AGED CARE - WHERE TO NOW?

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Significant and monumental changes have taken place in the recent past in the structure of Australia's population, in the needs exhibited and expressed by the population, and in the methods used to attend to those needs.

For conventional reasons those aged 65 or more are regarded as constituting our population of elderly persons. 10.5% of South Australia's population is aged 65 or more. Most are not in the labour force and thus rely for their security on past investments; government pensions and benefits and services; and their families. Some are fortunate in having a combination of all three, others survive on one or two of these.

S.A.'s elderly population is increasing at a much faster rate than that of any other State. 10.5% today c.f. 9.7% 2001 around 14% c.f. 11.5% 2021 around 19% c.f. 15%. Median population forecasts for 2011 in S.A. show that population will rise by 27 per cent; the numbers over 65 by 67 per cent; and those over 75 by 118 per cent; over 85 by 224%. Those over 75 who in 1901 comprised less than one quarter of the over 65s, today comprise just over one third, and by 2011 will comprise 50 per cent. At least 2 distinct elderly populations.

Most of the "young-old" are of an age where people are usually physically healthy and mentally alert. Their main problems relate to adjusting to retirement, and in most cases the associated income reduction. Income maintenance and preventive health services are of great importance. 35 per cent of people over 65 are over 75, the "old-old", and thus are of an age where most people need more than average levels of support from the community. In addition to economic and social dependencies, physical limitations and disabilities become part of the lives of many people.

Most elderly people in Australia live in private residences. 93.6 per cent of people aged 65 and over live in private households and only 6.4 per cent live in institutions (nursing homes, hostels, homes for the aged, etc.). Institutional rates vary by age and sex: 2.1 per cent of men aged 65-74; 2.4 per cent of women 65-74; 8.1 per cent of men 75+; 17.2 per cent of women 75+ live in institutions of various types.

Rates of institutionalisation are directly related to demographic factors. Having a spouse is the greatest defence against social isolation, public dependency and poverty. 72 per cent of men aged 65 and over have a spouse. 37 per cent of women aged 65 and

over have a spouse. There are considerably more elderly women than men, and when we translate the percentages into actual numbers, there are in S.A. about 15,000 elderly men without a spouse, yet 46,000 elderly women without a spouse. At all ages (above 65) the proportion of married men far outweighs the proportion of married women. For example 32 per cent of men over 90 have spouses while only 4.8 of women over 90 have spouses. There has been a significant change in marital status statistics for men since the 1921 Census. In that Census 59.4 per cent of elderly men had wives. Today the proportion has grown to 72 per cent. The proportion of women with spouses has remained constant over the same period. Has the male married rate peaked? Will it keep rising? What about female married rates - will they increase? What will be the impact of rising divorce rates (these are presently 2.7 per cent and 2.3 per cent for elderly males and females respectively, compared with 1.1 per cent and 0.9 per cent at the 1961 Census and 0.2 and 0.1 per cent at the 1921 Census). When developing policies for care of elderly people these demographic changes are of considerable consequence.

I would love to keep talking demographics and the policy ramifications of demographic change - but perhaps another time, another place.

While demographers argue about the extent to which the population is ageing, and about dependency ratios in years to come, the key issue is really why ageing is seen as a problem in the first place. In the second place, the question of for whom is it a problem, must be raised; and third, what interventions are appropriate to deal with the situation.

Ageing is seen as a problem because a situation of dependency can be identified. The dependencies of ageing are chronic not transitional and are social, economic, physical and political.

Ageing can be seen as a problem if transitional periods are used as a means of creating, for elderly people, and for the society they live in, a situation of exclusion from the mainstream of life. To maintain high rates of inclusion requires substantial public intervention, and of course there is a price to be paid. Role of Commissioner - max. inclusion - minimise exclusion. If we turn to the second question, for whom is ageing a problem, we can identify three parties whose situations are affected. This is not to say that ageing actually is a problem for all concerned. First of all there are the elderly people who are excluded from the mainstream of life by virtue of their dependencies; second there are the relatives who may find themselves in time-consuming and expense-producing caring arrangements; third there are taxpayers and politicians who maintain that elderly people cost too much.

The third question, what interventions are appropriate to deal with the situation, is primarily a political question.

There has been no shortage of political controversy lately about the degree to which government should provide support to elderly people. Arguments about whether age pensions should be provided on a universal basis, whether elderly people should receive health care and housing support at less than market rates are perpetually in the political arena.

As the rate of economic growth slows down, competition for resources becomes more fierce and the legitimacy of the 'non-productive' sector is increasingly questioned. Accepted and potential interventions come under greater scrutiny and the politics of backlash is evident amidst arguments about "responsible government spending", "excessive taxation", "system overload", "family responsibility" and so on. One long running argument is to suggest that government is replacing the family as a primary care agent. To rectify this situation and to save public funds, one solution offered is a diminution of public services and a thrusting upon the family of greater responsibility for a primary caring function. It can be argued that many of the "problems" associated with ageing are largely political. Although Australia is not a rapidly ageing society, ageing is big business and big politics.

I would argue that the big political issue relates to the claims that are made in our society and the response to those claims. All persons, elderly and non-elderly alike make claims for alloc-

ations, which affect their well being, on four institutions - the State, the family, employers and the local community. Elderly people make claims mostly for an adequate income, for appropriate living arrangements, for high quality services, for independence and dignity, and for institutional responsiveness and a sympathetic attitude towards ageing.

We live in interesting times because there are four major delivery systems which can act on these claims, and politically and socially we have not been able to determine authoritatively, how they should relate to elderly people.

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

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

Third, there is the non-government welfare sector - sometimes called the voluntary sector. This is a large and complex web of organizations varying in size, scope, activity and interest. It is too diffuse to be regarded as a unified sector. Our research has identified up to 49,000 NGWOs in Australia, of which 6 to 8,000 deal with aged people. There are complex funding and service arrangements between NGWOs and government.

Fourth, there is the informal system of social care. The help and support that family, friends and neighbours give one another is so often just taken for granted that it seldom enters discussions of service provision. Informal supports include provision of care in the home of dependent and disabled people, young and old; transfers of material resources within families; provision of advice and psychological support in coping with difficult situations.

One of my first tasks as Commissioner for the Ageing is to sort through this complex structure of statutory, commercial, non-government and informal services - to examine the needs of S.A.'s 140,000 elderly people; of S.A.'s 800 or so "voluntary" welfare organisations in aged care; of the mishmash of government activities at Commonwealth, State and Local levels.

With your help I want to identify conditions, needs, problems, service strategies, solutions. I want to identify gaps in services; I want to identify mechanisms which broaden inclusion and reduce dependency. I want to look at pressures on service providers as well as gaps in services.

The Commissioner for the Ageing Act, 1984 has objectives oriented to the enhancement of the quality of life of elderly people and the reciprocal enrichment of the community in which elderly people live. The Act requires the Commissioner to provide policy advice relating to programmes and services for the ageing, and in so doing to monitor practices of all levels of government, gather data and undertake research, and consult widely.

I plan to embark almost immediately on an extensive information gathering exercise - elderly people
- service providers
- govt.
- researchers

Aim to build a human services grid to identify points of intervention and gaps to be filled.

For example a service structure for elderly people across a broad spectrum might look like this.

(S L I D E 1)

Who provides what?
Under what auspices?
Who finds what?
Who is accountable for what?

My research in recent years shows incredible confusion about goals and objectives.

When all the evidence is assembled and assessed it seems that services for elderly people exhibit characteristics of fragmentation, discontinuity, a touch both of duplication and scarcity, easy access to some and virtual inaccessibility to others, and overall, a very low level of accountability. And right up there in this mayhem, in this farrago of disorder, are both government and the voluntary agencies circling our elderly population, realising that the old folk will be best served if harmony can be made to prevail above mistrust. The relationship is clearly an uneasy one. It is characterised by uncertainty, suspicion, lack of broad principles, adherence to procedures which do exist, political activity, attempts at rationality, rapid decision-making and a whole host of other issues which make the elderly the meat in this awkward sandwich.

There are three things I should like to call for. First there should be developed, right across the country, with S.A. setting the trend, a set of regional registers of services. All would then know, at the grass roots, what is available and what is not, what sorts of things are provided by statutory bodies and by voluntary organisations. Such a register would be of immense use to elderly people, to local service personnel of all types, to organisations who are in the planning and delivery business, and to governments who should be engaged in policy, planning, funding, and co-ordination pursuits.

Second, I should like to add my voice to the call for one unit only, within the Commonwealth Government, to have central policy making, planning, funding, and co-ordinating authority, a body which can assess the data, determine the needs, allocate the resources, and measure the outcome.

My third call is for the development of a standing consultative arrangement in which service providers, governments and consumer representatives feed in their interests and their expertise. The Commissioner for the Ageing Act requires me to consult widely and this I plan to do as part of the policy process.

As I said my task is to enhance the quality of elderly people in S.A. and by developing an information and work strategy we will be able to take the necessary first steps along a ragged path that hopefully will soon look more coherent.