housing authorities and other public sector organisations in Australia take a more positive role in facilitating the provision of integrated housing, support and care options?
2. If so, what form should this take? What might be the roles of the public sector in funding, supporting, monitoring, regulating and generally enabling the development of a wider range of integrated housing, support and care services?
3. Are there particular service types that should be developed?
4. What kinds of demonstration projects might governments fund in order to expand understanding of the range of possible and desirable models?

5. What principles should underlie the development of integrated housing, support and care services by the public, community and private sectors?
6. What should be the relationship in policy terms between the development of integrated housing, support and care services and the existing funding and provision of community and residential aged care services?
7. What further research is required to provide an evidence base for policy development?

4.4 Summary

The positioning paper has laid the foundation for this study of integrated housing, support and care in Australia in the following ways:

1. It has set out the research context and objectives, clarified the six research questions, defined key terms, and laid out the significance of the study (chapter 1 and glossary);
2. It has examined in some detail the Australian policy context, showing in particular how this issue has been shaped by housing policies for older people, and aged care policy (chapter 2);
3. It has identified international models of integrated housing, support and care, and indicated points of relevance of these models to the Australian context (chapter 3);
4. It has proposed a set of case studies designed to indicate the range and diversity of Australian approaches to integrated housing, support and care, and a method for case study data collection, and case presentation (chapter 4);
5. It has introduced key themes relating to classification, issue analysis and policy implications for further consideration in the final report (chapter 4).

The next steps in the project are the data collection and writing of the case examples, and in-depth analysis of nomenclature, classification issues, and policy issues and implications. These will be addressed in the final report. The final report will provide an evidence base for consideration by the policy community of ways to further develop integrated housing, support and care services, alongside the other housing and aged care programs that constitute the Australian community's response to the housing and care needs of its expanding, ageing population.

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APPENDICES

Appendix 1: Methods for the international literature review

The international and Australian literature review was based on a comprehensive search of the academic and industry literature conducted in 2006. The following electronic databases were searched:

- Social Services Abstracts
- Sociological Abstracts
- Family and Society Plus
- Australian Public Affairs Information Service.

The following search terms, and combinations of these terms, were used in searching the four databases:

Search terms

<i>Column 1</i>	<i>Column 2</i>	<i>Column 3</i>
Housing	Age*	Services
Accommodation	Ageing	Car*
Place	Senior*	Support*
Home	Elder*	
Villag*	Old*	
	Retir*	

During the search term stage, abstracts were read and references were selected with the following broad parameters in mind:

- housing and care/support options;
- housing and care models;
- housing and care for the frail aged; and
- independent living.

An initial selection of references was undertaken for their relevance as per the broad parameters listed above. A second selection eliminated references that appeared peripheral to the main focus of the research. The search of the four databases sourced 181 references from Australian and international material.

Further identification of material was undertaken through searching relevant bibliographies and reference lists of articles retrieved in the database search and on the basis of 'key terms' identified during the initial search. These key terms included:

Australia:

Community Care; Community Based Care; Community Care Services; Home Care; Home Services; Independent Living; Granny Flats; Day Care Programs; Aged Care; Aged Care Services; Ageing In Place; Independent Living Units; Seniors Housing; Affordable Housing; Social Housing; Abbeyfield; Retirement Village; Home and Community Care (HACC); Home Renovation Service (Vic); Group (shared) Housing Program (Vic); Assistance with Care and Housing for the Aged (ACHA) (1993–?); Healthy Older People Program (Sydney); Moveable Units Program (Vic) (1975);

USA:

Assisted Living Facility(ies) (ALFs); Assisted Living Services (ALS); Congregate Housing (CH); Congregate Housing Facility(ies); Leisure Oriented Retirement Communities (LORCs); Ageing In Place; Continuing Care Retirement Communities (CCRCs); Continuing/Life Care Facilities; Public Senior Housing (PSH); Subsidized Senior Housing; Senior Housing; Residential Care; Supportive Housing; Supportive Living Environments; Planned Independent Housing (1970's), Small-Scale Congregate Residences; Enriched Senior High Rise Apartments; Homesharing Agencies; Residential [Living] Care Facilities (RLCFS); Long-Term Care (LTC); Shared Housing; Nursing Homes; Group Housing; Multigenerational Households; Home Health Care; Accessory Apartments; Intermediate Housing Models; Small Group Home; Resident Services Coordinator Program; Area Agencies on Aging (AAA); Shared Aide Program (Cluster Care); Homecare Suite; Enriched Housing Program; Share-A-Home (1980-?); NORC Supportive Service Program (NY); Congregate Housing Services Program (CHSP) (1978)

Canada:

Homesharing Agencies; Ageing-In-Place;

United Kingdom:

Extra Care Housing; Sheltered Housing; Very Sheltered Housing; Public Sheltered Housing; Abbeyfield; Supported Housing; Should I Stay or Should I Go (Care & Repair)

European Union:

Ageing-In-Place; Home Care; Care Homes; Assisted Living; Independent Living; Co-Housing; Sheltered Housing; Planned Housing; Inter-Sectoral Coordination

Denmark:

Sheltered Housing; Long-Term Care

Sweden:

Group Living (GL)

Netherlands:

Home Care; Care Homes;

Asia:

Multigenerational Households; Elderly Care; Community Care Approach; Long-Term Care; Extended Family Care;

India:

Free Homes, For-Pay Homes; Old-Age Homes;

Israel:

Multigenerational Housing; Sheltered Housing; Age-Integrated Living; Assisted Living Facility(ies); 'Supportive Community'.

Appendix 2: Interview schedule for the case studies

Introduction

Thank you for your assistance with our research project.

We are developing a series of case studies of forms of accommodation for older people that bring together the provision of housing, support and care.

This study has been commissioned by the Australian Housing and Urban Research Institute (AHURI), a national research consortium funded by the Commonwealth and state governments and 13 Australian universities.

We are members of a research group located at The University of Queensland, under the direction of A/Prof Andrew Jones, who is leading this research project.

We would like to ask a number of questions concerning your service/project, and generally have a discussion about the service/product, the ideas underlying it, what it provides, what it aims to achieve for residents, and similar matters.

The concept

We would like to begin by asking you about the ideas that underpin your service/product.

1. In broad terms, what kind of service/product are you aiming to provide?
2. What concepts or set of ideas underpin the service or product?
 - What values and beliefs (philosophy) underpin the service or product?
 - What perception of need or demand underpins the service or product?
 - What is the evidence or basis for this perception of need or demand?
3. Where does the concept underlying the service or product come from?
 - Is it based on other Australian services or products?
 - Is it based on international models?
 - Has it evolved or been adapted from other services or models?
4. In summary, what is the rationale for the service or product? Why is it being provided or developed?
5. Does experience thus far justify or bring into question this rationale?

The proponent

Now we would like to turn to the issue of the organisation, groups and individuals who have been involved in the development of this service/product.

6. Who was responsible for initiating the product or service?
 - Whose idea was it?
 - Has there been a person or group of people who were influential in the development of the service/product?
7. Who is or was responsible for the development of the product or service?
 - Which companies or organisations have been involved in the development of the service/product?
 - What have been their roles?
8. Who is or will be responsible for the management of the product or service?
 - What is the management structure?
9. Who is responsible for the funding or financing of the service, and what is the funding or financing structure?
 - What (if any) have been the structures and processes for private investment?

- What (if any) has been the role of public funding?
 - What (if any) has been the role of philanthropic funding?
10. Are there any plans for extension of these services or products or for development of similar services/products?

The housing form and location

Let us now look at the service/product in more detail. Let us start with the location and form of the housing.

11. What is the geographic location of the dwelling (if not already known)?
- [We need the local authority, the state/territory, the street address, the suburb, and any specific geographic features – views, surrounding developments, built-up area or isolated, relation to transport, etc]
12. What were the factors that led to this choice of location?
- Its appeal to potential residents?
 - Its proximity to services and convenience? Which services?
 - Considerations of land cost and land availability?
 - Its proximity to potential residents?
 - Other factors?
13. How would you describe the overall housing development?
- Form - high-rise, low-rise, or campus style?
 - Scale – large to small, number of units of accommodation?
 - Quality – luxury to affordable?
 - Facilities – which? Extensive or limited?
14. What are the characteristics of the individual dwellings?
- Type – self-contained apartments, separate houses, studio apartments, bed-sitters, single rooms?
 - Size – number of bedrooms, sq. metres?
 - Quality – luxury to affordable?
 - Furnished, semi-furnished, unfurnished??
 - Design (access, suitable for older people, use of assistive technology, etc.)?
15. To what extent and in what ways does the housing address issues of environmental support, i.e. how is the physical environment designed to maximize independence and support lifestyle?
16. How do the location, the characteristics of the overall development, and the characteristics of individual dwellings relate to the underlying concept of the development that we discussed earlier?
- What is the rationale for the location and the physical structure of the development (overall and rooms)?
 - Does experience thus far justify or bring into question decisions made concerning housing form and location?

Support and care services

17. What range and intensity of care and support services are provided? In particular, what provision is made for (see Table 1):

- Assistance with self-care – bathing, toileting, dressing, eating, personal grooming?
- Meal preparation – delivered meals, restaurant service?
- Domestic work – washing and ironing, shopping, linen service, household management?
- Property maintenance – household repairs, grounds, facility and garden maintenance?
- Transport – to appointments, shopping, etc.?
- Social activity and recreation, including recreational facilities?
- Health care – home nursing, allied health, medication assistance, on-call nursing care?
- Life planning and management – assistance in organising other care providers including community care services?

18. Under what conditions are support and care services provided?

- Are care and support services included in a standard service package or can services be obtained or purchased on an optional basis as needs and preferences change?
- What role does the housing organisation play in organising care and support services provided by other organisations such as community care providers
- Are there limits to the level of support and care that can be provided?
- Are support and care services provided on-site, or in other locations?
- Are services provided by paid workers, by volunteers, or on the basis of mutual aid?
- Is or is there not clear separation between the housing provider and the support and care provider?
- How are support and care services funded?

19. What is the rationale for the support and care arrangements, and how do these relate to the underlying concept?

20. Does experience thus far justify or bring into question decisions made concerning provision of support and care?

The consumers or market

21. Which consumer group or market segment is the target of the service/product?

- Are there any eligibility requirements or criteria?
- Are any types of older people given priority, or are any excluded?
- Is the service or product aimed at older people with low, medium or high need for support and care?
- Is the service or product aimed at older people with complex needs? What types of complex needs?

- Is the service or product aimed at older people in particular age groups (50s, 60s or older?), or any other market segments?
- Is the service or product aimed at older people in the high, medium or low-income and wealth group?
- What are the entry and ongoing charges?

22. Does experience thus far justify or bring into question decisions made concerning the consumer group or market?

The terms of provision

23. What legislation or other governmental requirements govern or influence the operation of the service/product?

- Does the service or product operate under the provisions of retirement village legislation? With what impacts?
- What other legislative or regulatory requirements govern the operation of the service, e.g. residential tenancies, urban planning requirements? What impacts do these have on the operational or financial viability of the development?
- Does the service or product operate under any funding conditions, and what impacts do these have?
- What requirements or agreements relating to accessible, adaptable or universal housing design have impacted on the development?

24. What are the management structures for the service or product, and what opportunities are there for resident input, feedback or decision-making?

- Is there an on-site manager and what other staff are involved in the management of the service/facility?

25. What is the form of tenure under which residents occupy the housing?

- Do tenants own, lease, or rent their dwelling?
- What is the rationale for this arrangement?

26. Does experience thus far justify or bring into question decisions made concerning the terms of provision?

27. Are there any other matters relating to your service/product that we need to understand?

Thank you very much for your assistance with our study.

A report on our study will be available on the AHURI website in the near future.

GLOSSARY OF TERMS

Abbeyfield housing

A form of group housing for older people first developed in the United Kingdom and developed on a small scale in Australia. The living environment consists of approximately ten separate, unfurnished bed-sit rooms located in a communal dwelling, with common dining, living and laundry facilities. The communal environment encourages a community atmosphere, mutual aid, and companionship. Main meals preparation and cleaning of shared areas is provided by a housekeeper, with residents maintaining their own rooms and doing their own laundry.

Active adult retirement community (AARC)

This term is used in the United States to refer to retirement communities designed to attract retirees, often from the young-old, who are active, fully independent, and (often) affluent. They may provide access to a range of lifestyle activities including golf, tennis, swimming, club house, etc. Other terms used in the United States context are leisure oriented retirement community, retirement community, retirement resort, retirement new town, retirement village, and retirement housing for special affinity groups. These types of development are sometimes referred to in Australia as Lifestyle villages.

Apartments for life

A European housing model for older people in which residents are guaranteed housing continuity for life, with care, health and other services provided in the older person's dwelling. A small number of community organisations in Australia are currently developing housing projects based on this model.

Assisted living facility (ALF)

A term used widely in the United States to refer to a housing option that involves the delivery of professionally managed supportive services in a group setting that is residential in character and appearance. The intent of assisted living is to accommodate physically and mentally frail older adults without imposing a heavily regulated, institutional environment. ALFs accommodate frail older people who need significant levels of assistance with daily living, but who do not require continuous nursing care.

The term is increasingly used in the Australian context to refer to similar services provided in retirement villages such as serviced apartments. This term is proposed as a category of integrated housing, support and care in this report, defined as 'congregate living arrangements for older persons requiring a significant level of assistance with activities of daily living including self-care and ongoing health care assistance' (Table 3).

Board and care homes

In the United States context, a housing facility for older people or people with disabilities who wish or need to be in a group living situation and who may need assistance with personal care and daily living activities. They are often located in converted single family houses and provide food, shelter, assistance with tasks of daily living, and supervision.

Boarding house

Boarding houses, also known in Australia as rooming houses and private hotels, provide low-cost accommodation for low-income people, mainly in inner-city areas of

larger cities. They provide long-term single or shared rooms, often furnished, and usually shared bathroom, kitchen and laundry facilities. In many but not all boarding and rooming houses meals and serviced rooms may be provided. Historically, most boarding houses have been provided by the private sector, but the community and public sectors are also involved in boarding house provision. Boarding houses are available to people of all ages, and accommodate significant numbers of older people, especially older men.

Close care

See very sheltered housing.

Co-housing

A European housing model involving households of various ages opting to live together as part of a supportive community, with a mix of personal and public spaces.

Collective home care

Arrangements in which an organisation provides a range of home care services to a designated group of older persons living in their own homes in close proximity to one another. See naturally occurring retirement community.

Community aged care package (CACP)

Packages of community care services provided as part of the Australian aged care system to older people assessed as eligible for entry to residential care. These packages provide the equivalent of low-level residential aged care in the older person's home.

Community care

In the Australian aged care context, community care, also known as home and community care, refers to the provision of aged care services in an older person's home. Formal community care services are provided through the Home and Community Care program (HACC) and through community aged care packages (CACP) and packages provided through the Extended Aged Care in the Home program (EACH). Most community care is provided informally through family members and friends.

Congregate seniors housing (CSH)

A term used in the United States to refer to housing provided on a congregate basis for older people who receive some common services but who require only minimal assistance with activities of daily living. The term emerged in the context of the Congregate Housing Services Program, a federal program providing assistance to public and non-profit housing projects to provide meals and other supportive services to increasingly dependent populations.

Continuing care retirement community (CCRC)

A term used in the United States to refer to complexes which provide a continuum of care from independent living through to nursing care within the same community. Also known as lifecare communities.

This term is proposed as a category of integrated housing, support and care in this report, defined as 'Congregate living arrangements for older persons characterised by continuity of care within the same facility or location ranging from independent living through to high-level nursing care' (Table 3).

Enriched housing

See service-enriched housing.

Extended Aged Care in the Home (EACH)

Packages of community care services provided as part of the Australian aged care system to older people assessed as eligible for entry to residential care. These packages provide the equivalent of high-level residential aged care in the older person's home.

Extra care housing

A term used in the United Kingdom to refer to housing schemes that provide extra support to older people to enable them to live as independently as possible and retain their own tenancy. It is designed for older people who are physically or mentally frail and need extra help to manage, and who might otherwise need residential or nursing care. Extra care housing typically provides an on-site care team to meet needs flexibly twenty-four hours a day.

Extra care services

Some Australian retirement villages offer 'extra care' services on a user pay basis to those residing in independent living units. Services may include assistance with self-care, home nursing, meals, laundry services, transport services and domestic help.

Flexi-apartment

A term used in some Australian retirement villages to refer to apartments in which self-care, health and other support services are available for purchase on an optional basis.

Group or shared housing

This term is proposed as a category of integrated housing, support and care in this report. Group or shared housing is defined as 'living arrangements for older people where at least two, and usually no more than fifteen, related persons live together in a dwelling unit with a mix of shared and private facilities with the aim of providing a supportive and caring environment' (Table 3).

Heavy service housing

A term used in Finland to refer to service housing with higher levels of care.

Home care

A term used in the United States to refer to the provision of aged care services in an older person's home. It is also referred to as 'in-home care' or 'long-term care'. In Australia the more common term is community care or home and community care.

Home health care

A term used in the United States to refer to the provision of health care services in an older person's home.

Home share

An organised arrangement designed to assist older people to continue to live in their homes by providing a match with another, usually younger person, able to provide assistance, security and companionship in return for inexpensive or free accommodation.

Hostel

Prior to the 1997 Commonwealth Aged Care Act, 'low care' residential aged care services were referred to as hostels. Initially funded under the Aged Persons Homes Act, 1954 as low-cost, shared accommodation for older people, hostels gradually came to provide higher levels of care such that by the 1990s they had become the lower level of care tier of Australia's two-tier residential aged care system (alongside higher care nursing homes). In 1997, hostels and nursing homes were combined into an integrated residential aged care system, providing aged care to older people of all levels of dependency.

Independent living facility (ILF)

A term used in the United States to refer to a seniors-restricted complex for those able to live independently. An ILF may provide minimal services other than buildings and grounds maintenance, or a wider array of services may be provided. According to some definitions, if a common dining facility is provided the facility is no longer an ILF and has become congregate seniors housing.

Independent living unit (ILU)

In the Australian context, this term is used specifically to refer to dwellings provided by community sector organisations that were originally funded under the Aged Persons Homes Act, 1954. These dwellings are provided for older people with low income and limited assets and are usually provided in a small-scale campus setting. They are provided either on a rental basis or on the basis of a modest entry contribution (usually less than \$100,000). See McNelis 2004 for further detail.

The term is also used to refer to the dwellings of those living independently in retirement villages. These dwellings are also referred to as self care units.

Leisure-oriented retirement community (LORC)

See active adult retirement community.

Lifecare community (or facility)

A term used in the United States to refer to continuing care retirement communities.

Lifestyle village

An Australian term referring to retirement villages that are focused on lifestyle, including recreational and social activities.

Long-term care (LTC)

A term used in the United States to refer to the long-term provision of aged care services in an older person's home, often as an alternative to care in a nursing home. It is also referred to as 'in-home care' or 'home care'. In Australia the more common terms are community care and home and community care.

Manufactured home estate

A term used in Australia to refer to a residential park comprising prefabricated manufactured homes. The resident purchases the home and pays rent and/or charges for land and facilities.

Multigenerational household

This term refers to a household where two adult generations live together, with or without minor children. These households include those with one or more adults aged 65 and over, where the older person is receiving and/or providing accommodation and care and support.

Multigenerational housing models

Housing models involving older people and younger families living in close proximity (e.g. within the same block of apartments) with the aim of providing mutual support and care.

Naturally occurring retirement community (NORC)

Naturally occurring retirement communities are suburbs, neighbourhoods or buildings where as a consequence of the 'ageing in place' of the local population, or other factors, a high concentration of older people has occurred. They are distinguished from planned retirement communities that are specifically designed to accommodate older people. The term is mainly used in the United States. A number of government and non-government organisations have developed supportive service programs to enable older people living in NORCs to successfully age in place.

Nursing home

In the Australian context, a nursing home is a residential aged care facility providing accommodation, nursing care and support to older people no longer able to live independently in their own home. Prior to the 1997 Commonwealth Aged Care Act, Australia's residential aged care system comprised 'low-care' hostels and 'high-care' nursing homes. In 1997, hostels and nursing homes were combined into an integrated residential aged care system, providing aged care to older people of all levels of dependency, and collectively referred to as 'aged care facilities'. See also skilled nursing facility.

Public seniors' housing

Housing for older people provided in the public housing system.

Renter by choice

This term refers to an older person who chooses to rent rather than own their dwelling. 'Renter by choice' has been developed as a model of housing provision for older people by some Australian companies.

Residential aged care or Residential aged care home

Aged care provided for older people in residential or institutional settings. In Australia the two main forms of residential aged care have been hostels and nursing homes. These two forms of residential aged care services were combined into an integrated residential aged care system in 1997, and the term residential aged care home is widely used in Australia to refer to all such services.

Residential park

A park comprising caravans and cabins where rent and/or charges are paid for the land and use of facilities. Caravans may be owner-occupied or rented.

Retirement community

See active adult retirement community.

Retirement housing

A generic term for housing of any form that is built for and marketed to people in later life.

Retirement housing for special affinity groups

Housing built for and marketed to people in later life who have a common interest, e.g. former academics, former military officers, older gay people, etc.

Retirement resort

See active adult retirement community.

Retirement town (or new town)

This term is used in the United States to refer to retirement communities on a township scale designed to attract retirees, often from the young-old, who are active, fully independent, and (often) affluent. They may provide access to a range of lifestyle activities including golf, tennis, swimming, club house, etc. See active adult retirement community.

Retirement village

In the Australian context, this term broadly refers to a housing complex comprising multiple dwellings primarily designed for people in later life, and involving the provision of communal facilities and services. Residents are usually deemed to be 'independent', meaning that they do not require the level of care and support associated with residential aged care facilities. The legal definition of a 'retirement village' in state and territory legislation is usually somewhat more restrictive and includes reference to particular types of tenure arrangements.

In the United States context, the term can have a somewhat different meaning, referring to large-scale, planned retirement developments, often offering recreational activities and security.

Self-care unit

A term used in the Australian context to refer to the dwellings of those living independently in retirement villages. These dwellings are also referred to as independent living units.

Seniors housing

A generic term referring to all housing specifically designed for occupancy by people in later life. In the Australian context this most commonly refers to housing for people aged 65 and over, but the term can also be used to refer to people aged 55 and over.

Service housing

Term used in Sweden and Finland to refer to non-institutional housing with care for older people. Independent accommodation is provided in housing blocks, with access to a range of in-house facilities and to home care services.

Service-enriched housing (SEH)

A generic term (also called supportive housing and enriched housing) used in the United States to refer to living arrangements for older people able to live independently with the assistance of a range of services in an accessible, supportive environment. This term is proposed as a category of integrated housing, support and care in this report and defined as 'congregate living arrangements for older persons deemed able to live independently, but involving the provision of services such as meals, and/or domestic assistance, and/or low-level self-care and health assistance' (Table 3).

Serviced apartment

In the Australian older person's housing context, a serviced apartment is a one or two-bedroom apartment located within a retirement village that provides supported accommodation for residents who require some assistance with daily living. Services such as cleaning, laundry and assistance with self-care activities are usually provided.

Meals are often provided in a dining room setting, and a small kitchenette may also be included within the apartment.

Shared housing

Shared housing is a situation in which at least two unrelated persons live together in a dwelling unit, each having their own private space and sharing other common areas, such as kitchen, living and dining rooms. Shared housing can be self-initiated, agency-assisted, or agency-sponsored.

Sheltered housing

A term used in the United Kingdom to refer to small, purpose-built accommodation for older people involving private space and shared facilities, with limited support and care and the services of an on-site warden. The term is also used in a number of other countries, including The Netherlands, Canada and Singapore, to refer to a range of types of service-enriched housing.

Skilled nursing facility (SNF)

A term used in the United States to refer to a residential facility for older people requiring high levels of nursing care, broadly equivalent to a nursing home in the Australian context.

Supportive community

'Supportive communities' have operated in Israel since the 1990s and provide support and care for about 200 members who remain living in their own home. The supportive community organisation coordinates the provision of support services, and there is a 24-hour emergency call service available. A range of services are coordinated ranging from medical services to minor home repairs. They are mainly located in areas that are densely populated by older people

Supported residential service (SRS)

In many Australian states there are facilities which provide accommodation and care for people with disabilities, including frail, older people, who need support in tasks of daily living. These are variously known as supported accommodation (Queensland), licensed residential centres (NSW), supported residential facilities (South Australia), and supported residential services (Victoria). They are usually provided by the private sector, and are not part of the residential aged care system. Accommodation is in furnished single or shared rooms. Care provided usually includes assistance with showering, personal hygiene, dressing, meals and medication, as well as physical and emotional support.

Supportive housing

See service-enriched housing.

Vertical village

An Australian term that refers to a retirement village located in a high-rise apartment building.

Very sheltered housing

A term used in the United Kingdom to refer to sheltered housing that provides meals, as well as additional levels of care. Other terms used are close care and assisted living.

Virtual retirement community

A term used in the United States to refer to the coordinated provision of support, home care and home health services in a local community. See also naturally occurring retirement community.

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