Speech by Adam Graycar:

"Sociological perspectives"

presented at the Uniting Church National Aged Care Conference, Adelaide, 14th-17th July, 1986.

UNITING CHURCH NATIONAL AGED CARE CONFERENCE

ADELAIDE

14th - 17th AUGUST, 1986

Sociological Perspectives

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I am very pleased that you have asked me to speak about sociological perspectives because it means that for the next 20 minutes or so I can forget that I am a bureaucrat and think and expound instead on broader sociological issues. As a bureaucrat I spend my time contemplating, dealing with, and co-ordinating policy outputs which affect the lives of older people. I continually face a situation in which older people sometimes condescendingly, sometimes patronisingly, and sometimes compassionately referred to as "the aged", are perceived as a homogeneous entity. "The aged" a term from which I resile, are perceived symbolically as problems for society. Of course it is important continually to remind ourselves 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. The message I keep stressing is that we must discard the totally inappropriate cliche that older people are problems, and concentrate instead on the problems they have. To do so requires good policy analysis, strong community responsiveness, and very importantly the elimination of unrealistic patronising and unhelpful stereotypes. With good social theory, better social understanding and a marked improvement in our knowledge of social facts and phenomena we will be able to fashion, from a sociological perspective, appropriate actions and activities in this changing and ageing society.

Changing demographic patterns have brought about sociological changes of some magnitude. We have considerably more older people today than we have ever had before, and on average a 60 year old male can today expect to live another 18 years while a 60 year old female can expect to live about 22½ years. A seventy year old male can expect to live another 11 years, while a 70 year old female can expect to live another 15 years.

In giving people more time to live science and medicine have also given them more time to die. 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 are skilled in coping with problems that are purely technical. We can send people to the moon, yet we can't find jobs for our young 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 20 - 25 years beyond retirement, yet we can't always ensure that they can live those years in dignity. While life expectancies have increased, the associated dependencies are more chronic than transitional, and families are less able to provide the supports required, and less able to cope. Hence older people are more likely to look,and to look for longer periods,to formal services for support.

As you are well aware most old men have a spouse and most old women don't have a spouse. Having a spouse is the greatest defence against social isolation, public dependency, and poverty. Seventy-two per cent of men aged 65 and over have a spouse. Thirty-seven per cent of women aged 65 and over have a spouse. There are considerably more elderly women than men and when translated into actual numbers, we have in Australia well over half a million elderly women without a spouse and somewhere in the order of 168,000 elderly men without a spouse. I won't go into the details but at all ages above 65 the proportion of married men far outweighs the proportion of married women.

Not only do older women not usually have a spouse but it is unlikely they would have, as the fairy tales would have it, an unmarried daughter not in the labour force. We have seen significant shifts in recent times in marriage rates and in female labour force participation. When we combine this with a smaller family size we have a situation where family supports often cannot be relied upon. Of people forming families in the mid 19th century, eighty per cent had four or more children. Of those presently in their seventies only twenty-five per cent have had four or more children and furthermore about thirty per cent have no children or only one child. Although I haven't done any calculations for Australia the situation is probably not too different to that in the U.K. where a demographer has recently calculated that a typical British couple married in 1920 and still alive today would have forty-two living female

relatives of whom fourteen are not working. In contrast the typical couple married in 1950 are likely, when they reach eighty, to have only eleven living female relatives of whom only three will not be in paid jobs, but probably not live near enough to be able to provide care. I mentioned the role of women because gender is a very important sub-part of the status element in the basic sociological trilogy of class, status, and power.

In developing a sociological perspective we can break our elderly population into three general strata. I am not including in these three strata that 4 per cent of elderly people who live in nursing homes - those people who are probably the most isolated and powerless in our society. By far the most numerous group of elderly people, comprising approximately sixty per cent of our older population are what we might call a middle stratum. They are usually home owners, they might have some assets or some money in the bank, they don't have sufficient assets to prevent their getting a pension but they have accumulated, over a lifetime, their major asset - their house, and have done this on the basis of some steady occupational background. They are usually fairly well integrated into their community and participate actively in their churches, bowling clubs, and other community activities.

About twenty per cent of our older population comprise an upper stratum of wealthy people. Mostly they have come from professional or business backgrounds, have accumulated substantial assets over a lifetime. Some are fully retired, some are only semi retired and retain an interest in their businesses or their professions. In many cases they continue to participate as they always have in their adult life - participate not in aged-related activities, but moreso in the organizations and associations with which they have always been associated - varying from private, exclusive clubs to local golf clubs or family activities.

At the other end of the spectrum is a stratum, again comprising approximately twenty per cent of the elderly population, characterised by poverty and exclusion from the mainstream. In this stratum most older people have very few resources - their only income is the pension and while some are home owners a significant number pay rents - those who are fortunate pay rent in the public sector and those who are unfortunate, usually women living alone, pay rent in the private rental market. These people are poor, not because they are old, not because they may be sick or disabled, but rather because of their social situation which was probably economically precarious in the first place. It is made worse because they have not accumulated assets over a lifetime, are excluded from the paid labour force, and lack tangible financial resources upon which to build a satisfactory economic base.

By understanding these three strata, by understanding the spatial, gender, and ethnic differences that are woven into these three strata, we can better understand how people live, we can better understand their needs, and together we can start to build a better framework and a better base for policy intervention to maximise their life chances and enrich their lives as much as possible. Those of us in government can develop policy options and structure intervention, those of you in the service industries and in the churches can also respond accordingly.

Overwhelmingly our policy interventions tend to be health oriented. Impairment, disability and handicap cut across class barriers. In Australia just over one third of people aged sixty-five to seventy-four have a disability and just over one half of those aged seventy-five and over have a disability. In many cases these disabilities are not handicaps but nevertheless they do limit mobility and they do have a profound effect on people's lives. About two thirds of all disabled elderly persons were found to be handicapped in some way. The three most prevalent disabling conditions reported by elderly people were muskuloskeletal disease, followed by hearing loss and circulatory diseases. Almost three quarters of those with muskuloskeletal or circulatory disease were handicapped whereas less than half of those with hearing loss were handicapped. The overwhelming majority of elderly people live in households as we all know. Furthermore the overwelming majority of people with

handicaps also live in private residences - of the 450,700 people over 65 identified as having handicaps, eighty-two percent live in private households and eighteen per cent in institutions. Of those aged 65-74 ninety-two per cent of those with handicaps live in private dwellings. Of those aged 75 and over seventy-two per cent of those with handicaps live in private dwellings. 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, living alone.

When preparing responses we rarely think in sociological terms. Analyses of class, status and power show us that those who have lost least in the process to retirement have at their disposal the best access to services, and the best set of services.

That 20 per cent that forms the lowest stratum in our society finds that upon retirement their income is reduced dramatically, their role as consumers and as producers is severely diminished. In the past they have never had any political power so they lose nothing in this respect upon retirement. However, they may be forced into ghettoization, and isolation by the forces of economic, social and political power.

The middle stratum has better access to some assets, and retirement is not a dramatic change from an income point of view although there is some adjustment to a lower income. The main

loss however is one of prestige associated with their declining expertise or ownership and their marginal status. Experiencing a loss of prestige they may turn upon themselves for reaffirmation of their status and this has often led to self-imposed segregation. These are the people who join the clubs, who participate in activities that are very much age oriented and hence we get the development of "activity theory" which sees adjustment to retirement as characterised by staying active, by resisting shrinking social involvement through finding substitute roles and activities, but usually with people of the same age.

The upper stratum retains its higher levels of economic power that it has held throughout its life. By retaining positions of ownership and control, dabbling in the professions and having command over assets, the upper stratum is still able to wield power based on position and wealth. If there is loss of prestige it is perhaps related to declining health status, but often prestige is retained by staying in selected positions, through conspicuous consumption or perhaps by being active in various enterprises.

The exercise, or lack of exercise of economic, social and political power structures the nature of inclusion and exclusion for people in our society, yet in developing ageing policies, health status seems to be the main criterion, and sociological perspectives are rarely prominent. I have been calling recently for the development of a State Plan on Ageing in each State - a plan built on consensus and understanding.

The search for a consensus which ensures the protection of the weak, the vulnerable and the disadvantaged must begin with an understanding of Australian social structure and it is from this perspective that one can start to delve into the sociological analysis of class, status and power. Among our elderly population we have some of the richest people in this society and some of the poorest. An older person's place in society is structured by how they live, where they live, what resources they have at their disposal, how they are able to partake of the mainstream of society, who they can rely on, who they live with, what sorts of community supports they can count on in their local environment, their health status and their mobility. Good social policy focuses on processes which maximise inclusion and minimise exclusion of people who are sometimes deemed marginal.

The well-being of our elderly population is intricately related to the well-being of our society as a whole. Just over six years ago I wrote a piece in which I assumed that the 1980s would be a decade of declining economic growth, of steady or declining public resources, and increased demand on those resources. I pointed out that sluggish, sporadic and even declining economic growth would sharpen social divisions and place great pressure on our conciliatory and allocative mechanisms. As a result uncertainty and exclusion would be the lot of many people in the 1980s, people who find they have no worthwhile place in a competitive industrial society.

The conditions of Australia's vulnerable and poorest people - those people without sufficient income, services, and power by virtue of their class, status and power, their disabilities, age, isolation, ethnicity and lack of life chances, are clearly apparent all around us. We are seeing today a more unequal Australia than we have seen for some time, with massive poverty and broad social exclusion, and it is unlikely that next Tuesday's budget will contain measures to broaden the base of inclusion. Major debates about broadening the base of inclusion involve perennial disagreements about the permissible degree of income and resource inequality, and any government worth its salt must try to create and recreate an evolving social consensus which will protect the weak, the vulnerable and the disadvantaged.

As well as data on social dependency, we have oodles of data on impairment, disability and handicap, phenomena which cut across class boundaries. In order to deal with increasing dependencies among our elderly population, there exists a continuum of care, ranging from self, through primary groups, extended families, neighbourhoods and formally organised services, statutory and non-statutory including those you provide. Your task and mine is to work together to develop a co-operative strategy to maximise the well being of our older population.

We are involved mostly in formal rather than informal services and no service system can function satisfactorily without professional back-up. It is essential that those planning and delivering services work from a strong knowledge base, especially a knowledge of social processes and social linkages. Service deliverers work in the most real of real world situations and make a great contribution to our older population not only by delivering high quality professional services where appropriate, but by being skilfully able to translate these real-world individual cases and situations into social issues and issues of policy.

This comes from good social theory and thoughtful practice. If their knowledge and practice bases are sound, age care workers will be best able to determine whether certain needs require supportive, supplementary, or substitutive services. It takes a lot of skill to know which needs require supportive, supplementary or substitutive services - that is what all our assessment work is about at the moment - but for you it is important to recognise the range of supports that takes place within our community and to understand the capacity of the various service providing sectors to provide what service they can. To do this, built on a foundation of good sociological knowledge, will certainly make more pertinent your practice and enhance and enrich the lives of our marginal and dependent older citizens.