



*Final Report*

# Service integrated housing for Australians 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
ACSA	Aged and Community Services Australia
ADPHA	Aged and Disabled Persons Homes Act
AHURI	Australian Housing and Urban Research Institute
AIHW	Australian Institute of Health and Welfare
ALF	Assisted Living Facilities
ANUHD	Australian Network for Universal Housing Design
APHA	Aged Persons Homes Act
CACP	Community Aged Care Package
CCRC	Continuing care retirement communities
CSH	Congregate seniors housing
CHSP	Congregate Housing Services Program
COP	Community Options Project
CSHA	Commonwealth-State Housing Agreement
DOHA	Department of Health and Ageing
DTRD	Department of Transport and Regional Development
EACH	Extended Aged Care in the Home
EACH-D	Extended Aged Care in the Home – Dementia
EU	European Union
FAHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
HCBC	Home and Community Based Care
HACC	Home and Community Care
IAHSA	International Association of Homes and Services for the Aged
ILF	Independent living facility
ILU	Independent living unit
LORC	Leisure oriented retirement community
LTC	Long term care
MACC	Mercy Arms Community Care
NAHA	National Affordable Housing Agreement
NORC	Naturally occurring retirement community

NPA	National Partnership Agreement
NRAS	National Rental Affordability Scheme
RACH	Residential aged care home
RCS	Resident Classification Scale
RVAA	Retirement Village Association of Australia
RVCP	Retirement Villages Care Pilot
SAAP	Supported Accommodation Assistance Program
SHA	State and Territory housing authority
SNF	Skilled nursing facility
SRO	Single room occupancy
SRS	Supported residential service
UK	United Kingdom
US	United States

# EXECUTIVE SUMMARY

## *Aims, context and definition*

The aim of the study is to analyse the diversity and types of service integrated housing that have been developed in Australia, and to consider the policy and research implications. It includes examination of the implications of international experience with service integrated housing for Australia. The term service integrated housing refers to:

all forms of housing for people in later life where the housing provider deliberately makes available or arranges for one or more types of support and care, in conjunction with the housing provision.

Interest in this form of housing provision derives from the ageing of the Australian population, and the impacts of disability and frailty on the capacity of many individuals and households to manage the tasks of daily life in the domestic housing environment without support. While the majority of those in need of assistance live in the general community with care from formal services and /or family or other informal carers, a proportion live in a range of purpose-built housing for older people that also provides varying levels of support and care services. Little systematic information is available on these forms of housing and the services they provide, but there is increasing recognition that as the period of later life for many Australians lengthens, and as the overall number of older Australians grows, greater consideration needs to be given to the range of housing and care choices available to older Australians.

In order to provide a foundation for improved understanding of service integrated housing, this research project addresses the following objectives:

1. To clearly identify and define service integrated housing as an approach to the provision of housing, support and care in later life in Australia that is intermediate between delivery of community care to people living in the general community and residential aged care.
2. To outline the historical development of service integrated housing in Australia, and show how this pattern of development has shaped the size and organisation of the sector, and the predominance of certain service types.
3. To place the development of service integrated housing in Australia in an international context, and to clarify the terminology used in Australia and internationally as a foundation for more rigorous use of terminology and more systematic international comparison.
4. To provide a classification of the various forms of service integrated housing in Australia.
5. To provide case examples of the various forms of service integrated housing in the contemporary Australian context, and thus illustrate the diversification that has occurred.
6. To identify and consider the policy and research issues associated with the future development of service integrated housing.

## *Service integrated housing as a component of aged care*

In the Australian context the main form of service integrated housing is the retirement village. However, 'retirement village' is now an umbrella term that encompasses a range of different kinds of service integrated housing. Some retirement villages focus on recreational activities and these are often referred to as lifestyle villages. However,

most are concerned with providing a supportive environment for older people, and an increasing number are catering for older people requiring care as well as support in serviced apartments and assisted living facilities. Many are also involved in assisting 'self-care' retirement village residents to access community care services. Several new forms of retirement village are also emerging, including affordable rental villages for low-income, low-asset aged pensioners.

There are also important developments in service integrated housing outside of the retirement village sector. Service integrated housing is provided through many of the independent living units built for older people from the 1950s to the 1980s, as well as in supported residential services and in some boarding houses and manufactured homes estates. Service integrated housing is provided to many older people with complex needs, particularly older people at risk of homelessness. There are also well-established services such as Abbeyfield Housing, and experimental models such as Apartments for Life.

Service integrated housing has received far less policy attention in Australia in recent years than community care and residential care. However, with an estimated 130,000 residents, service integrated housing is comparable in size to residential aged care with an estimated 165,000 residents (permanent and respite). There are also close linkages and inter-connections between service integrated housing and other aged care services. There are strong grounds for arguing that service integrated housing should be viewed as the third component of aged care in Australia intermediate between community care and residential care as shown in Figure 2 (p. 30), and that the role of service integrated housing should be given greater recognition in policy and research.

### *The historical development of service integrated housing*

One reason for the limited policy attention to service integrated housing is its complex history which is portrayed in Figure 1 (p. 14). The history of service integrated housing can be understood in terms of four tiers of development, underpinned by the growth of community care services. The first tier was the development of independent living units by community organisations from the 1950s to the 1980s. However, the cessation of government capital funding meant that policy subsequently neglected these developments. The second tier took the form of hostels whose growth was accelerated by the introduction of care subsidies for hostel residents in 1969 and new legislation in 1972. However, over time the balance of hostel roles shifted away from accommodation towards a greater emphasis on care, bringing them closer to nursing homes. This transformation was completed when hostels and nursing homes were brought together under the *Aged Care Act 1997*. The third tier was the development and diversification of retirement villages by community and private sector organisations since the 1970s. While shaped indirectly by aged care policies, and in part filling the gap left by these policies, this development has come about without an explicit policy framework. The fourth and as yet small tier of service integrated housing comprises a number of innovative projects developed to address the needs of particular groups, including insecurely housed and homeless older people who require special support, and older people who lack the financial resources to buy into retirement villages.

These developments came about at the same time as home and community care services were expanding. Delivering these services themselves or drawing on services delivered by other agencies gave housing providers much of the service component for new service integrated housing arrangements. Community care can thus be seen as a general infrastructure supporting residents living in various forms of

housing purposely built for older people as well as serving those living in the wider community.

The consequences of this somewhat untidy history are that service integrated housing lacks both a clear identity and a continuous history of government involvement. Important types of service integrated housing such as independent living units and hostels were discontinued or deflected to other purposes, and the main form of service integrated housing, retirement villages, were developed by the community and private sectors with limited government direction. Public sector leadership has been restricted to specific and relatively small areas, such as service integrated housing for homeless and insecurely housed older people. Australia has an extensive service integrated housing sector, but its contribution towards meeting the accommodation and care needs of older Australians has received little policy recognition.

### *The international context*

To understand the future of service integrated housing in Australia, and the roles that public policy might play, it is instructive to look at service integrated housing in comparable overseas countries such as the US, the UK and the countries of Europe. All of these countries have many forms of service integrated housing, but the wide range of terms used to describe service integrated housing has made international comparison difficult. The international translation chart provided in this report (Table 2 and full chart at the end of the report) addresses this issue. It defines over 90 terms referring to types of service integrated housing, and identifies the international equivalents to Australian terms and housing forms.

There is much to be learnt from the international experience as shown in Chapter 3. One central message is that in the US, the UK and most European countries, service integrated housing has emerged as a key service sector for older people, alongside community care and residential aged care. For example, almost one million people live in assisted living facilities in the US. Similarly, in the UK sheltered housing provides approximately 400,000 units of accommodation and has been at the centre of public policy debate about housing, support and care for older people.

The international experience also shows that there are three broad sub-types or clusters of service integrated housing that are present in the UK, the US and many European countries. Firstly, there is service integrated housing offering lifestyle and recreation. The strongest tradition of this sub-type is in the US where such housing forms are referred to as 'active adult retirement communities', 'leisure oriented retirement communities', 'retirement housing for special affinity groups' and 'retirement resorts'. In Australia the most commonly used term is 'lifestyle village'.

Secondly, there is service integrated housing offering support. Support includes such features and services as barrier-free environments, on-site management, general property maintenance, social and recreational activities, group transport, limited supervision including personal alert/emergency call systems and social support. In the United States these housing forms are known by terms including independent living facilities and board and care homes. In the UK such housing is called sheltered housing, a term also used in the Netherlands, Canada, Germany and Israel. Some forms of co-housing for older people in Europe, and Abbeyfield Housing as it has been adapted in Australia, also fall into this category. The 'self-care' and 'independent living' units in Australian retirement villages are the main Australian examples, together with independent living units that offer some support, affordable rental villages, and some boarding houses and manufactured home estates.

Thirdly, there is service integrated housing offering support and care. In addition to 'support services', care services may include property maintenance in response to

individual needs, assistance with domestic work (cooking, cleaning, laundry, shopping and household management), individualised transport service, assistance with self-care (bathing, toileting, dressing, grooming, eating, medication), nursing care, allied health services and case management and counselling. In the US this category includes congregate seniors housing, assisted living facilities and continuing care retirement communities. In the UK it includes very sheltered housing, extra care housing and some retirement communities. In some European countries it is termed service housing and heavy service housing. The Netherlands' model of apartments for life also falls within this category. In Australia this form of housing is provided in retirement villages as serviced apartments and assisted living, and by the provision of community care services to retirement village residents.

The international experience of service integrated housing shows that the roles played by the public, private and community sectors in service integrated housing provision can vary widely from country to country. For example, in the US the public policy framework is relatively weak, and the private sector has played the main role in developing new forms of service integrated housing. The community sector has been active in extending service integrated housing to lower income-groups. In the UK, the public sector has taken a leading role in the development of service integrated housing. Sheltered housing and extra-care housing has mainly been provided by local authorities and housing associations operating within an explicit national policy framework. In the UK the private sector has played only a minor role.

### *Classifying service integrated housing*

The three broad sub-types or clusters of service integrated housing identified in the international context are helpful in describing the nature and pattern of service integrated housing in Australia. However, if we are to understand the composition and shape of service integrated housing it is helpful to develop a more detailed classification system. There are many different dimensions of service integrated housing including sector, tenure arrangements, dwelling structure or form, physical form, size and scale, design, level and types of services, service arrangements, market, geographic location, and age-range. Classifying the different forms of service integrated housing based on a selection of these variables assists in understanding the range of 'possible permutations and combinations' and provides a conceptual foundation for detailed, empirical analysis.

A classification of service integrated housing developments in Australia is developed in Chapter 4 and presented in Figure 4 (p. 66). It is built around three variables: the sector of the organisation providing the housing; the dwelling form; and the nature of service provision arrangements.

The *sector* of the organisation responsible for the housing component of service integrated housing is a fundamental and defining characteristic. Each of the three sectors – private, community and public – has a distinctive history and role in service integrated housing, as well as more general characteristics that shape its current and emerging roles. The *dwelling form* of a service integrated housing development is of fundamental importance as it affects the way that housing is experienced by residents and the ways that services are provided. Three main types of dwelling form are distinguished: detached villa; private apartment and shared, non-private dwelling. The *service arrangements* for provision of care services are the third variable. An external service arrangement is where the housing provider relies on delivery from an external agency, overwhelmingly HACC agencies, that are separate to the housing provider. Internal service arrangements are where the housing provider takes a role in providing care services, either by providing services directly or facilitating access to services and making arrangements with service providers.

The three sectors x three housing forms x two service arrangements result in 18 possible categories for describing older persons' service integrated housing. All forms of service integrated housing can be located within one of these categories. Hence, the classification provides a means for identifying the most prevalent forms of service integrated housing as well as forms that are under-represented either because they are under-developed or are unlikely to develop for one reason or another. The classification may also identify 'boutique' cases that can be noted as such, especially if they have some features that are likely to limit wider take up.

### *Applying the classification to cases*

In Chapter 5, 14 case examples of a diversity of service integrated housing arrangements in Australia are presented, using the classification categories as the descriptive framework. As well as illustrating the utility of the classification scheme, the case examples illustrate the diversity of types of service integrated housing that have developed in Australia. The case examples cover 11 of the 18 categories shown in Figure 4, and examples falling into the remaining categories are also identified.

The classification and case examples suggest patterns of likely associations amongst variables that would be found were a large-scale study of service integrated housing in Australia to be undertaken, and the overall patterns that are likely to emerge under current policy settings. Based on the case studies and the historical material presented in Chapter 2 a number of generalisations concerning the roles of the community, private and public sectors in service integrated housing can be made.

It has been the community and private sectors that have played the main roles in the development of service integrated housing in Australia since the 1980s. The resident-funded financing model involving residents purchasing the right to occupy retirement village units with the proceeds of the sale of the family house, and paying management fees and a deferred management fee, has enabled both sectors to develop retirement villages without public subsidy. In the community sector many of the organisations developing retirement villages have been the same organisations involved in provision of aged care services including both community care and residential aged care homes. This has enabled many organisations to offer residents of retirement villages the possibility of moving to co-located or closely located aged care facilities as their care needs increase. It has also opened up the possibility of providing community care services to residents of their retirement villages, and has provided the experience and expertise to develop serviced apartments and assisted living facilities within retirement villages. Many of the community sector providers of retirement villages are large state-wide or nation-wide providers of services to older people, with affiliations to church or welfare organisations. The community sector is also the main provider of service integrated housing to older people with complex needs, and the sponsor of innovative developments in service integrated housing.

The private sector's involvement in service integrated housing has also been predominantly through retirement villages, although private sector organisations are also involved in supported residential services, manufactured home estates and boarding houses. The sector includes large providers of retirement villages across the country and smaller operators of single villages. There is a great diversity of private sector retirement village developments catering to the luxury, medium priced and affordable segments of the market. The private sector has pioneered affordable rental villages for low-income, low-asset older people. Many private sector retirement villages have developed support and care services such as serviced apartments and assisted living facilities, and have shown considerable interest in expanding their role in provision of support and care to their residents. Many private sector providers of retirement villages have experience as providers of residential aged care homes,

especially high care, although their involvement in provision of community care has thus far been minor.

By contrast with the community and private sectors, the public sector has played a relatively minor role in service integrated housing. The Australian Government was initially involved in stimulating the involvement of the community sector in retirement villages through its capital grants for independent living units, hostels and nursing homes from the 1950s to the 1980s. But since the 1980s the attention of the Australian Government in this broad area has mainly been focused on home and community care and residential aged care homes, and capital funding has been largely withdrawn. The extensive development of retirement villages since the 1980s has occurred largely without direct public sector funding or provision. The Australian Government has been involved through the CSHA in providing housing for older people in public housing, but this has not involved direct funding or support for service integrated housing in public and community housing, other than in a few isolated examples. The main form of support from the Australian Government for service integrated housing has been for older people with complex needs through programs such as the Assistance with Care and Housing for the Aged program, and there have been some similar programs at the state level. However, the Retirement Villages – Ageing in Place initiative may pave the way for a renewal of interest by the Australian Government in mainstream service integrated housing and provide a platform for more extensive involvement in the future.

State and Territory Governments have only a low level of involvement in service integrated housing, mainly around regulation linked to consumer protection of retirement village residents. In some states planning policies and regulations address issues of the location and standards of housing for older people, including service integrated housing, but these regulations are far from standard across the country. Some state housing authorities and community housing facilities supported by state housing authorities have developed support programs for older public housing residents with complex needs, but these are small scale.

### *The future – drivers of change*

It is not possible to provide a definitive analysis of the drivers of change in service integrated housing in Australia without further research. However, on the basis of the analysis presented in this report, six key drivers can be tentatively identified, three on the demand side and three on the supply side.

The first driver on the demand side is the ageing of the Australian population which will increase demand for all forms of services for older people including service integrated housing. The number and proportion of Australians aged 65 and over living in retirement villages has been steadily increasing over the past two decades. These trends are set to continue especially from around 2020 when many baby boomers will be entering their 70s. A high proportion of people entering later life over the next two decades are home owners who will have the capacity to sell their home and purchase a place in a retirement village. The scale on which retirement villages have grown shows that they have been accepted by many consumers. It seems likely that the diverse forms of service integrated housing offered by retirement villages will continue to appeal to segments of the older population looking for or requiring a supportive living environment and/or the lifestyle offered by retirement villages, and with the means to make the choice.

The second driver is the likely demand for service integrated housing offering a significant level of care, but less than that offered in residential aged care homes (RACHs). This is the experience of the US in the form of assisted living, and in the UK



in the form of extra-care housing. In the Australian context, as residential aged care homes have become increasingly targeted to older people with high-care needs, it seems likely that housing options that offer significant levels of care outside of RACHs will be in high demand. This is evidenced by the increasing number of private and community sector providers offering assisted living, in part as an alternative to low-care RACH. However, we lack comprehensive data on demand for all forms of service integrated housing in Australia, and this is an area for further research.

The third demand-side driver is the current and emerging need for service integrated housing for older people who do not have a housing asset or other financial resources to enter the mainstream retirement village industry, but whose frailty or disability is such that they require some level of support and care. There are three main groups of such older people who are likely to require service integrated housing. The first group are those living in inappropriate, unsupported and often expensive housing in the private rental market. While this group can access community care services, it is often the case that physical and social aspects of their housing circumstances make effective provision of community care difficult and they would in many cases benefit from more supportive living arrangements. The second group are older public housing tenants whose needs for support and care services are increasing. The third group are older people with complex needs who in many cases are insecurely housed, at risk of homelessness, or homeless. There will be a continuing demand for service integrated housing for this small population. Many in this client group are relatively young and stabilising housing and ensuring access to basic services as they enter old age can improve wellbeing and moderate their needs for higher levels of on-going support and care as they age.

On the supply side, the primary drivers of service integrated housing are to be found in the characteristics of the overall retirement village industry. There has been no major study of the retirement village industry since Stimson's study published in 2002, and in the absence of detailed recent research, predictions concerning the future of the industry have to be based on piecemeal evidence and so are necessarily somewhat speculative. Stimson predicted significant future expansion of the industry, and a continuation of the trend of the past three decades which has seen retirement villages firmly established as the fastest growing type of housing oriented to the needs of older people in Australia. Stimson based his analysis on the ageing of the population, and the likelihood of increased market penetration as providers responded to different market segments and developed new village forms. He foresaw greater concentration of ownership and management and maturation of the industry as a whole. His predictions of continuing industry growth were affirmed by the number of retirement village residents enumerated in the 2006 census. Uncertainties in the Australian residential property market generated by the global financial crisis in 2008 and 2009 appear to have had a short-term negative impact on demand for retirement villages and some disruption to the industry as a whole. However, there is no compelling evidence to suggest that the short-term issues facing the industry in the wake of the global financial crisis invalidate Stimson's longer-term predictions.

Within the retirement industry, further drivers of the supply of service integrated housing are the relative capacities of the community and private sectors. Many large, community sector providers of retirement villages hold a competitive advantage over private sector providers insofar as they are also providers of both community care and RACHs. This facilitates the provision of HACC and CACP and EACH packages to residents in community sector retirement villages and the provision of assisted living services by staff located nearby in community care or RACH services. It also facilitates service integrated housing in the form of three-tier complexes, and day care services using the facilities of either retirement villages or RACHs. By contrast, private

sector providers of retirement villages are only minor providers of community care services at this stage, although their role has grown and may continue to grow in line with increases in CACP provision. The capacity of retirement village providers to readily access community care services for their residents is a major driver of service integrated housing. While the Retirement Village – Ageing in Place initiative encouraged all retirement village operators to apply for allocation of CACP places and the related approved provider status, it seems likely that community sector retirement village providers will be best placed to take advantage of this opportunity.

The final set of drivers is the renewed interest since 2007 in housing policy by the Australian Government. Policy initiatives such as the National Partnership Agreement on Homelessness, the National Partnership Agreement on Social Housing, the Social Housing Initiative and the National Rental Affordability Scheme indicate the renewed and strong emphasis in current Australian Government policy on expanding the availability of social and affordable housing and reducing homelessness. Many of these initiatives have direct implications for the housing of older Australians. The emphasis on older people in the NPA on homelessness is an extension of the Australian Government's longstanding involvement in provision of service integrated housing for older people with complex needs. Expansion of social and affordable housing provision through the NPA on social housing, the social housing initiative and NRAS will add to the stock of housing available to lower income, older renters. The emphasis on barrier-free design in all of these programs is an important step towards more supportive housing for older people.

Nevertheless, apart from the focus on older people in the NPA on homelessness, these policy initiatives do not directly address the issue of the supply of service integrated housing for older people. A question therefore remains: in a policy climate conducive to policy innovation and expansion in housing for older people, how can the provision of service integrated housing for older people be advanced?

### *Policy and research options*

One policy option is to *do nothing*. Service integrated housing has developed over the past 30 years with little or no policy direction and no direct funding or provision by government other than for people with complex needs. It might be argued that this represents a significant policy success, or at the least an example of successful policy by default. Policy settings that have seen the retirement village sector expand to some 130,000 units over 30 years without direct public investment can hardly be counted as a failure. This approach appears to have provided greater flexibility than seems to be apparent in many overseas models, and providers have been opportunistic and innovative in developing many models that work. Why consider new forms of policy intervention?

There are five answers to this rhetorical question.

Firstly, it can be argued that there are ways that policy interventions could *facilitate current trends* and enhance the roles that are being played by retirement village providers in service integrated housing. Over the last decade retirement villages have been diversifying, particularly in the ways that they provide care services to residents. This diversification includes the development of serviced apartments and assisted living arrangements and the provision of community care to 'self-care' residents through various internal and external arrangements for delivery of care services. One policy option would be to find ways to facilitate these trends, while still relying principally on the entrepreneurship of private and community sector operators to expand the volume and range of these options. This would involve the Australian Government moving from the 'hands off' approach that has prevailed to date to a

more 'hands on' approach that would facilitate, but not dictate, closer integration of service delivery with a variety of housing forms. By enabling community care services to be delivered in all forms of housing, the Australian Government has laid the foundation for a highly flexible and diverse approach to the provision of service integrated housing. This facilitative approach has been strengthened by the Retirement Villages – Ageing in Place initiative which provides further opportunities for retirement village operators to become involved in community care provision, albeit at this point on a small scale. This foundation could now be built on more widely.

Secondly, it can be argued that the *needs of low-income, low-asset older people* are not met in existing arrangements and that governments need to selectively intervene on behalf of this group of older people. The main limit of the mainstream retirement village model in Australia is that it is restricted to those who can pay the entry charge through sale of their family home or some equivalent funding source. Low income, older renters are thus excluded in most cases from retirement villages. It seems likely that as the number of low-income older renters increases, the demand for forms of supportive housing with care options will also increase.

If governments wish to increase access to service integrated housing for lower-income, low-wealth older renters, a number of options might be considered. One approach would be to further encourage the development of supportive housing developments for older, low-income people as part of the social housing initiative, the NPA on social housing, NRAS and/or similar future initiatives. Such housing developments might involve co-location of older people in new 'rental retirement villages' or by including a proportion of rental units in existing or proposed conventional retirement village developments. Ready access to community care provision would be included in the design of the housing development, and one responsibility of the manager of the housing service would be to facilitate provision of community care. The housing provider for such facilities could be a public housing authority, a community housing provider, a not-for-profit retirement village or aged care provider, or a private sector organisation.

Service integrated housing developments for lower-income low-wealth older renters such as those proposed above might restore, resurrect or recommission housing facilities developed as part of earlier public policies. The Social Housing Initiative and NRAS appear to present four particular opportunities for community sector providers to redevelop outdated accommodation that is in need of renewal. These opportunities could be pursued through a sub-program of NRAS to provide affordable service integrated housing. Firstly, redevelopment of a number of clusters of outdated ILUs has been under discussion for some years, but action has been slow to eventuate. A dedicated sub-program could be the trigger for action to refurbish the ILUs or rebuild on the sites. Secondly, the extensive restructuring of residential aged care over the last decade has seen the closure of some homes, particularly small homes. While the growth of larger homes has meant that the total number of places in RACH has increased, little is known about the exit pathways of homes that have closed. As restructuring of RACHs is continuing in line with rising standards required for buildings and care environments, more purposeful exit strategies could see some of these facilities and sites used as forms of service integrated housing at least on an interim basis, or redeveloped for this purpose. Thirdly, and more generally, some small, stand-alone low-care RACHs are reported to be experiencing difficulties in delivering higher levels of care, especially nursing care, to provide effectively for ageing-in-place. Rather than being lost to aged care altogether, providers of these facilities could be enabled to opt out of the residential aged care program to become part of a service integrated housing program, with care services delivered through community care packages. Fourthly, some public housing complexes comprising solely or mainly

of older people might also become part of a service integrated housing program by instigating deliberate arrangements for community care provision. A 'service integrated housing' program involving both new-build and redeveloped complexes would respond to the housing and care needs of a growing older population in a targeted and effective way as supplements to the generic programs aimed at increasing the supply of social and affordable housing.

Thirdly, a case can be made that there is a need to address the *geographic spread* of service integrated housing so that older people can adjust their housing while remaining in their familiar local neighbourhood and maintaining their local social networks. One measure would be the provision of information on the distribution of the current and projected aged population in relation to the distribution of various forms of older persons' housing. Such a database would serve an important function in supporting planning by providers in the private and community sectors. A second measure would be to promote more provision of service integrated housing in under-supplied localities. Joint ventures between public housing authorities and private or not-for-profit agencies are among the options available, particularly as part of urban redevelopment projects in inner-city areas and public housing redevelopments.

Fourthly, there is an argument for governments to play a role in *setting principles and developing guidelines for good practice* in the retirement village sector. The encouragement of good practice via practice standard and guides, codes of practice, rating scales and the like could well be an appropriate role of government in association with industry bodies. Standardisation of terminology to assist consumers to understand their options and what to expect from particular types of services could be one aim of such an approach. An example of one area where governments are already encouraging good practice is barrier-free design. The facilitative role that governments are playing in this area, in conjunction with organisations such as the Australian Network for Universal Housing Design, could be extended to a wider range of practice areas.

Finally, there is a strong argument for *developing a stronger evidence base* to underpin public policy. The development of policy options for service integrated housing in Australia is handicapped by the limited research evidence base. A first step would be to obtain data on the current level and type of provision in Australia. There has been no survey of retirement villages since 2000–2001. There is a need for a survey to determine the state of supply, using the classification system developed in this report and including information on emerging types of services such as serviced apartments, assisted living and affordable rental villages.

It is also important to make estimates of demand for service integrated housing in Australia. Without this information, it is not possible to assess with any certainty whether there is a sufficient volume of all or some of the options available. Demand could be estimated from demographic data, waiting lists and/or vacancies for various forms of service integrated housing, and market surveys undertaken by providers.

An important part of any study of supply and demand is the geographic distribution of services. A mapping exercise plotting the distribution of older persons housing against the distribution of the population aged 55+ would address the issue of the accessibility of service integrated housing for older people wishing to remain in their own locality, and provide guidance for the location of new facilities.

Another fundamental gap is data on the characteristics of the population in retirement villages and other forms of service integrated housing. This would provide a better understanding of the characteristics of those living in service integrated housing and how this differs from the overall population aged 65+. Data on the differences in the

characteristics of residents in different types of facilities will provide a better understanding of the relationship between different types of services and particular segments of the older population. Such data can make a valuable contribution by indicating the extent of matches between different segments of demand and supply of different types of service integrated housing, and especially point to demand that is going unmet.

Studies that further examine the constellation of factors underpinning the decision to move into service integrated housing are also required. There have been a number of mostly small-scale studies examining the 'push' and 'pull' factors associated with moves to retirement villages, but these factors need to be linked to the financial decision-making processes involved. It seems likely that there are many middle to low income home owners – the classic asset-rich-income poor – who are using the move to a retirement village to downsize, thereby releasing assets to boost an Age Pension income. Increased understanding of how these financial factors interact with the retirement incomes system, and how they combine with lifestyle and support factors to result in moves to retirement villages would be helpful in determining the kinds and levels of service integrated housing that offer viable responses to the diversity of housing and income needs of many older Australians.

Finally, there is a need for case studies or evaluations of a range of types of service integrated housing. More information is required on consumers' knowledge of and perceptions about service integrated housing, and on issues that have been more widely addressed in the international literature such as 'institutional drift', the quality of management practices, the capacity of service integrated housing to respond to continuing care needs as the care requirements of residents increase, and the cost effectiveness of service integrated housing compared to community care and residential care for residents with varying levels of dependency.

As well as generating a body of empirical data on service integrated housing, this research should inform the reconceptualisation of service integrated housing as the third component of the aged care system, intermediate between and interacting with community care delivered to individuals living in the general community and residential care.

### *Conclusion*

Retirement villages and other forms of service integrated housing have developed in Australia over the past 30 years mainly through initiatives of the community and private sectors. The key question that now arises, in a policy context characterised by renewed government interest in housing, concerns the ways in which a stronger leadership role could best be pursued. The strategies to this end identified in this report include facilitating the role of the community and private sectors in providing service integrated housing; addressing the need to expand the provision of service integrated housing to low-income, low-asset older people; addressing the geographic distribution of services; developing principles and guidelines for the operation of service integrated housing; and expanding the research evidence base.

# 1 INTRODUCTION

## 1.1 Aim and objectives

The aim of the study is to analyse the diversity and types of service integrated housing that have been developed in Australia, and to consider the policy and research implications. It is particularly concerned to examine the implications of international experience with service integrated housing for Australia. The term 'service integrated housing' refers to all forms of housing for people in later life where the housing provider deliberately makes available or arranges for one or more types of support and care, in conjunction with the housing provision. In broad terms, interest in this form of housing provision derives from the anticipated ageing of the Australian population in the early decades of the twenty-first century (ABS, 2003), and the impacts of disability and frailty on the capacity of many individuals and households to manage the tasks of daily life in the domestic housing environment (Howe, 1992, p. 87). Fewer than one in five of those aged 65 and over who have a limitation in activities of daily living are living in residential aged care homes, and only one in three of those with severe or profound limitations (Howe, 2008, p.16). While the majority of those in need of assistance live in the general community with care from formal services and /or family or other informal carers, a proportion live in a range of purpose-built housing for older people that also provides varying levels of support and care services. No systematic information is however available on these forms of housing and the services they provide, but there is increasing recognition that as the period of later life for many Australians lengthens, and as the overall number of older Australians grows, greater consideration needs to be given to the range of housing and care choices available to older Australians.

Australians in later life who require formal support and care services have three possible alternative living arrangements. Firstly, they can remain living in a private dwelling and have services provided in their home. In Australia these services are provided through the Home and Community Care (HACC) program and, for those with higher levels of dependency, through Community Aged Care Packages (CACP) and the Extended Aged Care in the Home (EACH) program. The second possible option, restricted to those with high levels of dependency, is to gain entry to a residential aged care home (RACH). These two forms of provision are the cornerstones of Australian aged care policy (Gibson, 1998). The third possible choice is that they can move into service integrated housing where support and care are provided as part of their living arrangements. The provision of service integrated housing, while widespread, has received less policy and research attention than aged care, although this is beginning to change (AIHW, 2006). This study aims to establish the basis for a more systematic approach to service integrated housing in Australia.

The provision of service integrated housing has a long history in Australia and internationally, especially in the countries of Europe and North America. In Australia, early examples included some of the independent living units developed by non-government organisations with Australian Government capital subsidies from the 1950s to the 1980s (Howe, 1982; McNelis, 2004). Many types of service integrated housing have been developed since the 1970s in the form of retirement villages, a term that now encompasses a wide diversity of housing forms and arrangements. This diversification has been accompanied by an increase in other forms of service integrated housing, including an increase in the number and range of arrangements targeted at older people with high and special needs. The historical development of service integrated housing in Australia is outlined in Chapter 2.

Internationally, there is also a wide diversity of types of service integrated housing and a profusion of terminology that makes international comparison difficult. In the US, service integrated housing includes leisure-oriented retirement communities, supportive housing, service-enriched housing, congregate housing, group housing, assisted living facilities and continuing care retirement communities. In the UK, service integrated housing has historically been known as sheltered housing, very sheltered housing and extra-care housing. More recently other models such as retirement communities and all age communities have been developed. In various other European countries other housing types have been provided including service-enriched and extra-care housing, small group housing, apartments for life, co-housing, collective home care, and various forms of multigenerational housing. This plethora of housing types and terms were reviewed in an earlier report on this research project (Jones, Tilse, Bartlett and Stimson, 2008), and are examined in Chapter 3.

Although the provision of service integrated housing for people in later life is widespread and well-established in Australia, as well as internationally, it is not well researched in the Australian context. In order to provide a foundation for improved understanding of this service sector and to scope the key research and policy issues, this research project addresses the following objectives:

1. To clearly identify and define service integrated housing as an approach to the provision of housing, support and care in later life in Australia that is intermediate between delivery of community care to people living in the general community and residential aged care.
2. To outline the historical development of service integrated housing in Australia, and show how this pattern of development has shaped the size and organisation of the sector, and the predominance of certain service types.
3. To place the development of service integrated housing in Australia in an international context, and to clarify the terminology used in Australia and internationally as a foundation for more rigorous use of terminology and more systematic international comparison.
4. To provide a classification of the various forms of service integrated housing in Australia.
5. To provide case examples of the various forms of service integrated housing in the contemporary Australian context, and thus illustrate the diversification that has occurred.
6. To identify and consider the policy and research issues associated with the future development of service integrated housing.

## **1.2 Definition**

The term 'service integrated housing' has been intentionally chosen to refer to all forms of housing for people in later life where the housing provider deliberately makes available or arranges for one or more types of support and care, in conjunction with the housing provision. The term has not previously been widely used in the Australian or international context. It is intended as a generic, analytical term to encompass a wide array of housing arrangements that are otherwise known by terms that have emerged in particular national, historical or legislative contexts. It replaces the somewhat awkward term 'integrated housing, support and care' that was used in the earlier report on this project (Jones, Tilse, Bartlett and Stimson, 2008).

The three defining characteristics of service integrated housing are:

1. It is a form of housing where the housing supplier makes deliberate provision for support and/or care services, either by direct provision or through arrangements with service providers. In this sense, service integrated housing is distinguishable from housing arrangements where care and support are initiated and organised by the householder or some other third party, such as a family carer.
2. It is a form of housing where support or support and care services are integral to the housing arrangements. Services may or may not be used by each and every resident, and may be made available to residents under a range of eligibility and payment arrangements. However, the availability of services associated with the housing is explicit, organised and intentional.
3. It is a form of housing in which the resident has the enjoyment of private space. In dwelling structures such as houses and apartments this means that a resident has 'his or her own front door'. In a communal dwelling it means the resident has their own room or suite that other residents and/or staff cannot usually enter without the agreement of the resident. In this sense, service integrated housing is distinguishable from nursing homes, residential aged care homes and other such living arrangements where residents may have their own room and en-suite bathroom, but do not usually have their own private space and have all meals provided.

Within this broad framework, service integrated housing takes many different forms. The housing supplier may be a public, community or not-for-profit, or private sector organisation. The form of tenure may be ownership, leasehold or rental. The type of dwelling may be a detached or semi-detached housing, a flat or unit, or a form of congregate housing. The layout of the housing complex may be campus-style, multi-storey (low or high rise) or dispersed. The complex may be small or large in scale. It may be specially designed for older people including various assistive technologies or it may have no such features. There may be high or low levels of care and support provision. Care and support services may be supplied by the housing provider or by a separate organisation at the instigation of the housing provider. Service integrated housing may be targeted at the upper, middle or lower price segments of the market. It may be located in inner-city, suburban, outer suburban, provincial city or rural areas. It may be exclusively provided for people in later life or be inclusive of several age groups including people in later life. These different aspects of the forms of service integrated housing are considered later in the report as part of the discussion of classification of service integrated housing arrangements.

As well as taking many different forms, service integrated housing can also involve the provision of many different types and combinations of care and support services. Even though the boundary between support and care is somewhat blurred, it is important to distinguish them. Support services are those services generally available to residents in service integrated housing that enhance their wellbeing and reduce their vulnerability to adverse events, both physical and social. They can include barrier-free environments, on-site management, general property maintenance, social and recreational activities, group transport, limited supervision including personal alert/emergency call systems, and social support. Generally individuals have a choice as to how far they avail themselves of most such services. Care services are those provided on a 1-to-1, 'as needed' basis to individuals whose wellbeing will be considerably compromised if they do not receive this care. They can include property services such as installation of aids and equipment in response to individual needs, assistance with domestic work (cooking, cleaning, laundry, linen, shopping and household management), individualised transport service, assistance with self-care



(bathing, toileting, dressing, grooming, eating, medication), nursing care, allied health services and case management and counselling.

The critical link between support and care is that good support in service integrated housing can reduce the need for 1-to-1 care, and hence the cost of services to individuals and government. For example, barrier free bathrooms with rails, hobless showers, non-slip surfaces, etc., can enable a person with quite a high level of handicap to shower independently instead of having to call on an informal carer or a personal care worker. Policy-makers and providers need to give considerable attention to strengthening the foundation of these supports rather than just increasing the level of care services that are provided in service integrated housing.

An established reference point for identifying the types of care and support services that may be provided in a housing context is the list of service types in the program guidelines for the Home and Community Care program (DOHA, 2007). This list covers:

- domestic assistance (cleaning, dishwashing, clothes washing and ironing, unaccompanied shopping and bill paying)
- social support (friendly visiting, letter writing for the person, accompanied shopping and bill paying, banking and telephone-based monitoring)
- personal care (assistance with daily self-care tasks such as eating, bathing, toileting, dressing, grooming, getting in and out of bed and moving about the house)
- centre-based day care (participation in structured group activities designed to support independent living and social interaction)
- meals and food services (delivered meals or assistance and advice with cooking meals in the person's home)
- respite care (assistance to a carer from a substitute carer)
- nursing care (professional care from a registered or enrolled nurse)
- allied health care (includes podiatry, occupational therapy, physiotherapy, social work, speech pathology and advice from a dietician or nutritionist)
- assessment, client care coordination and case management
- home maintenance (maintenance and repair of a person's home, garden and yard to keep the home in a safe and habitable condition)
- home modification (structural changes such as grab rails, hand rails, shower rails, ramps and appropriate tap sets; installation of emergency alarms and other safety and mobility aids; other minor renovations)
- provision of goods and equipment to assist a person's mobility, communication, reading, personal care or health care (e.g. incontinence pads, dressing aids, wheelchairs)
- linen service (provision and laundering)
- transport (taxi or bus service)
- counselling, information and advocacy.

While this list of services is oriented to provision to people living in private dwellings in neighbourhoods, it can be readily transposed to service integrated housing. Table 1 shows the types of support and care that can be provided in service integrated housing for older people categorised in terms of their relationship to:

- the physical environment
- household tasks
- social participation
- personal care
- nursing and other health care.

**Table 1: Types of support and care services provided in service integrated housing for older people, categorised by life activities**

<i>Life activities</i>	<i>Services</i>	<i>Mode of delivery in older persons' housing</i>
<b><i>Relating to the physical environment</i></b>		
Barrier-free environment and accessibility features	<p>Examples include:</p> <ul style="list-style-type: none"> <li>• low tech:               <ul style="list-style-type: none"> <li>- interior: wide doors for wheelchairs, non-slip floors in bathrooms</li> <li>- exterior: wider parking spaces, spoon gutters for wheelchair access</li> </ul> </li> <li>• intermediate tech:               <ul style="list-style-type: none"> <li>- movement activated lighting, temperature controlled hot water</li> </ul> </li> <li>• high tech:               <ul style="list-style-type: none"> <li>- surveillance systems triggered when no movement over given period</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Built into the housing and immediate environment to facilitate access for people with disabilities</li> <li>• Provide 'passive' support: resident does not have to actively engage with the feature to benefit from it</li> <li>• Increasing attention to environmental design to support independence and reduce need for personal care</li> </ul>
Property maintenance and modifications	<ul style="list-style-type: none"> <li>• On-site management</li> <li>• Grounds and garden maintenance</li> <li>• Household repairs</li> <li>• Minor modifications (e.g. grab rails, shower rails, taps)</li> <li>• Major modifications (e.g. hoists, ramps)</li> </ul>	<ul style="list-style-type: none"> <li>• Across the whole of the housing environment</li> <li>• Routinely delivered to all residents on a regular or periodic basis e.g. checking fire alarms</li> <li>• 1-to-1 in response to individual needs for repairs or modifications</li> </ul>
<b><i>Relating to household tasks</i></b>		
Assistance with meals	<ul style="list-style-type: none"> <li>• Meals</li> <li>• Nutrition, food preparation and storage advice</li> </ul>	<ul style="list-style-type: none"> <li>• Delivered meals or cooking in person's home</li> <li>• Available in on-site day centre, dining room, café or restaurant</li> </ul>
Assistance with domestic work	<ul style="list-style-type: none"> <li>• House cleaning, dishwashing</li> <li>• Clothes washing and ironing</li> <li>• Linen service</li> <li>• Shopping</li> <li>• Household management, e.g. paying bills, making telephone calls,</li> </ul>	<ul style="list-style-type: none"> <li>• 1-to-1</li> <li>• On 'as needed' basis or needs assessed basis if using subsidised service</li> <li>• May be available from housing operator or from outside service</li> </ul>

<i>Life activities</i>	<i>Services</i>	<i>Mode of delivery in older persons' housing</i>
	etc.	<ul style="list-style-type: none"> <li>• Charges may be income related</li> </ul>
Transport	<ul style="list-style-type: none"> <li>• Transport to and from appointments, shopping</li> <li>• Group transport for recreation, shopping, etc.</li> </ul>	<ul style="list-style-type: none"> <li>• 1-to-1 on 'as needed' basis</li> <li>• Participation in group transport at resident's choice</li> </ul>
<b><i>Relating to social participation</i></b>		
Convenience services	<ul style="list-style-type: none"> <li>• Kiosk or news agency</li> <li>• Hairdresser</li> </ul>	<ul style="list-style-type: none"> <li>• On-site</li> <li>• Visiting services</li> <li>• Used at resident's choice</li> </ul>
Social activity and recreation	<ul style="list-style-type: none"> <li>• Friendships among residents</li> <li>• Friendly visiting and companionship</li> <li>• Centre-based social activity, e.g. exercise classes, cards, movies</li> <li>• Provision and maintenance of recreational facilities, e.g. swimming pools, sporting facilities, recreational areas, hobby rooms, workshops, libraries</li> <li>• Organised activities, outings, trips, holidays</li> </ul>	<ul style="list-style-type: none"> <li>• On-site and at other locations</li> <li>• Participation at resident's choice</li> <li>• Payment covered in part by service fees and in part by users paying when they engage in activities</li> </ul>
<b><i>Relating to personal care</i></b>		
Supervision	<ul style="list-style-type: none"> <li>• Personal alert/emergency call systems</li> <li>• Medication assistance</li> </ul>	<ul style="list-style-type: none"> <li>• 1-to-1, requires resident to activate as needed</li> </ul>
Self-care	<ul style="list-style-type: none"> <li>• Bathing/showering and toileting</li> <li>• Dressing and personal grooming, e.g. shaving, hairdressing, make-up</li> <li>• Assistance with eating</li> <li>• Provision of goods and equipment, e.g. dressings, wheelchairs</li> </ul>	<ul style="list-style-type: none"> <li>• 1-to-1, on basis of assessed need</li> <li>• Delivered by external provider and/or internally by housing provider</li> <li>• Combination of subsidised services and user pays</li> </ul>
Caring	<ul style="list-style-type: none"> <li>• Attendance at day centre</li> <li>• Short stay respite admission to residential care, including specialised dementia care</li> <li>• Support for carers – counselling, self-help groups</li> </ul>	<ul style="list-style-type: none"> <li>• 1-to-1 on as-needs basis</li> <li>• On-site or at other location</li> </ul>

<i>Life activities</i>	<i>Services</i>	<i>Mode of delivery in older persons' housing</i>
Life planning and management	<ul style="list-style-type: none"> <li>• Information, advocacy</li> <li>• Service coordination and case management</li> </ul>	<ul style="list-style-type: none"> <li>• 1-to-1 on 'as needed' basis</li> <li>• At time of admission, then in response to significant changes in care needs</li> <li>• May involve Aged Care Assessment Team at any time and required when move to RACH under consideration</li> </ul>
<i>Relating to nursing and other health care</i>		
Nursing care	<ul style="list-style-type: none"> <li>• Nursing</li> </ul>	<ul style="list-style-type: none"> <li>• 1-to-1 on 'as needed' basis</li> <li>• On-site nursing for short-term needs</li> <li>• On-going nursing care almost always delivered by external nursing services</li> </ul>
Other health care	<ul style="list-style-type: none"> <li>• General practitioner</li> <li>• Allied health (mainly podiatry, occupational therapy, physiotherapy, pharmacy)</li> </ul>	<ul style="list-style-type: none"> <li>• 1-to-1 on 'as needed' basis</li> <li>• Group sessions</li> <li>• Visiting professionals <ul style="list-style-type: none"> <li>- In resident's dwelling</li> <li>- In dedicated treatment rooms provided on-site</li> </ul> </li> <li>• Resident attends community health centre, day centre or day hospital, on-site or at other location</li> </ul>

### 1.3 Policy significance

Service integrated housing has historically received limited policy attention, although there are signs that this is now changing (see Chapter 6). This lack of policy recognition probably reflects the absence of direct public funding, especially capital funding, of this sector, other than for a small number of services to high need groups (see Chapter 2). It also reflects the central role of the community and private sectors, and the relatively limited role of the public sector, in service provision. Direct policy involvement in the sector has mainly been limited to legislation regarding the financial operation of retirement villages and related issues of consumer protection. The sector has otherwise remained largely outside the purview of public policy for housing and aged care, although growth in the sector has been stimulated indirectly since the mid-1980s by changes to funding of hostels (low care residential aged care homes) and changes to capital funding of residential aged care homes under the *Aged Care Act 1997* (Chapter 2).

Despite this limited policy attention, service integrated housing has grown in size to become a significant segment of overall housing provision for people in later life. One corollary of restricted policy recognition is the absence of comprehensive or standardised data on the number of persons living in this form of housing, or on the number of housing facilities of this kind across the country. The best estimate of the number of persons and households in service integrated housing for older persons is derived from census data on retirement village residents. The 2006 census enumerated 88,950 households in which the household reference person was aged 65 and over living in retirement villages in self-contained accommodation (ABS, 2006). Of these households, 62,768 were lone-person households. Assuming that most other households were couple households, this indicates a total population in retirement villages of some 127,808 persons aged 65 and over, which is 4.8 percent of the population aged 65 and over. With respect to the population aged 85 and over, retirement village residents comprise 8.6 percent of the population. It is important to note that it is likely that a significant number of dwellings for older people offering integrated care and support services are not enumerated as retirement villages in the census. For example, the census enumerated 8,978 households in which the household reference person was aged 65 and over living in manufactured home estates. There are also other housing developments offering care and support services but not structured as retirement villages whose residents are not included in the census enumeration of retirement village residents.

By way of comparison, the 2006 census enumerated 154,437 persons (5.8 percent of the population aged 65 and over) in 'nursing homes' (94,247 persons) and 'accommodation for the retired aged (not self-contained)' (60,190 persons) (ABS, 2006). This suggests that the service integrated housing sector and the residential aged care sector are somewhat comparable in size. This similarity puts the policy neglect of service integrated housing into perspective. The residential aged care sector is closely monitored and regulated and receives widespread policy attention. The service integrated housing sector has received far less consideration.

There are two sets of arguments for service integrated housing to receive greater policy attention. Firstly, the size, scope, distribution and quality of service integrated housing are matters that are in themselves of substantial public interest. A small but growing proportion of older people depend on this sector for their housing, support and care, and there is a public interest in the quality of the housing and services provided, and in the availability of service integrated housing to all segments of the older population, especially those with modest or low income. Issues include the protection of residents with respect to security of tenure and service quality, the

quality of management, and the design and location of service integrated housing developments.

Secondly, service integrated housing sector interacts in important ways on other areas of public policy, including aged care and the provision of affordable housing to people in later life. Service integrated housing can play important roles in reducing demand for residential aged care homes, which are facing strong demand pressures in line with the growth and ageing of the older population. It can also play a role in meeting the housing needs of older people with low or no housing assets who often have very limited options for moving to more supportive accommodation. Increased access to service integrated housing for those with modest housing assets can also have wider implications for housing and urban development. As well as achieving better outcomes for older individuals who relocate to service integrated housing, it may be that their former housing adds to the stock of housing available to younger home buyers and renters. Furthermore, the medium density form of most service integrated housing can contribute to urban consolidation objectives and free mostly lower density family housing in established localities.

For these reasons, and in light of the anticipated large increases in the number and proportion of older people in the population in coming decades, service integrated housing requires a far greater level of attention than has been the case over the last two decades. Recent government announcements indicate that opportunities for renewed policy discussion and service development are opening up. This study does not attempt to address the full range of policy issues in detail. Rather it aims to provide a foundation for further research and analysis by clearly identifying and defining this sector as a third approach to the provision of housing and care in later life in the Australian context. This task includes locating the sector in historical and international comparative context; classifying the various forms of service integrated housing; providing case examples of many of these different forms; and identifying key issues for further research and policy analysis.

## **1.4 Methods and overview**

The research methods used corresponded to the research objectives of the study. There were five stages to the research, and each adopted a different methodology. The stages are reported in the chapters of this final report as follows.

Stage 1 comprised a review of the Australian literature on service integrated housing, including independent living units, retirement villages and housing for older people with special needs. This review was reported in the positioning paper (Jones, Tilse, Bartlett and Stimson, 2008) and is developed further in this report in Chapter 2. This overview identifies and defines service integrated housing as a third approach to the provision of care and support in later life in Australia, and traces its historical development (research objectives 1 and 2).

Stage 2 comprised a review of the international literature on service integrated housing, with particular attention to service integrated housing in the US, the UK and Europe. A detailed review of this literature was provided in the positioning paper (Jones, Tilse, Bartlett and Stimson, 2008). In this final report, international developments are compared and contrasted with the development of service integrated housing in Australia. The complex terminology used to describe various forms of service integrated housing both in Australia and internationally is discussed and an international translation chart is developed to show the similarities and differences between various forms of service integrated housing in different national contexts (Chapter 3). This provides a foundation for more rigorous use of terminology and more systematic international comparison (research objective 3).

Stages 3 and 4 involved the development of a classification of the various forms of service integrated housing in Australia, and the presentation of case studies illustrating the different types of service integrated housing in Australia (research objectives 4 and 5). Details of the process of developing the classification system are presented in Chapter 4 and the case study methodology and case studies are provided in Chapter 5. The classification provides a foundation for understanding the range and types of service integrated housing that can be provided, and a basis for more detailed consideration of the policy and research issues associated with the service integrated housing sector (research objective 6). Drawing on the findings of all earlier chapters, these policy and research issues are identified and discussed in the fifth and final stage of the project, reported in Chapter 6.

## **1.5 Summary**

Service integrated housing can be viewed as the third set of choices to be made available to Australians in later life requiring formal support and care as part of their living arrangements. While the provision of service integrated housing has become widespread both in Australia and internationally, it has received far less policy and research attention than developments in community care and residential aged care. This study aims to establish the basis for a more systematic approach to the understanding of service integrated housing provision in Australia. This is done by tracing the history of service integrated housing in Australia; by developing a framework and terminology for more rigorous international comparison; by constructing a classification system of types of service integrated housing; by illustrating the classification with case examples; and by identifying the key policy and research issues.



## 2 HISTORY

### 2.1 Introduction

The historical development of service integrated housing for older Australians has not been a straightforward process. As in many areas of public policy, the history of this service sector has been marked by major changes in legislation and shifts in public expenditure priorities. While the early development of service integrated housing in Australia was shaped by explicit public policy initiatives, attention to the direction that developments in the sector were taking lapsed over time. Programs supporting aged persons' housing commenced in the 1950s and ceased in the mid-1980s, and from that time, housing became increasingly separated from residential aged care. Residential aged care became the focus of policy attention, and a major review of older persons housing in the early 1990s observed that past program guidelines created problems for innovative approaches that did not fit neatly within the boundaries for either aged care or housing programs. Developments that sought to unpack elements of recurrent funding for care and capital funding for accommodation that were tied together in existing programs and recombine them in new and more flexible ways made little progress (Howe, 1992, pp. 90–3). Further policy changes since that time widened the gap between residential care and housing for older people. While this outcome went largely unnoticed in formal policy, initiatives taken by the community and private sectors saw a number of developments in service integrated housing that aimed to fill some of this gap and point to options for the future.

Understanding this history is important. One major impediment to the introduction of explicit policies to develop service integrated housing in Australia is the lack of a prior history of systematic government involvement. Furthermore, any policy initiatives in this area must be cognisant of the strands of services involved and their historical antecedents. A concerted approach to developing service integrated housing must take account of the roles that significant organisations and sectors have played over time, the reasons for historical developments to this point, and relations with other policy and service areas.

In order to unravel the historical growth of service integrated housing in Australia, five sets of developments can be briefly traced. These are:

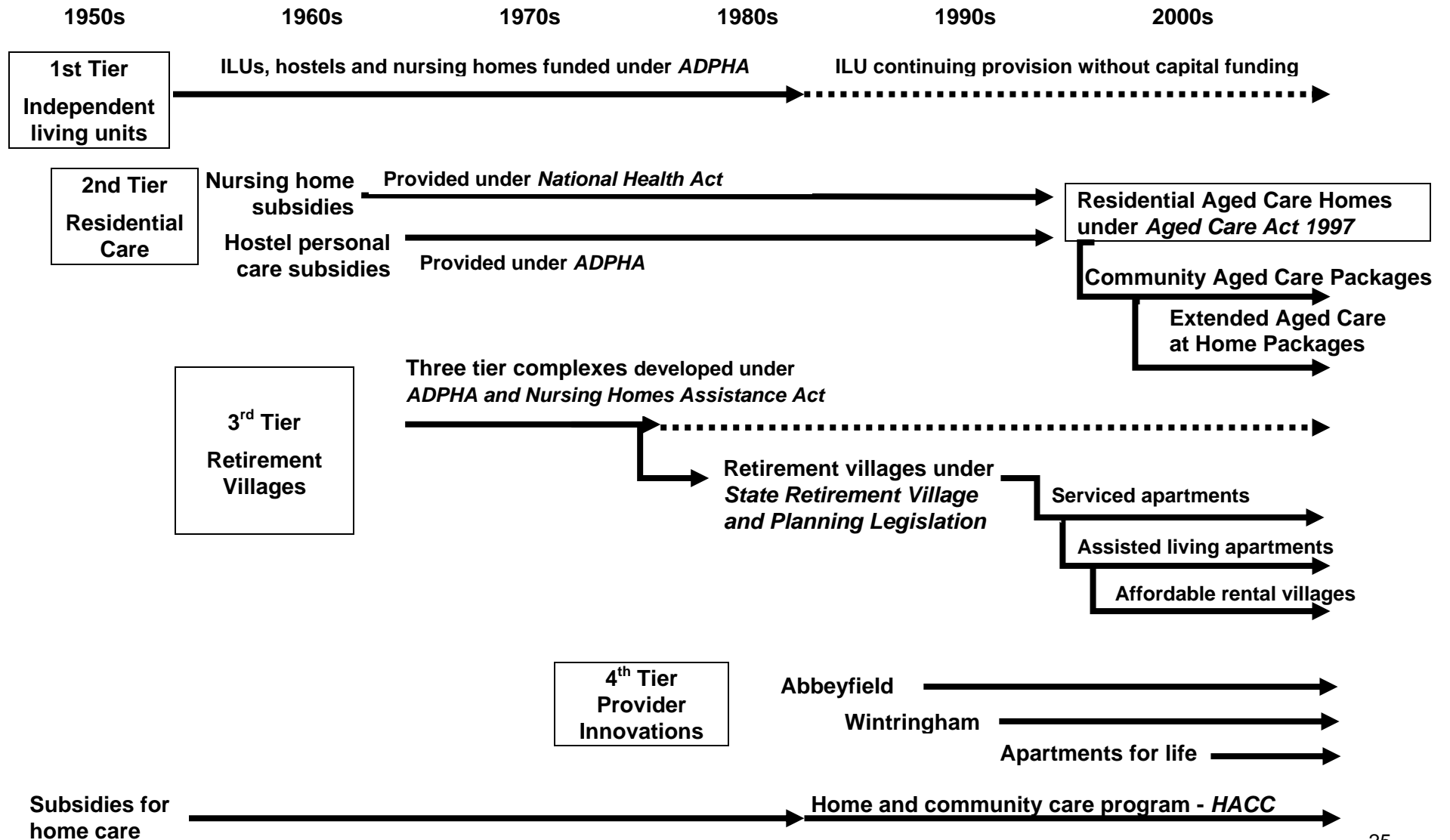
1. Independent living units developed by community organisations from the 1950s to the 1980s built the first tier of service integrated housing in Australia, but the cessation of capital funding meant that policy subsequently neglected these developments.
2. A second tier of service integrated housing in the form of hostels was advanced with the introduction of care subsidies for hostel residents in 1969 and new legislation in 1972, but over time, the balance of hostel roles shifted away from accommodation towards a greater emphasis on care, bringing them closer to nursing homes. This transformation was completed when hostels and nursing homes were brought together under the *Aged Care Act 1997* which established a single residential aged care program. Not only was service integrated housing side-lined from public funding and policy, but a gap was left between growing provision of residential aged care and a shrinking supply of housing with less intense levels of support and care.
3. The development and diversification of retirement villages by community and private sector organisations since the 1970s has emerged as the third tier and main location for service integrated housing in Australia. While shaped

indirectly by aged care policies, and in part filling the gap left by these policies, this development has come about without an explicit policy framework.

4. The fourth and as yet small tier of service integrated housing comprises a number of innovative projects developed to address the needs of particular groups who generally lacked the capital resources to buy into retirement villages and required special support. Since the late 1980s, one set of initiatives have addressed provision of service integrated housing arrangements for older people who are marginally housed or homeless since the late 1980s. More recently, since the mid-1990s, community sector organisations and, to a lesser extent, state sector organisations, have experimented with a range of other forms of service integrated housing.
5. All of these developments have come about at the same time as home and community care services were expanding. Delivering these services themselves or drawing on services delivered by other agencies gave housing providers much of the service component for new service integrated housing arrangements. Community care can thus be seen as a general infrastructure supporting residents living in various forms of housing purposely built for older people as well as serving those living in the wider community.

These developments are depicted in Figure 1 and discussed in the following sections of the chapter.

Figure 1: Historical development of housing and aged care services for older people in Australia since the 1950s



## **2.2 The 1st tier: development and subsequent policy neglect of independent living units**

The origins of service integrated housing in Australia are to be found in the history of the independent living units (ILUs) developed by church-based and other non-profit organisations during the period 1954 to 1986. A number of these organisations had provided housing for low-income older people prior to 1954. But in that year the Australian Government passed the *Aged Persons Homes Act 1954* (APHA) which funded a major boost to housing provision for older people (McNelis, 2004, p. 7). The APHA provided matching capital grants to community organisations to provide affordable, independent housing for lower-income older people, and between 1954 and 1986 approximately 34,700 independent living units (ILUs) were built in Australia under the terms of this legislation.

The APHA imposed few conditions on the church and community organisations providing housing for older people. Notably, the types of housing to be provided and the rules governing allocation of housing to older people were largely left to the discretion of the provider organisations. As a consequence, three factors that came into play during the 1960s saw the initial goals of APHA being deflected from the intended purpose of providing independent housing to low-income older people (Howe, 1982). Firstly, housing provided under the program became available not solely to low-income individuals but also to those able to provide a non-returnable 'in-going donation' to the community organisation which was used to attract the matching Australian Government subsidy. Secondly, small 'sick bays' that had been included with independent living unit developments become eligible for receipt of nursing home benefits that were introduced in 1963 under the National Health Act, giving provider organisations the incentive to expand their provision of nursing homes using capital funding available through AHPA. This trend was given added impetus by deficit financing arrangements introduced in 1974 that covered operating deficits of not-for-profit nursing homes. Thirdly, some ILU developments had included hostel accommodation to cater for less independent residents and over time it became apparent that many hostel residents and older people living in ILUs required support and care as well as housing. In recognition of these needs, the *Aged and Disabled Persons Homes Act* (ADPHA) introduced in 1969 provided a Personal Care Subsidy as well as capital grants. The subsequent growth of hostels and nursing homes by non-profit organisations far outstripped the continuing development of ILUs, and combined with construction of nursing homes by private sector providers, residential aged care became increasingly developed separately from housing for older people.

Capital funding under the APHA and ADPHA was discontinued in the mid-1980s when the program was superseded by new policy and funding arrangements for both residential and community aged care on one hand, and on the other hand by new arrangements under the Commonwealth-State Housing Agreement (CSHA) for the funding of targeted, affordable, independent rental housing for low-income older people (Jones, Bell, Tilse and Earl, 2007, pp. 79–80). From the mid-1980s, Australian Government funding for housing of older people was channelled through the CSHA for rental housing for low-income older people able to live independently.

The APHA and ADPHA left three legacies to service integrated housing. The most tangible was some 34,700 purpose-built ILUs owned and operated by community sector organisations. Many of the dwellings continue to be available for the housing of older people in the early twenty-first century. They are predominantly cottage-type dwellings, built at low densities on mainly small but well located sites with less than fifty units. Their older style means that these ILUs have come once again to cater primarily for households of limited assets and low incomes. They have received little

policy attention since the 1980s and 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 since the 1980s have not been linked to any public policy goals. Much of the existing stock of ILUs 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 is unclear. In a major review, McNelis argued the need for those organisations managing ILUs ‘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, 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 one third of their residents require assistance such as formal or informal support, practical assistance, personal care or home nursing. Approximately 35 percent of 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 home-based aged care services receiving funding from the HACC, CACP and EACH programs, and some four out of five are also providers of residential aged care homes, sometimes on the same or a contiguous site as the ILUs. Outreach community care programs run by these organisations 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 service integrated housing although this is not widely or formally recognised (McNelis, 2004, pp. 49–52). The extensive experience and capacity of these organisations, together with the capital assets held in land and buildings, makes for a strong platform for new initiatives in service integrated housing through the redevelopment of ILUs. Recognising and realising this potential would give these providers and the non-profit sector overall a clear mission for the future and fill what is currently a significant policy vacuum (McNelis, 2004).

The second legacy was the transfer of the ‘ingoing donations’ to a model of resident funding for retirement villages. The stimulus to the growth of retirement villages provided by this funding model is discussed further in section 2.4.

The third legacy was the development of higher levels of community care to make up for the growing shortfall of hostel places. Through the late 1980s, and notwithstanding considerable increases in the number of hostels, provision remained well below the targets set to bring about a shift in the balance of hostel places to nursing home beds. To avoid a loss of capital and recurrent funding budgeted for hostels, these funds were reallocated to new community care programs funded fully by the Australian Government without cost-shared contributions from the States. The growth of community care package programs is taken up in section 2.5.

As well as laying the foundations for service integrated housing, these three legacies mean that the APHA made a significant contribution to the continuing development of the sector, and arguably to its future development. It was also an important contributor to the development of hostels as a second tier of service integrated housing until hostels were merged into the single residential aged care program. This growth and transformation are discussed in the next section.

## 2.3 The 2nd tier: transformation of hostels into residential aged care homes

The historical development of service integrated housing has also been shaped by the historical evolution of residential aged care homes in Australia. As discussed in section 2.2, the capital funding of independent housing for low income, older people, and of hostels and nursing homes under the APHA was supplemented from the mid-1960s with other measures that funded care services in both settings. Initially, the APHA envisaged two types of housing services: independent housing provided on small, campus settings and hostels which were conceived as low-cost, independent accommodation in a shared building with limited support and supervision (Australian Parliament, 1982, p. 48).

Hostels as initially conceived were clearly a form of service integrated housing, and the *Aged and Disabled Persons Hostels Act 1969* was modelled on the APHA, and so had its origins in housing policy. In contrast, the origins of nursing home subsidies funded under the National Health Act lay in the health insurance and hospital system. Convergence of these different pathways over time saw the accommodation function of hostels become secondary to provision of care, and this process of transformation was completed when the merging of hostels and nursing homes into a single residential aged care system cut off any connection with policies and programs for aged persons' housing.

The change in hostels from a form of service integrated housing to a form of residential aged care home was advanced from the late 1960s, through extension of capital subsidies and provision of the recurrent personal care subsidies under ADPHA. Hostels were increasingly encouraged to cater for frail older people with some level of dependency, and by the 1970s, hostels were viewed as providers of care for frail older people with 'low' levels of dependency (Baldwin, 1982, pp. 18–19). Continuation of this trend saw growing concern on the part of providers that hostels were caring for residents with care needs equivalent to those in nursing homes but without commensurate funding.

These changes to recurrent funding served as a magnet to draw capital funding under the APHA increasingly towards construction of nursing homes and hostels rather than ILUs. While these care benefits were also paid to nursing homes in the public and private sectors, the Nursing Homes Assistance Act provided additional funding to non-profit providers from 1974 to cover operating deficits. This last measure added to the stimulus for non-profit providers to build nursing homes and from the late 1970s to mid-1980s, nursing home beds accounted for over half the places receiving capital funding through the APHA each year (Gibson, 1998, pp. 29–30). Although number of new hostel places stabilised, the combined nursing home and hostel places meant the non-profit sector came to dominate residential aged care, and from the mid-1970s to the present time has persistently accounted for around two thirds of all provision. Notwithstanding growth controls implements in the early 1970s, the number of nursing home beds continued to grow rapidly and by 1985, the 75,281 nursing home beds outnumbered the 35,250 hostel places by more than two to one (Department of Community Services, 1986, p. 25).

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 this period, the boundaries of 'aged care' as a policy and service sector that included residential care and home and community care but excluded service integrated

housing, were clearly established. Developments in home and community care during this period are discussed in section 2.6. The Aged Care Reform Strategy maintained the distinction between nursing homes and hostels and sought to shift the balance towards more hostel provision. This goal was only partially realised. The absolute number of hostel places continued to increase, and the ratio of places per 1000 population aged 70 and over increased from 33 in 1985 to 41 in 1995, but slowing growth of nursing home places saw this ratio fall from 71 in 1985 to 51 in 1995. Overall provision of residential care places declined from 104 per 1000 aged 70 and over to 92 per 1000 over the decade. The decline continued to 85 places per 1000 in 2005, and only a slight recovery has occurred since then. The ratio used in planning residential aged care was adjusted downwards from 100 per 1000 in 1985 to 88 per 1000 in the late 2000s, and the balance of hostel and nursing home places changed from 60:40 to 44:44. The substantial margin for service provision to substitute for care of people who would previously have been admitted to residential care, especially the lower levels of hostel care, was to be filled by community packages, to be provided at a ratio of 25 per 1000. The extent to which packages have been used to integrate services with various forms of aged persons housing as well as being delivered to people living in the wider community is taken up in the next section.

The causes of the decline in residential care places lie in the increasing restriction of public funding for the capital component of residential aged care and increased reliance on user payments, and growing concerns about levels of recurrent funding through the early 1990s. The structure of nursing home capital and recurrent funding came under review and the viability of hostel funding was also raised in this review (Gregory, 1993, 1994). Waiting for action to follow on from this review put a further brake on development in the mid-1990s.

Although private sector providers were eligible for recurrent funding of hostels from 1991, they did not have access to capital grants and few entered the field, keeping instead to the higher returns from nursing home provision. While only some 10 percent of hostel places were provided by private sector operators by 1995, some of those who also operated retirement villages were prompted to look for ways of supplementing independent living units with additional services and to construct medium density apartment accommodation incorporating accessible design features as alternatives to hostels. These developments are taken up in the next section.

The relative decline in residential care places combined with the introduction of more systematic rationing of access through mandatory pre-admission assessment by an Aged Care Assessment Teams (ACATs) to bring about a shift in the profile of resident dependency. The outcome was to squeeze out hostel residents whose needs were primarily for supported accommodation rather than care, and who thus attracted little if any care subsidy. The more constrained access to nursing homes simultaneously saw more residents remain in hostels to levels of dependency similar to many nursing homes residents. This overlap was recognised by the Commonwealth in 1997 when the two previously separate funding instruments applied in hostels and nursing homes were replaced with a single classification scale implemented as part of the reforms under the *Aged Care Act 1997*. 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 resulted in considerable increases in the number and proportion of residents in former hostels who were classified as higher-dependency and an increase in the proportion of residents in residential aged care homes assessed as requiring high levels of care (AIHW, 2002,

pp. 3–8). By 2008, the proportion of all residents in aged care homes classified as high care exceeded 70 percent (AIHW, 2009, p. 43).

The measures introduced through the *Aged Care Act 1997* finalised and formalised the transformation of hostels from a form of service integrated housing into a component of an integrated residential care system. This step, and the suite of other measures attached to the Aged Care Act, reflected new policy directions that followed the change of government in 1996. While the second stage of the Mid Term Review of the Aged Care Reform Strategy that reported in late 1993 made several proposals for further linking of aged care services and housing, including expanded roles for hostels, action on these recommendations was overtaken by the relegation of responsibility for all housing policy to State and Territory Governments. But the continuing impact of other measures implemented through the Aged Care Reform Strategy and some effects of the *Aged Care Act 1997* a decade on left legacies for service integrated housing, albeit by default rather than deliberate policy design.

Firstly, from the mid-1980s, the Home and Community Care Program supported a rapid expansion of both the level and range of services available to frail older people (and also younger people with disabilities) in their own homes (Gibson, 1998, pp. 35–7). For the purposes of HACC, an ILU or unit in a retirement village constituted the residents own home and they were eligible to receive HACC services except where equivalent services such as property maintenance were covered in their weekly service fee.

Secondly, many not-for-profit organisations operating mainly residential care had expanded their roles in delivery of community care services through HACC and particularly through Community Aged Care Packages. These developments resulted in a blurring of the distinction between providers of residential aged care and providers of home and community care provision (Howe, 1995, pp. 222–3). One result was the emergence of a new form of continuing care in which providers delivered services to clients in the community who were later admitted to the same provider's residential care home, often using residential respite care as a stepping stone.

The third legacy was an increased interest in the provision of service integrated housing as an alternative to hostel care. Increases in the amount of bonds charged for entry to low care homes had the effect of creating a market for alternatives such as serviced and assisted living apartments, and all the more as residents secured firmer tenure over their accommodation. While the private sector showed most interest in development outside the constraints of the residential aged care program, not-for-profit providers were also keen to expand in a potentially capital-rich field. Expanded community care also contributed some of the service component in these developments and they are discussed further in the next section.

Notwithstanding these initiatives, the continuing unresolved position of service integrated housing remains a final legacy. 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 levels 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, that is, 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 minimises the distinction between residential care and service integrated housing, arguing that there are 'several trends that suggest that care and accommodation are already fanning downwards and outwards' (Howe, 1999, p. 16). Initiatives of this kind taken over the last decade occurred in a policy vacuum, but new policies formulated



following the change of government in 2007 present new opportunities and are discussed in section 2.6.

In summary, the history of residential aged care has impacted on the development of service integrated housing in several ways. Hostels were originally conceived as a form of service integrated housing for older people requiring low levels of support and care. Notwithstanding considerable growth, they have over time instead been integrated into the residential aged care program alongside nursing homes and have ceased to be a form of publicly-subsidised service integrated housing. Although the Aged Care Reform Strategy of the 1980s focused on the expansion of community care and containment of nursing home growth, the identity of hostels as a form of service integrated housing was maintained in some of the measures proposed for furthering links between aged care services and housing in conjunction with the National Housing Strategy. This position changed with a marked shift in policy direction given effect in the *Aged Care Act 1997*. The boundaries of residential aged care policies and programs were sharply defined and initiatives drawing on community care services to further service integrated housing were left to providers. The cumulative effect was that service integrated housing was defined out of formal policy and programs covering the publicly-funded residential aged care sector, but was not been taken up in the housing sector. So while hostels and to a lesser extent nursing homes could be regarded as a second tier of service integrated housing through the mid-1980s, subsequent policy and program changes had the effect of progressively repositioning hostels to become part of the residential aged care system. The inextricable links between the delivery of care services and accommodation in residential aged care homes means that they do not come within the scope of 'service integrated housing' as defined for this project, namely housing arrangements for older people where the housing provider deliberately makes available one or more types of support and care as part of the housing provision. Accordingly, only limited reference is made to residential aged care in the remainder of this report.

## **2.4 The 3rd tier: development and diversification of retirement villages**

### *2.4.1 Growth trends*

The involvement of not-for-profit organisations in the provision of ILUs from the 1950s to the 1980s provided these organisations with substantial expertise in the development and management of housing for older people. As discussed in section 2.3, by the mid-1970s, providers were scaling down their use of APHA capital funding for ILUs in favour of hostels and nursing homes which attracted increasing recurrent funding. But being familiar with the concept of using non-returnable 'ingoing donations' to fund the matching component of publicly funded capital subsidies, they adapted this approach and applied their expertise to become developers and managers of unsubsidised retirement housing. These housing complexes became known as retirement villages. By the early 1980s, private sector organisations had joined not-for-profit organisations in the growing market for resident funded retirement accommodation in village settings.

Resident funding tapped the capacity of older home-owners to realise their housing assets and invest in retirement accommodation that came with some level of support services. It also provided developers with substantial flows of capital as soon as units in a village came on to the market. It is a remarkable and entirely unintended legacy of the ADPHA that over the next 30 years, retirement villages became the main form of service integrated housing in Australia. A survey of hostels conducted in 1994 for Aged Care Australia, the not-for-profit industry body demonstrates the considerable

extent to which hostels operated as part of at least two tier complexes with ILUs: 40 percent of all hostels were co-located with ILUs and just over half of all hostels operated in conjunction with other facilities at other locations. Co-location was associated with larger size of hostels and more cost effective operation (Aged Care Australia, 1994, pp. 3-4).

In the Australian context, the term 'retirement village' 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 homes. In keeping with their origins in APHA-funded dwellings, private dwellings in retirement villages are often referred to as 'independent living units' or 'self-care units'. Since the 1970s, retirement villages have been the fastest growing type of housing oriented to the needs of older people in Australia (Stimson, 2002, p. 6). It is estimated that by the late 1990s there were approximately 1,500 retirement villages in Australia, with some 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](http://www.villages.com.au) accessed 5 August 2007). As noted in Chapter 1, the 2006 census enumeration produced the more conservative figure of 127,808 older persons living in retirement villages, 4.8 percent of the population aged 65 and over (ABS, 2006). On the basis of the ABS figures, this scale of provision amounts to close to 80 percent of the 164,000 places available in residential aged care homes in 2006.

Although the planning and development of retirement villages is not subject to central planning along the lines of residential aged care, it is a lengthy process and large-scale providers have land holdings and plans set many years in advance. Providers thus have some capacity to slow down or speed up development in response to changing economic conditions. Falls in the residential property market in particular affect demand as potential buyers wait for a recovery to maximise their assets. The rate of development has fluctuated in the past and is likely to have experienced some slow down in the wake of uncertainty in the property market generated by the global financial crisis from mid-2008 through 2009. Recovery over the next decade could however see retirement villages outstrip the growth of residential aged care.

#### *2.4.2 Diversification*

Growth in the number of retirement villages has been accompanied by increasing diversity and product differentiation. Initially, most retirement villages were developed and marketed to older people of modest or average means who typically sold their family home to meet the costs of leasing a retirement village unit. However, in recent years retirement villages have been developed at the luxury as well as the affordable end of the market. 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 location of villages, the socio-economic characteristics of residents, the size of residential units and environmental amenity, the range and quality of on-site services and facilities (Stimson, 2002, pp. 31–3 and 202). There has also been diversification of tenure and contract arrangements, the physical form of villages and the range of services included in weekly fees.

Most retirement villages are designed for older people able to live, for the most part, independently. However, part of their attraction is that they provide a range of services on-site, including some of the support and care services identified in Chapter 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, visiting hairdressers and so forth (Stimson, 2002, p. 33). Most villages provide some form of transport service such as 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 for nursing care and medical rooms that are used by visiting doctors and other health providers.

A significant number of Australian retirement villages have historically been co-located with residential aged care services, and are based on the concept of 'on-going care' (Australian Parliament, 1982, pp. 63–5) or the 'continuum of care' (Stimson, 2002, pp. 211–12). 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 professional assessment of need by an ACAT and is not guaranteed (Buys, 2000), the concept of jointly sited independent living units, hostels and nursing homes seems to have considerable and continuing attraction (Buys, 2000; Stimson, 2002, pp. 55 and 211). This model has also been developed by private sector providers who are involved in residential aged care, particularly nursing home provision, as well as retirement villages.

A growing number of Australian retirement villages also provide the option of 'serviced apartments' and 'assisted living units'. Serviced apartments provide services such as cleaning and laundry, an alarm call system and meals available in a dining room. These services, apart from meals, are included in the weekly fee. Assisted living apartments provide additional assistance with daily living, either by direct services or by facilitating access to services delivered by outside providers, and these services are usually charged on a user pays basis. Even where personal care and other allied health services are available on-site, 24 hour, on-site nursing care is generally not provided, although managers are often nurses who are able to provide periodic, short-term nursing care.

As their name suggests, the distinctive feature of this form of retirement living is the built form of medium density, multi-storey buildings rather than villa units. These larger buildings also include a range of common areas and a high level of accessibility and universal design features. Apartments vary in size from one to three bedrooms and include full kitchens, and span a wide price range. Apartment retirement villages are growing in inner and middle distance suburbs where higher land costs require higher density development. An added but rarely recognised benefit of this form of development in the context of overall urban planning is that retirement villages free up established family housing in these areas.

### *2.4.3 Consumer acceptance of retirement villages*

In contrast to admission to residential aged care which is a matter of necessity and requires an ACAT assessment, entry to a retirement village is a matter of choice by the consumer. The growth of this form of service integrated housing indicates that it has stood the test of the market and its diversification can be read as responsiveness to consumer demands and preferences. Consumers have also been protected by retirement village legislation and instances of disputes that go beyond village management appear rare.

The perception that retirement villages provide access to support and care services appears to be of great importance in the decision to move to a retirement village. Actual or anticipated declines in 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 retirement villages, although for others lifestyle factors may be of most importance (Stimson, 2002, pp. 60–s2). Support services such as 24-hour emergency call systems rate highly as desirable attributes of retirement villages (Stimson, 2002, p. 73). While there is some evidence of a gap between expectations and the reality of the availability of services in retirement villages (Buys, 2000), 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 support provided for house and garden maintenance, the health support and the quality of the physical environment (Gardner, Browning and Kendig, 2005).

In terms of responsiveness to consumer demand, one important development over the past decade has been the emergence of ‘affordable’ rental retirement villages targeted at older people wholly or partially dependent on the Age Pension (Jones, Bell, Tilse and Earl, 2007, pp. 114–124) and with limited assets. Companies such as Village Life developed a nationwide network of retirement villages offering accommodation in partially self-contained units, a congregate meals service, a linen service and some village facilities at a cost equivalent to 80 per cent of the full age pension, including Rent Assistance.

Rental retirement villages were initially in high demand when introduced around 2000, but some subsequently experienced major financial and management difficulties, including high vacancy rates. These initiatives can be viewed as attempts to meet need and demand for service integrated housing for people in later life with limited or no financial resources. The need for affordable forms of service integrated housing remains a significant gap that has not been met by the community or public sectors. While not an age-based program, the recently announced National Rental Affordability Strategy (NRAS) presents some prospects for addressing this gap and these are taken up in Chapter 6.

#### *2.4.4 Policy interest in retirement villages*

The growth of service provision in retirement villages, and particularly in assisted living apartments, appears to have been stimulated in part by the slowing of hostel development from the early 1990s within the residential aged care program, and by the expansion of HACC and particularly CACPs which could be drawn on to provide higher levels of support and care. While individual residents could access generally available HACC services and care packages on the basis of assessed need, retirement village operators who were also Approved Providers of Commonwealth funded programs could apply for packages to be delivered to residents in their villages as well as to those living in the wider community. Access to subsidised care services also made it very cost effective for residents to ‘top-up’ packages by paying for further hours of services from the same provider if they needed or wanted additional support.

The use of CACPs to enhance service integration in retirement villages attracted policy interest and led to the Retirement Villages Pilot, announced in the 2002–2004 Australian Government budget. Policy interest focused on two areas. First, the extent to which providing packages in retirement village enabled residents to remain in their unit and defer or prevent a move to a residential aged care home. Second, by taking advantage of the structured environment of retirement villages and the services already available, it was considered that packages could be funded at a discounted rate. The pilot delivered packages to around 250 residents in 45 retirement villages operated by 10 providers; 18 of these villages were operated by three private sector providers, only one of which was an established community care provider, and the remaining villages were operated by seven not-for-profit providers, five of which were established community care providers.

The Retirement Village Pilot demonstrated flexible ways of delivering care packages to residents of retirement villages and received a positive evaluation (AIHW, 2006). This paved the way for the *Retirement Villages – Ageing in Place* initiative in 2006, and on-going funding was confirmed in the 2006-07 budget. The initiative encourages retirement village operators to apply for package places, and if not already Approved Providers, to gain Approved Provider status. Operators are able to provide community aged care places (CACP and EACH packages) for their residents either in their own right or in partnership with an aged care provider (DOHA, 2006). All providers need to demonstrate how their village environment will allow for ageing-in-place and contribute to the continuity and quality of care for residents. They also need to demonstrate what other benefits they will make available to their retirement village residents to increase diversity of choice and to allow older people to continue to live in their established place of residence (DOHA, 2008).

Take-up of the initiative has been variable but is growing. The Retirement Villages Association has identified a number of factors affecting provider interest, including whether a village caters for 'fit and well' residents rather than those needing some care, and the extent to which the village operator also provides or arranges for private purchase of care services on a user-pays basis rather than calling on subsidised services. From the residents' point of view however, there are concerns about access to subsidised services for which they are eligible on the basis of assessed need.

Retirement villages have become Australia's largest sector of service integrated housing for people in later life. Unlike residential aged care homes, this has occurred largely without direct state support. Howe refers to the development of retirement villages as 'an outstanding example of policy by default' (Howe, 2003, p. 4). Public policies have impacted on the growth of retirement villages indirectly and there have been no explicit policies to promote (or contain) their growth or shape their character or geographic distribution. Rather, the growth of retirement villages triggered policy development in two areas. First, retirement villages have tested some aspects of State planning regulations and lead to amendments in some case. Only in NSW, however, has a planning framework specifically for retirement villages, SEPP 5, been established. The second area of legislative development was the implementation of retirement village Acts that are primarily concerned with consumer protection for those residing in retirement villages under a range of tenure arrangements, some of which are far from standard, and with varying contracts for service provision (Stimson, 2002, pp. 25–8 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. He argued that the industry was likely to increase its market penetration as suppliers responded to different market segments and developed new village forms including high-rise and more compact medium-density designs. He also predicted blurring of the differences between profit and not-for-profit providers as each become more corporatised and greater concentration of ownership and management. Examples of some of these trends are provided in Chapter 5.

## **2.5 The 4th tier: innovation and experimentation**

### *2.5.1 Providing housing for people with complex needs*

Since the late 1980s, a number of initiatives were taken by not-for profit organisations to address the needs of older people who are homeless or living in insecure accommodation. These individuals' needs for long term, stable housing could not be met by the Supported Accommodation Assistance Program (SAAP) which addressed

transitional and short term housing needs, and many had other support and care needs. The early initiatives were taken up in a small-scale program of Assistance with Care and Housing for the Aged (ACHA) which was implemented on a pilot basis in 1993 and has continued since. ACHA provides funds to local government and not-for-profit organisations to assist financially disadvantaged frail older people who were renting, who had insecure tenure or who were homeless to meet their accommodation and support needs to enable them to continue living in the community. The dual problems addressed by this kind of assistance are that on one hand, this group did not have equitable access to community care in part because their housing was unstable or did not provide a suitable care environment, while on the other hand they were over-represented in hostels, again due to their previously poor housing conditions.

ACHA does not fund either accommodation or care services directly but focuses on support workers who assisted clients find more appropriate and affordable accommodation and linked them to services where necessary. Support workers could be based in a service agency and work on an outreach basis, linking clients to housing and further services in a defined locality, or on-site in a designated housing development, either a public housing development or a private rooming house, or through a combination of these approaches. ACHA funded services work closely with state housing authorities, and all clients are eligible for public housing, although not all may choose to live in public housing. The roles of support workers include identifying frail older clients with housing and other support needs, linking clients to suitable care options and housing services, and to other needed services such as Aged Care Assessment Teams or Indigenous community organisations.

A total of 49 projects were funded in the first three years of ACHA, and 26 of the projects were based in large not-for-profit agencies that were also Approved Providers of residential aged care and packages. A comprehensive evaluation of the first round of ACHA projects found that provider experience with community care networks and delivery of community care contributed to positive outcomes for clients and providers. The projects were very cost effective as the intensive interventions over periods of 3 to 10 months enabled support workers to assist a large number of clients at an average cost of \$649 per client, excluding the cost of services and accommodation secured. A comprehensive evaluation of the first round of ACHA projects (Alt Statis and Associates 1996) found that provider experience with community care networks and delivery of community care contributed to positive outcomes for clients and providers.

As of late 2009, ACHA funded 42 services, many of which have been involved since the inception of the program. Over time the number of providers and organisations involved has varied slightly: a number of smaller projects operating under the auspices of a single organisation have merged, some services have come under different auspice organisations and there have been some new providers. In line with the distribution of the client population, the largest number of ACHA funded services are in NSW, 11, and Victoria, 13, with smaller numbers in other states. The scale of individual services also varies, but overall ACHA currently serves around 3,000 clients a year.

Some State Governments have also initiated support and care programs along the lines of ACHA, through special initiatives within HACC and working with public sector and community housing providers. In Victoria, a pioneering role in the development of services providing housing and support to this population group was taken by Wintringham, a housing and aged care providers established in Melbourne in 1989. Wintringham's approach has been to provide service integrated housing to older

people at risk of homelessness drawing on funding available through the aged care system and state housing authorities (SHAs) 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 low cost private rental accommodation (Lippman, 2003; Lippman, 2006). A number of other organisations also provide similar services to this group.

Service integrated housing has also been developed for some 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. Their residents include significant numbers of frail, older people (Jones, Bell, Tilse and Earl, 2007, pp. 148–9). There are also some specialised housing and care services for older people with developmental and other disabilities (Milne and De Mellow, 1996; Bridge, Kendig, Quine and Parsons, 2002).

### *2.5.2 Experimenting with other approaches*

Since the early 1980s there have also been other approaches to the provision of service integrated housing, although none of these has met what Howe has referred to as ‘the ‘sliced bread’ test of successful innovation – they have not caught on widely’ (Howe, 2003, p. 3). Perhaps the best known of these is Abbeyfield Housing, a housing model for older people adapted to the Australian context from the UK. The Abbeyfield model 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. 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.

Another model is ‘Apartments for Life’, a concept developed in the Netherlands and being developed in the Australian context by the Benevolent Society of NSW. 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 HACC, CACP, and EACH. Rent levels will be based on the individual financial circumstances of clients. Both Abbeyfield and ‘Apartments for Life’ will be examined in Chapter 5 as examples of service integrated housing in Australia.

Other approaches to service integrated housing have been developed by community organisations funded under the Community Housing Program of the CSHA (Jones, Bell, Tilse and Earl, 2007, pp. 104–5) and by public housing authorities in response to the increasing number of public housing tenants requiring higher levels of care and support in later life (McNelis, Neske, Jones and Phillips, 2008). Several examples of these developments are also considered in Chapter 5.

## **2.6 Home and community care: providing the infrastructure for service integrated housing**

### *2.6.1 Expansion of community care services*

Since the mid-1980s, the Australian Government and State and Territory Governments have given concerted attention and commensurate funding to the

expansion of home and community care in efforts to contain the growth of residential care and to offer frail older people greater opportunities to remain in their own homes and communities even with some degree of dependency. National subsidies for home care services began in the 1950s and 1960s on a somewhat piecemeal basis. The first Australian Government program was the introduction in the 1950s of a subsidy for home nursing, followed a decade or so later by financial support for senior citizen centres, community-based paramedical services, and delivered meals (Gibson, 1998, pp. 31–3). However, prior to the 1980s home care services were small-scale in comparison to the rapidly growing residential age care sector. By the early 1980s there was increasing concern that many older people being admitted to nursing homes and hostels could be cared for more effectively and inexpensively in their own homes (Australian Parliament, 1982).

These concerns resulted in the establishment in 1984 of the Home and Community Care (HACC) program to provide home and community care services and support services for people with a moderate or severe level of disability. The broad goals of the HACC program were to enhance the independence and lifestyle of disabled and frail aged people and to avoid premature admission of older people to residential aged care homes (Australia, Parliament, 1994; Australia, 2002). HACC brought together under one umbrella a wide range of pre-existing services that had been funded through the Australian Government and the States and Territories, and funded new types of services. The program has grown steadily since its establishment in overall levels of funding, range of services and coverage of the older population, including particular attention to special needs groups. Total funding in 2008–2009 is \$1.788 billion of which \$1.090 billion is provided by the Australian Government (DOHA 2009). Community care services are now widespread; on the basis of service usage as of 2003–04 reported by AIHW (2007, p. 103), it is estimated that formal community services, primarily HACC, were used by around 80 percent of the older HACC target population, defined as those aged 65 years and over with moderate, severe or profound activity limitations who were living in the community on the basis of the 2003 Survey of Disability, Ageing and Carers (ABS, 2004). Services provided include assessment, care coordination and care management; home and community based nursing and allied health; delivered meals, meals at centres and other food services; domestic assistance; personal care; home modification and maintenance; transport; centre-based and in-home respite care; counselling, support, information and advocacy. HACC funds are channelled through some 3,000 agencies comprising not-for-profit organisations, local government and public health services.

The distinction between the wide range of HACC services delivered to clients across a range of dependency levels and care packages is the inclusion of case management in the latter services. Packages are specifically 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, 1998, pp. 37–38; DOHA, 2004). Community Options Projects (COPs), first introduced with Commonwealth only funding in 1987, were 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. Funding for COPs was subsequently rolled into HACC and has grown only in line with HACC funding overall.

A much more significant development came in the early 1990s when Community Aged Care Packages (CACPs) were introduced. CACPs began as Hostel Options which delivered services to residents in ILUs on an outreach basis from hostels, and were soon extended to frail older people living in the community who had been assessed by an ACAT as eligible for hostel care (Gibson, 1988, pp. 62–4). CACPs funding was set at the lowest level of hostel care funding and had been tied to that



level ever since. Many CACPs have been delivered as outreach programs from hostels (Howe, 1995, p. 223). CACPs have grown rapidly in number from some 2,500 in 1995 to 40,280 in 2008 (AIHW, 2009a, p. 2). In 1998, the Australian Government also introduced Extended Aged Care in the Home (EACH) packages to provide higher levels of care to people living at home, with funding set at the lowest level of nursing home funding (Australia, DOHA, 2004, p. 18), and even higher funding, equivalent to the highest level of nursing home funding was subsequently provided for EACH packages targeted to clients with dementia. By 2008 there were 6,240 EACH packages and 1,963 EACH-D packages. Further growth of both CACP and EACH is envisaged. These package programs have provided significant resources for community care for older people with higher levels of dependency, but it is HACC that is the mainstay of community care.

While increased access to community services is seen as filling the gap left by the relative reduction in residential aged care places, it also needs to be recognised that some of the gap has been filled by alternative forms of housing with varying levels of support and care services. Community care is not a substitute for the accommodation function previously provided by hostels for those with only low dependency but who needed social support and more appropriate housing. It is apparent that a proportion of these individuals have turned to various forms of retirement housing, in which they may also receive HACC services or care packages in addition to the supports that are integral to the retirement housing environment. Continuation of this kind of demand is a factor underpinning the further integration of community care with different forms of retirement housing.

### *2.6.2 Integrating community care with housing*

Some HACC providers were initially 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 for HACC services (Australian Parliament, 1994, pp. 101–2). However, this situation has been clarified and residents of retirement villages and independent living units are eligible for HACC services except when a resident's contract specifically includes these services (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 can also receive HACC services.

All providers of care packages are Approved Providers and given the origins of CACPs in relation to hostel care, it is not surprising that a high proportion also operate residential aged care homes. Not-for-profit organisations account for 55 percent of package providers, 40 percent are local government agencies and private providers have a small presence at 5 percent (AIHW, 2008, p.20). These shares suggest that where not-for-profit providers deliver packages to residents in ILUs and retirement villages, they are likely to do so directly. For-profit providers of retirement villages and residential aged care are however much less likely to have CACPs, and so are more likely to make arrangements with other CACP providers to have packages delivered to village residents, or leave it to the individual resident.

In summary, the creation of extensive home and community care programs covering older people across a range of levels of dependency has had and continues to have important implications for the development of service integrated housing. The development of HACC, CACP and EACH has not only extended opportunities for older Australians to age in place in their own homes or neighbourhoods, but has also presented opportunities for housing providers to work with home and community care providers to develop service integrated housing arrangements.

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 to develop closer links between community care and public housing providers (Jones, Bell, Tilse and Earl, 2007, pp. 102–3). Several of the innovative approaches to service integrated housing examined in Chapter 5 similarly rely on the availability of HACC, CACP or EACH to provide supportive housing environments for older people.

## 2.7 Conclusion

Australia has an extensive service integrated housing sector, but its contribution towards meeting the accommodation and care needs of older Australians receives far less formal policy recognition than residential aged care or community aged care services. The reasons for this lack of recognition can be attributed partly to its somewhat muddled history. Public subsidy of hostels in the mid-twentieth century under the APHA for older people requiring low levels of support and care might have developed into continuing public support for service integrated housing. However, by the turn of the century hostels had been clearly integrated into a tightly organised residential aged care system focused on the needs of older people with high levels of dependency. Similarly, capital subsidies of independent living units under the APHA from the 1950s to the 1980s might have led to a housing sector for low-income older people clearly focused on integrated service provision. The faltering of these programs means that the challenge of developing the ILU sector as a vehicle for service integrated housing has been left to providers and has never been taken up other than in a piecemeal fashion.

It was not until the early 1990s that policy interest in service integrated housing was renewed in the Mid-Term Review of the Aged Care Reform Strategy and the National Housing Strategy. Research commissioned by the Mid-Term Review reported on 23 case studies of innovations in housing for older people, including independent housing with support and hostel innovations (Forsyth, 1992). As well as reviewing developments in ILUs and hostels, the report on the second stage of the Mid-Term Review noted projects for older people funded under the Local Government and Community Housing Program, a component of the Commonwealth-State Housing Agreement, and envisaged further opportunities arising through the Community Housing Program introduced in the 1992–93 budget. Recommendations to further links between aged care and housing, including promotion of flexible service delivery in different housing settings, were not however to come to fruition. Again, only piecemeal development occurred, assisted to some degree by drawing on expanding community care services.

The integration of hostels into the residential aged care program under the *Aged Care Act 1997* effectively removed hostels from consideration as a form of service integrated housing. With responsibility for housing policy assigned largely to the States and Territories from 1996 to 2007, policy development to advance service integrated housing faltered once more.

Thus, from the 1970s, it was left to the community and private sector housing providers in the nascent retirement village industry to develop service integrated housing arrangements without direct public subsidy. Over the next 30 years, and especially since the turn of the century, retirement villages have diversified and now provide a wide range of service integrated housing including villages targeted at the affordable, modest and luxury segments of the market, and villages offering different tenure arrangements, physical forms and types of services. Important developments

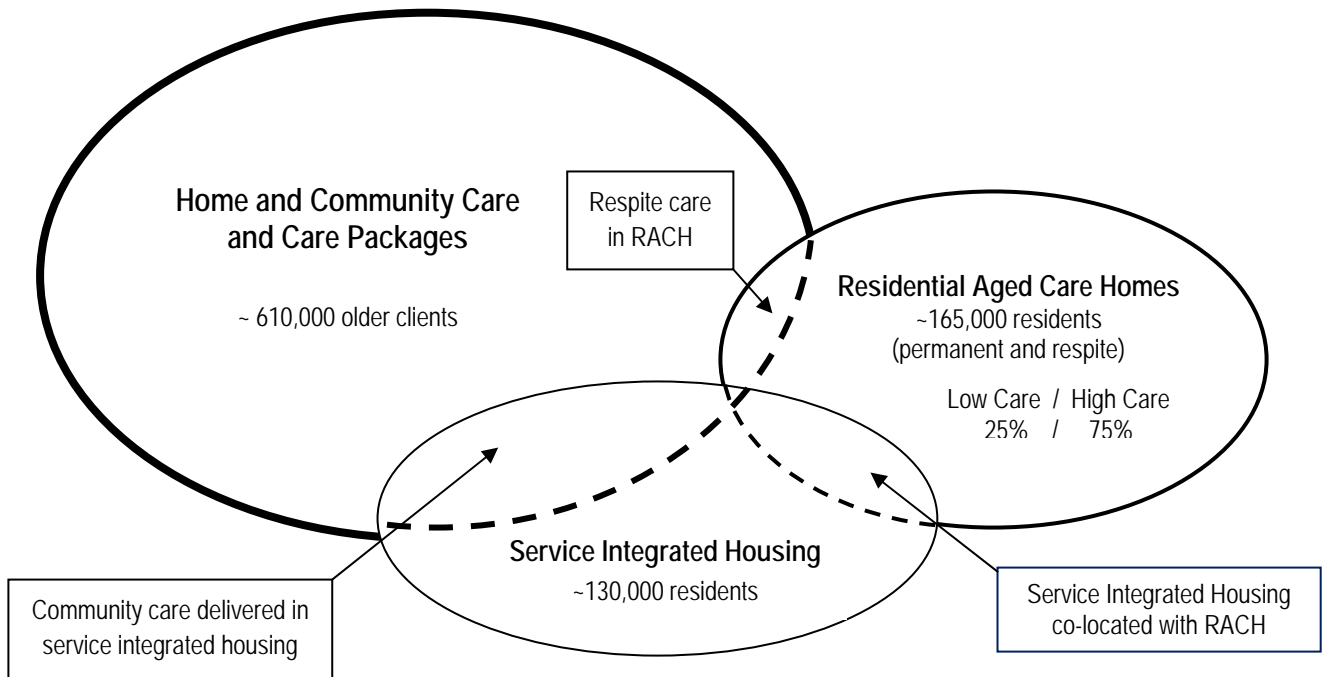
include villages offering a continuum of care, serviced apartments and assisted living units, and new village types such as affordable rental villages.

Since the 1990s a number of other forms of service integrated housing have also emerged including service integrated housing for homeless older people and other innovations based on international models such as Abbeyfield Housing and Apartments for Life, all on a small scale. As larger numbers of public housing tenants increasingly require care and support services, public housing authorities are joining community organisations in looking at new ways of integrating provision of housing and provision of care and support, drawing in particular on the support services available through the HACC, CACP and EACH programs.

The current shape of community care, residential aged care and service integrated housing can be depicted as three overlapping circles, as in Figure 2. From the perspective of residents of service integrated housing, the overlap with community care comes by way of delivery of HACC services and packages, and the overlap with residential aged care comes by way of on-going care provided in co-located RACH. From the provider perspective, the overlap represents providers who are involved in housing and community care and/or residential care. Critical issues for the future are how these areas of overlap are changing and the factors driving change in different directions.

This historical overview suggests that there is now a strong case for reassessing the role of service integrated housing and investigating factors driving change to different ends. The policy climate also appears conducive to action through the new National Rental Affordability Scheme (NRAS) and the National Affordable Housing Agreement (NAHA) which has replaced the Commonwealth State Housing Agreements. It is true that the retirement village industry in both the for-profit and not-for-profit sectors has thrived for the past three decades with minimal public policy direction or government involvement, but this is hardly a sound basis for addressing future needs for service integrated housing. The main constraint of retirement villages is that they cater largely for those who have housing assets that they can realise, but there is great diversity in the needs and preferences of this potentially large market, and the needs of those outside this group also require renewed attention. As argued in section 1.3, more diverse forms of service integrated housing are likely to have the potential to play a far more significant role in responding to the housing and care needs of the rapidly growing population of older Australians than has been the case to this point, and future directions are discussed in the final chapter of this report.

**Figure 2: Service integrated housing as a third component of aged care intermediate between community care and residential care**



# 3 TERMINOLOGY AND INTERNATIONAL COMPARISONS

## 3.1 Introduction

The development of service integrated housing in Australia is paralleled by similar developments in many other countries, and one aim of this research project is to examine the significance of international models for the Australian context. The view that there may be models that could be usefully transplanted to the Australian context is widespread, with interest in overseas models channelled through international networks of housing and community care providers in the public, community and private sectors, such as the International Association of Homes and Services for the Aged (IAHSA). One example of such transfers is the incorporation of assisted living, an approach to service integrated housing widely used in the US, into Australian retirement village developments over the past decade. Other models from other countries such as the UK Abbeyfield Housing have been imported, although with limited take-up. Yet others, such as the Netherlands 'Apartments for Life' are still in the process of being developed in Australia. How far then should Australia be looking to North America, the UK and Europe for sources of innovation in service integrated housing?

In order to address the question as to how far Australia should be looking to North America, the UK and Europe for other sources of innovation in service integrated housing development, a literature review of service integrated housing in the US, the UK and a selection of European and other countries was conducted and reported in the positioning paper for this project (Jones, Tilse, Bartlett and Stimson, 2008). The review identified a wide range of forms and types of service integrated housing, and widely varying funding and regulatory arrangements from country to country. It concluded that international experience does have relevance to the Australian context, and that models developed in other countries can be a source of innovation and learning. However, this broad conclusion is subject to two qualifications. Firstly, as in all areas of public policy and social provision, the singularity of national history, culture and institutions must be taken into account. Approaches to housing and care of older people are embedded in particular national contexts, and caution must be exercised when considering the applicability of models and service types that have emerged elsewhere. The broad parameters in which service integrated housing has developed are set by the roles of different levels of government and varying involvement of private, non-profit and public sector providers in each country, and the Australian context presents both opportunities and constraints for adopting overseas models. Secondly, there is a major difficulty with international terminology in this sector. A plethora of terms are used internationally to describe service integrated housing and little or no standardisation of terminology. One conclusion of the literature review was that there is a need for an 'international translation chart' providing guidance to those seeking to learn from international experience.

The starting point for this chapter is then the issue of clarification of terminology which underpins meaningful international comparison. The summary international translation chart provided in Table 2 lists terms, grouped into broader clusters of service types, and identifies those Australian and international terms that have equivalent or approximately equivalent meanings (in bold). An expanded version of Table 2 presented at the end of the report gives definitions of all the terms listed and notes further aspects of comparability. The aim of these translations is to show similarities and differences in terminology and the associated forms of housing and services and so facilitate comparisons between countries. Clarifying terminology in this way is a

prerequisite to meaningful comparison. It provides a foundation for identifying similar and different forms of service integrated housing across countries (including Australia), and hence provides a basis for learning from international experience. In the later sections of the chapter, the similarities and differences in terminology between Australia and other countries are discussed in greater detail and the relevance of the experiences of other countries with service integrated housing to Australia is examined.

## 3.2 Terminology

The terms used to name and describe many Australian and international models of service integrated housing are complex, imprecise and often confusing. There are many sources of complexity including public sector funding and regulatory arrangements, the involvement of different professions, the hybrid nature of many products, the rapidly evolving nature of the industry and the marketing endeavours of private sector and community providers (Benjamin and Anikeeff, 1998, p. 15; Scribner and Dalkowski, 1998, pp. 73–4). Efforts to standardise terminology in the US have been frustrated by the diversity of services and the dynamic nature of the service field (Anikeeff and Mueller, 1998; Scriber and Dalkowski 1998; Sexton 1998).

Unclear terminology presents obvious difficulties for providers and users of service-integrated housing alike, 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 and service development, and international knowledge transfer. If the public, community and private sectors are to become more involved in the development and provision of service integrated housing, terminology issues must be addressed.

Within Australia the lack of clear and agreed terminology to describe and analyse models of service integrated housing is clearly apparent. Within residential aged care the terms 'nursing home' and 'hostel' are giving way to the generic term 'residential aged care home' divided into 'high care' and 'low care', as a result of the legislative changes of 1997. However, outside aged care, terminology is imprecise and often confusing. The term 'retirement village' covers a great diversity of forms of service integrated housing, and there is a need to find better ways of classifying retirement villages and the services they offer to reflect their differing objectives (Stimson, 2002). The term 'independent living units' is used to refer to those dwellings funded by the Australian Government and community organisations from the 1950s to the 1980s (McNelis, 2004), but this term is also used more generally to refer to 'self-care' units within retirement villages. Some new housing forms such as the low-cost, rental units developed by companies such as Village Life over the past decade are not readily described using existing terminology. Terms such as 'serviced apartments', 'assisted living' and 'flexi-apartments' have entered the lexicon of the retirement housing industry over the last decade, 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.

One way of identifying more precisely the nature of the international terminology problem is to distinguish four types of relationships amongst terms and meanings. Firstly, we can identify terms that have the *same meaning in a range of national contexts*. Surprisingly, there are few such terms in common usage to describe the same or closely equivalent forms of service integrated housing in different countries. 'Nursing home' is the single most widely used term with a common meaning and in all countries refers to accommodation in which on-going nursing care is provided. The

term 'retirement village' has a common meaning when used broadly, but rather than describing a single, common form of housing and services, it breaks down into a variety of forms that are described by more specific terms whose meanings often diverge in different settings. Some other terms have acquired common meanings akin to brand names for specific models. 'Abbeyfield Housing' and 'HomeShare' are two examples where UK models have been adopted in Australia and adapted to Australian circumstances.

Secondly, we can identify examples of *the same terms being used with different meanings in different contexts* with consequent confusion. The terms 'extra services', 'extra care' and 'extra care services' are cases in point. In many contexts, 'extra' has a generic meaning as provision of services over and above those usually available in a given setting. However, in the context of the Australian residential aged care program, 'extra service homes' are those that offer residents a higher standard of 'hotel' services such as a bigger room, a wider choice of meals, or wine with meals at a higher fee. 'Extra service', in this context, does not mean that residents will be provided with a higher level of care, because all homes have to provide the same level of care to their residents.

The third situation is *where different terms have the same meaning*, that is, where some broadly similar forms of service integrated housing are described by different terms. An example is the use of the term 'hostel' in the Australian context to refer to accommodation usually in the form of a individual bed-sitter with en-suite facilities linked to services spanning levels of social support and personal care, but specifically exclude on-going nursing care. No other countries use the term 'hostel' as it is used in the Australian context, yet many have one or more forms of accommodation with a similar range of services. The terms 'congregate housing' as used in the USA and 'sheltered housing' in the UK broadly approximate hostels as they include some shared amenities such as a dining room, but neither of these terms is used in Australia. Since 1997, the term 'hostel' has been replaced by 'low care' within the Australian residential aged care program, but it is still widely used. It has, however, never been used outside of the residential aged care program. Instead a range of terms such as 'serviced apartments' and 'assisted living' have developed to describe forms of housing that offer a similar range of support and care services, and as with hostels, they do not include nursing care.

Finally, considerable confusion can arise when *terms that have a particular meaning in one country are used more generically in other contexts*. The term 'continuing care retirement community' (CCRC) has a very specific meaning in the US context where it refers to service integrated housing in which residents pay a premium to cover the possibility of future access to care services, somewhat akin to an insurance arrangement. Retirement villages in Australia which offer what used to be called 'three-tier complexes' of ILU, hostel and nursing home do provide for 'continuing care', but they are not underpinned by the same funding arrangements and should not be referred to as CCRCs. Indeed, on the contrary, rather than covering charges for future possible use of care services in a blanket weekly service charge from the time of entry, the trend in Australia is to offer assisted living services on a user pays basis in order to minimise the weekly service charge. In Australia the practice in many retirement villages is to further minimise the cost of assisted living and other services by drawing on HACC and CACPs which provide some level of means-tested public subsidy for users.

The international translation charts address these issues in three ways. Firstly, all terms identified internationally and in Australia referring to service integrated housing and related services are listed in Table 2 and defined in the longer version of the table

presented at the end of the report. Secondly, terms used in other national contexts that are equivalent, or approximately equivalent, to Australian terms are shown together, so that their similarities and differences are displayed. Where no equivalent terms are given, it does not necessarily mean that there is no equivalent form of housing, but rather that equivalent housing forms are not differentiated by separate terminology. Thirdly, all of the terms used in Australia and other countries to describe service integrated housing and related aged care services are grouped into six broad clusters. This grouping of terms and service types is discussed further in later sections of the chapter and in the chapter conclusion. Two of the groups of terms cover general terminology and four cover different types of service integrated housing: the latter groups, and sub-types within them, are listed in order of increasing levels of support and care. The six groups of terms are:

1. Generic terms used to refer to housing for people in later life.
2. Terms used to refer to 'home and community care services' which, while primarily focused on people living in private housing in the community, play key roles in many forms of service integrated housing both in Australia and in many other countries.
3. Terms used to refer to 'service integrated housing offering lifestyle and recreation'.
4. Terms used to refer to 'service integrated housing offering support'.
5. Terms used to refer to 'service integrated housing offering support and care'.
6. Terms used to refer to 'residential aged care homes', which, while not a form of service integrated housing, play key roles in shaping service integrated housing both in Australia and in many other countries.

### **3.3 Generic terms for housing for people in later life**

The generic terms that are widely used to cover housing for people in later life distinguish broadly between housing with varying levels of support and care and facilities offering care services, particularly nursing care that is available to all residents. The former types of housing are much more varied than the latter and this study proposes the term 'service integrated housing' to encompass all forms of housing for older people in which the housing provider makes available one or more types of support and care services. Provision of services may be made either internally by the housing provider or through an arrangement with an external service provider. The term is seen to have international relevance as it can be applied to the range of forms of housing with various types of services listed in the rest of Table 2. Provision of care is integral to the latter types of accommodation coming under the generic terms for residential aged care, rather than various means being used to integrate services with housing. Residential aged care is thus not regarded as a form of service integrated housing and only limited attention is given to residential aged care in the rest of this report.



**Table 2: International translation chart of terms used to describe types of service integrated housing**

<i>Australia</i>	<i>Other countries</i>
<b>1. Generic terms for housing for people in later life</b>	
<b>Housing for the elderly/for the aged</b> <b>Retirement housing</b> <b>Seniors' housing</b> <b>Retirement housing</b>	<i>These generic terms are also widely used with the same meaning in most, if not all, other countries.</i>
<b>Residential aged care</b> Care in a residential aged care home (RACH)	<b>Long-term care – US</b> <b>Residential care – UK</b>
Service integrated housing	<i>The term 'service integrated housing' is intended to have international relevance.</i>
<b>2. Terms for 'home and community care'</b>	
<i>'Home and community care' is the generic term used in this translation chart to refer to provision of aged care services in the home of a person in later life.</i>	
<b>Community care</b> <b>Home and Community Care</b> – generic term used in this report to refer to the provision of aged care services in the community and in the person's home. Formal programs are: <ul style="list-style-type: none"> <li>• Home and Community Care Program (HACC), including Community Options sub-program (known as Linkages in Victoria).</li> <li>• Community Aged Care Packages (CACP)</li> <li>• Extended Aged Care in the Home (EACH) Packages</li> </ul>	<b>Community care</b> – widely used <b>Home and Community Based Care (HCBC) – US</b> Home health care – nursing and allied health Social care – other home and community care. Home care Home care services In-home care
<i>There is no equivalent of collective home care in Australia.</i> <i>Naturally occurring retirement communities exist in Australia but are not specifically identified as such</i> <i>Multigenerational housing support models have not been a feature of service integrated housing in Australia.</i>	Collective home care Naturally-occurring retirement community (NORC) Virtual retirement community Multigenerational housing support models
<b>3. Terms for 'service integrated housing offering lifestyle and recreation'</b>	
<i>Services typically include sporting and recreational facilities and activities, and social activities focused on a club house or community centre.</i>	
<b>Lifestyle village</b>	<b>Active adult retirement community (AARC) – US</b> <b>Leisure oriented retirement community (LORC) – US</b>
<i>Australia has no equivalents to the large-scale retirement resorts of the US.</i>	Retirement community Retirement housing for special affinity groups Retirement resort Retirement new town Retirement town

<i>Australia</i>	<i>Other countries</i>
<b>4. Terms for 'service integrated housing offering support'</b>	
<b>4a. Independent living complex</b>	
<b>Independent living unit (ILU)/Self care units</b> <b>Retirement village – includes variants such as vertical village and rental retirement villages</b> <b>Manufactured home estate/Residential park</b> <b>Affordable rental villages</b>	<b>Sheltered housing –UK</b> <b>Independent living facility (ILF)</b> <b>Retirement village – UK and US</b>  <b>Mobile home park – US</b>
<b>4b. Shared housing</b>	
<b>Abbeyfield Housing</b> <b>Agency assisted shared housing (only one project known to operate in Australia)</b>  Boarding house Rooming houses	<b>Abbeyfield Housing – UK</b> <b>Agency-assisted shared housing – UK</b> Co-housing – Europe Board and care home – US  Single room occupancy (SRO) hotels – US
<b>5a. Housing with support and care</b>	
The term congregate housing is not widely used in Australia. Hostels provide housing with care other than continuous nursing care in congregate settings and are similar to several forms of congregate housing with care in other countries, but the term 'hostel' is not used outside of Australia to refer to these forms of service integrated housing. Supported residential service (SRS) Victoria, other terms are <i>supported accommodation</i> (Queensland), <i>licensed residential centre</i> (NSW) and <i>supported residential facility</i> (South Australia).  Serviced apartment <b>Assisted living facility (ALF)</b> Flexi-apartment	Congregate seniors housing (CSH) – US Supported housing – US Service coordinators – US Service-enriched housing – UK Extra care housing – UK Assisted living – UK Close care – UK Flexi-care – UK Integrated care – UK Supported housing – UK  <b>Assisted living facility (ALF) – US</b> Very sheltered housing – UK Service housing – European countries Service flats – Denmark Heavy service housing – Finland Small group housing – Sweden

<i>Australia</i>	<i>Other countries</i>
<b>5b. Housing with continuing care</b>	
Three-tier complexes Continuum of care Ongoing care	Continuing care retirement community (CCRC) – US Life care community – US Retirement community – UK <b>Retirement village – UK (some)</b> All age community – UK
Apartments for life	<b>Apartments for life – Netherlands</b>
<b>6. Terms for ‘residential aged care homes’</b>	
This is the generic term used to refer to provision of aged care services in a residential setting.	
<b>Nursing home</b>	<b>Nursing home (general)</b> Skilled nursing facility (SNF) – US
<b>Residential aged care home</b>	<b>Residential care home – UK</b>

### 3.4 Home and community care

#### 3.4.1 Services delivered in all forms of housing

‘Home and community care’ is the generic term used in the translation chart to refer to aged care services provided in the home of a person in later life or at a setting in the community. While these services are primarily focused on people living in their own home in the community, in many countries including Australia they play a key role in many forms of service integrated housing. The term ‘home and community care’ covers a wide range of support and care services, as per the list provided in section 1.2.

As discussed in Chapter 2, in Australia these services are most commonly referred to as ‘home and community care’ services in line with the name of the main national funding program, the Home and Community Care program (HACC). However, the term also encompasses other aged care services provided in the home including the case-managed services provided through the Community Aged Care Package (CACP) program, the Extended Aged Care in the Home (EACH) program and the Community Options sub-program within HACC. Prior to the establishment of the HACC program in the 1980s, aged care services provided in the home were often referred to as ‘home care services’ and this term is still in use in Australia as is the term ‘community care services’. Aged care services provided to older people in their homes in other countries are variously referred to as community care services, home care services, in-home care, social care and home health care. These terms are similar in meaning to their Australian equivalents. However, the terminology used to refer to particular types of home and community care services in other countries often differs from that commonly used in Australia (see Kane, 1999). A major difference is that whereas HACC includes nursing and allied health together with personal care and a range of social support services, in most other countries home health care is distinguished from other services that come under the term ‘social care’, a term not widely used in Australia.

Publicly-subsidised home and community care services have played a vital role in the development of service integrated housing in Australia (see Chapter 2). Older people who are frail or who have disabilities are generally eligible for home and community

care services irrespective of the kind of housing in which they live (except for RACH). This has meant that many residents of retirement villages and other housing complexes for older people have been able to access home and community care services on the basis of assessed need. Some providers and managers of retirement villages have become involved, to varying degrees, in coordination and direct provision of these services. This has happened in particular when the same organisation, mostly not-for-profit organisations, is both a provider of retirement villages and a provider of home and community care services. Some examples of the ways that this has occurred are provided later in the report.

Similar developments have occurred in most other countries, although the particular pattern of development is shaped by the funding and organisational arrangements for home and community care services and housing services in each national context. For example, the US lacks a nationally legislated home and community care service on the Australian model. In the US, policy and funding arrangements for the provision of home care services are complex with multiple funding streams and administrative agencies (Stupp, 2000; see also Jones, Tilse, Bartlett and Stimson 2008, pp. 26–7). Even though the use of Medicare waivers for delivery of home and community based care has expanded, the involvement of multiple agencies makes the task of linking housing, home health care and other home care services highly complicated. In the UK, these issues have been shaped by relations between social services departments of local authorities, who have the main role in community care provision, health authorities who have the main responsibility for home health care, and housing authorities and housing associations, who have responsibility for social housing provision and for forms of service integrated housing such as sheltered housing (Heyward, Oldman and Means, 2002, pp. 61–6).

### *3.4.2 Locality-based home and community care*

In some countries the line between home and community care services and service integrated housing has been somewhat blurred by the development of organisations providing a range of home care services to a designated group of older persons living in their own homes in close proximity to one another, but not in the same housing complex or linked to particular forms of housing. While these forms of locality based community care provision are not evident in Australia, there are variations in the way publicly funded home and community care services operate in localities with different numbers and concentrations of older people. The development of Multi-Purpose Services, for example, has been a response to the needs of people living in small rural and remote communities.

#### *Collective home care*

The term ‘collective home care’ has been used to refer to such 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. An example of collective home care is the ‘supportive communities’ scheme that has operated in Israel since the 1990s. In 2004 there were about 88 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). Arrangements of this kind have also been called ‘virtual assisted living communities’.

### *Naturally-occurring retirement communities*

In the US, the term 'naturally-occurring retirement communities' (NORCs) was 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 such as retirement migration that lead to concentrations of older people in small local areas (Hunt and Hunt, 1985). These localities were not originally planned or designed for older people, are not age-restricted, and initially did not have any particular arrangements for services, but they are, it has been 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, and arrangements for service provision are also variable. 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 US, 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 14 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 US. 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), although an evaluation of NORCs conducted by the Urban Institute in 2004 was more cautious in its findings (Ormond, Black, Tilly and Thomas, 2004).

### *Similar UK models*

In the UK, an approach resembling the NORC model has been trialled in tower blocks housing high concentrations of older people. These tower blocks were redeveloped with upgraded concierge services and application of new electronic technologies (McGrail, Percival and Foster, 2001, pp. 148–53). The concierges perform similar roles to wardens in sheltered housing (see below) 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).

While arrangements such as collective home care and NORCs are sometimes presented as forms of service integrated housing, they are in fact home and community care programs in which eligibility is defined in terms of locality as well as other criteria. Australia has many examples of localities with high concentrations of older people, and the number of such localities will increase with the ageing of the population. While organisations providing home and community care services in such localities are not differentiated from those operating in other areas, they could be deemed to be offering NORC programs as that term is defined and used in some places in the US.

### *Multi-generational housing models*

Another set of services that blur the distinction between home and community care services and service integrated housing are multigenerational housing models that involve older people and younger families living in close proximity (e.g. within the same block of apartments) with the aim of facilitating informal support and care provision. Some of these models have developed in Asian countries where strong cultural norms underpin family care of elderly people (Ara, 1997; Chi and Chow, 1997; Hwang, 1997). In countries such as Singapore housing policies provide strong incentives for families to live with, or close by, ageing parents (Harrison, 1997). In Japan, public rental housing authorities provide 'paired apartment units' to enable families to live next door or in the same apartment complex as elderly parents (Kose, 1997, pp. 153–4).

A number of other initiatives to build multigenerational housing models that facilitate informal support can be identified. In Israel, a multigenerational housing project in Jerusalem 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 support 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. 152–4; Katan and Werczberger, 1997, p. 61).

The Supportive Home Living program in Nova Scotia, Canada is a somewhat different approach to multigenerational housing support. This program, which operated during the 1990s, comprised duplexes 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 support services at various levels. It was 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 (DTRD, 1996, pp. 21–2).

The closest that Australia comes to multigenerational housing is provision for medium density, small houses suited to older residents mixed in with family housing in large scale housing developments. While proximity may encourage support between generations within families, the housing developer in these cases does not have a role in delivery of support and care services. In other cases, retirement villages may be developed as part of a larger, general housing development and the housing developer may take on varying roles in management of the retirement village and delivery of services.

### **3.5 Service integrated housing offering lifestyle and recreation**

The first grouping of terms relating to service integrated housing in the international translation chart is 'service integrated housing offering lifestyle and recreation'. A limited number of similar terms are used to describe these types across countries and their common features are the provision of sporting and recreational facilities and activities, and social activities which typically have as their focal point a club house or community centre. Shared leisure interests and mutual informal support among residents also contribute to positive lifestyles. Service integrated housing of this kind

is typically aimed at older people in their 50s and 60s who are retired, in good health and seeking a lifestyle focused on sport and recreation. While some new developments have provided luxury accommodation and an expanded range of leisure facilities, some of the early established communities have responded to the ageing of their residents and developed more support services; these latter trend is discussed in sections 3.6 and 3.7.

### *Leisure oriented retirement communities*

The country with the greatest experience of service integrated housing offering lifestyle and recreation for retirees is the US. The first retirement communities or retirement resorts, as these developments were known, were built in the early 1960s. The best known examples are Leisure World in California and Sun City in Arizona. Initially retirement resorts were groups of small, relatively inexpensive dwellings located in an environment that offered a wide range of recreational facilities such as swimming pools, golf courses, a club house and organised leisure activities. Some were organised as cooperatives, but the dominant model by the late 1960s was home ownership combined with collective ownership of grounds and facilities. Some of the early retirement resorts have grown into retirement towns. Sun City, Arizona now has a population of 40,000 residents and Leisure World, California a population of 9,000.

During the 1970s and 1980s, some retirement resorts became increasingly luxurious and expensive, offering resort style amenities, wide choice of architectural styles, master-planned communities and security gating (Folts and Muir, 2002, pp. 20–1). As retirement resorts diversified, new terms were coined to describe housing models providing opportunities for older households to live in co-located settings oriented towards leisure and lifestyle goals. These terms were 'leisure-oriented retirement community' (LORC) and active adult retirement community (AARC).

In addition to sporting and recreational facilities and activities, LORCs and AARCs typically provide hotel services such as laundry, linen, building and grounds maintenance and transportation. 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 at special interest or affinity groups such as retired military officers or retired university staff (Benjamin and Anikeeff, 1998, pp. 14-15).

In the 1980s, a new phase of development of LORCs emerged involving age-restricted luxury rental apartments with a wide range 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. However, early estimates of demand for this type of housing proved over optimistic. By the late 1980s, private developers in the retirement housing industry shifted their primary attention to assisted living and similar products offering health services (Fairchild, Higgins and Folts, 1991). However, a recent study of LORCs concluded that many continue to provide a good quality of life for the small sector of the older population that are attracted to them (Streib, Folts and Peacock, 2007).

### *Lifestyle villages*

Many Australian retirement villages classified by Stimson as 'resort style' could be viewed as the equivalent of LORCS, although many such retirement villages also offer a range of other support services (Stimson, 2002, pp. 31–3). Many Australian retirement communities that primarily offer recreational, sporting and social facilities and activities to the over-55s are called 'lifestyle villages' and this term has been increasingly adopted over the last decade to highlight the active living environment over support and care, although these services may be available on an as-needs basis.

National Lifestyle Villages, a Western Australian company, has developed a chain of such villages mainly in Western Australia and there are self-styled 'lifestyle villages' in most Australian States. Lifestyle villages vary widely in their level of amenity. There is little systematic information concerning the residents of lifestyle villages, and it is too early to tell whether this form of service integrated housing will attract high demand over the longer term in the Australian context.

## **3.6 Service integrated housing offering support**

The second grouping of terms relating to service integrated housing in the international translation chart is 'service integrated housing offering support'. Table 2 shows a range of terms are used to describe this housing, with some common usage across countries. The housing types in this group have in common that they offer some or all of the following support services:

- barrier-free environments
- on-site management
- general property maintenance
- social and recreational activities
- group transport
- limited supervision such as personal alert/emergency call systems
- social support.

Within this broad service type, two sub-types can be identified: independent living complexes and shared housing. Shared housing by definition involves closer interaction between residents and is also distinguished by the provider taking a greater role in organising social and recreational activities, transport and so on, whereas in independent housing, more is left to the initiative of residents. These forms of service integrated housing are clearly distinguished from those offering lifestyle and recreation (outlined above in section 3.4) in that they offer a wider range of support services and are intended, for the most part, to offer a supportive environment. They are distinguished from service integrated housing offering support and care (described next in section 3.6) in that, in general, they do not provide 1-to-1 care services.

### **3.6.1 Independent living complexes**

The generic term 'independent living complex' is used in the translation chart to refer to forms of independent living arrangements designed for older people in a communal environment providing basic support services such as on-site management, property maintenance, limited supervision including personal alert/emergency call systems, and some social and recreational activities. The main term used internationally to refer to this form of service integrated housing in the US is similar, namely 'independent



living facility' (ILF), but the UK term 'sheltered housing' connotes a more supported environment although this is not the case.

In Australia, independent living units funded under the *Aged Persons Homes Act 1954*, together with many retirement villages and manufactured home estates can be categorised as independent living complexes. Recent diversification of retirement villages, however, means that many now combine independent living or self-care units with other categories identified in the translation chart.

### *Independent living facilities*

'Independent living facilities' (ILF) in the US are retirement communities that provide a supportive living environment for older people who are able to live independently without regular nursing or personal care assistance (Anikeeff and Mueller, 1998, p. 97). Many terms are used to refer to particular ILFs in the US including retirement communities, retirement homes, senior apartments and independent living communities. Typically, ILFs provide on-site management, property maintenance and some social and recreational activities, and some also provide hotel services. In many ILFs the typical age of residents is late 70s to early 80s, although some are oriented toward younger residents. Residents pay a monthly rental charge to cover their accommodation and services and while costs vary, ILFs are generally accessible only to middle income older people with some assets.

Over time, as residents have become frailer, some ILFs have made arrangements for provision of additional services and so ILFs have moved towards categories of service integrated housing providing support and care. This direction of development exemplifies the trends to market segmentation, and contrasts with other trends, such as the growth of more luxurious leisure focused retirement communities noted above.

### *Sheltered housing*

While ILFs are somewhat similar in concept to many Australian retirement villages, sheltered housing as developed in the UK is a markedly different housing model. 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 describe sheltered housing 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. 27–8).

This definition draws attention to the key defining features of sheltered housing: small scale; based on self-contained accommodation; providing shared facilities; and involving the support of a warden. While these are the essential characteristics of sheltered housing, there is now wide variation within the model in size, design, accommodation, range of facilities and level of support provided (Dickinson and Whitting, 2002, p. 39). Historically, sheltered housing can be seen as positioned between Australia's ILUs and hostels prior to 1997, but the more current comparison is with self-care units in retirement villages.

An extensive discussion of the history of sheltered housing in the UK provided in the earlier report on this research project showed how what was once seen as a positive model in the 1950s and 1960s became less acceptable and indeed controversial by the 1980s and 1990s (Jones, Tilse, Bartlett and Stimson, 2008). Unlike many ILFs in

the US and retirement villages in Australia which have been developed in the private sector, much of the sheltered housing in the UK has been funded and provided by local authority housing departments, with local authority social services departments providing occasional services to residents as required. While residential care was also provided by local authorities, few sheltered housing complexes were co-located with nursing homes. The role of housing associations as providers increased over time, in part through purchasing sheltered housing projects sold off by local authorities through the 1980s under the Thatcher Government.

From the 1950s to the 1980s, provision of sheltered housing grew steadily as it was viewed as a cost-effective alternative to residential care and nursing homes (Heywood, Oldman and Means, 2002, pp. 124–5). A key claim was that sheltered housing was the antithesis of the total institution:

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).

These claims sustained the growth of sheltered housing for many years. However, during the 1980s sheltered housing dropped out of favour at the policy level as opinion shifted in favour of community care. Sheltered housing was depicted as a thinly disguised form of institutional care, that is, expensive and stigmatising and not in harmony with independent living and personal autonomy (Oldman and Quilgars, 1999, pp. 368–9). Furthermore, by the 1990s demand for sheltered housing fell away due to higher home ownership and better housing of successive cohorts of older people, and a number of sheltered housing schemes became difficult to let. In some older schemes the housing was unattractive and poorly located, comprising small bed-sitter accommodation with shared facilities (Appleton and Porteus, 2003; Dickinson and Whitting, 2002).

Other difficulties related to aspects of the housing model itself. One such feature 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 required (Appleton and Porteus, 2003, p. 4). In the 1990s this concept was widely criticised on the grounds that it represented a confused understanding of the role of sheltered housing: 'there is a contradiction at the heart 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 was also argued that the term 'warden' had strong institutional connotations that were inappropriate for a housing service emphasising independent living (Clapham and Munro, 1990, pp. 35–6). While the term 'warden' persists, the role appears to have shifted since the early 1990s towards one of care management, linking residents to community care services (Heywood, Oldman and Means, 2002, p. 127). However, conflicting expectations and lack of clarity regarding the warden's role were seen to reflect fundamental ambiguities about the service model.

Despite these criticisms, there is 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 main attractions appear to be the support, monitoring and service coordination provided by wardens, the provision of

maintenance and repairs services, the reduction of social isolation, and the sense of security (Nocon and Pleace, 1999). Recognition of these benefits has led some to argue that more attention needs to be given to the specific roles and purposes 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. 131–2).

The sheltered housing model and similar models are widespread elsewhere in Europe and in some other countries. In the Netherlands, 'sheltered housing' comprises a wide range of forms of independent living, usually in an apartment complex and including an electronic alarm system and links to nearby service centres (Van Vliet, 1995). Some sheltered housing in the Netherlands is upmarket 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 Egdorn, 1997).

In Denmark, 'sheltered housing' for elderly people was developed in the 1970s and 1980s. Sheltered housing consisted of a number of two-room flats, along with common rooms, alarm systems, and staff support. However, 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 outsourced to local home and community care providers. The designation of these dwellings as 'sheltered housing' was removed in 1995 (Gottschalk, 1995).

Other countries that have developed sheltered housing models include Germany, Israel, Singapore and Japan. Much of this development occurred in the 1980s, and was based on the UK model (Heumann, 1995, pp. 142–9). Germany has limited provision of sheltered housing for the elderly comprising purpose-built apartments and assistance in utilising locally available services (Dieck, 1995). Sheltered housing is also available on a limited scale in Israel provided primarily by state and non-government organisations, with some 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). Singapore has a number of 'sheltered homes' located within apartment buildings which combine self-contained units and collective facilities (Harrison, 1997, pp. 45–6). Japan has 'silver housing projects' which provide specially designed dwellings, social support and 'life support advisors' (Kose, 1997, p. 156).

### *Australian models*

The main Australian models of independent living complexes were discussed in Chapter 2. Many independent living units funded under the Aged Persons Homes Act 1954 continue to operate as small-scale cluster housing providing varying levels of support and care (section 2.2). These older ILUs are akin to basic retirement villages, but newer retirement villages that are now the main form of independent living complexes in Australia are rapidly diversifying (section 2.5). Most provide the basic range of support services associated with independent living complexes, but increasing numbers are also providing or facilitating the provision of other services including hotel services and varying levels of care (discussed later in this chapter). Many established retirement villages and some newer villages have emulated the three-tier complexes that initially developed under the APHA by drawing on a range of

options for capital and recurrent funding to provide assisted living and residential aged care homes on the same or contiguous site. The physical form of retirement villages is diversifying with more medium-density apartments and a few 'vertical villages' designed as high-rise apartments. Some retirement villages are offering rental tenure rather than conventional strata title, leasehold and licensing arrangements.

Another form of diversification of retirement villages is the development of affordable rental villages as a new service type during the last decade, particularly by Village Life and other private companies. These villages provide low-cost accommodation that includes apartments with kitchenettes, basic support services, the provision of all meals in a central dining room and a linen service. However, no care services are provided by the village operators. Concerns have been raised that the high proportion of their income that many residents pay for this accommodation, combined with the lack of fully self-contained apartments, leaves residents highly dependent on village management (Jones, Bell, Tilse and Earl, 2007).

Growing numbers of older people in Australia also live in manufactured home estates and residential parks in which occupancy is restricted to seniors. While terminology varies from state to state, these developments can be viewed as types of independent living complexes. Housing forms range from manufactured or relocatable homes to small cabins and caravans. Typically, residents own their home but lease the site and pay a charge for use of amenities and facilities. These tenure arrangements are designed particularly for those who downsize but whose realised assets are not sufficient to buy into a conventional retirement village, and may enable some residents to qualify for Commonwealth Rent Assistance. Manufactured home estates are comparable to mobile home parks in the US, where specialised parks for those aged 55 and over are commonly referred to as 'retirement communities'.

### *3.6.2 Shared housing*

In this context, the term 'shared housing' refers to living arrangements for older people where small numbers of unrelated persons live together in a dwelling unit, with a mix of shared and private facilities, with the aim of providing a supportive environment. Internationally, there are a number of forms of shared housing that have played a significant role in the housing of older people. One of these is Abbeyfield Housing, a form of group housing for older people first developed in the UK. The living environment in an Abbeyfield House consists of around 10 separate bed-sit rooms located in a communal dwelling, with common dining, living, and laundry facilities. The communal environment is designed to encourage 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 (Hallman and Joseph, 1997).

A somewhat similar model of small group housing for older people from rural communities is the French MARPA project (Maison d'Accueil Rural pour Personages Agés). This model comprises a complex of up to 20 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 activities 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 financially structured to be accessible to those on low incomes (DTRD, 1996, p. 15).

Another form of shared housing is 'agency-assisted shared housing', a supervised matching service that brings together a provider of housing, typically an elderly homeowner requiring assistance, security and companionship, and another person, usually younger, able to provide this support in return for inexpensive or free

accommodation. Home Share is a UK program of this kind, and there have been similar organisations in the US since the 1980s (Pranschke, 1987; Rahder, Farge and Todres, 1992; Schreter, 1985, pp. 123–4). A related model in the US was Share-a-Home which 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 in the 1970s 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).

Another form of shared housing for older people in the US is the board and care home (Oltman, 1981). Board and care homes are housing facilities for older people or people with disabilities who need assistance with personal care and daily living activities. 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). Standards of care in board and care homes are uneven, but it has been argued that many provide good quality care in relatively informal contexts, thus providing an important alternative to more institutionalised settings (Eckert, Namazi and Kahana, 1987).

The final type of international shared housing identified for this study is co-housing. Co-housing is a European cooperative housing model involving households opting to live together as part of a supportive community, with a mix of personal and public spaces. Co-housing typically involves 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. It 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). The model is most prevalent in European countries including Denmark, the Netherlands and Germany, but has not been adopted widely in other countries. A study of intentional intergenerational households in the US concluded that housing models based on notions of shared community tested the boundaries of cultural acceptability in the US context (Folts and Muir, 2002, pp. 19–20).

Shared housing has remained a small segment of service integrated housing provision in all countries, with the partial exception of the US, and attempts to export models such as Abbeyfield Housing, Home Share and co-housing to other countries have had only modest success. This is certainly the case in Australia. There are a number of Abbeyfield Houses scattered across Australia, but the model has not been widely embraced by the community housing sector or government. Wesley Home Share in Melbourne, which is based on the UK Home Share program, is the only agency assisted program for shared housing for older people in operation in Australia. There is no formal, direct equivalent to board and care homes for older people in Australia. Co-housing has so far received only limited attention in the Australian context (Bamford, 2002). It seems unlikely that these forms of shared housing will play more than a minor role in the future development of service integrated housing in Australia.

Boarding houses, particularly larger ones, fit somewhat awkwardly into the category of shared housing. They are the only form of such housing that has been widespread in the Australian context. Boarding houses provide low cost accommodation mainly in inner-city areas of larger cities. Residents are low-income people, including significant number of older people, especially men. Boarding houses offer long-term single or shared rooms, often furnished, and usually shared bathroom, kitchen and laundry facilities. In many boarding houses meals and serviced rooms are provided. Historically, most boarding houses have been privately run, but the community and public sectors are also involved in boarding house provision. Boarding houses are regulated by state governments. Residents receive Commonwealth Rent Assistance but operators do not receive any subsidies for support services, and usually the support provided by on-site managers is minimal. However, residents are eligible for HACC and other community services. Boarding houses are of variable quality and most private boarding houses are operated solely as low-cost accommodation rather than as formal services for older people.

### **3.7 Service integrated housing offering support and care**

The third grouping of terms relating to service integrated housing in the international translation chart is 'service integrated housing offering support and care'. In addition to offering some or all of the support services offered by the service integrated housing types offering support described in section 3.6, they provide care services that may include:

- property maintenance in response to individual needs, such as installation of aids and equipment
- assistance with domestic work (cooking, cleaning, laundry, shopping and household management)
- individualised transport services, such as for those using mobility aids
- assistance with self-care (bathing, toileting, dressing, grooming, eating, medication)
- visiting or on-call nursing care (not on-site 24 hours)
- other health care including facilities for visiting allied health services (podiatry, occupational therapy, physiotherapy)
- case management and counselling.

The large number of different terms used to describe the types of services and housing within this group may suggest that they have little in common. This diverse terminology however derives from the many options for combining a wide range of forms of housing with different mixes of support services and care services, and changing mixes over time, and masks a considerable degree of commonality:

Within this broad service type, two sub-types can be identified: 'housing with care', in which care is provided across a limited range of resident dependency, and 'housing with continuing care' in which the resident can receive increasing levels of care as their needs increase.

#### **3.7.1 Housing with care**

The term 'housing with care' refers to housing arrangements that offer support services and a range of care services to frail older people, but which do not provide access to 24-hour nursing care on-site. The most common type of housing with care in Australia emerged through the provision of subsidies for personal care for hostel residents, but limited development of hostels in the early 1990s and their subsequent

absorption into the residential aged care program under the *Aged Care Act 1997* saw the role of hostels in providing supported accommodation with only limited care services give way to a much greater focus on care. This shift in the role of hostels left a gap that Australian policy-makers and providers have been slow to address compared to the new forms of housing with care that have emerged in the US, the UK and a number of European countries over the last decade or two.

Paradoxically, while Australia was aligning hostels and nursing homes in a single residential aged care program, new models of integrating care services with housing in other countries have aimed at providing alternatives to nursing homes. The last few years have however seen new models of housing with care emerging in Australia, often based on international models, and it is therefore instructive to examine the international models which include congregate seniors housing (CSH), service coordinators and assisted living facilities (ALFs) in the US, extra care housing in the UK, and service housing in Europe. More extensive descriptions of each of these models is provided in the earlier report on this project (Jones, Tilse, Bartlett and Stimson, 2008).

### *Congregate seniors housing*

CSH is a term used in the US to refer to housing provided on a congregate basis for older people who receive support services plus meal services and low-level assistance with activities of daily living. CSH is also known as service-enriched housing and supported housing. Most facilities referred to as congregate housing have separate apartments for each resident plus shared areas for meals and recreation. Most CSH facilities offer on-site management, at least one shared meal per day, housekeeping, property maintenance, transportation, organised activities and some assistance with activities of daily living. 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. 96–7; Howe, 1999).

The term emerged in the context of the Congregate Housing Services Program (CHSP), a federal program that commenced in the 1980s to provide assistance to public and non-profit housing projects to provide meals and other supportive services to increasingly dependent populations. The origins of congregate housing lay in concerns about the increasing frailty and dependency of older residents in public and community housing apartments (Sheehan, 1987). In the early 1970s large numbers of older social housing tenants were facing eviction due to their inability to continue to live independently, and this trend directed attention to the need to develop housing options that provided support services for lower-income, older people. Supplementation of previously independent living complexes with congregate services demonstrates the dynamics of service integrated housing as existing forms change and in turn shape the development of new services, and alongside the CHSP, many other federally assisted housing projects introduced support services in ways that brought them very close to the definition of congregate housing (Monk and Kaye, 1991, pp. 9–11; Moore, 1992; Warach, 1991). ‘Congregate seniors housing’ can now be viewed as a generic housing type as well as housing subsidised under a particular program, and is now also provided through the private sector, and price and quality now vary widely.

### *Service coordinators*

An alternative to direct provision of services as found in congregate housing is the employment of service coordinators in older persons’ housing projects to facilitate linking residents with home care and home health services. The service coordinator program began as a federally funded program in the US in the 1990s, and by 2003

there were over 3,000 service coordinators employed in publicly funded housing complexes for older people (Pynoos and Nishita, 2005, p. 253). Service coordinators assess the needs of residents, provide information and referrals 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. 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).

### *Assisted living*

The term 'assisted living' is widely used in the US to refer to residences designed for frail older people who need, or anticipate needing, 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). ALFs have been distinguished from other forms of service integrated housing on four criteria:

- 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 [nursing] care' (Kalymun, 1990, p. 129).
- Making neither an explicit or implied commitment to provide continuing care to meet increasing care needs, nor having the capacity to provide such care.

Many definitions of ALFs seek to distinguish them from nursing homes on the basis of these criteria. For example, a recent definition proposes that:

Assisted living is a housing option that involves the delivery of professionally managed supportive services and ... 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.

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), and this growth is expected to continue. Figures from the National Centre for Assisted Living indicate that in 2004 there were approximately 36,000 assisted living residences in the US housing more than 900,000 people (NCAL, 2007). Most of the growth in assisted living has been initiated by the private sector, rather than the not-for-profit sector. A number of large companies providing ALFs have emerged during the past decade, the largest being Sunrise Senior Living with 397 facilities in 38 states.

One consequence of the rapid growth of ALFs has been the development of a significant body of research addressing issues of service quality and access. Four key themes have been the quality of the physical environment, the quality of life of residents, continuity of residence and affordability.

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 approach 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).

Nevertheless, the physical environment of some ALFs limits their capacity to provide a residential setting with high levels of privacy and autonomy. The 1998 national survey of ALFs found that more than one-third (38 per cent) of all ALF units required the resident to share a bathroom and 25 per cent of residential units were units shared with unrelated persons. The survey classified ALFs in terms of level of privacy and level of services. Only 10.9 per cent scored high on both criteria (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).

A number of studies have explored the factors associated with the quality of life of residents in ALFs. 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 are key strategies (Cummings, 2002; Dobbs, 2004). The quality of the physical environment has also been identified as a factor impacting on perceived quality of life (Brandt, Kelley-Gillespie, Liese and Farley, 2004).

The issue of continuity of residence in ALFs has also been examined (Frank, 2001). Most ALFs 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 for many self-care activities. However, most ALFs do not offer ongoing care irrespective of changes in health and cognitive functioning (Hawes, Phillips, Rose, Holan and Sherman, 2003, pp. 880–1), and 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 only 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).

Finally, research has focused on the affordability of assisted living, and consideration of ways to extend assisted living to lower income households. Most residents in assisted living pay for their accommodation and 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). 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). There is evidence that racial and ethnic minorities are significantly under-represented in ALFs (Dietz and Wright, 2002).

### *'Extra care' or 'very sheltered' housing*

The UK equivalent to assisted living is known as 'extra care' or 'very sheltered' housing. In the UK context, extra care housing has been described as '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). Typically extra care housing comprises a small housing development based on self-contained one or two-bedroom accommodation (usually flats or bungalows) and a resource centre (Riseborough and Porteus, 2003). It usually includes accessible design features and assistive technologies and provides a range of care services including: care staff, (probably providing 24-hour coverage); 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 include all of these elements, but a combination involving most of these is the distinguishing mark of extra care housing.

Extra care housing first developed in the late 1970s when a number of local authorities and housing associations recognised 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. Initially called 'very sheltered housing', extra care housing grew steadily in the 1980s and boomed in the 1990s. Whereas early models included supplementation of existing sheltered housing, new developments included more accessible design features and higher standards of accommodation overall.

The growth of extra care housing received official endorsement from the 1994 Department of Environment report on *Living Independently* and from the 1999 Royal Commission on Long Term Care (Peace and Holland, 2001a, p. 15). During the 1990s there was a diversification of terminology and forms of provision. Housing arrangements in the UK 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. However, it is important to note that the sector remained 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 emergence of extra care housing is the most significant and widespread innovation in service integrated housing in the UK 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). A number of key issues highlighted in this and other research can broadly be divided into 'consumer-focused' issues and 'policy and management' issues.

From a **consumer perspective**, evaluations of extra care housing are generally highly positive. In terms of independence, residents strongly value their own self-contained accommodation, which provides privacy as well as autonomy, a sense of being at home, and continuation of family relationships. 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. The security of knowing that help is on hand is also valued, as is a sense of feeling safe from crime and intruders. 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 the health and wellbeing of residents. 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 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. 56–69).

From a policy and management perspective, evaluations of extra care housing are more mixed and a range of concerns have been raised. Prominent amongst these are concerns about **institutional drift**, that is, 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 UK 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. 128–9). Similar concerns have been raised in the US that increasing regulation of ALFs will 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).

A related issue 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. 129–30). Some extra care housing developments in the UK 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 37–8).

One of the most contentious management issues in extra care housing is that of **continuing care**. Heywood, Oldman and Means (2002, p. 130) have posed the question 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? 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. 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 care in a residential care home or nursing home for some, for some period of time, it is not likely to be a replacement for these forms of more intensive care (Croucher, Hicks and Jackson, 2006, pp. 70–80).

Finally, there is the issue of the **cost-effectiveness** of extra care housing relative to residential care and home care. While definitive evidence is lacking, there is some 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, which in turn raises issues concerning the financial arrangements under which extra care housing is provided, and the issue of affordability to low income older residents (Croucher, Hicks and Jackson, 2006, pp. 80–5).

### *Service housing*

'Service housing' is the term used in several European countries including Sweden, Finland, Denmark and Germany to describe forms of service integrated housing that are broadly equivalent to extra care housing in the UK and assisted living facilities in the US, and which grew from around the same time. In Sweden, service housing comprises non-institutional housing with care for older people within housing blocks, including access to a range of services including restaurants, hairdresser, chiropody, activity rooms and occupational therapy. Care services are provided in-house or by home care services (Phillips, Means, Russell and Sykes, 1998, p. 1). Service houses are owned and operated by municipal governments and typically ranged in size from 40 to 100 apartments. 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). Similar forms of service housing are found in Denmark (Gottschalk, 1995, pp. 30–1) and Germany (Dieck, 1995, pp. 125–6).

As a variation on service housing, Sweden has developed 'small group housing' 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 houses have been described as 'a kind of hybrid that combines features of both institutional and community care' (Monk and Cox, 1995, p. 263).

Service housing in Finland was developed in the 1980s as part of a general policy to decrease the level of residential care for older people. It is built according to accessible design principles, and includes communal facilities such as kitchen, dining room and laundry. Meals are also provided. There is access to 24-hour care and home care services were provided. Most service housing is rented, and residents have the option of paying for extra services. There are state-funded care packages for

individuals with high needs. For individuals requiring higher levels of care, 'heavy service housing' is available with higher staff/resident ratios (Phillips, Means, Russell and Sykes, 1998, pp. 3–4).

### *Australian models*

Several quite diverse forms of housing with care are to be found in Australia, although variants of this type of service integrated housing have been slower to emerge than in the US and UK. As originally conceived, hostels funded under the *Aged Persons Homes Act 1954* were to provide independent accommodation for older people in a shared building with limited support and supervision. However, over time the range of services and the proportion of residents receiving care services increased, and for many years hostels were a form of service integrated housing that was very similar to congregate seniors' housing in the US and extra care housing in the UK, all catering for frail older people requiring support and personal care services.

By the late 1980s, hostels had become a form of residential care for frail older people whose dependency ranged from low levels up to nursing home care. This upwards shift was especially evident where hostels and nursing homes were co-located or operated by the same providers who sought to maintain residents in hostels rather than requiring them to move. Recognition of this overlap in dependency of hostel and nursing home residents was one of the main drivers of changes the 1997 funding changes that enabled residents of hostels to 'age in place' and receive nursing home care. The terms 'hostel' and 'nursing home' were replaced with 'low care' and 'high care' respectively, and the nexus between level of care and type of facility was blurred as the two separate scale that had been used for recurrent funding was replaced with a single scale applied across all residential aged care homes.

As discussed in Chapter 2, in recent years many Australian retirement villages have begun to provide serviced apartments within their facilities as an additional option to standard independent living units. In this context, the term 'serviced apartment' refers to a one or two-bedroom apartment in a retirement village including services such as cleaning, laundry and assistance with self-care activities. Meals can be provided in a dining room setting, and a small kitchenette may also be included within the apartment. In some retirement villages these services have been extended to also include personal care services including medication supervision and podiatry. The range and level of assisted living services is tailored to the needs of residents and use is instigated by the resident. In addition, the full spectrum of HACC services, including nursing care, may be available to residents in serviced apartments. The development of serviced apartments and assisted living facilities represents an important diversification of retirement village services.

The final group of Australian services that can be included in this category is supported residential services (SRS), also known as supported accommodation services, licensed residential centres and supported residential facilities. These terms refer to residential homes which provide accommodation and personal care for people with disabilities, including frail older people, who need support in tasks of daily living. Accommodation in SRSs is usually in furnished single or shared rooms. Care usually includes assistance with showering, personal hygiene, dressing, meals and medication, as well as emotional support. Residents may receive rent assistance. Most SRSs are provided by the private sector and they are not funded as residential aged care homes.

#### *3.7.2 Housing with continuing care*

The term 'housing with continuing care' refers to housing arrangements that, in addition to offering support and care services, also emphasise their capacity to

provide continuing care that is adaptive to the changing needs of the older person over the whole period of later life. In the US these services are often referred to as continuing care retirement communities (CCRCs) or life care communities. In the UK they are referred to as retirement communities. Apartments for Life is a model developed by Humanitas in the Netherlands that also emphasises continuing care and which has attracted considerable interest in Australia. The distinctive features of these international models are briefly described below.

### *Continuing care retirement communities*

In the US context, 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). CCRCs offer continuity of care – often termed ageing-in-place – with flexible accommodation designed to meet health and housing needs as these change over time. 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. These contracts usually involve a sizeable entry fee as well as monthly rents/charges. Contracts are effectively a form of insurance against the risk of requiring nursing care in later life. The levels of entry and service fees charged by most CCRCs restrict entry to households with above-average income and assets.

Much of the growth of CCRCs in the US occurred in the 1980s and by 1990 there were approximately 800 CCRCs in the US (Netting and Wilson, 1991). However, expectations that their number would continue to grow (Williams, 1985) do not appear to have been realised. Many CCRCs have encountered financial problems due to the difficulty in accurately predicting the risk of residents requiring relatively high levels of care (Folts and Muir, 2002, pp. 21–2; Nyman, 2000, pp. 95–6; 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 promise of lifelong housing and care (Nyman, 2000, p. 96; Alperin and Richie, 1990). In some CCRCs the period of nursing care provided under the initial contract is capped, and in others nursing care and other services incur additional charges. In this sense many CCRCs in the US should be viewed as offering continuous care within the one facility, but not necessarily on terms that guarantee complete 'life care'.

### *Retirement communities (UK)*

Retirement communities have not been part of the UK experience with service integrated housing until quite recently. It is only in the last decade that a small number of retirement communities have been developed, and these reflect the influence of international models, particularly CCRCs in the US (Bernard, Bartlam, Sim and Biggs, 2007). Two projects in particular have been viewed as important pioneering approaches: Hartrigg Oaks located on the outskirts of York, and Berryhill Retirement Village in the North Midlands.

Hartrigg Oaks which opened in 1999 is an initiative of the Joseph Rowntree Housing Trust. It is widely described as the first example in the UK 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 and 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 covering 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). 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 has been described as 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 (Croucher, Hicks and Jackson, 2006, pp. 560–85). Home-based care services were used quite extensively by residents and there were both short-term and permanent admissions to the residential care home. 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 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 or not 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. 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 UK'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 service integrated housing in other national contexts.

### *Apartments for life*

The concept of 'apartments 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 'apartments for life' was coined by the Humanitas Housing Foundation based in Rotterdam, the Netherlands, and there are several such complexes operated by the 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 also been a focus of public policy in Denmark (Cates, 1994). Since the 1980s, the Danish approach has been 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 frail older people located close to service centres that provide and coordinate the provision of home-based nursing and community care. In response to criticisms that older people felt too isolated in special housing, more common spaces and service facilities were introduced (Lindstrom, 1997, pp. 115–24). This approach effectively does away with the dichotomy between residential and community-based care and is similar to the 'apartments for life' approach (Monk and Cox, 1995, p. 263).

### *All age communities*

A different approach to the provision of service integrated housing for older people is the concept of 'all age communities', that is, housing with care arrangements for older people that are included within the wider community and not 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. 46–9). 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 40 apartments for frail older people. It is argued that this approach,

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)

### *Australian models*

Three different models of providing continuing care in service integrated housing have developed in Australia, but rather than providing for increasing levels of care to be delivered to the resident who remains in the same housing unit, all may require some degree of transfer to accommodation in a residential aged care home as needs change.

The longest established model is the three-tier complex of ILUs, hostels and nursing homes developed under the APHA. Co-location facilitates moves to a more appropriate setting as the needs of the older person change. In this model, also known as 'ongoing care' and 'continuum of care', admission to residential aged care is subject to external assessment of need which then confirms access to care subsidies.

Some retirement villages also offer continuing care through the same three-tiers, or increasingly with serviced and assisted living apartments as alternatives to the hostel tier. Care services in these alternatives are provided by drawing on HACC services and the various forms of community care packages, in some cases delivered by retirement village operators who are Approved Providers under the Aged Care Act, and in other cases through arrangements with external providers.

Access to subsidised HACC services and care packages also enables operators of retirement villages to provide some level of continuing care that may support a resident in an independent unit through the level of low care that would otherwise require a move to a hostel, so that if and when a move is necessary, it is likely to be to a nursing home. These models are based on the original model of CACPs which began as 'hostel options' that delivered hostel services on an outreach model to residents in ILUs. The resident's unit in the retirement village is 'their own home' as is the home of resident living in the wider community for the purposes of delivering care services. It can be argued that this approach provides a more flexible model of continuing care than the international models described above as it involves a wider mix of housing and community care providers and tailoring of support and care more specifically to the needs of individual residents in independent living settings rather than having particular levels of care services delivered only in particular housing settings. This model has also gone some way in meeting calls made in the early 1990s for unpacking the level of care that was tied to hostels, but this progress on the ground has not been widely recognised in policy making.

## **3.8 Residential aged care homes**

The term 'residential aged care home' (RACH) is the generic term used in Australia to refer to all facilities providing accommodation, support and care, including 24-hour nursing care, to older people no longer able to live independently in their own home,

and approved for benefits paid by the Australian Government. As indicated elsewhere in this report, prior to 1997 RACHs were divided into hostels providing 'low care' and nursing homes providing 'high care' services. Nursing home and hostel are still used to refer to different kinds of facility rather than levels of care, they no longer have official status.

The term 'nursing home' is used in many countries and has the same meaning as that provided above in the definition of RACHs. The other term commonly used in the UK is 'residential care' which refers to residential accommodation for older people provided by local authorities, which in many instances provides accommodation, support and care similar to that provided in nursing homes. The term 'skilled nursing facility' is a term meaning 'nursing home' that is widely used in the US.

Residential aged care homes do not fall within the definition of service integrated housing used in this report as they are not private dwellings. They are included in the international translation chart as they are terms widely used in discussion of service integrated housing, but they are not discussed further in this chapter.

### **3.9 Summary and conclusions**

Approximately 90 terms have been identified in this chapter referring to various types of service integrated housing and closely related services or facilities. In the course of the chapter the meaning of each of these terms has been defined, and terms used in other countries that are equivalent or approximately equivalent to terms used in Australia have been identified. All of the terms used in Australia and internationally to refer to service integrated housing and related age care services have been grouped into six broad categories. This categorisation has been used as the basis for considering the lessons that can be learnt from the experiences of other countries for service integrated housing in Australia.

This analysis of types of service integrated housing in Australia, the US, the UK, Europe and a number of other countries has led to a number of conclusions that are relevant to the aims of this study. Importantly, the analysis has found that in all the countries reviewed service integrated housing is playing an important role in meeting the need for housing, support and care in the older population. In the US, the UK and throughout Europe there are three broad sets of services that comprise aged care provision: home-based care; residential aged care homes; and service integrated housing. In both the US and the UK the service integrated housing sector is characterised by expansion and innovation, and is receiving extensive attention from policy-makers and service-providers in the public, community and private sectors.

The analysis has also found that, despite great differences in terminology, the broad types of housing that comprise the service integrated housing sector appear to be generally similar in the countries reviewed. Most service types fit into one of the following categories:

- Service integrated housing offering lifestyle and recreation.
- Service integrated housing offering support: group housing.
- Service integrated housing offering support: independent living complexes.
- Service integrated housing offering support and care.
- Service integrated housing offering support and continuing care.

This broad categorisation serves a number of purposes. Firstly, it provides a basis for making general statements about the distribution of types of service integrated housing within a country at a particular time. Definitive statements about what kinds of

- While there are providers in Australia focusing on provision of service integrated housing primarily offering lifestyle and recreation for the healthy aged, this does not appear to be the main market.
- Group housing models have attracted only a modest level of interest in Australia.
- The main development in Australia has been in independent living complexes (mainly retirement villages) providing independent accommodation and support services.
- Service integrated housing offering support and care has been slower to develop in Australia than in the US and UK where assisted living facilities (US) and extra care housing (UK) are relatively well established. However, this is changing with the growth of serviced apartments and assisted living facilities in retirement villages.
- Service integrated housing offering support and continuing care appears to be taking a different path to that in the US and UK where 'insurance' models have emerged in continuing care retirement communities (US) and retirement communities (UK). More flexible models involving three-tier complexes and the use of HACC services and CACP and EACH packages in retirement villages seem more likely to develop.

The identification of categories of service integrated housing and the location of service types within these categories is also important for lesson learning from the international research literature. There is now a quite extensive literature on service integrated housing much of which has been referred to in this chapter. For example, research on assisted living facilities in the US and extra care housing in the UK provides a strong evidence base on topics such as the factors associated with perceived quality of life; the factors which promote independence, autonomy and choice; the problem of 'institutional drift'; the barriers to providing continuing care; problems of access for low-income older people; and the cost effectiveness of service integrated housing providing support and care compared with residential and home-based aged care. These are significant policy and service provision issues and will be discussed further in the final chapter of the report.

## **4 CLASSIFICATION OF SERVICE INTEGRATED HOUSING**

### **4.1 Introduction**

Service integrated housing in Australia comprises an assortment of housing types that are described by many terms including: independent living units, retirement villages, boarding houses, manufactured home estates, lifestyle villages, serviced apartments, affordable rental villages, supported residential services, assisted living facilities, three-tier complexes, Apartments for Life, and Abbeyfield Housing. The purpose of Chapter 3 was to clarify this terminology both as a set of terms used within Australia and as a set of terms that are located within an international context. This was achieved by:

- Providing precise definitions for each term and for terms used in other countries.
- Identifying similarities and differences in terms used in Australia and in other countries by locating terms with similar meanings adjacent to one another on the international translation chart.
- Further identifying these similarities and differences by grouping terms and the services that they refer to into broad categories based on the range and type of services they provide.

With this clarification of terminology achieved, the aim of Chapter 4 is attempt to provide a classification of the various forms of service integrated housing that have developed in Australia. The classification is build around three parameters: the sector of the organisation providing the housing; the dwelling structure/type; and the nature of service provision arrangements. In the next chapter, case examples of service integrated housing are provided to illustrate the significance of these dimensions, the ways that the classification system can be used, the diversity of housing in Australia, and the likely future shape of service integrated housing in Australia. The implications for policy and service provision that are raised by this classification and by consideration of the cases will be discussed in the conclusion to the chapter and in the final chapter of the report.

### **4.2 Classification**

Service integrated housing can take many different forms. In section 1.2 of this report, the following dimensions of diversity of service integrated housing for people in later life were identified:

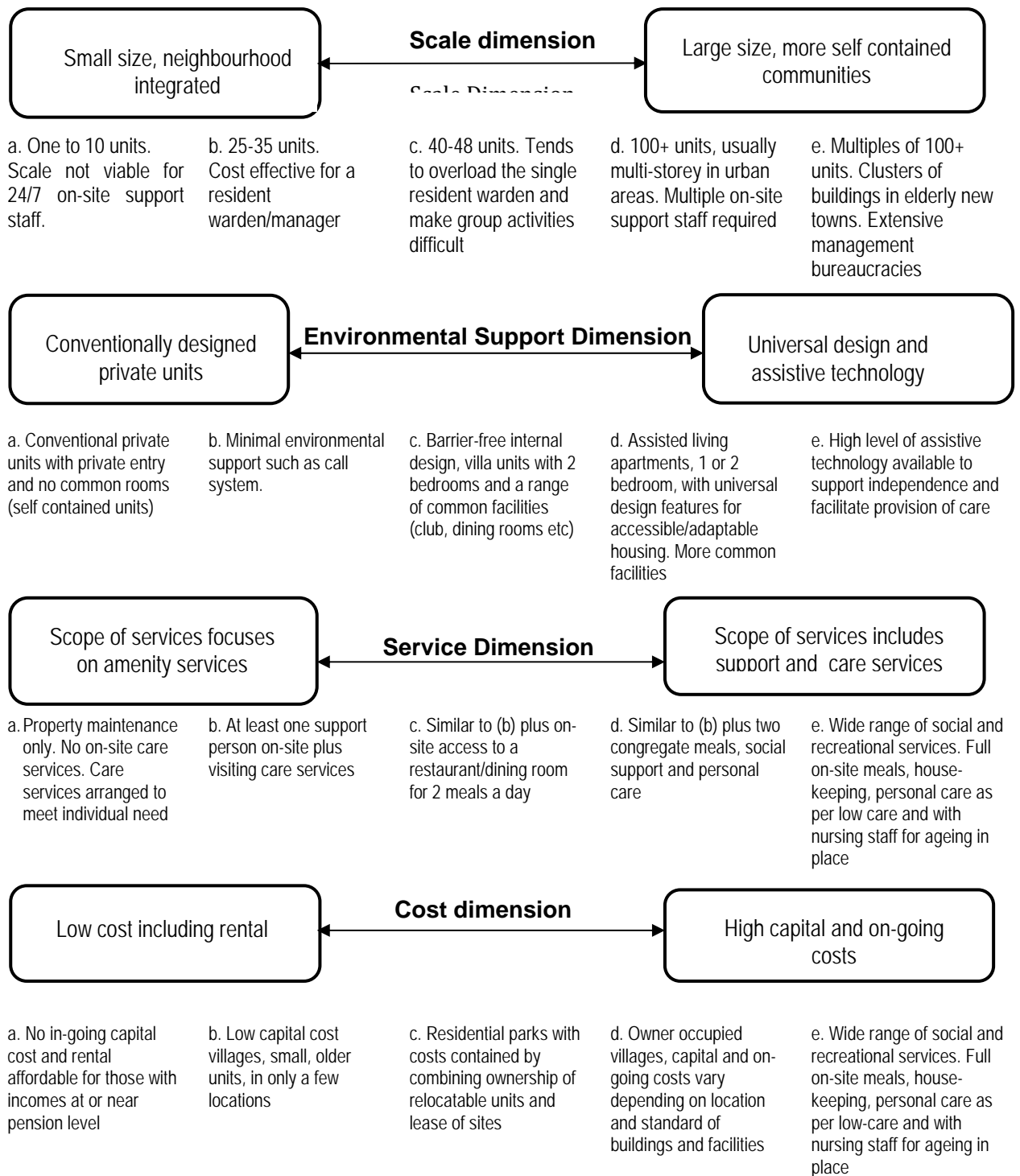
- sector
- tenure
- dwelling structure or form
- physical form
- size
- design
- level of services
- type of services
- service arrangements
- market

- location
- age-range.

A number of schema have been developed to demonstrate the diversity of forms of older persons' housing (Lawton, 1981; Lawton, 1981a; Heumann and Boldy, 1982; Folts, Yeatts and Dwyer, 1991; Heumann and Boldy, 1993; Giarchi, 2002). In the Australian context, Howe developed such a schema in her report for the National Housing Strategy (1992, p. 92), based on an earlier version by Heumann and Boldy (1982). The schema is reproduced in Figure 3. The purpose of the schema was to show 'the range of possible permutations and combinations for providing care services and environmental support in housing settings of varying scales' (Howe, 1992, p. 93). This schema continues to have considerable utility as a framework for distinguishing existing approaches and suggesting new possibilities.

The classification developed in this chapter seeks to go beyond the identification of dimensions of service integrated housing to provide a means of categorising all forms of service integrated housing. This is an important exercise in the light of the many possible types of service integrated housing and the lack, at this time, of a clear policy framework. As well as adding to an understanding of the range of 'possible permutations and combinations', a classification system clarifies key choices and issues for providers and consumers. For providers, planners and policy makers, classification provides a basis for identifying types of service integrated housing that may be over- or under-supplied. It provides the basis for analysis of the structure and shape of the service integrated housing industry and a conceptual foundation for detailed, empirical analysis.

**Figure 3: Dimensions of retirement accommodation<sup>1</sup>**



<sup>1</sup> Adapted from Heuman and Boldy (1982) by Howe (1992).

The approach taken to developing the classification was as follows:

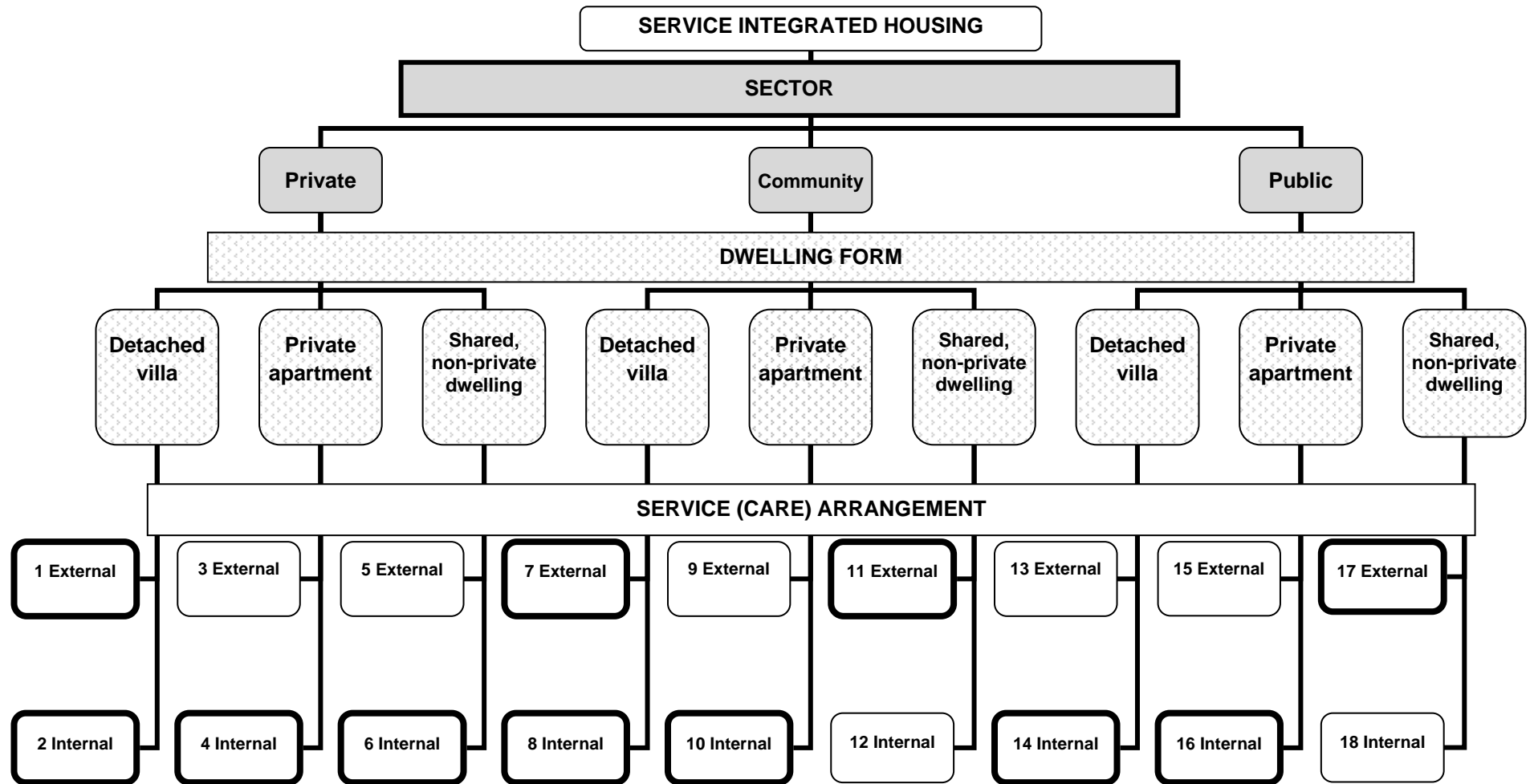
1. Identify the key criteria for classification based on defining features that are of central significance to policy and service provision.
2. Identify no more than three key criteria and limit the number of categories within each criterion so as to avoid excessive complexity.
3. Develop clear-cut, mutually exclusive, comprehensive and meaningful definitions for criteria and categories within each criterion.
4. Develop formal decision rules which lead to accurate classification and which minimise the number of borderline cases requiring some discretion in classification.
5. Identify sub-categories that can be used for more detailed examination of cases that have been categorised within the primary classification. These sub-categories can be thought of as secondary criteria that can provide for further elaboration within the main categories. The sub-categories can be applied differentially to the main categories as relevant rather than breaking down all the main categories on all the secondary criteria.

The classification system developed through this approach is shown in Figure 4. The three key criteria and categories identified in Figure 4 are:

1. Sector
  - 1.1 Private
  - 1.2 Community or not-for-profit
  - 1.3 Public
2. Dwelling form
  - 2.1 Separate or semi-detached house, villa unit
  - 2.2 Flat or apartment
  - 2.3 Shared non-private dwelling
3. Service arrangement
  - 3.1 Internal – support and care services made available to residents directly by the housing provider
  - 3.2 External – support and care services delivered by outside providers.

The ways in which each of these criteria contributes to the classification system are now briefly discussed.

Figure 4: Classification chart for service integrated housing for people in later life in Australia<sup>2</sup>



<sup>2</sup> The forms of service integrated housing represented by case examples in Chapter 5 are shown in bold boxes.



### 4.2.1 Sector

It is a widely established practice when describing the formal elements of social organisation, and particularly the provision of human services, to distinguish between the private, community and public sectors. As all social organisations can be classified into one of these three discrete sectors, sector provides a practical and conceptually useful starting point for classification.

The private sector, also known as the 'for-profit' or 'market' sector, comprises companies and similar entities established to make a profit for those who own and manage the enterprise. The community sector, also known as the 'voluntary', 'not-for-profit' or 'third sector', comprises associations and similar organisations established to achieve a social goal or some other public good. The public sector, also known as the state sector, comprises governmental bodies such as departments and statutory agencies that exercise the power and authority of the state. Boundaries amongst these sectors are sometimes blurred, such as when local government sets up a discrete not-for-profit body to operate a housing project at arm's length. The threefold classification is however robust for most analytical purposes. By including 'sector' as a primary criterion for classification, attention is drawn to the history, structure and capacity of the providers of various forms of service integrated housing.

When applied to service integrated housing, the classification of organisations into private, community and public sectors is based on the sector or organisation responsible for the housing rather than the service component. There are several reasons for giving responsibility for housing precedence over responsibility over services. Firstly, all developments considered for classification must, by definition, have an organisation responsible for the housing component, but some may not have a single organisation that with clear responsibility for the service component. Secondly, housing developments usually precede the service inputs, and arrangements for integration of services for the housing development as a whole can usually change over time much more readily than the housing. Thirdly, there is much greater flexibility in responsibility for service provision which can be contracted to different agencies at different times, and one housing development may be served by several service providers. Furthermore, organisations that are service (rather than housing) providers can deliver services to housing organisations in more than one sector, for example, not-for-profit organisations provide services to the public housing sector as well as to non-government housing organisations.

Each of the three sectors has a distinctive history and role in service integrated housing and aged care provision, as well as more general characteristics that shape its current and emerging roles. The private sector has a long history of involvement in both retirement villages and nursing homes, but has minimal involvement in hostels and the delivery of HACC, CACP and EACH services. The role of private sector retirement village operators has historically been limited to support rather than care services, although this is changing with the development of assisted living apartments as alternatives to low care residential aged care and the use of CACPs to deliver care services to retirement village residents. There has been considerable consolidation of private sector retirement village providers into larger companies providing chains of villages across the country (Stimson, 2002) and this is likely to facilitate the spread of new initiatives such as assisted living apartments. The private sector is driven by the need to show a return on investment in what has become a highly competitive market. This competition has driven innovation with some providers developing particular niche markets ranging from luxury retirement developments to affordable rental villages. A further driver of innovation is the desire of some private sector providers to avoid government regulation, leading them to develop models outside formal program

structures. While some providers have a background in the aged care industry, others have been attracted into the retirement living area from a background in property and hotel services, and it is likely that this has influenced some developments.

The community or not-for-profit sector has the longest history in provision of older persons' housing, including housing with some elements of service integration. This history was traced in Chapter 2 from the early involvement in provision of independent living units under the APHA (later the ADPHA). Not-for-profit organisations deliver the major share of residential aged care homes and are even more dominant as providers of CACP and EACH packages and HACC services. A small number of large not-for-profit providers are involved in all the above programs, and often in several states. They are also expanding their provision of retirement villages including independent living units in both stand-alone developments and co-located with residential aged care homes. The not-for-profit sector has shown considerable capacity to keep pace with, and even set the pace for, the private sector as exemplified by recent diversification into serviced apartments. This range of capacity and experience gives the sector a key role in the development of service integrated housing. The sector is well situated to develop higher levels support and care within retirement villages, as demonstrated by the retirement villages care pilot (AIHW, 2006). It is also involved in service integrated housing in the public and private sectors as the main provider of HACC and CACP services.

Community sector involvement in service integrated housing for older people also involves organisations such as Wintringham that are focused on older people who are insecurely housed or homeless; organisations providing distinctive service types such as Abbeyfield Housing; and organisations involved in innovative approaches to service integrated housing such as the Benevolent Society of NSW and its 'apartments for life' project. These organisations do not have the size and scope of activities of the large, not-for profit providers of aged care services and retirement villages, and are more specialised in their focus. Community housing organisations that have been funded under the Commonwealth-State Housing Agreement (CSHA) and that now fall under the National Affordable Housing Agreement (NAHA) are also providers of housing to low-income older people, although they too have played a far smaller and more specialised role than the not-for-profit aged care and retirement village providers. However, the anticipated expansion of the role of community housing associations under NAHA may result in these organisations playing a greater role as providers of service integrated housing in the future (Milligan, Phibbs, Gurran, Lawson and Phillips, 2009).

The public sector also has a long history of involvement in older persons' housing, although it has had little direct involvement with service integrated housing. Approximately 30 per cent of residents in public housing provided by State and Territory housing authorities are aged 65 and over (Jones, Bell, Tilse and Earl, 2007). These residents include long standing tenants who have aged in place and others who moved into public housing on reaching old age and so qualifying for places in older persons' housing developments. Until recently, public housing has focused solely on housing provision, with relatively little attention to provision of support and care services. However, the growing number of older people who are ageing-in-place in public housing is resulting in housing authorities paying greater attention to support and care provision to public housing tenants. This growing need is emerging as a major challenge for public housing authorities (McNelis, Neske, Jones and Phillips, 2008). It may also be a growing opportunity for collaboration between public housing authorities and not-for-profit organisations involved in community care service provision.

Two further considerations make sector a particularly useful basis for classification. Firstly, sector provides a broad indicator of the market segment that a development is targeting, and a partial indicator of tenure.

- *Market*: service integrated housing may be targeted at the luxury, mid-range or affordable segments of the housing market. Market also bears on access and affordability issues, as well as the issue of quality of services provided in low-price, service integrated housing.
- *Tenure*: the residents may be owner-occupiers or renters or they may lease their dwelling; tenure also has a major bearing on the rights of residents as well as on issues of access and affordability.

While these two dimensions could be included as classification criteria, any one service integrated housing development may serve a range of market segments and offer a mix of tenures, making concise classification difficult. They can usefully be included in examinations of specific cases, as the next chapter shows.

Private sector providers cater for the full market spectrum, from luxury retirement resorts to boarding houses for residents who are totally reliant on the Age Pension, with tenures ranging from forms of ownership to occupancy with ill-defined tenure. The community sector is less likely to establish projects specifically for the luxury market, and are more likely to respond to the needs of low income individuals, often with assistance from government. Tenures vary from forms of ownership or leasehold to standard tenancies or related forms of occupancy. The public sector is essentially restricted to serving low income individuals with low if any assets, and rental tenure.

Secondly, sector is of considerable policy relevance, particularly in terms of defining conditions for participation in programs and eligibility for public funding. Gaining Approved Provider status to qualify for funding for residential aged care and community care package programs is a significant example. Governments can, and indeed have at times restricted public funding to not-for-profit bodies to the exclusion of private sector providers, while engaging public sector organisations may raise the complexities of inter-governmental relations. In turn, the three sector may vary in their propensity to respond to the terms and conditions on which public funding is offered.

It is clear from the above discussion that 'sector' is a defining feature of service integrated housing types, influencing as it does the nature of current services and future opportunities. In some cases more than one sector may be involved as a provider of service integrated housing, for example, different sectors may be involved in the financing, development and management phases of a housing service, and there may also be cross sector partnerships of various kinds. Nevertheless, in most cases 'sector' provides a clear-cut, comprehensive and meaningful criteria for the first level of classification of the various forms of service integrated housing.

#### *4.2.2 Dwelling form*

The second criterion proposed for classifying service integrated housing is dwelling form. As used here, dwelling form incorporates two terms used by the ABS that refer to the form of housing provided: 'dwelling structure' and 'dwelling type'. Housing form is of fundamental importance to service integrated housing as it affects the way that housing is experienced by residents and the ways that services are provided. Housing form is also useful in distinguishing service integrated housing from residential aged care facilities.

The term 'dwelling structure' is used by the ABS to classify the structure of private dwellings enumerated in the census (ABS, 2006a). The main categories are 'separate

house', 'semi-detached, row or terrace house, townhouse, etc.', 'flat, unit or apartment' and 'caravan, cabin, houseboat'.

The term 'dwelling type' essentially distinguishes between 'private dwellings' and 'non-private dwellings'. Non-private dwellings are 'establishments which provide a communal type of accommodation' (ABS, 2006a, p. 229). The essential feature of non-private dwellings as defined by the ABS is that residents do not have access to individual cooking facilities as their living quarters are not self-contained. Categories of non-private dwellings include 'nursing home' and 'accommodation for the retired or aged (not self-contained)'. The latter is defined as 'accommodation for retired or aged people where the occupants are not regarded as being self-sufficient and do not provide their own meals' (ABS, 2006, p. 157).

Taking into account these definitions as well as common usage in the field, three categories of dwelling form are proposed. The first is 'detached villa'. 'Villa' or 'villa unit' is commonly used in the industry to refer to separate or semi-detached dwellings provided in retirement villages, and carries the connotation of a compact dwelling that is smaller than a family home. This category includes dwellings that fall within the ABS 'dwelling structure' categories of 'separate house' and 'semi-detached, row or terrace house, townhouse, etc.' The distinguishing features of this form are that each dwelling has an entrance on to the street, and most developments are single storey. Many ILUs were built in this form, and recent developments of cluster housing in the form of terrace houses are in this category. Manufactured or relocatable homes and caravans are also included.

The second proposed category is 'private apartment'. This includes all dwellings categorised by the ABS as 'flats, units or apartments', and refers to self-contained dwellings in a multi-dwelling housing development, usually multi-storey. Apartments have private internal entrances but do not have individual street entrances (other than ground floor apartments in some cases). Apartments are generally on a single level internally. While not all retirement apartments provide assisted living services, retirement housing that does provide serviced apartments or assisted living services is increasingly in this form.

The third category is 'shared/non-private dwelling'. The term 'non-private dwelling' is consistent with the ABS term referring to communal types of accommodation. Residents in these forms of housing share facilities such as kitchens, dining rooms and lounge areas (although individuals may have a kitchenette). In older and lower cost accommodation of this kind, residents may also share bathrooms and toilets. Forms of housing coming into this category include boarding houses and similar accommodation such as supported residential services and Abbeyfield Houses.

There are also important aspects of the physical form that are not captured by these distinctions. These can be treated as sub-categories of the main classification. They include:

- *Geographic location*: service integrated housing is found in all geographic locations, but different kinds of developments are unevenly spread across inner city areas, middle- or outer-ring suburbs, provincial cities and rural and coastal areas; coastal areas of high amenity close to metropolitan areas have attracted a wide range of service integrated housing.
- *Physical form*: the housing complex may take the form of a high density, multi-storey buildings, a medium density campus style layout, or low-density dispersed villas.

- *Size*: a development may be for many hundreds of households or for less than ten people.
- *Size of dwellings*: size varies not only in square metres and number of bedrooms, but private open space and pro-rata communal space.
- *Design*: the design of dwellings and the physical form may be conventional or it may be oriented to the needs of older people including barrier-free environments and assistive technologies.

#### 4.2.3 *Service arrangement*

The third classification criterion is the arrangement made for provision of care services. While there are many wide-ranging issues associated with service arrangements, for the purpose of this classification, the focus is on the arrangements that the housing provider makes for provision of care services to residents who need these services, as distinct from support services. Care services are of direct concern to public programs and policy whereas other kinds of recreation and support services can be secured by a variety of means if they are not provided in conjunction with housing, and many supports are integral to living in purpose built housing, whether passive supports by way of barrier-free environments or active supports by way of an on-site manager. Classification is based on the balance of the housing provider's role in terms of reliance on external care service agencies vis-à-vis arrangements that are more internal to organisations that are both housing and service providers.

An external service arrangement is where the housing provider relies on delivery from an external agency, overwhelmingly HACC agencies, that are separate to the housing provider. Delivery of care services through external care agencies is left largely to the resident and the care agency, and although the housing provider may periodically facilitate contact with services for individual clients, there is a minimal on-going role and no arrangement exists to cover residents as a whole. External arrangements are generally associated with housing that includes only limited support services, with the range of HACC services that are called on complementing the range of support services provided by the housing provider. For example, individual residents may call on HACC to deliver meals where the housing does not have a dining room or restaurant and for transport where no community bus is provided by the housing operator.

Internal service arrangements are where the housing provider takes a role in providing care services, either by providing services directly or facilitating access to services and making arrangements with service providers. The most direct internal arrangements occur where the housing provider is a not-for-profit agency which is also a community care provider. Some housing providers also provide HACC services such as delivered meals, home care/personal care and day care, and enrol residents in these services, subject to the same assessment of need as other clients. However, very few housing providers have nursing staff, and almost all draw on HACC for domiciliary nursing. Internal service arrangements have especially developed where the organisation that provides the housing also has an allocation of CACPs and is thus able to deliver packages to residents in their own ILUs or apartments as well as to clients in the community at large. Larger not-for-profit agencies typically employ their own staff to deliver the range of services that make up the care packages, but in some cases, providers with CACPs may operate primarily on a case management model and purchase services from other agencies.

In yet other internal arrangements, the service provider offers a range of services that are included in on-going weekly charges, or more often, that residents can purchase as they choose, whether on the basis of preferences, such as for eating in a dining

room rather than cooking their own meals, or having cleaning done rather than doing it themselves even though able to, or to meet support and care needs.

In other less direct but still internal arrangements, housing providers who do not have CACPs may make an arrangement with a CACP provider to deliver services to residents on more than an individual, client by client basis. Other arrangements that involve formal partnerships between a housing provider and a service provider are also classified as internal. These arrangements can be labelled as facilitating access to services rather than direct provision.

As well as the issue of internal or external provision, there are other aspects of service arrangements that are important and can be treated as sub-categories of the main classification. These include:

- The range of support and care services available internally and which services have to be secured from outside providers.
- Whether services are provided as part of a standard package and covered in the weekly service charge, or whether they are available on an optional basis and paid for as used.
- The extent to which services provided by paid workers are supplemented by volunteers, or the promotion of mutual aid.
- Whether services are provided on an income or means-tested basis or on a universal basis.

#### *4.2.4 Categories resulting from the classification*

The three sectors x three housing forms x two service arrangements result in 18 possible categories for describing older persons' service integrated housing. All forms of service integrated housing can be located within one of these categories, although some developments may have more than one dwelling form, such as villas and apartments on the one site. Although informed decisions have to be made on some borderline cases, especially with reference to service arrangements, the 18 categories are mutually exclusive, and at the same time are comprehensive, that is, all forms of older persons' housing can be classified into one of the 18 categories when the three classification criteria are taken into account. Hence, the classification provides a means for identifying the most prevalent forms of service integrated housing as well as forms that are under-represented either because they are under-developed or are unlikely to develop for one reason or another. The classification may also identify 'boutique' cases that can be noted as such, especially if they have some features that are likely to limit wider take up.

### **4.3 Applying the classification**

The classification chart presented in Table 3 was based on understanding of the history of service integrated housing in Australia (discussed in Chapter 2) and knowledge of the range of contemporary services and service arrangements in the Australian and international contexts (discussed in Chapter 3). In order to test the utility of the classification chart, a number of case examples of a diversity of service integrated housing arrangements in Australia were developed. These cases were then classified in terms of sector, dwelling structure/types and internal/external service arrangements and grouped into service types. As well as illustrating the utility of the classification scheme, the case examples provide a representation of the types of service integrated housing that have developed in Australia. The case examples also inform the discussion of policy and service provision issues in Chapter 6.

It is stressed that the case studies are not evaluations, and no evidence has been gathered 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 emerging issues. They illustrate the emerging roles of the private, community and public sectors; the range of dwelling structures and types in contemporary service integrated housing; types of internal and external service arrangements; and other key issues such as changing tenure arrangements and the market segment targeted by providers.

### *Choice and development of cases*

Choosing a sample of service integrated housing was 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 in varying stages of development. The process followed was as follows:

1. All cases had to fall within the definition of service integrated housing for older people presented in Chapter 1.
2. Services funded as residential aged care services were excluded from consideration. A previous compilation of case studies of innovations in housing for older people included low-care hostels (Forsyth, 1992). However, as hostels are now treated as residential aged care homes in policy and program terms, they are excluded from this study.
3. Examples were drawn from the private, community and public sectors. 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.
4. 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. In particular, 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 important service integrated housing developments within their jurisdictions.
5. All organisations identified through these processes were contacted to ensure that they fit within the parameters of the study.
6. 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.
7. In some cases, services that are still in the process of development were included if it was determined that they illustrated important emerging trends.
8. Inclusion of cases was dependent on agreement by the owners and/or managers to participate in the study.

Through these processes, the fourteen services listed in Table 3 were chosen. These included five private sector cases, five community sector cases and four public sector cases. Information on each service, based on the dimensions of service integrated housing included in the classification chart and discussed in section 4.2, was obtained through the following processes:

1. Examination of the websites 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.
4. Development of a detailed description of each organisation drawing on all these data sources.

Data was collected in late 2007 and is accurate as of that time.

It was found that all cases could be classified into one of the 18 categories shown in Figure 4. The 11 case studies include a mix of more common types of service integrated housing, some more boutique types and some types that are unusual in that they cater for groups of residents with very particular needs. There are nine categories that are not illustrated in the case studies; while some of these types of service integrated housing are less common than those which are represented, the lack of a case study does not mean the type concerned is of any less importance or less interest. Rather, this incomplete coverage highlights the need for fuller investigation of the spectrum of service integrated housing across all 18 categories of the classification.

The key characteristics of each case example are summarised in terms of the criteria used in developing the classification chart in Table 3, and Table 3 also serves as an index for the next chapter which reports the case studies. Each case example reports details of the provider organisation, including any roles in community and residential aged care, the dwelling and village form, the care arrangements and tenure, noting any specific legislative conditions that apply.



**Table 3: Classification of case examples of service integrated housing in Australia**

<i>Dwelling form</i>	<i>Service arrangement</i>	<i>Category</i>	<i>Case study</i>	<i>Key features</i>
<b>PRIVATE SECTOR CASE EXAMPLES</b>				
Detached villa	External	1	Oxford Crest, Eagleby, Queensland	<ul style="list-style-type: none"> <li>→ Rental retirement village operated by small private company</li> <li>→ Located in southern suburbs of Brisbane, Queensland</li> <li>→ Targets pensioners with limited financial resources</li> <li>→ Provides 72 semi-detached 1-bedroom villa units with kitchenette on a campus-style site</li> <li>→ Main support services are on-site management, linen service, social activities and optional meals service (twice per day)</li> <li>→ No care services provided directly by the village and these must be obtained from HACC providers</li> <li>→ Operates under the Residential Tenancies Act</li> <li>→ Classified as TYPE 1 as operator does not provide care services</li> </ul>
Detached villa	External	1	Aveo The Braes, Reynella, South Australia	<ul style="list-style-type: none"> <li>→ Retirement village operated by large, national private sector provider with strong brand based on the 'live well' motto offering support and 'lifestyle'</li> <li>→ Located in Reynella, South of Adelaide, South Australia</li> <li>→ Targets middle-income retirees who typically sell their home to meet entry fee</li> <li>→ Provides 82 independent living units ( 1, 2 and 3-bedroom) in form of duplex villa units and 28 'flexi-units' with higher level of support and services</li> <li>→ Central dining area and lounge for flexi-unit residents</li> <li>→ Well-staffed on-site management including care attendants, recreational activities, 24-hour emergency call system and residents' association</li> <li>→ House cleaning and meals service available on a paid basis</li> <li>→ 'Transfer package' to facilitate transfer from independent living to flexi-care</li> <li>→ Some assistance provided with referral to ACAT for CACPs and to HACC</li> <li>→ Leasehold tenure and governed by Retirement Village Act</li> </ul>
Mainly detached villa	Internal	2	Tall Trees Supported Living	<ul style="list-style-type: none"> <li>→ 'Supported living community' operated by a Queensland-based company</li> <li>→ Located in Rochedale, a southern suburb of Brisbane, Queensland</li> <li>→ Targets middle-income retirees who typically sell their home to meet entry fee</li> </ul>

<i>Dwelling form</i>	<i>Service arrangement</i>	<i>Category</i>	<i>Case study</i>	<i>Key features</i>
			Community, Rochedale, Queensland	<ul style="list-style-type: none"> <li>→ Aims to meet the gap in market between RACHs and retirement villages</li> <li>→ Provides 80 1½ to 2-bedroom independent living units in clustered villa units with barrier-free design features</li> <li>→ Leisure centre with wide range of recreational facilities</li> <li>→ Well staffed on-site management including care, kitchen, activities and grounds staff</li> <li>→ Provides care and support on an 'as-needed' basis with aim of providing continuing care (not dementia)</li> <li>→ Wide range of support and care provided including meals, self-care, domestic assistance, home nursing and other health care</li> <li>→ Residents can also access HACC and CACP and organisation investigating becoming approved community care provider</li> <li>→ Leasehold tenure and governed by Retirement Village Act</li> </ul>
Private apartments	External	4	Grande Pacific, Broadwater, Gold Coast, Queensland	<ul style="list-style-type: none"> <li>→ A private sector 'lifestyle retirement resort' located on the Broadwater, Gold Coast, Queensland, with prime ocean views</li> <li>→ Targets wealthy, self-funded retirees who want a luxury, retirement village environment</li> <li>→ 116 apartments on 25 levels with barrier-free design features</li> <li>→ 12 studio apartments designed for residents with higher needs</li> <li>→ Wide range of support services and high quality recreational facilities</li> <li>→ Arrangements made for provision of nursing care by private aged care nursing service, and no stated intention to rely on community care services provided through HACC and CACP</li> <li>→ Leasehold tenure and governed by Retirement Village Act</li> </ul>
Shared non-private dwelling	Internal	6	Highgrove House Supported Residential Service, Studley Park, Victoria	<ul style="list-style-type: none"> <li>→ Supported residential service provided by the private sector in suburban Melbourne</li> <li>→ Targets older people with high-care needs able to pay the substantial weekly fee</li> <li>→ 45 one-room and 5 two-room apartments in the context of a non-private dwelling with no private kitchen facilities and meals served in dining room</li> <li>→ Support and care services provided internally include laundry, cleaning, meals, personal care, physical assistance, recreational activities, care planning</li> <li>→ A range of externally provided services are also made available including nursing, allied health, hairdressing</li> </ul>

<i>Dwelling form</i>	<i>Service arrangement</i>	<i>Category</i>	<i>Case study</i>	<i>Key features</i>
→ Regulated under SRS specific legislation as well as local and State health regulations				
<b>COMMUNITY SECTOR CASE EXAMPLES</b>				
Detached villa	External	7	Wishart Village, Brisbane, Queensland	<ul style="list-style-type: none"> <li>→ Retirement village operated by Queensland Baptist Care, a church-based not-for-profit that also provides other retirement villages and aged care services</li> <li>→ Targets older people from the local area with low-to-average financial resources who are able to live independently</li> <li>→ Located in Brisbane southern suburbs close to shopping, transport and recreational facilities</li> <li>→ Comprises 62 independent living units in detached or semi-detached villa style; includes 1, 2 and 3-bedroom units</li> <li>→ Support services include barrier-free design, social activities, availability of meals on request and emergency call button</li> <li>→ No care services in independent living units but provider will assist in making referrals to an external HACC and CACP provider</li> <li>→ Co-located with hostel and nursing home which facilitates transitions</li> <li>→ Governed by retirement village legislation; residents have 'licence to occupy'</li> </ul>
Mainly detached villa	Internal	8	Wintringham, Melbourne, Victoria	<ul style="list-style-type: none"> <li>→ Community organisation providing housing, support and care services to older people who are financially disadvantaged and homeless</li> <li>→ Provides a wide range of housing including independent living units in both campus and high-rise settings and hostels and nursing home accommodation</li> <li>→ Emphasises the necessity of high levels of support and care for this group of older people due to their complex problems</li> <li>→ Support includes supervision, health support, meal support, cleaning, recreational and social activities</li> <li>→ The organisation is an accredited community care provider providing CACP or EACH to over half of its residents</li> <li>→ If level of frailty increases residents are assisted to move to Wintringham's hostel and nursing home accommodation</li> </ul>

<i>Dwelling form</i>	<i>Service arrangement</i>	<i>Category</i>	<i>Case study</i>	<i>Key features</i>
				→ Governed by the Aged Care Act for hostels and Residential Tenancies Act for independent living units
Private Apartment	Internal	10	Ocean Street Project, Bondi, NSW	<ul style="list-style-type: none"> <li>→ Innovative 'Apartments for Life' project being developed by Benevolent Society of NSW based on Dutch Humanitas model</li> <li>→ Concept that residents can stay in same apartment irrespective of care needs</li> <li>→ Located in upmarket Bondi, Sydney close to all services and beach</li> <li>→ Designed as a 2-block high-rise with 1½ and 2½ bedroom private apartments plus wide range of ground level facilities for residents and the community</li> <li>→ Building and apartments designed for barrier-free living and assistive technologies</li> <li>→ Targeting local people from a wide range of income and asset groups and with a wide range of dependency/independence</li> <li>→ Formal care will include care adviser to link residents to community care services provided by Benevolent Society and other local providers</li> <li>→ Informal care facilitated through apartment design and community activities</li> <li>→ Governed by the Retirement Villages Act with loan/licence and rental tenure</li> </ul>
Private apartment	Internal	10	Irving Benson Court, Coburg, Victoria	<ul style="list-style-type: none"> <li>→ Low-cost rental accommodation and care for older people at risk of homelessness provided by Wesley Aged Care Housing Services</li> <li>→ Two-storey complex of 35 self-contained bed-sit units with common recreational area and dining room</li> <li>→ Support services include an evening meal, personal support and social activities</li> <li>→ Many residents receive HACC and CACPs which are provided by Wesley Mission</li> <li>→ Care services typically provided include direct personal support, assistance with self-care, administration of medication, transport to health-related appointments, management of finance, shopping and domestic work</li> <li>→ Close links with hostel and group home also operated by Wesley Aged Care Housing Service facilitates progression as needs increase</li> <li>→ Governed by residential tenancies legislation</li> </ul>
Shared, non-private dwelling	External	11	Broadview House, Adelaide,	→ Shared housing for frail and isolated older people requiring supported accommodation, but not necessarily high levels of care

<i>Dwelling form</i>	<i>Service arrangement</i>	<i>Category</i>	<i>Case study</i>	<i>Key features</i>
			South Australia	<ul style="list-style-type: none"> <li>→ Operated by Northern Suburbs Housing Cooperative in inner North-Eastern Adelaide</li> <li>→ A 10-room converted house with private rooms and en-suite and shared living areas</li> <li>→ Support services on site include housekeeper, meals, cleaning of communal areas, shopping, laundry, alarm pendant, social support</li> <li>→ No community care services provided, but staff assist residents to access HACC, CACP</li> <li>→ Modelled on Abbeyfield Housing and represents this form of housing in these case examples</li> <li>→ Governed by the <i>South Australian Cooperative and Community Housing Act</i>, and residential tenancies legislation</li> </ul>
<b><i>PUBLIC SECTOR CASE EXAMPLES</i></b>				
Private apartment	Internal	16	Dougherty Apartments Retirement Village and Care Facility, Chatswood, NSW	<ul style="list-style-type: none"> <li>→ Joint venture of Willoughby City Council, the NSW Department of Housing and Uniting Care</li> <li>→ Comprises retirement village including residents who purchase their apartment under loan/licence arrangement and public housing tenants, and a low-care residential aged care facility</li> <li>→ High-rise building with 84 one-, two- and three-bedroom apartments, 51 hostel units and 12- room dementia-specific unit</li> <li>→ Barrier-free design of rooms being gradually introduced and extensive facilities including garden, gym, café, communal lounges, security</li> <li>→ Support includes Vital Call pendant, emergency call buttons in units, on-site management, recreational activities and social support</li> <li>→ Two weeks of care provided after hospitalisation and other care services available, on fee basis from hostel</li> <li>→ Some residents use HACC and Uniting Care provide CACPs for some village residents; Dougherty Apartments is not itself a CACP provider</li> <li>→ Operates under retirement village legislation and public housing tenants enter into standard tenancy agreements</li> </ul>
Private apartment	Internal	16	Older Persons' High Rise Support Program,	<ul style="list-style-type: none"> <li>→ Program of the Victorian Department of Human Services to provide support to older public housing tenants with complex needs in inner-city high-rise towers</li> <li>→ High-rise towers are older buildings not originally designed for this tenant population</li> <li>→ Support workers provide case management, social support, low-level monitoring, practical</li> </ul>

<i>Dwelling form</i>	<i>Service arrangement</i>	<i>Category</i>	<i>Case study</i>	<i>Key features</i>
			Footscray, Victoria	<p>assistance, recreational activities and links to health and community services</p> <ul style="list-style-type: none"> <li>→ A pool of flexible care funds is available for a wide variety of purposes</li> <li>→ Tenants are referred to community care organisations as well as other services, and to ACAT if it felt that a higher level of care is required</li> </ul>
Private apartment or detached villa	Internal	14 or 16	Housing and Support for the Aged, Melbourne, Victoria	<ul style="list-style-type: none"> <li>→ An initiative of the Victorian Department of Human Services providing case-managed packages of support to people aged 50 and over with a history of homelessness</li> <li>→ Tenants may be living in any type of public housing in Victoria including high-rise towers, low-rise apartment blocks and medium-density cluster housing</li> <li>→ Provides funding for case management/support workers employed by community health centres and brokerage funding for individual tenants</li> <li>→ Focus is on tenants with complex needs but still able to live independently</li> <li>→ Tenants are assisted to access a range of community health and community care services including HACC and CACP</li> <li>→ Some tenants may be referred to higher support options such as supported residential services or residential aged care homes</li> </ul>
Shared non-private dwelling	External	17	Matavai Group Living Project, Waterloo, Sydney	<ul style="list-style-type: none"> <li>→ A collaborative project of the NSW Department of Housing and Mercy Arms Community Care (MACC) in high-rise public housing in Waterloo, Sydney</li> <li>→ A group living model for frail older public housing tenants with complex needs who are able to fit into a group living housing model</li> <li>→ Involves co-location of long-term residents on one floor of the building to facilitate high level support through pooling of CACPs</li> <li>→ One floor of the building was renovated to make it suitable for the project and barrier-free design features were installed</li> <li>→ Support includes meals, an emergency call-button, care services including self-care, medication assistance, transport, cleaning, laundering, shopping</li> <li>→ Some consideration of expanding the project into other areas of public housing</li> </ul>

## 5 THE CASE STUDIES

### 5.1 Introduction

This chapter provides succinct descriptions of the 14 case studies introduced in chapter 4 to illustrate the classification system of service integrated housing. Generally speaking, the cases are described using the three criteria for the classification: sector of the provider organisation, the form of dwellings and the wider complex, and the service arrangement. Additional comments are made on tenure and the resident group catered for. Some of the case studies are of widely established forms of service integrated housing while others are of more specialised initiatives catering for particular groups of older people. It is reiterated that the case studies are not evaluations. They are designed to illustrate the nature and diversity of current developments, and to stimulate consideration of emerging issues. Other case examples of service integrated housing can be found in the case studies prepared for the evaluation of the Retirement Villages Care Pilot (AIHW, 2006). Information is correct as of the time of interview in late 2007.

### 5.2 The private sector cases

Five private sector cases are described in this section:

- Oxford Crest, Eagleby Queensland
- Aveo, The Braes, South Australia
- Tall Trees Supported Living Community, Rochedale, Queensland
- Grande Pacific, Broadwater, Gold Coast, Queensland
- Highgrove House, Studley Park, Victoria.

#### 5.2.1 Oxford Crest, Eagleby, Brisbane

##### *Provider organisation*

Oxford Crest is a small unlisted, public company that at the time of interview operated six villages of a similar style in various locations in Queensland. These villages are based on a model first developed in the 1990s by a company called Westminster House. Westminster House's hostel-style rental accommodation became known in the industry as the 'Queensland model'. The rental villages provided by Village Life and other companies are also based on this model.

##### *Dwelling and village form*

Oxford Crest is a low-cost rental village located in the southern, outer suburbs of Brisbane. It offers affordable rental accommodation for older people linked to a range of support services. The total cost of rent, food and services has been set so as not to exceed 85 percent of the rate of the single pension, and eligible residents may also receive Rent Allowance. However, the village has in recent times set rents to be competitive to the local market, which has resulted in an actual cost of much less than 85 percent. The village comprises villa-style housing built as blocks of six or eight with a communal carport, community dining hall, kitchen and property management office. All units are 1-bedroom, single-story dwellings with kitchenette and en-suite bathroom. They range in size from 35 square metres to 60 square metres. Kitchen facilities can be adapted to include a microwave and cook-top stove if a resident decides to opt out of the meals service. Until recently all units were fully furnished, but some units have had furnishings removed to allow more choice for residents. There are 72 units on the Eagleby site.

### *Service arrangement*

A number of support services are integral to the village environment. While individual units do not cater for wheelchairs, some barrier-free elements have been included in bathroom design. Modifications such as grab rails can be installed, and in later model units support studs have been fitted for easier installation. Installation of grab rails and similar items is generally provided by HACC.

Other support services include a linen service, on-site management, social activities, grocery pick-up and an optional meals service. Meals include breakfast and lunch. Breakfast entails the residents collecting milk, bread and cereal every week to be eaten in their unit. Lunch is a two course meal eaten in the common dining room. The meals service is utilised by approximately 80 percent of residents. An evening meals service was discontinued in 2007. An off-site linen service is provided. Residents drop off and collect their linen at a central collection area within the village and some residents arrange for Home Assist or Blue Care, two large HACC providers, to assist with dropping off and collecting their heavy linen.

No care services are provided directly by the village, and this is made clear when residents enter the village. The village promotes a 'buddy system' between residents, which encourages safety and companionship. If medical (or other) attention is required the residents arrange this for themselves, for example, phoning for an ambulance. If residents require further support and care these must be obtained from HACC providers. Management play only a small role in arranging care and support for residents, but they do seek to maintain good relationships with local care organisations. Tenancy Advocacy and Advice Service, Home Assist Secure and Blue Care offer presentations to residents to inform them of their rights and services.

### *Tenure*

Tenants tend to stay at the village for an average of two to three years. It is reported that most residents are in their late sixties or early seventies. The majority of residents rent their property, however a few have taken the option of buying their unit. The village is governed by age restrictions placed on it via development restrictions from the local council. The organisation prefers to operate under the Residential Tenancies Act rather than the Residential Services (Accommodation) Act 2002, as it sees the former as offering more protection for both the owner and the consumer.

### *In summary*

Oxford Crest is a TYPE 1 form of service integrated housing run by a private company, providing detached villa accommodation and limited support services. Residents make their own arrangements for care services which are mainly obtained from local HACC providers. This is low-cost housing targeted to age pensioners with limited financial resources.

## *5.2.2 Aveo, The Braes, South Australia*

### *Provider organisation*

Aveo is a large national company formed some three years ago and operating 80 retirement villages Australia-wide. It has a strong brand built around the 'live well' motto. Each of its villages has a different design reflecting the character of the local community. There is an emphasis on accommodation with support and 'lifestyle'. Aveo is not an Approved Provider of residential aged care or packages.

The Braes is a private sector retirement village in a medium priced range that caters to retirees who typically sell their home to meet entry fees. Residents range from some who then rely on a full Age Pension to others who are fully self-funded retirees.



### *Dwelling and village form*

The Braes offers a range of accommodation options including independent living units, assisted living units and flexi-units. The village comprises 82 duplex-style independent living units and 28 'flexi units' with a central dining area and lounge for flexi unit residents. The independent living units comprise seven 1-bedroom units (44 square metres), 73 2-bedroom units (64 to 87 square metres) and eight 3-bedroom units (106 square metres). Units consist of a bathroom, laundry, kitchen, veranda, garage, and individual gardens and outdoor areas. There is wheel chair and walker accessibility throughout the village. Flexi units have higher level of security, quicker access to support, wheelchair accessibility, and a higher level of assistive technologies than the independent living units. Flexi-unit residents are provided with all meals, a linen laundry service and cleaning. Many of the independent and flexi units are fitted with assistive technologies such as grab-rails and easily accessible showers.

### *Service arrangement*

Located in Reynella, south of Adelaide, The Braes is in close proximity to services including shopping centres, doctor and hospitals, and the retirement village itself provides extensive support services. The village staffing includes a site manager, care attendants, administrative assistant and handyman. Reflecting the strong emphasis on 'life-style', there is an extensive program of recreational activities and an active resident committee. A house cleaning service and a daily meal are available on a fee basis. The village can arrange medical care if required. Each resident has access to a 24 hour emergency call system (neck pendant) which is staffed by care attendants who have first aid training. Care attendants do not provide any form of personal care to residents.

It is also possible for residents to move from the independent living units to flexi units if their care needs increase. The village has developed a transfer package which makes moving into the flexi-units more attractive to existing residents. When residents require further care and support, managers at the village provide them and their families with information on what assistance may be needed and what options they have available to them. If an ACAT assessment is needed the managers can refer them to the appropriate services. Residents are able to receive care and support in their own units in the form of CACPs packages, assistance through domiciliary care services, and private nursing care from local providers.

### *Tenure*

The usual tenure is leasehold. The Braes is governed by the South Australian Retirement Villages Act and adheres to state Occupational Health and Safety legislation.

Most residents in the independent living units are single women. Many residents are from the local area or have local family connections. The average age of residents is around 78 to 80 years of age. The initial purchase price for independent living units ranges between \$160,000 and \$240,000, and in addition there is a service fee and a deferred management fee.

### *In summary*

The Braes is a TYPE 1 form of service integrated housing run by a private company, providing independent living in a retirement village environment, and a higher level of support in flexi units. Care services are not provided by the retirement village provider, but the provider can provide advice and referral to HACC and private providers. This

is a medium priced retirement village option targeted on home owning retirees who wish to live in a supportive environment.

### *5.2.3 Tall Trees Supported Living Community, Rochdale, Queensland*

#### *Provider organisation*

Tall Trees Supported Living Community was established in 2000 by Tall Trees Group Pty. Ltd., a Brisbane-based private, unlisted company. At this time the company only operated one retirement complex at Rochdale, in the Southern suburbs of Brisbane, Queensland. However, the company plans several similar developments elsewhere in Queensland and NSW. Tall Trees Group Pty Ltd is not an Approved Provider for Commonwealth residential aged care or packages.

#### *Dwelling and village form*

Currently, the complex provides 80 one and a half and two bedroom single storey, low density low-set clustered apartments. Apartments range in size from 55 square metres to 71 square metres. A two level, 30 apartment clustered complex including lift access is currently under construction. All apartments comprise a full kitchen and laundry, in-home security features, support and safety rails, and an in-home emergency response system. Apartments have barrier-free features such as no threshold, wide doorways and hallways that can be modified for increased disability access. Four apartments in the new development will be designed specifically for disability.

The complex is close to transport and a shopping centre and is in close proximity to a large business and entertainment centre. Reflecting its strong focus on recreational activity and social interaction, the complex includes a large leisure centre area including lounge, library, a full commercial kitchen and dining area, a tea-making kitchen for residents, a room used by on-site nursing staff, manager's room, common toilets, a children's play area, community garden, and swimming pool. There is resident parking, a community garden available to residents, extensive use of ramps for disability access and an electronic external entry (locked at night). There is extensive on-site management of care services, administrative, kitchen, activities and ground staff.

#### *Service arrangement*

Tall Trees explicitly aims to bridge the gap between residential aged care homes and retirement villages by offering a hospitality and care model that emphasises independent living. The term 'supported living community' reflects this concept which is based on a model chosen after study of the US retirement living sector. Central to the model is the provision of support and care on an 'as needed' basis, the intent being that residents do not have to move to a residential aged home if their needs increase. An enrolled nurse is employed during the day and nine Certificate III carers provide rostered seven-day, 24-hour care. A registered nurse is contracted one day a fortnight and is on call as a consultant when needed. The enrolled nurse is responsible for managing the care team and there is a program of staff training for carers. At the time of applying to purchase a unit, residents are required to undertake a physical and psychological assessment, and provide a current report from their doctor. The main exclusionary criterion is medium or high level dementia.

Tall Trees aims to be able to cater for all residents' care needs up to the time of their death, with the exception of severe dementia. Residents with increasing dementia symptoms are assisted to move to a high care facility by referral to an ACAT and support through any subsequent move. Residents from time to time require hospital admission for health issues beyond the resources of Tall Trees.

Residents are offered a choice of four 'comfort packages'. These include choice of: all or no meals (including in-home delivery of meals and eating assistance); self-care (including showering, dressing, toileting, grooming); domestic work (washing, house cleaning, shopping; paying bills, ironing, clothes alterations and dry cleaning); transport to appointments; home maintenance; social activities; and health care. Health care can include on-call nursing care, assistance with medication, assistance in obtaining medical aids, organisation of visiting allied health services, home nursing, accompanying to appointments and provision of medical information. Packages are costed on a 'per hour' user pays system on a cost recovery basis and range upwards from approximately \$70 a month. Residents are billed on a monthly basis only for services provided.

Residents can be assisted to apply for government-funded community care services to supplement or provide an alternative to care purchased through Tall Trees. Tall Trees would like to be able to provide CACPs in their own right as they believe this would enhance their model. However, they are concerned that meeting requirements to become an Approved Provider might compromise the 'non-institutional' character of the complex. They are investigating the possibility of becoming a sub-contractor of an existing community care provider.

### *Tenure*

Tall Trees comes under the Queensland Retirement Villages Act and is accredited with Aged Care Queensland. Residents have leasehold tenure.

Tall Trees caters for middle-income retirees and residents generally sell their family home to buy into the village. The purchase price of a unit in Tall Trees is around \$260,000 plus management fees and a deferred management fee. The weekly general service charge is of the order of \$97 - \$111 a week, and there is a maintenance reserve fund of about \$10 per week. Tall Trees is affordable for those with incomes at or above the Age Pension.

The average resident age is 81. Tall Trees promotes itself as a vibrant community attractive to independent retirees who have a preference for recreational activities and social interaction. Many residents are local or have children living in the local area.

### *In summary*

Tall Trees is a TYPE 2 form of service integrated housing run by a private company, providing independent living in villa units in a community environment. Care services are provided internally, and residents can also access externally provided community care. This is an example of medium-priced service integrated housing targeted on home owning retirees who wish to live in a community environment offering recreational activities and support and care services to meet increasing levels of dependency.

## *5.2.4 Grande Pacific, Broadwater, Gold Coast, Queensland*

### *Provider organisation*

Grande Pacific is described by its private sector developers as a 'lifestyle retirement resort'. It is located on the Broadwater at Southport, at the centre of Queensland's Gold Coast, and was opened in November 2008.

The apartments, with prime views of the Pacific Ocean, are aimed towards wealthy, self-funded retirees. The resort style development targets older people who want the security and community of retirement villages, but also want to live in a prime position with luxurious surroundings in keeping with a high-income lifestyle.

### *Dwelling and village form*

Grande Pacific is promoted as the 'first high rise retirement resort in Australia' and as a 'vertical retirement village' offering five-star hotel accommodation.

The development comprises 108 apartments on 25 levels ranging from one to four bedrooms, as well as a penthouse and sub-penthouse floor. The units range in size from 70 square metres to 370 square metres. One level of the building contains 12 studio apartments with accessible bathrooms and small kitchenettes.

Each living unit includes barrier-free design features. All bathrooms in the complex are fitted with 820mm shower screens to allow for walking frame access and with grab rails. All common areas are wheelchair friendly and all bathrooms are able to be easily converted to enable access for people with disabilities.

### *Service arrangement*

Grande Pacific has a wide range of facilities on-site, including restaurant, doctors' room, gymnasium, nurse's station, lounge area with water views, bar, kitchen, theatre/meeting room, library and hair salon.

The complex also offers a range of support services and recreational facilities for residents. The 'day' staff includes a manager, a receptionist, a registered nurse, a cleaner, a maintenance person and a social coordinator. The registered nurse can provide injections or changing of dressings for residents requiring regular or occasional care. The maintenance person also acts as bus driver, pool maintainer, etc. The 'night' staff comprise an on-call night nurse who is on-site from 4.30 p.m. until 8.30 a.m., and security is provided by an external provider. There is a 24-hour emergency call system which the nurse on duty responds to. A community vehicle is available for residents' use, as is a community bus.

Additional off-site services are contracted with various providers and users pay according to use. Grocery delivery, linen service and private room cleaning are contracted to external providers and available to residents on a fee-for-service basis. Residents can have meals delivered to their apartment at menu costs from the on-site restaurant. Health care provision is facilitated through a designated space allocated to visiting doctors, podiatrist and masseuse, who charge residents directly for their services.

Provision for continuing care is made by inclusion of a meals area, lounge room and library on the third floor. It is envisaged that apartments on this level will house residents with higher care needs who can access full meals packages and a higher level of nursing care on a user-pays basis. Lift access to the floor can be altered to make the floor secure for residents with dementia if necessary. As the number of places on this floor is limited, similar services are available to residents in other apartments depending on the level of care required. Residents who move from a general apartment to a level three studio apartment in order to access a higher level of care will not be charged exit fees on sale of their apartment. Residents are encouraged to continue to live at Grande Pacific as their care needs increase, and full-time nursing care can be made available on a user pays basis. Residents are welcome to access community care services provided through HACC and CACPs if this is their preference.

### *Tenure*

The complex is developed and operated under Queensland retirement village legislation and residents purchase a 99 year lease.

Prices of apartments range from \$399,000 to \$2.2m. Residents must be 60+ years and the average age is approximately 72 years.

#### *In summary*

Grande Pacific is a TYPE 4 form of service integrated housing run by a private company offering independent living in private apartments in a luxury 'vertical retirement village'. It provides a wide range of support services internally and has provision for 'serviced apartment' accommodation within the complex, although this term is not used. Higher level care services are provided on a fee-for-service basis. As the provider takes responsibility for these arrangements and they are not left entirely to individual residents, this an internal arrangement.

#### *5.2.5 Highgrove House Supported Residential Service, Studley Park, Victoria*

##### *Provider organisation*

Highgrove House is a supported residential service (SRS) located in Studley Park, a middle ring, affluent suburb in eastern Melbourne. It is one of three SRSs managed by a subsidiary company of Blue Cross Nursing Home and Hostel Care Group, which is also a large provider of residential aged care and CACPs.

##### *Dwelling and village form*

The two storey building includes one and two room accommodation, a dining room, kitchen, laundry, office space, two sitting areas, and two external courtyards. There are 45 one room and five two room apartments. The rooms have their own bathroom and some have space for a bar fridge and basin. There are call-bells in the rooms, rails in corridors and rooms, and higher than normal beds. Rooms are accessed by an internal lift. Accessories such as shower chairs, toilet seats and other assistive equipment are provided where necessary.

##### *Service arrangement*

Highgrove House provides temporary, respite and permanent 'accommodation and assistance with personal and special care' to older people aged 50 years and over who can afford the weekly fees. Staff employed at Highgrove includes a full time manager/care coordinator, personal carers, an activities coordinator and kitchen and grounds staff.

Its services include laundry, room cleaning, all meals, personal care, physical assistance for those with mobility difficulties and recreational and social activities. Residents are also able to access other visiting services including a hairdresser and manicurist, and allied health, mental health, disability services and nursing. Residents can have breakfast delivered to their rooms, while lunch and dinner are provided in the dining room. There is a range of visiting health services including a podiatrist, physiotherapist, occupational therapist and dietician. An ongoing care plan for each resident is developed in consultation with the resident and relatives.

##### *Tenure*

SRSs are private sector facilities that must be licensed under specific state legislation and also governed by a range of local and state government health regulations. Residents enter into a Residential Agreement that outlines the roles and responsibilities of the resident and the proprietor. There are a number of accountability measures including a community visitors program.

Highgrove House is an 'above pension' SRS with fees that range from \$800 a week for a single room to \$1000 a week for a double room. It is at the top end of SRS services, which range from 'pension only' services. Residents are generally from the

local area and there is a wide age range from 60 through to people in their 90s. There is no age restriction for entry to an SRS and they cater for a wide age and income range. Younger people with disabilities are more likely to be living in 'pension only' SRS, whereas more frail older people are in above pension SRS.

### *In summary*

Highgrove House is a TYPE 6 form of service integrated housing run by a private company offering accommodation, support and care to older people requiring care on a daily basis, and able to pay for the level of care provided. It provides most of its care services internally, but is reliant on external providers for a range of other convenience and care services.

### *5.2.6 Summary: private sector cases*

The five case examples described above illustrate the great diversity of private sector provision of service integrated housing, although it should be stressed that no claim is made that these are fully representative of the sector as a whole. Aveo, The Braes is in a number of respects typical of many retirement villages operated by large national retirement village companies and targeted at middle-income retirees who sell their home to meet the entry fee. These retirement villages primarily offer support and lifestyle services, but through serviced apartments (called flexi-units at The Braes) and assisted living units are increasingly offering a level of 1-to-1 care, as well as providing some services such as cleaning and meals to residents in independent living units on a fee-for-service basis. Residents of independent living units at The Braes are also receiving HACC and CACP services with some assistance by way of referral from village management, who also facilitate transfer from independent living to flexi-care within the village. The Braes relies mainly on external providers for care services and is therefore classified as a type 1 service, but internal as well as external care arrangements are being used to respond to the care needs of residents.

Tall Trees and Grande Pacific are independent retirement village operators who have both developed innovative service integrated housing models that are quite different in conception and targeted at different markets. Grande Pacific represents the providers of luxury, resort-style retirement villages with a wide range of support services and high quality recreational facilities. While it includes a serviced apartment facility (not named as such), the main source of nursing care (other than the on-site nurse to respond to emergencies) is an external private service, thus making it a Type 3 service. Tall Trees, by contrast, provides a wide range of support and care services on-site on a fee-for service basis, as well as encouraging residents to access HACC and CACP services. It aims to provide continuing care (except dementia care) and has investigated the possibility of becoming an approved community care provider. It is a type 2 service.

Both Oxford Crest and Highgrove House are out of the mainstream of retirement village provision, and serve as a reminder that service integrated housing is not to be simply equated with retirement villages. Oxford Crest is a so-called 'rental retirement village', although in fact it operates under residential tenancies legislation. It provides modest support services, but residents must rely entirely on external community care providers for care services. The provision of affordable service integrated housing for low income, older people without financial resources is an important policy issue to be discussed in the final chapter of the report. In clear contrast to Oxford Crest, which is a type 1 service, Highgrove House is a non-private dwelling providing a high level of personal care, i.e. a type 6. Above pension SRSs are one of the few forms of service integrated housing making internal provision for relatively high levels of care in the

Australian context, although their dwelling structure is closer in form to residential aged care homes than it is to independent living.

The case examples discussed so far include types 1, 2, 3 and 6 of the classification chart (Figure 4). The lack of examples in categories 4 and 5 reflect limitations of the case example selection process rather than any suggestion that these are improbable categories. Category 4 would include a privately operated retirement village structured as an apartment block with private apartments, operated by a provider who was an Approved Provider (or sub-contractor) of packaged community care, or possibly a residential aged care home, most likely a high care home. Category 5 would include a pension-only SRS relying on HACC and CACPs for a significant proportion of provision of community services. As the private sector continues to respond to the varying demands from older Australians for service integrated housing, it seems likely that a greater number and diversity of examples of types 1-6 will emerge.

### **5.3 The community sector cases**

Five community sector cases are described in this section:

- Wishart Village, Brisbane, Queensland.
- Wintringham, Melbourne, Victoria.
- The Ocean Street Project, Bondi, NSW.
- Irving Benson Court, Coburg, Victoria.
- Broadview House, Adelaide, South Australia<sup>3</sup>.

#### *5.3.1 Wishart Village, Brisbane, Queensland*

##### *Provider organisation*

Wishart village is operated by Queensland Baptist Care, a church-based not-for-profit organisation that also operates extensive HACC, package and residential aged care services and five further retirement villages in Queensland. Queensland Baptist Care is the welfare arm of the Baptist Union of Queensland.

##### *Dwelling and village form*

Wishart Village is located in the outer southern suburbs of Brisbane, Queensland. It is centrally located close to a shopping centre, transport and recreational facilities. It comprises 62 independent living units, a 60 room low care and a 44 room high care home. The units are either stand-alone or duplex design with a large lock up garage. There are one, two and three bedroom units, with two and three bedroom units also having either a study or study nook and patio. The size of units range from 90 square metres for a one bedroom unit, to 112 square metres for a two bedroom unit and 125 square metres for a three bedroom unit.

There are a number of barrier-free design elements within the village, although there is a strong desire on the part of management to avoid an institutional feel. All units are wheelchair accessible, with no steps up into the units and larger than average entrances and doorways. Bathrooms have grab rails and wheelchair accessible showers and vanity units. Residents are allowed to make additional modifications in response to increasing disability as long as they pay for these changes and remove them upon leaving. Each unit is fitted with an emergency call button in the bedroom

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<sup>3</sup> Broadview House is closely modelled on Abbeyfield Housing as it has developed in Australia and serves as an example of this form of service integrated housing for older people.

and bathroom. The emergency button is linked to an outside provider that has a database including a brief medical history of the resident.

### *Service arrangement*

Wishart Village does not have any recreational facilities, such as a pool, tennis courts and bowling greens, and instead residents are encouraged to use the services available in the local community. There is a residents' committee which organises social activities and there is a large auditorium. No meals are provided to residents in the independent living units, but meals can be purchased from the low care residential aged care home for a modest fee.

Generally, Wishart Village does not provide care services to residents in the independent living units, and if residents require on-going assistance they need to make their own arrangements with an external provider. The village manager can provide some assistance in this process. It is possible for residents with care needs including mild dementia to continue residing in independent living units if they are receiving support from a partner or family. Residents requiring higher levels of support are put in contact with external aged care providers. A few of the other retirement villages run by Queensland Baptist Care have on-site CACP packages that can be provided to residents but this is not the norm. Staff from the co-located residential care homes can on occasions provide services to residents in independent living units but, because the facility does not receive any government subsidy for such provision of care, it is costly and not recommended to residents.

If residents' care needs increase to the point that they cannot be supported by CACPs, they can move into the on-site aged care homes at Wishart Village, following assessment by an ACAT. There is a 12 room dementia-specific facility in the hostel and secure dementia accommodation in the nursing home. If a resident needs to move into residential care at either low or high care, they are put on a waiting list and are often given a high priority.

### *Tenure*

Wishart Village is governed by retirement village legislation. In addition to the entry contribution, residents pay a service charge and a deferred management fee on exit. Residents have a 'licence to occupy', a form of tenure that provides residents with the right to live in the unit during their lifetime. As the title of the unit is not held by the resident they are not required to sell the unit upon exiting.

The Village provides retirement village accommodation to older people with low to moderate financial resources. Ingoing contributions by residents are \$240,000 on average, although this can be varied for people with limited financial assets. The service fee is generally between \$132 and \$156 per fortnight and so easily affordable for those whose income is at or only a little above the Age Pension. The majority of residents come from within a 5 to 10 kilometre radius of the Village. Residents need to be over 65 years of age and they have an average age of 77. Residents must be retired and able to live independently, and capacity to live independently is assessed at the time of entry. The average length of stay for residents is around 10 years. There is a long waiting list for the village.

### *In summary*

Wishart Village is a type 7 form of service integrated housing. It provides detached villa housing in a retirement village environment and sources care services externally. It has a number of basic support services and residents whose care needs increase are likely to have the opportunity to move to the co-located hostel and nursing home.



### *5.3.2 Wintringham and Wintringham Housing Ltd, Melbourne, Victoria*

#### *Provider organisation*

Wintringham is a community organisation that is structured as a public company under the leadership of its founder, Bryan Lipmann. It provides a variety of housing and care services for older people who are financially disadvantaged and are either homeless or at risk of homelessness. In order to be eligible for housing, clients must be over 50, low income and without assets and be at risk of homelessness. A broad range of housing is provided from inner-city apartments to self-care apartments and units in 'village' 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.

#### *Dwelling and village form*

In 2008, Wintringham established a wholly owned subsidiary, Wintringham Housing Ltd to manage and develop all its housing activities. Its current diverse housing stock comprises 140 independent living units in a number of locations: a 60-unit facility in Williamstown; 20 houses in East Bentleigh; 40 units in the CBD on Little Collins Street and Guildford Lane; 20 houses in Kensington Banks; 10 rooming houses in Flemington. Most of the housing is located close to public transport, shops, and other amenities. All houses have barrier-free design features. All independent living units are self-contained one bedroom units with an en-suite bathroom, small lounge room, kitchen facilities and a personal balcony. Apart from the CBD high-rise units, there are gardens attached to each site. Free communal laundry facilities are also available in all the housing sites. Common rooms on some sites are available for communal activities. All units are furnished.

In 2009, Wintringham Housing Ltd was appointed as a registered Housing Association by the Victorian Government, thus making it eligible to receive growth funds. Wintringham Housing Ltd is the only housing association with direct links to the aged care and housing sector.

Wintringham Housing Ltd has now also been appointed manager and developer of the Alexander Miller Estate which owns a range of housing units throughout regional Victoria. As a result of successful applications to state government and funds made available through the National Partnership Agreement on the Nation Building and Jobs Plan, Wintringham Housing Ltd has embarked on a \$35 million renovation and new build program for the Miller Estate that will result in approximately 180 units for older regional Victorians.

#### *Service arrangement*

One of the concerns underpinning the development of Wintringham was that homeless people had great difficulty receiving support from aged care services. Rather than 'conventional' problems of ageing, many of this group have complex problems including mental health issues, intellectual disability, alcohol problems and behavioural problems that most aged care services are not well equipped to manage. Support of residents is therefore seen as integral to ensuring residents' capacity to maintain their housing. Support includes supervision, working through compliance issues, including compliance with medication, nursing, assistance in preparing meals and with cleaning as well as direct provision of meals and cleaning. Wintringham has its own nursing staff in recognition of the prevalence of health problems amongst homeless people. Wintringham also employs recreation officers to assist residents to engage in social and recreational activities.

Wintringham is also an Approved Provider for community and residential aged care services and uses its own staff to deliver CACP and EACH packages. Approximately 50 per cent of tenants receive care through CACPs or EACH packages. By using its own staff, Wintringham can ensure that workers are skilled to deal with the complex behavioural issues of some residents. Wintringham also provides CACP packages to financially disadvantaged older people in the general community who are not Wintringham tenants. If residents' level of frailty increases to the point that they can no longer live independently, even with assistance from CACPs, they are assisted to move into Wintringham's hostel and nursing home accommodation.

### *Tenure*

All residents in Wintringham's independent living apartments and villas are tenants with low incomes, and their tenure is governed by the Victorian Residential Tenancies Act for its independent living units. Residents in the residential aged care homes come under the provisions of the Commonwealth Aged Care Act 1977.

### *In summary*

Wintringham is a type 8 form of service integrated housing for low-income, homeless people requiring stable housing and high level of support and care. Residents live in mainly detached housing and care services are provided internally by Wintringham through CACP and EACH packages.

### *5.3.3 Ocean Street Project, Bondi, NSW*

#### *Provider organisation*

Ocean Street is a project of The Benevolent Society, Australia's oldest charity and a large not-for-profit organisation involved in a wide range of community service provision, including ageing services. The project, still in development, is based on the Dutch Humanitas 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 and care services and appropriate technologies. It is intended as 'a place where older people can live for the rest of their lives in the same apartment with the support of health, community and other services when needed'. The expectation is that 95 percent of residents will be able to stay living at Ocean Street for the rest of their lives.

Ocean Street represents a significant change in direction for The Benevolent Society which has recently began the process of divesting itself of its five residential care homes.

#### *Dwelling and village form*

The site is located in the up-market, beachside suburb of Bondi in Sydney, close to services, shops, transport and the beach. The project will involve redevelopment of the site which has been owned by the Benevolent Society for some years and the new complex will be set in a small precinct that contains a heritage-listed building and surrounding grounds which are incorporated into the overall design concept. It is adjacent to a council park.

The complex has been designed as two high-rise blocks comprising a total of approximately 140 one and a half and two and a half bedroom apartments. A number of community facilities including cafés, activity rooms and a child-friendly space will be located at ground level for use by residents and the broader community. The building will include administrative areas, consulting rooms for community care service providers and visiting health specialists, a dementia day centre, a café, a men's shed,

and exercise and meeting spaces. The open space will include both passive and active recreational areas and may include community and private gardens.

### *Service arrangement*

Ocean Street is being designed to cater for different levels of mobility and frailty, and to meet a number of standards for barrier-free housing. There will be a range of apartment sizes, all with sufficient space to enable a family member or carer to stay and provide 'informal' care. There will be reinforced ceilings to enable hoists to be installed. The apartments will be fully self-contained to enable independent living and will include emergency call buttons. Consideration is being given to ensuring that appropriate infrastructure is in place to cater for future technological developments in non-invasive, low level monitoring, for example, a system that will register if someone falls that will not require the resident to press a call button. Underground car parking will be available to residents, and parking will be available for visitors, visiting care services and community transport buses. The project is also aiming to incorporate a high level of sustainable design in the construction.

The project has a strong focus on ensuring older people remain connected to their local community and social networks, and is hoping to draw residents from the local area. It plans to attract residents from three income groups that reflect the differing economic circumstances of households in the area. These groups are low income renters (10%), those with modest property assets (30%), and those who are asset-rich (60%). The costs of purchasing are still being determined. Residents will pay rent linked to their financial circumstances. Age eligibility will be set at 55. Consideration is being given to ways of maintaining a spread of clients in terms of their level of dependency and independence. It is hoped to have a 40-year age range among residents, but that applicants with moderate to severe dementia will not be accepted. However residents who develop dementia or other disabilities while residing at Ocean Street will be cared for appropriately, unless this poses a threat to themselves or others.

The complex will rely on both informal and formal support and care. A care adviser, concierge and community development worker will be attached to the complex, and volunteers will play supporting roles. The care adviser will play an active role in linking residents to care services provided by local organisations, including The Benevolent Society, through the HACC, CACP, and EACH programs, as well as to other social and recreational services. It is envisaged that community care provisions will be coordinated in such a way as to facilitate efficiencies. Meals will be provided on site. Informal support including mutual support among residents and support from family and friends will be encouraged. The design feature of an added half bedroom is intended to enable carers or family members to stay overnight if needed or desired. The community development worker will be responsible for facilitating recreational and other social activities.

### *Tenure*

It is proposed that the Ocean Street Project will come under the *NSW Retirement Villages Act*. The tenure of most residents will be under a loan-licence arrangement involving an ingoing payment, a weekly service fee and a deferred management fee. About 10 percent of residents will be renters. The Benevolent Society will retain freehold to ensure the building and apartments retain their purpose of providing retirement living and aged care. The Benevolent Society will also be the manager of the building.

### *In summary*

The Ocean Street project is envisaged as a type 10 form of service integrated housing to be run by a large community organisation as a project that will demonstrate the value of the 'Apartments for Life' concept. Accommodation will take the form of private apartments in a high-rise building. Extensive arrangements will be made by the provider for care arrangements for residents on an as-needed basis. These will be provided by The Benevolent Society itself as well as by other local community care providers. While there is a mix of internal and external care provision, this is predominantly an internal service arrangement involving the housing provider taking a high level of responsibility for ensuring that residents receive the care that they require.

#### *5.3.4 Irving Benson Court, Coburg, Victoria*

##### *Provider organisation*

Irving Benson Court is an initiative of Wesley Aged Care Housing Services of Wesley Mission Melbourne, a large scale not-for-profit provider of community and residential aged care services. It provides low-cost rental accommodation and care to older people who are homeless or at risk of homelessness. While many of the residents need minimal support to be able to live independently, the nature of their needs means they do not require the level or type of care provided in low care residential aged care homes.

##### *Dwelling and village form*

The building is centrally located in Coburg in close proximity to shops, the area mental health service, churches, and public transport. It is a two-story complex of 35 self-contained bedsit units, set around a central quadrangle and a recreation area. Office space and a dining/activities room are also located within the complex. The building is secure and only allows access to residents and staff. The units comprise a living room which also serves as a bedroom and has kitchenette (cook-top; fridge) leading to a walk through robe and bathroom. Feature includes a call-bell and bathroom grab rails. Three units have been specifically designed for wheel-chair access. Where residents do not bring their own furniture, which is not uncommon, this is provided by Wesley Mission.

The service offers residents a safe and supportive environment with low rents. Staff located at Irving Benson Court includes the manager of the housing service, the CACP coordinator and residential support workers. Social interaction is encouraged amongst residents and an evening meal is provided. Residents participate in a number of social activities run by volunteers.

Many residents at Irving Benson Court are in receipt of HACC services and the housing provider also provides approximately 20 CACPs to residents needing higher levels of support. The CACP coordinator prepares a care plan for a resident which is reassessed on a regular basis. The care plan typically includes direct support, assistance with self care; administration of medication; transport to health-related appointments; management of finances; shopping and domestic work. Many residents receive a delivered meal from Meals on Wheels during the day. There are regular visits from health practitioners including doctors, physiotherapists and podiatrists.

Irving Benson Court is one of a number of housing and aged care services run by the Wesley Mission. In the event that residents require higher levels of care, they can move to a group home or low care aged care home also operated by Wesley Aged Care Housing Services. In some other cases where there has been significant recovery from illness such as alcoholism, residents move from Irving Benson Court to

mainstream public housing. However, Irving Benson Court is not intended to be transitional housing and residents are entitled to stay at Irving Benson Court for as long as they need.

### *Tenure*

Tenure is governed by Victorian residential tenancies legislation and residents are required to sign a tenancy agreement. Residents pay a fortnightly rent of \$205 and a small daily contribution to their CACPs package, readily affordable with Age Pension income.

Most residents are from the local area or the inner suburbs of Melbourne. Of the 30 residents currently housed at Irving Benson Court, all but two are aged over 50 and the average age is 65 years of age, much lower age than the average of those in residential aged care homes. Many residents are suffering from mental illness and most are referred from hospitals or the local mental health services, and a small number self-refer.

### *In summary*

Irving Benson Court is a type 10 form of service integrated housing run by a community organisation for insecurely housed older people with high needs. It provides inexpensive, small private apartment type housing that is closely linked to internally provided care services in the form of HACC and CACP. Through the Wesley Mission the housing service has close links with other aged care services which are used for referrals for residents who are not able to continue to live independently.

## *5.3.5 Broadview House, Adelaide, South Australia*

### *Provider organisation*

Broadview House is located in an established, inner North-Eastern suburb of Adelaide and operated by the Northern Suburbs Housing Co-operative, an incorporated, non-profit community housing organisation. The organisation was established in 1981 and currently manages 131 independent one and two bedroom units located on 38 different sites, as well as Broadview House. The organisation's philosophy is that 'housing should be more than just shelter'.

### *Dwelling and village form*

Broadview House was built by joining two standard detached houses with a newly built common area. The result is a 10 room semi-independent accommodation facility consisting of 10 carpeted, air-conditioned one bedroom rooms each with their own en-suite bathroom. There is also one respite room with an adjacent bathroom. All rooms are located on the ground floor, are unfurnished and range in size from 24-35 square metres. In addition, there is a common area, dining area, communal kitchen, laundry and front and rear spacious, landscaped gardens. Wheelchairs can fit into the rooms but not the bathrooms. Grab rails have been fitted as required. Each resident has their own key and are free to come and go as they please. Resident rooms are treated as the residents 'home' and private space. A spare room can be booked for visitors, and the respite care room is available for non-residents.

### *Service arrangement*

Broadview House was established as a housing alternative for people aged 55 years and older on low incomes who are somewhat frail but not needing the level of care provided in a nursing home. It is designed for people seeking support within a setting that also provided security and companionship. Applicants must meet a number of criteria including being aged 55 years and over, on a low income with limited assets,

in reasonable health, having a housing need, capable of independent living and willing to participate actively in the cooperative. Broadview House does accept people with some level of complex needs (e.g. homelessness and depression), however the number of people with complex needs housed at any one time is rationed.

Broadview House provides a number of support services on-site. It employs two housekeepers on a rotating week schedule and a relief housekeeper who works every second weekend. Two main meals are served each day from Monday to Friday and one main meal is served on Saturday and Sundays. The housekeepers prepare and serve the meals and are also responsible for cleaning the communal areas, weekly shopping for household supplies, assisting residents with heavy laundry, and being on call for emergencies. Residents are responsible for the care of their own rooms.

Mutual support is a key feature of Broadview House. Family support and other social networks of residents provide some help and support and a volunteer care group visits the residents to provide social contact. Residents are supplied with their own personal alarm pendant, which provides 24 hour emergency access to doctors or the Ambulance Service.

Broadview House staff and volunteers will assist residents to gain access to community care through HACC, CACPs and EACH. Broadview House provides housing and support for as long as possible, but if residents' care needs increase beyond a level that the service can provide, they may be encouraged to move to more appropriate accommodation in a residential aged care home and referred to an ACAT for assessment.

It should be noted that Broadview House was designed on the Abbeyfield housing model, as described in chapter 3.

### *Tenure*

Broadview House is incorporated under the *South Australian Co-operative and Community Housing Act 1991*. Broadview House residents are encouraged to be involved in the day to day running of the house and to participate in decisions on house rules. Tenants of Broadview House enter into a lease agreement under the *Residential Tenancies Act 1995*, but their legal status as tenants in a cooperative housing facility is unclear.

Funding for the running of Broadview House is provided through tenants' fees and State Government subsidies. An affordability guarantee is provided to residents to ensure no-one pays more than 25 percent of their gross income as rent, in line with public housing rents. The service fee is 70 percent of the basic single pension, which covers light and power, cost of meals, heavy laundry assistance, maintenance and gardening, and basic household supplies.

The age of residents generally tends to be a mix with younger and older seniors. At the time of interview, residents' ages were in the range from 72 to 92 years. Residents are predominately women, but there is a policy of having at least one man in the house at any time.

### *In summary*

Broadview House is a type 11 form of service integrated housing for low-income, frail older people wanting to live in a supportive environment. Residents live in a shared, non-private dwelling and are provided with a range of support services. However, care services are not provided and residents requiring care are referred to external community care organisations.

### 5.3.6 Summary: community sector cases

The five examples of service integrated housing provided above give some indication of the diversity and scope of the community sector's involvement in service integrated housing for older people. Wishart Village exemplifies the key role that large church-based organisations have played in the development of retirement villages that provide supported, independent living for many older people. It illustrates in particular the model of the 'three tier complex' dating from the APHA of the 1970s, which facilitates transfer from independent living to low and then high care residential care homes as needs increase.

However, other ways in which retirement villages have increasingly addressed the issue of care services provision are not illustrated by this sole example. Some community sector retirement villages have diversified into providing serviced apartments and assisted living units within retirement villages, thus providing additional care options. Others have used their status as both community care providers and retirement village operators to provide integrated support and care for residents in independent living units in retirement villages through provision of HACC, CACP and EACH packages. As noted earlier in the report, the *Retirement Villages—Ageing in Place* initiative has opened up the possibility of extension of delivery of community care to older Australians living in retirement villages, by opening up the possibility of retirement village operators becoming approved providers of aged care packages or developing partnerships with existing providers. The community sector retirement village providers have particularly responded to this opening.

Looking beyond the retirement village industry, the examples of Wintringham and Irving Benson Court illustrate the community sector's important role in providing service integrated housing to older people with complex needs, especially those who are insecurely housed or homeless. Broadview House illustrates one form that the Abbeyfield Housing model has taken in Australia. The Ocean Street Project demonstrates the interest of the community sector in developing innovative models of service integrated housing that bring housing, support and care together in different ways. The Ocean Street project can be viewed as a retirement village development that begins with the premise that older people should be provided with aged care services in their apartment (or independent living unit) for as long as possible, with residents only rarely having to move to residential aged care. Those retirement villages moving towards greater provision of HACC, CACPs and EACH packages to residents in independent living units are moving in a similar direction.

The examples of community sector service integrated housing projects provided above include types 7, 8, 10 and 11 on the classification chart (Figure 4). No case study is provided for type 9, although there would be examples of community sector retirement villages providing apartment-type dwellings and making external arrangements for care provision. Type 12 approximates the function of hostels prior to their integration into the residential aged care system. Two types of services not represented by the case examples are the stand-alone, small groups of independent living units whose residents source care services from HACC and CACP providers described in section 2.2 (many would be type 7), and community sector retirement villages that are involved in the Retirement Village – Ageing in Place initiative (which could be examples of types 8 and 10).

## 5.4 The public sector cases

Four public sector cases are described in this section:

→ Dougherty Apartments Retirement Village and Care Facility, Chatswood, NSW.

- The Older Persons' High Rise Support Program, Footscray, Melbourne.
- Housing and Support for the Aged, Melbourne.
- Matavai Group Living Project, Waterloo, NSW (also known as Matavai Ageing-in Place initiative).

#### *5.4.1 Dougherty Apartments Retirement Village and Care Facility, Chatswood, NSW*

##### *Provider organisation*

Dougherty Apartments were constructed in 1989 as a joint venture between the Willoughby City Council, the NSW Department of Housing and the Uniting Church who came together to form the Dougherty Apartments Retirement Housing Project. The Project is a company limited by guarantee, with representation on a Board of Directors of all three parties. The development is located in close proximity to the central business district of Chatswood, a middle distance suburb on Sydney's affluent North Shore.

##### *Dwelling and village form*

There are 84 retirement village apartments (42 single Department of Housing units and 42 Dougherty Apartments comprising 22 one bedroom, 19 two bedroom and one three bedroom apartments) and 51 rooms in the associated low care residential care home which also has a 13 room secure dementia specific unit. The complex is designed with three wings to each floor and floor access is by internal lift. The ground level has reception, staff offices, a chapel and a communal lounge. Level one includes the dementia unit and a large open air roof garden. The gym and internet café are located on level two as well as one self-care resident apartment. All other self-care apartments are located on levels three to eight with the public housing and self-funded apartments interspersed across all the floors. A communal lounge and drying room are located on each floor. The complex is secure with an intercom system and CCTV, and exterior entry is by a security swipe card. A car park is located in the basement.

Residents furnish their own apartments which are fully self-contained and include a full kitchen and combined lounge and dining room. Each apartment has its own balcony with views. The size of the one and two bedroom self-care apartments are 47 and 68 square meters respectively. Grab rails are fitted in bathrooms. Management is progressively refurbishing units as residents vacate to include widened doorways, wheelchair accessible bathroom facilities and height adjustments to light switches.

##### *Service arrangement*

A number of support services are available for the residents of the retirement village. On-site management maintains and organises the facility as a whole. Residents have a Vital Call pendant and a fixed call button in the bathroom of their apartments which links them to registered nurses employed by the hostel. There are organised recreational activities and residents can participate in arranged activities at the adjacent community centre. There is a significant level of mutual support among the residents. The central location of Dougherty Apartments facilitates access by relatives, and this is also an important source of support for some residents.

The retirement village residents also have access to support and care services that are available as a consequence of the co-location of the low care residential care home. One significant benefit is a provision for residents to receive two weeks' care at no additional charge following a period of hospitalisation. This care may entail provision of meals in the resident's room, cleaning, access to physiotherapy, assistance with self care, and provision of equipment. Retirement village residents



may access, on a user pays basis, services available through the hostel such as meals (short term only) and the laundry service. They can access the visiting GP and podiatrist, and join in activities provided to hostel residents such as the physiotherapy class. They can access subsidised transport services through Council Cab, a service provided through the Willoughby City Council. On occasions, staff will provide transport for medical and other important appointments when other transport options are not available. Some of the residents of the self-care units use HACC services such as meals on wheels, home help and shopping services. Staff refer residents to the adjacent community centre for assistance in accessing community care services.

Retirement village residents needing higher levels of care can, following an ACAT assessment, access CACPs or move to the low-level care home or dementia unit within the Dougherty Apartments complex. Dougherty Apartments has made a number of applications to obtain CACP provider status in order to deliver services itself to its retirement village residents, but has yet to receive an allocation.

### *Tenure*

Dougherty Apartments includes a retirement village in which residents purchase the use of their apartments under a loan-licence arrangement, and public housing tenants who rent their units under an agreement between the NSW Department of Housing and Dougherty Apartments. Retirement village residents come under NSW retirement village legislation. Entry costs of one and two bedroom apartments range from \$345,000 to \$360,000 and \$445,000 to \$460,000 respectively. Occupants who are public housing tenants enter into a standard tenancy agreement with the Department of Housing. Tenant selection is the responsibility of the Department of Housing, although there is consultation with the management of the facility to ensure that new tenants are suitable. The NSW Department of Housing meets the costs incurred by Dougherty Apartments with respect to the public housing units and tenants.

### *In summary*

Dougherty Apartments is a type 16 form of service integrated housing. It involves two public sector organisations - Willoughby City Council and the NSW Department of Housing – combining to develop a retirement village with private apartments and providing support and care services internally through a partner community organisation, Uniting Care, who also provide a low-care residential aged care home in the same complex. The co-location of independent living units and low care home has enabled provision of a level of care above that usually found in retirement villages that do not have a co-located aged care home, and approximates an assisted living environment. The public housing tenants in Dougherty Apartments are receiving a far higher level of support and care than that provided in conventional public housing settings. The social mix of residents is a contrast to many retirement facilities that are explicitly targeted on specific, and often narrowly defined, income and wealth groups.

## *5.4.2 Older Persons' High Rise Support Program, Victoria*

### **Provider organisation**

The Older Persons' High Rise Support Program is funded through the Aged Care program of the Victorian Department of Human Services. It is an on-site support program assisting people aged 55 and over and living in inner-city high-rise public housing towers 'to improve their health and wellbeing and maintain stable tenancies'. Residents of the high-rise towers are tenants of the Victorian Office of Housing and the program involves collaboration between two divisions of the Victorian Department of Human Services. The program was established in 2000 to serve two towers, housing 120 and 100 tenants respectively, and has since expanded to 11 towers on

six sites so the total project now serves a total of around 1000 residents, although only a proportion of these are clients at any particular time.

The program was introduced following a study of the support needs of older people in inner-city, public housing, high-rise towers that cater primarily for older people. The report identified a significant proportion of older tenants who were socially isolated, who suffered from conditions such as mental illness, drug and alcohol dependence and acquired brain injury, but who were not accessing health and community support services. The program is targeted at such vulnerable and isolated older tenants, particularly those who are frail or who have disabilities.

### **Dwelling form**

The two high-rise buildings where the program was established are older buildings which have been partially renovated, including conversion of many of the original bedsit units into one bedroom apartments. Accommodation previously housing a caretaker is now used as an on-site office for support workers. The buildings were not originally designed for older people with complex needs. Some physical supports such as grab rails can be provided following an assessment by an occupational therapist. An emergency call and buzzer system was an original feature of the high rise sites, and has been re-introduced as part of the high rise support program. The call button, located in the bathroom of the apartments, triggers a buzzer system on the level on which the call button is located. Neighbours are relied on to report the buzzer to the support worker or after-hours support worker.

### **Service arrangement**

Support services are provided by state government community health services and one large church organisation. Support workers provide case management, social support, monitoring, practical assistance, recreational activities and links to health and community services. Informal support amongst tenants is encouraged. A range of allied health workers, including a podiatrist and masseuse, from the local community health service visit the two high-rise buildings on a regular basis.

A pool of flexible care funds is available to assist tenants, especially those with complex needs. Flexible care funds are used for a variety of purposes including paying for over the counter medication, providing transport, arranging cleaning of apartments, meeting outstanding bills, bringing in mobility aids, using interpreters, assisting with the purchase of white goods, and organising social and recreational activities. These flexible packages are similar in form to CACPs but able to provide a different range of services. Funds are also used for the salaries of the support workers who link tenants to mainstream services including community health, housing and community care services. Tenants are referred for ACAT assessment if it felt that a higher level of care, including CACPs, is required.

### **Tenure**

The program serves tenants in public housing who pay 25% of their income in rent. Virtually all rely on a Disability Support Pension or Age Pension for their income and so also have Health Care Cards and are eligible for other concessions on utilities and some other services.

### **In summary**

The Older Persons' High Rise Support Program is a TYPE 16 form of service integrated housing. It involves an internal service arrangement for support to public housing tenants living in private apartments in a high-rise building. However, there is

### *5.4.3 Matavai Group Living Project, Waterloo, NSW*

#### *Provider organisation*

Matavai Group Living Project is a collaborative project involving the NSW Department of Housing and Mercy Arms Community Care (MACC), a service of Catholic Healthcare Ltd. Catholic Healthcare provides residential aged care, community care and seniors' living services across metropolitan Sydney and regional NSW. Mercy Arms Community Care was established in 1991 to provide services in the Redfern/Waterloo area, a low income area of central Sydney, and now has more than 1,000 clients. The collaboration involves the Department of Housing as the provider of housing and tenancy manager and MACC as the provider of community care services.

#### *Dwelling and village form*

The Matavai Group Living Project is a group living model within a public housing high rise apartment block for frail older people with complex needs. When it was first developed in 1993, MACC was providing assistance to 42 clients living in public housing in South Sydney. It was felt that significant advantages could be gained through a new 'cluster development' model of service delivery, based on a Scandinavian model. The model involves co-locating a small number of long-term residents of the building requiring high levels of support and care on one floor of the building. The aim was to facilitate the efficient provision of high-level support services funded through pooling of CACPs. The aims are improved quality of life; improved well-being through regular provision of meals and consistent monitoring of physical, medical and emotional needs; improved safety; and reduced likelihood of institutionalisation. On-site carers provide the main component of care, supported by other community care staff.

The project is located on the fourth floor of the 29 level Matavai public housing complex in Waterloo, Sydney. Two one bedroom units and five bedsits have been converted into three one bedroom units and four studio/bedsits and a shared kitchen and dining room facility with an attached bathroom. Each of the units and bedsits is self contained. A shared lounge and communal laundry is also located on the floor. Features include grab rails, adaptable design for the installation of further grab rails as necessary, hob-less showers and shower door design to ensure access by frame or wheelchair. The complex is wheelchair friendly and tenants have lift access. The age and original design of the building presented some challenges to adapting all units to the same level of disability access. The building as a whole comprises approximately 200 units. A community room, kitchenette and small library are located on the ground floor. The garden is well developed and contains a large water feature providing a shady relaxing space for tenants.

#### *Service arrangement*

The project aims to ensure public housing clients retain their independence. The support and care provided is described as equivalent to low level residential aged care. Tenants requiring further care will have an ACAT assessment and will be transferred to a residential aged care at the appropriate level. The ability to fit into a group living model of housing and care is taken into consideration when older people are referred to the project. Clients are drawn from the Matavai and Tarunga public housing buildings and then from the wider Waterloo area.

Meals are provided by a private catering company. Units have kitchenettes that enable tenants to prepare their own meals, but all residents choose to pay to have their meals provided. A personalised care plan is devised for each tenant. This might include monitoring medication, assistance with self-care, arranging appointments, providing transport and accompanying clients to appointments, cleaning rooms, laundering and shopping with or for clients. Some clients access day care services in the community and allied health services such as podiatry visit Matavai. Staff assist clients in paying bills, letter writing and other daily activities as requested by the client. Clients participate in occasional social events arranged by MACC such as the annual Christmas party.

An after-hour emergency call button system is in place. The call button is installed in each area of the units and is linked to the Department of Housing security. A common phone is located in the kitchen and dining area that is linked to MACC after-hours on-call service.

Funding is provided through CACPs, with MACC allocating some of its packages to residents of Matavai and Tarunga, but the quantity of care provided well exceeds standard CACP benchmarks and staffing arrangements are under review. A second floor in the Matavai building has been operating since December 2008, and negotiations are underway for a third floor in the nearby Tarunga building where HACC funding will be used to support residents to remain living independently. The NSW Department of Housing is interested in expanding the project into other areas or other buildings.

#### *Tenure*

The project is open only to public housing tenants who are in receipt of a CACP. Tenants are subject to the same tenancy agreement with the NSW Department of Housing as other tenants.

MACC does not have the authority to transfer clients to other facilities as they are tenants of the NSW Department of Housing, and this situation has resulted in the project continuing to serve some clients to higher levels of care than would otherwise be the case.

#### *In summary*

The Matavai Group Living Project is a TYPE 17 form of service integrated housing providing support and care to frail, older public housing tenants through MACC, an external provider via pooled CACP packages. Tenants continue to have their own flats but are brought together on the same floor where they share living areas and laundry facilities, suggesting that this housing should be classified as a shared non-private dwelling rather than private apartments.

### *5.4.4 Housing and Support for the Aged, Melbourne, Victoria*

#### *Provider organisation*

The Housing and Support for the Aged program is an initiative of the Victorian Department of Human Services that parallels the Commonwealth ACHA program. The program provides funding for case management or support workers employed by community health services or community organisations across the state, and brokerage funding of \$5,000 per client place per year.

#### *Dwelling and village form*

Unlike all the other case examples, HASP is not linked to a single set of dwellings but is instead dispersed across individuals on a public housing waiting list wherever they

are living and those already in public housing in a variety of locations who are experiencing difficulty in managing their tenancy.

### *Service arrangement*

The aim of HASP is to assist people aged over 50 with complex needs including age-related frailty, serious mental health, psychiatric disability, alcohol and substance abuse and similar problems, to secure and maintain a stable public housing tenancy. The service includes case management, care coordination, monitoring, practical assistance, social support, and a pool of flexible care funds. There are 12 equivalent full-time support workers across Victoria. The tenants receiving support through the program may be located in any type of public housing throughout Victoria, including housing in high-rise towers, low-rise apartment blocks and medium density cluster housing.

The program provides case-managed packages of support and services to people who are entering public housing with a history of homelessness or insecure housing. As support is usually for a relatively short term rather than ongoing, the \$5000 funding for each client place can support a number of clients in turn with short interventions with on-going services then drawn from HACC, CACPs and other services such as community health. The example discussed here focuses on the Inner South Community Health Centre which receives funding for one half-time support position as well as an allocation of brokerage funding (\$35,000 per annum) to deliver the program.

The program focus is tenants who have complex needs but who are still able to live independently. In the Inner South Community Health Centre the caseload of approximately 25 clients is shared across a pool of case management workers. Referrals are made from a number of organisations including the Office of Housing Area Office which refers clients who are entering public housing or who are currently living in public housing but experiencing tenancy difficulties.

An individualised case plan is developed for tenants entering the program. Brokerage funds are used for a range of purposes including paying rent arrears, meeting transport costs, arranging medication and taking part in social and recreational activities. Case managers assist with a wide range of day-to-day activities. Tenants are also assisted to access a range of community health and community care services, including HACC and CACPs. Intensive support can be provided through brokerage funds for short periods. There is a regular case review of tenants being supported through the program, and once their housing and daily living activities have stabilised, clients are usually moved to a less intense case management service, including CACPs and disability service packages for on-going support. A relatively small number of clients who need higher levels of on-going support and care are referred to ACATs and then Supported Residential Services or residential aged care homes depending on their age and type of care needs.

### *Tenure*

All clients of HASP are public housing tenants or on public housing waiting lists.

### *In summary*

The Housing and Support for the Aged program could be viewed as a type 16 or type 14 form of service integrated housing, although tenants are not co-located in any particular public housing building. Tenants may be living in flats in high-rise towers, low-rise blocks or medium density cluster housing. The internal service arrangement is an internal arrangement between a public housing authority and a provider of support services located in the same government department who also draws on

services provided by other HACC, community health and disability and aged care services for on-going support.

#### *5.4.5 Summary: public sector cases*

All of the case examples provided in this section concern the provision of support and care services to older public housing tenants. Historically, housing authorities in Australia have viewed their role solely as housing providers and have not made direct provision of or been responsible for support and care services for their tenants. While this has now markedly changed in most states, housing authorities have been slower to recognise the support and care needs of older public housing tenants than of some other groups of public housing tenants (Jones, Bell, Tilse and Earl, 2007; McNelis, Neske, Jones and Phillips, 2008).

However, as increasing numbers of people age in general public housing, as well as those who enter dedicated older persons housing, the need to address the support and care needs of public housing tenants is increasing. Two of the cases discussed above – the Older Persons' High Rise Support Program and Housing and Support for the Aged – are relatively unusual cases of public sector community aged care and community health providers and housing authorities jointly developing internal support and care arrangements. As such they are classified as type 16 (the High Rise Support Program) or 14 and 16 (the Housing and Support for the Aged program). The Matawai Group Living Project involves the establishment of a group living and care program in public housing using the resources of an external community care provider. As such it can be classified as a type 17 form of service integrated housing. Dougherty Apartments is an example of support and care being provided internally to public housing tenants and other older people in an innovative arrangement involving 'social mix' within a retirement village and co-location of the village with a low-care hostel. This is a type 16 arrangement brought about through a partnership of two levels of government and a voluntary sector aged care provider.

As the number of older people with support and care needs in public housing increases with the ageing of the population, alongside a relative decline in access to low care residential aged care homes, an increase in all types of service integrated housing in public housing can be expected. In some cases, responses may simply take the form of public housing authorities employing workers to liaise with community care providers to ensure that public housing tenants receive the care they require. In terms of the classification chart, such initiatives sit on the boundary between internal and external service arrangements. Where a worker is employed by the housing authority to link clients to services and provide other support but is not directly involved in provision of on-going services, the role is similar to that of a retirement village manager under external service arrangements. Even though the support workers' roles may be more intense and cover a wider scope of support, these service arrangements are external and illustrate types 13 or 15, depending on the form of the public housing dwelling and setting. Type 18 arrangements could occur in public sector boarding houses that developed internal support programs similar to the High Rise Support Program.

## **5.5 Conclusion**

A classification chart distinguishing the various types of service integrated housing in Australia was presented in chapter 4 based on three criteria: sector, dwelling form and service arrangements. This classification resulted in a typology of 18 types of service integrated housing as shown in Figure 4. The case examples provided in this chapter cover 11 of the 18 categories shown in Figure 4 and illustrate the diversity of service

integrated housing in Australia. Examples falling into the remaining categories have also been identified.

The classification and case examples suggest patterns of likely associations amongst variables that would be found were a large-scale study of service integrated housing in Australia to be undertaken, and the overall patterns that are likely to emerge under current policy settings. Most private sector provision at the present time is likely to fall into types 1 and 3, i.e. retirement villages that provide a supportive living environment but which rely on local community care organisations to provide care services for residents. This pattern may change as more private retirement villages develop assisted living services, thus increasing their capacity to provide care services to residents in independent living unit. It may also change if, as encouraged under the *Retirement Villages – Ageing in Place* initiative, private retirement villages become more active in either gaining the status of Approved Providers of CACP and EACH packages and/or entering into partnering or sub-contracting arrangements with existing providers. These trends would result over time in a growth of types 2 and 4 and a realignment of the role of retirement villages to include the provision of support *and* care services in a range of dwelling forms. Such development is likely to be taken up by both not-for-profit and private retirement village operators who also provide residential aged care services, and especially where services are co-located.

The pattern of provision by the community sector is likely to be somewhat different to the private sector for the reason that community sector providers of retirement villages are much more likely to also be approved and experienced providers of community care as well as residential aged care homes. It seems reasonable to expect that these capacities will generate the emergence of a higher proportion of internal service arrangements (especially types 8 and 10) than in the private sector. Internal service arrangements may also be facilitated by co-location with residential aged care homes (although this was not the case with the example of Wishart Village). Internal service arrangements may also be more likely to emerge in apartment buildings than in detached villa housing, perhaps because of the opportunities for efficient service provision (this point applies equally to the private sector). Furthermore, community sector projects targeted on older people with complex needs are perhaps more likely to rely on internal service arrangements due to the need to provide tightly designed and delivered programs (e.g. Wintringham, Irving Benson Court).

In general, public housing would be expected to rely heavily on external service arrangements given the primacy of its role as a housing provider, rather than a support and care provider. Projects such as the Older Persons' High Rise Support Program where the housing authority has employed workers to take on responsibility for arranging support and care services but not on an on-going basis are on the margin of external and internal arrangements, and programs such as Dougherty Apartments are classified as internal service arrangements as they involve a formal partnership between a public housing authority and a community care provider formed with the assistance of an enterprising local government. It seems likely that public housing will address the needs of its older tenants for support and care by advocating for them with care providers to gain access to community services care rather than by providing care as an integral part of the housing service, but this role may extend beyond the current focus on those with complex needs to facilitating access to services for the wider population of frail older tenants in public housing.

## **6 OVERVIEW AND IMPLICATIONS**

### **6.1 Introduction**

This final chapter explores the policy and research implications of the study. The report is the first attempt in the Australian context to examine the service integrated housing sector as a whole, rather than focusing on specific types of housing such as retirement villages (Stimson, 2002) or independent living units (McNelis, 2004). In this sense, the report is exploratory and can be viewed as laying the foundations for an extensive program of research. Based on these foundations, this chapter firstly provides an overview of the 'state of play' of service integrated housing in Australia at the present time. This overview draws attention to the diversity of types of service integrated housing in Australia; the international context; the roles of the private, community and public sectors; the key drivers of change; and, importantly, the opportunities presented by the current national policy context. The chapter then moves to consideration of options for governments wanting to shape policy for the future of service integrated housing in a more purposeful manner than has been the case in the past. One clear conclusion of the chapter is that further evidence is needed as a foundation for sound policy, and a number of directions for further research are proposed.

### **6.2 The state of play**

#### *6.2.1 Diversification of service integrated housing in Australia*

Over the past 50 years, and particularly over the past 30 years as community awareness of the ageing of the Australian population has grown, new service systems designed to meet the needs of the growing number of older Australians have been developed. Prominent amongst these is the aged care system, including community care and residential care, which has undergone major reform and development as well as considerable expansion since the mid-1980s.

Closely related to aged care is the set of housing, support and care services referred to in this paper as service integrated housing. The term service integrated housing is defined in Chapter 1 as:

All forms of housing for people in later life where the housing provider deliberately makes available or arranges for one or more types of support and care, in conjunction with the housing provision.

Service integrated housing has not to this point received the same level of public and policy recognition as aged care in Australia, notwithstanding sustained growth on the ground. However, there is a strong case for viewing service integrated housing as a key component of the repertoire of services that ageing societies need to develop for their ageing populations. There are recent indications of increasing policy attention to service integrated housing in Australia, and this report is itself evidence of increasing research attention to this topic.

In the Australian context the main form of service integrated housing is the retirement village. The scale of provision now compares with that of the residential aged care program, and retirement villages have diversified to the point that 'retirement village' should be considered an umbrella term that encompasses a range of different kinds of service integrated housing. Some retirement villages focus on recreational activities, usually for the healthy, younger-old, and these are often referred to as lifestyle villages. However, more are concerned with providing a supportive environment for older people as well as lifestyle services, and an increasing number are catering for



older people requiring a level of care as well as support. In the past the main strategy for providing care as well as support in a retirement village environment was to co-locate retirement villages with hostels and nursing homes. The so-called three-tier complexes that developed early on, assisted by capital funding under the APHA, continue to operate. However, the cessation of capital funding has been a factor driving the development of other forms of retirement villages offering support and care, such as serviced apartments and assisted living facilities. Retirement village operators are also more actively involved in assisting 'self-care' retirement village residents to access community care services such as HACCP and CACP and EACH packages, as well as making provision for some services directly on a user pays basis. Alongside these mainstream developments in retirement villages, new forms of the retirement village concept are emerging. Perhaps the most significant of these from a public policy perspective are so-called affordable rental villages designed for low-income, low-asset aged pensioners. But there are also other new forms including other types of rental villages, villages based on freehold tenure, and villages aimed at the luxury market sourcing care services from private sector providers.

There are also important developments in service integrated housing outside of the retirement village sector, as conventionally defined. Many independent living units built from the 1950s to the 1980s continue to house older people, and many of them provide support and care to varying degrees. Services to older people are also provided in some boarding houses and manufactured homes estates, and supported residential services provide support and care to frail older people as well as people with disabilities. Service integrated housing is provided to many older people with complex needs, particularly older people at risk of homelessness. There are also well-established, albeit small scale, services such as Abbeyfield Housing, and emerging experimental models such as apartments for life.

### *6.2.2 The international context*

If we are to understand the future of service integrated housing in Australia, and the roles that public policy might play in shaping this future, it is instructive to look at the ways that service integrated housing has developed in comparable overseas countries such as the US, the UK and European countries. All of these countries have developed many forms of service integrated housing. However, the wide range of terms used to describe service integrated housing in different national contexts has made international comparison difficult. The international translation chart that appears in this report as Table 2 (and in an expanded form at the end of the report) addresses this issue. It defines and compares over 90 terms referring to types of service integrated housing, and identifies the international equivalents to Australian terms and forms.

There is much to be learnt from international experience as there is now a significant body of research literature on many forms of service integrated housing. This literature is reviewed in the positioning paper for this project and is summarised in Chapter 3 of this report. One central message is that in both the US and UK, and most European countries, service integrated housing has emerged as a key service sector for older people, alongside community care and residential aged care. For example, almost one million people live in assisted living facilities in the US and there is a large research literature on this form of service integrated housing. Similarly, in the UK sheltered housing provides approximately 400,000 units of accommodation and has been at the centre of public policy debate about housing, support and care for older people.

This international experience strongly reinforces the case that service integrated housing should be viewed as a critically important part of the provision of housing,

support and care for older people in Australia. A central theme of this report is that when thinking about the provision of support and care to older people, it is important to recognise the role of service integrated housing as a form of home care, intermediate between and linked to community care delivered to individuals in their housing in the wider community on one hand and care in residential aged care homes on the other. This view of service integrated housing was depicted schematically in Figure 2.

The international experience also shows that while there are many individual types of service integrated housing, each with their own distinctive features, it is possible to recognise sub-types or clusters of service integrated housing that are present in each individual country. There are three broad sub-types. Firstly, there is service integrated housing offering lifestyle and recreation. The strongest tradition of this sub-type is in the US where such housing forms are referred to as 'active adult retirement communities', 'leisure oriented retirement communities', 'retirement housing for special affinity groups' and 'retirement resorts'. In Australia the most commonly used term is 'lifestyle village'.

Secondly, there is service integrated housing offering support. Support includes such features and services as barrier-free environments, on-site management, general property maintenance, social and recreational activities, group transport, limited supervision including personal alert/emergency call systems and social support. In the United States these housing forms are known by terms including independent living facilities and board and care homes. In the UK such housing is called sheltered housing, a term also used in the Netherlands, Canada, Germany and Israel. Similar housing is called a sheltered home in Singapore and a silver housing project in Japan. Some forms of co-housing for older people in Europe could also be classified here. Abbeyfield Housing as it originally developed in the UK, and as it has been adapted in Australia, is a form of service integrated housing offering support. The 'self-care' and 'independent living' units in Australian retirement villages are the main Australian examples of service integrated housing offering support. Other examples are those independent living units that offer some support, affordable rental villages, and some boarding houses and manufactured home estates that offer support services.

Thirdly, there is service integrated housing offering support and care. In addition to 'support services', care services may include property maintenance in response to individual needs particularly by way of installation of aids and equipment, assistance with domestic work (cooking, cleaning, laundry, shopping and household management), individualised transport service, assistance with personal care (bathing, toileting, dressing, grooming, eating, medication), nursing care, allied health services and case management and counselling. In the US this category includes congregate seniors housing also known as service-enriched housing, service coordinators in older persons' housing and assisted living facilities. In the UK it includes very sheltered housing and extra care housing, and in some European countries it is termed service housing and heavy service housing. In the US, housing that offers support and care on a continuing basis including nursing care is often referred to as a continuing care retirement community or a life care community. The equivalent in the UK is sometimes called a retirement community. The model of apartments for life developed in the Netherlands also falls within this category.

The international experience also shows that the roles played by the public, private and community sectors in service integrated housing provision vary widely from country to country. The contrast between the US and the UK illustrates this point. The US is illustrative of a context where the public policy framework is relatively weak, and the private sector has played the main role over the past 30 years in developing new

forms of service integrated housing, especially assisting living facilities which have become widespread. The community sector has been active in seeking to extend service integrated housing to lower income-groups by bringing together housing and home-care funded through a vast diversity of programs. The UK exemplifies an approach in which the state (and more recently the community sector) has taken the lead in the development of service integrated housing. Sheltered housing and extra-care housing has mainly been provided by local authorities and housing associations operating within a national policy framework for service integrated housing that is far more explicit than that in the US or, for that matter, Australia. In the UK the private sector has played only a minor role, but with some recent expansion evident.

### *6.2.3 The roles of the public, community and private sectors*

A useful way of reviewing the current state-of-play in service integrated housing in Australia is by summarising the respective roles of the public, community and private sectors in service provision. Sector is the first criterion in the classification of types of service integrated housing presented in Figure 4. The future of service integrated housing in Australia will depend on the roles that each of these sectors is able and willing to play or can be persuaded to play.

The first point to note is the relatively minor role that the public sector has historically played in funding, providing and regulating service integrated housing. The Australian Government was initially involved in stimulating the involvement of the community sector in retirement villages through its capital grants for independent living units, hostels and nursing homes from the 1950s to the 1980s. But since the 1980s the attention of the Australian Government in this broad area has mainly been focused on aged care in the form of home and community care and residential aged care homes, and capital funding has been largely withdrawn. The extensive development of retirement villages since the 1980s has occurred largely without direct public sector funding or provision. The Australian Government has been involved through the CSHA in providing housing for older people in public housing, but this has not involved direct funding or support for service integrated housing in public and community housing, other than in a few isolated examples. The main form of support from the Australian Government for service integrated housing has been for older people with complex needs through programs such as ACHA, and there have been some similar programs at the state level. The Retirement Villages – Ageing in Place initiative signals a renewed interest by the Australian Government in mainstream service integrated housing and provides a platform for more extensive involvement in the future.

State and territory governments also have had only a low level of involvement in service integrated housing. State and Territory Governments regulate retirement villages, but this mainly focuses on consumer protection, especially the financial arrangements under which residents enter retirement villages and other contractual areas. In some states planning policies and regulations address issues of the location and standards of housing for older people, including service integrated housing, but these regulations are far from standard across the country. Some state housing authorities have developed support programs for older public housing residents with complex needs, as illustrated by the cases in Chapter 5, but these are small scale. Some community housing facilities supported by state housing authorities also provide support, for example Broadview House in South Australia (case study 5.3.5), but once again this is usually on a small scale. Local government is also involved to a limited extent in housing provision for older people. But there are few examples of innovation such as Dougherty House developed by Willoughby Council in NSW in partnership with the state housing authority and Uniting Care (see case study 5.4.1).

It has been the community and private sectors that have played the main roles in the development of service integrated housing in Australia since the 1980s. The resident-funded financing model involving residents purchasing the right to occupy retirement village units with the proceeds of the sale of the family house, and paying management fees and a deferred management fee, has enabled both sectors to develop retirement villages without public subsidy. In the community sector many of the organisations developing retirement villages have been the same organisations involved in provision of aged care services including both community care and residential aged care homes. This has enabled many organisations to offer residents of retirement villages the possibility of moving to co-located or closely located aged care facilities as their care needs increase as in the case of Wishart Village (case study 5.3.1). It has also opened up the possibility of providing community care services to residents of their retirement villages, and has provided the experience and expertise to develop serviced apartments and assisted living facilities within retirement villages. Many of the community sector providers of retirement villages are large state-wide or nation-wide providers of services to older people, with affiliations to church or welfare organisations. The community sector is also the main provider of service integrated housing to older people with complex needs, as in the examples of Wintringham and Irving Benson Court (case studies 5.3.2 and 5.3.4), and the sponsor of innovative developments in service integrated housing such as the Ocean Street Project (case study 5.3.3).

The private sector's involvement in service integrated housing has also been predominantly through retirement villages, although the case studies in section 5.2 show private sector organisations are also involved in a diversity of provision such as supported residential services (e.g. Highgrove House), as well as manufactured home estates and boarding houses. The great diversity of retirement villages is shown by the cases of Oxford Crest Retirement Village, Aveo The Braes Retirement Village, Tall Trees Supported Living Community and Grande Pacific, although these are not a fully representative sample of the kinds of retirement villages provided across the sector. The sector includes large providers of retirement villages across the country (e.g., Aveo) and smaller operators of single villages (e.g., Tall Trees). Private sector retirement villages are targeted to the luxury (e.g., Grande Pacific), mid-range (Tall Trees Supported Living Community) and affordable (e.g. Oxford Crest) segments of the market. A number of private sector retirement villages have developed support and care services such as serviced apartments and assisted living facilities, and some have shown interest in expanding their role in provision of support and care services to their residents through participation in the retirement villages care pilots and the *Retirement Villages – Ageing in Place* initiative. Many private sector providers of retirement villages have experience as providers of residential aged care homes, especially high care, although their involvement in provision of community care has thus far been minor.

It is clear from this overview that it has been the community and private sectors that have been the main drivers of the development of service integrated housing, and that these sectors have been quite innovative in responding to changing demands and circumstances. This suggests that policies designed to expand or shape the future of service integrated housing should focus on ways of steering and facilitating the activities of the community and private sectors, and a number of ways in which this might be done are suggested later in this chapter.

#### *6.2.4 Drivers of change*

It is not possible to provide a definitive analysis of the drivers of change in service integrated housing in Australia without further research. But on the basis of the

analysis presented in this report six key drivers can be tentatively identified. Three of these are demand-side drivers: population ageing; the limitations on access to residential aged care homes and hence demand for housing with support and care; and the demand from older people who do not have a housing asset or other financial resources to enter the mainstream retirement village industry, but whose frailty or disability is such that they require significant levels of support and care. The other three are supply-side drivers: the established and dynamic nature of the overall seniors housing industry; the 'competitive advantage' enjoyed by the community sector as both retirement village and aged care providers; and Australian Government policies towards the development of service integrated housing and related areas including affordable housing and community care provision. The first five of these are discussed in this section and the sixth is discussed separately in the following section.

### *Demand-side drivers*

The first driver is the ageing of the Australian population which will increase demand for all forms of services for older people including service integrated housing. The number and proportion of Australians aged 65 and over living in retirement villages has been steadily and consistently increasing over the past two decades. These trends are set to continue especially from around 2020 when many baby boomers will be entering their 70s. A high proportion of people entering later life over the next two decades are home owners who will have the capacity to sell their home and purchase a place in a retirement village. The scale on which retirement villages have grown shows that they have been accepted by many consumers, and all the more so when it is recognised that moving to a retirement village is largely a matter of consumer choice compared to the necessity of entering an aged care home. It seems likely that the diverse forms of service integrated housing offered by retirement villages will continue to appeal to segments of the older population looking for or requiring a supportive living environment and/or the lifestyle offered by retirement villages, and with the means to make the choice.

The second driver is the likely demand for service integrated housing offering a significant level of care, but less than the 24-hour care offered in residential aged care homes. One source of support for this proposition is the high level of demand for this form of housing in the US in the form of assisted living, and in the UK in the form of extra-care housing. In the Australian context, as residential aged care homes have become increasingly targeted on older people with high care needs, and as access to aged care is rationed through Aged Care Assessment Teams (ACATs), it seems likely that housing options that offer significant levels of care outside of RACHs will be in high demand. This is evidenced by the increasing number of private and community sector providers offering assisted living, in part as an alternative to low-care RACH. However, we lack comprehensive data on demand and supply of serviced apartments and assisted living in retirement villages and on the extent of use of HACC and CACPs and EACH packages in retirement villages. It is important for such data to be collected on a regular and systematic basis in order to understand the emerging role of service integrated housing in the provision of housing, support and care in Australia.

The third demand-side driver is the current and emerging need for service integrated housing for older people who do not have a housing asset or other financial resources to enter the mainstream retirement village industry, but whose frailty or disability is such that they require some level of support and care. There are three main groups of such older people who are likely to require service integrated housing.

The first group are those living in inappropriate, unsupported and often expensive housing in the private rental market. While this group can access community care

services, it is often the case that physical and social aspects of their housing circumstances make effective provision of community care difficult and they would in many cases benefit from more supportive living arrangements. The private sector response to the needs of this group has been the development of affordable rental villages, examples being Oxford Crest (see Chapter 5) and the national Village Life chain. However, this model of retirement villages has experienced financial and operational difficulties, provides quite limited support, and does not facilitate access to community care services other than on an informal basis. The other types of private sector initiatives for this group are pension-only supported residential services and boarding houses. It appears that there are relatively few large-scale community sector initiatives for this group. Although some of these renters are accommodated in independent living units run by community sector organisations, the geographic distribution of these units is uneven and not well matched to the current and future distribution of the older population.

The second group are older public housing tenants whose needs for support and care services are increasing. Public housing has historically not provided or arranged support and care services for its residents, relying on community care providers. As the number and proportion of older public housing tenants with support and care needs increase, there are likely to be pressures on state and territory housing authorities to take greater responsibility for either providing or arranging support and care to older tenants. This may result in internal arrangements such as the Matavai Group Living Project (see Chapter 5), the appointment of service coordinators in public housing to coordinate external support and care for tenants, or other arrangements.

The third group are older people with complex needs who in many cases are insecurely housed, at risk of homelessness, or homeless. Organisations such as Wintringham (see Chapter 5) provide service integrated housing to this group of older people, who are in most cases unsuited to conventional retirement village living. Programs such as ACHA and state-level equivalents such as Victoria's Housing and Support for the Aged program (see Chapter 5) are designed to assist this population to find suitable housing, sustain tenancies and access support and care services. There will be a continuing demand for service integrated housing for this small population. Many in this client group are relatively young, and stabilising housing and ensuring access to basic services as they enter old age can improve wellbeing and moderate their needs for higher levels of on-going support and care as they age.

### *Supply-side drivers*

On the supply side, the primary drivers of service integrated housing are to be found in the characteristics of the overall retirement village industry. There has been no major study of the retirement village industry since Stimson's study published in 2002, and in the absence of detailed recent research, predictions concerning the future of the industry have to be based on piecemeal evidence and so are necessarily somewhat speculative. As discussed in Chapter 2, in his 2002 study Stimson predicted significant future expansion of the industry, and a continuation of the trend of the past three decades which has seen retirement villages firmly established as the fastest growing type of housing oriented to the needs of older people in Australia. Stimson based his analysis on the ageing of the population, and the likelihood of increased market penetration as providers responded to different market segments and developed new village forms. He foresaw greater concentration of ownership and management and maturation of the industry as a whole. His predictions of continuing industry growth were affirmed by the number of retirement village residents enumerated in the 2006 census.

Uncertainties in the Australian residential property market generated by the global financial crisis in 2008 and 2009 appear to have had a short term negative impact on demand for retirement villages and some disruption to the industry as a whole. However, as discussed in Chapter 2, the development of new villages is a long term process. Large scale providers especially have land holdings and plans set many years in advance and can adjust the pace of development in line with wider economic conditions. While the industry faces many contemporary and emerging challenges including the availability of suitably located and priced land for village development and the changing aspirations of future cohorts of older people, there is no compelling evidence to suggest that the short term issues facing the industry in the wake of the global financial crisis invalidate Stimson's longer-term predictions.

Within the retirement industry, the supply of service integrated housing is driven in significant part by the differences in the roles of the community and private sectors in aged care as well as retirement village provision. As discussed in section 6.2.3, many large, community sector providers of retirement villages hold a competitive advantage over private sector providers insofar as they are also providers of both community care and RACHs. This facilitates the provision of HACC and CACP and EACH packages to residents in community sector retirement villages and the provision of assisted living services by staff located nearby in community care or RACH services. It also facilitates service integrated housing in the form of three-tier complexes, and day care services using the facilities of either retirement villages or RACHs. By contrast, private sector providers of retirement villages are only minor providers of community care services at this stage, although their role has grown and may continue to grow in line with increases in CACP provision. The capacity of retirement village providers to readily access community care services for their residents is a major driver of service integrated housing. While the Retirement Village – Ageing in Place initiative encourages all retirement village operators to apply for allocation of CACP places and the related approved provider status, it seems likely that community sector retirement village providers will be best placed to take advantage of this opportunity.

The final set of drivers of provision of service integrated housing is Australian Government policy. As the policies and priorities of the Australian Government are of central importance to the future of service integrated housing they are considered in some detail in the following section.

#### *6.2.5 The national policy context*

In Chapter 2 the roles played by Australian Government policies in the development of service integrated housing from the 1950s to the mid-2000s were reviewed. A central theme of that chapter was that the development of service integrated housing for older people gradually ceased to be an explicit goal of public funding and policy as hostels were increasingly viewed as part of the residential aged care system, a process that was completed with the passage of the *Aged Care Act 1997*. The main form of service integrated housing in Australia, the retirement village, developed from the 1970s without an explicit policy framework and without direct public funding. While the Australian Government has played an important role in provision of service integrated housing for older people who are marginally housed or homeless since the late 1980s, it was left to the community and private sectors to build the mainstream system of service integrated housing. However, a critical contribution made by the Australian Government to the development of service integrated housing since the 1980s has been the development of community care, firstly in partnership with the State and Territory Governments in the form of the HACC program and subsequently through the provision of CACP and EACH packages. These developments gave community

and private sector providers of retirement villages and other forms of service integrated housing an expanding source for much of the service component for service integrated housing. While some retirement village providers deliver these programs directly to retirement village residents, a variety of other partnership arrangements have also been established for delivering care services.

A number of recent developments in Australian Government housing and aged care policy indicate renewed interest in housing for older people and point to the ways that an explicit policy designed to expand and enhance service integrated housing could be developed. This renewed interest has involved interdepartmental policy development bringing together housing initiatives taken by the Department of Families and Housing, Community Services and Indigenous Affairs (FAHCSIA) and care programs delivered by the Department of Health and Ageing (DoHA), and these departments have provided information on the initiatives that are now being implemented.

The Retirement Village – Ageing in Place initiative, the only initiative specifically for older people, has already been mentioned and its further expansion is noted below. Four other initiatives that have been introduced since the election of the Labor Government in 2007 which identify older people within wider target populations have not yet been considered. The opportunities now presented by these programs are outlined below. They are:

- The National Partnership Agreement on Homelessness.
- The National Partnership Agreement on Social Housing.
- The Social Housing Initiative.
- The National Rental Affordability Scheme.

#### *The Retirement Village – Ageing in Place initiative<sup>4</sup>*

The Retirement Village – Ageing in Place initiative reinforces the role of retirement villages as service integrated housing providers, and underscores the finding of the evaluation of the Retirement Villages Community Care Pilot that providing home care to people living in retirement villages can avoid or defer moves into residential aged care homes. The pilot and the further initiative, already mentioned in several places in this report, encourage retirement village operators to apply for new CACP and EACH packages in the annual allocation of aged care places and, if they do not already have it, to obtain Approved Provider status. Identifying retirement villages as priority areas for the allocation of new aged care packages is significant at two levels. Firstly, it increases the availability of aged care packages for retirement villages which otherwise need to source packages from prior allocations or other general allocations. Secondly, and importantly, it gives explicit recognition to retirement villages as providers of service integrated housing.

For many years there have been no impediments to the provision of HACC services and CACP and EACH packages to residents of retirement villages, and as this report has shown many retirement villages have used this opportunity to provide care services to their residents. In promoting the role of retirement village providers as CACP providers, a third issue has been to address consumer concerns. Some residents appear to be uncertain about their access to subsidised services vis-a-vis services provided under their retirement village contract, including care services available on a user pays basis. Extending village operators roles in delivering CACPs

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<sup>4</sup> Information on recent developments in this and the other national initiatives discussed in this section was provided by FAHCSIA and DOHA.



is a means of promoting equitable access to services for which residents qualify on the basis of assessed need.

### *The National Partnership Agreement on Homelessness*

In January 2009 the Australian Government introduced a new national housing policy framework, the National Affordable Housing Agreement (NAHA), to replace the Commonwealth State Housing Agreement (CSHA) and the Supported Accommodation Assistance Program (SAAP). The NAHA is supported by four National Partnership Agreements (NPAs), one of which is the NPA on Homelessness. The NPA on Homelessness is a wide-ranging measure designed to prevent homelessness and improve housing and service provision for people who are homeless. Older homeless people fall within the ambit of the NPA and one optional output measure that State Governments can include in their implementation plans is 'measures that will provide support services and accommodation to assist older people who are homeless or at risk of homelessness'. It seems likely that this will result in some new service integrated housing projects for older homeless people. For example, South Australia has proposed provision of 48 dwellings (with capital provided under the economic stimulus package) across the state linked to HACC services and state health services. As well as capital funding, funds will be provided for support packages and brokerage. Additionally, the Australian Government has committed to allocating aged care places and capital for at least one new specialist facility for older people who are homeless in an area of need for each of the next four years (Department of FAHCSIA, 2008). It is also supporting the development of Common Ground, a supportive housing model for homeless people, in several states. These and similar initiatives represent a continuation and extension of the Australian Government's involvement in provision of housing for older people with complex needs (see section 2.5.1), an involvement that is also demonstrated through its commitment to increase funding for ACHA as part of the homelessness initiatives (Department of FAHCSIA, 2008).

### *The National Partnership Agreement on Social Housing*

The NPA on social housing involves the Australian Government providing capital funds to the States and Territories for building at least 1,600 new social housing dwellings by 2009–2010. There is no particular emphasis on providing housing for older people, but one criteria is that projects 'should adhere to universal design principles that facilitate better access for persons with disability and older persons'. Data is being collected on the number of older tenants being accommodated in dwellings being funded under the NPA on social housing.

### *The Social Housing Initiative*

The Social Housing Initiative is part of the Nation Building – Economic Stimulus Plan providing \$6.4 billion to State and Territory Governments to substantially boost the supply of social housing currently available for disadvantaged Australians over the period 2009–2012. Of 19,300 new dwellings to be constructed, around 4,300 are targeted specifically for older people or have been identified as being suitable for older persons, and a number of approved projects involve the construction of independent living units for older people. There is a strong emphasis on incorporation of universal design elements in these new dwellings, as there is on new dwellings being built under the NPA on social housing.

### *The National Rental Affordability Scheme*

The National Rental Affordability Scheme (NRAS) is an Australian Government initiative to stimulate the supply of new affordable rental dwellings by 50,000 by June

2012. Successful NRAS applicants will be eligible to receive a National Rental Incentive for each approved dwelling where they are rented to eligible low and moderate income households at 20 per cent below market rates. Priority is given under NRAS to proposals that target special needs groups, one of which is older people. So far some 15-20 projects have been approved which directly target older tenants including some projects within retirement villages. Aged and Community Services Australia (ACSA) were engaged in the early stage of the scheme as a partnership facilitator to particularly assist aged care providers to participate in the scheme.

Two NRAS projects providing rental accommodation to low income older people warrant note as both are being developed by not-for-profit agencies, but unlike earlier ILU development, they will not be require ingoing payments by residents. St Ann's project in Tasmania involves construction of 80 modern affordable dwellings in a development targeted at people aged over 55 years. St Ann's provides residential and other services to aged people, and as well as facilitating access to health and community support services, the project aims to be economically, environmentally and socially sustainable and features energy and water saving measures, and open spaces for recreation. The Elderly Citizen's Homes Inc. project in South Australia will see NRAS funds applied to upgrading of 120 Independent Living Units located in inner and middle metropolitan areas of Adelaide and are close to health services, shops and convenience services such as pharmacies. ECH is a long established and large not-for-profit provider of aged care and affordable housing to older people in South Australia. The units are 35-45 years old and need significant renovation to meet current standards for disability access. The dwellings will be fitted out with design features that particularly assist older people, optimise accessibility and reduce ongoing costs for tenants. The dwellings will be targeted to older people (over 60 years) on low incomes, particularly those on the Age Pension, with rents at below 74% of market rates.

Both these projects will offer service integrated housing as defined for this project, and demonstrate the opportunities available for wider development of service integrated housing through NRAS.

### *Summary*

The policy initiatives described above indicate the renewed and strong emphasis in current Australian Government policy on expanding the availability of social and affordable housing and reducing homelessness. Many of these initiatives have direct implications for the housing of older Australians. The emphasis on older people in the NPA on homelessness is an extension of the Australian Government's longstanding involvement in provision of service integrated housing for older people with complex needs. Expansion of social and affordable housing provision through the NPA on social housing, the social housing initiative and NRAS will add to the stock of housing available to lower income, older renters. The emphasis on barrier-free design in all of these programs is an important step towards more supportive housing for older people.

Nevertheless, apart from the Retirement Village – Ageing in Place initiative and the focus on older people in the NPA on homelessness, these policy initiatives do not directly address the issue of the supply of service integrated housing for older people, the central focus of this report. The wider question therefore remains: in a policy climate conducive to policy innovation and expansion in housing for older people, how can the provision of service integrated housing for older people be advanced?

## 6.3 Policy options

In this final section six policy options for service integrated housing are briefly canvassed. These are:

- do nothing
- facilitate existing trends
- address the needs of low-income older people
- address the geographic distribution of services
- develop principles and guidelines
- expand the evidence base.

### 6.3.1 *Do nothing*

Service integrated housing has developed over the past 30 years with little or no policy direction and no direct funding or provision by government other than for people with complex needs. It might be argued that this represents a significant policy success, or at the least an example of successful policy by default. Policy settings that have seen the retirement village sector expand to some 130,000 units over thirty years without direct public investment can hardly be counted as a failure. The growth and diversification of retirement villages indicates that older Australians are prepared to convert their housing assets into retirement village accommodation and services. Furthermore, this approach has allowed great flexibility for providers, an attribute that is often much sought after by organisations wanting to 'do their own thing' rather than being subject to what they may view as the restrictions of government programs and regulation. This approach appears to have provided greater flexibility than seems to be apparent in many overseas models, and providers have been opportunistic and innovative in developing many models that work. Why consider new forms of policy intervention?

There are five answers to this rhetorical question. Firstly, it can be argued that there are ways that policy interventions could facilitate current trends and enhance the role that is being played by the retirement village sector and other forms of service integrated housing. A clearer policy framework could reduce some of the uncertainties that providers now face and encourage development and further innovation. Leaving each provider to make their own decisions runs risks not only for investors but also for residents in existing housing and in future developments as poor decisions could lead to under-occupancy and in turn reduce the viability of delivering care services. While larger providers may be more able to ride out adverse conditions in the short term, increasing scale means that the consequences of poor decisions are magnified. Secondly, it can be argued that the needs of low-income, low-asset older people are not met in existing arrangements and that governments need to selectively intervene on behalf of this group of older people. Thirdly, the case can be made that governments have a particular interest in the geographic distribution of retirement villages and this should be a focus of public action. Fourthly, there is an argument for governments to play a role in setting principles and developing guidelines to improve practices in the retirement village sector. Finally, there is a case for saying that the evidence base required to underpin public policy is so inadequate that it is not possible to assess the outcomes of 30 years of policy by default. From this perspective, the next step should be to expand the evidence base.

### 6.3.2 *Facilitate existing trends*

It was shown in Chapters 2, 4 and 5 that over the last decade retirement villages have been diversifying, particularly in the ways that they provide care services to residents. This diversification includes the development of serviced apartments and assisted living arrangements and the provision of community care to 'self-care' residents through various internal and external arrangements for delivery of care services. One policy option would be to find ways to facilitate these trends, but to rely principally on the entrepreneurship of private and community sector operators to expand the volume and range of these options. In this way, retirement villages would hopefully continue to diversify both in terms of target market (from low/middle income retirees through to the wealthy) and support and care arrangements.

The kinds of arrangements that have been canvassed in this report point to ways in which the Australian Government could move from the 'hands off' approach that has prevailed to date to a more 'hands on' approach that would facilitate, but not dictate, closer integration of service delivery with a variety of housing forms. As a matter of policy, HACC and CACP and EACH packages are currently available to eligible older people in all forms of accommodation (other than RACHs), including retirement villages. The way has been and should remain open for retirement village providers to be proactive and innovative in the ways that they make available or arrange the provision of care services within their facility. Retirement village providers have a wide range of options available to them. They can become providers of community care services in their own right or enter into partnership arrangements with community care providers. They can develop serviced apartments and assisted living facilities either using their own staff or drawing on community care providers. They can use private providers to offer care services as either a supplement or an alternative to publicly-subsidised community care providers. They can co-locate with RACHs in order to provide continuity of care and to take advantages of economies of scale in care service provision. They can develop 'seamless' links for clients between community care and residential care by providing respite care in RACHs and in HACC funded day centres. By enabling community care services to be delivered in all forms of housing, the Australian Government has laid the foundation for a highly flexible and diverse approach to the provision of service integrated housing. This foundation can now be built on intentionally.

This facilitative approach has been strengthened by the Retirement Villages – Ageing in Place initiative which provides further opportunities for retirement village operators to become involved in community care provision, albeit at this point on a small scale. They can do this by applying for approved provider status (if they are not already approved providers), by entering into a brokerage arrangement with an existing provider or by co-locating aged care services within the retirement village precinct. To obtain community care funding operators need to demonstrate how their village environment contributes to the continuity and quality of care for residents, and how they are increasing diversity of choice of care arrangements for residents. As well as providing enhanced opportunities for service integrated housing arrangements, this initiative legitimises the care provision role of retirement villages.

There are a number of ways in which the role of retirement villages as service integrated housing providers could now be further facilitated. The Australian Government could make explicit the range of options available to retirement village operators and encourage, rather than simply allowing, a range of forms of community care provision in retirement villages. It could also significantly expand the number of community care packages available through the Retirement Villages – Ageing in Place initiative. It could also monitor the level of provision of care services in

retirement villages and identify and address barriers to care provision. One issue that may need addressing is the advantageous position of large, community sector providers, who have greater scope for 'internal' integration of their housing and care services than most private sector providers. The extent to which private sector providers of retirement villages will take up opportunities to become providers of community care services is not clear. While some providers may want to offer a range of services on a user pays basis, from a consumer perspective, there is a need to ensure that all residents have the opportunity to access publicly subsidised services for which they qualify on the basis of assessed need, and for which they pay standard means tested fees.

### *6.3.3 Address the needs of low-income, low-asset older people*

The main limit of the mainstream retirement village model in Australia is that it is restricted to those who can pay the entry charge through sale of their family home or some equivalent funding source. Low income, older renters are thus excluded in most cases from retirement villages. The only exceptions are that some community sector retirement villages retain a number of units on a rental basis and, as shown in the Dougherty Apartments example (Chapter 5), there are a few instances of public housing tenants being placed in retirement villages.

It is interesting that the main response to this limitation has come from the private sector with the development of affordable rental villages by companies such as Village Life and Oxford Crest (see the case example in Chapter 5). However, as previously noted, some of these companies have had difficulty with their financial models and have been able to provide only limited support services while charging a high proportion of the aged pension in rent and for services, with services provided by the operator without regard to residents' choice. Protection of consumers' access to publicly funded services becomes an issue in these situations.

It seems likely that as the number of low-income older renters increases, the demand for forms of supportive housing with care options will also increase. If governments wish to increase access to service integrated housing for lower income, low wealth older renters, a number of options might be considered. One approach would be to further encourage the development of supportive housing developments for older, low-income people as part of the social housing initiative, the NPA on social housing, NRAS and/or similar future initiatives. Such housing developments might involve co-location of older people in new 'rental retirement villages' or by including a proportion of rental units in existing or proposed conventional retirement village developments. They would include support in the form of barrier-free design and on-site management, probably with a shared facility such as a community centre or a meeting/administration area. Ready access to community care provision either through a community-based provider or via a housing provider who was also an approved aged care provider and/or a HACC provider would be included in the design of the housing development, and one responsibility of the manager of the housing service would be to facilitate provision of community care. Provision for ongoing community care in such ways would be a condition of approval. The housing provider for such facilities could be a public housing authority, a community housing provider, a not-for-profit retirement village or aged care provider, or a private sector organisation.

Service integrated housing developments for lower income, low wealth older renters such as those proposed above might restore, resurrect or recommission housing facilities developed as part of earlier public policies. While the Social Housing Initiative and NRAS are at an early stage, and some projects for older people have been funded, as noted above, both programs appear to present four particular opportunities for community sector providers to redevelop outdated accommodation that is in need

of renewal. These opportunities could be pursued through a sub-program of NRAS to provide affordable service integrated housing. Firstly, redevelopment of a number of clusters of outdated ILUs has been under discussion for some years, but action has been slow to eventuate. A dedicated sub-program could be the trigger for action to refurbish the ILUs or rebuild on the sites. Secondly, there has been a considerable reduction in the number of RACHs over the last decade and little is known about the exit pathways of these facilities. As restructuring of RACHs is continuing in line with rising standards required for buildings and care environments, more purposeful exit strategies could see some of these facilities and sites used as forms of service integrated housing at least on an interim basis, or redeveloped for this purpose. Thirdly, and more generally, some small, stand-alone low-care RACHs are reported to be experiencing difficulties in delivering higher levels of care, especially nursing care, to provide effectively for ageing-in-place. Rather than being lost to aged care altogether, providers of these facilities could be enabled to opt out of the residential aged care program to become part of a service integrated housing program, with care services delivered through community care packages. This option could be of particular interest to providers who also operate community care services but not high care RACHs. Fourthly, some public housing complexes comprising solely or mainly of older people might also become part of a service integrated housing program by instigating deliberate arrangements for community care provision. This last proposal would also respond to the growing need for public housing authorities to develop support and care services for their own older tenants. A 'service integrated housing' program involving both new-build and redeveloped complexes would respond to the housing and care needs of a growing older population in a targeted and effective way as supplements to the generic programs aimed at increasing the supply of social and affordable housing.

It hardly needs to be said that strict income and asset testing needs to apply, and that any conditions on matching funding from providers preclude capital payments by residents so that the APHA, and its subsequent subversion, is not reinvented.

#### *6.3.4 Address the geographic distribution of services*

As well as general facilitation of service integrated housing and development of service integrated housing for lower income older people, there is a need to address the geographic spread of service integrated housing so that older people can adjust their housing while remaining in their familiar local neighbourhood and maintaining their local social networks. Aged care places including places in RACHs are distributed in accord with the distribution of the aged population through the Commonwealth needs-based planning process, but there is no equivalent mechanism to address the geographic distribution of retirement villages. While not proposing a similar needs-based planning process, a case can be made for public policy measures to shape the distribution of service integrated housing.

One measure would be the provision of information on the distribution of the current and projected aged population in relation to the distribution of various forms of older persons' housing. Such a database would serve an important function in supporting planning by providers in the private and community sectors. For example, knowing where older persons housing is to be developed under NRAS and other social housing initiatives will be particularly relevant to providers seeking to develop service integrated housing for those on lower incomes. More generally, a common and geographically comprehensive information base would be more reliable than each provider relying on their own market analysis for selected areas. There is scope for government to work with provider bodies such as ACSA and the RVAA on this area.

A second measure would be to promote more provision of service integrated housing in under-supplied localities. Joint ventures between public housing authorities and private or not-for-profit agencies are among the options available, particularly as part of urban redevelopment projects in inner-city areas and public housing redevelopments.

### *6.3.5 Develop principles and guidelines*

As shown in Chapter 3 and in the earlier positioning paper on this project, there is a large body of international research literature on service integrated housing that identifies key issues associated with service quality and consumer satisfaction. It is important that principles and guidelines for good practice drawn from this literature, and from the experience of respected providers, be available to developers and managers of service integrated housing. It is not necessarily desirable to develop a regulatory approach similar to that which is in operation in RACHs. However, the encouragement of good practice via practice standard and guides, codes of practice, rating scales and the like could well be an appropriate role of government in association with industry bodies. Standardisation of terminology to assist consumers to understand their options and what to expect from particular types of services could be one aim of such an approach.

One critical area where governments are encouraging good practice is barrier-free design. While much of the older persons' housing built some years ago has little or only basic features of this kind, newer developments are incorporating more and more such features in both dwelling design and external environments. These features, both low and high tech, are becoming increasingly important in all forms of housing for older people, and while they may be not required by occupants when they move in, they can go a long way to enabling independence and ageing-in-place. They can be regarded as a form of 'passive support' that are not just integrated with housing but are integral to it.

The Australian Network for Universal Housing Design (ANUHD), a national network of housing industry bodies, housing professionals, government professionals, designers and builders, researchers and home occupants, is the principal organisation promoting accessible and adaptable housing in Australia. ANHUD participants share the philosophy that the homes built for today's Australia should be fit for all of tomorrow's Australians, at all ages, and of all abilities. The Australian Government provided funding for redevelopment of the ANUHD website, [www.anuhd.org](http://www.anuhd.org), in 2009.

There are as yet no required standards for barrier-free/accessible housing in the older persons' housing sector, and it seems unlikely that the accessibility standards prescribed for public buildings under the Disability Discrimination Act will be extended to housing for older people or people with disabilities. One approach would be for government to promote a voluntary 'accessibility rating scale' that could be used to rate older persons' housing in much the same way that energy ratings apply to electrical appliances. The Sustainable Housing Code, developed by the South East Queensland Regional Organisation of Councils provides an example suited to Australian retirement housing. Further development may be stimulated by the emphasis on universal design in housing being built under the social housing initiative and the NPA on social housing and this provides an important example to the industry as a whole.

### *6.3.6 Expand the evidence base*

The development of policy options for service integrated housing in Australia is handicapped by the limited research evidence base. There is a marked contrast between the extensive data available on the publicly funded aged care program and

the extremely limited data available on service integrated housing in Australia. A first step is to obtain data on the current level and type of provision in Australia. There has been no survey of retirement villages since 2000–2001. There is a need for a survey to determine the state of supply, using the classification system developed in Chapter 4 of this report and including information on the new and emerging types of services such as serviced apartments, assisted living and affordable rental villages. The classification developed in this report could provide a framework for such a survey and in turn be revised and refined in the light of findings.

It is also important to make estimates of demand for service integrated housing in Australia. Without this information, it is not possible to assess with any certainty whether there is a sufficient volume of all or some of the options available. Demand could be estimated from demographic data, waiting lists and/or vacancies for various forms of service integrated housing, and market surveys undertaken by providers.

An important part of any study of supply and demand is the geographic distribution of services. A mapping exercise plotting the distribution of older persons housing against the distribution of the older population would address the issue of the accessibility of service integrated housing for older people wishing to remain in their own locality, and provide guidance for the location of new facilities. While the population aged 70 and over is used in planning residential aged care, a younger age group is appropriate for considering the distribution of retirement housing. Age 55 or 60 and over not only accords with the age specifications in retirement village legislation in different states but also provides a good indicator of future concentrations of older populations as people age in place, and can also identify areas that are attractive for retirement migration which tends to occur around retirement age.

Another fundamental gap in the research literature is data on the characteristics of the population in retirement villages and other forms of service integrated housing. This would provide a better understanding of the characteristics of those living in service integrated housing and how this differs from the overall older population by way of being older, more likely to be women, less likely to be ever or currently married, to be living alone, and so forth. Data on the differences in the characteristics of residents in different types of facilities will provide a better understanding of the relationship between different types of services and particular segments of the older population. Such data can make a valuable contribution by indicating the extent of matches between different segments of demand and supply of different types of service integrated housing, and especially point to demand that is going unmet.

Studies that further examine the constellation of factors underpinning the decision to move into service integrated housing are also required. There have been a number of mostly small scale studies examining the 'push' and 'pull' factors associated with moves to retirement villages, but these factors need to be linked to the financial decision-making processes involved. It seems likely that there are many middle to low income home owners – the classic asset rich-income poor – who are using the move to a retirement village to downsize, thereby releasing assets to boost an Age Pension income. Increased understanding of how these financial factors interact with the retirement incomes system, and how they combine with lifestyle and support factors to result in moves to retirement villages would be helpful in determining the kinds and levels of service integrated housing that offer viable responses to the diversity of housing and income needs of many older Australians.

One barrier to housing adjustment has been the perception that increased assets remaining after realising housing assets and purchasing alternative housing could affect eligibility for the Age Pension, and this barrier needs to be investigated. Policy measures to address this barrier also need to be considered. One possibility is that



some of those approaching retirement have realised housing assets and used any surplus to boost their superannuation, with attendant tax advantages. Extending such an option to post retirement housing adjustments for those who have limited superannuation could provide an incentive for homeowners whose housing is increasingly out of tune with their needs.

Finally, there is a need for case studies or evaluations of a range of types of service integrated housing. More information is required on consumers' knowledge of and perceptions about service integrated housing, and on issues that have been more widely addressed in the international literature such as 'institutional drift', the quality of management practices, the capacity of service integrated housing to respond to continuing care needs as the care requirements of residents increase, and the cost effectiveness of service integrated housing compared to community care and residential care for residents with varying levels of dependency.

As well as generating a body of empirical data on service integrated housing, this research should inform the reconceptualisation of service integrated housing as the third component of the aged care system, intermediate between and interacting with community care delivered to individuals living in the general community and residential care.

## **6.4 Conclusion**

The aim of this study has been to more clearly identify service integrated housing as a central approach to the provision of housing, support and care for Australians in later life, and to consider the implications of the emergence of this type of housing for Australian public policy and policy research. Despite its important place as an increasingly popular housing option for many older Australians, and as a location for the provision of support and care of older people, service integrated housing has attracted far less policy and research attention than other areas of ageing policy and provision for many years. This policy context has now changes and this report provides a basis for future policy and research by providing:

- A definition of service integrated housing that distinguishes it from community care, residential aged care homes, and other forms of housing.
- An historical account of service integrated housing that clarifies the processes and developments that have led to the current structure and pattern of provision.
- An examination of the various forms of service integrated housing that have developed internationally, especially in the US, UK and Europe, and an international translation chart that facilitates comparison.
- A classification scheme that identifies the various types of service integrated housing based on sector of provision, dwelling structure/type and arrangements for provision of care services.
- A series of case examples that illustrate the diversity of service integrated housing provision in Australia and that show how the classification scheme can be used to distinguish different housing types.
- A discussion of policy options and a proposed research agenda.

Retirement villages and other forms of service integrated housing have developed in Australia over the past thirty years mainly through initiatives of the community and private sectors. The key question that now arises in a policy context characterised by renewed government interest concerns the ways in which a stronger leadership role could best be pursued. The strategies to this end identified in this report include facilitating the role of the community and private sectors in providing service

integrated housing; addressing the need to expand the provision of service integrated housing to low-income, low-asset older people; addressing the geographic distribution of services; developing principles and guidelines for the operation of service integrated housing; and expanding the research evidence base.

## INTERNATIONAL TRANSLATION CHART

**Table 4: Definition of terms used to describe service integrated housing in Australia and internationally. Identification of similarities and differences in the meanings of these terms**

<i>Australia</i>	<i>Other countries</i>
<b>Generic terms for housing for people in later life</b>	
<p><b>Seniors' housing</b> A generic term referring to all housing intended 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. See also: <i>retirement housing; housing for the elderly; housing for the aged.</i></p> <p><b>Retirement housing</b> See <i>seniors' housing.</i></p> <p><b>Housing for the elderly</b> See <i>seniors' housing.</i></p> <p><b>Housing for the aged</b> See <i>seniors' housing.</i></p>	<p><i>These generic terms are also widely used with the same meaning in most, if not all, other countries.</i></p>
<p><b>Aged care</b> Formal, long-term support and care of people in later life who are frail or who have a disability either in their own home in the form of <i>home and community care</i> or in a <i>residential aged care home (RACH).</i></p>	<p><b>Long-term care</b> Term used in the US to refer to formal, long-term support and care of people in later life who are frail or who have a disability either in their own home or in a residential care facility.</p>
<p><b>Service integrated housing</b> The term intentionally chosen in this study to refer to housing arrangements for older people where the housing provider deliberately makes available one or more types of support and care as part of the housing provision. <i>The term has not previously been widely used in the Australian or international context.</i></p>	<p><i>The term 'service integrated housing' is intended to have international relevance.</i></p>
<b>Terms for 'home and community care'</b>	

<i>Australia</i>	<i>Other countries</i>
<p>'Home and community care' is the generic term used in this translation chart to refer to provision of aged care services in the home of a person in later life.</p>	
<p><b>Community care</b> See <i>home and community care</i>.</p> <p><b>Home and community care</b> Formal provision of support and care services in the home of a person in later life. In Australia, Formal home and community care services are provided through the Home and Community Care program (HACC); the Community Aged Care Packages (CACP) program; and the Extended Aged Care in the Home (EACH) program. These services are delivered to eligible clients regardless of the form of their accommodation, except for those living in RACH. Formal home and community care services complement the widespread provision of informal care by family members and others. <i>Home and community care</i> is also the generic term used in this report to refer to the provision of aged care services in the home of a person in later life. Also known as <i>community care</i>.</p>	<p><b>Community care</b> Term used in the UK, Canada and some EU countries to refer to the formal provision of support and care services in the home of a person in later life. In some countries (not UK), community care services are commonly divided into <i>home health care</i> and <i>social care</i>.</p> <p><b>Home care and Home care services</b> Term used in the US, Canada and some EU countries (and in Australia pre-1980s) to refer to the formal provision of support and care services in the home of a person in later life. In some countries, community care services are divided into <i>home health care</i> and <i>social care</i>. Another term used in the US and Canada is <i>in-home care</i>.</p> <p><b>Home health care</b> In the US and EU countries refers to the provision of health care services, principally nursing, in an older person's home.</p> <p><b>In-home care</b> See <i>home care</i>.</p> <p><b>Social care</b> Term used in EU countries to refer to the provision of a range of non-health services in an older person's home.</p>
<p><b>Community Aged Care Package (CACP)</b> Packages of <i>home and community care</i> services, usually with case management, provided as part of the Australian <i>aged care</i> system to older people assessed as eligible for entry to <i>residential aged care homes</i>. Packages provide the equivalent of low-level residential aged care in the older person's home.</p> <p><b>Community Options</b> Case managed (brokered) home and community care services, usually with case management, provided through the HACC program delivered to older people who would otherwise require, or be at risk of requiring, admission to</p>	<p><i>A wide variety of service arrangements involving case management and care packages are found in other countries and share many features with CACPs.</i></p>

<b>Australia</b>	<b>Other countries</b>
<p>a residential aged care home. They are called <i>linkages projects</i> in Victoria.</p> <p><b>Extended Aged Care in the Home (EACH)</b>            Packages of <i>home and community care</i> services with case management, provided as part of the Australian <i>aged care</i> system to older people assessed as eligible for entry to <i>residential aged care homes</i>. These packages provide the equivalent of high-level residential aged care in the older person's home.</p> <p><b>Linkages project</b>            See <i>community options</i>.</p>	
<p><i>There is no equivalent of collective home care in Australia.</i></p> <p><i>Naturally occurring retirement communities are not specifically identified as such in Australia, although there are many examples of localities with high concentrations of older people, e.g. coastal areas of high amenity.</i></p> <p><i>Australian provision of home and community care services through program such as HACC, CACP and EACH are generally based on assessment of need rather than place of residence (NORC) or local group membership (collective home care).</i></p> <p><i>Multigenerational housing support models have not been a feature of home</i></p>	<p><b>Collective home care</b>            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 services by virtue of this membership, e.g. the 'supportive communities' scheme in Israel.</p> <p>Other terms include: <i>virtual assisted living community</i>.</p> <p><b>Naturally occurring retirement community (NORC)</b>            Buildings, apartment complexes, neighbourhoods or towns with a high concentration of older people as a consequence of ageing-in-place or other factors. They are distinguished from planned retirement communities that are specifically designed to accommodate older people. The term is mainly used in the US. 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.</p> <p><b>Virtual retirement community</b>            Term used in the US and to refer to the coordinated provision of home and community care services in a local community            See <i>collective home care</i>.</p> <p><b>Multigenerational housing support models</b>            A generic term referring to housing arrangements designed to facilitate</p>

<b>Australia</b>	<b>Other countries</b>
<i>and community care provision in Australia.</i>	informal support of older people by younger family members or other younger people.
<b>Terms for 'service integrated housing offering lifestyle and recreation'</b>	
Services typically include sporting and recreational facilities and activities, and social activities focused on a club house or community centre.	
<p><b>Lifestyle village</b> Term widely used in Australia to refer to retirement communities that offer recreational and sporting facilities and social activities to the over-55s (in some cases over-45s). Villages are designed on a campus model and typically include a central activities and functions facility. Lifestyle villages vary widely in their level of amenity.</p>	<p><b>Active adult retirement community (AARC)</b> Term used in the US to refer to retirement communities designed to attract retirees, often from the 'young-old' (55+), who are active, fully independent, and (often) affluent. AARCs may provide access to a range of lifestyle activities including golf, tennis, swimming, club house, etc. Also known as <i>leisure oriented retirement community (LORC)</i>.</p> <p><b>Leisure oriented retirement community (LORC)</b> See <i>active adult retirement community (AARC)</i>.</p>
<p><i>Australia has no equivalents to the large-scale retirement resorts of the US.</i></p>	<p><b>Retirement community</b> Term used in the US to refer to large-scale, planned retirement developments, often offering recreational activities and security. Also known as <i>retirement resort</i>.</p> <p><b>Retirement housing for special affinity groups</b> Term used in the US to refer to a <i>retirement community</i> for people in later life who have common interests, e.g. former academics, former military officers, older gay people, etc.</p> <p><b>Retirement resort</b> See <i>retirement community</i>.</p> <p><b>Retirement new town</b> See <i>retirement town</i>.</p> <p><b>Retirement town</b> Term used in the US to refer to retirement communities on a township scale designed to attract retirees by offering a wide range of recreational and lifestyle activities. Also known as <i>retirement new towns</i>.</p>

<i>Australia</i>	<i>Other countries</i>
<b>Terms for ‘service integrated housing offering support’</b>	
Support services may include some or all of the following: barrier-free environments, on-site management, general property maintenance, social and recreational activities, group transport, limited supervision including personal alert/emergency call systems, social support.	
There are two sub-sets:	
<ul style="list-style-type: none"> <li>• <b>Shared housing.</b> A living arrangement for older people where small numbers of unrelated persons live together in a dwelling unit with a mix of shared and private facilities with the aim of providing a supportive environment.</li> <li>• <b>Independent living complex.</b> A formal, independent living arrangement designed for older people in a communal environment providing support services.</li> </ul>	
<b>Shared housing</b>	
<p><i>The Abbeyfield Housing model has been replicated on a small scale in a number of localities in Australia.</i></p> <p><i>Wesley Home Share in Melbourne is the only agency assisted program for shared housing for older people known to operate in Australia. It is based on the UK Home Share program.</i></p> <p><i>Co-housing has so far attracted only limited attention in the Australian context.</i></p> <p><i>There is no formal, direct equivalent to board and care homes for older</i></p>	<p><b>Abbeyfield Housing</b> A form of group housing for older people first developed in the UK. The living environment consists of approximately 10 separate, bed-sit rooms located in a communal dwelling, with common dining, living, and laundry facilities. The communal environment is designed to encourage 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.</p> <p><b>Agency-assisted shared housing</b> A US and UK term referring to a supervised matching service that brings together a provider of housing, typically an elderly homeowner requiring assistance, security and companionship, and another, usually younger person able to provide this support in return for inexpensive or free accommodation. Home Share is a UK-based program of this kind.</p> <p><b>Co-housing</b> A European cooperative 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. Co-housing typically involves groups of 10–50 individual dwellings with common facilities that provide opportunities for</p>

<i>Australia</i>	<i>Other countries</i>
<p><i>people in Australia.</i></p> <p><b>Boarding house</b></p> <p>Boarding houses in Australia provide low-cost accommodation mainly in inner-city areas of larger cities. Residents are low-income people, including significant number of older people, especially men. Boarding houses offer long-term single or shared rooms, often furnished, and usually shared bathroom, kitchen and laundry facilities. In many boarding houses meals and serviced rooms are 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 regulated by State Governments. Residents receive Commonwealth Rent Assistance but operators do not receive any subsidies for support services. Residents are eligible for HACC and other community services.</p> <p>Also known as <i>rooming houses</i>.</p> <p><b>Rooming houses</b></p> <p>See <i>boarding houses</i>.</p>	<p>residents to share daily activities and mutual support without loss of privacy.</p> <p><b>Board and care home</b></p> <p>A US term for a group housing facility for older people or people with disabilities that 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.</p>
<b><i>Independent living complex</i></b>	
<p><b>Independent living unit (ILU)</b></p> <p>A term used with a specific meaning in Australia to refer to dwellings provided in a small-scale campus setting by not-for-profit organisations that received capital funding under the <i>Aged Persons Homes Act 1954</i>. Dwellings are usually provided for older people with modest income and assets, often on the basis of a modest entry contribution or on a rental basis. The term is also used to refer to the dwellings of those living independently in <i>retirement villages</i>.</p> <p>These dwellings are also referred to as <i>self-care units</i>.</p> <p><b>Retirement village</b></p> <p>This term is widely used in Australia to refer to a housing complex comprising multiple, self-contained dwellings for people in later life together with communal facilities and services. Most residents are deemed to be</p>	<p><b>Independent living facility (ILF)</b></p> <p>A term used in the US to refer to a seniors-restricted complex for those able to live independently. An ILF typically provides a limited range of services including on-site management, property maintenance, limited supervision and social activities. Some ILFs provide a wider range of services, although</p>



<b>Australia</b>	<b>Other countries</b>
<p>'independent', meaning that they do not require the level of care and support associated with <i>residential aged care homes</i>. Dwellings are usually referred as <i>self care units</i> or <i>independent living units</i>. Legal definition of a 'retirement village' in State and Territory legislation is usually based on restriction to residents aged over 50 or 55, and may also include reference to particular types of tenure arrangements.</p> <p>See also <i>rental retirement village, three-tier complexes, vertical village</i>.</p> <p><b>Vertical village</b> A <i>retirement village</i> located in a high-rise apartment building.</p> <p><b>Rental retirement village</b> A <i>retirement village</i> characterised by rental tenure, sometimes referred to as 'rental by choice'.</p> <p><b>Manufactured home estate</b> A housing estate comprising sites for manufactured or relocatable homes. Typically residents own their home but lease the site and pay a charge for use of amenities and facilities. Manufactured home estates are widely used by retired people in Australia.</p> <p>See also <i>residential park</i>.</p> <p><b>Residential park</b> A park comprising caravans or cabins where the resident may own or rent the dwelling and pay for use of facilities. Significant numbers of older people live in residential parks.</p> <p>See also <i>manufactured home estate</i>.</p> <p><i>There is no direct equivalent to sheltered housing in Australia</i></p>	<p>complexes providing additional services such as a common dining facility are more commonly referred to as <i>congregate seniors housing</i>.</p> <p><b>Mobile home park</b> A term used in the US for parks in which space can be rented for mobile or relocatable homes. Other terms include trailer parks, mobile home communities and manufactured home communities. One subset of mobile home parks, often known as retirement communities, restricts residents to those aged 55 and over.</p> <p><b>Sheltered housing</b> A term used in the UK to refer to small, purpose built accommodation for older people involving a mix of private space and shared facilities, with limited support and supervision provided by an on-site warden. The term is also used in a number of other countries, including the Netherlands, Canada, Germany and Israel, to refer to similar housing forms. In Singapore, housing similar in form to sheltered housing is called a <i>sheltered home</i>, and in Japan the term used is <i>silver housing project</i>. In some parts of the UK and in some other countries, sheltered housing provides a wider range of services</p>

<i>Australia</i>	<i>Other countries</i>
<p><b>Affordable rental villages</b></p> <p>An Australian term referring to a form of retirement village developed in the 2000s by Village Life and other private companies. Villages are low-cost providing apartments with kitchenettes, support services, all meals in a central dining room and a linen service, but no personal care services.</p>	<p>including care services.</p>
<p align="center"><b><i>Terms for ‘service integrated housing offering support and care’</i></b></p>	
<p>In addition to ‘support services’, care services may include property maintenance in response to individual needs, assistance with domestic work (cooking, cleaning, laundry, shopping and household management), individualised transport service, assistance with self-care (bathing, toileting, dressing, grooming, eating, medication), nursing care, allied health services and case management and counselling.</p>	
<p>There are two sub-sets:</p>	
<ul style="list-style-type: none"> <li>• <b>Housing with care.</b> Housing arrangements that offers support services and a range of care services to frail older people.</li> <li>• <b>Housing with continuing care.</b> Housing arrangements that offers support services and a range of care services and that emphasise continuation of care that is adaptive to the changing needs of the older person over the whole period of later life.</li> </ul>	
<p align="center"><b><i>Housing with care</i></b></p>	
<p><i>The term congregate housing is not widely used in Australia.</i></p>	<p><b>Congregate seniors housing (CSH)</b></p> <p>A term used in the US to refer to housing provided on a congregate basis for older people who receive support services including meal services and low-level 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.</p> <p>Also known as <i>service-enriched housing</i> and <i>supported housing</i>.</p> <p><b>Service-enriched housing</b></p> <p>See <i>congregate seniors housing</i>.</p> <p><b>Supported housing – US</b></p>

<i>Australia</i>	<i>Other countries</i>
<p><b>Hostel</b></p> <p>Hostels were established under the <i>Aged Persons Homes Act 1954</i> as independent accommodation in a shared building with limited support and supervision. However, over time their role changed, and they became providers of care for frail older people offering a wide range of support services and personal care. By the 1970s they were viewed as a form of residential care for frail older people with 'low' levels of dependency alongside nursing homes catering for older people needing a higher level of care. In 1997 the terms 'hostel' and 'nursing home' were formally abolished and all such facilities became residential aged care homes.</p> <p><b>Supported residential service (SRS)</b></p> <p>An Australian term referring to residential homes which provide accommodation and personal care for people with disabilities, including frail older people, who need support in tasks of daily living. Accommodation is in furnished single or shared rooms. Care usually includes assistance with showering, personal hygiene, dressing, meals and medication, as well as physical and emotional support. Residents may receive Rent Assistance. Most SRSs are provided by the private sector and they are not funded as residential aged care homes.</p> <p>Other terms are <i>supported accommodation</i> (Queensland), <i>licensed residential centre</i> (NSW) and <i>supported residential facility</i> (South Australia).</p> <p><b>Serviced apartment</b></p> <p>An Australian term referring to a one- or two-bedroom apartment in a retirement village providing services such as cleaning, laundry and assistance with self-care activities. Meals are often provided in a dining room setting, and a small kitchenette may also be included within the</p>	<p>See <i>congregate seniors housing</i>.</p> <p><b>Service coordinators</b></p> <p>A US term referring to the employment of service coordinators in older persons' housing projects to facilitate linkages between residents and home care and home health care services.</p> <p><i>The term 'hostel is not used outside of Australia to refer to service integrated housing for older people.</i></p>

<i>Australia</i>	<i>Other countries</i>
<p>apartment.</p> <p><b>Assisted living facility (ALF)</b>  A term increasingly used in Australia to refer to the extension of hotel services in serviced apartments in retirement villages to also include personal care services such as medication supervision and access to podiatry. The range and level of assisted living services is tailored to the needs of residents and use is instigated by the resident. The full spectrum of HACC services, including nursing care, may also be available to residents in serviced apartments.</p> <p><b>Flexi-apartment</b>  A term used in some Australian <i>retirement villages</i> to refer to apartments in which additional self-care, health and support services are available for purchase on an optional basis.</p>	<p><b>Assisted living facility (ALF) – US</b>  A term used in the US to refer to a housing option that involves the delivery of professionally managed support and care services in a 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</p> <p><b>Extra care housing</b>  A term used in the UK to refer to housing schemes that provides 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 24 hours a day.  Also called <i>very sheltered housing</i>.</p> <p><b>Assisted living – UK</b>  See <i>extra care housing</i></p> <p><b>Close care</b>  See <i>extra care housing</i></p> <p><b>Flexi-care</b>  See <i>extra care housing</i></p> <p><b>Integrated care</b>  See <i>extra care housing</i></p> <p><b>Supported housing – UK</b>  See <i>extra care housing</i></p> <p><b>Very sheltered housing</b>  See <i>extra care housing</i>.</p>

<i>Australia</i>	<i>Other countries</i>
	<p><b>Service housing</b>  Term used in a number of European countries including Sweden, Finland, Denmark and Germany 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 services and to community-based home care services.  Also called <i>service flats</i> in Denmark.  See also <i>heavy service housing</i>.</p> <p><b>Service flats</b>  See <i>service housing</i>.</p> <p><b>Heavy service housing</b>  A term used in Finland to refer to <i>service housing</i> with higher levels of care.</p> <p><b>Small group housing</b>  Term used in Sweden and other European countries for small group dwellings comprising apartments as well as communal spaces for people with high-support needs, including dementia.</p>
<b><i>Housing with continuing care</i></b>	
<p><b>Three-tier complexes</b>  Australian retirement villages comprising ILUs, hostels (low care) and nursing homes (high care) as part of the same complex, thus facilitating continuing care provision as the needs of the older person change. However, costs of residential aged care is publicly subsidised and admission to aged care is subject to external assessment of need.</p>	<p><b>Continuing care retirement community (CCRC)</b>  A term used in the US to refer to housing complexes which offer a continuum of care from independent living through to nursing care within the same community. Residents enter into a long-term contract that provides for housing, services and nursing care, as required. The contracts usually involve a sizeable entry fee as well as monthly rents/charges, and are</p>

<i>Australia</i>	<i>Other countries</i>
<p>Also called <i>ongoing care</i> and <i>continuum of care</i>.</p> <p><b>Continuum of care</b> See <i>three-tier complexes</i>.</p> <p><b>Ongoing care</b> See <i>three-tier complexes</i>.</p>	<p>effectively a form of insurance against the risk of requiring nursing care in later life. Also called <i>Life care community</i>.</p> <p><b>Life care community</b> See <i>continuing care retirement community</i>.</p> <p><b>Retirement community (UK)</b> A UK term referring to a housing complex comprising private bungalows and a wide range of services and communal facilities including a central building containing a residential care home. 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. The leading example is Hartrigg Oaks, York which was developed by the Joseph Rowntree Housing Trust. Also known as <i>retirement village (UK)</i>.</p> <p><b>Retirement village (UK)</b> See <i>retirement community</i>.</p> <p><b>All age community</b> UK term referring to the provision of a diversity of forms of service integrated housing and aged care services within a local area to enable older people to age in place.</p>
<p><b>Apartments for life (Australia)</b> Housing models being developed by community organisations in Australia based on the Humanitas model.</p>	<p><b>Apartments for life</b> A housing model for older people developed by Humanitas in the Netherlands in which residents are guaranteed housing continuity in the community for life, with support and care services brought to the older</p>

<i>Australia</i>	<i>Other countries</i>
	person's dwelling.
<b><i>Terms for 'residential aged care homes'</i></b>	
This is the generic term used in this translation chart to refer to provision of aged care services in a residential setting.	
<p><b>Nursing home (Australia)</b> A residential aged care home providing accommodation, support and nursing care to older people no longer able to live independently in their own home. Prior to the 1997 Commonwealth <i>Aged Care Act</i>, Australia's residential aged care system comprised 'low care' <i>hostels</i> and 'high care' <i>nursing homes</i>. In 1997, hostels and nursing homes were brought together and collectively renamed <i>residential aged care homes</i>.</p> <p><b>Residential aged care home</b> The collective term used in Australia to refer to all facilities providing accommodation, support and nursing care to older people no longer able to live independently in their own home. See also <i>nursing home (Australia)</i>.</p>	<p><b>Nursing home (general)</b> Term used in many countries to refer to a residential aged care home providing accommodation, support and nursing care to older people no longer able to live independently in their own home.</p> <p><b>Residential care</b> Term used in the UK to refer to residential accommodation for older people provided by local authorities.</p> <p><b>Skilled nursing facility (SNF)</b> A term used in the US to refer to a residential facility for older people providing high levels of nursing care, broadly equivalent to a <i>nursing home</i> in the Australian context.</p>

## REFERENCES

- Aged Care Australia Inc. (1994). *Inter-hostel Financial Comparison Survey*. Curtin ACT: Aged Care Australia Inc.
- Alperin, D. E. and Richie, N. D. (1990). Continuing/life care facilities and the continuum of care. *Journal of Housing for the Elderly*, vol. 6, no. 1/2, pp. 125–30.
- Alt Statis and Associates. (1996). Connecting Aged Care and Housing: An Evaluation of the Assistance with Care and Housing for the Aged Program (ACHA). *Aged and Community Care Service Development and Evaluation Reports*. No. 23. Canberra: AGPS.
- Anikeeff, M. A. and Mueller, G. R. (eds.) (1998). *Seniors Housing*. Boston: Kluwer Academic Publishers.
- Anikeeff, M. A. and Mueller, G. R. (1998a). Towards standardising seniors housing: industry definitions by project type. In Anikeeff, M. A. and Mueller, G. R. (eds.), *Seniors Housing*. Boston: Kluwer Academic Publishers.
- Appleton, N. and Porteus, J. (2003). *Extra Care Housing for Older People: an Introduction for Commissioners*. London: Department of Health.
- Ara, S. (1997). Housing facilities for the elderly in India. *Ageing International*, Winter/Spring, pp. 107–14.
- Australian Bureau of Statistics (ABS) (2003). *Ageing in Australia*, ABS Catalogue No. 2048.0. Canberra: Australian Bureau of Statistics.
- Australian Bureau of Statistics (ABS) (2004). *Disability, Ageing and Carers: Summary of Findings*. ABS Catalogue No. 4430.0. Canberra: Australian Bureau of Statistics.
- Australian Bureau of Statistics (ABS) (2006). *Census of Population and Housing, 2006*. Customised Tables.
- Australian Bureau of Statistics (ABS) (2006a). *Census Dictionary Australia 2006 (Reissue)*. ABS Catalogue No. 2901.0. Canberra: Australian Bureau of Statistics.
- Australian Institute of Health and Welfare (AIHW) (2002). *Ageing in Place: Before and After the 1997 Aged Care Reforms*. Canberra: Australian Institute of Health and Welfare.
- Australian Institute of Health and Welfare (AIHW) (2005). *Australia's Welfare 2005*. AIHW cat. no. AUS 65. Canberra: Australian Institute of Health and Welfare.
- Australian Institute of Health and Welfare (AIHW) (2007). *Australia's Welfare 2007*. AIHW cat. no. AUS 93. Canberra: Australian Institute of Health and Welfare.
- Australian Institute of Health and Welfare (AIHW): Hales, C., Ross, L., and Ryan, C. (2006). *National Evaluation of the Retirement Villages Care Pilot, Final Report*. Aged Care Series no. 11. AIHW cat. no. AGE 49. Canberra: Australian Institute of Health and Welfare.
- Australian Institute of Health and Welfare (AIHW) (2008). *Aged Care Packages in the Community 2006-07: A Statistical Overview*. AIHW cat. No. AGE 57. Canberra: Australian Institute of Health and Welfare.



- Australian Institute of Health and Welfare (AIHW) (2009). *Residential Aged Care in Australia 2007-08: A Statistical Overview*. AIHW cat. no. AGE 58. Canberra: Australian Institute of Health and Welfare.
- Australian Parliament (1982). *In a Home or at Home: Accommodation and Home Care for the Aged*, Report from the House of Representatives Standing Committee on Expenditure. Canberra: AGPS.
- Australian Parliament (1994). *Home But Not Alone: a Report on the Home and Community Care Program*. Report from the House of Representatives Standing Committee on Community Affairs. Canberra: AGPS.
- Baldwin, T. (1982). Resident funded housing. In *New Options in Effective Care for the Elderly*, Proceedings of the Annual Conference of the NSW Council on the Ageing, 8 November. NSW Council on the Ageing: Sydney.
- Ball, M. M., Whittington, F. J., Perkins, M. M., Patterson, V. L., Hollingsworth, C., King, S. V. and Combs, B. L. (2000). Quality of life in assisted living facilities: viewpoints of residents. *The Journal of Applied Gerontology*, vol. 19, no. 3, pp. 304–25.
- Bamford, G. (2002). 'Living together on one's own': cohousing for older people, a new housing type in Denmark and the Netherlands. Paper presented to the Australasian Centre for Ageing Colloquia. Brisbane.
- Bassuk, K. (1999). NORC supportive service programs: effective and innovative programs that support seniors living in the community. *Care Management Journals*, vol. 1, no. 2, pp. 132–7.
- Bendel, J. and King, Y. (1988). A model of community age-integrated living for the elderly in Israel: does it work? *The Journal of Aging and Judaism*, vol. 3, nos 1 & 2, pp. 58–84.
- Benjamin, J. D. and Anikeeff, M. A. (1998). Primer on key issues in seniors housing. In Anikeeff, M. A. and Mueller, G. R. (eds.), *Seniors Housing*. Boston: Kluwer Academic Publishers.
- Benjamin, A. E. and Newcomer, R. J. (1986). Board and care housing: an analysis of state differences. *Research on Ageing*, vol. 8, no. 3, pp. 388–406.
- Bernard, M., Bartlam, B., Sim, J. and Biggs, S. (2007). Housing and care for older people: life in an English purpose-built retirement village. *Ageing and Society*, vol. 27, pp. 555–78.
- Billig, M. (2004). Supportive communities: an optimal arrangement for the older population? *Journal of Sociology and Social Welfare*, vol. 31, no. 3, pp. 131–51.
- Bishop, J. (2004). *Investing in Australia's Aged Care: More Places, Better Care*. Canberra: Commonwealth of Australia.
- Brandi, J. M., Kelley-Gillespie, N., Liese, L. H. and Farley, O. W. (2004). Nursing home vs. assisted living: the environmental effect on quality of life. *Journal of Housing for the Elderly*, vol. 18, no. 1, pp. 73–88.
- Brenton, M. (2001). Older People's Co-Housing Communities. In Peace, S. M. and Holland, C. (eds.), *Inclusive Housing in an Ageing Society: Innovative Approaches*. Bristol: The Policy Press.
- Bridge, C., Kendig, H., Quine, S. and Parsons, A. (2002). *Housing and Care for Younger and Older Adults with Disabilities*, Final Report. Melbourne: AHURI.

- Buy, L. (2000). Care and support assistance provided in retirement villages; expectations vs reality. *Australasian Journal on Ageing*, vol. 19, no. 3, pp. 149–51.
- Cates, N. (1994). Denmark: changes in health and social services for the elderly and comparative observations. *Home Health Care Services Quarterly*, vol. 15, no. 1, pp. 57–71.
- Clapham, D. and Munro, M. (1990). Ambiguities and contradictions in the provision of sheltered housing for older people. *Journal of Social Policy*, vol. 19, no. 1, pp. 27–45.
- Chi, I. and Chow, N. (1997). Housing and family care for the elderly in Hong Kong. *Ageing International*, Winter/Spring, pp. 65–77.
- Cox, B. M. (2001). Linking housing and services for low-income elderly: lessons from 1994 best practice award winners. *Journal of Housing for the Elderly*, vol. 15, no. 1/2, pp. 97–110.
- Croucher, K., Hicks, L. and Jackson, K. (2006). *Housing with Care for Later Life: a Literature Review*. York: Joseph Rowntree Foundation.
- Cummings, S. M. (2002). Predictors of psychological well-being among assisted-living residents. *Health and Social Work*, vol. 27, no. 4, pp. 293–302.
- Department of Community Services (1986). *Nursing Homes and Hostels Review*. Canberra: AGPS.
- Department of Families, Housing, Community Services and Indigenous Affairs (FAHCSIA) (2008). *The Road Home: A National Approach to Reducing Homelessness*. Canberra: FAHCSIA.
- Department of Health and Ageing (2004). *The Way Forward: a New Strategy for Community Care*. Canberra: DOHA.
- Department of Health and Ageing (DOHA) (2006). More Aged Care in Retirement Villages. Accessed 31 August, 2009. Available at: [http://www.health.gov.au/internet/budget/publishing.nsf/Content/DC28CFC01F990C2CCA257167000E046C/\\$File/afact011.pdf](http://www.health.gov.au/internet/budget/publishing.nsf/Content/DC28CFC01F990C2CCA257167000E046C/$File/afact011.pdf).
- Department of Health and Ageing (DOHA) (2007). *National Program Guidelines for the Home and Community Care Program*. Canberra: DOHA.
- Department of Health and Ageing (DOHA) (2008). *2008–09 Aged Care Approvals Round – Essential Guide*. Accessed 31 August 2009. Available at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acar2008-essential-guide.htm~ageing-acar2008-essential-guide-01.htm>.
- Department of Health and Ageing (DOHA) (2008a). *Report on the Operation of the Aged Care Act 1997, 1 July 2007–30 June 2008*. Accessed 3 November 2009. Available at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-reports-acarep.htm>.
- Department of Health and Ageing (DOHA) (2009). *Home and Community Care Program Overview*. Accessed 31 August, 2009. Available at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/hacc-index.htm>

- Department of Health, Housing, Local Government and Community Services. (1993). *Aged Care Reform Strategy Mid Term Review Stage 2 Report*. Canberra: AGPS.
- Department of Transport and Regional Development (DTRD) (1996). *Review of Overseas Experience with Older People's Housing*. Canberra: AGPS.
- Dickinson, P. and Whitting, G. (2002). *Older People: Main Report*, The Big Picture Series. London: The Housing Corporation.
- Dieck, M. (1995). Housing elders in Germany. In Pynoos, J. and Liebig, P. S. (eds.), *Housing Frail Elders: International Policies, Perspectives, and Prospects*. Baltimore: Johns Hopkins University Press.
- Dietz, T. L. and Wright, J. D. (2002). Racial and ethnic identity of older adults residing in assisted living facilities in central Florida. *Care Management Journals*, vol. 3, no. 4, pp. 185–91.
- Dobbs, D. (2004). The adjustment to a new home. *Journal of Housing for the Elderly*, vol. 18, no. 1, pp. 51–71.
- Eckert, J. K., Namazi, K. H. and Kahana, E. (1987). Unlicensed board and care homes: an extra-familial living arrangement for the elderly. *Journal of Cross-Cultural Gerontology*, vol. 2, pp. 377–93.
- Fairchild, T. J., Higgins, D. P., and Folts, W. E. (1991). An offer they could not refuse: housing for the elderly. *Journal of Housing for the Elderly*, vol. 9, no. 1/2, pp. 157–65.
- Folts, W. E. and Muir, K. B. (2002). Housing for older adults: new lessons from the past. *Research on Ageing*, vol. 24, no. 1, pp. 10–28.
- Folts, W. E., Yeatts, D. E. and Dwyer, J. W. (1991). The continuum of care: refining the conceptual model for frail elders. *Adust Residential Care Journal*, vol. 5, no. 1, pp. 63–6.
- Forsyth, A. (1992). *Changing Places: Case Studies of Innovations in Housing for Older People*, Report prepared for the Mid-Term Review of the Aged Care Reform Strategy, Stage 2. Canberra: AGPS.
- Frank, J. (2001). How long can I stay?: the dilemma of ageing in place in assisted living. *Journal of Housing for the Elderly*, vol. 15, no. 1/2, pp. 5–30.
- Gardner, I. L., Browning, C. and Kendig, H. (2005). Accommodation options in later life: retirement village or community living? *Australasian Journal on Ageing*, vol. 24, no. 4, pp. 188–95.
- Giarchi, G. G. (2002). A conspectus of types, options and conditions of elder-accommodation in the European continent. *Innovation*, vol. 15, no. 2, pp. 99–119.
- Gibson, D. (1998). *Aged Care: Old Policies, New Problems*. Melbourne: Cambridge University Press.
- Gottschalk, G. (1995). Housing and supportive services for frail elders in Denmark. In Pynoos, J. and Liebig, P. S. (eds.), *Housing Frail Elders: International Policies, Perspectives, and Prospects*. Baltimore: Johns Hopkins University Press.
- Gregory, R.G. (1993). Review of the structure of nursing home funding arrangements, Stage 1. *Aged and Community Care Service Development and Evaluation Reports*. No. 11. Canberra: AGPS.

- Gregory, R.G. (1994). Review of the structure of nursing home funding arrangements, Stage 2. *Aged and Community Care Service Development and Evaluation Reports*. No. 12. Canberra: AGPS.
- Hallman, B. C. and Joseph, A. E. (1997). Housing the rural elderly: a place for Abbeyfield? *Journal of Housing for the Elderly*, vol. 12, no. 1/2, pp. 83–103.
- Hanson, J. (2001). From 'special needs' to 'lifestyle choices': articulating the demand for 'third age' housing. In Peace, S. M. and Holland, C. (eds.), *Inclusive Housing in an Ageing Society: Innovative Approaches*. Bristol: The Policy Press.
- Harrison, J. D. (1997). Housing for the ageing population of Singapore. *Ageing International*, Winter/Spring, pp. 32–49.
- Hawes, C., Phillips, C. D., Rose, M., Holan, S. and Sherman, M. (2003). A national survey of assisted living facilities. *The Gerontologist*, vol. 43, no. 6, pp. 875–82.
- Heumann, L. F. (1981). The function of different sheltered housing categories for the semi-independent elderly. *Social Policy and Administration*, vol. 15, no. 2, pp. 164–80.
- Heumann, L. F. (1991). A cost comparison of congregate housing and long term care facilities for elderly residents with comparable support needs in 1985 and 1990. *Journal of Housing for the Elderly*, vol. 9, no.1/2, pp. 75–97.
- Heumann, L. F. (1995). Housing the elderly in Israel. In Pynoos, J. and Liebig, P. S. (eds.), *Housing Frail Elders: International Policies, Perspectives, and Prospects*. Baltimore: Johns Hopkins University Press.
- Heumann, I. and Boldy, D. (1982). *Housing for the Elderly: Planning and Policy Formulation in Western Europe and North America*. New York: Croom Helm.
- Heumann, L. F. and Boldy, D. (1993). Classifying ageing in place programs. In Heumann, L. F. and Boldy, D. (eds.), *Ageing in Place with Dignity*. Westport, Connecticut: Praeger.
- Heywood, F., Oldman, C. and Means, R. (2002). *Housing and Home in Later Life*. Buckingham: Open University Press.
- Holland, J. M., Ganz, L. J., Higgins, P. T. and Antonelli, K. I. (1995). Service coordinators in senior housing: an exploration of an emerging role in long-term care. *Journal of Case Management*, vol.4, no. 3, pp. 109–11.
- Home and Community Care (HACC) (2002). *National Program Guidelines for the Home and Community Care Program*. Canberra: HACC.
- Howe, A. (1982). How aged care subsidies have been subverted. *Australian Planner*, vol. 20, pp. 153–55.
- Howe, A. (1992). *Housing for Older Australians*, National Housing Strategy Background Paper No. 8. Canberra: AGPS.
- Howe, A. (1995). Housing frail elders in Australia. In Pynoos, J. and Liebig, P. S. (eds.), *Housing Frail Elders: International Policies, Perspectives, and Prospects*. Baltimore: Johns Hopkins University Press.
- Howe, A. (1997). The aged care reform strategy: a decade of changing momentum and margins for reform. In A. Borowski, S. Encel, and E. Ozanne (eds.), *Ageing and Social Policy in Australia*. Melbourne: Cambridge University Press.

- Howe, A. (1999) Future directions for residential care. *Australasian Journal on Ageing*, vol. 18, no. 3, pp. 12–18.
- Howe, A. (2003). Housing an older Australia: More of the same or something different? Keynote Address, *Housing Futures in an Ageing Australia Conference*, 10 November, 2003. Melbourne: AHURI and The Myer Foundation.
- Howe, A. (2008). Is bigger better when it comes to defining target populations for aged care programs? *Australasian Journal on Ageing*. Vol. 27, pp. 14–19.
- Hwang, Y. (1997). Housing for the elderly in Taiwan. *Ageing International*, Winter/Spring, pp. 133–47.
- Hunt, M. and Gunter-Hunt, G. (1985). Naturally occurring retirement communities. *Journal of Housing for the Elderly*, vol.3, pp. 3–21.
- Jones, A., Bell, M., Tilse, C. and Earl, G. (2007). *Rental Housing Provision for Lower-Income Older Australians*, Final Report. Melbourne: AHURI.
- Jones, A., Tilse, C., Bartlett, H. and Stimson, R. (2008). *Integrated Housing, Support and Care for People in Later Life*, AHURI Positioning Paper No. 108. Melbourne: AHURI.
- Judd, B., Kavanagh, K., Morris, A., and Naidoo, Y. (2004). *Housing Options and Independent Living: Sustainable Outcomes for Older People Who are Homeless*, Final Report. Melbourne: AHURI.
- Kalymun, M. (1990). Toward a definition of assisted-living. *Journal of Housing for the Elderly*, vol. 7, no. 1, pp. 97–132.
- Kane, R. A. (1999). Goals of home care: therapeutic, compensatory, either, or both? *Journal of Ageing and Health*, vol. 11, no. 3, pp. 299–321.
- Katan, Y. and Werczberger, E. (1997). Housing for elderly people in Israel. *Ageing International*, Winter/Spring, pp. 49–64.
- Kendig, H. and Gardner, I. (1997). Unravelling housing policy for older people. In A. Borowski, S. Encel and E. Ozanne (eds.), *Ageing and Social Policy in Australia*. Melbourne: Cambridge University Press.
- Kim, Y. (2002). Assisted Living Facility as a Home: Cases in Southwest Virginia. PhD Thesis, Virginia Polytechnic Institute and State University.
- King, N. (2003). Continuing care retirement communities: description and an evaluation. *Housing, Care and Support*, vol. 6, no. 4, pp. 29–33.
- Kose, S. (1997). Housing elderly people in Japan. *Ageing International*, Winter/Spring, pp. 148–64.
- Lawton, M. P. (1981). Alternative housing. *Journal of Gerontological Social Work*, vol. 3, no. 3, pp. 61–80.
- Lawton, M. P. (1981a). Community supports for the aged. *Journal of Social Issues*, vol. 37, no. 3, pp. 102–15.
- Lindstrom, B. (1997). Housing and service for the elderly in Denmark. *Ageing International*, Winter/Spring, pp. 115–32.
- Lipmann, B. (2003). Providing housing and care to elderly homeless men and women in Australia. *Care Management Journal*, vol. 4, no. 3, pp. 23–30.

- Lipmann, B. (2006). Housing and support: the need to make the connection. *Parity*, vol. 19, no. 7, pp. 7–8.
- Marsden, J. P. (2001). A framework for understanding homelike character in the context of assisted living housing. *Journal of Housing for the Elderly*, vol. 15, no. 1/2, pp. 79–96.
- McGrail, B., Percival, J. and Foster, K. (2001). Integrated segregation? Issues from a range of housing/care environments. In Peace, S. M. and Holland, C. (eds.), *Inclusive Housing in an Ageing Society: Innovative Approaches*. Bristol: The Policy Press.
- McNelis, S. (2004). *Independent Living Units: the Forgotten Social Housing Sector*, AHURI Final Report No. 53. Melbourne: AHURI.
- McNelis, S., Neske, C., Jones, A. and Phillips, R. (2008). *Older Persons in Public Housing: the Policy and Management Issues*, AHURI Final Report No. 121. Melbourne: AHURI.
- Milligan, V., Phibbs, P., Gurrán, N., Lawson, J. and Phillips, R. (2009). *Growth and Innovation in Affordable Housing in Australia: the Role of Not-for-Profit Providers*. AHURI Research & Policy Bulletin Issue 119. Melbourne: AHURI.
- Milne, F. and De Mellow, A. (1996). *The Price of Independence: The Housing and Care Needs of Ageing People with Developmental Disabilities and Aged Carers*. Sydney: Balmain Uniting Research Unit.
- Monk, A. and Cox, C. (1995). Trends and developments in home care services: an international perspective. *Journal of Gerontological Social Work*, vol. 24, no. 3/4, pp. 251–70.
- Monk, A. and Kaye, L. W. (1991). Congregate housing for the elderly: its need, function and perspectives. *Journal of Housing for the Elderly*, vol. 9, no.1/2, pp. 5–19.
- Moore, S. T. (1992). Housing policy and the elderly: the case for enriched senior high-rise apartments. *Journal of Housing for the Elderly*, vol. 10, no. 1/2, pp. 117–24.
- Myer Foundation (2002). *2020: A Vision for Aged Care in Australia*. Myer Foundation: Melbourne.
- NCAL [National Centre for Assisted Living] (2007). *Assisted Living Facility Profile*. <http://www.ncal.org/about/facility.cfm>. Date accessed 22 August 2008.
- Netting, F. E. and Wilson, C. C. (1991). Accommodation and relocation decision making in continuing care retirement communities. *Health and Social Work*, vol. 16, no. 4, pp. 266–73.
- Netting, F. E., Wilson, C. C., Stearns, L. R. and Branch, L. G. (1990). CCRC statutes: the oversight of long-term care service delivery. *The Journal of Applied Gerontology*, vol. 9, no. 2, pp. 139–56.
- Nocon, A. and Pleace, N. (1999). Sheltered housing and community care. *Social Policy and Administration*, vol. 33, no. 2, pp. 164–81.
- Nyman, J. A. (2000). Continuing care retirement communities and efficiency in the financing of long-term care. *Journal of Ageing and Social Policy*, vol. 11, no. 2/3, pp. 89–98.
- Oldman, C. and Quilgars, D. (1999). The last resort? Revisiting ideas about older people's living arrangements. *Ageing and Society*, vol. 19, pp. 363–84.

- Oltman, R. M. (1981). The small group home: needed option for the poor elderly. *Home Health Care Services Quarterly*, vol. 2, no. 3, pp. 59–66.
- Ormond, B. A., Black, K. J., Tilly, J. and Thomas, S. (2004). *Supportive Services Programs in Naturally Occurring Retirement Communities*. Washington, DC: Urban Institute.
- Peace, S. M. and Holland, C. (eds.) (2001). *Inclusive Housing in an Ageing Society: Innovative Approaches*. Bristol: The Policy Press.
- Peace, S. M. and Holland, C. (2001a). Housing an ageing society. In Peace, S. M. and Holland, C. (eds.), *Inclusive Housing in an Ageing Society: Innovative Approaches*. Bristol: The Policy Press.
- Phillips, J., Means, R., Russell, L. and Sykes, R. (eds.) (1998). *Broadening our Vision of Housing and Community Care for Older People*. London: Anchor Trust.
- Pine, P. P. and Pine, V. R. (2002). Naturally occurring retirement community-supportive service program: an example of devolution. *Journal of Ageing and Social Policy*, vol. 14, no 3/4, pp. 181–93.
- Pranschke, S. E. (1987) Share-a-home; a service to elders. *Journal of Religion and Ageing*, vol. 2, no. 4, pp. 33–9.
- Pynoos, J., Liebig, P., Alley, D. and Nishita, C. M. (2004). Homes of choice: towards more effective linkages between housing and services. *Journal of Housing for the Elderly*, vol. 18, nos. 3/4, pp. 5–50.
- Pynoos, J. and Nishita, C. M. (2005). The changing face of senior housing. In Hudson, R. B. (ed.), *The New Politics of Old Age Policy*. Baltimore: Johns Hopkins University Press.
- Rahder, B., Farge, B. and Todres, R. (1992). A review of the Canadian and American literature on homesharing agencies with a service component. *Home Health Care Services Quarterly*, vol. 13, no. 1/2, pp. 71–90.
- Riseborough, M. and Porteus, J. (2003). Extra care housing: getting the facts straight and improving practice. *Housing, Care and Support*, vol. 6, no. 4, pp. 22–9.
- Roberts, M. (1997). Housing with care: housing policies for an ageing Australia. *Ageing International*, vol. 23, pp. 90–106.
- Rugg, J. (2000) *Hartrigg Oaks: The Early History of a Continuing Care Retirement Community*. York: Centre for Housing Policy.
- Schreter, C. A. (1985). Advantages and disadvantages of shared housing. *Journal of Housing for the Elderly*, vol. 3, no. 3/4, pp. 121–38.
- Schulman, A. J. (1996). Service coordination: program development and initial findings. *Journal of Long-Term Home Health Care*, vol. 15, no. 2, pp. 5–12.
- Sexton, C. M. (1998). Overview of seniors housing. In Anikeeff, M. A. and Mueller, G. R. (eds.), *Seniors Housing*. Boston: Kluwer Academic Publishers.
- Sheehan, N. W. (1987). 'Ageing in place' in public senior housing: past trends and future needs. *Home Health Services Quarterly*, vol. 8, no. 2, pp. 55–77.
- Sheehan, N. W. (1996). Management issues in service coordination: the experience of the resident services coordinator program. *Journal of Gerontological Social Work*, vol. 26, no. 1 / 2, pp. 71–86.

- Sheehan, N. W. (1999). The resident services coordinator program: bringing service coordination to federally assisted senior housing. *Journal of Housing for the Elderly*, vol. 13, no. 1/2, pp. 35–49.
- Spitzer, W. J., Neumann, K. and Holden, G. (2004). The coming of age for assisted living care: new options for senior housing and social work practice. *Social Work in Health Care*, vol. 38, no. 3, pp. 21–45.
- Stimson, R. J. (ed.) (2002). *The Retirement Village Industry in Australia: Evolution, Prospects, Challenges*. Brisbane: The University of Queensland.
- Streib, G. F., Folts, W. E., and Peacock, J. (2007). The life course of leisure-oriented retirement communities. *Journal of Housing for the Elderly*, vol. 20, no. 4, pp. 39–59.
- Stupp, H. W. (2000). Area agencies on ageing: a network of services to maintain elderly in their communities. *Care Management Journals*, vol. 2, no. 1, pp. 54–62.
- Van Vliet, W. (1995). Housing an ageing population in the Netherlands. In Pynoos, J. and Liebig, P. S. (eds.), *Housing Frail Elders: International Policies, Perspectives, and Prospects*. Baltimore: Johns Hopkins University Press.
- Van Egdon, G. (1997). Housing for the elderly in the Netherlands: a care problem. *Ageing International*. Winter/Spring, pp. 165–82.
- Warach, B. (1991). Enriched housing for the elderly; the JASA experience (1968–1990). *Journal of Housing for the Elderly*, vol. 9, no. 1/2, pp. 141–56.
- Williams, S. (1985). Long-term care alternatives: continuing care retirement communities. *Journal of Housing for the Elderly*, vol. 3, no. 1/2, pp. 15–34.
- Wright, B. (2004). *Assisted Living in the United States: Research Report*. Washington, DC: American Association of Retired Persons.



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