Adam Graycar

START

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Nurse

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Between July 1, 1980 and June 30, 1981, 111,220 Australians turned 65 - that is 325 per day. Approximately 73,000 people over 65 died in the same period, that is 210 per day. Thus our "aged" population increased by around 42,000 in the year or by 105 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.

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 10.0 per cent of the population, will by the year 2001, comprise about 12.0 per cent, and by 2021 about 15.0 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. 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. This mortality drop means a larger population aged 75 and over. Different supports are needed for an elderly population which is mostly aged 65 to 75, compared with one in which a substantial number are aged 75 or more — and it is this latter situation towards which we are heading.

S.A. 14 + 18

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~~ around 900,000 more elderly people than there are today, but more significantly there will be 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~~

The population as a whole 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 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.

Rates of institutionalisation are directly related to demographic factors. Having a spouse is the greatest defence against social isolation, public dependency and poverty. 72 per cent of men aged 65 and over have a spouse. 37 per cent of women aged 65 and over have a spouse. There are considerably more elderly women than men, and when we translate the percentages into actual numbers, there were, at the last Census 168,000 elderly men without a spouse, yet 521,000 elderly women without a spouse. At all ages (above 65) the proportion of married men far outweighs the proportion of married women. For example 32 per cent of men over 90 have spouses while only 4.8 of women over 90 have spouses. There

Have to be clear on having spouse - Hinwood Nicholls

has been a significant change in marital status statistics for men since the 1921 Census. In that Census 59.4 per cent of elderly men had wives. Today the proportion has grown to 72 per cent. The proportion of women with spouses has remained constant over the same period. Has the male married rate peaked? Will it keep rising? What about female married rates — will they increase? What will be the impact of rising divorce rates (these are presently 2.7 per cent and 2.3 per cent for elderly males and females respectively, compared with 1.1 per cent and 0.9 per cent at the 1961 Census and 0.2 and 0.1 per cent at the 1921 Census). When developing policies for care of elderly people these demographic changes are of considerable consequence.

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. The 'old-old', those over 75, 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.

Most 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 abhorrence of institutional care.

The Commonwealth Government, however, directly or indirectly helps keep 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. 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.

Rhetoric - 9 pp/principles, action
GBS - dinner party

Given the very strong emphasis on institutional care, two issues need attention. First, how can the mismatch between institutional care and home support be ameliorated. 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.

While demographers argue about the extent to which the population is ageing, and about dependency ratios in years to come, the key issue is really why ageing is seen as a problem in the first place. In the second place, the question of for whom is it a problem must be raised; and third, what interventions are appropriate to deal with the situation.

Ageing is seen as a problem because a situation of dependency can be identified. In earlier times when life expectancy was lower and the proportion of older people smaller, it was regarded as quite an achievement to have survived to old age, and status and prestige were accordingly granted. To-day, with one in ten over sixty five and the prospect of one in seven over sixty five within two generations, prestige is diminished and novelty value has disappeared. The older person's reputation as a repository of knowledge and fount of wisdom has been eroded by modern education and technology. The Henderson Report found that before housing costs were taken into account, almost one quarter of elderly income units were "very poor". (The high rate of home ownership among elderly people reduces this proportion to about 8%, but this still represents many tens of thousands of people falling below Henderson's very stringent line).

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Ageing therefore 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 a substantial public intervention, and of course there is a price to be paid. If we turn to the second question, for whom is ageing a problem, we can identify ~~three~~ four 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; second there are the relatives who may find themselves in time consuming and expense producing caring arrangements; third there are service pro Fourth are taxpayers and politicians who maintain that elderly people cost too much.

Our third question, 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. Age pensions, for example, are paid to women over 60 and men over 65 - almost 1.5 million people (including 30,000 who receive wife's allowance). This is about three quarters of the population in the eligible age groups. The cash cost is around $6.0 billion per annum - slightly under half of the social security budget and about 11% of the whole of the Commonwealth Government's budget. In addition there are expenditures on social, housing and health services.

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 the 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 publc services and a thrusting upon the family of greater responsibility for a primary caring function. It can be argued that many of the "problems" associated with ageing are largely political.

Defining what we mean 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 a working definition which went like this :

> "old age begins at the point in an individual's life when she ceases to perform all those duties, and enjoy all those rights, which were hers during mature adulthood, when she 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".

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.

Social policy is about interventionist activities which attempt to alter life chances. It is about a theory of benefits and their distribution, and in determining the distribution or redistribution of our social resources a conflict situation develops, and with it arguments about the relative responsibilities of "the state" "the taxpayer" "the family" "individuals" as if they were all discrete categories rather than integrated entities.

The basic social policy issues of how targets are set, of how strategies are planned, of how resources are allocated and of how results are assessed are primarily questions of values. Rarely does a (Federal) parliamentary sitting day go by without some Members telling us that we in Australia can not afford our welfare bill - that the taxpayer is being bled dry by people who cannot or will not provide for themselves and who thus have become dependent on the state. Yet dependency is not something that people seek out - people do not choose to become dependent - rather dependency is socially structured and created, and the social consequence of ageing is cumulative exclusion of a significant number of people from income, jobs and meaningful roles in society.

We must note however that physiological and psychological changes do not occur consistently in the aged population, but as they do occur, they are sequential, and irreversible. The dependencies associated with ageing are chronic rather than transitional, and it is the way in which our socio-economic and socio-medical system affect these dependencies which tells us how effective our social policy is.

Through the Departments of Social Security, Health, Veterans Affairs, and Housing and Construction the Commonwealth Government allocates somewhere around $10 ~~between $5.8 billion and $7.3 billion~~ per annum for services for elderly people. This is about ~~between 15% and~~ 18% of Commonwealth budget outlays. Now, some critics might argue that elderly people who constitute 10 ~~9.5~~% of our population, yet receive ~~12.5~~ 18% of Commonwealth budget outlays, are getting more than their fair share. Any analysis of the data which illustrates the mantle of disadvantage which envelopes elderly people, in particular elderly women, will show that this is not so. But this is the very crux of social policy - planned intervention to allocate and redistribute resources in society. A political battle of competing interests - against a backdrop of social values, stated and unstated goals, and specific resources, determines our social policy outputs.

After a White House Conference on Ageing in the United States ten years ago, Richard Nixon announced a new national policy towards ageing and the aged. He specified 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. It does, however, contrast with the situation in Australia where 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 U.S.A. of course, is not alone in having co-ordination headaches, ~~as Peter Sinnett's comments below indicate.~~ I could tell some hair-raising stories too

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% 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 (see below, p. 10) 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 organizations 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 wih 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.

If we just look at the Australian population for a moment we find that about 1.5 million people are aged 65 or more - 10% of the population. 50 years ago the proportion was 6.5% - in 50 years time it will be around 15.5% - about the rate which prevails in most of Europe to-day. Over this century life expectancy at birth has increased from 47 to 70 for males and from 51 to 77 for females. Elderly people have less income than people in the population at large. 72% of elderly men earn less than half average weekly earnings, 92% 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% on transport and 12% on housing. Elderly people however travel less, make fewer daily journeys and one could argue that this is a form of exclusion from many activities. 70% 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% to 8%. On the health front, 77% of elderly people report one chronic condition, 50% report two. A very small number are bedridden, but 6% are housebound and a further 10% need assistance in getting out of the house. There has been a dramatic shift in labour force participation rates and in the past 15 years the percentage of males aged 65 and over in the labour force has declined from 23% to 11% - this applies to both full time and part time participation rates, and it is important when one considers the important role that part time work can play in the lives of elderly people.

As noted earlier, 35% of those over 65 are aged 75 or more. At the turn of the century the proportion was 25%. Most old people are women, of those over 75, 60% are women, 40% are men - as ages go up so does the proportion of women. Most men have a spouse. Most women do not. 65% of men over 70 have a spouse, but only 27% of women over 70 do. Widowhood and living alone are of greater significance for the more numerous female population.

Around 89% of males and around 82% of females aged 75 or more in Sydney live in private dwellings. The remainder live in nursing homes, homes for the aged, or hospitals. Of those in private dwellings living arrangements of males and females differ dramatically.

Percentage distribution, persons aged 75+
in private dwellings in Sydney (approximates)

	living alone	living with spouse	living with relatives
Males	20	60	20
Females	42	16	42

Slightly more people over 75 live in institutional settings than with relatives. Before jumping to conclusions that families no longer care for their elderly it is important to note that families often simply do not have the capacity to provide adequate care.

Care is needed if elderly people find themselves in a state of dependency. As I said before, dependencies of ageing are chronic rather than transitional

[redacted]. The care task is becoming longer and harder, and there has developed a special need to integrate statutory and non-statutory services as supports for those providing care. Without these supports, the dependent people who are being cared for will increasingly be cared for by family members who themselves will be locked into states of dependency. [redacted]

We have heard a lot lately about families abdicating their responsibility to care for their elderly members. What evidence there is suggests that the families are not at all abdicating their responsibility, but rather they are under enormous pressure because their capacity to deal with and provide adequate care for elderly dependent relatives is diminishing. Advocates of family care often assume that caring presents little difficulty for the family, and while caring for an elderly relative can be a positive experience, what is ignored are the many accompanying stresses and costs related to the caring role. The day-to-day responsibilities of care usually fall on one person - generally a spouse, a daughter, or a daughter-in-law. Most families continue to care for elderly relatives until a crisis point is reached where there no longer exists any alternative to institutionalising their relative. Usually the decision is made as a last resort after the family has exhausted both coping abilities and resources.

[redacted]

The carers themselves felt a strong sense of obligation towards their elderly relative and accepted the caring task because they loved their relatives and in general believed the family has responsibility to care and they loved their parents. We also identified a lot of pressures on the people who were performing caring functions.

The carers by and large felt themselves fairly isolated. Few had anybody to provide any periodic relief when it was required. Those who had husbands and children found them generally supportive, but very often the support was only verbal and did not translate into action. Many of the carers themselves had health problems. When ill, they had no option but to continue offering care. 60% had not had a holiday for years. They resented their loss of independence and the decline in their health which was caused by stress. Also they experienced great anxiety - on the one hand they felt they could not leave their elderly relative for any length of time and on the other hand some felt that they were neglecting their responsibilities to other family members. Some felt a tremendous emotional drain on themselves and one said to us "at 80 I'm going over the Gap - I couldn't put my kids through this".

Overall, the research found that the carers :

- had less time for recreation and leisure activities
- had less time to complete housework and allied chores
- were less able to relax and sleep at night
- were apprehensive about their growing older

In addition to a decline in emotional state of the carers, the three negative features which stood out dramatically were :

- loss of independence for carers
- loss of privacy/intimacy within the family
- tension/disruption of family life.

Surprisingly, 82% reported that caring did not present them with financial difficulties, even though our sample was predominantly low-income and 56% had as income only pensions or benefits.

We collected a lot of data on income, housing, and employment, and these appear in the published report and will not be dealt with here. Rather than go through the great mass of data we have, I want to mention only three items of interest, formal supports, informal supports, and reasons for giving up care.

We all know that domiciliary services are stretched to the limit, yet surprisingly we found service usage quite low. Our sample was biased in that we obtained it from home nursing services, yet apart from home nursing, the service mostly used was Day Care Centres, used by 31.% of the sample. The only others to reach double figures were respite beds (15%) and

CONCLUSIONS

What threads can we draw together? First of all ~~our 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.

Family care in reality is care by women. When I said that people were likely to look more towards formal care systems than informal care systems I was thinking of the fact that the potential pool of caretakers in Australia - those unmarried women not in the labour force who formerly saw it as their role to look after elderly parents - is rapidly diminishing. There are fewer never married women in middle age to-day than there ever have been. There are also more women in middle age in the labour force than there have ever been. The situation has been characterized by an American social scientist Elaine Brody, who in describing the phenomenon of "the woman in the middle" wrote :

> "such women are in middle age, in the middle from a generational standpoint, and in the middle in that the demands of their various roles compete for their time and energy. To an extent unprecedented in history, roles as paid workers and as care giving daughters and daughters-in-law to dependent elderly people have been added to the traditional role of wives, homemakers, mothers and grandmothers. Many of them are also in the middle in that they are experiencing pressure from two potentially competing values - that is the traditional value that care of the elderly is a family responsibility vis-a-vis the new value that women should be free to work outside the home if they wish."

The women in our study found very often they could not manage all of these competing demands. An increase in overall dependency can result if we develop the idea 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. This seems a very shaky basis on which to plan the expansion of care.

There is no evidence to show that formal services weaken informal provision, and hence weaken the social structure. As families will always want to provide for dependent relatives (even though their capacity may be limited), public policy jectives must be re-oriented to bolstering and enhancing y care support. It would be a mistake to work on the f assuming that family care is always viable, and available, a he onerous burdens of care experienced by many While families are not likely to be able to extend s they do play a significant role, and policies loped that enhance the natural system of family care ding adequate and relevant formal services.

The key policy question relates to determining the most appropriate instrument of intervention and the most appropriate point of intervention to meet the various needs that emerge at various stages of the life-cycle. The dependencies of old age are chronic rather than transitional and may foreshadow continuing or increasing dependency. The dependencies are expected and accepted and by our study we hope to be able to provide more information on how these dependencies can best be dealt with in terms of the provision of support and services for family members and elderly dependent people.

In our society different needs are met by different support systems. The inter-relationship between statutory, commercial, voluntary and informal systems of care is not easily defined, nor is it in any way fixed. It is open for negotiation and rearrangement. To assume that the relationship can be redefined

on the expectation of greater informal care, more unpaid labour, and less statutory provision, is quite unrealistic. To assume that the so-called "Welfare State crisis' can be resolved by exhortations of greater family support and ncreased family care is to take the soft option in difficult s. A community which has benefitted from the endeavours population cannot in conscience abandon those requiring re and argue that their needs are not sufficiently for the allocation of public resources. To date, provision has not responded well to rapid socio-demographic changes. The community cannot n its obligations to its citizens.

AGENDA FOR AGEING

* INCOME SECURITY
* HEALTH CARE
* SOCIAL SERVICES
* HOUSING

  ABOUR FORCE & OLDER WORKERS

  COMMUNICATION AND TRANSPORT

* LIFE ENRICHMENT
* GEOGRAPHIC ISOLATION
* CRIME
* GENDER BALANCE
* FAMILY SUPPORT