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AGEING POPULATIONS AND SOCIAL CARE: POLICY ISSUES

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ABSTRACT

Official policy statements and parliamentary recommendations are re-emphasizing the importance of community care for elderly people. This paper examines questions of responsibility in the light both of demographic changes and the associated increases in dependency amongst the elderly in Australia. Definitional questions are raised in relation to the concept of community. The distinction between care in and by the community is probed in relation to evidence concerning the role of women in the provision of care. The responsibilities for provision which exist at the statutory, commercial, voluntary and informal levels are outlined. Actual allocation of fiscal resources to home support services is detailed and policy considerations which arise from this analysis are proposed.

The issues of concern in this paper relate to determining the response or range of responses to a situation where the numbers of dependent elderly people will increase, and one in which the present caring systems (formal and informal) are greatly extended. Questions arise about care capabilities of the family and the state; about the resources, both financial and non-financial which are devoted to various caring situations; the resevoir of caring skills in the community and the capacity to finance the development and delivery of these skills. If we limit our examination to community care (and leave for other papers issues in income maintenance, housing, transport, hospital care etc), there are two distinct target groups to consider. First there are those elderly people with chronic conditions or activity limitations who live alone and have no relatives who provide support. Second there are those with chronic conditions or activity limitations who have relatives (either in the same household or nearby) who provide assistance.

In developing policy it is necessary to have a clear conception of the objectives of the proposed interventions. In Australia the Commonwealth Government has devised a number of accommodation programs - both residential institutional and self-contained accommodation. In addition domiciliary services are provided to support people who wish to live in their own homes. If successful, the services will help keep people in a familiar environment, keep them out of more expensive institutional care and improve their quality of life. Services such as home help services, home nursing services and meals on wheels are provided under a wide variety of auspices - sometimes by government, sometimes by non-government non-profit welfare agencies, sometimes by commercial enterprises and sometimes by volunteers, neighbours, friends and family.

In general terms, the Commonwealth Government provides approximately ten dollars for nursing home and hostel expenditure for every dollar which it provides for domiciliary services.

Approximately 6 per cent of Australia's elderly population lives in institutional care, and they are outnumbered, by about 15.5 to 1 by people living at home, yet the bulk of the resources go to maintenance of institutional settings. This is interesting in view of the fact that for some time political statements have always stressed the importance of, and policy preference for proposals which assist people to stay in their homes, and delay (if appropriate) any move from a domestic to an institutional setting.

This paper will focus on policy issues in community care. The great bulk of the elderly population require some form of social and or medical support to maintain their quality of life. It has frequently been argued that community care will help maintain as natural as possible a lifestyle. To do so, however, involves a range of costs - costs to the community in financing services, costs to elderly people in losing some of their dependence and costs to the families of the eldery people, in their provision of care. In general, four systems which provide care can be identified (Wolfenden, 1978).

First there is the statutory system, that is government provided and operated services. They are costly, but in their favour is the argument that they can provide on a universal basis - they are publicly supported by the majority of the population who are not in need, so that a minority of the population, who are in need, can receive services.

Second is the commercial system, in which services are bought and sold at a price that the market will bear. Apart from most housing, there are few commercial services - most medical and hospital services are subsidized, though at the top end, private nursing home and private nursing services have a commercial market.

Third is the non-government welfare sector - sometimes called the voluntary sector. This is a large and complex web of organisations varying in size, scope, activity and interest. Our research has identified 37,000 non-government welfare arganizations (NGWOs) in Australia, of which over 5600 deal with aged people. There are complex funding and service arrangements between NGWOs and government.

Fourth there is the informal system of social care. The help and support that family, friends and neighbours give one another is so often just taken for granted that it seldom enters discussions of service provision. We have no way of estimating the extent of informal halp, but we are presently conducting studies on family care of elderly people and on volunteer activity. Informal supports include provision of care, in the home of dependent and disabled people, young and old; transfers of material resources within families; provision of advice and psychological support in coping with difficult situations.

Our focus in this paper is on community care. Definitional issues have probed the distinction between care in the community and care by the community. (Finch and Groves, 1980). Care in the community refers only to the environment in which care occurred, while care by the community involves assumptions regarding responsibility for this care. Simply to advocate "community care" without addressing the question of responsibility maintains the ambiguity which has surrounded the use of the term. Indeed, the term "community" itself is one which is clearly associated with the images of integration, activity, and stability. Given this, it is difficult to imagine any opposition to community care. In his introduction to a recent book on community care, Alan Walker (1982b:19) has commented

> "Underlying the precariousness of community care policies, therefore, is first, the absence of a clear and consistently applied definition of community care in public policy. ... In fact the term's durability and attractiveness probably owes much to its manipulation to encompass the widest possible range of institutions - it is all things to all politicians and policy makers".

In Australia, as in Britain, the actual and potential role of the community as opposed to families in providing care and support to elderly people has only recently begun to be explored. The part which statutory, commercial and voluntary service play requires more detailed consideration.

Community care, therefore, can be seen as a mix of formal and informal care systems. Assuming that assistance is required, and that demographic developments augur for an increased set of needs the policy provision will pivot around a planning objective which involves one of: maintaining people in their homes because it is cheaper for the state; maintaining people in their homes because institutional care is regarded as a desparate, demeaning and dreadful last resort; admitting people to institutional care because it is simple, easy and reasonably expedient. It can be demonstrated that community care can act as a means of maintaining people in the community, but the costs to those providing this care must also be recognised.

This paper examines a range of policy alternatives in attempting to cater for a population which is ageing and which experiences high rates of chronicity. Community care is seen as a fashionable alternative, but implies that families can be expected to play a greater caring and support role than they presently play. At present family care is predominantly care by one women from within the family, and it has been shown (Kinnear & Graycar, 1982) that the continuing capacity of families to provide this care has reached its limit. While families may wish to extend their caring functions, there are insufficient community resources to support them. Traditional family caring roles cannot apply in a situation where life expectancy, chronicity, and labour force participation rates have altered significantly.

The four systems mentioned above, the statutory, the commercial, the non-government agencies, and the informal, intervene to provide supports, primarily to limit dependency. There are, of course, important value questions about where the responsibility lies. Should individuals be responsible for their own health and welfare? How far must a situation deteriorate before the state should step in? Should the state be primarily responsible for the provision of care? Should families care for their dependent members? What if elderly people have no family or if their family does not have the resources to play the caring role?

These questions are particularly important if viewed in the light of demographic change in Australia. For every 1000 elderly people in Australia (age 65+), 776 experience at least one chronic condition, and these 776 people experience a total of 1791 chronic conditions (2.3 each). 15 per cent of females aged 65+ and 11 per cent of males aged 65+ have some activity limitation (these data from ABS Australian Health Survey: Chronic Conditions, (Cat.No. 4314.0)).

Activity limitations mean that people with chronic conditions need some form of social and medical support. It is not known how many people with activty limitations live in institutional care, how many live alone, or how many live with relatives. The significance of these data is that the dependencies of ageing, which are chronic and cumulative rather than transitional, build up and have the greatest impact as disability combines with age. As people get older living arrangements often become more precarious and this has implications for the elderly people themselves, for the formal service provision system, and for the families of the elderly people. Elderly people are vulnerable to poverty, social isolation, and public dependency (Rowland 1982). Elderly females are more vulnerable than elderly males because they have fewer protective barriers (the greatest barrier is a spouse).

Social policy is about interventionist activities which attempt to alter life chances. It is about a theory of benefits and their distribution, and in determining the distribution or redistribution of our social resources a conflict situation develops, and with it arguments about the relative responsibilities of "the state" "the taxpayer" "the family" "individuals" as if they were all discrete categories rather than integrated entities.

Australia's population is ageing slowly. 9.6 per cent of the population is over 65 today. By the turn of the century elderly people will comprise 10.6 per cent by the year 2031 about 13.6 per cent of the population - about the rates which prevail in much of Europe today. Over the last 100 years, life expectancy has increased and this has two consequences. First, the income security system has more people to support and for longer. Second, as life expectancy increases, so too does frailty and disability among the elderly - and this involves both personal and economic costs.

Over the past 100 years life expectancy at birth has increased from 47 to 70 for males and from 51 to 77 for females. At age 65 life expectancy for males is 13 years, and for females 17 years; at 70 it is 10 years for males and 14 years for females, at 75, 8 years for males and 10 for females, while at 80 it is 6 years for males and 8 for females (these data have been developed by Rowland 1981:6).

If there is a problem it is not the proportion of elderly people in the community, but the lag in adapting social institutions to the needs of older people, in particular in developing the care structures required to support the increasing number of "old-old" people.

The slow rate of ageing of the population will still mean a rise in absolute numbers. By the turn of the century there will be somewhere between 600,000 and 900,000 more elderly people than there are today, but more significantly, a change in the age distribution of elderly people. For example, if mortality is down by 1.5 per cent and there is modest migration, between now and 2001 the population will rise by 31 per cent; the numbers over 65 by 64 per cent; and those over 75 by 11.3 per cent. Those over 75 who today constitute 36 per cent of the aged will, in 2001 constitute just under half - 47 per cent.

Issues of responsibility shape the reality of caring situations. Why supports are provided, and who provides the supports depend on whether the manifest objective is the prevention of dependency, improvement in quality of life, the saving of public funds or whatever. It has been forcefully argued (Walker 1982a) that dependency has, in addition to a physical component, strong economic and social origins and consequences. This makes the state a prime actor in matters concerning the creation and alleviation of dependency.

State provision of care has generally taken the form of providing institutional care for dependent elderly people, and in the last decade this policy option has been questioned as the most appropriate solution for those eldery people who require long-term care. The literature on the dehumanising nature of aspects of institutional care is well known. The overall provision of services within the welfare state occurs on both a formal level, through statutory authorities and NGWOs, and on an informal level, through neighbours, friends, and predominantly, families. The implications of locating delivery, at either of these levels will relate to assumptions regarding the roles of the state and the family, between whom responsibility has been divided.

At the formal level state intervention is seen as appropriate, and the responsibilities of state services are usually defined in specific legislation (e.g. legislation which provides Home Care, Meals on Wheels). They have a legal basis, and within the machinations of bureaucratic structures, a line of accountability. The legislation usually provides permissive or mandatory powers to government to create and develop certain trends of provision either for all or some. Whatever the degree of intervention, debates about the nature and purpose of intervention and whether the family or state is the base of this intervention will structure the growth of welfare provision. NGWO services are included as formal services, in that while they are not established through statute, they are usually reliant on the state for financial assistance, and may be answerable to government.

Within NGWOs the formal at times melds with the informal, as many of the paid providers find themselves in certain situations, for funding is haphazard and irregular, and much of their work goes unpaid. As NGWOs through both paid staff and volunteers provide varying degrees of support and assistance to elderly people, their accountability and funding positions need to be considered when dealing with issues of resources and responsibility.

At the informal level, which relates closely to community care, responsibility has been divided within families according to a sexual division of labour. The lack of resources allocated to those in need, as well as the low status which is associated with family care, have served to relegate almost always to women the task of providing for the elderly. The separation of public and private spheres of social life (Wilson 1982) has resulted in the maintenance of a lack of knowledge about the caring situation, and the impact of policies on those involved. It also results in family care being hidden, and regarded as natural and inevitable by society. The realities of the caring situation are rarely taken into account. "The old are being cared for exclusively and predominantly by daughters and daughters-in-law. They may be visited by professional helpers, or even volunteers, but this is not what I would understand by community care... We need to know and think much more about these informal (mostly female) networks". (Wilson 1982:-5).

A recent Australian study (Kinnear & Graycar 1982) found that family care was not a total family responsibility in that members of the family did not contribute equally to the care of the elderly relative. Husbands undertook little or no direct care themselves. The effect of the elderly relative's presence on the carers' marital and/or family lives was considerable. Tension had increased within most families, and women with children expressed feelings of missing out of full involvement in their growing up. Negative effects on carers' self-esteem and identity were reflected in statements regarding the anxiety and depression which many of them experienced. While the capacity of women to continue caring for elderly relatives cannot be taken for granted, (due to labour force participation rates) it is notable that caring for an elderly relative is still regarded as appropriate for middle aged single women.

If there is an increase in labour force participation rates it is most likely in the part-time labour force. There are important ramifications of a changing family sociology and family policy as women continue to fulfil care expectations at enormous costs to themselves and their families (Brody 1981, Nissel & Bonnejea 1982, Kinnear & Graycar 1982).

Current concepts of community care build on traditional sex roles, and the practice, if taken as an operational maxim, continues a sexual division of labour which makes it a viable and cheap care alternative for the state. The unpaid work which women perform both as volunteers and as paid staff "working in their own time" is only now being documented in Australia. Several studies have shown the overwhelmingly female nature of volunteer work (Baldock 1982; Hamilton-Smith 1973; Hardwick & Graycar 1982). Baldock (1983) points out the primary responsibility of women to society is not as paid members of the work force but, rather, in other, non-paid roles. Volunteer work may be seen as one of these. She examines volunteering as being commonly assumed to be "a typically feminine trait", and relates this to the sexual division of labour within the family. Further questions are raised concerning the hypothetical eradication of structural and ideological divisions between "home makers" and "breadwinners", and what would become of volunteer work in this event.

It is clear that social expectations regarding the location of responsibility for care and support continue to dictate to informal supports (where they exist) the primary function. To suggest that the state has usurped the role of the family and is now handing it back does not accord with the evidence, especially that which shows that policies on eligibility for formal services can, in times of economic recession, severely penalize dependent people. "Some services which are supposedly 'available' are not available in any real sense of the word.... The relative cloak of secrecy maintained about them serves to act as a rationing device, while the myth is preserved that they are freely available. The result is the arbitrary distribution of services in favour of those who are lucky enough to hear about them" (Chapman 1979:).

The constraints which services themselves experience may result in the practice of an ideology of family care. This will have an obvious influence on the objectives of service provision. In many services there is an assumption that families will provide care, and consequently domiciliary services are often withheld if the elderly person lives with or near relatives, regardless of whether the relatives are willing or able to provide care (Hunt 1970:338-9; Moroney 1976:28). It is the elderly person who is penalized and in such a situation the family is manipulated into serving the need of the state rather than vice versa (Moroney 1976:28).

Having highlighted the operational and conceptual distinction between formal and informal services we can now identify some of the services which are actually provided in Australia today, and the auspices under which they are provided. Services provided within the home include home care/home help services; meals on wheels; home nursing; home maintenance; visiting and shopping; mobile libraries; family care. Services provided outside the home include community health services; respite care; nursing home and hostel care; rehabilitation services; hospital care; transport services; senior citizens centres. A classification exercise of immense magnitude would be required to provide a still life cross section of this diverse kaleidoscopic amoeba which we simplisticaly call services for the aged. To identify consumers served (and not served), and resources expended for each of the above services; and then to determine whether they are statutory, commercial, voluntary or informal (but usually they are a mix); and then to identify (for those which are partially or wholly supported by government) the balance of federal/state/non-government funding and associated planning, regulatory, or accountability patterns; and then to identify whether local conditions or perhaps State government policies produce different services and outcomes in different parts of Australia; and then to determine which services work, and which ones work well; is not an easy task. An attempt at all of this is presently being commenced by the authors.

Aggregate funding data are available from Commonwealth sources but other than that, comprehensive and comparable data are not available. In a soon-to-be-published study on home help services in Australia we were not able to discover for example, how many people in Australia received the services which are funded under the State Grants (Home Care) Act

The Commonwealth Department of Social Security administer four relevant Acts: The Aged or Disabled Persons Homes Act which in 1981/82 approved $28.72 million for new capital projects and spent $22.24 million for the Personal Care Subsidy; The Aged or Disabled Persons Hostels Act which in 1981/2 allocated $8.3 million; The Delivered Meals Subsidy Act which in 1981/2 spent $4.25 million in providing subsidies to 738 service providers who provided 9.65 million meals; and $18.07 million under the States Grants (Home Care) Act of which $12.67 million was provided for home care services, $4.0 million for Senior Citizens Centres and $1.4 million for salaries for Welfare Officers.

As can be seen, the bulk of this funding goes for residential care. Of the $81.58 million 72.6 per cent goes towards residential care. Only $16.92 million or 20.7 per cent goes to in-home services. In the first three Acts mentioned, funds go to approved organizations (and in the first two Acts go only on the condition that they are matched, while in the States Grants (Home Care) Act non-capital funds are provided on a dollar for dollar basis to the States.

Department of Social Security expenditures are small when compared with Department of Health expenditures. Nursing Home Benefits under the National Health Act comprise the largest relevant expenditure item. $407.3 was spent in 1981/2 in providing approved nursing homes with a daily benefit for each patient. The dollar amount provided by the Commonwealth varies from $18.55 per patient per day in Western Australia to $31.65 in Victoria. Budget estimates for 1982/3 are that $534 million will be spent on Nursing Home Benefits - an increase of $126.7 million or 31 per cent, by far the largest item increase in the Department of Health budget (Budget paper No.1, 1982(3:88); Nursing Homes Assistance comes under the Nursing Homes Assistance Act 1974, and in 1981/2 $164.1 million was spent in meeting approved operating deficits for private non-profit nursing homes. The estimated 1982/3 expenditure is $205.9, an increase of 25 per cent; under the Domiciliary Nursing Care Benefit $21.2 million was allocated in 1981/2 to people providing care at home "as an alternative to institutional care"; Home Nursing Services subsidy is paid to non-profit services currently receiving matching State Government funding. In 1981/2 $16.5 million was allocated. Again it can be seen that the bulk of the funding, $571.4 million out of $609.1 million (93.8 per cent) goes to institutional care.

The Domiciliary Nursing Care Benefit is a prime example of a small payment made to encourage those caring for relatives at home. Although introduced as a compensatory payment, the allocated $3 per day would not go far if it was used for the purchase of services.

Assessing health expenditures is different for many general health services are heavily used by elderly people, both hospital services and the lowly funded Community Health Services. Many other services are exclusively for veterans, and most veterans presently utilising them are eldery. In the health field there is a mixture of public and private, formal and informal, but in resource allocation very little goes to in-home services.

Myriad funding arrangements apply for respite care, day care, mobile libraries, transport and the many other services found irregularly and haphazardly throughout Australia. Since 1975 there have been at least eight Commonwealth reports which have examined programs for elderly people and which have commented on the balance of institutional and at-home services, the best known of which are commonly known as the Seaman Report, the Holmes Report, the Bailey Report, the Auditor Generals Nursing Home 1981 Report, the McLeay Report. This is not the place to review those reports other than to say that most were concerned to extend at-home services; limit inappropriate institutionalization of elderly people; and ensure better planning, assessment and co-ordination mechanisms.

Better mechanisms will relate to developing a model of service delivery which assesses in-home and out of home services by objectives; equity and efficiency criteria; target coverage; funding and accountability mechanisms; and evaluative procedures. Careful analysis of the role played by statutory, voluntary commercial and informal services will add meat to the bare bones.

The dominant conception in the past decade has been that future directions for service provision should fall under the "community care" or "home support" rubrics. Actual expenditure figures do not match the rhetoric, for example of Commonwealth funds provided for home care and institutional care, in 1976/7 10.09 per cent went to home care services

and 89.91 per cent went to institutional care; in 1977/8 the home care component rose to 10.31 per cent, in 1978/9 it was 9.61 per cent, 1979/80 9.68 per cent, 1980/1 10.66 per cent, 1981/2 8.75 per cent and the estimate for 1982/3 is 8.32 per cent (calculated from McLeay Report, 1982:122-3).

However an awareness of personal and social costs associated with institutional care (Goffman 1961; Swain and Harrison 1979) as well as increasing concern over financial costs to government have formed the basis for recommendations regarding 'deinstitutionalization' of the elderly. The McLeay committee recommended that "further control of nursing home growth be applied so as to limit the number of occupied beds receiving subsidy and contain expenditure on institutional care". (5.57), and saw this restraint as allowing for expansion of expenditure on domiciliary care services, day care centres and day hospitals. The removal of disincentives to the expansion of home care services, alongside a reallocation of resources between institutional and community care was viewed by the committee as the ideal framework for service development. The incorporation of domiciliary programs into a proposed Extended Care Program would serve as the avenue through which a co-ordinated program of support to elderly people living at home might function (McLeay, 1982: 3.2).

Prior to winning office the present Health Minister, Dr. Blewett released his Party's platform which proposed the development of a community care program, along the lines suggested by the McLeay Report, to provide support for elderly people who wish to remain in their own homes. In a speech on February 4, 1983 Dr. Blewett proposed the creation of a "structure of services designed to bring support to the elderly .... as well as to bring the elderly to community services", and the expansion of the roles of existing Commonwealth-State co-ordinating committees to include the overseeing of the provision of domiciliary and home care services. In tandem with these proposals were promises regarding "an increase in the number of community health centres, day care centres and attached transport services, and provision of a greater range of services within these centres".

It is obvious that assistance for elderly people will be required at an expanding rate, and from a policy perspective the purpose of each type of intervention must be addressed. Of particular concern are those elderly people most likely to require assistance in order to remain in their own homes. It may, of course, be the case that this assistance acts as a prevention against their requiring institutional care, although this may not necessarily be the basis upon which such assistance is or should be provided.

Those people requiring spasmodic or occasional help at home form a different policy target to those who are reliant upon frequent, regular and reliable support. Those most likely to require such support are women living alone. In his analysis of census data Rowland (1982) identifies what may be considered the major factors determining elderly people's "vulnerability" to public dependency, social isolation, and poverty. He examines living arrangements, life-cycle stages, gender and socio-economic status in relation to dependency and concludes that the presence of a spouse as adult offspring provides a degree of protection against isolation and dependency. He refers to the 'double jeopardy' in which elderly people living alone on a low income may find themselves. In view of this, it is widows who comprise the majority of the elderly most likely to be "vulnerable".

Despite a regular flow of pronouncements over the years about the desirability of community care, and its social and moral superiority over institutional care, there has been no accompanying shift of actual resources from the residential to the domiciliary sector or from formal to informal sources of support. All forms of care involve a cost, and at present the cost is being borne prdominantly by women as carers, volunteers and low paid workers, and what community care policy there has been has accepted this situation.

It has been strongly argued by two British researchers that the unfair pressures on women carers make residential care the most suitable "non-exploitative" alternative (Finch and Groves 1982). Their argument seems to have come full circle from community care to independent but

supported, residential care. It is based on arguments about the way in which expectations of traditional roles are built into policy. Policy considerations will obviously need to take account of resources and responsibilities, and the balance among the many issues outlined above.

This final section raises a number of policy considerations. These are not written as a set of recommendations nor are they discussed here. They follow from the issues raised in this paper and are listed here as items worthy of consideration in policy development in the field of ageing populations and social care.

* The continuation of substantial state resources is required for the development of equitable and humane social care provisions for elderly people. The statutory sector alone has the resources and the auspices to develop comprehensive and equitable policies for the expansion of social care. Clarity of service objectives is required, particularly objectives relating to the balance or redirection of extended care and residential services. In giving consideration to the implementation of proposals which alter the balance of services (such as the recommendations of the McLeay Committee) an adequate financial commitment is necessary to make any changes effective and to support new responsibilities.

* Considerations for services for elderly people might examine both a diversity of services and an expansion of service types. Services such as day care, respite care, and various in-home services should be examined within a local context to ensure that local needs are considered. It is much easier, of course, to assume a passive role for clients and have them fit into existing services rather than create choices and try to reflect local needs.

* Consideration should be given to a more positive orientation to be provided for planning and service personnel to community care. With this orientation will come an awareness of the burdens placed on families and

workers in the informal sector (as well as those on the margin of formal and informal services) in implementing community care policies. This will involve both an attempt to reconcile practices within the formal and informal sectors as well as a recognition by professions of the importance of non-professional personnel involved in home help and home visiting.

* Consideration should be given to the status and working conditions of those in the tending occupations. Industrial conditions for those at the margins are not good, and this reflects both the lack of industrial awareness among many welfare personnel, and the haphazard nature of service funding. Training issues are also important, in particular the transfer and reinforcement of skills of both volunteers and the very low paid service providers.

* The needs of those both providing and receiving social care require attention, especially appropriate choices and supports available to them, and their role in the decisions which affect them.

* When community care policies are espoused but not adequately resourced, great pressures are placed upon both formal and informal providers as well as upon community workers and planners.

* Consideration of the structure and functioning of assessment teams is necessary. If there is to be appropriate placement of and support for elderly people, regular assessment is required, and this is costly. The cost relates not only to the actual assessment process, but also to the provision of suitable facilities and services to effect the decisions of assessment teams. Again choices and alternatives need examination.

* Consideration of the capacity of families to provide support services and extended care is required. This involves issues of skills, responsibilities, financial ability, and community expectations. Related are questions of the division of functions and roles within families.

* Recognition must be made of the special needs of elderly people without family support, and those who experience social isolation.

* Structural issues in the development of formal services create difficult funding and responsibility issues. The most appropriate level of government intervention and support - Commonwealth, State or Local - is deeply enmeshed in the politics of federalism and fiscal federalism in particular. Elements of fiscal politics percolate into the uncertain, spasmodic, and desultory nature of NGWO funding.

* To call merely for increased resources for community care is an insufficient response. This conference is dealing with resources and responsibilities, and consideration needs to be given, not only to increased resources, but also to the realistic analysis of the structure and location of responsibilities in community care. The assumptions which underpin policy as well as the objectives of intervention affect both service recipients and providers. Community care is costly in many respects and urgent consideration must be given to the question of who will be expected to bear these costs in the future.

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