Speech by Adam Graycar:

"Developments in ageing"

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NOARLUNGA FAMILY SERVICES BOARD INCORPORATED

DEVELOPMENTS IN AGEING

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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.

Australia's population is ageing slowly. Those aged 65 and over, who today comprise 9.8 per cent of the population, will by the year 2001, comprise about 11.0 per cent, and by 2021 about 14.0 per cent. A dozen wealthy countries in Europe have elderly populations right now, much larger than those projected for Australia even fifty years down the line.

In South Australia, there are, 118,000 people in their sixties, 72,000 people in their seventies, and 27,000 in their eighties and over, that is about 217,000 people over 60, and 100,000 over seventy. Comparing our population today with that in the census before last (1976) the number of people in their sixties has increased by 14.3 per cent; the number in their seventies and eighties by 25.8 per cent. During the same period the population as a whole increased by only 9.5 per cent. As we look to the future, over the next 25 years South Australia's population will increase by 27 per cent; the population aged 65 and over by 67 per cent; the population aged 75 and over by 118 per cent and the over 85s by 225 per cent.

When translated into goods and services and social facilities and supports, this warrants careful policy attention. Elderly people require a wide range of supports, mostly income support, but also 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.

The diversity of the elderly population is enormous. About two thirds of those over 65 are under 75, that is most elderly people 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.

For them, income maintenance and preventive health services 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 economic and social dependencies, physical limitations and disabilities become part of the lives of many people.

Dependencies increase with age and we have noted two significant features. The rate of institutionalisation for people aged 75 and over is more than double than of those aged 65-74. And second, the incidence of dementia increases with age. Today it has been estimated that there are about 10,000 people in South Australia suffering from dementia - this is equivalent to the population of a city like Port Pirie. As the structure of the elderly population changes, so too will the incidence of dementia - from one in 20 of people over 65 to one in 5 people

over 80 - we are on the verge of an explosion of care.

As ages go up, so too does the proportion of women. At age 65, for every 100 men there are 113 women; at age 75 there are 136 women for every 100 men, and among the over 80s there are more than twice as many women - 219 women for every 100 men. Most elderly men have a spouse, but most elderly women do not have a spouse, but most elderly women do not have a spouse, and having a spouse, according to researchers working in the field is the greatest defence against social isolation, public dependence and poverty.

The overwhelming majority of elderly people live in private households. In its 1981 Handicapped Persons Survey, the Australian Bureau of Statistics identified Australia wide, 450,700 people over 65 as having handicaps, and of these 82 per cent live in private households and 28 per cent in institutions. Again age was significant. Of those aged 65-74 per cent of those with handicaps live in private dwellings while for those aged 75 and over 72 per cent of those handicaps live in private dwellings and 27 per cent in institutions. Therefore, not only do the overwhelming majority of elderly people live in private households, the overwhelming majority of elderly people with handicaps live in private dwellings. And most are women, mostly living alone.

Ageing is not a problem, <u>but</u> 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. If ageing is seen as 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.

Now, turning to 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. The biggest expenditure area is in pension payments and you are all aware of the inconsistencies in pension policy.

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 reponsibility 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.

We can identify four major goals:

1. assuring an adequate income;
2. assuring appropriate living arrangements;
3. assuring independence and dignity;
4. assuring institutional responsiveness and a new attitude towards ageing.

Having these goals spelt out does not guarantee political action. In Australia we have never had clearly articulated national policy goals, nor any overall national policy on ageing. The Americans have legislation in the form of an Older

Americans Act which attempts to deal comprehensively with the elderly population. The Act, passed in 1965, was initially designed to stimulate the development of needed services for the elderly. Massive co-ordination problems have since emerged with eighty federal programs providing or financing services. These involve twenty-three different federal agencies in seventeen departments each having separate authorizations and appropriations. The USA of cours, is not alone in having co-ordination headaches, as our experiences with developing a national nursing home policy and a national HACC policy.

Despite our lack of national policy goals, we do have a plethora of services delivered by quite a range of instrumentalities.

- Income maintenance services are designed to ensure a basic regular income. In the public sector there are age pensions, fringe benefits, and various allowances and concessions. In the private sector there are private pension schemes and also certain concessions.

- Health services are geared, not only to elderly people, but to the whole population. Elderly people, however, are greater users of medical services than all others except children under 5, and they are the greatest users of hospital services. Health services cover a wide spectrum of government provided services, services provided by non-profit bodies, services provided on a commercial basis;

and the debates about financing health services have filled our Hansards and our newspapers for much of the past decade with no sign of easing up.

- Accommodation services have been developed to provide both residential institutional and self-contained accommodation. Government funds provide self-contained accommodation directly through Housing Commissions, and residential care facilities in certain nursing homes; government subsidises non-government welfare agencies in their provision of self-contained units, nursing home beds and hostel beds; about 8 per cent of elderly people rent in the private market, and for developers there seems to be a boom in building for the affluent elderly. A significant number of elderly people live with relatives.

- Domiciliary services are provided to support people who wish to live in their own homes. If successful, the services will help keep people in a familiar environment, keep them out of more expensive institutional care and improve their quality of life. Services such as home help services, home nursing services and meals on wheels are provided under a wide variety of auspices - sometimes by government, sometimes by non-government non-profit welfare agencies, sometimes by commercial enterprises and sometimes by volunteers, neighbours, friends and family.

I have outlined these services, not so we can now assess them in terms of adequacy, equity, or efficiency, but rather to illustrate that provision cuts right across our social institutions and right across our society. In the rough description just given we can note four major systems which deliver services to elderly people.

First, there is the statutory system. This comprises government 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 a minority of the population, who are in need, can receive services.

Second, there is the commercial system. There services are bought and sold at a price that the market will bear. Apart from most housing, there are few pure commercial services - most medical and hospital services are subsidized, though at the top end, private nursing home 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 organisations varying in size, scope, activity and interest. It is too diffuse to be regarded as a unified sector. Our research has identified 37,000 NGWOs in Australia, of which 4,000 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. We have no way of estimating the extent of informal help, but we are presently conducting studies on family care of elderly people and on volunteer activity. 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.

These four systems, the statutory, the commercial, the non-government agencies, and the informal, intervene to provide supports, primarily to limit dependency. There are, of course, important value questions about where the responsibility lies. Should individuals be responsible for their own health and welfare?

How far must a situation deteriorate before government should step in? Should the state be primarily responsible for all risks? Should families care for their dependent members? What if elderly people have no family, or if their family does not have the resources to play the caring role?

Responsibility is a matter of balance, and can be discussed only

in the light of the characteristics of the population in question and the nature and extent of their dependency.

Dependency is not a new phenomenon, but is highlighted because in the past many people did not live long enough to be dependent, but dependency has now been imposed, encouraged and sustained by social relations and social developments. Restriction of access to a wide range of social resources, including income, status and power, not to mention physical well-being, imposes a reduced social status on elderly people.

It is important for us to try to understand whether these types of dependencies can be addressed by the four main care systems - the commercial, the statutory, the voluntary and the informal. Once we can understnad these and relate them to a value position which recognises need for <u>inclusion</u> - especially in terms of cash, services and power for elderly people, then we are on the way to developing humane and workable social policy.

Role of the Office of the Commissioner for the Ageing

- advocate for older people;
- policy advice, etc.