NATIONAL COUNCIL ON THE AGEING

SAN FRANCISCO

APRIL 21 - 24

AGED CARE IN AUSTRALIA: CONFLICTING ISSUES

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For conventional reasons those aged 65 or more are regarded as constituting our population of elderly persons. 9.7% of 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.

The population is ageing slowly and the implications of this for social security and health and social service provision have caused alarm in some government circles. That Australia has been able to achieve, over the last 100 years, an increase in life expectancy at birth from 47 to 70 for males, and 51 to 77 for females, is an achievement rather than a calamity for society. We have witnessed, in recent years a significant decline in age specific mortality rates. Mortality per 100,000 for 75 year old men dropped from 8055 in 1954 to 6600 in 1981. For 75 year old women the drop was much more dramatic, from 5500 to 3501. I am using 75 rather than 65 because different supports are needed for an elderly population which is mostly aged between 65 and 75, compared with one mostly aged 75 or more - and it is this latter situation towards which we are heading.

On the whole Australia's population is ageing slowly. Those aged 65 and over, who today comprise 9.7 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.

The slow rate of ageing of the population will still mean a rise in absolute numbers. By the turn of the century there will be somewhere between 600,000 and 900,000 more elderly people than there are today, but more significantly, a change in the age distribution of elderly people. For example, if mortality is down by 1.5 per cent and there is modest migration, between now and 2001 the population will rise by 31 per cent; the numbers over 65 by 64 per cent; and those over 75 by 113 per cent. Those over 75 who in 1901 comprised less than one quarter of the over 65s, today comprise just over one third, and by 2001 will comprise 47 per cent, just under half of those aged 65 or more.

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.

The population is ageing slowly, but the proportion aged 75 or more is increasing. Most old people are women. Of those over 75, 60 per cent are women, 40 per cent are men - as ages go up so does the proportion of women. Most men have a spouse. Most women do not. 65 per cent of men over 70 have a spouse, but only 27 per cent of women over 70 do. Widowhood and living alone are of greater significance for the more numerous female population. Elderly people have less income than people in the population at large. 72 per cent of elderly men earn less than half average weekly earnings, 92 per cent of elderly women earn less than half A.W.E. For most (82% of those over 70) the main source of income is the age pension. One quarter of their income goes on food, 15 per cent on transport and 12 per cent on housing, though those renting in the private market spend an average of 20 per cent on rent. Elderly people however travel less, make fewer daily journeys and one could argue that this is a form of exclusion from many activities. 70 per cent of elderly people own their own homes and this proportion is declining. In the past 5 years the proportion renting in the private market has doubled - from 4 per cent to 8 per cent. On the health front, 77 per cent of elderly people report one chronic condition, 50 per cent report two. A very small number are bedridden, but 6 per cent are housebound and a further 10 per cent need assistance in getting out of the house.

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.

Many elderly people with chronic conditions do not live in institutions but live at home 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. Approximately 150,000 elderly people in Australia live with their adult children. Not all are fully dependent, but a great many are, and their accommodation circumstances are a result of a lack of choice and/or an utter abhorence of institutional care.

The Commonwealth however directly or indirectly provides a roof over the heads of approximately 200,000 elderly people at any one time, or 13.7 per cent of those aged 65 or more. 32,205 independent units have been funded under the Aged or Disabled Persons Homes Act; 30,737 under the Commonwealth State Housing Agreement, 70,574 Nursing Home beds have been funded, 34,741 Hostel beds, and a further 30,555 elderly people spent census night 1981 in a hospital. There is, however, an imbalance

between Commonwealth support for institutional and non-institutional care. For every dollar the Commonwealth Government spends on services for elderly people at home, it spends approximately 10 dollars for elderly people in institutional care. Yet almost 15 times more elderly people live at home than live in institutions.

Given the very strong emphasis on institutional care, two issues stand out. First, how can the balance between institutional care and home support be rectified. (our research in the Social Welfare Research Centre shows that it desparately needs rectification). Second, if the balance is rectified, what are the issues involved in ensuring a strong formal support system rather than a highly pressured and grossly inequitable informal support system.

To answer the first question I refer you to Report No.35 from the Social Welfare Research Centre, Options for Independence Home Help Policies for Elderly People, copies of which will be available after this session. In this report we examine the great variety of home care policies and services available in Australia and examine the conflicting auspices, and both the implementation issues and relevant issues in Australian federal/state relations.

While the Commonwealth Government spends approximately $1 billion per year on institutional care for elderly people it spends less than one tenth of that on home care - on programs under the State Grants Home Care Act, the Delivered

Meals (Subsidy) Act, and on Home Nursing Services. These three services need a massive funding boost and although the Commonwealth is now embarking on consolidation through the Home and Community Care program (HACC) the funding levels are insufficient to deal with the very great needs, and the quality of life of elderly people at home suffers accordingly.

To deal with the second question, the need for social care is bound to expand as a consequence of changing socio-technical and population dynamics and the resultant slow social policy response.

Contemporary welfare debates operate in an alarmist environment in which it is commonly argued that welfare expenditures are excessive and are expanding too quickly. Solutions are nominated in areas of cost cutting, "return to the family", privatization, and volunteerism. It is doubtful however, that any of these alone or together can provide the desired solutions. It is unlikely that the family can play an expanding caring function — after all, formal services came into being because informal structures (namely the family) were not able to cope with care issues. Even moves into the formal sector, moves based on increasing privatization and/or increasing voluntarism have their limitations. Equitable social care is most feasible when a well resourced public sector offers leadership and service support.

It is obvious that the family cannot play all of the roles which are found in the personal social services. Changes in demographic patterns, marriage rates, life expectancy, fertility, as well as labour force participation rates for women mean that the traditional caretaking role expected of women cannot be taken for granted, as the pool of potential caretakers is diminishing. There is no evidence, however, to show that the state is replacing the family as the primary agent of care, and, if anything, official policies and service cutbacks are placing more of the care function onto families. Both the family, and the formal system have different supports to offer, and can meet different types of needs. Eugene Litwak (1965: 299-300) argues that the family structure is able to deal with idiosyncratic events because it can define, as a result of its intimacy and small size, that which is to be valued and it can respond, where appropriate, with speed and flexibility. Bureaucracies within formal structures, on the other hand, are better equipped to deal with routine needs, and needs which require specialized knowledge or perhaps professional skills. Specialized institutions in health and education, for example, have removed the concentration of skill and services transmission from the family or the primary group.

In a recent revision of his famous 1960 study Filial Responsibility in the Modern American Family, Alvin Schorr points out that filial responsibility, i.e. the responsibility of children to care for their aged parents, as a precursor or alternative to care by government or charitable institutions, is a relatively modern idea and that it came into prominence only as economic changes loosened the grip of aged parents on property and income. For the bulk of the elderly, there was no golden age hundreds of years ago, where family care was more forthcoming than it is today.

Certainly some families have the capacity to provide care fo their members — but it can be suggested that those families in which the need for care is the greatest are those least equipped to provide it.

Changing demographic patterns demonstrate the limitations on the pool of potential caretakers. In Australia the middle aged unmarried woman, not in the labour force, who could be counted on to provide care is a disappearing species. Labour force participation rates for women have increased by 15 per cent in the past decade so that 44.4% of married women aged 45-54 are in the labour force. Furthermore, there are fewer "never marrieds" in Australia than ever before. Of women aged 45-49, 22% in 1901 were never married. Today the proportion is only 4.8%. For every 100 elderly persons in 1901, there were 8.7 unmarried women aged 45-59. Today there are only 4.1. Of those forming families in the mid-19th century, 80% had four or more children. Of those presently in their seventies, only 25% have had four or more children and furthermore, about 30% have no children or only one child.

With the obvious diminution in the pool of potential care-takers any suggestion of developing care policies based on the presumption that in the future women can provide care for their relatives because they will in any case be at home, financially dependent on a man, is a shaky basis upon which to plan the expansion of care (Finch & Groves, 1980: 506). There is no suggestion that women are rejecting caring roles. This is still deeply ingrained in most cultures. The issue relates to whether it is to be expected as a matter of course. Planning systems often fail to appreciate the overwhelmingly female nature of tending — where most professionals, assistants, volunteers, family carers, and those cared for are women. This combined with the demographic and labour force changes listed above, and the implementation of explicit family policies by way of state intervention into domestic arrangements makes for a difficult policy situation which is criss-crossed by issues of distribution, redistribution, gender, class, administration and ideology.

The picture that emerges is of a caring situation which involves disruption and adjustment, often resulting in the isolation of the caring family from almost all other informal and formal networks. In turn, this isolation increases the pressures experienced by families providing care; pressures that result in cumulative social, emotional and financial costs. It is instructive that family care entails heavy costs because embodied in the current rhetoric is the belief that community care is a less costly form of care.

If they are to maintain a situation whereby support needs ar· met, elderly and disabled people will have to turn more to government than to informal or voluntary sector supports. Government has a range of resources simply not found in informal support systems. Contemporary political rhetoric idealises the family as a support system and statements abound which expect the family to play a greater caring role than the enormous support presently provided across the life cycle. There are limits obviously, to what families can do.

To expect families to provide professional-like services in a complex world is to misunderstand modern division of labour principles. In all developed countries, as individual needs both increase and are differently defined, functions which once may have been the unique province of the family become shared between the informal and formal systems. This applies not only in caring arrangements but in income arrangements as well.

In no way is the suggestion being made here that family care or informal care patterns are not important, and thus do not require support. The bulk of care that is provided comes through informal channels. Different needs, however, are met by different systems. A continuum can be drawn up, moving from informal and intimate support to formal and institutional support. At the informal end are personal needs involving affectual relationships, emotional interaction, intellectual stimulation. Straddling informal and formal are needs for personal and physical maintenance, such as washing, toileting,

moving about, eating, etc. A little further on is the need for housing, the need to be productive, and ultimately the need for full security in terms of specialised medical and rehabilitative services, residential care, and/or total income support.

If the community — and the family — are to be expected to play a more active caring role in the face of public sector cutbacks, it is essential that strong supports should be made available through explicit policies. To suggest that the state has usurped the role of the family and is now handing it back does not accord with the evidence, especially that which shows that policies on eligibility for formal services can, in times of economic recession, severely penalize dependent people. In many services there is an assumption that families will provide care, and consequently domiciliary services are often withheld if the elderly person lives with or near relatives, regardless of whether the relatives are willing or able to provide care

In conclusion, it is important to note carefully the demographic characteristics and living conditions of our elderly people now and in the future. Second it is necessary to rectify the inappropriate balance between institutional care and home support, but in doing so the third point comes into play, and that is the limits on informal supports, and in

particular the limits on family capacity to provide all the care that is required.

In Australia we are fortunate in having the opportunity to plan for our elderly population but we would be making a grave mistake to build our plans on the basis of greater informal care. Our research has shown that Australian families have the willingness, but not necessarily the capacity to provide the support which elderly people need. We are faced with a set of very challenging planning tasks in the next few years, and unless we respond vigorously and innovatively those of us who reach old age in the next thirty to forty years will have only ourselves to blame.