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Speech by Adam Graycar:

"Government policies in aged care"

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VOLUNTARY CARE ASSOCIATION

ANNUAL GENERAL MEETING

ADELAIDE

7th September 1987

GOVERNMENT POLICIES IN AGED CARE

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COMMISSIONER FOR THE AGEING

The looming explosion in social care poses formidable challenges for policy makers in the gerontological arena. Policies, programs and services that reflect the interests of our older population, families of older people, workers in the aged care industry, and the community at large (tax payers) would ideally exhibit characteristics of equity and efficiency, accessibility and accountability, and most elusively of all, wide acceptability.

There is no shortage in Australia of detailed reports comprising a litany of solutions and suggestions of how to develop most suitably the services required to support our older population. The key policy issues seem to me to be:

- how to cater for an increasing old-old population that almost certainly will put greater pressure on our nursing home beds, while at the same time implementing growth control principles.

- how to provide that population with appropriate professional support which will have to be accompanied by a more relevant orientation, almost certainly involving substantial attitudinal change among nursing home administrators and personnel.

- how to develop policies within a dynamic system of federal/state relations, a system in which responsibilities are not clearly defined and in which political and fiscal factors shape decisions, often to the great consternation of those

who are closest to the care being dispensed - the providers and the recipients.

- how to fund high quality services, and determining what proportion of the cost should be borne by governments by the individuals, by their families or by service providers.

If as is likely the number of nursing home beds is reduced to 40 per 1,000 persons aged 70 or more, and if, as is also likely other changes are instituted, then it follows that the

reduced number of nursing home beds will, of necessity, be filled by people who are considerably more dependent than many of the people in nursing homes today. There will be no place in Australia's nursing homes for people who are not highly dependent and who have not been assessed as such.

Changes in Commonwealth policy will ensure that those who are resident in NHs, will have some physical condition requiring such accommodation. Furthermore, their disabilities and dependencies will require good professional and other support to ensure that their needs are met and so they can be maintained at a quality of life that is deemed appropriate. With the high prevalence of organic disorders such as strokes, cancers, and Alzheimers disease, strict attention will need to be paid to issues of social justice and maximisation of opportunities and rights.

The demographics don't have to be laboured. Here in South Australia our population aged 85 and over will almost double between now and the year 2001. The increaase will be from twelve and a half thousand people to almost twenty three thousand people. As you know the dependencies of age are more pronounced at the top end of the age spectrum. About half of all nursing home residents today for example are over the age 85. And looking at the figures here in South Australia about 20 per cent of people in the 85 to 89 age group live in nursing homes, about 35 in the 90 to 94 age group, and just half of those in the 95+ age group.

Of every one hundred thousand females born, in 1901 34,000 survived to age 75. By 1984 70,000 survived to age 75. That is one of the most dramatic and monumental mortality drops. To say to people that they have a 70 per cent chance of surviving to age 75 would have been unheard of not only at the beginning of this century but as recently as a decade ago. When we look at the next age group, those surviving to age 85 we find that in 1901 10 per cent survived to age 85, now it's 38 per cent. When we look at the 95+ we see the largest proportional increase of all. In 1901 687 of our 100,000 women survived to age 95. By 1984 it was almost 6,000. Looking at life expectancy figures a 75 year old male can expect to live approximately 9 years and a 75 year old female approximately 11. An 85 year old male approximately 5 years and an 85 year old female approximately 6.

Given that the incidence of dementia, the incidence of incontinence, and the incidence of immobility increases with age we find ourselves in a situation where our responses have to be clear, consistent, and obviously well resourced.

If we take incontinence as one of the issues the point to note is that incontinence is one of the major causes of admission to nursing home accommodation. As a State government we are enormously concerned about it but we need to work jointly with the Commonwealth government and with service providers.

Incontinence is enormously costly to governments, communities, and individuals in terms of the use of financial resources for the management of incontinence, the valuable nursing time that is spent on incontinence, the loss of dignity and independence for the independence, premature admission to nursing home care, and the additional laundry costs that nursing homes face.

It is estimated that about 800,000 of Australians (about 5% of the total population) share the problem of incontinence and the condition is frequently left unevaluated and improperly managed. Current figures suggest that about 10 per cent of men and 15 per cent of women over the age of 65 suffer from urinary incontinence but about 60 per cent of the nursing home population is so affected.

Leaving aside the cost to individuals the costs of laundry in nursing homes are just enormous. It has been suggested to me that a 20 bed nursing home has additional laundry costs due to incontinence of something in the order of $772 per week or $40,158 per annum. A one hundred bed nursing home has additional laundry costs of $3,860 per week or about $200,720 per annum.

Putting resources into an all out attack on incontinence now is clearly good professional practice and good economic practice. But of course this all takes place within a situation where professional values, political values, and financial values may well be in conflict.

We are in a situation where we are dealing with something that is clearly big business and big politics. While it is fine to describe age care in professional terms we can't avoid the big business, big politics tags that go with aged care.

The overheads show the Commonwealth spends close to ten billion dollars a year on services for older people - over 80 per cent of this goes in income support. What is of interest is that when we look at the rates of growth we see that the rate of growth of income support expenditures has slowed down in recent years. The rate of growth of HACC services has increased while residential programs have seen a decline in the rate of growth.

The big dollars are administered by the Commonwealth. The new Department of Community Services and Health has somewhere in the order of 20,000 employees. While that is a figure for all of Australia it still indicates for us that we are dealing with a large and complex set of programs and administrators. We in the State Government seem very small fry in comparison.

We are in the business of somehow trying to sort out the issues of making programs work in what can only be described as the bizarre nature of our Federal State system.

Integrating Federal and State activities is not easy. Following the release of the Commonwealth's Nursing Home and Hostels Review the South Australian Government, together with those of the other States, agreed to participate in a joint working party to consider the development of national standards in nursing homes, to work jointly on developing a strategy for assessment teams, to move for standard inspection systems, and to work to protect consumer rights. We are also jointly implementing the Home and Community Care Program, which when combined with suitable assessment will ultimately bring about changes to our nursing homes.

The conundrum of federal/state relations confounds us all. All Australian States provide roughly similar services to their elderly population. In drawing up a catalogue of services we were able, in South Australia, to identify 30 statutory services for older people, of which 7 are Commonwealth funded, 15 are State funded and 8 receive a combination of Commonwealth and State funding. The list is long and sometimes defies logic, but each part contributes to the well being of the whole and thus a shortfall in one area can have effects across a wide front. Developing such a catalogue identifies bizarre irregularities. For example, the State, through the Pensioner Dental Scheme and the S.A. Spectacles Scheme looked after pensioners' teeth and eyes, while the National Acoustic Laboratory tested hearing and provided hearing aids. We often contemplate the logic of eyes and teeth being a State responsibility, and ears being a Commonwealth one!

What this quaint example highlights is the expediency and the opportunism that characterises the service structure. Given limited resources it is always worth trying to get somebody else to fill the gap. There are never enough dollars, never the right planning and co-ordinating mechanisms, and one can describe federalism, originally a means of controlling power by dividing it, as the bane of planners, the euphoria of procrastinators and the indulgence of buck passers. Nowhere is this more obvious than planning for our older population - securing the right mix of services and the right funding arrangements.

In structuring a suitable environment for our older population we have to sieze the planning initiative, develop our allocative mechanisms along credible and humane lines and ensure we have a good theoretical and empirical basis for social activity and interventionist practices affecting the lives of older people. To do so requires a position on philosophy, process and action.

One of the philosophies that I have a problem with is that of normalization. The principles are highly desirable and truly admirable. What concerns me is the ignorance about ageing of many of the converts, the search for simple solutions to complex problems, and the unbelievable authoritarianism and conservatism that are part and parcel of normalization as taught and practiced here in Australia. In times of financial constraint there is a particular onus on service providers to become more efficient and productive, while not lowering the quality of care and support. During the Ministerial Task Force on Nursing Home Accommodation we received a large number of submissions, many of which expressed great concern over the implementation of practices inspired by the philosophy of normalization.

As our Office had also received a number of confidential complaints from consumers, relatives, staff and administrators on the effects of the implementation of normalization on powerless individuals, I felt an obligation and a necessity to pursue the issue further.

There had been no real public debate of this far-reaching philosophy and its impact on the lives of older people. I opened up a debate by raising the issue in an address to the Australian Association of Gerontology, and in an article published a national journal.

The response to these was overwhelming, but polarized. The most unexpected was the national written and verbal support from senior administrators, academics and professionals, welcoming the analysis as being a much needed initiative to begin a rational, objective, public debate on the issues. The very small number of aggrieved professionals who responded, expressed their opposition with great vehemence.

The original misgivings about normalization which were based on consumer and other complaints and professional doubts, were confirmed, and the stage is now set for a constructive debate on the implementation practices of normalization.

The Nursing Home Task Force which I mentioned, reported earlier this year. Many of you are familiar with the recommendations and issues. The 22 recommendations covered 5 general areas. There is an implementation plan and on some of the big issues such as staffing levels, negotiations with the Commonwealth are still under way. The recommendations covered...

SUMMARY OF IMPLEMENTATION PLAN

RECOMMENDATION	LEVEL OF GOVERNMENT SUPPORT PROPOSED	ACTION
STANDARD OF CARE, FUNDING		
1 Benefit Levels and Care		SAHC, OCA to advise MH on implication of any changes to benefit levels.
6 Institutional/Community Linkages	Support	Refer to HACC Policy Committee, MCS.
7 Resist Lowering of Standards	No Support	Reiterate SA position to MCS.
8 Staffing by Dependency	Support in principle	Refer to SAHC rep on C/W-State W.P. on MH Standards.
QUALITY OF CARE		
2 Rights and Responsibilities	Support	Refer to OCA for model set.
3 Complaints Mechanism	Support in principle	Refer to OCA and C/W MCS.
4 Uniform Quality of Care Standards	Approved	Agree to consultations on draft standards.
5 Quality Assurance Mechanism	Support in principle	Refer to OCA.
18 Incontinence Groups	Support	Refer to OCA for advice on nature and level of support.
19 Injuries	Support	Refer to SAHC.
20 Rehabilitation	Support	Refer to C/W MCH.
STAFFING ISSUES		
9 Nursing by Qualified Nurses	Support in principle	Advise SAHC.
11 Nursing/Non-Nursing duties	Support in principle	Advise SAHC and refer to C/W MCS.
12 Uniform definition of domestic duties	Support in principle	Refer to C/W MCS.
13 Personal Care Attendant	Support in principle	Refer SAHC
EDUCATION ISSUES		
10 Assistants to Enrolled Nurses	Support in principle	Refer to SAHC for advice and plans.
14 Educational Strategies	Support in principle	Refer to SAHC for advice and plans.
16 Continence Workshops	Support	Refer to HACC Policy Committee.
17 Community Incontinence Training	Support	Refer to SAHC and C/W MCS.
OTHER ISSUES		
15 Inspection	Support	Refer to SAHC.
21 Research	Support in principle	Refer to OCA
22 Reference Group	Support	Refer to OCA.

I mentioned the complexity of Federal/State relations. The State Governments are not significant funders in residential care. Our duties and responsibilities are of a different order. The big question, however, is who should call the shots. The Commonwealth pays the piper. Should the Commonwealth call the tune?

While the old adage suggests that he who pays the piper calls the tune, one could suggest that he who calls the tune is often tone deaf. One of our university research studies concluded

> "those who dispense funds may not have complete information nor are they always rational and consistent. They may hold values that encourage agencies to react in debateable ways."

My study confirmed that he who calls the tune is tone deaf. The confirmation can only be general because the data show that many tunes are played, and these do not harmonise into a sweet melody but rather a cacophanous irregular jam session. With many tunes being called and played by the tone deaf, any semblance of coherence in the service system is slight. While it is one thing for academic writers to suggest there should be harmony, the reality which faces the agencies is one of discordance and dissonance.