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Developing Policies for the Ageing : the Importance of Family Indicators

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AGEING AND COMMUNITY RESPONSE

At an Institute of Family Studies conference in 1984 I argued that the major indicators of family well being were access to and receipt of tangible resources, effective services, and close companionship. In very crude terms it could be argued that the first is best delivered by government because only government really has the resources to meet the non-market income maintenance needs evident in modern societies. The second, effective services comes largely through an incredibly complex network of government service agencies, community agencies, and commercial services and this mix of government and non-government, community and commercial, shapes our service systems. The third, companionship and family support cannot be delivered bureaucratically, and analysis here gets us into the realm of informal services, family care systems, informal supports, and all the things that come with kinship and friendship networks.

Applying these three sets of indicators to older people gives us a start in understanding how older people live and a start in understanding policy responses to data about income, service access and relevance, and family structure. When we look however at who delivers each of these we find that the main deliverers, governments, community agencies, and families are all under great pressure. As we are faced with an explosion of care we can see the traditional care providing organisations all facing different sorts of pressures. What is very obvious is that no one sector alone can provide all that has to be provided - certainly not government - cetainly not community agencies - certainly not families. Different needs are met by different support systems.

Given the pressures on each of these, one operationally heuristic tool might be to examine issues of capacity and willingness of the various major actors and delivery systems. Government's activities in family support are determined largely by its willingness, and notwithstanding heated debate over deficits and the tax system, it can be argued that the tax

system has the capacity, but not the willingness to provide adequately. Families, the other end of the spectrum have the willingness but not the capacity to provide the care and support that is required, and although the bulk of care which is provided does come through the family, policy makers must ensure that boundaries of capacity are carefully understood and that unrealistic expectations of family care do not become the norm.

If we think of governments, community service agencies, and families as in some sort of capacity hierarchy, we can argue that willingness is inversely related to capacity and that as one moves down the hierarchy the operator in question is less and less able to deflect or reject claims made upon it. Government with its eligibility requirements can quite dispassionately send claims which it cannot meet onto community agencies and families. Community agencies likewise can draw lines and pass the excess onto families. Families are the providers both of first and last resort - and as our research has shown, a repository of willingness, but often lacking in capacity.

Planning and developing programs for a diverse elderly population clearly requires good data and dynamic knowledge of relevant indicators. Planning, a conscious attempt to solve problems and control the course of future events by foresight, systematic thinking, investigation, and the exercise of value preferences in choosing among alternative lines of action - is both a techno-methodological and a socio-political process which operates within a given political-structural configuration.

In planning for societal well-being and the allocation of scarce resources, there are a number of scientific techniques and processes used by policy-makers and analysts. I have described these techniques - ranging through social research techniques (surveys, controlled experiments, case studies), monitoring techniques, policy science and cost analytic techniques - in my Welfare Politics in Australia: A Study in Policy Analysis (Macmillan 1979) and in that work developed models for the

formulation, implementation and evaluation of policies, programs and services. Noting that ideology and expediency temper so-called rational decision making it is necessary always to relate the dynamics of relevant interest groups in the process.

In developing programs for our elderly, family indicators comprise one set of variables - the interests of the providers and recipients, the bureaucrats and the do-gooder all combine together to shape programs which sometimes appear inconsistent, incoherent, incompatible and incomprehensible.

The diversity of the elderly population is enormous. About two thirds of those over 65 are under 75, that is most of the people are of an age where they are usually physically healthy and mentally alert. The "young old" have as their main problems issues relating to adjusting to retirement, and in most cases the associated income reduction. For them income maintenance and preventive health are of great importance. About one third of people over 65 are over 75, and thus of an age where most people need more than average levels of support from the community. In addition to the economic and social dependencies, physical limitations and disabilities become part of the lives of many people. The dependencies of old age are much more likely to be chronic than transitional. Multiple disabilities interact and compound, so that what may initially have appeared only physical, takes on broader social dimensions. In this paper I want to focus not on the population over the age of 65 but rather on the population over the ageof 75. In essence the 65 to 74 population and the 75 and over population are two different populations with two different sets of needs. The crucial point to note is that within 25 years approximately half of our over 65 population will also be over 75, and thus policy makers are faced with a formidable set of planning tasks.

The attached tables show the numbers aged 75 and over, the growing proportion of the total population that is projected to be 75 and over, the proportions living alone, the proportions with mobility problems. Other relevant data include the male to

female ratio - at age 65 for every 100 men there are 113 women, at age 75 - 136 women, and over 80 - 219 women.

Women have a particular set of vulnerabilities. Most elderly men have a spouse, but most elderly women do not have a spouse, and having a spouse as Hal Kendig and his colleagues have demonstrated is the greatest defence against social isolation, public dependency, and poverty.

Turning to potential family support, Australian data do not exist to give us comparable figures for British estimates of female family numbers. David Eversley has calculated that a typical British couple married in 1920 and still alive today has 42 living female relatives, of whom 14 are not working. In contrast, the typical couple married in 1950 are likely, when they reach 80, to have only 11 living female relatives, of whom only 3 will not be in paid jobs, but few of these relatives will live near enough to be able to provide care.

SERVICE INDICATORS

Indicators relevant to effective services for people over the age of 75, and the appropriateness of those services relate largely to:

a) Living Arrangements,
b) Disability Level,
c) Level of Caregiving,

The way in which these are linked, and in particular the deficits flowing from each comprise the analytical dynamics.

a) LIVING ARRANGEMENTS

Table 2 identifies 189,400 people over 75 living alone. This comprises almost 40 per cent of the population aged 75 and over in private residences. Whereas 3.9 per cent of the population is aged 75 or over, 19 per cent of Australia's 997,800 single person households are headed by a person aged 75 and over. Altogether there are over 420,000 people over 65 living alone. There are no ABS data on proximity to or frequency of contact with children, although ACOTA published such data for its Victorian and South Australian sample. The latest HES estimates a very low disposable income of those who live alone ($104.79 per week).

Not only do more than 80 per cent of people aged 75+ live in private residences, the overwhelming majority of people aged 75+ with handicaps live in private households. According to the 1981 Handicapped Persons Survey (Cat. No. 4343.0) 72.3 per cent of people aged 75+ with handicaps live in private residences.

Turning to nursing home accommodation Table 3 shows both the small proportion of older people who live in nursing homes and the incidence by age. Whereas somewhat fewer than 4 per cent of people in their late 70s live in nursing homes, that proportion rises to under 10 per cent of those in their early 80s, under 20 per cent late 80s, and just over 30 per cent early 90s. Table 4 shows that almost half of nursing home residents in South Australia and Victoria are aged 85 or over.

Nursing homes deal with only a small proportion of our elderly population and other policy and care responses have been deemed more appropriate in the past, and given the current thrust of policy will be deemed more appropriate in the future for our dependent elderly. The sort of care that is deemed appropriate - supported accommodation or some form of in-home support depends on level of disability.

b) DISABILITY LEVEL

Three major risk factors are more likely for people over the age of 75 -

i) immobility
ii) dementia
iii) incontinence

The response in the past to many of these has been institutional care. The balance has altered with the development of the Home and Community Care program and with a planned reduction in the ratio of nursing home beds. Therefore, after appropriate assessment the limited number of nursing home beds will be available for those not able to be supported in the community. This lays the basis for an appropriate and suitable care package to be worked out.

i) Immobility

The response to immobility has usually been admission to institutional care or support in the home if

a) community domiciliary services were available;

b) the dependent person had family members willing and able to provide care and tending services;

c) the dependent person could afford to purchase services privately.

Table 5 shows the higher incidence of immobility at greater ages. There are no data combining degree of immobility with residential status (e.g. living alone), with income or with family composition. One could build a set of dependency indicators but many

assumptions would creep in e.g.

a) the greater the immobility the more care is required. In fact a moderately immobile person may require greater support and assistance than a totally immobile person.

b) immobile people would be prepared to spend money on services

c) families are both willing and able to provide support

ii) Dementia

Data on the prevalence and incidence of dementia are equivocal. It has been estimated that there are between 97,800 and 115,000 demented elderly people in Australia, and that in less than 20 years time those numbers will grow to between 173,300 and 194,200 (Table 6). The percentage increase over the next 20 years of elderly dementia sufferers will be considerably greater than that of the population as a whole and the elderly population (Table 7). Incidence increases with age (Table 8).

Pressures on those in the community caring for demented people at home are significant, and inability to continue support often leads to the older persons' admission to residential care. Policy issues on both home care and residential care are now being addressed.

Experience has highlighted the difficulties of accommodating severely demented people. Two issues stand out - first the most suitable type of

accommodation for the demented person and the most suitable level of support and care staff, and second the problems associated with accommodating severely demented people with non-demented people.

iii) Incontinence

Urinary incontinence is estimated to affect between 4 and 6 per cent of the total population and 10 to 15 per cent of those aged 65 and over and 60 per cent of the nursing home population. Industry sources estimate that about 700,000 Australians suffer from incontinence.

The costs to the individual and their families are great. Not only are there issues of self-esteem and self-confidence, there are substantial financial costs in the purchase of appliances - costs of up to $500 p.a. for a male and up to $1000 for a female.

Incontinence is one of the major causes of admission to our billion dollar plus nursing home industry and within nursing homes laundry costs directly attributable to incontinence are $40,000 per annum for a 20 bed nursing home and $200,000 p.a. for a 100 bed home. It is estimated that in nursing homes 25 per cent of nursing time is spent managing incontinence.

Data on incontinence are skimpy because the ABS says it is too embarrassing to ask about incontinence in detail in its surveys. Indicators about incontinence could be developed if better data were available and thus would strengthen the lobbying process already under way.

c) LEVEL OF CAREGIVING

The changing capacity of women to provide care for older relatives has been well documented. Changes in family structure and in female labour force participation rates demonstrate the diminishing pool of unmarried non-working middle aged women who could be counted on to provide care (Tables 9 and 10). Informal care systems are by far the cheapest, yet we do not know if they are satisfactory. Certainly people manage - but at what cost? We have no clear indicators of levels of care nor of satisfactory outcomes.

It is a naive policy to assume that the unpaid labour of women is a satisfactory basis of care provision, yet in times of stringency governments are forever looking for mixtures of formal and informal care. Two issues stand out. First with notable demographic and labour force changes the pool of potential caretakers has diminished. Second the more professional requirements for caring for somebody with immobility, with incontinence or dementia - is often beyond the skill level or emotional capacity of an untrained relative. This is not however to suggest the blurring of the tending issues as opposed to the professional care issues.

CONCLUSION

Given the earlier comments on capacity and willingness it is important to be able to identify an appropriate policy path to follow from each of the indicators that have been described. It would be extremely naive to assume that having good data alone would ensure that things get on to the policy agenda.

Items get onto the policy agenda because somebody makes a fuss or takes some action. Public distributive systems allocate resources on the basis of need, contribution, and citizenship. Each of these is highly political and each could be the subject of major debate, especially if we get into motives for allocation or distribution. Whether we develop provisions to respond to need, contribution, or citizenship, policies themselves become manifest as a result sometimes of planning (scientific processes), sometimes of negotiation, bargaining and horse trading, (both intra and intergovernmental and between governments and interest groups), sometimes just incrementally. Each of these processes have within them value positions, political preferences, political tactics, and complex interconnections. What I would want to argue is that success in getting something onto the policy agenda lies not in blind adherence to a particular method, but in knowing where to break in - sensing when scientific processes are more important than bargaining, or vice versa - knowing what is worth negotiating on and what is not, knowing what knowledge base to plan from, and knowing when to let things ride and take their course. The type of knowledge is really a sympathetic understanding of opportunism and expendiency tempered by solid and markable indicators and clear directions of service provision to ensure optimum support for our older population.

TABLE 1

PERSONS AGED 75 AND OVER
Australia

	1911 Census	1986 E.R.P.	2001 ABS Projection Series A and B
Total 75+ Population	58,821	630,122	1,022,900
Total 65+ Population	190,582	1,669,609	2,259,000
Total Population	4,455,005	15,973,907	18,917,400
75+ as % of 65+ Population	30.9	37.7	45.3
75+ as % of Total Population	1.3	3.9	5.4

TABLE 2

PERSONS AGED 65 AND OVER LIVING ALONE
Australia, 1986

	Age 65 - 74			Age 75 and over			Total			
	in private residences ('000)	living alone ('000)	% living alone	in priv. res. ('000)	living alone ('000)	% living alone	in priv. res. ('000)	living alone ('000)	% living alone	of those living alone % aged 75+
Males	462.7	54.8	11.8	202.7	42.1	20.7	665.4	96.9	14.5	43.4
Females	551.6	176.6	32.0	305.3	147.3	48.2	856.9	323.9	37.8	45.5
Total	1,014.3	231.4	22.8	508.0	189.4	37.3	1,522.3	420.8	27.6	45.0
% Female		76.3			77.8			77.0		

Source: ABS Internal Migration, Australia 1985-86
Cat.No.3408.0 (unpublished data)

TABLE 3

Nursing Home Residents Per 1,000 Population Aged 65 and Over, by State, 31 December 1985

State	Age (years)						
	65-69	70-74	75-79	80-85	85-89	90-94	95+
	Rate per 1,000 ERP						
NSW	7.4	16.1	37.6	92.9	200.3	352.1	567.4
Vic	4.4	10.1	26.4	63.4	150.0	292.0	476.4
Qld	6.3	15.6	34.3	88.3	184.9	328.0	507.1
SA	5.6	13.6	34.7	84.2	200.8	352.9	494.4
WA	6.7	16.5	38.1	84.4	205.9	347.9	514.5
Tas	6.4	13.3	34.9	91.8	196.8	331.3	489.3

Source: S.A. Ministerial Task Force on Nursing Home Accommodation, Interim Report, Adelaide, April 1986, p.51

TABLE 4

Age Distribution of Nursing Home Residents as a Proportion of Residents Aged 65 years and Over, by States, 31 December 1985

(Rank: Highest = 1)

State	Age										TOTAL
	65-69	Rank	70-74	Rank	75-84	Rank	85-94	Rank	95+	Rank	
NSW	5.9	1	10.6	3	39.7	3	37.4	5	6.3	3	100.0
Vic	4.5	6	8.8	6	38.5	5	41.5	1	6.8	1	100.0
Qld	5.3	=2	10.9	1	39.3	4	38.4	4	6.2	4	100.0
SA	4.6	5	9.5	4	38.1	6	41.4	2	6.4	2	100.0
WA	5.0	4	10.8	2	42.5	1	36.4	6	5.1	6	100.0
Tas	5.3	=2	9.3	5	40.8	2	38.9	3	5.7	5	100.0
All States	5.3		10.2		39.6		38.9		6.3		100.0

Source: As for Table 3

TABLE 5

IMMOBILITY OF PERSONS AGED 65+
Australia, 1981

		No. of Immobile Persons	Total Number in age group	Immobile as a proportion of age group
AGE GROUP				
65 - 69	Males	44,800	243,879	18.4%
	Females	53,200	281,006	18.9%
	Persons	98,000	524,885	18.7%
70 - 74	Males	38,600	174,043	22.2%
	Females	51,400	220,259	23.2%
	Persons	90,000	394,306	22.8%
75+	Males	59,500	183,198	32.5%
	Females	152,400	327,014	46.6%
	Persons	211,900	510,212	41.5%

Source: ABS Survey of Handicapped Persons, Australia, 1981 (unpublished data)

TABLE 6

Projected numbers of demented elderly people
in the Australian population ('000s)
(based on ABS population projections, Series A&B)

Using Prevalence Rates from Campbell et al. (1983)

	Year		
Age range	1986	1996	2006
65-69	39.4	47.8	49.1
70-74			
75-79	20.7	26.7	31.7
80-84	20.1	30.9	38.7
85+	34.8	53.8	74.7
Total 65+	115.0	159.2	194.2

Using Prevalence Rates from Kay et al. (1985)
and Preston (1985)

	Year		
Age range	1986	1996	2006
65-69	9.1	10.7	11.5
70-74	11.3	14.0	13.6
75-79	21.7	27.9	33.2
80-84	20.2	31.2	39.0
85+	35.5	54.8	76.0
Total 65+	97.8	138.6	173.3

Source: A.S. Henderson and A.F. Jorm
The Problem of Dementia in Australia
Canberra, ANU Social Psychiatry Research Unit, 1986.

TABLE 7

Percentage increases in particular groups
of the Australian population
(Using ABS Series A&B projections)

	Years	
	1986-1996	1986-2006
Total Population	12.9%	24.3%
Population Aged 65+	28.8%	44.3%
Persons with dementia (based on Campbell et al.)	38.4%	68.9%
Persons with dementia (based on Kay et al./Preston)	41.7%	77.2%

Source: As for Table 6

TABLE 8

Age-specific prevalence rates for moderate and severe dementia
in Australasia

Age Range	Community and Institutional Elderly in New Zealand (from Campbell et al., 1983)	Community Elderly (from Kay et al., 1985)	Institutional Elderly (from Preston, 1985)	Estimated Total Prevalence for Community and Institutional Elderly in Australia (Kay plus Preston)
65-69	3.8%	(1.0%)*	0.6%	1.6%
70-74		1.3%	1.1%	2.4%
75-79	6.4%	4.1%	2.6%	6.7%
80-84	11.0%	3.7%	7.4%	11.1%
85+	28.2%	13.9%	14.8%	28.7%

*This age group was not studied, so a rate of 1% was assumed

Source: As for Table 6

TABLE 9

MIDDLE AGED WOMEN - Females Aged 45 - 59
Australia

	1911 Census	1986 E.R.P.
As a proportion of female population	250,247	1,141,302
	11.7%	14.3%
		1981 Census
Average number of children	5.7	3.0
Marital Status		
Number married	180,078	849,336
As a proportion of 45 - 59 population	72%	78.2%
Number never married	30,321	46,764
As a proportion of 45 - 59 population	12.1%	4.3%
Number widowed, separated divorced	39,848	189,552
As a proportion of 45 - 59 population	15.9%	17.5%
Total number of females all ages	2,141,970	8,005,293 (1986 E.R.P.)

TABLE 10

LABOUR FORCE PARTICIPATION RATES
Females Aged 45 - 54
Australia
(Per cent)

	Married	Not Married	Total
1966	31.9	62.3	36.7
1987	54.6	55.5	54.8

Source: The Labour Force, Australia, Historical Summary 1966 to 1984
ABS Cat.No.6204.0

and

The Labour Force, Australia, February, 1987
ABS Cat.No.6203.0