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AGED CARE - CURRENT CHALLENGES

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100 years ago life expectancy at birth was 47 years for males and 51 years for females. Today it is around 70 for males and 77 for females. At age 60 it is 18 years for men and 23 for women. In some circles this increase in life expectancy is seen as a calamity for society - but I think it would be more reasonable to regard it as a major achievement. There is, however, a price to be paid for the privilege of living longer and that price is paid in the terms of an increase in the nature of degenerative diseases. The rates of chronic illness in all industrial societies are very high and Australia is no exception. What becomes important is trying to understand the network of the services - statutory and non-statutory - formal and informal - what can be blended together to improve the quality of life of the person suffering from chronic illness, and to ensure that those who care for these people have their needs met as well.

The diversity of the elderly population is enormous. About two thirds 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.

For them, income maintenance and preventive health services are of great importance. About one third 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.

Over the next 25 years South Australia's population will increase by 20.8 per cent; the population aged 65 and over by 48.3 per cent; the population aged 75 and over by 118 per cent and the over 85s by 147.5 per cent. Changing demography, changing chronic illness patterns including the prevalence of dementia at higher ages signals that we are on the verge of an explosion of care.

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 them?

It seems crass perhaps to ask who's going to pay. It is an important question. Australia's $2\frac{1}{2}$ million people aged 60 and over, including the million people over 70 and the 300,000 over 80, are part of our largest industry. More Commonweatlh Goverment dollars go into age and veterans pensions than into anything else. Our pension bill, at 9 billion dollars is $1\frac{1}{2}$

billion dollars greater than our whole defence budget. The amount we put into nursing homes and hostels exceeds our whole Foreign Affairs and Overseas Aid budgets.

Closer to home, South Australia has a higher proportion than every other State of people in their 60s, 70s, 80s and over. In December 1985 there were, in South Australia 135,078 people in their fifties, 120,115 in their sixties, 74,777 in their seventies and 28,486 aged eighty or over. Altogether more than one in four South Australians is aged 50 or over. Conventionally we have thought of people aged 65 or over as comprising our elderly population, and this benchmark is a carry over from earlier times when life expectancy was lower and retirement more predictable. Even using 65 as a benchmark, there were in December 1985 in South Australia 155,732 people aged 65 or over, 11.4 per cent of the population. If we look in five year groupings, in every age group South Australia has a higher proportion of older people than the national proportion, and as we look to the future the rate of growth of the older population will be greater than the population as a whole.

There are 7600 nursing home beds in S.A. and the great majority, (86%) are occupied by people aged 75 and over. Just half of all nursing home beds in S.A. are occupied by people aged 85 or over. Planning our nursing home futures is a difficult task. The planning context involves the Commonwealth and State governments, professionals and entrepreneurs, unions and churches, and anyone else who might care to make a difficult planning task virtually impossible.

Without boring you with statistics however, the overwhelming majority of elderly people live in private households. In its Handicapped Persons Survey, the Australian Bureau of Statistics identified 31 per cent of people over the age 65 as having handicaps, and of these 82 per cent lived in private households and 18 per cent in institutions. Again age was significant. Of those aged 65-74, 92 per cent of those with handicaps lived in private dwellings while for those aged 75 and over, 72 per cent of those with handicaps lived in private dwellings and 27 per cent in insitutions. 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.

This highlights that the development and maintenance of high quality professional home care services is a matter that must be placed high on our policy agenda, and currently is being addressed by the Home and Community Care program.

Our older population is very much differentiated by age, by sex, by class, by ethnicity, by spatial location, and by health status. It is important to remember 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 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.

As a person involved in problem seeking as much as problem solving, as somebody involved in policy I can reel off a string of problems facing policy makers in ageing.

We have problems working out equitably and efficiently how to convert 40 years of earnings into over 70 years of life. We have problems with concepts like "double dipping", "tax treatments", "income and assets", "taxpayers' capacity", and so on.

We have problems restructuring a nursing home system which seems to have lost its way as rising expectations of nursing home care have created a larger than warranted population anticipating ultimate nursing home admission. This is a billion dollar Government financed industry which strains basic concepts of equity, and leaves many people grossly unsatisfied.

We have problems with our transport systems which cannot cope with elderly people both with and without mobility limitations and thus confine too many people to home, magnifying their exclusion from fruitful community integration.

We have problems expecting families to play roles that are considerably in excess of their capacity to support older people, particularly those who are severely physically disabled or the burgeoning number suffering from some form of dementia.

We have problems with a health care system which has been in the political spotlight for most of the last 15 years and which is not sure how to handle the balooning costs, the changing technologies nor how to treat with appropriate respect, not only the clientele, but the many professionals who have always taken a back seat to and been patronised by doctors.

We have problems devising a set of home care services that are efficient, flexible, accountable, acceptable, comprehensive, accessible, co-ordinated and equitably allocated.

We have problems ensuring that those who choose to enter resident funded retirement villages have the appropriate legal protections and that those retirement villages meet suitable standards of design and accessibility.

We have problems providing suitable accommodation for the most severely disadvantaged - those 50,000 elderly people, three quarters of whom are women, who rent in the private market.

The policy spectrum before us is complex and convoluted. So as we move into greater dependence on formal care we are all faced with challenges in planning, structuring and delivering services which will have to be relevant, effective and compassionate, and these challenges are spectacular, formidable and unprecedented.

In a nutshell, in giving people more time to live, science and medicine have also given them more time to die. We have all seen technical changes of astounding, stunning and overwhelming consequence. We can find technical solutions to many of our problems. We can think the unthinkable and do the undoable - yet are we a lot better off? We can do magic on our computers, land a person on the moon, analyse the gases surrounding Jupiter, fire a probe into the nucleus of Halley's Comet. We have learned brilliantly the means of accomplishing scientific and technical advance. 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're skilled in coping with problems with no human ingredient at all, as in the physical sciences or in the technologies. We can send people to the moon, yet we can't find jobs for our young people; or appropriate accommodation for all our older 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 twenty to twenty five years beyond retirement yet we can't ensure that they can live those years in dignity.

As most older people with handicaps live in the community we often hear the call for families to play a greater role in care. Oh for the golden age, people often lament, when families did more for their older relatives than they do today! In reality there never was such a golden age when family care was more forthcoming than it is today. In general, people did not live long enough to become dependent, and work patterns in pre-industrial societies usually meant that one worked until one died.

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.

Changing demographic patterns demonstrate the limitations on the pool of potential caretakers. In Australia the middle aged unmarried woman, not in the labour force, who could be counted on to provide care is a disappearing species. Labour force participation rates for women have increased by 15 per cent in the past decade so that 44.4 per cent of married women aged 45-54 are in the labour force. Furthermore, there are fewer "never marrieds' in Australia than ever before. Of women aged 45-49, 22 per cent in 1901 were never married. Today the proportion is only 4.8 per cent. For every 100 elderly persons in 1901, there were 8.7 unmarried women aged 45-59. Today there are only 4.1. Of those forming families in the mid-19th century, 80 per cent had four or more children. Of those presently in their seventies, only 25 per cent have had four or more children and furthermore, about 30 per cent have no children or only one child.

The general expectation that women not in the labour force would provide care for our elders does not hold up with demographic reality though it is still part of our traditional set of role expectations,a nd the result has been described by an Americal social scientist, Elaine Brody, as the phenomenon of the "woman in the middle".

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

The reality is that older poeple in future will look more towards formal systems of care and less towards their families. Many families want to look after their elderly relatives but they are not equipped to do so, nor do they have the social supports they need. Well intentioned family members do not have the professional skills you have. They have the ability to provide comfort and support but not to do the job of the visiting nurse or to deal with the big issues of now and the future, brittle bones, dementia and incontinence. Nurses are a key part of our formal system of care, and key players in passing knowledge onto informal carers.

While they are key players in our nursing home system, qualified nurses are not by any means in the majority. In South Australia's 157 nursing homes there are about 2000 registered nurses and 900 enrolled nurses (head count, not FTE). This compares with about 4400 unqualified personnel.

Our nursing home system is being redefined and the practice of nursing is part of that redefinition. A nursing home is the resident's home. It is not somewhere that one goes to get fixed up or cured - it is where one lives.

As you are all aware your prime task is to ensure that an individual maintains personal integrity, identity, autonomy, self esteem. In an acute hospital setting these factors may be secondary to more urgent therapeutic interventions. In somebody's home - in a setting where you have responsibility for their well being a holistic approach is mandatory.

Nursing older people therefore is quite a different professional task to nursing younger, sick people. It focuses more on the whole individual and I'm sure you understand that fully. But do you have the skills to respond? My guess is that your educational background has not necessarily given you these skills - those of you who have them have had to seek them out. A more important question is do you have the professional permission to focus on the individual as a whole - to put an individual's preference above what you think is right for them? For you to have the skills to respond to the whole individual and work to assist them to do what <u>they</u> want to do rather than what <u>you</u> want them to do is one of the challenges facing your educational and attitudinal approaches.

I am presently chairing a Ministerial Task Force on nursing home accommodation and I am pleased to say that the RANF contribution to our task force has been outstanding. In our recent meetings we have been grappling with factors leading to dependency of nursing home residents, means of alleviating those dependencies and means of identifying the feasibility of setting standards which focus on quality of care outcome for residents instead of just concentrating on inputs.

In our analysis we have identified about 22 factors contributing to dependency among nursing home residents. We have broken them into 4 categories - those reflecting broad societal values and conditions, those individually centred and based, those pertaining to nursing homes in general, and those pertaining to particular nursing homes. By breaking them down in this way we can identify how to go about finding an appropriate policy target and point of intervention. For example lack of privacy and powerlessness of residents applies in all institutional settings, while low staff morale, poor management of poor staff education applies in some nursing homes but are not universal phenomena. To address these issues we have been exploring a quality assurance program focusing on structure, process and outcome.

The development of a quality assurance program and a quality assurance support team will be considered when framing our final recommendations. I'm sure you all know and understand, better than I do, what can be achieved by a quality assurance program. The jargon may mean different things to different people. I think a quality assurance program, based on structure, process and outcome will serve our older population better than some of the woolly headed philosophies which talk about de-professionalisation. I could not countenance a situation in which an older person with chronic multiple diseases were not to receive the highest standard of care, delivered by the most appropriate professionals in the circumstances.

My statutory task is to enhance the quality of life of older people, to blaze a trail for the future - a future in which our

older people are respected, highly regarded, and encouraged to contribute from their enormous resevoir of talent, experience and skill. As I look around me I am filled with optimism. I do not regard older people as a problem, not do I capitulate to a scenario of impending and monumental social dependency. I reject the pessimism of the harbingers of doom and gloom who say all is lost as we become engulfed in a geriatric tidal wave. Our elderly population is increasing slowly and we do have the time to plan - we do know how many older people we have today and will have in 10, 20, 30, 40 years from now.

As planners we have a challenge before us now, but we certainly have the skills to develop workable, equitable and humane policies. I am working on developing an agenda for ageing. During this conference you too, might like to think of what such an agenda might constitute.

The items that stand out to me include suitable income security, efficient, effective and equitable health care, accessible social services, life enrichment and life enhancement, suitable housing and accommodation, policies on work and leisure, communications and transport, issues of safety and consumer protection.

As we look to the future in gerontological planning it will be necessary to develop the philosophical concepts, the framework for action, the process, and the product. And to do that we have to work in conjunction with organisations such as yours - in collaboration and not in isolation.