Speech by Adam Graycar:

"Will you still need me, will you still feed me, when I'm 64?

presented at the Extended Care Society of Victoria Seminar, Melbourne, 8th June 1988

EXTENDED CARE SOCIETY OF VICTORIA

SEMINAR

MELBOURNE

8TH JUNE 1988

WILL YOU STILL NEED ME, WILL YOU STILL FEED ME, WHEN I'M 64?

ADAM GRAYCAR

Commissioner for the Ageing
Box 1765, GPO ADELAIDE. 5001

Romeo + Juliet
- Grand Canyon
- Elephant — Headings — 1) majesty + Grandeur
2) Bigger is better
3) C... a risk

Of all the boys born in Australia in 1924 - 64 years ago, 78 per cent are alive today. Of all the girls born in that year 88 per cent are still alive today. The 135,000 Australians who are 64 comprise 83 per cent of their birth cohort - an amazing survivorship phenomenon.

At the turn of this century, only 52 per cent survived to 64. Will you still need me, will you still feed me when I'm 64 isn't really a very challenging question. Nobody would write a song asking will you still need me, will you still feed me when I'm 44, and being 64 isn't all that different except perhaps for one major change. Most people aged 64 in Australia today are not part of the paid labour force. Less than half of males and about one tenth of females are part of the paid labour force - compared to more than three quarters of males and one fifth of females 20 years ago.

We all need to be needed and fed. There was a time when being part of the paid labour force was the main means of being fed. Now some experts say that we're being swamped by a geriatric tidal wave, overunning all that lies in front of it, churning out people more numerous than the desert sands and swallowing up taxation dollars in health care costs, pension costs, home care costs and nursing home costs at a rate that leaves one breathless and stunned. But the reality is quite different from the rhetoric.

"Fine" = low elderly mother communicator daily
"I'll make sure that I come & visit you

Most who are 64 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 stereotype that older people <u>are</u> problems, and concentrate instead, on the problems they <u>have</u>. To do so requires good policy analysis, strong community responsiveness and very importantly, the elimination or unrealistic, patronising and unhelpful stereotypes. Woman trying to convince her financially indep elderly mother to move into a hostel. Lots parked around in the country home — took her to visit "See how much fun they're having playing cards = cooked the daughter "I'd In their age I'd love to live here =

Analysing the demographics we have greater life expectancy at birth and at all advanced ages, substantial drops in age specific mortality rates at higher ages, high rates of chronicity, a surplus of women at higher age groups, most of whom have no spouse, nearly all older people living in private dwellings, nearly all older people with handicaps living in private dwellings, a nursing home population with a median age approaching 85 and a situation soon in which half of our over 65s will be over 75.

When translated into goods and services and social facilities and supports our changing population structure warrants careful policy attention. Elderly people require a wide range of supports, mostly income support, but also health services. Who is going to respond? Who is going to be able to assess the needs and know what services are most appropriate? Who is going to deliver these services? Who is going to pay for our older population which is very much differentiated by age, by sex, by class, by ethnicity, by spatial location, and by heath status.

In essence we have and will continue to have two older populations each defined as old with very different and incompatible definitions. One population is deemed too old for the paid labour force, and one deemed too old to participate physically and emotionally in mainstream society. It is incumbent on us not to get our policy wires crossed.

We are facing two explosions - an explosion of perceived uselessness and an explosion of care. Assessing the impact of, determining the response to, and trying to pre-empt these explosions will be our key task for the 1990s.

In a nutshell, in giving people more time to live, science and medicine have also given them more time to die. We live amidst astounding technological sophistication. We can think the unthinkable and do the undoable, yet are we a lot better off? We can analyse the gases surrounding Jupiter, we can fire a probe into the nucleus of Halley's Comet and do other assorted magic. 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 or human context. We can send people to the moon, yet we can't find jobs for our young people; we can keep people alive for twenty to twenty five years beyond retirement yet we can't ensure that they can live those years in dignity.

Ensuring they live their lives in dignity places monumental challenges before us. Not just needing and feeding people who are 64, but developing a social infrastructure that provides supports that are relevant and compassionate, humane and

effective. Targetting 64 year olds is very important, but often ignored. Being needed and fed at 64 is important, as it is at any age. 64 is an important year largely because it marks for many, the explosion of perceived uselessness, being pushed onto a societally structured scrapheap. At 64, when people are fit and healthy, but perhaps showing the first signs of some problems, they are in a wonderful position to be advocates - advocates for themselves as 64 year olds, advocates for the 84 year olds, and advocates for themselves when they'll be 84 year olds. 64 year olds are often politically powerful, have the skills, knowledge and experience to get their points across. It is an age where there is often the solid capacity, physically, financially and emotionally, to make an impact, an impact to lessen any ultimate dependency.

The dependencies that can come after 64 are both physical and financial. I don't want to talk about financial dependency now, though it is an issue that governments cannot ignore. The physical dependencies that can have devastating consequences on our social and health services can be attacked squarly if you're 64. It is a time when primary health care can play a very large role. Of course primary health care should not wait until one is 64 but if the preventive and basic interventions have been left until then its still not too late at 64.

It is a time for careful examination of lifestyle and diet, exercise and leisure, preventive and acute health care. Women's health needs acute attention. Many women find their female

parts behaving differently, and many male doctors don't really know what is best - problems not sorted out at 64 become horrendous at 84. Increasing numbers of 64 year olds for example, have their own teeth - this is an achievement, but it will also require a great deal of extra care. Women's health and teeth are just two examples of extra care required in our health systems. They are both issues that can benefit from resource allocation, educational programs and self-care. 64 year olds are right there able to advocate and lobby and able to ensure through their advocacy that they can be needed and fed.

To be needed is one of the richest forms of moral and spiritual nourishment and not to be needed is one of the most severe forms of psychic deprivation. When we look at young people who feel they are not needed and when we look at old people who think they have been placed on the scrapheap we see the basis for a massive disjunction in societal continuity and coherence.

When we look at being needed we must examine the contributions of both our formal and informal mechanisms as they relate to post-retirement adaptations, and with the greater life expectancy the chronicity and disability that characterises those extra years of life, not evident in earlier decades - those extra years of life which are also extra year in which to die.

The four main issues for a person facing retirement are income - having enough and having it regularly; having adequate health care; having appropriate living and housing arrangements; and having interest and purpose in life. Old people are not at all

different from their younger contemporaries in the requirement that life must have some meaning. We have made enormous advances in recent years in the first three of these areas, income, health, accommodation. The fourth issue, interest and purpose in life is is often the least recognized and most neglected. Yet it is the heart of many of our difficulties in retirement.

Today there is a cruel and ironic contradiction in the fate of our older citizens. Never before have older people been able to look forward to so many years of vitality but never before have they been so firmly shouldered out of every significant role in life - in the family, in the world, at work and in the community.

Lets look at the 84 year olds. Of all the girls born 84 years ago 43 per cent are still alive today. Of all the boys born in 1904 22 per cent are still alive. Their needs and wants are quite different to those who are 64 - but they still need to be needed and fed.

When we combine the being needed and having a meaningful role with the three big health losses - increases in dementia, immobility and incontinence at advanced ages, there is a great onus on planners and service deliverers to structure home care and residential care systems that are efficient, flexible, accountable, acceptable, comprehensive, accessible, co-ordinated and equitably allocated. If you can plan and deliver such services, and make sure they are both compassionate and

professional as well, can you see me at morning tea, and I'll get your names and pass them on to those who decide the Nobel Prize.

We have problems of both a planning and delivery nature in both our home care and residential care programs. At a conference in Adelaide a couple of weeks ago my theme was who plans and who delivers. I made the point that in aged care, many of those who plan don't know much about delivering, and many of those who deliver do so without effective communication with those who plan. I'm sure you can all relate to that, wherever you sit in the aged care industry.

When we examine who plans and who delivers we find a complex situation where side by side we can identify science and mumbo jumbo, self interest and altruism, skill and clumsiness, and power and authority. We find stereotypes and prejudices, knowledge and ignorance, compassion and indifferent disregard often co-existing, sometimes competing, yet always there.

Many of those who plan don't know much about ageing and many of the deliverers are too battered, too harrassed and too poorly managed to cope. What keeps the system going however, is goodwill. There is tons of goodwill in aged care and for a time will overcome the management crises which I'm sure you can all see. Without the goodwill our system would be hopeless and irredeemable. But goodwill is no substitute for education. I want to put forward some ideas later on developing excellence in planning and delivering in aged care.

We have seen enormous gains in the 1980s, but there is enormous economic and ideological pressure to limit those gains. Aged care costs money. There is no way to say it doesn't. Families are not able to provide the skilled and demanding care associated with some of the dependencies of age. Nor can untrained and unskilled do-gooders. Yet how often have we heard naive politicians and community leaders suggest that families should do more. How often have we heard the evangalists who preach normalisation say that all that frail elderly people need is a homelike environment and a smile. It is easy to pass the buck to families, or as some normalisers do, wish away the dependencies - dismiss them with a magic wand and hope they float away. We need a realistic orientation to our older population.

If as is planned the number of nursing home beds is reduced to 40 per 1,000 persons aged 70 or more, and if HACC services meet their stated objectives, then it follows that the reduced number of nursing home beds will, of necessity, be filled by people who are considerably more dependent than many of the people in nursing homes today. There will be no place in Australia's nursing homes for people who are not highly dependent and who have not been assessed as such. Their disabilities and dependencies will require good professional and other support to ensure that their needs are met and so they can be maintained at a quality of life that is deemed appropriate.

It is important to recognise that nursing home residents are among the most powerless, most isolated and most dispossessed in

our society. Many of these people are unable to organise and lobby on their own behalf. Most people in nursing homes will be there because they have chronic multiple diseases resulting in progressive disability and impairment, and these realities must be recognised in policy and planning.

The outcome standards have been set, signifying a move from custodial to holistic care. SAM and CAM have been debated ad nauseum, though many would say that the consultation process has stretched relationships between government and providers a bit thin. The validity of the RCI is being questioned and the standards monitoring teams are on their way. The last three years have been traumatic - traumatic since the benefit freeze was imposed in Victoria and South Australia. That was the attempt to punish those who wanted to have higher standards but not the way the Commonwealth saw it.

Then came the normalisation thrust.

A group of visionaries, with little background in aged care have learnt a few funny words, organised a few intense, but shallow workshops and presto, discovered a new philosophy of aged care.

If we strip away some of the absurd jargon, they are advocating what many of our good professional practitioners have been doing for ages - and doing well. We don't need the rigidity and utter conservatism that has characterised their brand of normalisation.

My Office has had numerous complaints from nursing home residents and their relatives and from staff working in nursing homes which have gone down the normalisation path. What I object to is the imposing on older people without consultation the values of those who have no experience in aged care, and whose perceptions have been developed by attendance at expensive evangelical courses, masquerading as education workshops.

The industry breathed a collective sigh of relief, when on May 3 Mr Staples, the Federal Minister for Aged Care announced that the evangelists in his department would no longer try to dictate their dogma to the industry.

In our residential system we have to have a commitment to excellence. We can't just go for a warehousing philosophy, and work we have done in South Australia has identified the need for a more highly educated, and not a more poorly educated care force in residential care.

The South Australian Ministerial Task Force on Nursing Home Accommodation 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. This program is already underway, developed and aministered by the Nurses Board of S.A. We recommended appropriate training for qualified nurses to equip them better to provide top quality care. This is presently being addressed by the Commonwealth. 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 recommend streamlining of the inspection system, linkages with community care, the establishment of a joint complaints mechanism and significantly, that quality assurance programs be implemented in all nursing homes.

It is poor planning to contemplate that undereducated and poorly skilled people can provide the support required within formal services. Yet all too often we hear from people who do not have an adequate knowledge base that any kindly person can deliver the care required. When we look at our nursing home population which is powerless, dispossessed, and vulnerable, it would be grossly deplorable if they were to receive care largely from unqualified people and hope that an advocacy system would bring into line those who don't deliver very well. Often the reason that care providers do not deliver very well is that they have not been educated to deliver well, and those who plan do not understand the structure of the target group nor how its needs might be met.

The Commonwealth's commitment to better education and training is welcome. It is not just the number of hours that is important, but the quality and skill of the staff delivering those hours. Our dependency profiles are such that aged care requires more than well meaning amateurs. I know I speak for many in saying that in the area of education the Commonwealth has a long way to go. Education is too important to leave to those with only a little learning. Following his April 21

statement of $2.75 million for gerontic education I am looking forward to the Minister's announcement about a new-look education process for aged care.

Many of our planners have an inadequate knowledge base. Many of our managers know a lot about running a facility, about the nitty gritty of funding, of meeting impossible targets and deadlines, of dealing with the complexities of the governmental and communal environment in which aged care operates. Where they're light on, it seems to me is in dealing with their staff and in some cases with their residents.

We have a situation where burnout is an evident characteristic among many care delivery staff, where staff morale is low and communication is all one way. We have stone age views of power and authority where all too often a female care deliverer gets a whack on the head from a male manager wielding a stone axe while espousing jargon that indicates he has left the stone age behind.

In the ageing industry many of the managers are managing multi-million dollar facilities, employing dozens and sometimes hundreds of staff. The managers feel pushed, pressured and pummelled from all sides and all they have to fall back on is goodwill and a strong desire to do the right thing. What they often do not have are the management and personnel handling skills so absolutely necessary. It's all like a rat race. The trouble with the rat race is that even if you win you're still a rat.

Those doing the hands-on work often do not understand the planning process which results in their daily activities. Being

separate from the planning process can contribute to burnout. Burnout involves the loss of concern for the people with whom one is working. In addition to physical exhaustion (and sometimes even illness), burnout is characterised by an emotional exhaustion in which the professional no longer has any positive feelings, sympathy, or respect for clients or patients. The professional who burns out is unable to deal successfully with the overwhelming emotional stresses of the job, and this failure to cope can be manifested in a number of ways, ranging from impaired performance and absenteeism to various types of problems (such as alcohol and drug abuse, marital conflict, and mental illness).

We don't have data on the extent of burnout in aged care in Australia. The literature says it comes from not being able to achieve one's goals. Then tension is always there if the management processes are not adequate, and managers can limit burnout by better participatory goal setting and time management, variety at work, developing special interests and activities, changing or adapting to distressing events etc.

Commonwealth planners concerned with the implementation of outcome standards should pay particular attention to burnout, especially given the strong correlation between unsatisfactory goal achievement and burnout. A very high set of standards and expectations have been set, and without good management and appropriate resource allocation, burnout, and its highly undesirable consequences could well be looming as an ongoing and expanding problem.

One way of pre-empting and limiting burnout is through the development of quality assurance programs. Quality assurance shows people where they are going and whether they're meeting goals. Good quality assurance - a concept and process widely used in all industries shows problem areas and deficits in the system. Quality assurance is a way of ensuring that favourable outcomes are occurring within a facility. Quality assurance simply means that quality, a degree of excellence, is assured, that is, positively declared and guaranteed. It lays a rigorous basis for setting goals and achieving outcomes. Quality assurance is a planned and systematic approach to monitoring the care provided (or service being delivered) that identifies opportunities for improvement and provides a mechanism through which action is taken to make and maintain these improvements. Many improvements can be achieved at little or no cost, but to be worthwhile, resources do have to be available to implement identified improvements.

The Commonwealth has given managers an incredible challenge by saying "we don't want to know about inputs, we just want first class outcomes - go for it." I think this is a little simplistic.

Clearly and unequivocally, quality of care outcomes result from inputs, in particular from structure and process. There is a need for a quality assurance program, of which outcome standards are one aspect.

It is necessary to point out the difficulty in relating the outcomes of care to the process of care. If only the outcomes are measured, without examining the process of care and the structure of the service or organisation, one cannot know what caused the favourable or unfavourable outcomes. Therefore, only an evaluation that encompasses structure, process and outcome has the potential for impact on the quality of care.

It seems to me that the Commonwealth has a problem with this. It has a commitment to only one part of the process, and may be trying to gloss over the rest.

Quality assurance provides a planned and systematic approach to monitoring and evaluating care standards. It is an important professional and management tool, something to significantly assist those of us wishing to provide relevant care in the 1990s.

The ageing industry, one of Australia's largest industries has come a long way in the last decade or two. It has moved very quickly from the stone age to the high tech age, and this has brought a lot of tensions. The squabbles and mistrust, anguish and tensions which have characterised the politics of ageing over the past few years have to stop if we want our outcomes to be effective - older people being needed and fed, as the song says. What I have tried to put forward is a recognition that 64 year olds play a stronger advocacy role, that primary health care has a place, especially in middle age, that home care services focus on accessibility and effectiveness, and that

better education, better staff management and quality assurance will provide better outcomes.

Policy issues in the ageing arena involve structuring an environment which responds effectively, efficiently and compassionately to a demographically changing elderly population. We all have a responsibility, organisationally and collectively to set the structures and processes to achieve excellent outcomes, and thus our deliverers will deliver well and the main beneficiaries will be the target population - elderly people who will feel valued and respected, and in turn our whole society will benefit and be enriched.