Archived at the Flinders Academic Commons:
http://dspace.flinders.edu.au/dspace/

Speech by Adam Graycar:

"Care of the aged"

presented at the Second National Meals on Wheels Conference, Adelaide, 1st October 1987

© Government of South Australia
This speech is made available under the CC-BY-NC-ND 4.0 license:
http://creativecommons.org/licenses/by-nc-nd/4.0/

NOT FOR DISTRIBUTION

SECOND NATIONAL MEALS ON WHEELS CONFERENCE

ADELAIDE

1ST OCTOBER 1987

CARE OF THE AGED

ADAM GRAYCAR

Commissioner for the Ageing
Box 1765, GPO ADELAIDE. 5001

Our society is ageing and people over pensionable age now represent almost 15% of the Australian population. This proportion will ~~remain roughly the same in~~to *increase only slightly* the next century but the numbers within it who are aged 75 and over will have increased by 62% between 1986 and 2001.

The fact that more people are reaching old age represents success: improvements in health, better housing, and better living standards. This success is something we will all benefit from if we learn to utilise the potential and tackle the challenges which ageing offers.

The majority of the 2½ million Australians who make up the retired population are fit and well and living in their own homes. Very small proportions of old people (around 7%) live permanently in a nursing home or hostel.

The image of elderly people as a burden is quickly shattered when their real contribution to society's well-being is examined.

For example, significant numbers of older people (twice as many women than men) are engaged in voluntary work and many who care for dependent elderly relatives are over retirement age.

Elderly people are a resource with knowledge, skills and time. Retirement can be about one-third of a lifetime: the potential

for enjoyment and fulfilment is enormous. The challenge posed by an ageing society is to enable everyone to fulfil this potential and to give adequate care to those who need support.

Poverty, ill-health, poor housing, lack of mobility, loneliness, fear of crime, and diminishing choice are not inevitable consequences of old age, but they are commonly associated with it.

Longer life and lower mortality rates at higher ages raises the potential for greater dependency. Of the many possible responses to greater dependency the development of suitable food policies and practices is an important step in allaying the unremitting consequences of increasing dependency. In this talk I want to highlight some aspects of food as part of a commuity care package and point out the benefits of a coherent food policy.

For most of us, dining is more than merely consuming food, it is a social event. Nutritionists tell us that eating with others tends to encourage good nutritional habits, increased care in food preparation and improved digestion. Older people have the same essential need for social contact at meal time as do other age groups. However, living arrangements, loss of family and friends, costs and other factors may make such contact infrequent. Recognition of this social need was a major factor in the development of services like Meals on Wheels.

Meals on Wheels is particularly valuable in three main ways. Firstly, the service is a provider of sustenance. Different forms of nutriment can be provided and reciprocated physically and psychologically as well as individually and socially.

Secondly, it can be of symbolic value. Food and the way it is offered can convey empathy and caring. We think of ourselves as caring people belonging to what at times can be an uncaring society, and the meals service reflects this social value, for good, bad or indifferent. The meal itself can indeed be a symbol of social caring, providing it is desired and required by and acceptable to the person who receives it. On the other hand, it may be that what is required is social contact, or help with shopping, or a fusion of the three. If the caring is not to become a mere ritual or token, then the onus is on the service to determine and respond to real need.

Third, the meals service is a microcosm of the main themes in social services provision for older people, which are found for example in the more costly services such as residential and day care. These themes relate to problems in developing service objectives, referral criteria and need assessment procedures, service monitoring and evaluation, and the eliciting of users' views. (Part of good management).

Considerable work, notably by a British expert, Louise Davies and the Gerontology Nutrition Unit, has been done in the field of nutrition, including the development of a meals on wheels assessment kit. It is possible to identify nutritional risk factors and to ensure that, substantially, meals are healthy.

Risks factors for older people include:

- Less than eight main meals, hot or cold, eater in a week.
- Less than half a pint of milk a day.
- Virtually no fruit or vegetable consumption.
- Food wastage.
- Long spells throughout the day without eating.
- Depression, loneliness or social isolation.
- Sudden change in weight, either gain or loss.
- Problems of shopping.
- Low income.
- Presence of other factors or disabilities (including alcoholism).
- Language barriers/difficulties.
- Widowers (particularly men who are newly widowed) who are non-cooks.
- A dearth or lack of appropriate ethnic meals.

The development of a food policy is one way in which principles of nutrition and strategies for their implementation can be laid down. A food policy helps to guide planning, rationalise provision and generally contribute to the clarity of practice.

Warwickshire's food policy for social services encapsulates financial, social and health considerations. It aims 'to produce safe food within a prescribed budget which is nutritionally sound, looks attractive and tastes good and that clients enjoy'. The policy specifies the objectives for budgeting, the contracting for provisions, social work practice and for nutritional needs; and the ways in which these objectives can be operationalised.

A food policy can relate diet to the promotion of health. It is argued that the practice of an enlightened dietary policy would contribute significantly to preventive medicine.

Guidelines would cover matters such as:

- Elderly people should receive a nutritionally adequate diet.
- Foods which are nutrient-dense should be offered or recommended over nutrient-poor, high sugar foods.
- Where appropriate, unrefined foods should be introduced gradually. (Items such as lentils and split peas would possibly be more familiar than chick peas to the older age group. Properly cooked pulses are easier to chew than many kinds of meat).
- In general, greasy foods are inappropriate and often not appreciated. This principle however should not be too strictly adhered to unless the person has a weight problem.
- Energy-dense foods which are rich in fat, such as puddings

and sponges, might be valuable in providing sufficient calories for persons with small appetites.

- A minimum fluid intake of two litres a day should be maintained. This may need to be encouraged in those who have a diminished thirst reflex.

With regard to food qualtiy:

- Appropriate portion control allowing for different appetites is recommended.
- Texture modification of food should be undertaken sensitively with liquidised food used only as a last resort.
- Elderly people should be encouraged, where possible, to choose their own food.
- Flavour enhancement without extra salt but with an emphasis on a variety of flavours and textures is important for elderly people who suffer from loss of taste and smell (flavour enhancers such as herbs, spices and vinegar can be used, and adaptation to lower intakes of salt without flavour loss is possible if carried out gradually).

The concern about food quality should also include avoiding a repetitive weekly menu cycle and subsequent meal monotony for consumers.

We must recognise that a large number of socio-economic factors may affect the nutritional levels of older adults; and that different combinations of risk factors will apply to groups of older people according to their psychological and socio-economic

conditions. Risk factors which may be related to malnutrition in elderly people, and which have not been previously mentioned are:

- Bereavement and dementia.
- Physical problems in food preparation such as arthritic hands.
- No stores of useful foods for emergencies.
- The assumption that a mobile meal is adequate for the entire day when it is designed to provide a third of necessary nutrients and energy.
- Dentition. Sore mouths and gums and/or ill-fitting teeth may result in a curtailment of food intake.
- Confusion or forgetfulness.
- Medication which may upset appetite, sense of taste and metabolism of nutrients.
- Difficulties with taste or smell. Between 10% and 15% of elderly people suffer a reduction in their sense of taste or smell.
- Swallowing problems.
- Regular use of laxatives.
- An increased nutritional requirement brought about for example by a recent hospital discharge, fever or slow-healing wound.

When we look at Care in the Community the conventional wisdom is that life in the community, preserving one's home and autonomy, is preferable to institutional life, whether it be in a nursing home or hostel. It is necessary to point out quite

categorically here that residential care should not be seen as an inherently inferior type of provision. Rather it fulfils a valuable role along the care continuum when it is used appropriately, and it should be recognised as part of the neighbourhood or locality in which it is situated. Community care, however, represents value for money and can be more cost-efficient than institutional care, both to carers and their families. These hidden costs need to be carefully assessed in the value for money debate.

When we talk about delivered meals we often talk about social contact. Since the earliest days of meals on wheels it has been claimed that such provision enables valued social interaction to take place.

It is unlikely that meaningful social contact can occur given the brevity of the meals delivery. The tendency to justify one activity (providing a mobile meal) in terms of another (providing contact) is dubious. The usually brisk delivery of a pre-cooked meal can rarely be a viable substitute for worthwhile social relations, and it is hazardous to regard it as such.

Whatever the care package put together, whatever the mix of home care services including home help, delivered meals, home nursing

or any other of the Home and Community Care innovations it is crucial and fundamental that the consumer have to have some say and that their rights and responsibilities are recognised.

OVERVIEW

If we are concerned with developing suitable effective, and relevant care services to make community care a workable reality we have to consider:

- Locally integrated services which are matched to lcoal areas which are of a manageable size and can be identified by clients and service providers enabling the latter group to know and thus work more easily with one another. Also the staff who plan strategically are linked with those who plan operationally so that there is cohesion between policy and practice.
- Focusing on action rather than bureaucratic machinery in a multidisciplinary/multi-agency team.
- Partnership between statutory and voluntary services and organisations.
- A team approach based on a multidisciplinary/multi-agency work ethic.
- Recognition of ethnic diversity.

To make community care work well we have limit problems such as interprofessional tensions, (particularly in an uncertain financial climate), and work on the fact that co-ordination of local services is generally incompatible with the present bureaucratic, professional and financial structures, combine with others to challenge attempts to plan successfully and provide services collaboratively.

Meals on Wheels, exists in a larger network of services. A case of need for the meals service may be a culmination of breakdown in one or more services in the surrounding network. It may of course be a clear-cut case in terms of cause, detection and resolution. Even in a situation where the meals service is a clearly desirable intervention in, for example, minimising the risk of malnutrition in an elderly person prematurely discharged from hospital, an understanding of the contributory factors of malnutrition in older people enables insight into the broader view that must be taken to ensure both assessment and treatment are appropriate. An intervention programme must be prepared to be wide ranging and flexible in its assessment and care procedures.

BARRIERS

The Financial Barrier

The Isolation Barrier

The Environmental Barrier

The Shopping Barrier

The Cooking Barrier

The Cultural Barrier

The Educational Barrier