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CURRENT DEVELOPMENTS IN AGED CARE IN AUSTRALIA

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During 1987 136,962 Australians turned 65 - that is 375 per day. Approximately 81,500 people over 65 died in the same period, that is 223 per day. Thus our 'aged' population increased by around 55,000 in the year or by 152 per day. When translated into goods and services and social facilities and supports, this warrants careful policy attention. Elderly people require a wide range of supports, especially income support, health services, housing support and social services. Public resources which are allocated are substantial, yet the range of incomes, access to services and housing situation of elderly people is probably wider than for any other population category. Our elderly population comprises a group spread across thirty or more years of life.

Australians are in general producing fewer children and living longer than their parents did. These two demographic trends plus changes in our migration patterns are affecting the fundamental makeup of our society. In the years to come the effects of such population changes will be quite significant.

In June 1987 there were in Western Australia 130,365 people in their fifties, 104,562 in their sixties, 66,362 in their seventies and 26,816 aged eighty or over. Almost one in four Western Australians is aged 50 or over. By the year 2021 one in 3 Western Australians will be 50 or over.

Ageing can be seen as an issue requiring policy attention because a situation of dependency can be identified. The dependencies of ageing are chronic not transitional and may be social, economic, physical and political.

Defining what is meant by 'old age' or 'aged people' usually involves drawing an arbitrary chronological line. The first social scientist to publish a comprehensive study of aged persons in Australia (Bertram Hutchinson) did so as recently as 1954, and in that study he developed this working definition

> "old age begins at the point in an individual's life when he ceases to perform all those duties, and enjoy all those rights, which were his during mature adulthood, when he begins to take over a new system of rights and duties. There is no particular year at which this process begins for all individuals, for its onset will vary quite considerably according to the family setting of each person'.
> (Hutchinson, 1954: 1)

From a policy or planning perspective this makes for a fairly amorphous target, and any specification of targets involves making a judgement on who is to be included and who is to be excluded.

An overview of various major and influential theoretical perspectives has been provided by McCallum ~~(1981)~~. His summary covers disengagement theory, activity theory and the 'roleless role'.

The most broadly promulgated theory has been that of disengagement, first postulated by Cumming and Henry (1961). They argue that ageing is an inevitable mutual withdrawal or disengagement which results in decreased interaction between the older person and the rest of the social system. It it based on a social psychological interpretation of withdrawal or disengagement in which the non-elderly cannot assign crucial roles to the elderly because they believe (as do the elderly) that they would not be able to respond. Their wish is to disengage and fade away.

Activity theory suggests that the old have to learn to recant the role of 'worker' and to engage in other roles which are permitted by society at large. High morale is obtained by re-engagement in those social systems which replace old roles (and old activities) with new ones. It is a prescription for 'successful' ageing which focuses on adapting to a new life and

new set of roles, even though these are at greatly reduced levels of influence. Developed initially by Havinghurst, Neugarten & Tobin (1963), this theory has been critically examined in the literature. On the basis of his empirical work McCallum (1981) concludes that activity theory is a failure in both theory and practice, yet it is interesting to note that its assumptions form the basis of many community programs.

After a lifetime of work, retirement comes to be seen in terms of individual loss and change, a time in which the old are 'imprisoned in a roleless role' (Burgess, 1960: 20). The roleless role theory works from the premise that the void created by retirement cannot be filled due to poorly developed adult socialisation processes. This approach uses a (premature) bereavement model in which those close to the elderly person in question (relatives, doctor, etc) are much more likely than the elderly person to attribute adaptive crises, and relegate the old person to the scrapheap. The evidence simply does not support this 'social abandonment' or 'roleless role' theory. For many (though not for all) retirement is a happy, joyful and worthwhile time of life, though it is essential that further study be undertaken to discover what makes retirement quite unpalatable for many.

These theories are derived from biological (the study of the ageing process), psychological (study of motor skills, perceptual and cognitive abilities and sensory processes) and social psychological (study of roles, statuses and expectations)

research. A different theoretical dimension operates from the perspective of position in society - inclusion or exclusion from economic power (or at least economic security); one's access to or participation in decision-making about one's own well being; and one's general position in the socio-economic structure.

McCallum (1981) develops a perspective which he calls the disprivileged minority perspective. This ties in closely with a social stratification approach for where there are ill effects due to retirement, these are laid at the door of society, not the individual. Theorists of this school equate retirement with disadvantage -something socially constructed and structured. The argument is that to blame the individual for his/her predicament and expect him/her to disengage, find meaningful activities or roles, is to misunderstand the social construction of disadvantage.

Whatever theories are useful and whatever theories inform public policy it is important to note that most older people are not sick, are not disabled, are not desperately poor, are reasonably well housed and like the locations they live in. There are however, significant numbers that do have difficulties in many areas. To respond to the real problems and not the folklore requires good policy analysis, strong community responsiveness and very importantly, the elimination of unrealistic, patronising and unhelpful stereotypes.

Elderly people require a wide range of supports, mostly income support, but also health services. Who is going to respond? Who is going to be able to assess the needs and know what services are most appropriate? Who is going to deliver these services? Who is going to pay for them?

It seems crass perhaps to ask who's going to pay. It is an important question. Australia's $2\frac{1}{2}$ million people aged 60 and over, including the million people over 70 and the 300,000 over 80, are part of our largest industry. More Commonwealth Government dollars go into age and veterans' pensions than into anything else. Our pension bill, at 10.5 billion dollars is 3 billion dollars greater than our whole defence budget, 2 billion greater than our Commonwealth Health budget - almost double our Commonwealth Education budget. The amount we put into nursing homes and hostels exceeds our whole Foreign Affairs and Overseas Aid budgets.

Our older population is very much differentiated by age, by sex, by class, by ethnicity, by spatial location, and by health status.

The range of needs and demands, wishes and hopes, desires and aspirations is as broad and diverse as is our older population.

The four main issues for a person facing retirement are income - having enough and having it regularly; having adequate health care; having appropriate living and housing arrangements; and having interest and purpose in life. Old people are not at all different from their younger contemporaries in the requirement that life must have some meaning. We have made advances in recent years in the first three of these areas, income, health, accommodation. The fourth issue, interest and purpose in life is often the least recognised and most neglected. Yet it is the heart of many of the difficulties in retirement. Processes of life enrichment are being seen by governments as important, especially in view of the fact that many people can expect to have twenty or thirty years of retirement.

In a nutshell, in giving people more time to live, science and medicine have also given them more time to die. We have all seen technical changes of astounding, stunning and overwhelming consequence. We can find technical solutions to many of our problems. We can think the unthinkable and do the undoable - yet are we a lot better off? We can do magic on our computers, land a person on the moon, analyse the gases surrounding Jupiter, fire a probe into the nucleus of Halley's Comet. We have learned brilliantly the means of accomplishing scientific and technical advance. When we look at our present capacity to solve problems it is apparent that we do our best when the problems involve little or no social context. We're skilled in coping with problems with no human ingredient at all, as in the physical sciences or in the technologies. We can send people to the moon, yet we can't find jobs for our young people; or appropriate accommodation for all our older people; we can build in our big cities, gleaming skyscrapers with computer controlled talking elevators, yet we can't make traffic flow; we can keep people alive for twenty to twenty five years beyond retirement yet we can't ensure that they can live those years in dignity.

To take an extreme example, when we compare the tasks involved with having landed a man on the moon with that of developing an equitable income security system or an effective nursing home system, was the technology of landing someone on the moon more simple, was the political commitment more easily realisable, was the management task easier? Absurd as it may seem, the answer to these questions is yes.

There are two types of difficulties that I am confronted with: difficulties that individuals have, and difficulties that arise from poor policy response to observed needs, conditions and problems. As a person involved in problem seeking as much as problem solving, as somebody involved in policy I can reel off a string of problems facing policy makers in ageing.

We have problems working out equitably and efficiently how to convert 40 years of earnings into over 70 to 80 years of life. We have problems with concepts like "double dipping", "tax treatments", "income and assets", "taxpayers' capacity", and so on.

We have problems restructuring a nursing home system which seems to have lost its way as rising expectations of nursing home care have created a larger than warranted population anticipating ultimate nursing home admission. This is a billion dollar Government financed industry which strains basic concepts of equity, and leaves many people grossly unsatisfied.

We have problems with our transport systems which cannot cope with elderly people both with and without mobility limitations and thus confine too many people to home, magnifying their exclusion from fruitful community integration.

We have problems expecting families to play roles that are considerably in excess of their capacity to support older people, particularly those who are severely physically disabled or the burgeoning number suffering from some of the dementias.

We have problems with a health care system which has been in the political spotlight for most of the last 15 years and which is not sure how to handle the ballooning costs, the changing technologies nor how to treat with appropriate respect, not only the client, but the many professionals within it.

We have problems devising a set of home care services that are efficient, flexible, accountable, acceptable, comprehensive, accessible, co-ordinated and equitably allocated.

We have problems ensuring that those who choose to enter resident funded retirement villages have the appropriate legal protections and that those retirement villages meet suitable standards of design and accessibility.

We have problems providing suitable accommodation for the most severely disadvantaged - those 50,000 elderly people, three quarters of whom are women, who rent in the private market.

We in South Australia have problems of relativity in that on ABS projections, S.A. will have notably higher proportions of older people than every other State in every age cohort and on each projection series right through to the year 2021. This poses long term planning challenges and will require special negotiations with the Commonwealth.

Service policies for elderly people in Australia are splattered across an expansive canvas and the major players pop up all over the place with policies and regulations, constraints and limitations, aspirations and hopes. Service policies for elderly people involve activity by all three levels of government, non-government welfare organisations (of whom about 6,000 in Australia are involved with the welfare of elderly people), private entrepreneurs, developers, and professionals, to name a few.

In ensuring 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. Grasping the initiative is important. For too long governments have responded rather than initiated - our whole nursing home crisis can be attributed to a "you hatch it, we'll match it" philosophy on the part of government, rather than a more structured and planned approach.

Outputs in ageing are developed and delivered by three main actors - governments, voluntary agencies, and families and informal support systems. Each plays significfant roles. These actors are able to generate three types of outputs - tangible resources, effective services, and close companionship. It is

the combination of these three things - tangible resources, effective services, and close companionship - to which our welfare futures must increasingly be geared. The balance and the best delivery system for each is a matter of passionate debate.

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.

It is important to understand capacity. It is important to understand need. It is important to understand the structures within which need and capacity operate. Gone are the days when families took the lead. Gone are the days when voluntary agencies took the lead. Governments - with their capacity tend to take the lead.

The conundrum of federal/state relations confounds us all. All Australian States provide roughly similar services to their elderly populations. 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.

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For example, the State Government, 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 expendiency 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.

Enough of the background - now to some nitty gritty! The message I keep stressing is that we must discard the totally inappropriate stereotype that older people <u>are</u> problems, and concentrate instead, on the problems they <u>have</u>.

a) <u>LIVING ARRANGEMENTS</u>

There are in Australia 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 and over almost one in 5 of Australia's 1 million single person households is headed by a person aged 75 or over. Altogether there are over 420,000 people over 65 living alone. Most elderly men have a spouse, most elderly women don't - and having a spouse is a major barrier against poverty, isolation and social dependency.

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.

Developing a service structure to deal with all of these requires a matrix of needs by services by providers.

Planning and developing programs for a diverse elderly population clearly requires good data and dynamic knowledge of relevant indicators.

Population ageing and demographic change push numerous policy issues to the fore. We have a lot of substantive knowledge, but at times the processes of achieving satisfactory outcomes are overhwelming. We have a crowded policy agenda and the items that stand out to me include suitable income security, efficient effective and equitable health care, issues of rights and discrimination, accessible social services, life enrichment and life enhancement, suitable housing and accommodation,

policies on work and leisure, communications and transport, issues of safety and consumer protection.

The policy spectrum before us is complex and convoluted. So as we move into greater dependence on formal care we are all faced with challenges in planning, structuring and delivering services which will have to be relevant, effective and compassionate, and these challenges are spectacular, formidable and unprecedented.