Speech by Adam Graycar:

"Accommodation issues for elderly people : State Government perspectives"

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Accommodation Issues for Elderly People:

State Government Perspectives

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Accommodation policies for elderly people in Australia are splattered across an expansive canvas, and daubed raggedly are policies and regulations, constraints and limitations, aspirations and hopes. There are numerous frescoes of the players, some sketched in outline, some drawn in substance, and some painted firmly and ferociously. Aged accommodation policies involve activity by all three levels of government, non-government welfare organisations (of which about 8,000 in Australia are involved with the welfare of elderly people including about 450 nursing homes), private entrepreneurs (including about 750 profit-making nursing homes), developers, and professionals, to name a few. At the Commonwealth Government level we have five main departments centrally concerned with well being and accommodation of elderly people - Community Services, Health, Housing and Construction, Social Security and Veterans Affairs. Several others are marginally concerned with these issues. It would be confusing and extremely time consuming of me to list the various roles of the numerous State and Local government involvements, but any realistic portrait would have more lines than a complex circuit diagram, but be less confusing than a Jackson Pollock masterpiece.

As we are all aware only a small proportion of older people ever come into contact with nursing homes. About 4.5 per cent in toto of those aged 65 and over live in nursing homes, and as the tables on page 17 show proportions increase with age, and vary quite notably by State. Victoria and South Australia have higher age profiles than the other States with almost half of the nursing home residents in those States aged 85 or over.

Many elderly people with chronic conditions do not live in institutions but live in private residences with limited or non-existent support. Their lives are characterised by lack of choice and a strong case can be made for policy intervention to provide for alternatives. Not many older people are highly dependent but a significant number are, and their living circumstances often are a result of a lack of choice and/or an utter abhorence of institutional care.

Some people like where they live, some don't. Some people can comfortably afford their accommodation, some can't. Some need better access to community services, some don't. Most live independently in ordinary housing, but around 160,000 live in nursing homes and hostels and a further estimated 150,000 (half as many again) live with younger relatives, usually adult children. Levels of dependency vary with income and mobility limitations, and with community formal and informal supports. Put all of that against a backdrop of a poorly planned,

privatised, inconsistently regulated, federal system, and accommodation policies border on the incoherent, incompatible and incomprehensible.

Research indicates that aged people in the future will probably look more towards the formal system of care and less to their families. Many families want to look after their elderly relatives but they are not equipped to do so, nor do they have the social supports they need. We all know about social, demographic and occupational changes which have transformed families in recent decades.

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.

It is not that we don't have the technical, social and medical knowledge to develop appropriate care systems but rather we don't have a sufficient grasp of the 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? Is private enterprise an effective service deliverer when consumers are under great pressure? 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? Nor have we developed a socio-political consensus which unequivocally and unambiguously agrees on the monumental question of what works and what doesn't, who wins and who loses, who bears responsibility and who pays.

I want to put forward a proposition that we can optimise the service system by State Governments taking more pronounced planning and brokerage roles; in the planning arena, developing in each State a State Plan on Ageing, and in the brokerage capacity developing a co-operative strategy, based on good data, informed and compassionate thinking, and extensive consultation for structuring the policy agenda.

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.

Successful implementation of the Commonwealth's plans, lower nursing home bed ratios, better assessment and better home care services will dramatically affect the resident profile in our nursing homes. The residents will be much more frail and dependent and will require more intensive high quality professional support. The States have a major role in ensuring high quality care and the compassionate and efficient meeting of resident's needs.

For too long our service system has been characterised by a "you hatch it, we'll match it" philosophy on the part of government - little planning, no direction setting, highly expedient. That was the past. I would like to think that government now has the expertise to take planning initiatives, and has the communication skills to consult with consumers and providers.

So far I have used the term 'government' in an undifferentiated way, not distinguishing between the resources, capacities and involvements of the three levels. The Commonwealth Government makes most of the running in the nursing home sphere, though State Governments are involved in many other sections on the accommodation canvas, from licensing and inspecting nursing homes, setting staffing regulations, developing hospice and rehabilitation policies, right through to more diffuse issues such as providing public housing for older people, and the development and implementation of urban planning legislation which determines where facilities for older people may or may not be built.

Very simply the point I want to make is that State Governments have a wide range of responsibilities in developing accommodation policies and practices. Their role is conducive to integrating service provision, and if the States are able to develop State Plans on Ageing, as I have suggested, then some of the incomprehensibility and incoherence I mentioned before could be avoided.

I am presently chairing a Ministerial Task Force on Nursing Home Accommodation and in our interim report we highlighted how the State Government might respond to likely changes. We recommended that staffing levels needed urgently to be examined to ensure that the level of care is not compromised. As the States set but do not pay for the staffing levels, we have to work jointly with the Commonwealth, present unimpeachable evidence and demonstrate political negotiating and bargaining skills.

We had a number of recommendations relating to the provision of appropriate educational opportunities for nurse assistants to qualify, through accredited educational programs as enrolled nurses, and for appropriate training for qualified nurses to equip them better to provide top quality care. Given the role of the States in the industrial arena we recommended that definitions of non-nursing duties formally be agreed upon by all parties concerned and that as a general guideline, nursing care should only be provided by qualified nurses. We recommended

streamlining of the inspection system, linkages with community care, the establishment of a joint complaints mechanism and most importantly, that quality assurance programs be implemented in all nursing homes.

These were not part of an unrealistic wish list, but rather part of a catalogue within the jurisdiction of State Governments which affect, for the better, we firmly believe, practices in nursing homes. We also examined the arbitrary, capricious and unwarranted freeze on benefit levels in South Australia and Victoria, but as that was beyond the State's jurisdiction our recommendation could only be that we protest vigorously, and gather more evidence to show the Commonwealth they were wrong.

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.

PHILOSOPHY

Our philosophy involves establishing a set of principles, about desirable outcomes for our older citizens. The situation I work from, a situation reflecting my government's orientation, is one of social justice.

Social justice is fundamentally concerned with equity, or fairness. It involves basic rights and equality of access to what our society has to offer. It is essentially an inclusionist philosophy ensuring that those at the margin are included in, and not excluded from, the fruits of our society's endeavours. It involves plans to improve people's access to income, goods and services, and quality of life. I could get into a long academic treatise on each of these three, income, goods and services, and quality of life, but I won't. Each is an underpinning support, among other things, of a desirable accommodation system for older people.

It is important to recognise that most of the people we are dealing with are among the most powerless, most isolated and most dispossessed in our society. Our philosophies and practices must be developed to give them that which is regarded as equitable and just. Politically State Governments, through a comprehensive State Plan on Ageing, can lay out social justice principles and accommodate within them the inevitable and difficult trade-off between equality and efficiency.

PROCESS

Once a person is admitted to a nursing home, the proprietor accepts a "duty of care" and is therefore accountable for the quality of care. Furthermore, if acceptable quality measures are not adhered to, the proprietor can be held negligent in a court of law. State governments can act as brokers to ensure suitable settings in which the care is provided, and the framework within which the carer works. Developing a process to facilitate and optimise the setting and framework is a policy exercise.

In aged care, as in any other field, policies come into being sometimes by planning, sometimes by negotiation, and sometimes just accidentally and incrementally. Only the naive and idealistic would believe that planning based on unambiguous data and clearly specified needs guides policy. Negotiation is tremendously important and can push accidental increment (a most unsatisfactory policy base) into oblivion. But this involves us all in an important political process.

In providing services for older people the issue is not simply one of doing what is considered to be the right thing. Philosophies and practices have to be placed on the policy agenda.

The getting of items onto the policy agenda involves the making of claims. Claims are made either by individuals, or made collectively. Nursing home residents and/or their families make claims, proprietors make claims, workers in the industry make claims, and on and on. The problem that has become evident is that government has had great difficulty, in times of declining economic growth, in responding equitably to the claims of the various more and less articulate groups.

Three types of claim articulators or lobbies, to put it more simply, can be identified. It is these who get items on the policy agenda. First there is the 'direct interest' lobby. Claims are made by those who are potential recipients of benefits - those with direct interest in the allocation. Within this category, two groups are identifiable - recipients, and providers. Both, for different reasons have an interest, sometimes joint interests, sometimes conflicting interests. ANHA for example, is a provider with good access and strong ability to articulate its claims.

Second there is what could be called an 'executive initiative' approach. Items are placed on the agenda by those in authoritative positions, and with some degree of expertise in the area. Third is the lobby of conscience comprising persons and groups acting out of a sense of noblesse oblige - those who have nothing direct to gain other than satisfaction of their humanitarian aspirations by positive social pay off. This lobby

includes individuals in the churches, voluntary organizations, professions and academia who possess a sense of social justice, a belief in a reduction of inequality and a hope for a better social future. This forms the basis of their activism.

The strengths, weaknesses, activities and interests of these three lobby types, referred to as the direct interest lobby, the executive lobby and the conscience lobby are matters of considerable concern to you and to me. You are part of the direct interest lobby - the provider part. I'm part of the executive lobby. Our objectives are sometimes in harmony, sometimes in conflict. I have a statutory obligation to look after the interests of older people. You are entrepreneurs and service providers. We all have different experiences, different motives and different contributions to make. Although I've never worked in a nursing home I believe I can blend my knowledge and experience with that of people who have, so that we might get top quality care onto the policy agenda.

ACTION

The tactics used by each of the groups involved in getting items onto the agenda will vary. Three types can be identified, simply labelled, co-operative strategy, campaign strategy, and contest strategy. The extent to which the various strategies are used depends on the amount of consensus that is deemed to exist in a society, or that is deemed desirable.

A co-operative strategy is appropriate when there is a fair level of agreement about the general nature of the change objective, and the task is to develop through co-operative methods, the best course for achieving the agreed-upon objective. The tactics most generally used are rational planning, action research, consensus decision-making, community development, fact-finding studies, and so on.

A campaign strategy is appropriate when there is no consensus on the need and no will to move ahead towards mutually agreed objectives, but when it is believed that agreement can be achieved through persuasion of some sort. In campaign strategies the popular tactics are advocacy research, educational and propaganda campaigns, proselytizing, 'consciousness-raising', rational persuasion and emotional appeals.

A contest strategy is appropriate where there is a basic disagreement about a change objective. In order to achieve that objective those who oppose it must somehow be defeated. The methods used here are the organising of opposition groups, appeals to third parties, disruption, and non-violent or even violent action.

I hope we can firmly and unequivocally dismiss a contest strategy from our aged care system. Disruption and violence has no place when trying to provide quality care for older people.

I would hate to see our most isolated, most frail and most powerless people used as bargaining chips. I can see our negotiating futures swinging between cooperative and campaign strategies.

CONCLUSION

Government is not going to be able to meet all of the demands from the community or even deal with all of the legitimate claims made on it. No one sector alone can provide all that has to be provided - not government, not the commercial sector, not the charitable sector and certainly not families. This is why I am arguing strongly for each State to develop a State Plan on Ageing - a Plan which deals with social justice, realistic policies, uncompromising care levels and equitable funding arrangements. This is consistent with a co-operative strategy.

The role of the States is crucial and self-evident. The Commonwealth is less likely to be able to deliver effectively across the full spectrum of aged care as the scale of operation allows it to deal best with broad principles. These are most necessary but must be blended with a more local touch. With State Plans on Ageing, the States then can bring together activities on either side - those of the Commonwealth, and by careful regulation and the development of contracted arrangements, those of the private for-profit sector and voluntary agencies.

The States are best suited to identifying need within their jurisdiction, planning to meet future need, initiating new processes and responding to local ideas and circumstances. It would make good sense for the States to take on an unambiguous planning and managerial role in organising services for elderly people. In most areas the State should work jointly with the Commonwealth in making decisions, but the ability of the States to harmonise numerous functions and services puts them into a stronger co-ordinating and brokering role.

The brokerage role is played when the State governments link funders, service providers, entrepreneurs and consumers. This can be done by reference to a State Plan on Ageing, backed up with procedures for letting service contracts, targetting services, and ensuring accountability from service providing agencies. Joint decision making with the Commonwealth plus a co-ordinating and brokerage role will go towards equity and service coherence for older people.

By developing a State Plan which includes mechanisms for regulating non-government and commercial service providers, State governments can ensure maximum consumer orientation and maximum sensitivity towards consumers. Through Offices such as mine, States can develop strong consultative arrangements with older people and be highly responsive to expressed and felt need.

My charter requires me first and foremost to look after the interests of our senior citizens. I am not so naive that I believe that this can happen by unilateral action on my part. I want to know more about what you do. I think you should know more about what is done at State level, and building on firm and sound foundations, I hope we can see the policy agenda developing by way of a co-operative strategy, though I can forsee occasions when a campaign strategy will be the name of the game.

As we look to the future, good and relevant practice and good and relevant research and good and relevant policies are attainable objectives, and when combined with good socio-political knowledge, are exceptionally important mechanisms in the development of a humane, equitable and relevant set of supports for our older population.

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Table 1

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	80-84	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: Compiled from data supplied by Department of Community Services, Canberra and Australian Bureau of Statistics, Adelaide.

Table 2

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

(Rank:Highest =1)

State	Age at 31 December 1985										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: Compiled from data supplied by Department of Community Services, Canberra.