

**Developing Aged Care in
South Australia, 1952-2002:
Conference Proceedings**

**Edited by
Brian Dickey**

Adelaide 2000

Contents

Editor's Preface <i>Brian Dickey</i>	iii
Introduction <i>Neville Hicks</i>	1
National funding for aged care and accommodation: a view from the South Australian office of the Commonwealth <i>Brian Fleming</i>	8
The work of Anglicare SA in aged care services in South Australia since ca 1950 <i>Brian Dickey</i>	29
Helping Hand Aged Care: developing a service, 1953-2002 <i>Pauline Payne</i>	52
Aged care in South Australia 1952-2002 <i>Peter Last</i>	65
Appendix: Government funding of services for old and dependent people: Some salient dates and facts <i>prepared by Peter Last</i>	74
Residential and community care development recollections <i>Kelvin Dickens</i>	77
Some important organisations in the development of aged care in South Australia <i>Barbara Garrett</i>	81
The development of aged care services in South Australia: domiciliary care and rehabilitation services <i>Sue Burnell</i>	85

Editor's Preface

In August 2002, the South Australian network for Research on Ageing (SANRA), convened a seminar on the history of aged care in South Australia over the last fifty years. The panel of contributors included two authors (Dickey and Payne), currently writing commissioned histories of non-government agencies delivering aged care services in the state, namely Anglicare SA and Helping Hand Aged Care. The panel also included Brian Fleming, a public servant active in administering Commonwealth funding for aged care. In addition, Dr Peter Last, Mrs Barbara Garrett MBE, Mr Kelvin Dickens and Ms Sue Burnell, all of whom had been significant participants in delivering aged care services in the state over some of the last fifty years, presented papers. These were intentionally reminiscent, catching some of the excitement and commitment these people and many others have shown during their engagement in this field of social service. We were fortunate to have Neville Hicks as our chairman, bringing his long experience of the field and his well-known style to the meeting.

The seminar was presented at Resthaven, Malvern, itself a significant example of aged care service delivery, before a vigorous and interested audience of more than a hundred people, some of whom offered their own memories and comments.

Unfortunately, the exigencies of university research funding have meant that SANRA no longer exists. Nonetheless, the organisational initiative taken by its officers, notably Pauline Brooks, to make the seminar happen, were invaluable.

Printing of the proceedings (after some editing) have been assisted by the Commonwealth department of Health and Aged Care.

The editor congratulates the contributors for their courage and commitment in participating and in following up with the texts, which they have presented here. We all trust that the collection will stimulate further discussion and thought on the nature, goals, purposes and quality of aged care services in South Australia and beyond.

Brian Dickey

July 2003.

INTRODUCTION

Neville Hicks¹

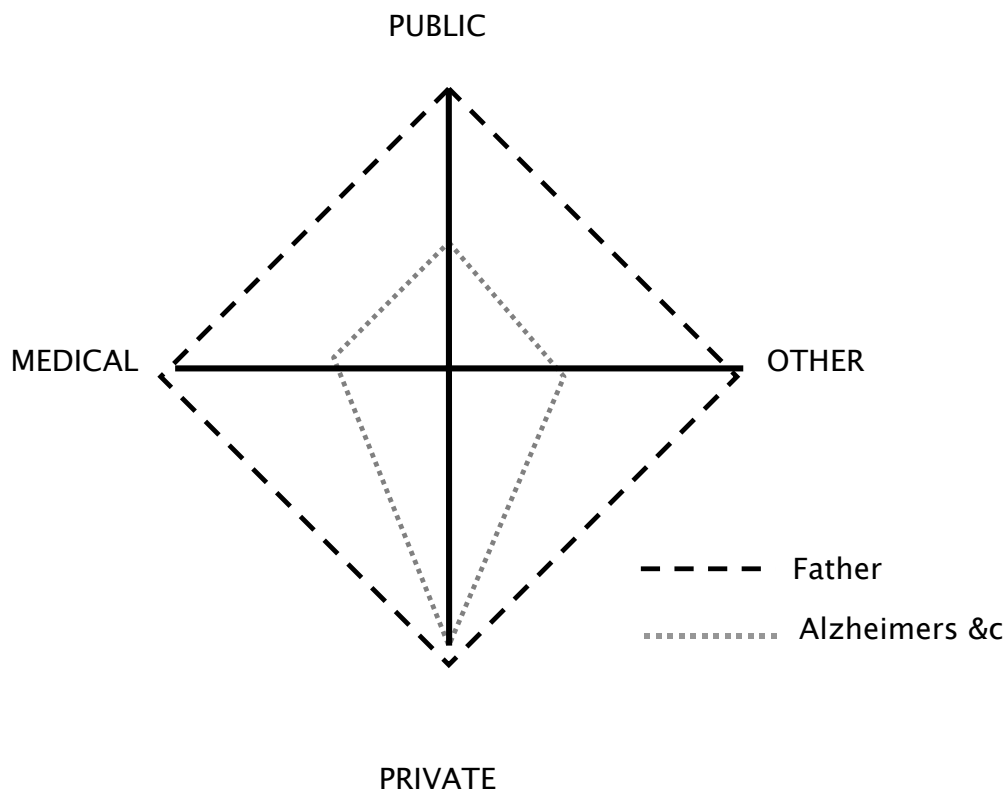
A passage in the Old Testament tells the tribes of Israel to bring their children annually to a cairn of stones, built where the ancestors came into the land of promise. When the children ask “what mean ye by these stones?”, they must learn not to worship the stones but to imagine the next venture. The following histories of aspects of South Australian aged care c.1950-2000 are good on the stones and honour several venturous prophets. This introduction asks the annual question.

I approached these papers with part of the story of my own tribe in mind. The better off of my grandfathers was one of eight children, and fathered five, while making a modest living on an inherited farm with little cash for capital improvements. He retired to Adelaide just before the Aged Persons Homes Act was passed, in 1954, and bought a large, rather run down, house too difficult for him and his wife to manage. A faithful retainer came with them from the farm and they had the attention of three married, non-employed daughters already living in the city. Grandpa received no domiciliary care and did not trouble the doctors much during the several years before dying after a week in a little private hospital.

Ten years after Grandpa died, good physicians restored my father following a mild heart attack. He went back to teaching for a while but soon opted for a 20-year retirement and the skilful gardening that he preferred. My parents married after the Depression and had their children before the baby boom. Mr Menzies’ expansion of the education system had meant that educating the children cost them little. Mr Menzies’ light hand on inflation, plus their Methodist way with money, saw them very comfortably off by the time the long boom ended about 1995. In 1989 I built a new house with their separate, manageable, accommodation next door. Dad’s Alzheimer’s symptoms were already clear when they moved in. He spent two years in the house, then two more in a nursing home that was adequately managed, charged 85 percent of the pension (a good deal lower than his superannuation) and did not require the up-front fee that my parents could have afforded.

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Just as my father was moving into the nursing home, I was invited to a meeting of the Association of Relatives and Friends of the Mentally Incapacitated. I recounted my father's experience of excellent private medical care from the GP of our choice and equally good assessment from the public hospital's geriatric unit. Local council services, such as showering, were readily available when my mother could no longer manage it, and other non-medical services could be bought if needed with the retained funds from the long boom. It seemed a rather attractive picture but the ARAFMI ladies dealt, in the main, with psychotic or schizophrenic sons or husbands. Private medical services, generally, did not wish to treat them and the public medical services were overwhelmed. The public non-medical services for chronic psychoses, in some suburbs, operate under considerable strain. I don't know whether low economic status predicts psychoses or vice versa but, either way, the caring families rarely seem to have the resources to buy non-medical support if they need it.



I draw from those stories two academic points, about cohorts and populations.

It makes a difference whether you were born in 1885 or 1911 or 1940, as my grandfather, my father and I were. Each cohort lives through a different window of material experience, involving differential exposure to risks, differential probability of being affected by the exposure and differential ownership of resources for dealing with the consequences. Different cohorts also live through different windows of idealist or moral response to material circumstance.

‘Populations’ is an important term, too. It is a collective noun, in public health, for people located, exposed and resourced in common. From a public health point of view, there are many publics or populations whose material circumstances vary widely. My Australian grandfathers and their cousins in England were both born in the 1885 cohort but the risks and exposures which they experienced from climate and population density, with their implications for health, were radically different. Even among the English cohort of 1885, there were many populations, rural (and those landowning or not) or industrial (and those skilled or not, in London or not). My grandfather, my father and I all developed our lung function and our food habits growing up in rural South Australia, not inner-urban Sydney or its English equivalents.

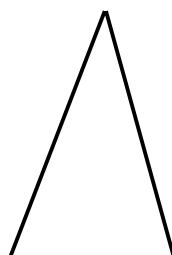
Running alongside that social history of my ancestors and me is what we might call, loosely, a history of the life sciences. About 1970, Thomas McKeown, the professor of social medicine at Birmingham, argued that Western Europe, in the nineteenth century, had gone through a demographic transition from high death and birth rates, to low mortality and low fertility. That transition was accompanied by an epidemiological revolution as premature death, chiefly by infection or injury, declined and gave way to degenerative conditions and delayed death. My great-grandfathers, who migrated to Adelaide by 1837, were survivors of those events. In 1986, Jerry Avorn, an American doctor, agreed with McKeown that social improvement had been the main reason for the decline of births and changed incidence of death from 1800 to 1940, well before effective pharmacotherapy was available. He added that even the unexpected drop in heart disease mortality during the 1960s had resulted chiefly from lifestyle changes. Avorn observed that the medical-technological inventions after 1945 had their greatest impact on people furthest past their 50s. He thought improvement in health for the non-ill elderly was a good thing but noted that ‘this ratcheting up will cause many chronically ill people, who otherwise would have died, to remain one notch below death’. Their condition, he regretted, would be met ‘with an ideology of “automatic therapy”, aimed at restoring physiological normality to patients in virtually all circumstances’.

The outline of a ‘Darwinist medicine’ has helped, during the past decade, to produce an understanding of the problems that Jerry Avorn described. By definition, all surviving populations will be well-equipped genetically to survive until reproduction. In general, they will have limited capacity for cell repair after reproduction. If the post-reproduction life expectancy of most western populations has doubled since 1800, we should expect either more cell breakdown (in the form of heart disease or cancer or, perhaps, senilities) or that more energy will go into producing the ‘automatic therapy’ which Avorn described. Medical, pharmaceutical (and surgical) skills have all contributed to a continuing rise in the length of life in Australia and a compression of morbidity into the later years of those lives. On a Darwinist medicine view, they have probably increased the likelihood of adverse drug reactions and immunological resistance. Gene therapy, of its nature, will not readily deliver the mass production

opportunities that the pharmaceutical companies require. We already face a situation in which the bulk of people outside aged-care institutions but needing a carer are aged 80 to 85. Their children, on average, are aged about 55 to 60. The rising age at family formation suggests that, for each of the two following generations, the caring children will be some five years younger when the call comes. On present indications, they will have greater difficulty in putting aside paid work to do underpaid caring.

Present 80 to 85 year-olds are likely to have lived in the top third or top half of the income profile in Australia and can afford an occasional paid companion or cleaner or handyman. The majority can not. A student working in those parts of Adelaide where ‘can not’ is common reports the considerable strain on carers, the clear inadequacy of carer pensions and the need for greater medical attention to the health of the carer. Carers’ associations may also have some trouble organising a lobby for these goods because their potential constituents are the people already under strain. Of course there are various publicly-funded community action packages, domiciliary support services and so on. Although the distribution of these things to individuals is needs-based, there are distinct regional differences in the age at which people become sufficiently dependent to qualify for support. The quotas seem to yield a situation in which differences in need are not matched – or may be contradicted – by the supply.

Beyond the realm of care at home lies residential care, of the kind whose history Payne and Dickey’s papers on *Helping Hand* and *Anglican Homes* reveal. The women I know who work in such homes, and my occasional visits to them, allow me to say that there is a great deal of decent care to be had there. The same experience suggests that, at a systematic level, things are a bit more fragile. Staffing ratios do not allow that time for personal, as distinct from technical, nursing care which might sustain those anchor points of familiarity and routine whose decay sees senile people slipping into frustration and anger. During the past decade, Commonwealth ‘welfare reforms’ have forced those agencies into a ‘return-on-capital’ approach to accounting for their other social welfare activities which must raise the risk of eroding the moral purposes which brought them into the aged care business. A couple of consultancies with church agencies suggest that when their board members draw lines in rough proportion to the importance they allow to financial, medical and theological values the result can be rather disappointing.



MEDICAL

FINANCIAL

- - - - -
THEOLOGICAL

If theology is in short supply, what other fountains of advocacy might shield from heightened vulnerability the people with physical or functional impairment whose life in homes for the aged distances them from mainstream society. If residents are to be treated as citizens should be, they will require the bridge of advocacy between their residents and the wider world. The staff of residences might offer a bridge but their capacity to be advocates has been eroded by the reduction in funding of hours per resident and by the fragmentation of contact which goes with the casualisation of staff. In addition, some workers find it hard to be advocates because of their responsibility to owners of the license.

More formal advocacy within the human services system could look to the doctrine of *parens patriae* – referring to the king and, later, the State, as father of the people. In the modern form it peeps through in election promises that ‘we will govern for all Australians!’ In recent times the doctrine has been eroded by market theories which represent cost containment as the principal object of governments and hold that the State ‘cannot act in the sole interest of any single person or group’. For several years Australian governments gave some financial support to 'citizen advocacy' programs, ‘intended to be independent from the interests of the State and the human services providers’. That support has declined as market values have displaced welfare values and the Consumers Health Forum and the Health Issues Centre, for example, no longer get grants in aid from government.

Some people suggest that the restraints on formal advocacy channels should push us to consider moral education as a step towards replenishing the spring of values that will make sense of their work. The values might be religious or secular: the key move will be to make them explicit. Proponents suggest that moral education should apply across the whole institutional framework from the policymakers in Canberra to each aged care setting around Australia: it isn't just something for the Director of Nursing to have an ethics consultant teach her staff. The Centre for Australian Community Organisations and Management points to a civic model of organisations such as aged care and community service agencies being

expressions of people's commitment to others ... which involve many stakeholders as possible in decision-making, even at the cost of being slow ... it is a model that draws on political science rather than economics; its emphasis is on maintaining democratic political processes.

Australia is noticeably undemocratic about these matters. Alan Peachment has described a ‘keepers syndrome’ in which nearly all advice to government comes from one or other of the professional silos. Psychologists or psychiatrists tend to own the questions about *appropriate tests for senility*.

Epidemiologists tend to own the questions about *who gets sick* or *what treatment works*. In public administration, narrowly trained economists own the questions about *the cost of welfare*. Evidence-based medicine now threatens to overrule medical judgement or reasonable negotiation between a patient and her doctor. Diane Gibson, head of the aged care branch of the Institute of Health and Welfare, tells the story of an old lady who was asked to mark on a Likert scale how many times she had used the home help service. ‘Oh, I never used the service, dear,’ she said, ‘but it was a comfort to know that it was there’.

Who might do for a new pattern of ageing, now, what the church agencies did for some ageing South Australians between my grandfather’s death and my father’s? How might the churches refurbish the grounded awareness of need that Pauline Payne discerns in the flexible Methodist structures that let Arthur Strange start a Helping Hand? The conditions of funding now permit care in such institutions chiefly to those needing sophisticated medical and nursing skills, answering to professional managers. There is a risk that their work will be chiefly technical and only incidentally pastoral. My mate Brian’s mum, Hazel, went for 50 years to a suburban congregation of denomination X, the capital value of whose nursing home bed licenses would surely interest readers of the *Australian Financial Review*. Hazel’s health ceased to support church-going five years ago and no officer of the congregation has visited her since.

Mums of Hazel’s age tend to be prey to minor difficulties like un-noticed unsteadiness or occasional cystitis or inability to drive to church. Some Lutheran congregations, I am told, employ a pastoral nurse to visit their ‘Hazels’ and respond to both their spiritual *and* their material condition. A few Catholic parishes still have an elderly nun doing the same function. Churches determined to be as responsive, now, to new material need as their predecessors were, 40 years ago, might contemplate capitalising their bed licenses and investing the proceeds in new skills to support the parts of our ageing population that the others don’t reach. If they did so, they would refurbish the streams of dedication and innovation located by Payne and Dickey; of humane attitudes, persistence and professional imagination with feet on the ground from emerging disciplines demonstrated by Burnell and Garrett; of intelligent public service that sustains the activities of Last and Fleming (and of what happens when that service retreats to management by formula). Churches that fostered such innovation, imagination and intelligence would also avoid the risk of revering the stones without asking the annual question.

NATIONAL FUNDING FOR AGED CARE AND ACCOMMODATION: A VIEW FROM THE SOUTH AUSTRALIAN OFFICE OF THE COMMONWEALTH.²

Brian Fleming³

Introduction

Most aged care is informal, most of that is provided by self-care and spouses, and then by relatives, mainly daughters.⁴ This paper, however, is about that part of aged care where the Commonwealth has been directly involved, since 1954. It is necessarily limited in scope to the perspective of the administrative unit that I shall refer to as the South Australian State Office of the Commonwealth, which has been located in various Commonwealth Departments over time; these are elaborated in this article. Commonwealth aged care fits as a primary level health resource in a continuum of resources represented by Figure 1.

² Disclaimer:

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⁴ See page 40 Commonwealth of Australia (1999). *Older People, Australia: A Social Report*. Canberra, Australian Bureau of Statistics, 134.

payments and domiciliary nursing care benefits. This group of twenty-odd officers included staff dealing with:

- deficit financing to not-for profit nursing homes,
- participating nursing home reconciliations,
- an embryonic inspections pair, and
- payments staff.

The separate administrations had two distinct orientations, along Departmental lines, one a welfare orientation with origins in housing, and one a health treatment services orientation with origins in hospital benefits.⁶ These two orientations formed the basis of long-standing tension within and outside the Commonwealth bureaucracy.

Several programs administered by the Department of Social Security (DSS), with legislation modelled initially on aged care, were brought together within DSS in 1980 to form a 'Subsidies' section, which comprised: Aged Persons Welfare, Child Care, Homeless Persons and, Handicapped Persons Welfare.

A reorganisation of Subsidies in 1981 into regional teams, each with officers responsible for multiple programs, was unique in Australia. In order to keep up with policy changes in the various programs, officers were deluged with carbon copies of correspondence colour-coded into the various programs; pink was for aged persons welfare.

By 1984, the experiment had not been copied around other State and Territory Offices, and individual programs were becoming more complex and more different. So, when the Commonwealth Department of Community Services (DCS) was formed in 1984, the programs split into their components again, this time on different floors in stand-alone premises in Pirie Street, Adelaide. DCS took Subsidies and rehabilitation from DSS and nursing home benefits from the Commonwealth Department of Health (DoH). The new logo of the DCS was a row of five red circles topped by a row of four partial circles then three semi-circles etc to form a pyramid. When Senator the Hon. Don Grimes officially opened the

⁵ Max Gilgen, Daryl Halliday, Ron Cassidy, John Griffin, Wally Schroeder, Dick Gower, Brian Fleming and Helen Sullivan.

⁶ The welfare intent of the capital side is apparent from the second reading speech by Hon W McMahon, Minister for Social Services, in moving the Aged Persons Homes Bill 1954: 'The purpose of this bill is to set up machinery so that the Commonwealth may make grants to churches and recognized charitable bodies and institutions to assist them in providing homes for aged people ... This bill breaks new ground in the history of Commonwealth social services for aged people. Hitherto the Commonwealth's activities have been mainly concerned with the provision of pensions and related benefits, leaving most of what may be termed welfare services, other than rehabilitation and social case work, to the churches, the State governments, voluntary organizations and other kindly groups.' (1954). Aged Persons Homes Bill 1954. *Hansard*, 2553-56 (HoR).

premises in Adelaide, he wryly described the logo as representing both the diminishing intelligence as one proceeds up the hierarchy and the blood that had been spilled in the new department's formation. Nevertheless DCS brought the administration of aged care and accommodation together, which had been a recommendation of the 'McLeay Report' in 1982.⁷ South Australians who continued to play major roles in aged care in the following decades were amongst the many contributors to that report.⁸

The administration of aged care and accommodation has been linked with health since then in various portfolio reorganisations. A diagram of the different department names appears at Figure 2 and the logos at Figure 3.⁹

When DCS was formed, the staff in the state and territory offices came mainly from the former DSS welfare programs collectively called subsidies and the funding mechanism was mainly through the local office direct to independent providers, both for profit and not for profit.¹⁰ By contrast the Department of Health's workforce and funding was and remains in 2002 overwhelmingly central, in Canberra, and its main relationships are with state and territory governments through which health care programs are delivered. These differences remain; the local administrations focussed mainly on aged care and the central office mainly on health care. The dominant ideas however have shifted from social welfare to individual health care.

⁷ See recommendation 9.6 on page 98 of Commonwealth of Australia (1982). *In a Home or At Home*. Canberra, House of Representatives Standing Committee on Expenditure, 143.

⁸ Anthony Radford, Peter Last, Phillip Henschke, Neville Hicks, John Pitchford, Gary Andrews and Lu Mykyta

⁹ Dates are available on the Department of Health and Ageing website <http://www.health.gov.au/history.htm#name>

¹⁰ A large group was also staff of the Commonwealth Rehabilitation Service

Figure 2 Aged care and accommodation – Commonwealth Departments

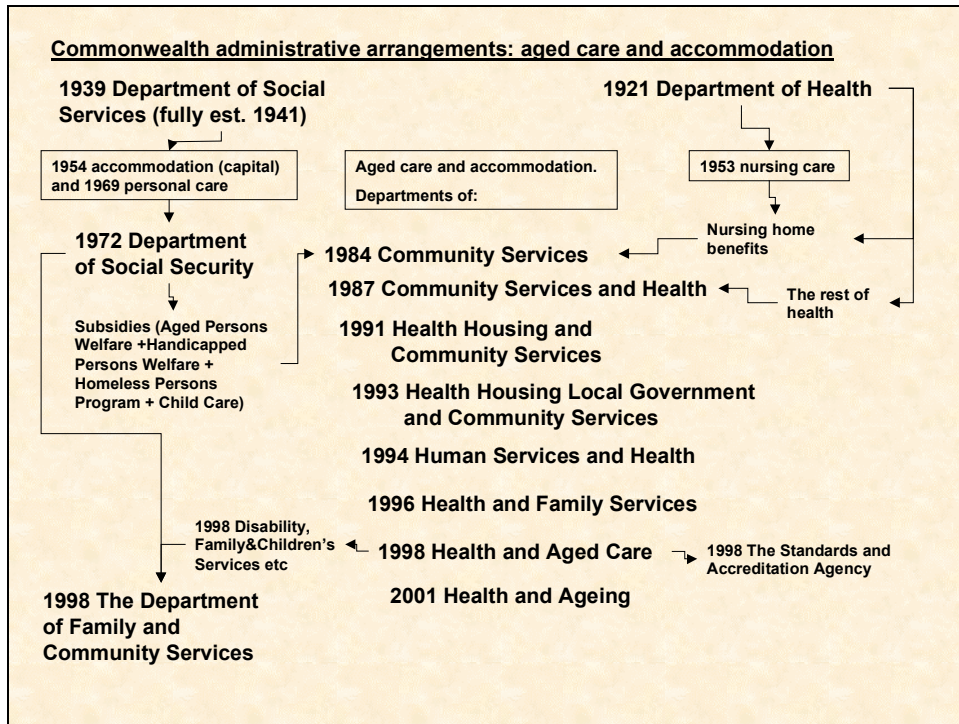
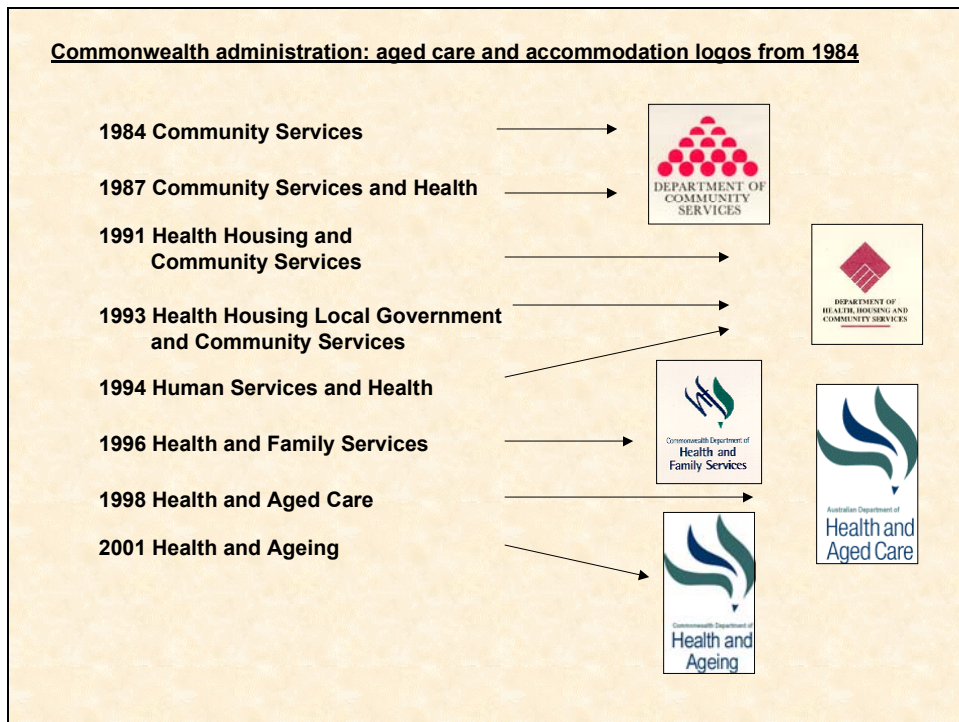


Figure 3 Commonwealth Departmental logos



Funding

Capital

I will address capital and recurrent funding for aged persons separately. The origins of capital funding for aged persons homes lie with a more general concern about housing with the return of thousands of ex-servicemen from war in the mid 1940s, which put pressure on housing supply for low income persons, including older persons.¹¹ Certainly religious and charitable organisations were providing for the welfare of aged persons prior to the introduction of the *Aged Persons Homes Act 1954*. Indeed the number of persons accommodated by these organisations prior to the Act featured in subsequent calculations of eligibility for additional funded places, both capital and recurrent.¹² The Act introduced 1:1 financial subsidies to construct housing for the aged. There is a story that Sir Robert Menzies' wife, Dame Patti, suggested Commonwealth involvement in aged care housing as an election policy plank when visiting a project initiated by the then Aged Cottage Homes in South Australia¹³.

An aged person was 65 for a man and 60 for a woman, corresponding with the eligibility criteria for an aged pension at the time. There was no specific type of eligible housing and, while the main form of new construction was the 'self-contained unit', larger premises were used to house groups of older people and provide for their recreation. An early example of the former is at Figure 4, which shows a photograph of two new developments by Aged Cottage Homes (SA) Inc. An example of group housing is the purchase and alteration of premises to accommodate 39 persons in share rooms, Figure 5. A third early example, Figure 6, shows the purchase and conversion of premises to include a recreation hall and 42-bed infirmary. Rural South Australia also received grants soon after proclamation of the legislation.

The 'infirmary' was a common part of larger accommodation at the time and, along with some private hospitals, evolved into the separate category of nursing home. As an aside, in 1997, changes to legislation allowed providers of residential hostel-type aged care to claim higher recurrent subsidies for nursing home care to enable 'ageing-in-place', that is, not to require residents whose condition had

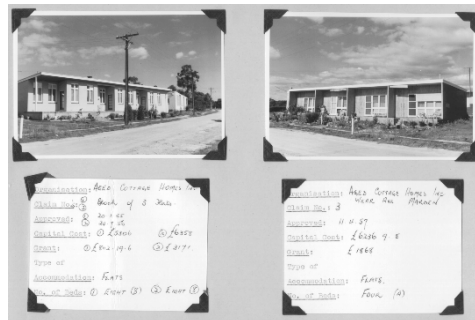
¹¹ See http://www.ahuri.edu.au/research/policyproject/pdf/fact4_historygovt.pdf 'In 1944, the Commonwealth Housing Commission examined existing housing conditions as well as the expectation of having to house thousands of ex-servicemen returning from war. The Commission argued for direct intervention on the grounds that 'private enterprise, the world over has not adequately and hygienically been housing the low income group'. This resulted in the first Commonwealth State Housing Agreement (CSHA) and the first time State and Federal governments intervened directly in supplying housing to low-income families.' Australian Housing and Research Institute (2001). Australian Housing Policy Project. Fact Sheet 4: A Brief History of Government Involvement, Australian Housing and Research Institute. 2002.

¹² There is also a reference to the South Australian government having a 1:1 subsidy a year before the Commonwealth. See page 1 of Gilgen, M. (1971). *Aged Persons Welfare*. Adelaide, Commonwealth Department of Social Security: 7..

¹³ That Dame Patti was influential is not in doubt. ACT *Hansard* refers to her role recorded in Sir Robert's book *The Measure of the Years*. 1970 Cassell. However, Kewley describes a longer period of debate on responsibility for aged persons accommodation, back to 1941 Kewley, T. H. (1973). *Social Security in Australia 1900-72*. Sydney, Sydney University Press..

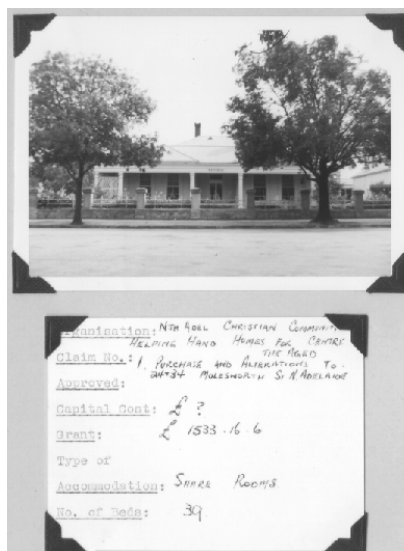
deteriorated to move to a nursing home. This is not unlike the situation in 1958 where there was, at least, 'ageing-on-site'.

Figure 4 Self-contained units 1955-7.

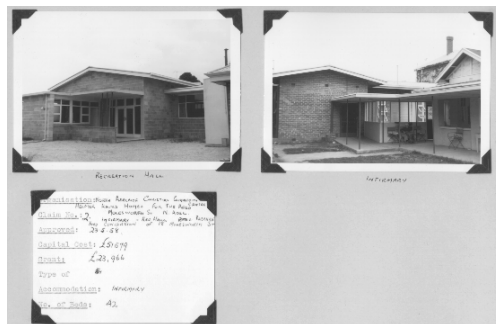


Aged Cottage Homes Inc. January 1955, £5,306 block of 3 flats, no address. 1957, block of four flats.

Figure 5 Share accommodation.



North Adelaide Christian Community Centre Helping Hand Homes for the Aged. 24 and 34 Molesworth Street North Adelaide

Figure 6 Infirmiry and recreation hall in 1958

North Adelaide Christian Community Centre Helping Hand Homes for the Aged 18 Molesworth Street. Capital cost £51,579 and grant, £23,966.

Capital subsidy began as 1:1, became 2:1 in 1957, 4:1 from 1974 and ceased in 1997 except for special needs groups.¹⁴ Grants were limited to 2:1 by cabinet decision from mid-1976. The *Aged Persons Hostels Act 1972* was novel legislation as it had a three-year limited time of operation. It provided 100% capital subsidy to qualifying organisations that had built accommodation without subsidy and/ or with 1:1 subsidy. The eligible number of places to be subsidised was determined by a formula based on the numbers of places that had been constructed at those lower levels of subsidy.¹⁵ The intention was to encourage the construction of hostels, a lower cost and, for a significant proportion of nursing home residents, a more appropriate form of accommodation and care.

Organisations raised their capital funds in part by accepting donations, also known as ‘entry contributions’, ‘key money’, ‘bonds’ etc. The Commonwealth began to regulate donations through an agreement with organisations aimed initially at protecting the welfare intent of the real estate. A long-standing clause, however, was that residents’ donations that were placed into a capital fund for future accommodation were not subject to the regulatory clauses of the agreement.¹⁶ The practice of accepting or requiring donations had the opposite effect, that is, of subverting the welfare intent of the legislation.

The 1970s saw the construction of large institutional buildings, where the Act had envisaged conditions approaching, as near as possible, ‘normal domestic living’. Capital subsidies are an input to aged accommodation and provided the main vehicle for scrutiny by the Commonwealth. Staff selection criteria in the Commonwealth included ‘the ability to read building plans’, and Commonwealth staff

¹⁴ An end to capital grants under aged care act, and their transfer to the housing portfolio, was recommended by the McLeay Report in 1982. Commonwealth of Australia (1982). *In a Home or At Home*. Canberra, House of Representatives Standing Committee on Expenditure: 143.

¹⁵ The legislation provided 100% capital subsidies, up to a maximum per place, for two places for every person accommodated without subsidy and for one person for every two previously subsidised at 1:1 in the period 1954-7.

¹⁶ Introducing the recurrent subsidies to hostels in 1969 the Hon. W. Wentworth, Minister for Social Services, noted that: ‘While in some cases there is what is called a ‘donation’ made by the first resident, we estimate that nearly two-thirds of the beds are being provided in the first instance on a charitable basis, free of ‘donation’ and that as more come up for second and later occupancy this proportion will increase’.

scrutinised every plan for accommodation. Commonwealth project staff therefore saw more accommodation design than anyone else in the sector. Discussion and negotiation were primarily with administrators in the 1950s and primarily with architects in the 1970s. By the 1980s Commonwealth staff preferred to include nursing staff in these discussions. Staff in the South Australian Office in 1980 took an active interest in normalization theory, which advanced valued roles for marginalised groups¹⁷. Scrutiny of plans shifted from an interest in fittings (eligibility for subsidy) to disability access and then to include an interest in programs inside the building and how the fabric supported valued roles for older persons. For example, plans were assessed for the ability of residents to have family visits with some privacy, how ablutions were to be completed with dignity, dealing with deaths, and how the layout, furnishings and colour supported people with dementia. Institutional style buildings with large numbers of 'beds' were out of favour and, when new applications were assessed for funding, such proposals rated a lower priority than more domestic-scaled proposals for the available capital grants. Staff had little enthusiasm to repeat institutions with long corridors, one of which had a main corridor the length of Adelaide oval. The debate included the affordability of more domestic scaled accommodation but selected organisations and architects were also interested in more home-like environments¹⁸. From 1997, the requirement shifted to certification of the building, after its construction, with no requirement for scrutiny of plans, that is, a move away from input controls. Staff in the SA office certainly felt, nevertheless, that attention to the fabric, both by South Australian organisations and in the South Australian office, had resulted in a very high proportion that passed certification standards (an output control) introduced in 1997.

Legislation

The name of the legislation reflected the changes to the program from its capital origins. In 1974 the *Aged Persons Homes Act 1954* became the *Aged or Disabled Persons Homes Act 1954*, to include both residents 'permanently incapacitated or blind' and 'the disabled' in existing accommodation. In 1991 it became the *Aged or Disabled Persons Care Act 1954*, reflecting the shift to recurrent funding and this in turn was replaced by the *Aged Care Act 1997*, substantially completing the move away from capital funding.

¹⁷ Wolfensberger, W. (1972). *The Principle of Normalization in Human Services*. Toronto, National Institute on Mental Retardation through Leonard Crainford, Wolfensberger, W. (1992). *A Brief Introduction to Social Role Valorisation as a High-Order Concept for Restructuring Human Services*. Syracuse N.Y., John Annison, Deakin University.

¹⁸ See, for example, the 1984 Brian Kidd design of the Aldersgate Nursing Home in Adelaide: 'which created an enabling and independence-creating environment. This project introduced a residential approach to aged care design and led to the publication of *Hostel Design Guidelines* written by Kidd and published by the Commonwealth Department of Community Services and Health (1988)'. <http://www.congresswest.com.au/IFA/kidd.html>

Summary

Substantial detail has been omitted from the brief overview of capital subsidies, such as the provision of day therapy centres, upgrading and other grants, land, the impact of high inflation in the 1970s, the role of state governments and the limited capital subsidies available from 1997. Nevertheless the broad outline shows that Commonwealth capital involvement in aged persons' care and accommodation shifted over time from welfare housing, to housing and nursing care, to promote the lower level of 'personal care', and subsequently withdrawing from a universal capital component – promoting user pays. The emphasis shifted from control over inputs to accountability for outputs and outcomes. South Australians played a significant role in development of policy, in the rapid development of infrastructure and in changes to the way that infrastructure promoted a valued social environment for residents.

Recurrent

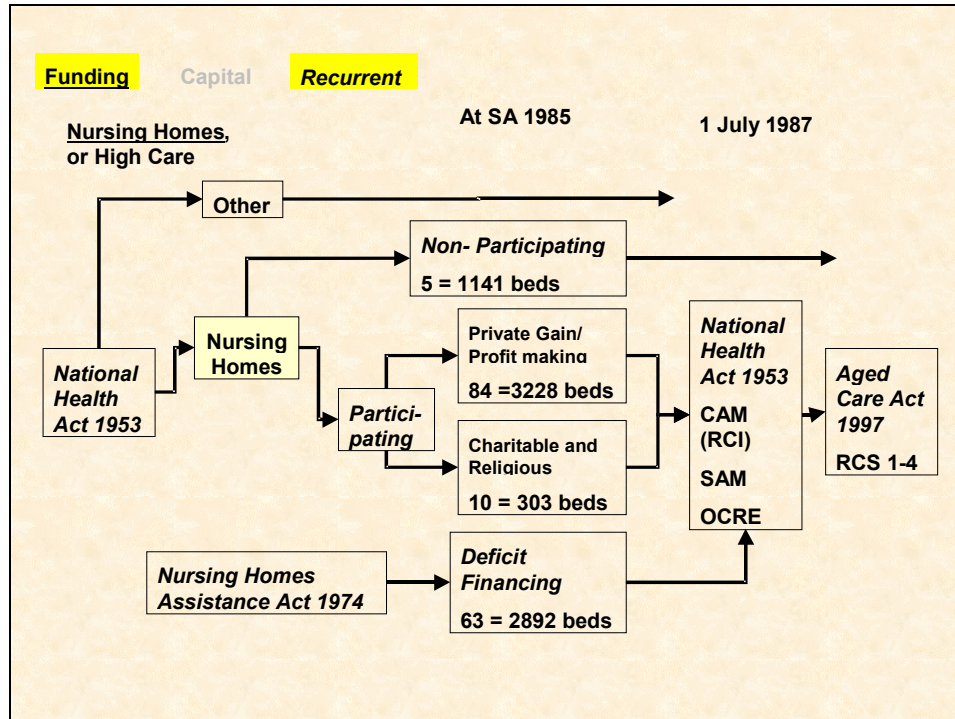
A referendum in 1946 gave the Commonwealth powers to legislate for the provision of sickness and hospital benefits. Benefits were paid to private hospitals, many of which later became nursing homes. An old, suede-backed ledger in the Department records hospital approvals from 1946. It shows Helping Hand Hospital, 24 Molesworth Street, with the earliest record, in February 1957, which is recognisably for benefits paid in respect of an infirmary run by an aged care housing organisation. This was after the introduction of the *National Health Act 1953*, a large piece of legislation, and much amended over time. A specific 'nursing home benefit' was introduced in 1963. Payments for aged care nursing were made under the National Health Act until 1974 when new legislation, the *Nursing Homes Assistance Act 1974* enabled not-for-profit organisations to have operating deficits covered by the Commonwealth for nursing homes and day therapy centres. The accounting for such operation was subject to 'validation' by Commonwealth officers with financial expertise. The two Acts operated together until 1987, with not-for-profit organisations able to elect to remain under the *National Health Act 1953* and accrue 'surpluses'. A broad diagrammatic history of the legislation and a breakdown of the distribution of high care places in South Australia in 1985 are shown at Figure 7. 'Non-participating' homes were those operated by the State Government. Nursing home payment rates included an 'ordinary' rate and, 'where a patient requires and receives intensive nursing home care', a supplementary benefit¹⁹.

In 1987 there was a major change to funding arrangements. Non-government nursing homes moved to a modular funding system with three components: the Care Aggregated Module (CAM), Standard Aggregated Module (SAM) and Other Cost Reimbursed Expenditure (OCRE). This system was an input-based funding mechanism, which separated the nursing and personal care subsidies, CAM, from the accommodation or hotel costs, SAM. Nursing homes had to account for the care inputs so that they were all actually spent on nursing and personal care, and financial monitoring by the Commonwealth continued. OCRE covered costs that were difficult to standardise between homes, such as insurance.

¹⁹ Kewley provides more detail for the period to 1978. Kewley, T. H. (1980). *Australian Social Security Today Major developments from 1900 to 1978*. Sydney, Sydney University Press.

CAM was calculated by classifying residents according to a Resident Classification Instrument (RCI), which had five levels. In 1997 'high care' became levels one to four of an eight-category system called the Resident Classification System, or RCS. The RCS has had one revision since its introduction.²⁰

Figure 7 High care, or nursing home care, recurrent funding



Hostel recurrent payments began in October 1969 with an amendment to the Aged Persons Homes Act.²¹ Personal Care Subsidy (PCS) was paid in respect of every resident over 80 years, each 28 days. This changed in 1973 to include, with those over 80 years, those residents assessed by the home as requiring and receiving certain care. South Australian individuals were prominent in two reports, in the 1980s, which looked at funding for hostels.²² The point was made that: 'the role of hostels as caring

²⁰ Cuthbertson, S., E. Lindsay-Smith, et al. (1998). *Review of the Resident Classification Scale*. Canberra, Commonwealth of Australia Department of Health and Family Services.

²¹ The purpose was to prevent unnecessary admission to a nursing home. See second reading speech by The Hon W. Wentworth, Minister for Social Services: 'The Government is deeply concerned at the fact that many people, whose only infirmity is the frailty of advancing years, are sometimes being admitted to nursing homes and other similar institutions unnecessarily. ... We have reached the conclusion that if these people were given an adequate standard of personal attention they could continue to live normal lives, which is what they want, for many more years. This Bill accordingly introduces a new benefit to be known as personal care subsidy, which will be paid to organisations providing approved personal care services in what is generally known as hostel accommodation'. (HoR).

²² Banks, J., R. Jackson, et al. (1980). *Report of the Joint Working Party on Hostel Accommodation*. Canberra, *Affiliation of Voluntary Care Agencies*, Department of Social Security.: 75, Commonwealth of Australia (1983). *Hostels for the Frail: A report to the Minister for Social Security by a Joint Working Party consisting of Department of Social Security, Australian Affiliation of Voluntary Care Associations, Australian Council on the Ageing, Department of Health*. Canberra.

facilities rather than as accommodation is not recognised sufficiently'.²³ This marks a point of departure from a program that commenced primarily as welfare housing. The 1983 report also raised some continuing concerns: lack of assessment for entry, concern with access for 'the financially disadvantaged' and, the costs of care for 'the confused'. The Working Party: 'agreed that hostel care should be available primarily to the financially disadvantaged', that is, to continue a welfare model but in both care and accommodation rather than just accommodation. For this reason the not-for-profit representatives: 'did not favour extension of Commonwealth subsidies to the private hostel sector'.²⁴ Personal Care Subsidy was increased and a lower Hostel Care Subsidy introduced. Hostel subsidies to the for-profit sector were introduced in 1990.²⁵ The recommendation for a higher level of subsidy for residents with dementia was not adopted, until 1991, when a targeted 'dementia grants program' was phased out.²⁶ A Personal Care Assessment Instrument (PCAI) was introduced in 1991, with three categories of care and a basic rate, which took the funding system closer to the nursing care classification instrument. The 1990-1 changes were another marker of the transition of hostels from welfare to a general health service. The completion of the commodification of aged care came in 1997 when hostel and nursing home systems were combined into one, eight-level payment system. This had add-on payments for various factors in both high and low care homes such as for financially disadvantaged residents, viability, enteral feeding, oxygen and, pensioner rent.

Changes in recurrent funding for hostels are illustrated in Figure 8 and the amalgamation of the two separate systems is illustrated in Figure 9.

²³ Commonwealth of Australia (1983). *Hostels for the Frail: A report to the Minister for Social Security by a Joint Working Party consisting of Department of Social Security, Australian Affiliation of Voluntary Care Associations, Australian Council on the Ageing, Department of Health*. Canberra, 7.

²⁴ *Hostels for the Frail*, 9.

²⁵ Note that the minister responsible for aged issues was the Hon. Peter Staples, Minister for Aged, Family and Health Services, but that the Hon. Ralph Willis, Minister for Finance, introduced the Bill. Commonwealth of Australia (1990). Community Services and Health Legislation Amendment Bill (no.2) - Second Reading, Commonwealth of Australia, *Hansard*, 3624 (HoR).

²⁶ The Bill was introduced by the Hon Peter Staples, Minister for Aged Family and Health Services. Commonwealth of Australia (1991). Health and Community Services Legislation Amendment Bill - Second Reading, Commonwealth of Australia - House *Hansard*: 2696.

Figure 8 Low care, or hostel care, recurrent funding

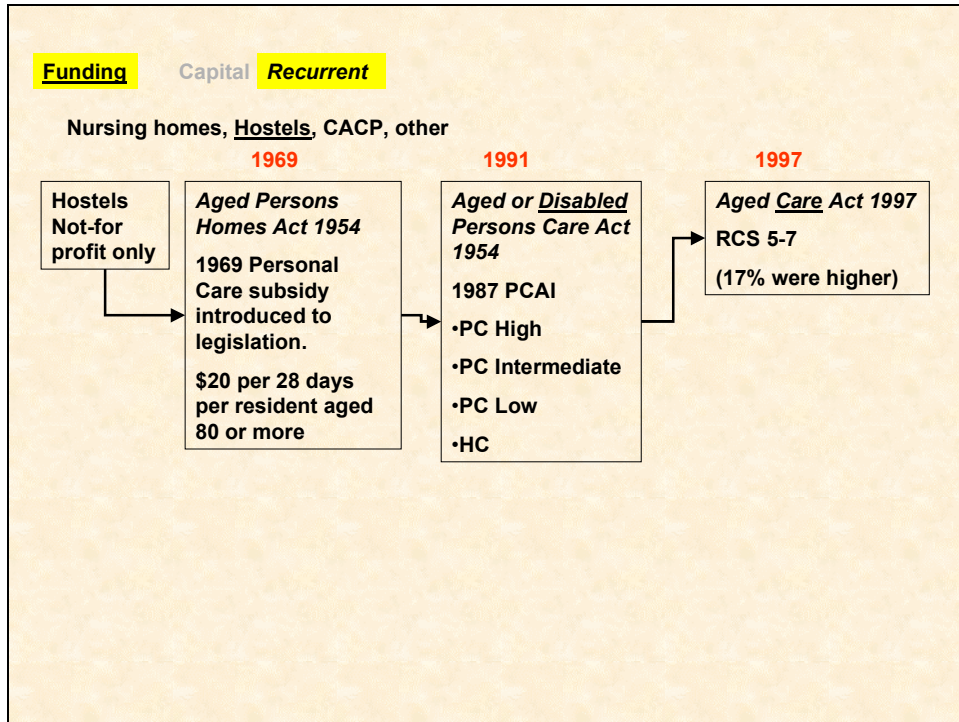
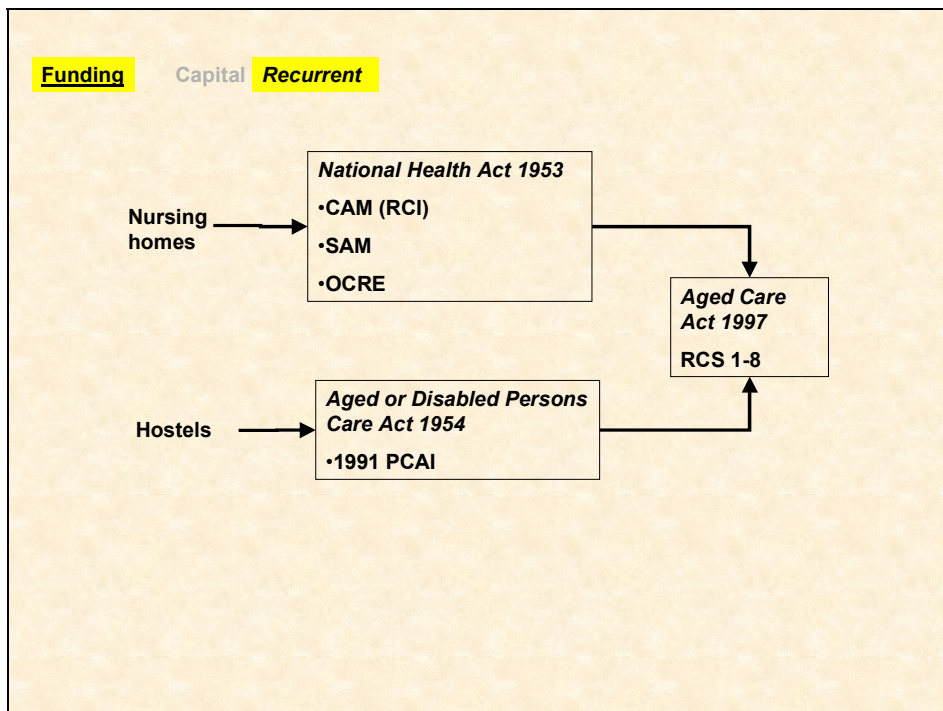


Figure 9 High and Low care recurrent funding brought together in 1997



Care at home

I have outlined the broad Commonwealth legislative involvement in aged care for people at home at Figure 10. The intention is to show that several pieces of legislation were rolled into the Home and Community Care (HACC) Program in 1985. HACC also had its formal origins in the McLeay Report in 1982.²⁷ The broad Commonwealth approach has been to deliver home-care services in conjunction with, and via, the states and territories. There are two notable exceptions. Day Therapy Centres were originally funded under nursing home legislation (for capital and recurrent) and Community Aged Care Packages had their origins as a substitute for hostel residential care. There are nevertheless a number of programs funded by the Commonwealth outside program-specific legislation, see Table 1.²⁸

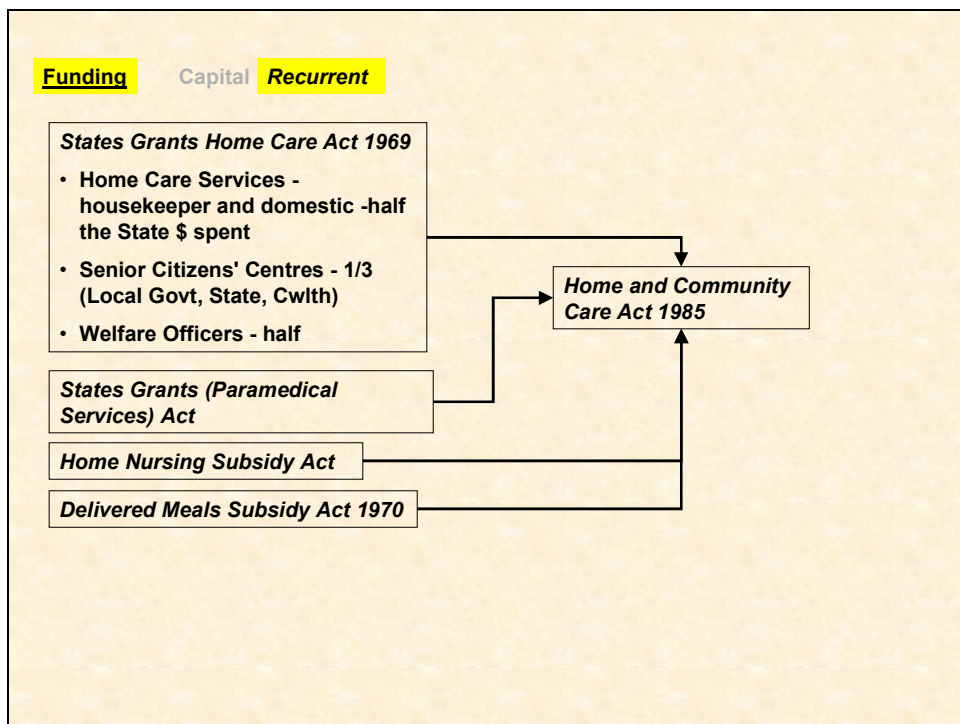
Table 1 Commonwealth funding for aged care outside legislation

	PROGRAM
Advocacy	Dementia Support
Aged Care Assessment Program	Home And Community Care
Assistance with Care and Housing for the Aged	National Respite for Carers Program <ul style="list-style-type: none"> • Resource Centre • Aboriginal Flexible Services • Commonwealth Respite for Carers
Commonwealth Carelink Program	Psychogeriatric Care
Day Therapy Program	User Rights

²⁷ See page viii: ‘... the basic reason for the predominance of institutional care (is) the relatively generous financing for construction and operation of nursing homes compared to the resources available for alternative forms of community care’. The report recommended an ‘Extended Care Program’. *In a Home or At Home*, 143

²⁸ Funding for these programs is provided through appropriation bills. For information on the process see Portfolio Budget Statements 2001-2001 Health and Aged Care Portfolio Budget Initiatives and Explanations of Appropriations Specified By Outcomes And Outputs by Agency, Budget Related Paper No. 1.11. The part relevant to aged care is Outcome 3 Enhanced Quality of Life for Older.

Figure 10 Community Care Legislation



What was different about SA?

A parochial view from the SA Office of the Department is that South Australia is an innovative state for aged care and accommodation. One explanation proffered for this being the case is that the not-for-profit sector had built a large base from which it drew both the experience to inform funding policy and the critical size to test new ideas. Some data outlined below support the first premise - that the not-for-profit sector has larger aged care organisations in SA. This may be because state governments led by Tom Playford from 1938-1965 preferred to act on social welfare issues via voluntary agencies and so favoured their growth. My view is that the SA Office was responsive to certain issues and to new ideas in the community and that partnerships between the office and a variety of agencies were important. That these were mainly with the not-for-profit sector may have been by construction; the means available, such as capital grants, were only available to the not-for-profit sector at the time. I have recalled some examples below from my own knowledge. This is not a comprehensive account and I apologise in advance for not including your favourite.

The office, in partnership with two lead aged care organisations, adopted the controversial 'normalization theory' from 1981. This emphasised the maintenance of valued roles for residents requiring assistance, and changed the way people thought about care programs and residential design. A later national policy that contained some similar themes was called 'Least Restrictive Alternative'.

In the early 1980s it became clear that certain groups were having difficulty accessing and participating in aged care. Demographic data on post-war migrants from non-English speaking countries and family reunification showed a rapidly rising aged population of people with different language and cultural needs. A partnership, between the then South Australian Ethnic Affairs Commission and the SA Office, worked with many communities to create a number of new models. In 1987, after two years' work, two smaller communities, whose countries of origin had been historical opponents, used the capital subsidies scheme to purchase and upgrade an existing nursing home within the Eastern suburbs. Since the Eastern suburbs were above national benchmarks, and access was not exclusive, general community access in the area remained at or above the national standard despite the service drawing residents from a much wider geography.

In another example, two not-for-profit organisations led some thinking about the triggers for entry to hostel (low) care, arguing that a proportion of people who entered hostels could, for the want of some specific assistance, have remained at home. The idea was trialed initially to the organisations' self-contained unit residents and became 'Hostel Options', which led directly to the later national program of Community Aged Care Packages, as a substitute for residential hostel-level care²⁹. Similarly, the same organisations later piloted nursing home care at home, known as the EACH program, which is now being extended.³⁰

The SA Office invested in some research on the issue of rehabilitation and the hospital/nursing home nexus in 1999, again actively participating with the state government and service providers aiming to minimise unnecessary transfers from hospital to residential aged care. Rural South Australians benefited from a dispersed model of nursing home care where country hospitals in a region catered to the volatility of demand in smaller populations by 'moving' the residential service to the resident's nearest hospital. Ageing-in-place', where nursing care was added as needed to residents of hostels was being trialed in South Australia and Western Australia when new legislation generalised the concept in 1997. Apart from accommodation, the South Australian government had led the nation with its Domiciliary Care and Rehabilitation Services prior to HACC, and an innovative multidisciplinary approach to aged care assessment, which was called 'The Ageing Project', at Netley.³¹

²⁹ For more information see *Evaluation of hostel options care packages*, McVicar and Reynolds Pty Ltd. Canberra: Australian Government Publishing Service, c.1993. 176 p. (Aged and community care service development and evaluation reports (ISSN 1038-426X); no. 8.) ISBN 0644289848.

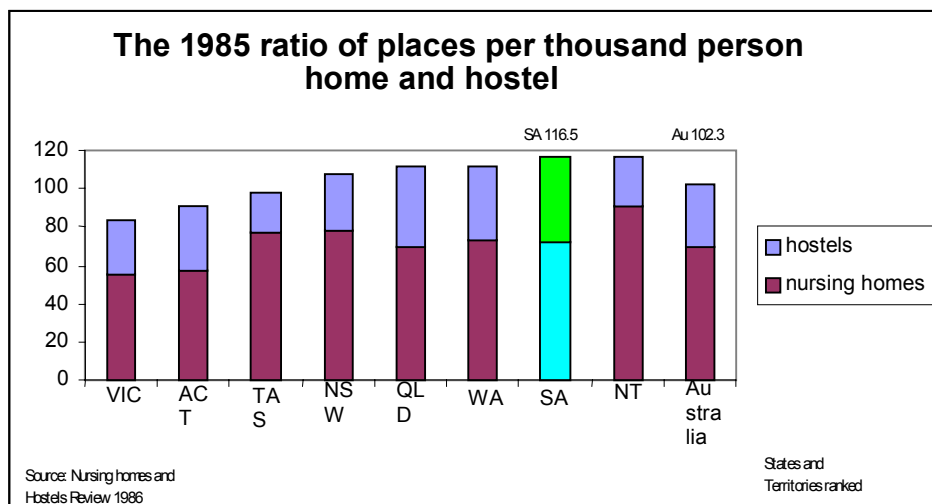
³⁰ Extended Aged Care at Home

³¹ For an on-line list of resources see <http://www.nla.gov.au/guides/aged/policy.html>. Included in this are two publications that may provide additional information about these projects:
South Australia. Committee on Accommodation, Domiciliary Care and Medical Rehabilitation for the Elderly. *Report of the Working Party to the Committee on Accommodation, Domiciliary Care and Medical Rehabilitation for the Elderly*. Adelaide: South Australian Health Commission, 1978. 462p. Chairman: J.W. Joel. ISBN 0724353771

Supply

South Australia has had an historically high supply of residential aged care. In 1985, when the background work for planning benchmarks was undertaken, SA had the highest state ratio of places per thousand people seventy years or more.³² This ratio was the combination of a slightly higher ratio of nursing homes but a much higher ratio of hostels, which were operated solely by the not-for-profit sector. See Figure 11, Figure 12 and, Figure 13. One consequence was that when the national benchmark was set at the then national average of places per thousand persons aged 70 and over, the addition of new places to South Australia slowed to a trickle as SA waited for the population over seventy years to ‘catch up’, and the ratio to fall to the benchmark, see Figure 14.³³

Figure 11 Supply of places 1985 by jurisdiction



McDonald, Anne. *The Centre Network Project: approaches to the issue of co-ordination*. Marlestone, SA: The Ageing Project, South Australian Health Commission. 1986. 116 p. ISBN 0724338950.

³² Commonwealth of Australia (1986). *Nursing Homes and Hostels Review*. Canberra, Department of Community Services and Health, 129.

³³ The rapid expansion of HACC services from 1985 needs to be taken into account when interpreting the impact of slower growth in supply of places in SA.

Figure 12 Supply of places 1985 by jurisdiction – nursing homes

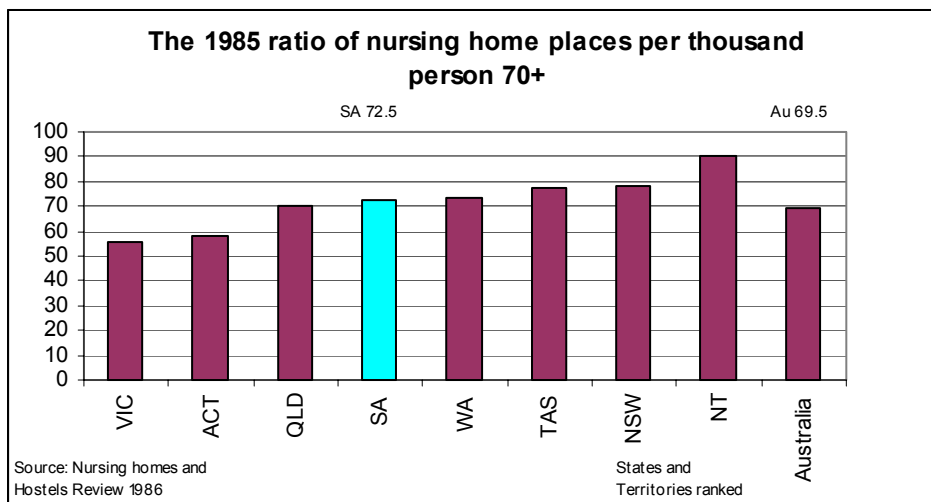


Figure 13 Supply of places 1985 by jurisdiction - hostels

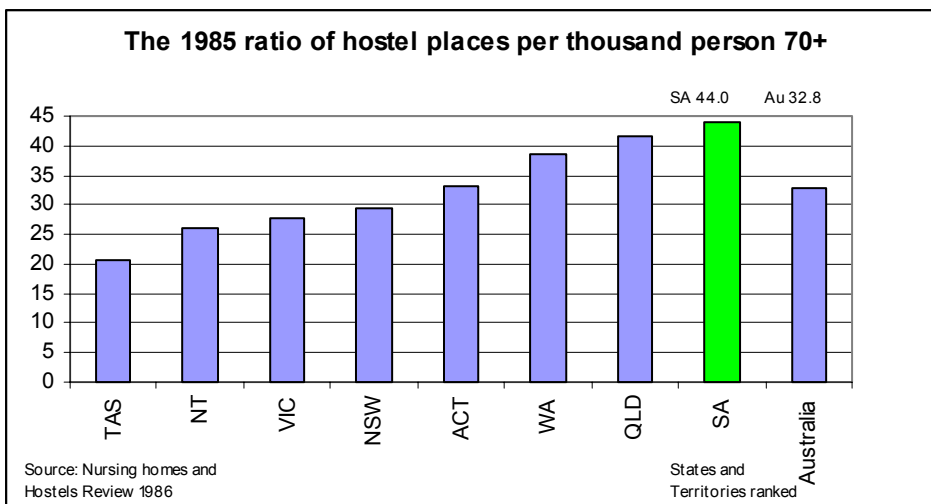
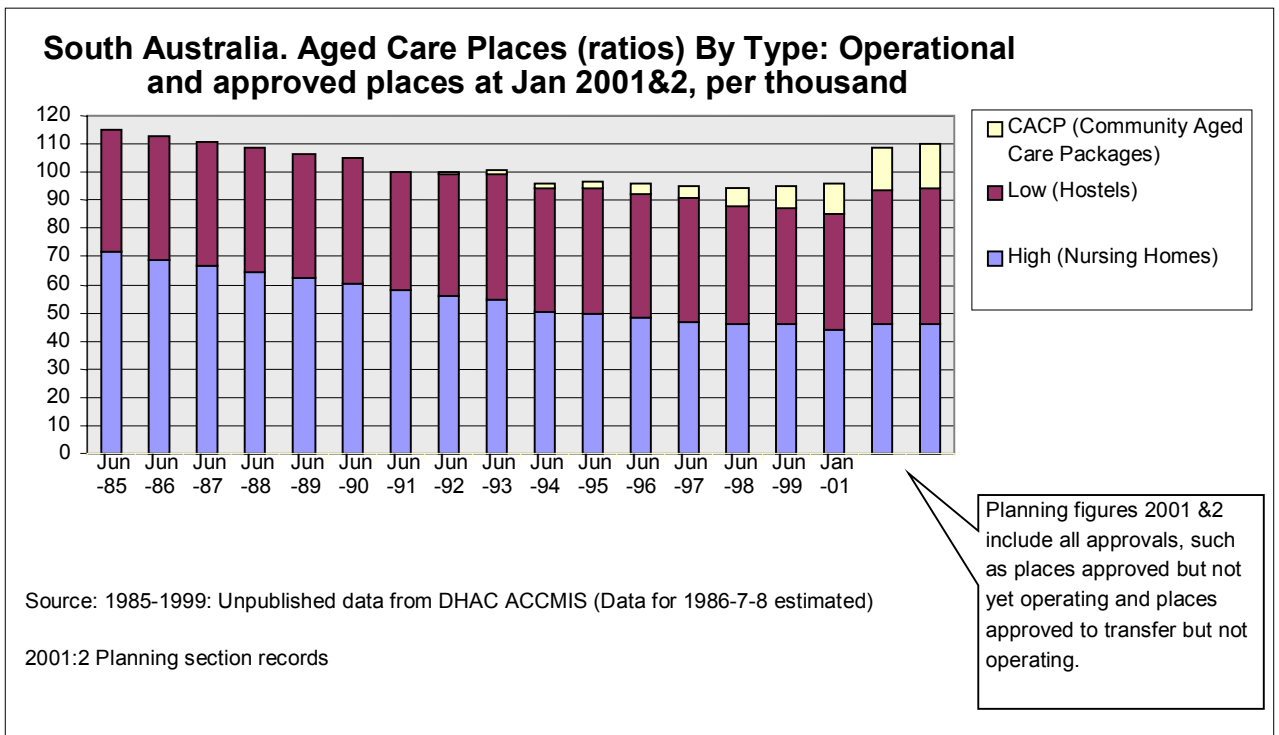
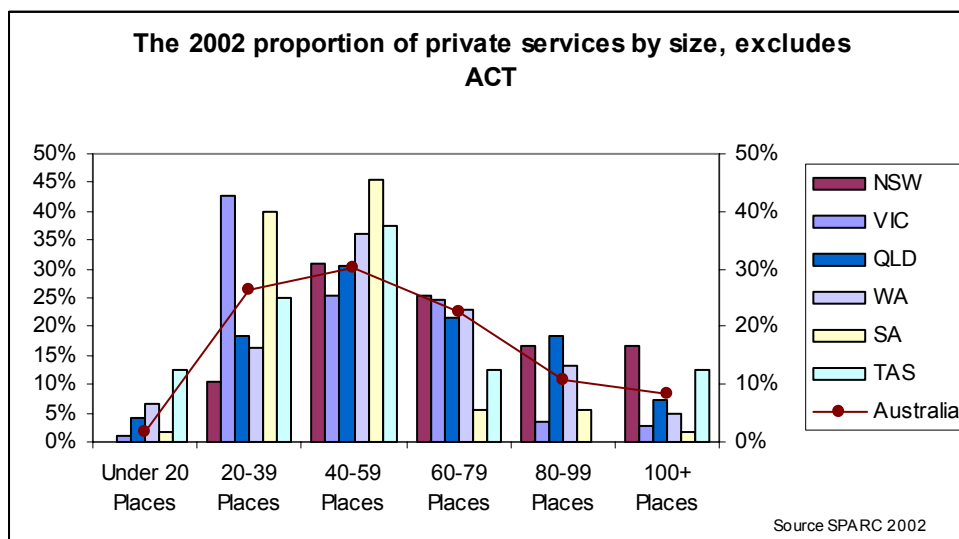


Figure 14 Supply of places 1985 – 2002 South Australia



The size of the not-for-profit sector, both as a proportion of total services and the scale of individual not-for-profit providers is different in SA. The not-for-profit sector includes sub categories of religious, charitable, local government and state government providers. In order to compare the not-for-profit with the for-profit, or private, sectors it is simpler therefore to take the not-for-profit sector as the complement of the private sector. The private sector in South Australia has a higher share of the services in the 20-59 size range. The not-for-profit has, therefore, the larger share of large homes, 60 places or more, and of the homes with fewer than 20 places, see Figure 15. The not-for-profit sector organisations that ran nursing homes under a deficit-financing system were also eligible for deficit-financing of Day Therapy Centres (DTC), and South Australia had a third of the national total of DTCs in 2002, much greater than its share of older people which was about 10%.

Figure 15 The mix of private and not for profit homes 2002



Conclusion

Since the mid-1950s, the purpose of Commonwealth funding for aged care has shifted from housing, with a welfare orientation, to commodified nursing and personal care services. Funding arrangements reflect the changes with a separation of accommodation costs, which have become the individual's responsibility, from personal care costs, which are subsidised. Regulatory mechanisms have shifted from input controls, via capital funding and agreements with organisations about the use of real estate, to service agreements and monitoring of standards by an agency separate from the funding agency. The shift in purpose from welfare is evident both from changes in legislation over time and, from a South Australian perspective, the administrative organisation of the Commonwealth in relation to aged care. One constant, however, has been a significant contribution to aged care policy by South Australians and South Australian not-for-profit organisations in partnership with the State Office of the Commonwealth.

The not-for profit sector in South Australia has a higher proportion of larger homes than the national average.

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THE WORK OF ANGLICARE SA IN AGED CARE SERVICES IN SOUTH AUSTRALIA SINCE CA 1950: ³⁴.

Brian Dickey

This paper, drawing on research for a history of Anglicare SA, tells the story of the efforts of the Church of England (later the Anglican Church of Australia) in Adelaide to develop a capacity to provide assistance to aged people in need of accommodation and associated supports. It is a case study in the issues confronting all non-government caring agencies in the last fifty years as they sought to address the social problems presented by aged people anxious about a roof over their heads and the necessary help to go with it. Sometimes issues of bricks and mortar dominated, sometimes questions about the quality of the care being delivered. Finance was always a problem, as was the supply of people to run the services, whether as volunteers or as paid staff. Careful thought had to be given (or should have been) to the nature of the social needs to be served. And there was always the principal agent in the story, the Commonwealth government, delivering funds and imposing increasingly rigorous standards of accountability.

Let us begin the story by briefly noting the existence of the Church of England Men's Hostel, conducted from 1929 to 1945 by the Church of England men's Society of the diocese of Adelaide. It provided accommodation for homeless men, first at Port Adelaide and then in the city. It was a sort of precursor of what was to come.

Now let us turn to the aged care project launched by the Social Welfare Committee of the Anglican diocese of Adelaide launched after the end of World War Two. Archdeacon Houison, in his 1943 Commission report to synod on the diocese's welfare opportunities, highlighted the challenge to deliver aged care. He argued strongly that 'Homes for aged and infirm church people' should be established 'with as little delay as possible'. He sought both homes where care could be given to aged people, and 'homes of three or four rooms for those who 'are yet

³⁴ This paper draws on the text of chapters Nine and Ten of Brian Dickey, *Giving a Hand. A History of Anglicare SA since 1860*, to be published by Anglicare SA later this year.

able to look after themselves'. He reminded synod that one sensitive category of needy applicants would be former church workers, both men and women, whose annuity arrangements with the Clergy Superannuation Fund would yield only modest payments.³⁵

Anglican leaders were well aware their church lagged behind others in the provision of such services. The Methodist Church had, either directly or through its Central Missions, already begun to offer aged accommodation in at least two sites in Adelaide. Houison himself drew attention to the work of the Little Sisters of the Poor in their home at Myrtle Bank.

Whatever the diocese attempted would need money, and could well attract a lot of support once the war was over. It was not long before the Social Welfare Committee, which had grown out of Houison's report, turned its attention to the challenge that he had issued. By February 1946 the Committee had identified an 'old folks home' as its next objective, and moved to appoint a working committee to focus on that task with a first gift of £500.³⁶ This committee advised Bishop Robin in May 1946 that a diocesan home for the aged should be established forthwith, structured to cater for women, for men, and for married couples. It urged that a site be found where new buildings could be erected, rather than purchasing an existing building. It also asked for permission to launch a public appeal for funds supported by a proper organising team.³⁷ All of this the bishop approved and in August 1949 the Committee bought 'Brig House', Grange, from the Red Cross, for £9000.

St Laurence's Home

A major community fundraising effort was launched, which was given a great deal of publicity by the *News*.³⁸ This appeal was a great success: £3500 was subscribed by the date of the opening, 18 February 1950. About 3000 people wandered that day through the two hectares of gardens and the large bungalow house. Bishop Robin dedicated the site, publicly named it St Laurence's Home, and thanked everyone involved. Twenty-nine residents moved in, at first occupying dormitory-style cubicles. The financial momentum was maintained over the rest of the year so that the borrowed money was paid off by September 1951.

Aged care facilities such as St Laurence's Home attracted widespread community support. Unlike financial aid to poor families, these projects could be expressed in bricks and mortar, and the residents could all be regarded as respectable and worthy recipients of aid. They

³⁵ SJ Houison, Report of Social Welfare [Commission], 1943, 9-10.

³⁶ Social Welfare Committee [SWC], mins, 6 July 1945, 8 Feb, 5 April 1946.

³⁷ 'Establishing a diocesan home for aged people', report in SWC mins, at 10 May 1946. Bishop's report to Synod, 2 Sep 1946, *Year Book [of the diocese of Adelaide] 1946-47*, 108.

were after all the hardworking parents of supporters. People found it easy to relate to such an appeal. Substantial donations flowed over the years to permit a series of wings to be built at Grange, and also to help cover the running costs of the facility.

Building plans dominated the affairs of the St Laurence's Committee over the next forty-five years. Makeshift arrangements ruled at first. The attached garage and its next-door room became accommodation for three men. A variety of arrangements permitted increased accommodation: doors were made, partitions moved, a verandah enclosed. The local council were sympathetic and cooperative.³⁹ The oratory became a staff bedroom.⁴⁰ The Committee quickly learnt of another need: 'because of illness among a number of residents a single room had been set aside as a sick room'. But one old lady who had become helpless was removed by her relatives at the direction of the Committee.⁴¹ The notion of an 'old folks home' had now to include the recognition of further physical frailty implying some degree of regular care. As yet, the management Committee could not cope with this level of service. The term 'nursing home' had not yet been used.

During late 1951 the 'Bennett cottage' was under construction, and Mrs Bennett (the donor) was identified as the first occupant.⁴² Then, following on from the closure of their hostel, the CEMS took up the Social Welfare Committee's challenge to raise funds for Grange. The members offered the £2228 they had raised as a contribution towards the erection of a 'men's wing'.⁴³ With additional funds from Mrs Bennett, the 'Men's Wing' was designed, built and finally, blessed and opened on 25 May 1953.⁴⁴ The building housed that same clientele of otherwise homeless men whom the city hostel had served a generation earlier. It reflected 1950s standards, not those of the depression, with small but adequate single rooms, after a more crowded bunk-bed solution was rejected. The dining and bathroom facilities were communal, as was the agreeable lounge-room, where no doubt a great fug of smoke went up after dinner. Because of changing standards and attitudes, that wing was not used during the 1990s. It was demolished in 2001.

Money was then identified in 1953 for a women's wing, including one of many generous gifts from Mrs Dorothy Mortlock. What transformed the plans for this extension was action,

³⁸ SWC Clipping Book 1948-53 contains several pages of clippings from the *News*, *Sunday Mail* and *Advertiser* advocating the appeal during Feb 1950, often illustrated with handsome pictures of Brig House. Opening covered in *Sunday Mail* 18 Feb 1950.

³⁹ St Laurence's Committee [StLC], mins, 6 Jan, 25 May 1951.

⁴⁰ SWC, Report 1950, *Year Book 1950-51*, 36.

⁴¹ SWC, mins, 7 Jul 1950, 29 Jun 1951.

⁴² StLC, mins, 5 Oct 1951.

⁴³ StLC mins, 26 May 1950.

⁴⁴ StLC, mins, 25 Aug 1950; SWC, mins, 7 Mar 1952, 5 Jun 1953, *Guardian* April 1952.

first by the state government, and then the Commonwealth government. Playford's Liberal Country League government offered a pound-for-pound subsidy towards the cost of the building. Then the Commonwealth government's 1954 *Aged Persons Accommodation Act*, with its generous offer of two pounds subsidy for every pound contributed by the welfare agencies for building programs designed to accommodate aged people, came into force. While the Committee found it had to review its fee structure in 1954 after another age pension increase, when they learnt they could apply for this government subsidy they more than doubled their financial target for the building program to about £50 000. True, there were constraints imposed by the new Act, but these were mainly consisted of bureaucratic procedures, forms and guarantees.

St Laurence's was one of many institutions around Australia to benefit during the 1950s and 1960s from this gold rush of federal money for aged care.⁴⁵ With state government funds in hand and plans drawn, the first part of the 'women's wing' took its place at St Laurence's by 1955, yielding forty new places. Extensions to the men's wing followed in 1956 with federal funds. Cottages for couples were now also in view, so ready was the Commonwealth with its money.⁴⁶ These could be funded by donations from prospective residents, or bank loans, which in effect meant that St Laurence's had only to find 25 per cent of the total cost of the new projects.

This slashing pace of growth took its toll on the staff. Mrs Warnes, the first matron, took several months sick leave in 1952, but soon after her return was asked to resign. In part this was because the Committee realised they now needed a trained nurse to take charge.⁴⁷ It would be one of many staff crises which the St Laurence's Committee had to surmount over the next fifty years. Developing workable procedures and good relationships, growing in an understanding of professional skills, making good choices, offering decent pay, measuring the nature of the working conditions would all become crucial parts of the role of the Committee.

Another issue was the accounting and general management tasks the project was generating. The solution adopted in 1956 was to appoint a resident manager alongside the matron.

At the same time, the Committee was moving towards the erection of an 'infirmary' or what was soon to be called around Australia a 'nursing home'. It would provide long-term bed

⁴⁵ StLC, mins, 26 Mar, 7 May, 4, 25 Jun 1954, 4 Feb 1955; *Guardian* Jun 1954 (Bishop Robin supports appeal).

⁴⁶ StLC, mins, 6 April 1955.

⁴⁷ StLC, mins, 9 May, 2 Oct, 4 Nov 1952, 24 Feb 1953, 20 Aug 1954 (special meeting).

care for immobile residents. It was predicated on new Commonwealth legislation extending the subsidy arrangement to such more medically-oriented services.

Joy MacLennan, Director of the Church of England Social Welfare Bureau, warned the Committee to think carefully about the rules of admission to this ‘infirmary’: would the new facility be purely for residents already living in the home, or could residents be admitted direct? A generous bequest from the Haeusler family of £20 000 permitted action. The Haeusler Infirmary was opened on 31 August 1958 with twenty-five beds.⁴⁸ For the next decade these beds were by law available only to existing residents.

The Management Committee turned vigorously to the continuing expansion of the Grange site. They began planning for an extension to the women’s wing for twelve extra rooms.⁴⁹ A further four beds for the infirmary were also planned. By late 1961 they learnt that the Commonwealth Department of Social Services had approved their plans and would again offer a capital subsidy. It was also likely that Cottage Homes Inc, another community group of long standing which was involved in providing aged accommodation mainly as small homes, would contribute £8000 to the base amount which would attract the Commonwealth subsidy. The extension was opened on 16 June 1962 with eighteen beds as a result of the aid from Cottage Homes, and so it was named the ‘Cottage Homes Wing’.⁵⁰ Eighteen months later another long-cherished ambition was realised when space in Brig House was dedicated as a chapel. It attracted a generous measure of donated furnishings. Like all such institutional chapels, it remained more a challenge than an effective instrument of Christian ministry. Many residents continued to worship with old friends, while others were too frail or just not interested to make use of this finely presented room. For some, no doubt, it became a focus for their ongoing Christian life.⁵¹

The issue of increasingly frail residents continued to worry the management Committee. The Department of Social Services advised that they could not hold chronically sick persons permanently. The infirmary was still only just that for securing the health of the nearly 100 residents at Grange. As Joy MacLennan pointed out: ‘the Church must look elsewhere to fulfil its obligations to such people’. The Committee took note of this advice, but realised that there remained the question of when are people ‘permanently infirm?’ and then what was to be done

⁴⁸ StLC, mins, 14 Sep, 7 Dec 1956, 9 May, 4 Jul, 7 Aug 1958 (the Henley & Grange Council objected to the erection of a mortuary).

⁴⁹ SWC, mins, 4 Nov 1960, 4 Aug 1961; StLC, mins, 29 Nov 1961.

⁵⁰ StLC, Annual Report 1962, *Year Book 1962-63*, 198.

⁵¹ The chapel was dedicated on 13 Dec 1963. The gifts are listed in StLC, Annual Report 1964, *Year Book 1964-65*, 221.

with them? They did not want to repeat the necessity of asking fearful relatives to remove such people from St Laurence's.⁵²

The other matter that was demanding attention was the increasing burden of running costs. The superintendent showed that at the end of 1962, while residents' fees averaged £4 18s 1d a week, it was costing £7 1s 11d for each of the 93 residents and the further 11 living in the flats. The immediate response was to increase the weekly fee being charged. It should also be pointed out that the Commonwealth had introduced a benefit of an extra £1 a day for nursing home residents. It is not clear if Gray took this additional funding paid to such residents against the fees they were charged in these calculations. Nevertheless, for the time being the annual shortfall of £5167 would have to be filled by bequests – £8835 in 1962-3 compared with £3916 in 1961-2 – and fundraisers such as the annual badge day (£969). Gray showed that the average age of residents was rising into the eighties and that the average length of stay was 3.4 years for the women and 3.6 years for the men. This gave some clue to the total scale of the task that was now being addressed.

Karingal

Since the principal area of extra cost lay in the infirmary, the news that the state government was willing to offer a subsidy of a pound-for-pound towards the capital costs of such infirmaries, or 'nursing homes' as theirs, was a great encouragement to the Committee. They began to look at possible sites for a new facility where they could provide 'care for aged persons needing permanent hospitalisation'. They also opened discussions with executives at the *Advertiser* about a fundraising campaign. They were looking at a total facility cost of about £56 000.⁵³ It was in November 1963 that 'Karingal' (West Hindmarsh) was offered to them by the Committee of the Youth Hostel.⁵⁴ With the assurance of state government subsidy, planning went ahead during 1964.⁵⁵ The Committee struggled to attract a matron, eventually appointing Miss MV Wyatt after agreeing to pay above award wages and make clear that she would have full responsibility at the site. The facility opened on 7 March 1965 and the first thirteen patients installed.⁵⁶ The Committee promptly began negotiations with both state and Commonwealth governments to expand Karingal to a viable size.⁵⁷ The federal government announced in

⁵² SWC, mins, 8 Dec 1961.

⁵³ StLC, mins, 27 Nov 1962, 3 May 1963.

⁵⁴ StLC mins, 19 Nov 1963.

⁵⁵ StLC, mins, 4 Feb, 7 Jul, 17 Nov 1964.

⁵⁶ St LC, mins,, 16 Feb 1965; StLC, Annual Report 1966, *Year Book 1966-67*, 221. There is a gap in the records of St Laurence's for 1966, around the time of the death of HH Gray and the takeover of the accounts by the accountant John Crosland, who was eventually appointed treasurer to the Social Welfare Committee on 7 Oct 1969.

⁵⁷ *Advertiser*, 23, 24 Feb, 1, 3 Mar 1966.

August 1966 that it was willing to subsidise existing aged accommodation providers for nursing home beds beyond the need to provide infirmary support.⁵⁸ This meant that Karingal could be expanded by fifteen beds with \$46 000 from the Committee (bequests and the like) and \$54 000 from the Commonwealth.⁵⁹ The extensions at Karingal were opened and dedicated on 5 November 1967.⁶⁰ With further funds in hand, a wing with seventeen beds was added and opened on 30 August 1969.⁶¹

With these changes achieved, Robert Rye could write in his first report as manager that Grange and Karingal had reached their full development, with 114 cottage and hostel residents at Grange, together with 26 nursing home residents and another 51 at Karingal. Much satisfaction was being expressed by many aged care agencies, including St Laurence's, at the introduction of a further cash payment by the Commonwealth. This was the 'personal care subsidy' of an additional \$3 a day towards the care of those residents over the age of eighty. At St Laurence's 70 per cent qualified for this new grant. Consequently, Rye and Crosland (the treasurer) were hopeful of balancing the books in 1970 without the aid of bequests, which had remained so important right through the 1960s.⁶² By 1972 a plateau had been reached in the volume of residential services, which would prove to be the peak of the numbers in these two facilities.

All Hallows, Westbourne Park

With Grange and Karingal fully developed, with an ever-growing waiting list and with a sense of urgency emanating from the Department of Social Services, the leaders of the Anglican aged care project (like many other agencies in Adelaide) set about searching for possible locations for a major new aged care facility.⁶³

In part the issue was foreseeable funds and in part available bed licences, which were now transferable among agencies. Various negotiations went on with a view to transferring such rights to the next St Laurence's site. In May 1971 the Committee bought two acres (0.8 ha) at Westbourne Park for \$33 000.⁶⁴ Probably the continued pressure from Joy MacLennan, with her

⁵⁸ T. Kewley, *Social Security in Australia 1900-72*, Sydney, University of Sydney Press, 1973, 2 ed, 472.

⁵⁹ SWC, mins, 4 Nov 1966; StLC, Annual report 1967, *Year Book 1967-68*, 286.

⁶⁰ *Advertiser* 6 Nov 1967. The federal Minister for Health, Dr Forbes, reported that the total number of approved nursing home beds had risen in Australia from 25 535 in 1963 when the daily rate subsidy had first been introduced, to 35 537, an increase of 39 per cent. The significance of such federal funding, including the new nursing home capital subsidy, was obvious.

⁶¹ *Advertiser* 31 Aug 1969.

⁶² SWC, Annual Report 1970, *Year Book 1970-1971*, 254-263.

⁶³ StLC, Executive and Finance Sub-Committee [E&F SC], mins, 17 Mar, April 1970. Its members were Bishop Lionel Renfrey (chair), Dr David Game, Joy MacLennan, TBS Tuckwell, Mrs LT Ewens, RJ Rye, JC Irwin, and John Crosland.

⁶⁴ StLC, E&FC, mins, 16 Jun, 3 Sep, 6 Nov 1970, 30 Mar, 7 May 1971.

reports of rising numbers of applicants pushed the Committee to act. As will become clear, the new site was never satisfactory, always crowded, always imposing limitations and compromises on what could be achieved. One of its few redeeming features was that the Methodist Church located one of its Resthaven facilities next door, eventually permitting some sharing of services.

Once more plans and money were needed. A modest gain came with the expansion of the Grange infirmary to 44 beds which were blessed by Bishop Reed on 3 November 1972. It would now be known as St Laurence's Nursing Home. But this only seemed a stop gap.⁶⁵ There was continuing pressure to meet rising costs. There were anxious deputations to the federal Liberal government, and then even more excited discussions as the election loomed and both parties made aged care a major election issue.⁶⁶ By February 1973 the plans for Westbourne Park provided for a 50 bed nursing home, and a 72 bed hostel, both to be subsidised by two-for-one federal grants. Plans for self-contained residential units were deferred.⁶⁷

Meanwhile, costs at Grange and Karingal were rising. The new ALP federal government responded by offering deficit financing for running costs, but also by announcing that it would exercise greater control over the creation of new nursing homes by taking account of what it regarded as the regional needs for such beds. The increase bureaucratic effort demanded by the Commonwealth department almost overwhelmed Rye and Crosland. Detailed forward financial statements on prescribed government forms had to be prepared before any new money flowed from Canberra. The plans for the Westbourne Park site were rejigged to meet the Commonwealth government's new demands. By June 1975 the first maintenance grants of \$44 193 for Grange and \$35 667 for Karingal were received, and the capital subsidy of \$574 875 for a 50 bed nursing home at Westbourne Park was advised.⁶⁸

Almost immediately questions were posed in the Committee. There was concern about the control of medical policy at the homes. Who decided the length of bed stay: the medical officer? The matron? The social worker? Who controlled the domestic staff? Robert Rye's response was a thoughtful call for a clear decision on the aims and function of the new nursing home at Westbourne Park. Would it be required to take residents from the hostel at Grange, or would it be available for direct admissions? These and other queries which Rye posed were relevant, but unfortunately he had shown that he tended to become overwhelmed by detail and it

⁶⁵ StLC, E&FC, mins, 18 Aug 1971, 17 Jan, 6 Oct 1972.

⁶⁶ SWC, mins, 24 Jul, 1 Sep 1972; Rye's report 26 July.

⁶⁷ SWC, mins, 9 Feb 1973, Annual Report 1973, *Year Book 1973-74*, 260..

⁶⁸ Planning group 1 Aug 1973; manager's report 23 Aug 1973, 20 Apr, 20 Jul 1974; Director's report Jun 1974, Jun 1975; SWC mins, 4 Oct, 13 Dec 1974, 4 Apr, 9 May, 6 Jun 1975; E&FC mins, 5 Nov 1974, 3 Jun 1975.

is unlikely that the Social Welfare Committee or its executive listened carefully to what he was saying on this occasion.⁶⁹

Inflation was a constant enemy. It was being driven by wage rises handed down by federal tribunals and also by the mid 1970s oil crisis. While deficit funding was helping, the accounts were always in arrears, and often the subject of government query. The penalty for such a close reliance on federal funding was plain. Nor would the politicians allow unlimited funding of hostels based on 'donations' by potential residents.⁷⁰

The new nursing home at Westbourne Park was opened in October 1976. It was named 'All Hallows', and set up independently of Rye's operation at Grange. Peter Webb, administrative secretary at the Social Welfare Bureau was now appointed in addition to manage Westbourne Park. Sister Keen was appointed sister-in-charge at All Hallows and given the task of preparing it for its first residents. Eventually the funding agreement for costs at All Hallows was settled with Social Services as the new bed-ridden patients settled in.⁷¹

Once more the Social Welfare Committee was pressing for more government funds, this time to expand at Westbourne Park. They found it hard to stomach Senator Guilfoyle's (minister in the Fraser Liberal-National government elected in 1975) decision not to include them in the next three-year plan.⁷² Could cottages be built instead, or something without federal funding?

The manager moved to cut costs by reducing nursing and domestic support, and regularly raising fees in line with pension increases. The Grange fete for 1978 raised \$5096. Rye also introduced 'regethermic' ovens for food preparation and reheating. It was an example of organisational cost control. Likewise, Ensign Linen service was monitored closely and a switch of suppliers was contemplated. A move to more efficient laundry equipment at Karingal was likely to save \$500 per month. Rye also installed time clocks to replace the previous attendance books. All these steps were reminders of the shifts to which the agency was still being put.⁷³

Peter Webb organised his first fund-raising fete at All Hallows in 1977, the first of many. One minor and persistent problem was the inadequacy of car parking at the Westbourne Park site, a problem that has never been solved at that crowded, suburban location.⁷⁴ His main concern was to find funds and opportunity for the much-desired expansion. It appeared that there would be no Commonwealth funding for the site before 1981-82. Webb therefore asked

⁶⁹ SWC, mins, Aug 1975, Rye 22 Aug 1975.

⁷⁰ Manager's report 26 Sep 1975; SWC mins, 10 Oct 1975, 9 April 1976.

⁷¹ SWC, mins, 6 Feb, 9 April, 7 May 1976; Webb report to E&FC, Sep 1976.

⁷² Nov 1976. Webb's report to E&FC.

⁷³ Rye report to E&FC, 28 Nov 1977, 23 Oct 1978, 23 Mar 1979; *Advertiser* 26 Nov 1977.

the Social Welfare Committee to consider a donor-funded project, but this was rejected as against existing policy, which tended to have a charity-based outlook which could not stomach the idea of residents 'buying' entry to care.⁷⁵

But it was remarkable what a substantial gift could do to those views. Harry Morrow (Joy MacLennan's successor as Director) advised the Committee in August 1980 that Mrs Dorothy Mortlock had made two substantial donations, one for Karingal, the other for the flats being thought of at Westbourne Park. Not long after, she underwent surgery. Harry Morrow reported her death and the bequest (eventually of \$250 000) at the September meeting, together with another \$100 000 from Miss M Williams.⁷⁶

Not only could the Committee now buy land next to Karingal to permit expansion there, they were now also willing to plan for the 'independent living units' at Westbourne Park. The initial costing hovered around \$150 000. This soon blew out to \$180 000, but now the Committee had accepted the notion of resident-funding, even though this meant the project would not be eligible for Commonwealth subsidy. They set the contribution from individual residents at \$8000 refundable and \$4000 non-refundable. This move to resident-funding was a shift for the Social Welfare Committee, which had been focussing since 1947 on delivering support to relatively disadvantaged people. But it was a shift actively encouraged by the Commonwealth government, which was finding its ongoing capital commitment to aged care an increasing burden.⁷⁷

With tenders called late in 1979, what was to be called 'Mortlock House' was built and occupied during 1980, costing \$300 000, of which the Committee had contributed about a third. Cottage Homes Inc contributed \$18 000 towards the cost of one unit.⁷⁸ Peter Webb soon found he had residents in significant need of support and, after protests to the Department of Social Services, Mortlock House residents were allocated Personal Care Subsidy funds.⁷⁹

Planning then went ahead for the long-delayed hostel units. There would be 72 of them, and eventually a day care service unit as well. Tenders were called early in 1981, and residents began moving in during April 1982. The buildings were officially opened on 19 June 1982. They had cost nearly \$1.2M, of which the Committee had contributed about \$124 000. The

⁷⁴ Webb, report June 1977 to E&FC.

⁷⁵ SWC, mins, 6 Apr 1979; Director's report April 1979; Webb's report to E&FC, June 1979.

⁷⁶ Morrow, report Aug 1979; SWC, mins, 6 Jun 1980.

⁷⁷ SWC 10 Aug 1979; Webb, report to E&FC, Aug 1979; Reference Panel 5 Oct 1979.

⁷⁸ Webb, report to E&FC, Aug 1980.

⁷⁹ Webb, report to E&FC, 27 Jan 1981.

Mortlock and Williams bequests had been crucial.⁸⁰ Once more however, the layout was tight, the standards of space per resident modest, with little effective communal space that did not see staff and visitors tracking through it.

Northern expansion

Even as these arrangements were being put in place, other long held ambitions were being pursued. Peter Webb advised the Social Welfare Committee in May 1980 that plans for a nursing home and hostel in the Elizabeth area were in hand, based on likely Commonwealth capital funds in 1982/83.⁸¹ In part, this move was driven by the adoption by the Commonwealth government of bed ratios for aged care places driven by census data. There were now, in the opinion of the Commonwealth bureaucrats, enough aged care places available in the older parts of Adelaide, but there was an acute need for more places in the now ageing population of the Elizabeth area. The Uniting Church's Helping Hand had begun plans for a facility at Parafield Gardens.

Negotiations by the Social Welfare Committee about possible land on Blamey Road, Elizabeth East to be purchased from the South Australian Housing Trust went ahead quickly. They were sponsored not only by Senator Chaney of the outgoing Liberal-National government, but by Dr Neal Blewett, member for the area and likely to be the relevant minister in the incoming Hawke Labor government. At the same time, an important bequest from the Penny family was being dealt with through the Supreme Court. Negotiations continued with the Department of Social Services on the Elizabeth project, which was now being planned in the first instance as an 'owned' nursing home or 'participating nursing home' in the departmental jargon. This meant the Social Welfare Committee would in the first instance accept responsibility for the full costs. In turn, this would permit the use of the Penny bequest, and the subsequent repayment by the Commonwealth of an equivalent amount. Sketches were developed for a nursing home with 51 beds in what had become the standard Social Services-approved footprint for such buildings: an H-shaped block with mainly four-bed rooms and central support facilities.

With the necessary approval from Diocesan Council, building began in November 1982 at the Blamey Road site. The foundation stone was laid on 26 February 1983. After a brief panic that the project would fail to gain eventual Commonwealth funding and some furious follow-up lobbying, the promise was received amid cheers. Indeed, it appeared likely that funding for the

⁸⁰ Webb, report to E&FC, 2 Feb, 31 Mar, May 1981, 29 Mar, 15 Apr 1982.

⁸¹ Webb, reports, 30 May, 30 Aug 1980, 6 Feb, 31 Jul, 26 Nov 1981; Director's report March 1982; SWC mins., 2 April 1982.

hostel and day-care components would also be available in due course. Occupation began in August 1983.⁸²

Planning then went ahead quickly to exploit the promise of federal funding for the associated 72-bed hostel and then the day-care unit at Blamey Road, which would eventually be called Canterbury Close. From about this time Dr David Game, a GP on the Committee and much interested in the care of aged people, convened the senior nursing sisters for regular discussions about common problems.⁸³ Fuller recognition of the status of these nurses came in mid 1984 when the Department of Social Services made it clear that the ‘Sisters in Charge’ should be treated and paid as directors of nursing, for which the department would now pay.⁸⁴

David Game and Harry Morrow produced a statement outlining what they called the ‘Philosophical Basis for residential and Nursing Care’. For the first time, it placed stress on the agency’s responsibility to deliver ‘a warm and caring environment’, to ‘respect the dignity of each individual’ and to ‘provide buildings that enhance residents’ and patients’ lifestyle’. It spoke of independence, being non-directive and supportive, and of ‘employing staff who empathise with the residents’. It was long overdue, and perhaps was the first move away from an accounting and institutionalised model of the way the care on offer was conceived.⁸⁵

Brian Hunter, as the new head of the Social Welfare Council’s Aged Care Division, and clothed with executive authority in a manner that none of his predecessors had possessed, moved to address a variety of issues. He identified accounting weaknesses and began to train the local managers to prepare their costing plans as required by Social Services. Past annual accounts of monies due from the department were resolved, yielding about \$400 000. Air conditioning was installed at All Hallows, a marked improvement in conditions in that crowded building. Plans were laid to erect a further hostel at 24 Norseman Avenue, Westbourne Park, as another set of resident-funded independent living units. He also began the planning for the hostel at Blamey Road, now to be for 40 units.⁸⁶

Commonwealth funding was tighter. One response was to introduce means-tested fees for hostel occupants linked to movements in the age pension.⁸⁷ Even worse, St Laurence’s was

⁸² Reference Cttee re Elizabeth 15 April 1982; Webb report 28 Sep, 25 Oct 1982, May, Nov 1983; St Laurence’s Administering Authority [St L AA] mins, 5 Oct 1982, 1 Feb 1983; SWC, mins, 3 Dec 1982; L&A West Cottage Homes Inc to SWC 15 Feb 1983; Director Feb 1983.

⁸³ Webb, report to Aged Care Services Division Cttee, 28 Nov 1983.

⁸⁴ St L AA, mins, 5 June 1984.

⁸⁵ Paper at SWC mins, Mar 1984.

⁸⁶ Job Specification, Aged Care Services Division, mins, Mar 1985; Hunter, reports Mar, Jun, July, Aug, Nov, Dec 1985, Mar 1986.

⁸⁷ SWC, 11 Dec 1987 (Circular letter to residents).

faced with a massive increase in its workers' insurance premium, of perhaps an extra \$380 000 annually.⁸⁸ The Department of Social Services was scathing about the size of this impending increase. While Hunter addressed this problem from the accounting end, the real issue was the quality of work practices and supervision at the various homes and hostels. No one appeared to be willing to accept responsibility for safety, few were trained to address it, and most had little understanding of the issues. Over the next few years Hunter, his successor Harold Bates-Brownsword, and then Gerard Menses as chief executive of what became Anglican Community Services, launched a major assault on poor work practices. They succeeded in reducing accidents and hence insurance premiums by many thousands of dollars.

Another constraint developed by the Commonwealth department as it struggled to apply stronger systems of accountability was the introduction of the 'Care Aggregate Model'. It required agencies to record staff time committed per resident against an overall budget allocated by the department. It implied a much tighter rein on the use of costly staff time. As means of controlling expenditure on nursing homes it might have satisfied the department, but in practice among the St Laurence's homes it meant on average a possible reduction of 25 per cent in income, and some enormous new administrative challenges for the directors of nursing. Much as they and the Aged Care Committee complained, such constraints did not go away. The managers did indeed have to think smarter. What George Martin of the Port Adelaide Central Mission and a major force in the development of aged care services described as the 'good old days' were over.⁸⁹

Brian Hunter and Mary Gould (DON at the Grange nursing home) took a fresh look at the worn, modest facilities in the hostel section at Grange (even though Gould was only responsible for the nursing home). The single rooms, shared bathrooms, and sometimes dangerous floor surfaces concerned them, again on safety grounds. Gould was well aware that, despite this, Grange was a popular site, with a strong sense of belonging among its hostel residents. While redevelopment was put on the agenda, it might remove facilities for disadvantaged men and women who had nowhere else to go. Meanwhile, Gould introduced a new layer of staff called enrolled nurses in her nursing home, drawing on her previous experience as a nurse tutor. She arranged for appropriate nursing assistants to undergo training both on the job and at Modbury Hospital. It was cost-effective, for they were paid on a lower scale to registered nurses. It also identified women with potential for future job enhancement.⁹⁰

⁸⁸ SWC, mins, 13 Feb 1987.

⁸⁹ Aged Care Services Divn, mins, 1 Mar 1988. Dickey & Martin, *Building Community*, 159.

⁹⁰ Aged Care Services Division, report to ACS, 4 Oct 1988; Gould interview 30 Apr 2001.

All Hallows also demanded attention. Some specific complaints led to a searching confidential review which eventually involved Archbishop Rayner. Challenged by the findings of this review, the Aged Care Division and Anglican Community Services, as it now was called, struggled to restate and apply their commitment to client priority and respect. The Aged care Division Committee adopted the idea of site management teams, which were to report monthly. Hunter claimed that most of the morale problems had gone, but did call for the appointment of a Division personnel officer, which would remove that portion of the Administrator's duties and implicitly improve personnel management. It had not proved to be Hunter's strong point. Chaplaincy and social work plans took even longer to work through.⁹¹

Nursing homes were now subject to survey and assessment by the Commonwealth Department of Community Services and Health with respect to standards of care and operation. A preliminary report required the replacement of white uniforms for registered nurses. Dr Game did not like the alternative of what he called the 'jeans uniform' but which was probably the widely adopted and convenient nurses 'culotte' dress, which Mary Gould was happy to adopt at Grange. The first monitoring team, which included Mary Gould as the professional representative from the agency, reported on All Hallows. It made a series of assessments against accepted standards of nursing home practice, and found many practices at All Hallows requiring 'urgent action' – for example with respect to 'informed choice', support for 'mobility and dexterity', 'freedom of movement', 'comments/complaints', 'security' dignity', 'privacy' 'activities & variety', 'risk' and 'safety'.

Under the rules governing these reviews, the initial report was subject to comment and review by the agency being reported on. Hunter claimed in his comments to the Division Committee that action was being taken, but the criticisms in the report were substantial. Anglican aged care in Adelaide was being called to account at the beginning of the 1990s. It proved to be a difficult process for established staff to learn to cope with new demands and new procedures. The Committee appointed Gould as a consultant to assist the staff at Westbourne Park in the implementation of the report. It also called for nursing review Committees to maintain quality assurance at the various facilities. The visits of these Commonwealth assessment teams brought repeated calls for change over several years until directors of nursing began to realise the benefits they could bring to the operation of their services, especially those at Grange and Westbourne Park which were admittedly less than best practice.⁹²

⁹¹ Aged Care Services Division, mins, 7 Mar, 4 April, 6 June 5 Dec 1989, 2 Feb 1990.

⁹² Hunter to Aged Care Services Division, 22 Feb 1988; Standards Monitoring Team, DCS&H to All Hallows NH, 10 Jan 1990 in Aged Care Services Division Ctee, mins, Feb 1990; Gould interview, 30 Apr 2001.

Seeking coherence in the 1990s

Meanwhile, the overall coordinating body had been experiencing changes in the late 1980s. By 1990, with a new name of Anglican Community Services (ACS), and a new chief executive, Gerard Menses in succession to Harry Morrow, the management of its aged care services attracted the attention of the Council of ACS. The generic name of 'St Laurence's' was dropped, and was now to apply only to Grange.⁹³ This meant 'All Hallows' became a common title for the Westbourne Park site, despite the confusion this created when people were really referring to Norseman House or Mortlock House, which nominally retained separate street addresses. Blamey Road eventually became 'Canterbury Close', matched later by Dutton Court, and St Laurence's Court at Grange.

Harold Bates-Brownsword's report in September 1991 covering his first five months in post as head of ACS Aged Care Division was the first time the Council had received a thorough review of their aged care project since the simpler days of Joy MacLennan.⁹⁴ He reminded the Council that there were now more than 600 clients, 464 of them resident, as well as many day therapy visitors. There were 409 paid staff. He wanted Anglican aged care to move from its present laggard position to the front of field. He roundly asserted with characteristic directness that currently a conservative approach focussed on residential care dominated the Division's work. 'The day the last brick was laid at Elizabeth Hostel in September 1987,' he claimed, 'the building was five years behind the best overseas and Australian experience'. Bates-Brownsword stated his preference for keeping people out of nursing homes, and for creating a domestic environment within them. As he reviewed each site, there were more home truths. 'In hindsight', he asserted, 'Norseman House should not have been built on this site'. He wished the Westbourne Park site could be opened up, for residents were cut off from the rest of world. At Elizabeth he wondered if the remaining land could be sold for housing to benefit the complex. Karingal possessed 'a certain charm' but it was 'higgledy piggledy'. He looked forward to the fulfilment of the Grange redevelopment plans. He also deployed demographic data on Grange residents which showed that the age range was from 75 to 94, there were 3.2 females to 1 male, 81% were financially disadvantaged, 73% were Australian born, and they were predominantly Anglo-Saxon. Plainly the residents were older than those surveyed twenty years earlier.⁹⁵ Overall, he called for better thought: why be conservative, he asked. Why were there not ACS representatives on advisory committees of government? What effort was being invested in enhancing resident rights? Finally and most tellingly, he asserted that the service generated no observable 'Christian difference', and that it should.

⁹³ Aged Care Services Division, mins, 24 May, 7 Dec 1990.

⁹⁴ Aged Care Services Director, report to ACS Council, Sept 1991.

⁹⁵ Aged Care Services Division to ACS, 11 Oct 1991.

The Council worked carefully through their aged care policy in March 1994. The Council adopted a long series of resolutions tending towards flexible, client-oriented services, encouraging the help of relatives, and engaging participation in community activities. The theoretical teaching underlying these policy outlooks included Maslow's 'hierarchy of needs', the idea of 'social role valorisation', and a 'developmental model of life-task resolution'. While jargon to many, these ideas helped give a clearer picture of how to imagine older and frailer people could still be aided to live their own lives with dignity and as much competence as they could muster. The Council also sought to recognise the importance of location and Anglican links in the character of the services they envisaged. They knew that they needed as much goodwill and support from the Anglican community as they could muster.⁹⁶

These discussions and some difficult staffing matters pointed towards the decision to appoint a General Manager, Residential, which would be a Director of Nursing post, and a Manager, Community Services (Aged). Julie Chenery was subsequently appointed to the former post. Harold Bates-Brownsword fulfilled a planning role for some months before leaving ACS. There would be managers for the four residential sites chosen from among the senior nurses. Priscilla Binks took charge of the community work among the aged, which linked both with her social work management tasks, and her duties as Public Officer of Laura and Alfred West Cottage Homes.⁹⁷ But this arrangement did not last long, mainly because 'ageing in place' required close coordination across the whole range of options. Chenery therefore assumed responsibility in 1995 for the whole residential and community aged care division.

Community aged care

Priscilla Binks oversaw the initial development of the organisation's home care services for aged people. The first venture, the Home Support Program, delivered short term care to elderly people in their own homes. Funded through the Commonwealth government's newly established Division of General Practice program, and reflecting the strong respect which local doctors had for St Laurence's at Grange, this program was a joint venture between Anglican Community Services and the Adelaide Western Division of General Practice, to which the program was later transferred.

In 1993 the organisation was successful in gaining licences from the Commonwealth to conduct a Community Aged Care Packages (CACPs) program. The Western Living at Home program was established, once more based at Grange. Providing long term support to elderly people who wished to remain in their own homes but who require hostel-level care, and

⁹⁶ ACS Council, mins, 4 Mar 1994

⁹⁷ CEO, report to ACS, 4 March 1994.

undertaken by a wide variety of agencies around Australia under Commonwealth supervision, CACP programs came to be a particular strength of ACS. In 1995 a second, the Northern Living at Home Program, was established at Elizabeth, followed in 1997 by the Inner City Aged Care Program, to be discussed in a moment. By mid-2002, Anglicare was licensed and funded by the Commonwealth government to care for 247 people in their own homes in and around Adelaide.⁹⁸ It had taken up this new Commonwealth service provision eagerly and successfully, along with many other agencies around Australia. From the Commonwealth government's perspective, the CACP program was much cheaper than funding hostel accommodation. From Anglicare's perspective, the satisfaction of seeing aged people continuing in their familiar surroundings and in touch with their local communities was an added bonus which reinforced the quality of the service they were delivering.

Gerard Menses agreed with the criticism of the design used at Westbourne Park and Blamey Road which Harold Bates-Brownsword had so bluntly expressed. He was attracted to the 'social role valorisation' model of resident management, which focussed on high recognition of the residents as people and therefore directed staff to adopt strategies to fit. There was also talk coming from officials of the Commonwealth department and others of 'ageing in place'. This to some extent was a reversion to the attitudes of the 1950s, with a focus on the evolving needs of the individual rather than the institution in which they were housed. It was based on a more careful control over assessment and admissions to programs and a stronger delivery of appropriate support services across the whole range required by aged people from simple residence to high-care nursing. As the process of Commonwealth government approvals developed during the 1990s, it eventually became possible to aim at keeping aged persons at home, adding CACP assistance as appropriate, or if they had moved into a retirement unit at Dutton Court, delivering hostel level care, without moving them from the living units to the residential section of the facility. It was thought to be less distressing to the recipients of the various levels of assistance, and (for the politicians) once again less expensive than the delivery of hostel and nursing home care in fixed institutions.

Could these ideas about a more generous focus on the evolving needs of the individual be expressed in new buildings for the residents at Grange? The architect chosen for the new hostel project there, Brian Kidd, certainly supported this model and, once Commonwealth funds of about \$3m had been secured, he set about applying it, even if at this stage there was no approval for moving resources with residents at Grange as they aged in place. Unfortunately, the builder contracted to erect the new hostel houses went bankrupt during the process and the liquidators

⁹⁸ Community Aged Care (Binks), 3 Feb 1995, in Council papers; CEO, report 7 Feb 1995. Further information from Priscilla Binks.

took years to negotiate a settlement. But despite the delays, the outcome was a series of six handsome ‘hostel houses’. A minor excitement occurred in April 1995 at the official opening and blessing of two of the hostels at Grange. As Gerard Menses drily informed the Council, the use of incense set off the fire alarms twice: it was ‘a rather expensive opening’.⁹⁹

Perhaps something might be attempted in the north with the remaining licences? With land on offer from the state government and a substantial bequest in view, Brian Kidd was called in again to design two similar fourteen-roomed hostel houses and then a supporting complex of independent living units, all within the 48 licences allocated for residential aged care at this site. This really was an application of the concept of ageing in place. Commonwealth funding ensured that a variety of food and care support could be delivered to residents in the units from the team based in the hostel buildings. Opened on 9 March 1997, Dutton Court captured the best intentions of Anglican aged care in the 1990s. There were touches of local creativity too. The delivery of meals to those residents in the cottages who needed them (or other support) was in electric buggies with purpose-designed boot space for the meal containers and protective covers for the driver in wet weather. They looked ‘better than presidential golf buggies’, as the Director of Nursing proudly claimed.¹⁰⁰

Karingal continued to be a burden to the budget with its high concentration of costly bed-ridden residents, especially as the Liberal-National federal government changed the funding base in the later 1990s. Finally the decision was taken to sell the site and its licences for \$2 405 000 to Fairlux, an authorised provider of several other facilities. On 31 January 2000 at Karingal there was a morning tea to mark the handover. It was a sad moment, although 43 staff remained with the site.¹⁰¹ The money from the sale went towards further capital works. Redevelopment planning at Grange had moved to the nursing home. During 2001 the men’s wing (the Cecil Gooden Wing) and the older parts of the nursing home were demolished. Two hostel houses will be erected, each to accommodate twenty-two residents with high care (previously ‘nursing home’) needs. Eventually the whole Haeusler nursing home building will be replaced to yield four main houses to accommodate the existing 53 high care bed licences and 29 new licences granted in January 2001 together with an upgrade of the therapy services and the kitchen/laundry area..¹⁰²

⁹⁹ Aged Care Services Division, mins, 24 May, 7 Dec 1990, Aged Care Director (Harold Bates Brownsword) on first five months, to ACS Council Sep, 11 Oct 1991 (\$3m from Commonwealth), 14 Feb, 1 May 1992, 4 Mar 1993, 6 May 1994, 7 Apr, 7 May 1995; *Advertiser* 12 Aug 1994: ‘Housing for aged moves into a decade of excitement’, ‘new designs emphasise residential independence’.

¹⁰⁰ Aged Care Services Division, report, 1 May 1992, 27 Jan 1993, 3, 7 Feb, 7 Apr, 7 Jul 1995, Feb, Apr, Jul 1996

¹⁰¹ CE, report to Anglicare Council, July, Aug, Nov 1999, Jan 2000.

¹⁰² Information supplied by Mandy Elliott, Manager of Residential Aged Care, 19 Feb 2002.

Nor was this all. Harold Bates-Brownsword had forcefully reminded ACS and its supporter base of the ‘forgotten aged’ in the early 1990s. He had brought an awareness from his work in community care of the issues concerning aged people, especially the frail aged poor living in difficult circumstances in the inner city. In 1995 he encouraged Priscilla Binks to join a group (later called the Inner City Frail Homeless Aged Persons Working Party) made up of highly concerned individuals from a number of agencies working in the city. This group was advocating vigorously to get help and care for the inner city frail aged who were homeless or at risk of being so. These vulnerable elderly people were really the successors to the men admitted to the CEMS hostel in the 1930s. In May 1997 a 20 place Community Aged Care Packages program was funded by the Commonwealth Department of Health and Ageing for Anglicare to conduct among these people.

Additional funds from the Department of Veterans’ Affairs and the Adelaide City Council permitted research into the needs of these people, not all of whom were men. Anglicare’s aged care staff in consultation with the working party then developed applications for residential aged care funding in the city of Adelaide for these disadvantaged people alongside an application (successful in late 1999) for 20 more CACPs, this time metropolitan-wide. In 2000 Anglicare learnt that 28 bed licences had been granted in response to these proposals. Together with 12 non-subsidised places these would form the basis of a 40 person accommodation project for the homeless men of the city.

This project was still in the planning stages in mid-2002. Licences to provide hostel accommodation were one thing, funding to buy and build a site that gained local government approval and community support was another. Negotiations with the state and federal government departments were arduous. By December 2001 \$2.7M from the state and \$800 000 from the federal government for capital works had been promised. A site in Brompton was purchased, plans were developed in close consultation with the city council and detailed consultations with the local community were put in place. Moreover, the hostel could be the administrative base for the community care packages available from Anglicare for the disadvantaged elderly.¹⁰³ The project, to be called Ian George Court, would need at least another \$1M, which was to be the target for the 2002 Archbishop’s Appeal. The opening days of that Appeal suggested strong community support, with two large gifts yielding \$400 000. The wheel had come full circle in delivering aid to needy homeless men in Adelaide from the days of the CEMS men’s hostel to this new facility at Brompton.

¹⁰³ By 2002 a further group of community care packages had been negotiated in part by trading in hostel or nursing home licences, for deployment in the ‘south’ to be administered from All Hallows, Westbourne Park. Information provided by Priscilla Binks.

The turmoil introduced after 1996 by the federal Liberal-National government's funding changes, with their cessation of direct capital grants for most types of aged care projects, their introduction of enforceable capital contributions by residents entering low-care (ie the former hostel) facilities, and their encouragement of a much more competitive market for delivery of these services, imposed new and difficult disciplines on Anglicare, as it did all other service providers. Julie Chenery and Gerard Menses began to report on the annual rate of profit achieved by the various units, wondering aloud why one was higher than another. In this context, comparisons, far from being odious, were a necessary management tool. Close attention was now paid not just to health and safety issues, but to all aspects of cost containment. Staff hours were closely monitored and managed. At the same time, the evolving commitment to valuing the residents as the principal issue imposed new disciplines on staff. Training programs were conducted. In 1996 the Revd Neil Forgie, who had worked as an administrator and priest in the Anglicare team at Elizabeth, was appointed to be full-time chaplain of ACS. By 2001 chaplains had also been appointed to all four aged care sites, with a brief to offer support to residents, families, staff and the congregation of believers which clustered around each site. Accompanying a sacramental ministry were now invitations to develop relationships, to receive counselling, to support those grappling with grief and the stress of difficult work tasks. Each chaplain now had a volunteer team in support, and worked with the local parishes.¹⁰⁴

The implications of the assessment visits by the teams under the aegis of the Department of Health and Ageing were now examined very closely, and changes swiftly introduced. The threat was the loss of government-recognised accreditation. Sometimes the very demand for such certificates produced a worrying backlog of inspections. When audits were carried out with laudatory results there was mutual congratulation all round. It was a far cry from the difficulties at Westbourne Park in the late 1980s.

During 1998-9 Anglicare commissioned and received a full-scale review on its aged care services from Swanbury Penglase Consultants. The review reinforced the attitudes already being enunciated and applied them in practical ways. 'Ageing in place' was reasserted as the central principle to guide policy and practice. Each resident was entitled to a private room with en suite facilities. Residential groupings should be modest in size, but linked if necessary. Respite facilities were needed. Information services demanded attention. There were opportunities to develop more income through cross-subsidy and consultancy services. Market share data suggested only limited new opportunities for residential facilities. This in part reflected the diocesan boundary to the south, which ran along O'Halloran Hill. During the following year this matter was addressed with the entry of representatives of the other two South Australian

¹⁰⁴ Aged Care, report, July 1996. *Chaplaincy in Aged Care* [pamphlet, 2000].

dioceses of The Murray and Willochra to Anglicare's Council, and the development of working agreements with those dioceses for the provision of specific services.¹⁰⁵ While no one report would solve problems, the clarity of this report left the Council and its administrators with clear guidelines for action as they contemplated the twenty-first century and its opportunities for service to the aged whether in their own homes or in residential facilities all over Adelaide.

In effect, this narrative simply ends. The services provided by Anglicare SA to aged people continue, largely in response to opportunities created by federal government funding, itself driven by increasingly sophisticated judgements about the character and location of need in the community. The agency has little freedom of action. Sometimes it can take a new initiative, but it requires substantial investment of accumulated capital reserves and some bold policy judgements. Like the other agencies in the field it continues to seek support from its base of friends and helpers, whether cash, time or prayer. While some agencies operate in the sector 'for profit', Anglicare SA continues its commitment to service of the aged for their sake: it represents part of the process of 'Giving a Hand'.

¹⁰⁵ Swanbury Penglase, *Anglicare Aged Care Review 1999*, Council Papers April 1999.

HELPING HAND AGED CARE: DEVELOPING A SERVICE, 1953-2002

Pauline Payne¹⁰⁶

In May 2003 it will be fifty years since a group of Methodist lay leaders decided to form a committee, purchase a property in Molesworth Street North Adelaide, and use it for a home for elderly women. The organisation grew from the North Adelaide Methodist Central Mission in Archer Street, North Adelaide, and went by the name of Helping Hand, under the dynamic leadership of the Revd Arthur Strange.¹⁰⁷ Helping Hand's history provides a case-study showing how an institution established in the 1950s successfully modified its program to respond to changes in community expectations. Over the last three decades Helping Hand has not only survived but provided leadership at both the state and national level. How did this organisation adapt to change and why was it so successful in doing so?

In the 1930s and 1940s non-government agencies providing community services began to explore the idea of providing aged care accommodation. Support for such proposals, spelt out in Revd CJ Perry's 'vision of service' address at the South Australian Methodist Conference in 1935, led to the establishment of Resthaven at Leabrook and Aldersgate at Payneham.¹⁰⁸ In the years after the Second World War there were significant developments in the provision of assistance to aged people in the area of accommodation and associated supports. Helping Hand

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¹⁰⁷ Accounts of the founding of Helping Hand's aged care services are found in the Minutes of the Committee of Management of Helping Hand Home for the Aged for 1953 and in personal accounts in manuscripts written by Rev AT Strange provided by the Strange family.

was one of a number of not-for-profit organisations that established a 'home' for the elderly during the period 1946-1956, among them Wesley House at Semaphore Park (Port Adelaide Central Mission), Lealholme at Port Pirie (Port Pirie central Mission), and Dunbar at Malvern (Presbyterian Church). Such ventures marked gradual acceptance that many elderly people, disadvantaged by physical frailty or social and economic conditions, were in need of care that could not be provided by family and friends.

Developing Helping Hand's first aged care services in North Adelaide

There is only limited information about the way in which funds were found to establish 'The North Adelaide Helping Hand Home for the Aged'. Statements of income and expenditure or other records that might indicate the source of funds for the purchase of properties are not to be found. As the Revd George Potter from the Uniting Church Historical Society commented: 'The Methodist Mission Superintendent led from the front! He pointed to the need! He acted, people were inspired to follow and the money was found'.¹⁰⁹ This is a far cry from today's careful accounting procedures, formal submissions and applications for government grants. Fifty years ago, 'Padre' Strange, as he was known, saw a suitable house for a group of people known to be in need. He gazumped a previous offer from another purchaser and, given twelve hours to find the deposit, raised the money with the help of family members, and only then, at a hastily arranged meeting, spelt out to his somewhat shell-shocked Mission Board members what he planned to do. The funds were found and the purchase price paid in May 1953. A constitution was adopted for 'The North Adelaide Helping Hand Home for the Aged' and a management committee was established. With the help of supporters the group opened the building that came to be known as 'Westering', which housed sixteen elderly women. The next year, 1954, they purchased the house next door which became known as Seymour Wing and was initially used as a home for men. A year later the group purchased a third house, still existing and now used for administration.¹¹⁰

By 1963 Helping Hand property extended in a northerly direction through to Buxton Street and included an infirmary, a recreation hall and independent living units. This was remarkable expansion. It was remarkable, too, that in the very first year the Mission also established a girls' hostel in Hill Street, North Adelaide, the first of a set of four hostels for young people from the country. Meanwhile alongside this the North Adelaide Mission had a

¹⁰⁸ T. H.Kewley, *Social Security in Australia 1900-1972*, Sydney University Press, Sydney, 2nd edn, 1973, pp. 3-4; Rob Linn, *Resthaven: the first sixty years*, Historical Consultants Pty Ltd, Blackwood, 1996, pp. 1-9.

¹⁰⁹ Discussion with Revd George Potter, 11 July 2001.

¹¹⁰ The North Adelaide Helping Hand Home for the Aged, Minutes of the Committee of Management 1953-5; and AT Strange undated typescript manuscript provided by the Strange family.

welfare centre, a hostel for homeless men, programs for migrants and youth work, and a Home for the Aged at Riverton in the Mid-North.

Seeing a need and taking action

There is no doubt that there was a huge need for accommodation for aged people in the immediate post-war years. Housing construction had virtually ceased during the war years and for a considerable time materials were in short supply. The national housing shortage was exacerbated by the baby boom and the migration scheme. Given a significant shortage of housing, low-income aged people were particularly vulnerable. Yet seeing a need and taking successful action to deal with a problem are very different things. Arthur Strange had both faith and vision. He and his wife Stella were known for their stamina, determination and compassion. Their success owed much to the fact that they worked extraordinarily long hours with amazing energy. He would be up at the crack of dawn to go into the East End market for fruit and vegetables, often getting goods as gifts or at a special rate. He attracted loyal supporters ranging from hard working staff and semi-retired people in the office to wealthy donors such as Tom and Mary Seymour. Strange's radio programs on 5KA and 5AD gave valuable media exposure.¹¹¹ The committee appears to have had people of great ability. Lawyer Sir Shirley Jeffries was a senior Methodist layman who had held Cabinet positions when in parliament. Dr Arnold Hunt described Sir Shirley Jeffries as the most influential Methodist layman of his time.¹¹² The architect Gordon Brown, late father of the Hon. Dean Brown, was a lay preacher who served in a number of Methodist and community organisations. Reginald Coombe was the first stipendiary magistrate to be appointed to the Children's Court. Roy Carter, a prominent businessman who was chairman and managing director of Austral Steel, had known Strange from the time he was at the Prospect North Church. There were also stalwart supporters of the Archer Street congregation on the committee.¹¹³

Strange was ordained in 1920. He commenced circuit ministry at Ardrossan, then Kadina, Yacka, Port Pirie, Prospect North and Glenelg. During the Second World War he served first as part-time Army Chaplain and later transferred to the Air Force. He went to the Archer Street Methodist Church in 1944. A year later the SA Methodist Conference, accepting the need for major changes, recognised the North Adelaide Methodist Church as a Central Mission. This provided greater flexibility of operation than was provided by a conventional circuit

¹¹¹ AT Strange, typescript for broadcast 17 January 1950 and covering letter from 5AD dated 22 November 1950.

¹¹² Arnold D Hunt, 'Jeffries, Sir Shirley Williams', *Australian Dictionary of Biography*, vol 14, p. 562.

¹¹³ Many people have been generous with information about the early years of Helping Hand, among them Ron Strange, Betty Croger and Janet Moyes, children of Revd AT Strange, Revd Keith Smith,

arrangement. As a Central Mission it would be a specially designated church which had a visible and active 'social' or 'welfare' dimension. Missions traditionally had a separate Board of Management whose chairperson was the Superintendent Minister. Mission Superintendents' 'stationings' as they were known, whilst subject to regular review, had the possibility of unlimited tenure. An attempt had actually been made in the 1930s to turn the North Adelaide church into a Mission but the plan had not been successful at that time.¹¹⁴

Under Strange's dynamic leadership a quiet church with a relatively small membership was transformed as Strange developed new services to meet community needs. Little used rooms in the Hall became bedrooms for troops on leave, the Strange family regularly entertained fifty servicemen in the Manse for Sunday tea before the evening service, and weekend hikes for servicemen were organised. After the war a hostel was established for men, who typically were unemployed, in transit or newly released from prison, and in addition there was a welfare program, a labour bureau, a program for young people, and a foot clinic. In later years Strange wrote that the announcer for the radio programme on 5KA gave them the name 'Helping Hand'. There are anecdotal accounts that the name was previously used by Strange himself when he served at Glenelg. The name had also been used by the Barrett brothers for a Central Mission in Sydney about fifty years earlier in 1901-3.¹¹⁵

The Home for the Aged at Riverton also dates from this period. When Strange was in England in 1950 he met Arthur J Rank who was treasurer of the Battersea Methodist Central Mission in London. Rank told him about homes for the aged in the country where elderly people were given a holiday. Strange returned home inspired with the idea of providing such a home in South Australia. His first radio broadcast brought a response from Mr and Mrs L Molineux whose generosity enabled the purchase of a ten-roomed house in Riverton that was to be the Riverton Rest Home. This was opened in 1951. Although it did not prove practical to provide short term care as originally intended, Riverton Helping Hand Home for the Aged developed as a successful organisation providing long term care for sixteen aged people.¹¹⁶

Local support from the Mission base, a capable and supportive committee, generous donors and the legendary energy of both Arthur Strange and his wife Stella were vital in

Revd Walter Clarke, Revd George Martin, Revd Don Haydon, Max Carter, Mrs Mavis Alexander and Miss Dolores Grimmer.

¹¹⁴ AT Strange, handwritten notes for a sermon [undated] and 1963 typescript, provided by the Strange family.

¹¹⁵ AT Strange, typescript for session 17 January 1950 and covering letter from SAD dated 22 November 1950; information sent by Revd Gowan Armstrong on the Helping Hand Mission in Balmain, NSW, taken from a Sydney City Mission '21st Birthday souvenir' booklet.

¹¹⁶ AT Strange, copy of undated typescript provided by the Strange family, held in Helping Hand Aged care archival collection.

establishing the aged care programme. The way in which an organisation such as Helping Hand held its property gave it relative independence within the church.¹¹⁷ The other factor of great importance was the introduction of government grants from both state and commonwealth governments.

Subsidies from government sources were becoming an important factor for those planning the financing of aged care accommodation. The Commonwealth *Aged Persons Homes Act* of 1954 enabled Commonwealth grants to be made to eligible non-profit organisations towards the capital costs of erecting or purchasing homes for aged people. The legislation was intended to encourage to voluntary effort and self-help. Organisations eligible to receive a grant included church bodies, charitable bodies and ex-servicemen's organisations but not state governments. Initially the grant from the Commonwealth government was to match the amount raised by the organisation towards capital costs, but in 1957 the legislation increased the basis of the grant from £1 to £2 for each £1 found by the organisation. The Act gave considerable encouragement to voluntary organisations to provide accommodation for aged persons and produced a significant public response throughout Australia, both in metropolitan and country areas. From the beginning of the scheme until 30 June 1964 1,033 grants were made, providing accommodation for some eighteen thousand people. Religious organisations such as Helping Hand received more than half of the grants.¹¹⁸

When Arthur Strange retired at the end of nearly two decades of work at North Adelaide, the committee could look back on some remarkable achievements. There were now 150 people in aged care and four hostels caring for 90 young people from the country. Strange, who had been awarded an OBE for his services, wrote at the time, 'Who would have believed in such developments?'. He recalled that his first theology came out of a little book he called *Oliver's Theology* where faith was described thus: 'Faith is the substance of things hoped for, the evidence of things not seen'. He could affirm 'together we have had faith'.¹¹⁹ His faith saw the foundations being laid. It would now be the task of the next superintendent to build on these foundations. It was a time for new skills and new ideas.

¹¹⁷ I am grateful to Revd Les Underwood for his comments on this matter, interview, Sydney, July 2002.

¹¹⁸ T. H. Kewley, *Social Security in Australia, 1900-1972*, pp. 319-320. I would like to acknowledge help from Brian Fleming and information from the paper he gave at the South Australian Network for Research on Ageing (SANRA) seminar, 'Developing Aged Care in South Australia 1952-2002' held at Resthaven, Malvern, 12 July 2002.

¹¹⁹ Strange was probably referring to Samuel Oliver's *Synopsis of Christian Theology*, T Woolmer, London, rev. edn 1913.

New leadership, new directions

Although Strange's official retirement was at the end of 1963, he found it hard to relinquish control. As he continued to be employed part time to do fund-raising and have a position on the committee of management, this was not easy for his successor, the Revd Don Howland. However Howland was able to consolidate and expand the work that had been achieved. A new two-storey block containing twenty independent living units on the north side of Buxton Street was designed and these units again attracted a Aged Persons Home Grant. Opened in 1966 it was named after architect and founding board member Gordon Brown. The budget for the project indicates the importance of Commonwealth grants. Anticipated funds for the project were £59 250, made up £19 650 from donations and a £39 600 Commonwealth government subsidy. A donation of about £1050 was requested for admission to these units and in addition residents paid about £1 a week (30s for couples) for maintenance costs. Two units were kept for applicants who could not afford to pay the donation. Two other blocks of small independent living units were constructed in Buxton Street during the period 1967-72, Buxton Lodge, which opened in 1968, and Harrison Court, opened in 1972, and in addition twenty people could be accommodated in the set of units known as Carter Court.

In 1966 Helping Hand had the good fortune to be able to acquire, for a very reasonable price, a block of six newly constructed two-bedroom units immediately to the north of Buxton Lodge in Childers Street. By now, with more people in independent living units and a group of more frail residents who were provided with full board, the need was for more 'infirmity' beds, as they were then known. Accordingly the next step was to seek help from the state government for funds to redevelop existing buildings in Molesworth Street to provide 113 nursing home beds. This project was finally opened in 1969.¹²⁰

Meanwhile Don Howland resigned in 1966 and, with some relief, returned to Circuit work. The third superintendent, the Revd Vernon Harrison, took up his appointment in January 1967. Vern Harrison and his wife Betty formed another strong husband and wife team like Arthur and Stella Strange, Vern developed some clear ideas about new directions for development and his vision was not for 'an old folks home' for people living out their sunset years. The Harrisons and senior Helping Hand staff attended conferences interstate, visiting aged care facilities to gain new ideas for buildings and programme development. In 1971, at the Board's suggestion, Vern and Betty embarked on a study tour of aged care facilities in England, continental Europe and the United States.¹²¹ This was a far-sighted move on the part of the

¹²⁰ Information for this section based on minutes of the committee of management 1963-1966, interviews with Rev Don and Mrs Moreene Howland and Revd Don Haydon.

¹²¹ Helping Hand Centre Minutes of the Board of Management 15 December 1970. A change of name was made in 1966. Helping Hand Centre Inc. was responsible for homes for the aged, relief work and

Board and it is significant that the proposal seems to have had strong backing from businessman and Board member Roy Carter. Roy Carter and his family gave significant financial support during these years and Carter was probably pivotal in encouraging Harrison to join Rotary International. Rotary provided important business links, gave valuable financial support and Rotary members joined the Board. By this time the Helping Hand Centre was an incorporated body and the committee of management had become a board of management.

Backed by the Board, Harrison developed Helping Hand's work in three directions. One was building and extensions to provide more options in aged care work. This included Rotary House, providing hostel care for the frail aged (some of whom had previously been in a nursing home area), the new Roy Carter Day Hospital, and better equipped nursing home and kitchen facilities. Secondly there was a significant programme development to provide a day hospital programme, activation, and facilities that had not existed before, including library, hairdressing, a shop and cafe. A group of committed staff, committee members, and volunteers was built up to carry out this work. Some of them still talk about the excitement of knowing that they were leaders in their field and that people would come from interstate and overseas to see what they were doing. As one of them explained 'Helping Hand was way ahead of its time'¹²². In the hostel the design was for small groups of people, each group with their own dining room and living area. The staff who worked with them did not wear uniforms and were referred to as 'nieces' rather than 'nurses', with the idea of getting away from the medical model. In programme development there was concern to provide a wide variety of opportunities for people to try new activities, such as painting or craft work, and have mental stimulation from current affairs discussions groups while the fitness group leader found herself developing new techniques for women who insisted on wearing corsets and skirts to their 'keep fit' class.¹²³

In the mid 1970s Harrison and his senior staff continued to make annual trips to interstate conferences, taking the opportunity to visit and check out interstate facilities, sometimes accompanied by architect Malcolm Doley. They were organising seminars for volunteer training and they were liaising with colleagues in domiciliary care, Department of Further Education, WEA and SA Women's Keep Fit Association. Former staff and volunteers speak of hosting training sessions for staff of other aged care organisations and developing training manuals because there was no suitable Australian style material.

youth hostels. Religious and spiritual work under the North Adelaide Methodist Mission would be the responsibility of the North Adelaide Methodist Memorial Church. North Adelaide Methodist Mission would be the overriding title applying to both sub-divisions.

¹²² Margaret Scharer, telephone interview, November 2002.

¹²³ Information from telephone interview with Margaret Scharer June 2002, also telephone interviews with Barbara Tapp and Jean Foord November 2001 and May 2002.

Thirdly, Harrison was working at the state level with his colleagues from other voluntary aged care agencies so that their voice could be heard at both state and national levels. These colleagues included the Revd George Martin from the Port Adelaide Central Mission, Ron Crettenden from Adelaide Central Mission, John Pitchford from the then Aged Cottage Homes and Kelvin Dickens who was then at Resthaven. The South Australian group was a strong one nationally. Melbourne aged care consultant Dr. Anna Howe has observed that the South Australian voluntary organisations working in aged care were relatively stronger in the 1970s in the aged care field than their counterparts interstate.¹²⁴ The South Australian group formed an Association of Voluntary Care, with leading members such as Dickens, Harrison, Crettenden and Martin working together successfully on submissions to the Commonwealth government. Those who worked in these years speak of a great deal of energy and a sense of getting things done. There was a desperate need for more adequate funding, exacerbated by inflationary pressures and rapidly rising wages bills. The Commonwealth government introduced deficit funding in 1975, allowing some stability for aged care organisations. By the latter years of that decade the Commonwealth government provided capital funding for what was then known as hostels and nursing homes, now known as low care and high care, as well as recurrent payments to hostels at two levels: a personal care subsidy and hostel care subsidy. In addition there was now a significant amount of government funding aimed at helping people to stay in their own homes, such as subsidies for meals provided by Meals on Wheels Inc and other organisations along with funding for domiciliary care services.¹²⁵

Helping Hand made some significant changes to its own organisation during these years. In 1973 the Riverton aged care centre came under a local board of management when the Riverton Rest Home Inc was transferred to the Gilbert Valley Senior Citizens Homes (Riverton) Inc. Welfare centre work, with its material aid service, and work in youth hostels was gradually phased out so that the focus was on aged care services. A day centre was established at Woodville Gardens, in cooperation with the Bowden and Brompton Mission, and four independent living units were built at Prospect. Then, in the mid 1980s a new complex was developed at Parafield Gardens in cooperation with the local church congregation.

The Parafield Gardens project was aided by two significant gifts and bequests and was backed by government funding that recognised the need for services to be delivered to the northern metropolitan region. The late Revd Murray Chambers, then working in the Parafield Gardens district, was acutely aware from his own family experience how distressing it was

¹²⁴ Dr Anna Howe, personal communication May 2002 and comments made at the 2002 Conjoint Scientific Meeting at the Hotel Adelaide International, 10 May 2002.

when an elderly person had to be moved to a nursing home in an area a long way distant from family and friends. It is fair to say that in the 1950s new projects were developed and were aided by government funding whereas with the Parafield Gardens project government funding helped to direct service development into a particular region. For Board members, many of whom came from the more affluent inner-city and eastern suburbs, it was not easy to take the step to develop the Parafield Gardens site. The North Adelaide site had developed some prestige, and as Parafield Gardens stalwart Geoff Ambler observed, Parafield Gardens was totally unfamiliar territory. Developing the new site was something of an act of faith. From Geoff Ambler's description, the faith of that original working group from Parafield Gardens Uniting Church certainly mirrors the faith of Padre Strange in the 1950s.¹²⁶ While they knew they needed an aged care service they really had no clear ideas about how to achieve it. This pattern of a smaller local group deciding that it was best to join a larger group such as Helping Hand to achieve their goals continues to the present day.

Into the nineties

With the 1990s a major change came with the decision not to appoint a minister of the Uniting Church to replace Harrison when he retired. Instead of a superintendent there would be a chief executive officer whose expertise was in administration. Ian Hardy was appointed in 1990 by a Board that by then not only had women members, there were none until 1979, but was soon to have a woman, Mrs Gene Wenham, as chairperson.

Under Hardy's leadership, Helping Hand's operations were to expand geographically to seven sites, with programs expanding and the budget doubling over the subsequent ten years. Planning for the Ingle Farm site began in 1993, using the 'intermix' or 'ageing in place' model, the first time in Australia that an aged care facility had been designed on these lines.¹²⁷ Helping Hand assumed responsibility for Lealholme at Port Pirie in 1995 and for the Barryne retirement village at Belair in 1997. There were also the Prospect independent living units, dating from the 1980s. Throughout the various sites some independent living units were designated Resident Funded Units while others were designated Entry Premium Units, thus catering for residents with varying levels of income and assets.¹²⁸

¹²⁵ Again my thanks to Brian Fleming for access to his summary of funding developments in a paper given to the SANRA seminar at Resthaven, Malvern in July 2002.

¹²⁶ Interview with Geoff Ambler June 2002 and discussions with Mrs Celia Chambers, September 2002.

¹²⁷ There had been an intermix trial in Perth but this was using existing facilities. The Ingle Farm project was a pilot scheme developed through cooperation between senior Helping Hand staff and officers of the Commonwealth government.

¹²⁸ The arrangement for Entry Premium Units replaced Capital Donations. It was still possible for an applicant who had very limited assets to pay only a monthly maintenance fee.

Negotiations began for Helping Hand to assume management responsibility for Carinya at Clare in the Mid-North and some other units at Clare, to take effect in 2002. This was another move in a northerly direction. In 2001 a site was purchased at Mawson Lakes. That site is now being developed with opportunities for cooperation with the University of South Australia for teaching and research. The Centre for Community Ageing will have funding from the University of South Australia, Delfin Lend Lease Ltd, the Regency Institute of TAFE and Helping Hand Aged Care. Meanwhile, plans are in hand to upgrade some of the 1960s buildings at North Adelaide. Applicants for accommodation are demanding a higher standard of accommodation with improved facilities. Aged care accommodation is now a competitive market.

Developing community services

While this physical expansion has occurred, the other dramatic development since 1995 has been in the provision of community services. This process was aided both by Hardy's management style that provided a degree of autonomy for senior staff, and some changes in philosophy of service delivery.

The first of these services, GP Home Link, began as a pilot service in 1996. In Home Support Service was launched in 1997, and the Healthy Lifestyles programme was launched in 1998. In a major reorganisation, work which had been carried out under the day centres programme became part of the Healthy Lifestyles programme. Healthy Lifestyles embraced Healthy Ageing (including physiotherapy, occupational therapy, podiatry, hydrotherapy and health promotion), Successful Ageing (which included lifestyle planning, counselling and personal growth courses), and Community Integration (which included advocacy, overcoming social isolation and linking with community activities). Funding for these services came from a wide range of sources, including Community Aged Care packages, HACC (Home and Community Care Programme) money, local government funds, funds from the Department of Veterans' Affairs, and fee for service, often very complex arrangements.

These services aim to fill niches rather than duplicate existing services, are tailor-made for individuals and typically are time limited. They include schemes to keep people from being admitted to hospital by providing rapid and substantial support; pilot schemes with acute hospital units to get people functioning better so they can be discharged; respite for carers schemes; projects to get isolated people back into community activities; the famous Wild Women's Weekends for personal development; seminars to encourage community action to deal with Elder Abuse; and In Home Support programs. This last mentioned, In Home Support, can provide carers to do cooking, shopping, gardening, cleaning or help with showering and dressing. Services are custom-made so that if someone living alone has a broken arm it can be

arranged that a carer will come in each morning at an arranged time for a half an hour to help the client get dressed. Many of us do not have relatives living nearby and do not feel comfortable about asking a neighbour to help us get dressed. In Home Support services can be made available on a fee for service basis. In the last few years rehabilitation projects have been much emphasised. The community service team is enthusiastic and innovative and there are strong parallels with the energy levels of the team in the 1970s that worked in the Day Hospital and the activation programme at that time.

In some ways Helping Hand has come back to where it started, because in the beginning the North Adelaide Mission was not just concentrating on accommodation for older people but rather it provided a wide range of services with an overall philosophy of supporting people who were vulnerable, helping to combat social isolation, and providing some options for people. From sixteen women in an old house in Molesworth Street there are now over eight hundred people in residential care with independent living housing, high care and low care accommodation in the various sites, served by about seven hundred staff members and five hundred volunteers. Up to four thousand people receive community services. There is a small internet café area in the foyer at Parafield Gardens run in cooperation with the local school. On one Wild Women's Weekend older women enjoyed white wine on a moonlit walk – a far cry from the more austere lifestyle sponsored by Helping Hand in the 1950s.

* * *

The story of Helping Hand's development provides a case study of how an aged care organisation adapted to changing conditions over a fifty year period. My colleague Dr Brian Dickey has been carrying out research on the way that the Anglican Church in Adelaide developed aged care services during this same period. As Dickey observes, sometimes the emphasis has been on bricks and mortar or on finance, and sometimes the issue of quality of care has predominated while always the role of the Commonwealth government has been critical as it 'delivered funds and imposed increasingly rigorous standards of accountability'.¹²⁹ A recent paper by Stan Manning, formerly of Wesley Mission, Sydney, at the national Aged and Community Services Australia (ACSA) conference focussed on 'prophetic leadership'.¹³⁰ At a South Australian Network for Research on Ageing (SANRA) seminar held at Resthaven, Malvern in July 2002, papers on the history of Anglicare aged care services in South Australia and on the history of Helping Hand Aged Care services revealed significant difference in the way the two services developed. One of the most striking relates to leadership. Strong

¹²⁹ Brian Dickey, Anglican Aged care services in South Australia since ca. 1950: the work of Anglicare SA, draft paper for proceedings of the SANRA seminar held at Resthaven, Malvern, SA in July 2002.

leadership has been a striking feature of Helping Hand's development over the past fifty years. Three people have had a particularly important leadership role in Helping Hand's development: Arthur Strange, Vern Harrison and Ian Hardy. Each had a great capacity to build up a loyal team of supporters, senior staff, volunteers and Board members and other colleagues. Hardy's leadership has been of a quieter, more democratic style than his predecessors. Like Harrison, he has had considerable influence at the national level. Hardy has brought Helping Hand into an era where, like all 'not for profit organisations', Helping Hand has to be profitable enough to be able to plough some funds back into innovation and improvements. This approach, combined with partnerships with other aged care providers, has provided opportunities for expansion.

At various times in the organisation's history the suggestion has been made that there might be a change of name. In the 1970s there were suggestions of 'Peaceville' and 'Wellington Court'. In recent times some have suggested that a new name might be an advantage for fund-raising purposes. Yet the concept of giving someone a 'helping hand', with the implication that it will enable a fellow human being to get along a little more easily or surmount an obstacle, seems to tie in well with the ideas recently expressed at the 2002 United Nations Second World Assembly on Ageing in Madrid that we should be supporting 'capacity building', enabling older people to have more control and opportunity to do things for themselves. For those involved with Helping Hand Aged Care, working out the best ways to provide a 'helping hand' and provide opportunities for 'capacity building' will continue to be the challenge as our ageing Australian population doubles in the next twenty to thirty years.¹³¹

¹³⁰ Stan Manning, address to the ACSA 2002 conference, Adelaide, 3 September 2002.

¹³¹ The research for this paper comes from a project commissioned by Helping Hand Aged Care Inc. to produce a book to commemorate the fiftieth anniversary of the organisation. Many people associated with the development of Helping Hand Aged Care services, and with South Australian aged care services more generally, have been very generous with their time while I have been carrying out research for the forthcoming book on which this paper is based. I would also like to express my gratitude to colleagues

who commented on earlier drafts of this paper, in particular Dr Brian Dickey, Dr David Hilliard, Dr Virginia Kenny and Revd George Potter.

AGED CARE IN SOUTH AUSTRALIA 1952-2002

Peter Last

In 1952 I was a final-year medical student. All I knew of aged care services was of referring patients with varicose ulcers to district nurses, and that frail old people blocking hospital beds might sometimes go to the squalid Magill Wards of Royal Adelaide Hospital, the nearby but separate Old Folks Home, and very rarely the War Veterans' Home or Sunset Lodge operated by the Salvation Army. Otherwise they disappeared home or went into private or religious hospitals. Nursing homes did not yet exist, but there were some strange little places called rest homes, of which I knew nothing. Some old people congregated in boarding houses. Those with pretensions of gentility lived in private (ie unlicensed) hotels, like 'Saint Olave's' at Glenelg and 'The Avenues' at Stepney.

Mad old people were confined in Glenside (née Parkside Lunatic Asylum) and Hillcrest (née Northfield Mental Hospital). There were no other public adult psychiatric services beyond the Enfield Receiving House and psychiatric outpatients at Royal Adelaide Hospital, with long waiting lists and no access to beds at North Terrace. Inpatient psychiatry began at RAH in 1963.

Next year, 1953, I spent time as a house surgeon (what is now called an intern) at what was still the Northfield Infectious Diseases Hospital. There I saw poliomyelitis kill people in a few days or leave them forever weakened. I shall never forget the induced sighing of the Both ventilators, with bellows made from kangaroo hides - an extraordinarily evocative sound. Years later I took part in a television program based on the resurrection of such a ventilator, with one of the Both brothers. As I came into the studio, he was demonstrating how simple it was to operate. Hearing the sound unexpectedly after so long an interval, I was embarrassed by uncontrollable weeping, provoked by the memories of the tragedies I had seen at Northfield.

In 1953 a couple of wards at Northfield had recently been used to decant otherwise unplaceable old patients from North Terrace. The visiting Honorary Physicians resented them as 'clinically uninteresting', and medically they were badly neglected. Later the hospital recruited

visiting staff more attuned to the needs of old people, and in 1978 I enjoyed returning there for a spell as a locum geriatrician.

In 1957 I was a general practitioner at Clovelly Park and Darlington, in the outer fringes of expanding suburban Adelaide. I had very few old patients, but I saw a little of the RDNS sisters. Their services were free, but they asked for a donation of half a guinea for a visit. In that area their funds came mostly from local councils and voluntary fund raising, possibly augmented by the recently enacted Home Nursing Subsidy Act. (That grew into a complex system of Byzantine tortuosity that very few people understood.) There were no public community allied health services, such as physiotherapy and not many in private practice. Social work was the province of hospital lady almoners and a few ministers of religion. Psychology, speech and occupational therapy existed only in the Repatriation system.

In 1964 I was appointed Senior Physician at Repatriation General Hospital, Daw Park. This gave me a good understanding of the wonderfully generous Repatriation Department for those who met the criteria of eligibility. Nothing else in the world could match it. Even so, even after eight years there I continued to discover new and strange aspects of Repat - like what was an OMW (Other Mother Widow), and who was eligible to have free canvas verandah blinds.

Late in 1972 my world changed. I took to doctoring institutions and communities instead of individual patients, by becoming an Assistant Director-General in the South Australian Hospitals Department. I hadn't properly adjusted to this, when early in 1973 the Whitlam volcano erupted. It was an extraordinary experience, as colleagues in Canberra pressed us with increasing urgency to spend, spend and then spend even more. One example must suffice.

One afternoon early in 1974 I had a call from the Commonwealth Health Department in Canberra. For party political reasons, Victoria had just refused its Community Health Program allocation for the year. As one of two Labor states, would South Australia like more than half a million dollars, providing we could give a cast-iron guarantee that it would all be spent before 30th June that year? I was the only person available to take the call, and a decision must be made in an hour or the money would be offered elsewhere. That was because of the deadline for the agenda of the federal cabinet.

Hastily I pedalled my bike to Victoria Square to consult the Minister, Don Banfield. Reluctantly he agreed, providing I gave no commitment to engage extra staff.

We were a small bureaucracy, with in this area only three active decision-makers - Bryan Shea, the DGMS, Howard Lloyd, another ADGMS, and myself. Each of us was exceedingly busy, with innumerable trips interstate and new projects to develop and supervise. Often we

hardly knew what the others were doing. There were other senior bureaucrats, of course, but they weren't so much involved in these matters.

Next day Bryan told me he couldn't be bothered by trivia like my Canberra call. He was preoccupied with making South Australia the first state to implement the original Medibank, with potentially major benefits for the State Treasury. (As a result, we got the best deal of all the states in the new system.) He told me to buy whatever real estate seemed relevant. That was how we got the Southern Community Health Centre at Clovelly Park; the Rehabilitation facility still operating on the Old Port Road, originally called Alfreda, a geriatric day centre at Port Pirie Hospital, and a defunct nursing home at Tennyson not far from Estcourt House, which was then a component of Adelaide Children's Hospital. This was for intellectually impaired and physically dependent children, in order to relieve the original Ru Rua at North Adelaide. This was later relocated to Estcourt House, but for legal reasons still had to be called Ru Rua on its new site. (Another very tortuous matter that few people understood.)

The last of these transactions was completed at 1600 hours on 30 June 1974. Had it been the next day, the State Treasury would have had to find many thousands of unbudgetted dollars.

Most of us were swept along by the sheer exhilaration of this enormous largesse, with the expectation of more of the same, expanding year after year like the universe. One person who kept his head was the Minister of Health, Don Banfield, for whom I had and retain great respect and affection. He had lived through the Great Depression, and he knew that a spurious boom like the completely undisciplined Whitlam explosion must be followed by a bust.

Don Banfield was especially, and quite justifiably, suspicious of the Community Health Program. It was too good to be true. A hundred percent Commonwealth funding - or Australian government, as Mr Whitlam and his ministers insisted. There would be 25% more next year, providing we spent all of this year's allocation, and if we went over, it wouldn't matter. They could always print more bank notes, as indeed they did, contributing to one of the greatest spurts of inflation in our history.

But as Don Banfield later bitterly pointed out, it might be Commonwealth money, but the staff were State employees, and with permanency required as a condition of funding. The whole scheme rested on a letter from the Commonwealth Minister for Health, Doug Everingham, which could not and did not bind his successor. He is now remembered for his attempts at spelling reform. He called himself Minister for *Helth*, and the secretaries had to address correspondence so. They no sooner grew used to that than Bill Hayden replaced him. He had other and more direct priorities.

As originally promised, in the second year the 100% Commonwealth funding for the Community Health [sic] Program became first 90% and was to be 75% thereafter. But in the Hayden budget of 1975 it prematurely fell to 50%. Fraser and Howard absorbed it all into a block grant under what they called New Federalism, and thereby the Community Health Program (as it was now sensibly denoted) died a natural death.

I was very much involved in the Community Health Program, and I received more personal authority than was desirable, mainly because nobody else could spare the time and at that stage the Commonwealth Health Department gave us the money and left us to it. There was little surveillance from Canberra in the early days, a happy situation that did not endure. The great expansion of the Commonwealth Health Department and its increasingly close involvement in policy decisions, priorities and operational matters were still ahead of us.

At the outset a lot of rhetoric was devoted to developments directed at demolishing the Medical Model, a loose concept, not defined beyond the implication that doctors were potential villains, determined to keep other staff and patients under their control and direction. This fixation was responsible for some unfortunate and avoidable problems elsewhere. One was that many patients, who must now be called clients by people quite ignorant of what that word originally meant, persisted in wanting to see doctors, not psychologists, social workers and health counsellors, most of whom had once been nurses. We were told that in Victoria some of the community health centres foundered from this cause, and there was little or no cooperation with local general practitioners. We got into health centres later than some of the other states, and a decision was taken that all such projects in South Australia must have the agreement of local doctors. We also must ensure that a due proportion of community health centres would be placed in country areas. Many of the resultant negotiations fell to me.

Fortunately there were some enlightened and enthusiastic general practitioners, so most of the projects got off to a good start. It was notable how congenial inter-professional relationships were in crowded temporary accommodation. Often they deteriorated once the grand new buildings provided personal offices for the staff, and they no longer were obliged to share desks and telephones.

During this period, partly through my own desire to get to know as much as I could about my own State, and partly by default, I became a principal link between country hospitals and government subsidies. Before Medibank and the creation of Sid Sax's Hospitals and Health Services Commission, the 57 'subsidised' country hospitals could ask for a 2:1 State government subsidy for capital works. By ensuring that local pensioners were privately insured (sometimes using hospital funds to do so) they accumulated capital for their one-third

component. This meant that many old people were admitted to the local hospital, who today would be at home or in a hostel. They were called patients, with temperature and similar records, and dressed in night attire when many were not truly sick. Their medical records were usually minimal and diagnoses were sometimes very sloppy. At that time, no monitoring of professional activity was possible, beyond the extreme cases brought before statutory registration boards.

Each hospital was a separate entity, fiercely territorial, and if one got something (such as a new operating theatre) the neighbours would querulously demand the same. There was no attempt at coordination, and local jealousies might result in seriously ill patients by-passing a better established hospital to be sent directly to Adelaide. Entirely avoidable tragedies from that cause created the Retrieval Team system, the first and for a long time the best of its kind in the country, but that story is an unwarranted digression.

At the same time as hospitals were negotiating their Medibank agreements (not through me) we were able to apply Community Health Program funds for rural outreach nursing, local domiciliary care schemes and what must look like pretty arbitrarily placed community health centres. Some, such as Ceduna, Tintinara and Coonalpyn, were fully justified, but I must confess that in retrospect a couple of the others look somewhat frivolous. All I can say is that they seemed good ideas at the time, and the atmosphere was that if the Commonwealth money was there, it would be wrong not to spend it while we could. If it did nothing else, it helped the local building industry.

In the context of aged care, we encouraged country hospitals to adapt nurses' residences to accommodate old people, by creating separate legal entities able to obtain Commonwealth subsidies, particularly under the pre-Whitlam *Aged Persons Hostels Act* of 1972.

The initial domiciliary care services (Western and Para) were set up in 1971 with funds from the States Grants (Paramedical Services) and States Grants (Home Care) Acts of 1969. In 1973 the Eastern Domiciliary Care Service (of which I was inaugural chairman) was funded this way. These acts provided Commonwealth subsidies on a 2:1 and 1:1 basis to match State funding, and were administered by the Commonwealth Departments of Health and Social Security respectively. South Australia and Tasmania were the only states to accept the subsidies, which were refused by at least one other state for party political reasons.

From our point of view, these methods of funding had two disadvantages. The State had to find its component from a stretched health budget, competing especially with rapidly developing building programs for country hospitals. There were also restrictions on the categories of staff who could be funded, the most important omission being nurses. We could

not sneak additional funds to RDNS or use hospital outreach nursing from teaching hospitals, although the rules were bent by Ken Treagus and John Joel to fund other aspects of the Western and Para Domiciliary Care Services.

By the time we came to set up the Southern service, we could use the Community Health Program, with its wonderful flexibility. The restrictions of the other services did not apply, which did not mean that Southern got disproportionately more funds. I was made a member of its committee of management, in part at least to ensure that this did not occur.

A condition of the original Community *Helth* Program was that services to the patient as client must be free, so no fees could be charged in the Southern Domiciliary Care Service. On the other hand, the other three metropolitan services had charged fees from their inception, especially for home help. A general practitioner caused a lot of political difficulty. His practice straddled Anzac Highway. Patients to the south got everything free, but those to the north had to pay. How could the Ministers justify that anomaly? I was sent to explain and to ask him to desist from his campaign, which only made his letters more strident. Fortunately the Hayden budget of 1975 allowed Community Health Program projects to charge fees at our discretion, so the problem went away.

In three of the Domiciliary Care Services we encouraged the Medical Directors (Drs AW Burnell, M Burr and B Walker) to try different ways of undertaking assessment and deciding what services to provide – short-term support after leaving hospital, for example, which some undertook and others didn't.

In the idealistic early days a favourite concept was evaluation, and some good work was done in this field. To the best of my knowledge, however, this matter was not followed up, and by the time we wanted to do so, there were no funds for the purpose.

One matter that irritated South Australian Ministers of Health was that the Aged or Disabled Persons Homes Act provided 2:1 Commonwealth subsidies for building projects, but the State provided 1:1 subsidies for furnishings and equipment. This had to be accommodated under what was called 'Minister of Health Miscellaneous', a line of funding in the State budget which gave the Minister total personal discretion on how these funds should be applied. For example, this was how the subsidised country hospitals received the funds for their ambitious building projects. I well remember the strong language of one Minister when he discovered that he was obliged to fund, *inter alia*, the crockery required for a new aged accommodation project at a time when he had much higher priorities and had made some tricky commitments. What especially irked him was that he was invited to the official opening, but was not thanked, either then or subsequently, for the money he had provided.

For many years South Australia was unique in this country because of its monopolies. We had only one radiotherapy service, one unit undertaking open-heart surgery (one of the biggest and busiest in the world), one community nursing service (RDNS) and in any given area only one domiciliary care service. The Home for Incurables maintained a highly undesirable monopoly of institutional care for physically dependent and intellectually intact adults not old enough to be called aged. As late as 1990 there were about 150 nursing homes in metropolitan Adelaide catering for old people, but only Julia Farr Centre (the Home for Incurables) accepted the rest. It is an indictment of all the Christian organisations that not a single one of them attempted to use the disabled component of the legislation to break that monopoly.

The South Australian monopoly tradition greatly contributed to the fact that our health delivery costs per head of population were lower than most states. The beggarly provisions in Queensland always kept it the cheapest in terms of health expenditure per head of population, just as the privileged Australian Capital Territory spent most.

In 1983 I visited the United States, to assess some important 'demonstration projects', of which I knew from closely following the literature on long-term (extended) care. The State Minister of the day was opposed to any form of monopoly, so I was charged to explore the contrasts between South Australia and the intensely competitive American systems. I spent most time with the ACCESS program of Rochester NY, which served a population of about 750 000. This compared well with Adelaide, which then had a population of about 850 000.

The outcome was to demonstrate very clearly that our monopolistic domiciliary care and community nursing services were not only much cheaper, they were more comprehensive, simpler and more humane. The fundamental reasons why the American services were so much more expensive was the need for brokerage and duplication from restricted eligibility under Medicaid and (US) Medicare. Brokerage added another tier of professionals, expanded bureaucracy and caused avoidable delays and frustrations, especially for recipients. In South Australia, the same staff undertook assessments as supplied the services and all ages were catered for. In the Community Health Program projects there were none of the constraints of such targeted services as those of the then Repatriation Department, for example.

In Rochester, staff of ACCESS were very envious of our monopoly situation. They had to decide which *of* many providers would be used for each recipient, whether it was home nursing, delivered meals, home physiotherapy or provision *of* aids to daily living. Nowhere in the United States was there anything like our excellent Independent Living Centre. I gained a strong impression that selection of suppliers very likely involved kickbacks to the staff concerned.

Wheelchairs were authorised by nurses, who had no special knowledge of the different kinds available, and physiotherapists, who did, were not involved.

On my return I strongly recommended that our existing provisions continue, which was not well received by the Minister. Since then, of course, all monopolies have been demolished and our system has grown increasingly Americanoid. I very much doubt that it is correspondingly better, but many people have found employment in this component of the industry for whom there would have been no place in my time.

Over the last half a century a large and elaborate aged care industry has been established, with multiple vested interests, both institutional and professionally territorial. Far more important than the capital plant has been the evolution of attitudes and standards, both within the professions and throughout the community. For my part I did my best in this process by accepting hundreds of invitations to talk to all sorts of audiences. I chattered for ten years or more on Philip Satchell's radio program. I produced lots of publications, of which only one was the big and influential Joel report entitled *Accommodation, Domiciliary Care and Medical Rehabilitation for the Elderly*. The work required was undertaken in the State Health Resources Unit, of which I was the Director.

The changes in care of old people during my professional lifetime have been truly prodigious and, generally speaking, very gratifying. Overall things are overwhelmingly better, but we are far from perfection.

One matter in particular is my most significant failure in trying to influence the system of aged care in this community. Sometimes I feel like an Old Testament prophet, because nobody takes much notice and then not for long. The people who live in places like Resthaven or Helping Hand have in common that they are members of the same birth cohort, but by conscious choice, by institutional and political policies and by wrong expectations, we segregate them solely on grounds of age. Thereby we create and perpetuate the geriatric ghettos against which I have long railed.

In doing this we deny our own biology. Man, *Homo sapiens*, however ancient the lineage may be, is an animal programmed by our genes to live in groups of mixed ages. We are the first generation to set out to do two things, both of which I believe are doomed to fail, and rightly so. Firstly, we are trying to abolish societal distinctions between men and women that go back to our ultimate past. Secondly, we perpetuate the segregation of dependent people solely on grounds of age. On such a site only old people live. Younger people and children come as workers and as visitors, but this is not their home.

For years I have tried to persuade people how wrong this is and that future generations will undoubtedly regret it. What troubles me right now is that when I come to need services like those of Resthaven, I will probably be one to suffer in this way, as indeed will most of us. On that depressing prospect I will conclude.

Appendix

GOVERNMENT FUNDING OF SERVICES FOR OLD AND DEPENDENT PEOPLE:

SOME SALIENT DATES AND FACTS

prepared by Peter Last¹³²

- 1946 A successful referendum created S 51 xxiiiA of the Constitution, which empowered the Commonwealth Parliament to make laws with respect to ‘the provision of maternity allowances, widows’ pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances’.
- 10 December 1949 to 2 December 1972 Coalition governments of Menzies, Holt, (McEwen), Gorton & McMahon.
- 2 December 1972 to 11 November 1975 Labor government of Whitlam.
- 11 November 1975 to 1983 Coalition government of Fraser.
- 1951 (approximately) ‘Free Medicine Scheme’, which became the Pharmaceutical Benefits Scheme.
- 1953 South Australia Housing Trust built the first ‘pensioner units’, originally exclusively for old people.
- 1954 Aged Persons Accommodation Act provided 2:1 Commonwealth subsidies for buildings, while separately, the South Australian Minister of Health provided 1:1

¹³² I’m sure Peter would be the first to acknowledge that ‘old men forget’: we are grateful to him for this aide memoire, but we know that there might be just a bit of imprecision. *Ed*

subsidies for furnishings and equipment. Between 1954 and 1990, in South Australia all these subsidies went to accommodation for old people. No religious or charitable organisation used them for accommodation for younger disabled people. By the 1976-77 fiscal year, South Australia, with less than 10% of the population of Australia, had 22.74% of subsidised independent living units, 12.07% of subsidised hostel and 14.22% of subsidised nursing home beds. Nevertheless the Oliver Twist syndrome was very active, with perpetual political pressure for more and more of the same.

- 1956 Home Nursing Subsidy Act subsidised Royal District Nursing Society (a nationally unique monopoly) by matching existing State grants under a complex formula of Byzantine tortuosity.
- 1970 Delivered Meals Subsidy Act subsidised meals delivered to the recipients' homes and excluded congregate meals elsewhere. Most cooks and deliverers were (and still are) volunteers.
- 1970 (approximately) States Grants (Paramedical Services) Act and States Grants (Home Care) Act provided Commonwealth subsidies on a 2:1 and 1:1 basis to match State funding. They were administered by the Commonwealth Departments of Health and Social Security respectively. South Australia and Tasmania were the only states to accept these subsidies, which were refused by at least one other state for party political reasons.
- 1971 Western Domiciliary Care Service was established by the Queen Elizabeth Hospital with States Grants Acts funding. The Newcastle service started at about the same time.
- 1972 *Aged Persons Hostels Act* restricted such Commonwealth subsidies to old people.
- 1973 The Community Health Program provided in the first year 100% Commonwealth funding for agreed projects, which involved, *inter alia*, widespread domiciliary care services (including outreach from country hospitals) and women's shelters. This never had a legislative basis, and rapidly fell through 75% to 50% to 0%. It had the great benefit of flexibility, but it produced unsustainable expectations and irreconcilable anomalies. In 1975 home help and handyman services were free to recipients south of Anzac Highway, but those on the north side had to pay, as one was a CHP project (necessarily 'free to the patient' with no means test) and the other was

funded under States Grants Acts. CHP funds were used for the first tentative explorations of congregate meals in newly established community day centres. One was at Hillcrest Primary School (Dr Lesley McLeay) and another was in a church hall at Colonel Light Gardens. Neither survived.

- At this time the Commonwealth invoked the so-called reserve powers of the states to refuse funding for any services (institutional or in the community) identified as being for people with dementia. The civil servants involved were inflexible on this principle for several years. Many token physical therapies were administered to evade this exclusion, especially to achieve day respite in 'non-profit' nursing homes.
- 1974 States Grants (Dwellings for Pensioners) Act greatly expanded SAHT 'cottage flats'.
- 1974 Nursing Homes Assistance Act created the Commonwealth-State Nursing Homes Advisory Committee, which was required to allocate new beds strictly according to population ratios by local government areas. Inclusion of the Home for Incurables (notionally 826 beds) in an area otherwise disproportionately provided with beds created in the City of Unley the most extreme ratio in the country.
- 1976 (approximately) Progressive inclusion of Commonwealth funds previously provided by specific legislation in all-embracing block grants to the states ('New Federalism') made it impossible to follow trends as readily as beforehand.

RESIDENTIAL AND COMMUNITY CARE DEVELOPMENT RECOLLECTIONS

Kelvin Dickens¹³³

Uniting Church of Australia organisations such as Resthaven (1935) and Adelaide Central Mission (1944) commenced as a result of a community need and some philanthropy from community leaders of the day. The people who entered care, even until my early days at Resthaven in the early 1980s, chose to move into the hostel environment for social and community purposes. They were predominantly older women (usually ‘frail genteel ladies who had served the church through their lives’). Movement into these hostels even until the early 1980s was usually into a shared room of up to three beds with communal toilets and bathrooms down the corridor, much like a family home on a larger scale.

During the early days, until the early 1950s, there was little or no government funding for aged care provision. Aged care was hostel-type care with a sick bay into which those people who were ill were transferred to be cared for under the supervision of one registered nurse or ‘Matron’. As soon as they were improving in health they returned to their room. There were no nursing homes or infirmaries at that time.

In the early 1950s some state government funding was available for the provision of aged accommodation. During 1954 capital assistance of pound for pound through the Commonwealth Aged Persons Homes Act became available to fund further such hostel-style aged accommodation. Discussion in government circles on such a subsidy scheme had begun as early as 1950. Deputations from organisations such as the Pensioners’ Amenities Society had supported such a move by 1952. It was reputed that Dame Pattie Menzies spoke with the Revd Erwin Vogt, the Superintendent Minister of Adelaide Central (Methodist) Mission, and he convinced her that funding was needed to develop nursing homes. I am aware that similar

¹³³ Director of Aged Care Services, Wesley Uniting Mission Inc. Former Executive Director of Resthaven Inc

claims were made by other leaders as well! In 1962 the Commonwealth agreed to pay \$2 a day for nursing home residents under the National Health Act. This payment grew in subsequent years. In 1969 the first Commonwealth government recurrent funding payment for hostel residents was introduced. It was set at \$5 a week for residents aged 80 and over.

As a result of the Mission's accounting system being able to separate the cost of heavy and light nursing home care (St Luke's Infirmary - heavy nursing care and the hospital wings - light nursing care) I was able to prepare data for a submission to provide for two levels of funding (ordinary and extensive or intensive care) for Dr A. J. Forbes, the Federal Minister for Health. This analysis of costs was adopted and the new funding base was established in 1966. This was the beginning of Commonwealth funding for specifically designated 'nursing homes'.

Aldersgate Village, operated by Adelaide Central (Methodist) Mission was a model village for aged care comprising at its peak in the 1970s and 1980s 450 residents in the three separate tiers of accommodation (independent living, hostel and nursing home as they had become named by this time). An outreach from Aldersgate was a service that was the precursor in a limited way to Domiciliary Care services called Central Mission Home Service to the Aged.

As more funding was provided by the Federal Government so too were more accountability requirements established and further controls on the standards of care being provided. Major reforms occurred in hostel care in 1973, in nursing home care in 1986 and in residential aged care in 1997. Each of these reforms increased the accountability and controls to the degree that care staff, particularly Registered Nurses, found that they were doing more documentation to ensure funding (and for professional duty of care purposes) than actually providing the care and support to residents. Certainly the funding equation prevents much of the quality personal time being spent with residents on 'non-care' contacts.

Community standards have required improvements in buildings and greater funding directly from residents (accommodation bonds and charges) has placed a much greater series of demands for an ever-increasing level of service. Consequently, at a time when there are insufficient Registered Nurses working in South Australia (and all other States), the aged care area has become too hard and salary differentials create further disincentives to attract suitable numbers of staff.

South Australia has always provided Australia with innovations in care standards and accommodation design for care of the aged. Leadership of Aged and Community Services Australia (formerly Australian Affiliation of Voluntary Care Associations and more recently Aged Care Australia) has been provided significantly by such people as Vernon Harrison, Ron

Crettenden, John Pitchford, Kelvin Dickens, George Martin, John Birkill, Kingsley Curtis, Terry Healey, and Ian Hardy.

Pilot projects for such services as Community Aged Care Packages, Extended Aged Care at Home, Domiciliary Care, Meals on Wheels and Ageing-in-Place were developed in South Australia. Some of these innovations were a direct result of the Aged Care and Housing Group's establishment of Normalisation workshops under the leadership of Wolf Wolfensberg and promoted locally by Mike Rungie. During my time at Resthaven (1992-93) I was able to develop the proposal that has resulted in the Ageing-in-Place concept enabling residents of hostels to remain in the hostel and receive higher levels of care as is currently the case.

I recall in a discussion with the Central Office of the Commonwealth Department of Health in 1981 a suggestion by one of the senior bureaucrats that in the not too distant future residents of nursing homes would have an average stay of 3 months. I remember my disbelief of the statement but today we are heading in that direction more rapidly. Our levels of care in residential aged care facilities have dramatically increased and many more people are being supported at higher levels of care in their own homes. The cost to the governments has increased but the cost to the community in supporting people in their home has also increased. But such arrangements are far cheaper than the older habit of early institutionalisation and rapid medicalisation of such people, removed from familiar community supports and contacts.]

In 1990 I spent four months overseas (Canada, United States, Switzerland, Belgium, The Netherlands, Czechoslovakia, Finland, Sweden and the U.K.) studying aged care provision and its funding and controls by governments. At that time, and today, our provision of care for the aged is second to none thanks to those people who promoted the needs for quality care and those who still do.

SOME IMPORTANT ORGANISATIONS IN THE DEVELOPMENT OF AGED CARE IN SOUTH AUSTRALIA

Barbara Garrett

The Old peoples' Welfare Council

This Council was the precursor to the Council on the Aging. It was established in the early 1960s by representatives of organisations concerned with the welfare of older people.: organisations such as the Royal District Nursing Service, SACOSS, and representatives of community groups concerned about aged care.

The first secretary was Mr Les Clutterbuck, who worked tirelessly to keep it alive and attract government support. Sir Stanton Hicks was its president. Over the years it has had considerable ups and downs, having a couple of directors with dubious financial management skills.

From inception, SACOSS has had representation on the committee and I acted in that position several times in the early years. It survived over time to become the Council on the Aging, which also had a couple of very shaky periods. It was pulled together by dedicated people like Murray Haynes and Dorothy Pash, with a long standing supporter in Vern Harrison at both State and national level.

In more recent time the Council on the Aging SA has become firmly established and recognised as an important advisory service on the needs of older people. Councils on the Aging exist in every State and Territory with a national office in Melbourne which has representatives from all COTAs and works to affect policy at a national level. The influence of the COTAs varies across the nation, but the national office and COTA (SA) have considerable influence. Representatives of COTA (SA) were members of the reference group established under Minister David Wotton (SA) to draw up the ten year plan on aging which was released in 1996.

COTA (SA) was closely involved in the creation of the Ministerial Advisory Board on Aging and I as a nominee have been a member of the Board since its inception in 1996 under the presidency of Dame Roma Mitchell. South Australia has been regarded as a leader in thinking and planning for aged care development.

Aged Rights Advocacy Service

In more recent times, concerned consumer groups approached COTA to assist in developing an aged care advocacy service with particular concern being raised by the Council of Pensioners and Retired persons under the chairmanship of Mary Miller. COTA established a committee to examine the situation under the chairmanship of Mary Miller. I represented COTA. We visited a number of nursing homes and institutions and talked about advocacy and residents' committees. Initially there was a distinct lack of enthusiasm towards these suggestions.

My own experience in placing patients of the Royal Adelaide Hospital and my mother's experience in Helping Hand, where management was difficult to reach, had convinced me of the need for residents' committees as part of the management structure and the need for an independent advocacy service. In 1990 such a service was established, the Aged Rights Advocacy Service (ARAS) with a very determined Mary Miller as president of the Board and Marilyn Crabtree as Director – she remains so today.

Seniors Information Service

COTA has always acted as a central point for information for older people and recognised the need for a special service to answer queries on accommodation, particularly about nursing homes. The then Commissioner on Aging, Lange Powell, supported the concept and recommended to the Commonwealth government that a Seniors Information Service be established under the auspices of COTA. SIS was born in 1994 in the capable charge of Marie Manning.

About 1997, the Commonwealth under Minister Bronwyn Bishop established Carelink across the country using different models to provide easy access to information about services, including local and regional, to everyone. This was particularly important for people living in rural and remote areas. In South Australia the central service is SIS, which had information already computerised, and SIS is linked with four other regional services to cover the State.

The Independent Living Centre

In the mid 1970s Kenneth Jenkin of Bedford Industries and Berendeen Anstice of the SA Association of Occupational Therapists encouraged the Australian Council for the Rehabilitation of the Disabled, ACROD, to support a drive for an Independent Living Centre in

each State. Independent Living Centres are advisory services to help people with disabilities, including disability through aging, manage their daily living. Suppliers of equipment for this purpose showcase their wares at the centres and clients are assisted by occupational therapists who advise and give information as to where the appliances may be accessed.

The move was supported by Cecily Bearup of the School of Occupational Therapy and Marie Hammond of the School of Physiotherapy. Cecily persuaded her School to provide a full-time position to such a service. A working party was established early in 1977 which I chaired, followed by a steering committee in mid 1977 with Berendeen Anstice, Richard Llewellyn, Marie Hammond, Sue Burnell, Donald Simpson, Bunt Burnell, Margaret Mayo, and myself. Early in 1978 two public meetings produced a constitution and elected a board and the ILC opened in St Margaret's Rehabilitation Centre (a Commonwealth facility).

It had a very shaky start and experienced ups and downs over the years with very little support and sometimes antagonism by some disabled groups, together with lack of understanding from Health ministers and the Health Commission. Today it is well regarded, and has a well equipped caravan for country visits, This permits displays at shopping centres, conferences, and country areas as far away as Alice Springs and in Aboriginal communities. But often there is not enough money. In addition, a more central location than Gillies Plains is desirable for its headquarters. Its information can be accessed by computer, but a visit and a meeting with one of the occupational therapists is more beneficial for individuals with disabilities. The goal is to assist such people to be as independent as possible.

Two other small but rewarding and important services occurred as the result of concerns expressed by Royal Adelaide Hospital social workers.

Lavender Lads and Ladies, RAH

It was known that a number of patients remained in hospital beyond the optimum discharge date due to the lack of community support services. To verify and accurately find the number of such patients and their needs, a survey of the total population of the hospital on one day was done.

At the same time I was invited to speak to the Women's Interchurch Council on ways they could service patients other than just visiting with posies. The President, Mrs Pauline Crosby, conferred with the RAH Administrator, Ron Hooper. He prised a small amount of money out of the Commissioner for Charitable Funds to be used to establish the RAH Volunteers, with Mrs Crosby as the first co-ordinator in 1971 under the auspices of the hospital's Social Work Department.

RAH Interpreter Service

The social work staff at the hospital were very concerned about the accuracy of information received about patients by various methods of interpretation, using a variety of personnel. Again we surveyed every patient in the hospital on one day to assess their competence in the English language. The result was very disturbing. It showed that there were a number of patients who were unable to communicate in English. Many domestic staff had been used as interpreters, but their English and their understanding of another language were shown to be often inappropriate.

The report was forwarded to the hospital Administrator, Ron Hooper, and then to the Commonwealth Department of Immigration. Through this, the position of professional interpreter was established under the auspices of the Social Work Department. Our first interpreter was a remarkable man from Central Europe who spoke a number of languages. At the same time, funds were made available for English classes for hospital staff. With a change of government, the interpreter service was centralised in the City of Adelaide. The problem has been relieved but still not solved.

THE DEVELOPMENT OF AGED CARE SERVICES IN SOUTH AUSTRALIA: DOMICILIARY CARE AND REHABILITATION SERVICES

Sue Burnell

This exercise pitched me into an orgy of recollection and many wasted hours. The memories of people and events have ranged from funny to, happy, sad, frustrating, depressing and just plain painful; but overall community care has been an utterly rewarding experience for me and I remain convinced and personally satisfied that we started and maintained for many years, an outstanding form of service delivery.

The three prime movers involved were my then husband Dr. Bunt Burnell, specialist in Physical and Rehabilitation Medicine at the Queen Elizabeth Hospital; Christine Munday, an inspired social worker and myself, a physiotherapist with an interest in rehabilitation.

Initially, my frustration as a therapist working for a Home Stroke Programme set up by Dr. Cliff Jungfer at the National Heart Foundation, was the planning trigger. Nagging Bunt every evening over such issues as lack of discharge planning, inappropriate equipment loan absence of an access point for meaningful follow-up eventually bore fruit. We sat down and sketched out what we would like to establish if an opportunity arose.

Serendipitously, in 1969, came the availability of funds. The Commonwealth offered the States grants on a dollar for dollar basis for Home Care and Paramedical Services for provision of home-based services for the aged and chronically disabled. Ren de Garis, State Health Minister, arranged a series of consultations, chaired By Dr Brian Shea, Director General of Medical Services. The first was at the RAH where Dr Rollo Greenlees addressed the meeting and the last was a week-end at the Raywood Conference Centre to select the proposals to go forward.

In between, two advisory groups were formed: one to contemplate the needs of the Physically handicapped and the other to discuss home care and community services, primarily but not exclusively for the aged. All manner of individuals and organisations were involved in the latter advisory group. Debates were extremely lively, even passionate at times and we were relieved when the Burnell proposal was finally supported.

Four pilot schemes were suggested:

- One in a far country town - Port Lincoln
- One in a near country town - Murray Bridge
- One affiliated with a teaching hospital, Woodville
- One based in a Senior Citizens Centre - Unley

A long wait ensued as the proposal got mislaid between Commonwealth and State desks: why was I surprised? However the delay was put to good use in preparing the Woodville Pilot scheme. Accommodation was offered; initially 3 rooms in a house in the Mareeba Annexe grounds; a minimal number of staff were press-ganged from the colleagues and acquaintances and we opened for referrals on 26 July 1971.

Port Lincoln and Murray Bridge also commenced that year but Unley failed. The service aims were straightforward enough and strangely durable.

1. To give support to aged or other people in their homes and to help relatives caring for patients who would otherwise need hospital or nursing home admission.
2. To avoid hospital admission if possible and to permit earlier discharge by provision of services in the home.
3. To utilise and coordinate existing community services and establish other services where deficiencies exist.
4. To provide training both at the graduate and undergraduate level to assist the future expansion of home care services.
5. To gather information for the statistical analysis of community needs.

Growth was extraordinary. We hit the ground running and the pressures never let up. In a remarkably short space of time, the Pilot scheme reports were in, the concept accepted and expansion approved.

1972 Woodville became the Western Region.

1973 Central Northern [Para] opened.

1974 Eastern Region commenced, closely followed by Southern Region

1978 13 country centres operating

by 1990 4 metropolitan regional services and 21 country services existed.

Another significant initiative was the establishment of the Paramedical Aide course. This training programme provided Multipurpose Aides for multidisciplinary teams. That whole enterprise deserves a dissertation in its own right but it created a remarkably resilient and holistic worker for the home care scene, who carried intelligently and well a huge proportion of the workload of the services and allowed us to make proper use of scarce professional skills.

Many developments, including case co-ordination/management area teams, case conferences, the Paramedical Aide training course, a Mobile Unit to assist the country centres, day centres, drop-in centres, men's wood workshop, liaison staff in hospitals, respite services, bi-lingual staffing and many more, long before we suffered a sea change in 1985 with the arrival of a new world order and a different form of funding through the Home and Community Care initiative.

At a personal level, the joys of the job revolved around the people, including those one worked for, with and sometimes against! The focus on functional independence was enhanced by meeting clients and carers in their own territory. Above all one could work in an extended time frame and sustain continuity of contact. It was wonderful to be able to design for individual problem-solving. I always felt that the magnitude of the problems we encountered among the first 300 people referred challenged our flexibility, ingenuity and lateral thinking enough to cope with anything that came later. We went through an almost vertical learning curve!

There were difficulties and issues galore too, but back then one had energy and enthusiasm to burn and everything seemed surmountable. Inevitably, over the decades, as in every health scene, rational service delivery became harder and standards difficult to maintain.

I retired gratefully in 1996, contemplating with wry amusement the wonderful and very relevant quote from the writings of Petronius Arbitrarius AD 66, who said, 'I was to learn later in life that we tend to meet any new situation by reorganising and a wonderful method it can be for creating the illusion of progress, while producing confusion, inefficiency and demoralisation'.