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AGEING IN AUSTRALIA : OVERVIEW AND SOCIAL POLICY

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by Adam Graycar

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Between July 1, 1980 and June 30, 1981, 111,220 Australians turned 65 - that is 305 per day. Approximately 73,000 people over 65 died in the same period, that is 200 per day. Thus our "aged" population increased by around 38,000 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.

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).

About 65% of those over 65 are under 75, that is most elderly people 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% of people over 65 are over 75, and thus 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.

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 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 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 1.4 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 $4.5 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 he ceases to perform all those duties, and enjoy all those rights, which were his during mature adulthood, when he 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 between $5.8 billion and $7.3 billion per annum for services for elderly people. This is between 15% and 18% of Commonwealth budget outlays. Now, some critics might argue that elderly people who constitute 9.6% of our population, yet receive 15 - 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.

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 1.4 million people are aged 65 or more - 9.6% of the population. 50 years ago the proportion was 6.5% - in 50 years time it will be around 13.5% - 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 and in our society they are seldom legitimized.

Dependency is not an unambiguous term and means different things to different people - it has a specific meaning in demography - a very different meaning in the bio-medical world and again a different meaning in terms of social constructs. In a social or medical service sense Bruce Ford has defined dependency as "the necessity to seek the assistance of some of the services our society provides". This is a useful, but limited understanding. It takes dependency as a fait accompli and relates to services "after the event" as it were.

A broader understanding comes from a British social scientist, Alan Walker, who in examining the causes of dependency among the elderly identifies four types of dependency.

First there is life-cycle dependency which relates to the exclusion from

productive and paid work. This could be examined in terms of retirement policies and demographics.

Second there is physical and mental dependency which relates to physical, social and psychological incapacity. There are arguments about the extent to which an impairment or disability may be a handicap but overall, dependency is a social relationship, the exact form and degree of which rests on interaction with at least one other person, but sometimes also with physical objects.

Third there is political dependency which is a curtailment or restriction of freedom on the part of the individual to determine his or her own course of action. This is based on unequal power relations between one person and another.

Fourth there is financial and economic dependency, which involves reliance wholly or partly on the state for financial support (over 80% of the aged in Australia list social security benefits as their main source of income).

Dependency is not a new phenomenon, but is highlighted because in the past many people did not live long enough to be dependent, but dependency has now been imposed, encouraged and sustained by social relations and social developments. Restriction of access to a wide range of social resources, including income, status and power, not to mention physical well being, imposes a reduced social status on elderly people. The categories of dependency distinguished here are structural rather than personal or psychological. The equation of dependency with natural stages of the life cycle legitimates the social construction of dependent status among elderly people.

It is important for us to try to understand whether these types of dependencies can be addressed by the four main care systems - the commercial, the statutory, the voluntary and the informal. Once we can understand these and relate them to a value position which recognizes need for inclusion - especially in terms of cash, services and power for elderly people, then we are on the way to developing humane and workable social policy.