AGEING AND FAMILY DEPENDENCY

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INTRODUCTION

Ageing is having a pronounced effect on elderly persons who find themselves estranged from the labour force and consequently more dependent on income and social service transfers; on relatives who find themselves bound up in caring arrangements; and the policy makers that apportion the resources towards the elderly population. This paper reports on a study of the effect of ageing on relatives who provide care for dependent elderly relatives.

Older age does not seem to present any insurmountable difficulties for elderly people who are employed as they have some means of claiming a modest share of society's gains. Once retired their access to resources diminishes because they are sidelined from the mainstream of social activity. Even more so, retirement becomes a batter for resources and in the process of the allocation of resources the elderly are extremely limited in their bargaining position (Fanshel, 1981). This is apparent in areas of both income support and service support. A rapid growth in institutional investment and concommitant escalations in cost ultimately has led to the questioning of the appropriateness of institutional care on both economic and humanitarian grounds. Relatively powerless to influence events, elderly people are therefore likely to suffer in comparison to other groups when resources are allocated and reduced economic growth and scarcity of resources has intensified the battle they face in attempting to secure more equitable allocations of resources.

Increased competition, says Hudson (1978, p.43) has arisen because of the 'growing absolute and relative cost burdens for meeting the needs of the older population, because of increasing debate over the actual distribution and intensity of older persons' needs, and because of sharpening competition for limited discretionary social-welfare dollars ... (all of which are) ... likely to erode traditional sources of support for the ageing while yielding new competitive and cost-based pressures'.

Thus much of the concern about the problem of ageing emanates from a seemingly rapid growth in the proportion of the aged and associated costs of care at a time of contraction and downturn in economic growth.
The 'graying' of Australia's population has been a regular topic of discussion in government, demographic, health, and social service circles in recent years. It has been noted carefully because shifts in population structure, particularly increases in the so-called 'dependent' populations have serious implications for resource allocation in areas of income support and service provision. Australia's current elderly population (those aged 65 and over) which at present comprises 9.6 per cent of the total population is projected to rise to between 13 and 14 per cent of the population in fifty years time. This proportion prevails in at least a dozen European countries today and thus it is not appropriate to say it is necessarily calamitous for Australia to head towards these proportions. Furthermore, the progression to these proportions will be fairly steady over the next 50 years, which provides an opportunity for sensitive planning.

While the projected overall proportion of elderly is not as great a concern in regard to resource allocation as many currently suggest, there is another changing demographic characteristic that rightly has a basis for concern. This is related to the change in the age distribution within the population aged 65 and more. In 1901, for those aged 65 and over the ratio of those aged 65-74 to those aged 75 and over was 75 : 25; by 1976 it had changed to 64 : 36. It has been projected that the over 75 population will increase rapidly from 36 per cent of those 65 plus in 1981 to about 47 per cent in 2001 or to a ratio of 53 : 47 (Borrie, 1981). This rise has and will continue to affect Australian dependency ratios. In 1901, for every 100 people aged 15-64 (labour force age) there were 64.5 either under 15 or over 65. By 2001 it is projected that this number will fall to 50.7 (see Graycar and Kinnear, 1981, p.96). While on the surface this does not indicate a serious situation, further analysis develops a different picture. In 1901 those 64.5 people comprised 57.9 under 15 and 6.6 over 65; that is 8.7 children for every elderly person. By 2001 the 50.7 will comprise 35 under 15 and 15.7 over 65, that is 2.2 children for each elderly person. With the ratio of those over 75 to those 65-74 increasing, much greater concern has been generated because recent estimates claim that public income and service support costs were approximately
three to four times as high for elderly persons as they were for children (Sax and Staines, 1981, p.6).

Elderly people suffer considerably higher rates of chronic illness than do other population groups as a national official survey showed. This survey confirmed a widely held belief that chronic conditions increase in incidence with age (Table 1.1).

### TABLE 1.1: Chronic Conditions per 1,000 Population

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of People Experiencing Chronic Conditions per 1,000 Population</th>
<th>Number of Chronic Conditions Experienced per 1,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 15</td>
<td>239.2</td>
<td>318.8</td>
</tr>
<tr>
<td>15 - 44</td>
<td>416.3</td>
<td>657.0</td>
</tr>
<tr>
<td>45 - 64</td>
<td>659.4</td>
<td>1,347.7</td>
</tr>
<tr>
<td>65 +</td>
<td>776.3</td>
<td>1,791.3</td>
</tr>
</tbody>
</table>

*Source: ABS Australian Health Survey 1977-78 Chronic Conditions, Cat.No. 4314.0.*

When activity limitations combine with chronic conditions people in this position require some form of social and medical support. The dependencies of ageing, which are chronic and cumulative rather than transitional, build up and have the greatest impact as disability combines with age. As people get older living arrangements often become more precarious and this has implications for the elderly people themselves, for the formal service provision system, and for the families of the elderly people.

In 1979 approximately one half of those aged 65 and more lived with their spouse, approximately one quarter lived alone, 16 per cent lived with other family members or other persons, and 7.6 per cent lived in an institution (Rowland, 1980, p.8). The uppermost consideration that policy makers face is what network of services can be developed that best meets the needs of elderly people. Increasingly importance is being placed on generating a network of
services, statutory and non-statutory, formal and informal that, when blended together, improve the quality of life of the elderly person, whether suffering from a chronic illness or not, whether living alone, with spouse, with other family, or in institutional settings. The important implication to recognise from the data on the demographic transitions stated earlier is the growth in the rise of dependent populations.

DEPENDENCY, STATE AND FAMILY CARE

Dependency has most often been defined in psychological terms, concerning fluctuations between the extremes of dependency and independence. Most writings have exemplified the biophychological aspects of dependency and, until recently, little attention has been given to evidence that suggests a social construction of dependency.

Recent theorising has widened the meaning of dependency to include exclusion from economically productive endeavours in complex industrial society. The influential theoretician, Richard Titmuss, outlined two types of dependency, the first being what he called the natural dependencies of childhood, child bearing periods, and extreme old age. Full dependencies are usually caused by physical and psychological ill-health or incapacity. The second type of dependency was that which he considered arose from culturally or socially determined forces, namely man-made dependencies (Titmuss, 1963:42). More recently others have termed it the social structuring of dependency (Townsend, 1981; Cass, 1982; Walker, 1980) and include unemployment, education, compulsory retirement, occupational injury, and unpaid work.

Analyses of the way in which social policies create and foster dependency can be applied to the position of elderly people. Walker contends that the work of the elderly is systematically devalued by bureaucratic structures which use such terms as 'efficiency' and 'productivity' to confirm that the elderly are no longer able to contribute effectively to capitalist modes of production (Walker, 1980:72). Thus dependency can be said to be socially constructed in that the predominant form is economic rather than physical.
By the social construction of dependency we mean that the political, financial, and to a great extent, physical dependency ensue from the social organisation and distribution of resources, status and power.

The socially structured life-cycle dependency of elderly people has been supported by the provision of a state income transfer and by the expectation that the family would meet its familial obligations and provide care and support. On the one hand government sought through the Welfare State to supplement the family in providing care and supporting the elderly, and on the other it totally replaced the family where this form of support did not exist or where the capacity of care had been exhausted. As Cass states, encouragement of family care was a major thrust of the expansionist economic policies of the post-war construction state. During this period '... the family was constituted as the recipient of a range of collective provision ... it was considered legitimate that public expenditure be directed towards the subsidisation of the market wage so that families could carry out their responsibilities of procreation and child care' (Cass, 1982:15). In effect, the family was legitimated as the basic institution for the social organisation of care and its responsibilities were extended beyond that of child care to embrace the notion of support for all stages of life-cycle dependency, including the elderly.

Conflict arises between the state and the family over who has responsibility for care. The 'problem' of ageing is individualised and the response to that is to see that the family should provide care for essentially what is a 'problem' for an individual. Welfare state policies as a response to this situation are based on a willingness of the family to care for those in social dependency. But our analysis should not end in such a partial state. We must penetrate beyond looking at family care to look at how family care is based on certain assumptions regarding family role and gender relations. State social policies according to Walker (1981, p.546), fail '... to recognize social inequalities in caring roles within the family ... (and) ... tended to support the unequal sexual division of labour in caring for the elderly. His analysis, however, does not go to its logical conclusion. He fails to
recognise that social policies not only reinforce gender divisions but in actuality are premised on those divisions. The welfare state is designed to complement and enhance a particular form of the family household which provides care and domestic services (C.S.E. 1982). Current rhetoric and political manouvres render ideological support to this particular family.

Increasingly there is appearing a link between family policies and a certain family form. We now hear advocated the idea of family policies which are an attempt to bolster the ideology of the family as the most appropriate caring unit. It is an attempt to idealise the notion of family care which with careful consideration, argues Finch and Groves (1980) is actually care by women. Gender divisions in society have generally established a cleavage between paid and unpaid work, whereby men are predominantly engaged in paid work and women predominantly in unpaid work. As Townsend says, capital and state separately or in combination have seized upon gender divisions and fostered dependency of women within the family (Townsend, 1981). But there has been a furtherance of dependency to include other family members as dependents upon the male breadwinner (Holden, 1980). Within the family, the function of women has been to secure the welfare of the various family dependents (e.g. children, aged) ...; those whose needs can only be met through others caring. As Cass and Edwards have pointed out, these various states of dependency have been legitimated by welfare state policies in the arena of the tax and social security systems. Emphasis on the spouse rebate, in the tax/transfer system served to focus attention on the proper role of families to care for their disadvantaged and disabled members.

There is now mounting evidence to suggest that the ideology of care is now 'care by the community' which does not necessarily mean provision of care by various statutory organisations, but rather greater reliance upon the informal and voluntary sectors of care, especially the family and self-help groups.
COMMUNITY CARE AND THE FAMILY

This emergent form of community care comes during a period of economic downturn and an ensuing commitment by conservative governments in western nations to curtail public expenditures, especially social expenditures. The prevailing ideology of welfare now is one of more responsibility for support to be assumed by the informal and voluntary sectors of care. Reminders through media comments and reports about the lack of responsibility on the part of families to care for their elderly relatives frequently conclude with statements concerning the need for society to return to an era when families recognised and assumed this responsibility, an ideology that Cass labels an attempt to invoke the traditional dependencies of the family (Cass, 1981a). While there appears to be state recourse to this action, there is much evidence which suggests that social supports and supplements to community care networks are being eroded. In Australia, it appears that the pressures being sustained by local service organisations impel them in relation to the elderly to restrict coverage of their services to those elderly who have no familial or social support networks (NCOSS, 1981).

There appears to be a lack of commitment to fostering the growth of community care. Rather, the new approach seeks to thrust greater responsibility of care upon informal care systems and emphasise service support to the 'truly' needy; these being the elderly without social supports.

The concern of the state has been to support and supplement, albeit in a meagre fashion, the informal sectors of care. It has not, contrary to popular belief, sought to replace informal organisations providing care with statutory organisation. The responsibility undertaken to encourage and enhance care by the community is embraced in an ideology that views community care as a less costly and more humane way of caring for dependent populations. Through enactment of legislation governing financial assistance to home support services Australia has witnessed more of a commitment to care by the community and less of a commitment to care in the community. This is highlighted by the crisis that has overtaken
these community-based organisations in the last five years. Increasingly, the growing demand for such services has pushed beyond the limit the ability of organisations to satisfy that demand. Shortages of resources have led to a rationalisation of services and reduced their coverage to those groups without adequate social and familial supports.

This brings us to the crux of the care issue, and that involves the relationship between statutory, voluntary sector, and family patterns of care. Obviously there is no single answer as to which is 'best'. Present policy interventions may result in the extension or diminution of much needed support and these interventions often work from assumptions about the relationship between family members and their dependent relatives, and assumptions about care patterns. It is instructive then to examine some data on the question of family care and its effects from a concern of its appropriateness as an autonomous caring system.

THE STUDY

A recent study of these issues was conducted by the authors to determine the (non-monetary) costs — physical, social, and economic, to the family and the state, of family care of dependent elderly relatives and to examine the needs of the caring family in relation to the provision of formal services. This paper will only focus on the physical and emotional costs to the family and the extent and type of support services required to lessen these costs. All of the issues are dealt with in greater depth in the major report of the study.

Data were gathered on the reasons leading to the decision to care, how that decision affected other family members, who was involved in caring in the home, the suitability of housing arrangements, the need for special adjustment or equipment within the home, the financial situation of the family, the day-to-day stress of caring, the availability and effectiveness of services in the area and the private costs of caring (social and psychological).
A sample of 75 carers were interviewed which was obtained from local home nursing organisations. This method had the effect of biasing the sample in two ways. First it is probable that the nurses may have selected out those families whom they felt would have the time and inclination to be interviewed despite instructions that all families should be canvassed in regard to the survey. Secondly, the population sampled was one already receiving one specific type of service - home nursing. While this approach ensured that there was a person being cared for who had an activity limitation it excluded families which were not fortunate enough either by virtue of physical isolation or other reasons to receive the nursing service. By interviewing in situations in which the service was being received there was a tendency for the sample to comprise of the 'lucky ones' thereby excluding families who arguably could be in greater need. If this was so, the situation for these families, according to the results, could well be much worse.

In accord with other studies, 99 per cent of the carers were women. The role of nurturant and domestic labourer ascribed to women within the family ensures that, in addition to those tasks that are solely their domain, they also become the principal carer of dependent elderly relatives.

What emerged is a picture of family care being a situation that entails considerable financial, social and emotional costs to both the family and to the principal carer.

In addition, families also experience tremendous emotional burdens. Considerable tension and conflict is generated within the nuclear family unit and between members of the extended family. Overall, the results showed the extreme difficulty under which most carers operate, and their extreme reluctance to consider other forms of care.

Alvin Schorr argues that much of the sociological literature which characterises living together as destructive of family life is off target. Citing American studies, he suggests that the emphasis on the nuclear family as the norm, as the basic economic and
emotional unit, means that living together is a recognition of failure, and ipso facto an imposition. He regards this argument as ideological, for independent living is an article of the American creed while living together is a 'lifeboat response' by family members when need is desperate and they cannot help in any other way (Schorr 1980, p.2). He suggests that evidence of severe family tensions and painful conflicts is often anecdotal, yet concedes that such arrangements 'may cause problems', but that the studies 'do not establish that it necessarily causes problems' (p.17). Our study was not one of cause and effect, but it did identify a greater degree of disharmony than Schorr suggests exists in the U.S.A. and it identified deteriorations in lifestyle. For example, carers:

- had less time for recreation and leisure activities (79 per cent);
- (in paid employment) suffered a deterioration in work performance (84 per cent);
- suffered from a deterioration in the relationship with their spouse (56 per cent);
- were less able to relax and sleep at night (60 per cent);
- were apprehensive about their growing older (51 per cent);
- relationships with brothers and sisters deteriorated rapidly (90 per cent);

In short, the pattern that emerged was a marked deterioration in many important areas of the carers' lifestyle.

The data demonstrated that the desire of families to provide care is extremely strong. Far from being isolated from the living circumstances of the elderly, the families appear to be the first initial place of care for dependent elderly relatives. Yet this strong desire to care when translated into action causes many costs and difficulties for families in the areas of housing space, reduced employment opportunities for women as carers and thus more economic and emotional dependence.

In regard to housing, it did not seem that there were any great difficulties for many families, yet 35 per cent of families
experienced extra financial costs through the addition of bath and
toilet rails, wheelchair ramps, raised toilet seats and non-slip
bath mats. Some 6 per cent of families had added, at great cost, an
additional room for their relative, while 7 per cent had purchased
relatively expensive communication systems for use in night
emergencies. One change that 5 per cent of families suggested might
be helpful was access to cheap means of adding an extra room for the
elderly person. Separate living space would guarantee some degree of
independence to both the aged person and the caring family. Those
carers who already had this arrangement unanimously felt that it
eased the 'burden' of care for them and, by creating more time for
family interaction, less conflict for the family. From this data,
it seems that another means of assisting families caring may be to
grant automatic access to services that would modify the family home
to make caring easier at no or nominal cost.

Since women are generally the people who provide the direct
care, the indirect financial costs associated with caring caused
through involuntary withdrawal from paid work fall mostly in the
first instance on the through foregone income, and then on the family
by reducing its disposable income. Over 50 per cent of those caring
had stopped working in order to care. In addition families also
experience tremendous emotional burdens brought about by the tension
and conflict generated both within the nuclear family unit and
between members of the extended family. The outcome of the tension
generated is unequally distributed within the family and usually
falls heaviest on women, being the principal carers. Apart from the
loss of independence, a changed life style for the worse and a
resumption in many instances of economic dependence upon a spouse,
or the state, there emerges a conflict of roles whereby the woman is
faced by competing demands for her love and affection, a position
that Brody (1981) has described as 'being in the middle', of roles
as mother, carer, worker, wife. Coupled with decreasing health
status associated with ageing by the carers, it places women in an
invidious position in that their social reality becomes constrained
within the parameters set by the experience and necessity of caring
and from which there appears no escape. Loss of employment
usually means their status is devalued and because caring has no social
status, they gain little positive reinforcement of and understanding about their new role.

Exceptions to this appear to be those carers from families of higher socio-economic positions. Although only 4 per cent of our sample fell into this category, their responses indicate that larger family resources permit the luxury of purchasing market services for extended periods. Families with considerably less resources simply could not afford to persist with using market services because, families attested, they proved too costly. Other research provides similar conclusions. Purchase of market services greatly increases the freedom and choice about social activities for carers within higher socio-economic families, and consequently there is not the same narrowing of social environment for them because of greater market power and capacity.

Family care is often equated with care shared by members of the immediate family and also with members of the extended family, but this rarely is the case. As other research indicates family care usually means care by one particular female member (Nissel and Bonerjea, 1982; Finch and Groves, 1980) with minimal support coming from spouses and children and the extended family. In our study, other family members (children/husband) seldom contributed significantly to the care of the elderly person. While 29 per cent of spouses and 75 per cent of children were supportive of the care given, neither group actually provided care of any significance. While the carers interviewed stated overwhelmingly that both spouses and children provided some assistance (76 per cent and 70 per cent respectively), when they were asked to elaborate on the assistance given, it turned out that both groups did little more than occasional bursts of night care and housecleaning.

The orientation of children (of the carer, i.e. grandchildren of the dependent person) to the elderly person was mostly one of tolerance and acceptance, and hardly ever one where they actively participated in providing care. With regard to husbands (of carers) they were positive in accepting that the family should care, except their definition of 'family care' was one which envisaged this being
an extension of their wife's role already within the family structure. Several reasons account for this. In some instances care by males was prevented because the elderly person was female and any attempt to bathe or dress the aged person was regarded as an impropriety; in other cases because the males were working; while others did not perceive care to be one of their tasks as reflected by one comment that 'you can't ask a bloke to chuck in his job'. Many carers' comments when speaking of their husbands' assistance, are epitomised by the following '... husband raises no objections, is very supportive and extremely helpful' and while each carer tended to state that the male did offer support and showed concern, the impression the interviewer was often left with after the carer had described her tasks and daily routine, is that it is almost a perfunctory gesture of concern on the part of the husband. It must be stated that there were a very small number of husbands who appeared to be providing an equal share of the care, a situation made easier in some cases, because they were retired.

It is often assumed that assistance and support will be forthcoming from other relatives. Although over half of the carers in our study had other relatives (sister/brother or both) not all relatives were supportive, and those giving assistance gave minimal support. Only 48 per cent of relatives gave support and of those almost 59 per cent were sisters of carers. The traditional caregiving role of women extends mostly to other women not directly involved in providing care. The care provided by relatives was predominantly that of occasional visiting to see the elderly person or to take them on a short holiday.

The lack of tangible support from relatives is not only attributable to their living elsewhere (in some cases in a rural area or interstate), but also figuring prominently is a simple preference to leave the routine of caring to the one person, a position of isolation that is reflected by a comment from a number of carers that 'if it was left up to others in my family, mum would be put in a nursing home'. A sentiment expressed by 86 per cent of carers in the sample.
Our data although from a small sample and thus not generalisable, does accord with British and American evidence that predominantly a 'selection' process occurs whereby one child is designated as carer with most other siblings giving token support such as visitations and infrequent day outings (Nissel and Bonnerjeea, 1982; Cantor, 1981). Thus family care contrary to opinion that it is harmonious tends rather to create rifts and divisions between relatives that ultimately lead to unequal distribution of care.

As well, evidence from our study and the others cited, shows that instead of welding a nuclear family together, a caring situation often creates unease between family members and this, in turn, makes the burden of care more onerous. Carers' children may feel uneasy about the presence of dependent grandparents and in some cases this manifests itself in disrespect and resentment. Through the changes that have overtaken the households husbands (of carers) sometimes feel angry towards the elderly person. The carer/mother/wife, trying to fulfil a number of competing roles is often caught in the middle, both as a super worker and family mediator, e.g.

'... the kids get resentful and I'm the one in the middle, I try to divide my time up between everyone.' another said:

'Time is not your own, rushing from children to father - continual demands the whole time - and trying to keep the children out of the way of their grandfather.'

Besides the minimal support offered by relatives, respondents often had little support to call upon from neighbours and friends. Almost three quarters of the carers did not receive any help from people outside the family. The remainder received help in the form of neighbourly visits and infrequent inquiries of concern about the present state of care. The reasons for this are many and varied. Many carers were reluctant to seek outside help for fear that it reflected some inability on their part to care. Others were unsure of who to ask since they felt that friends and neighbours should not be burdened unnecessarily with their problems. Almost one third said they found it difficult to ask for help, 17 per cent did not know who
to ask while a very small number (8 per cent) asked for help but were refused. Almost half felt they could manage it in their own way and did not want any help. Their attitude to outside help depended partly on the carers' reluctance to intrude upon neighbours not really seeing a role for themselves, and partly because carers felt guilty about asking others for help when they were actually responsible for care. Other studies (Equal Opportunities Commission, 1982; Bayley, 1973) obtained similar findings, suggesting that the belief towards a well-functioning informal sector of care is misplaced. It may well be that many families who provide similar care are equally disinclined to seek support and assistance from outside sources. Thus, it may be unwise if it is the intention of the state to predicate community/family care on the basis of less state support and more informal/voluntary support because a situation may evolve where the burden is wholly located within the family unit due to reluctance of families to ask for help or an unwillingness by outsiders to provide assistance. Ultimately it may be fallacious to conceive the family as the hub of a wider network of care. Acknowledging the limitations of our sample because of size and non-randomness, it is impossible to state emphatically that the informal economy will not replace the state but from our study, there is some suggestion that this may not happen. Other more detailed research currently being undertaken on the informal sector may provide the basis for a more rigorous analysis of this sector.

The reluctance of carers to seek outside help also permeated their attitudes to the use of social services. While almost 50 per cent of carers had some knowledge of various services (e.g. day care, meals-on-wheels, home care, home visiting service) there were only small percentages of take-up rates. For example, only 16 per cent of carers used day care services while 13 per cent used respite beds on some occasions to provide breaks in care. In the majority of instances over 50 per cent of carers did not know any services existed. Many of the carers who used services, while acknowledging that they were very helpful, were beset by feelings of guilt, first at wanting a break and second at placing their elderly relatives in the care of others.
CONCLUSIONS AND IMPLICATIONS FOR SOCIAL POLICY

The responsibility of children to care for their aged parents, as a precursor or alternative to care by government or charitable institutions, is a relatively modern idea that came into prominence only as economic changes loosened the grip of aged parents on property and income. For the bulk of the elderly, there was no golden age hundreds of years ago, where family care was more forthcoming than it is today. In the period, however, from the advent of the industrial wage system to the firm establishment of the Welfare State, dependent and poor elderly relatives usually had no place to go other than to their children. However, in this period lifespan was shorter than it is today and proportions of elderly people in the population were much lower. While there was no 'golden age' there certainly were, earlier this century, expectations of care. While in the United States during the quarter century from 1952 to 1976, the proportion of elderly people living with adult children halved, dropping from one third to one sixth (Schorr, 1980, p.13) there is no comparable data to suggest that there has been a similar drop in Australia over the same period. However, there is data available that shows there has been a slight increase in co-habitation between 1972-1982, something in the order of 2 per cent (ABS,

In all western nations provision for old age was regarded, until earlier this century, as a matter for the individual and his/her relatives. However, in the United Kingdom in 1954 there came a change with the Phillips Committee (Report of the Committee on the Economics and Financial Problems of the Provision for Old Age, Cmd 9333, HMSO - cited in Carter 1981, p.223) which endorsed the notion that community services should help old people stay in their own homes and argued that children should not sacrifice themselves to care for ageing relatives. As Carter (1981, p.233) points out, a considerable social and attitudinal change came with the Phillips Committee's public endorsement of the 'right' of adult children to lead a social and economic life separate from that of their ageing parents.

This 'public endorsement' of household separation has in part formed the basis for the belief that families were no longer
concerned to care for their elderly relatives. There was infused into social thinking a pervasive ideological myth that increased state provision in the form of social services and institutional care had eroded the basis of family care.

However our study showed that those families interviewed were very much at the forefront of the provision of social care to their dependent elderly relatives. What emerged was not neglect by families but a picture of a caring situation that involves disruption and adjustment after resulting in the isolation of the caring family from almost all informal and formal networks. In turn, this isolation increased the pressures experienced by the families providing care; pressures that resulted in cumulative social, emotional and financial costs. Our results when compared with those from other studies are suggestive that family care may be equally burdensome for a great number of families in this situation. It is instructive to understand that family care entails heavy costs because embodied in the current rhetoric is the belief that community care is a less costly form of care. The important fact is that it is less costly precisely because community and family care are virtually inseparable.

Our study sought to provide some reflections on and explanations of the process of family care. In doing so, it attempted to gather data that would go some way to answering the perplexing question of the role that the natural community supports (family, neighbourhoods) had in assisting in the care of the elderly and their interface with the state sector of care. Criticism has often been levelled at the state that it abrogates its responsibilities of care in favour of increased responsibility by the family/voluntary support system.

Any prescription proposed, however, must start from an ideological base and commensurate views about intervention into what might be regarded as personal, private family matters. Obviously different families will cope differently, but it would be erroneous to assume that solutions lie in the domain of better personal relations.
Increasingly policy prescriptions seem to be assuming the form of a family policy. It is because of this that it becomes important to note that family policy usually takes a dual thrust. On the one hand there are policies designed to affect families - to strengthen, enlarge or limit families. On the other there are policies designed to use, exploit or rely on families in carrying out social welfare functions (Macarov, 1978, pp.47-59). The dual aspects of family policy have already been placed on the political agenda in Australia and debated at length in the literature. Bettina Cass (1981, 1982) has traced how family policy has come onto the political agenda in Australia and argued that this has coincided with the period of 'restructuring' of the welfare state in a time of decline in the rate of economic growth and high rate of inflation and unemployment. After an extensive review of the evidence, Head (1980, p.50) concludes that there seem to be no persuasive grounds for believing that governments in the advanced capitalist societies are likely to bring about major increases in the welfare of the poorer half of the people in the next decade or two. However, the highly dependent situations which arise and the deeply troubled aspects of caring will need, for their alleviation, an increase in public expenditure. Indeed, it is difficult to pose options which do not involve expenditure increases. Equally, it would be dangerous to be lulled into the belief that expenditure cutbacks will be made good by informal care - care coming from family members and unpaid volunteers.

While families are not likely to be able to extend caring functions policies must be developed that enhance the natural system of family care, rather than cause its disintegration and destruction.

From this study we have identified difficulties and problems that suggest that, in the wider context of family care, families providing care require two levels of supportive services. At one level services are needed to provide support to the family unit and at the other level, services ought to be provided which are directly aimed at aiding the principal carer, in an attempt to allow her to co-ordinate and fulfil her continuing role as worker, mother, wife and carer. The key issue is that the impact of longer life in our society means a greater incidence of chronic illness among the
elderly which implies that greater resources will be expended on providing long-term care for the elderly whose condition requires such care. It follows that such care if provided by families must take on a different dimension to that which formerly existed. The care task is becoming longer and harder yet there is little questioning of the rhetoric which idealises and suggests strongly that family care is the most appropriate response to the emergent social policy dilemma. Largely unquestioned is the fact that present (and future) 'dependent' people who are cared for will increasingly be cared for by family members who themselves will be locked into states of dependency.

It has been established that family care is central to the welfare of the elderly. The requirement now is a range of services to service the family in its role. Social policy should aim at establishing a fully integrative social system incorporating a floor of formal services to complement and supplement the existing range of community care services.

Repeated statements are made concerning 'back to the family' ideals, based on notions of families 'spontaneously caring for aged relatives'. There remains neglected however the choices of the elderly regarding their living arrangements. As Soldo points out in the United States, co-residence often results more from lack of choice than from positive appeal. Certainly a number of elderly in our study were reluctant to relinquish their independence because of advancing frailty. There is at present a surgency of ideological nostalgia abased on happy, caring families. This is disturbing because there is a growing awareness of the problem of family abuse towards the elderly in situations of co-habitation.

Elderly abuse is slowly being seen not as an intermittent happening but a sustained activity largely caused by either psychopathological or environmental (i.e. social structural) factors or a combination of both (Rathbone-McCuan, 1980). In effect caring responsibilities impose heavy burdens and the consequent strain may be too much for families to cope with the dependency of caring.
This evidence does seem to suggest that family care ought not to be regarded as the ideal solution especially since many of the caring situations in our study began through functional dependence of the elderly relative.

Lately there has emerged the myth that there has been a marked decline in caring by the family. Research shows that families have not abrogated their responsibility for care of the elderly and do not seek to displace their elderly to situations of institutional care. Rather, what was revealed is that care tended to be concentrated within the family by women with minimal support from spouses, children, and extended family (Kinnear and Graycar, 1982). Overseas studies have reported similar findings (Shanas et al 1968; Bayley 1973; Parker 1981).

It must be realised that the family is currently acting as a hidden welfare service and is facing increasing pressure to enlarge its caring functions as the supportive functions of the state are withdrawn. In fact the family is now, along with other voluntary caring systems, substituting for the state in caring for elderly people. However, there is mounting evidence that the family cannot provide care without encountering many social, emotional and economic costs (Nissel and Bonnerjea, 1982; Kinnear and Graycar, 1982), and what social policy should be addressing is the issue of how to enhance the family as a functionary of care and consequently lessen the caring burden.

However, social welfare policy needs to be extended beyond merely looking at supporting the family to the provision of other options for the elderly in our society. While current opinion is tending to ignore the social, economic and emotional costs and state that the family (i.e. women) should retain the primary responsibility for care and receive supportive services (Moroney 1978) there is a tendency to look towards family support services as the means of redress. Families are at the forefront of care and desperately need supportive and supplementive social services but there is an urgency to extend the analysis towards alternative forms of care, making the family one of a range of options.
Otherwise what surely must result from blind adherence to family/female care is family situations entailing great tension and conflict, a breakdown of extended family relationships and, most importantly, the reinforcement of unequal gender relations whereby gender roles deem it acceptable that a woman (but hardly ever a man) give up paid work to provide care, and in doing so becomes herself dependent either on a man, or on the social security system (or rarely on the person being cared for). The end result is that without supports, dependent people will increasingly be cared for by women who themselves will be locked into states of dependency.


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