Accommodation After Retirement

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edited by

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PAPERS GIVEN AT A SYMPOSIUM HELD ON MARCH 13 1984

Social Welfare Research Centre
THE UNIVERSITY OF NEW SOUTH WALES
P.O. Box 1, Kensington, New South Wales, Australia 2033

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As with all issues in the Reports and Proceedings series, the views expressed in this number do not necessarily represent any official position on the part of the Centre. The Reports and Proceedings are produced to make available the research findings of the individual authors, and to promote the development of ideas and discussion about major areas of concern in the field of Social Welfare.

FOREWORD

The University of New South Wales prides itself on its close relationship with the community which supports it. Notions of universities as remote ivory tower institutions concerned only with abstract theory and introspective analysis cannot be sustained when we consider the constributions made to the well-being of our citizens, our social structures, and our overall development. The activities of the University in studies relating to the conditions of elderly people are one good example of this important relationship, and in some small way the University tries to play a role each year in Senior Citizens' Week.

People aged 65 and over comprise 9.7 per cent of Australia's population. By the year 2001 they will comprise approximately 11.5 per cent and by 2021 approximately 15 per cent. The elderly population which today stands at 1.5 million will grow to almost 2.4 million in 16 years time. Providing the basis for good standards of housing, health care, income support, social services, recreation and educational facilities is among the research challenges facing some of our University staff. I am pleased to say that researchers in this University have readily accepted the challenge of researching the conditions of life, among other things, of elderly people.

Each year in Senior Citizens' Week the University of New South Wales sponsors a forum on one aspect of life of elderly people. Last year (1983) it was on Nutrition and Diet, the year before it was entitled Age Care - Whose Responsibility? The forum is a means for the University to show how it grapples, across discipline boundaries, with important issues in our society. In this year's forum our four speakers come from four diverse parts of the University, the Social Welfare Research Centre, the School of Architecture, the School of Health Administration, and the School of Community Medicine. Together they present a range of perspectives on post-retirement accommodation, a matter of great and increasing concern to the Australian community.

Professor Michael Birt
Vice Chancellor.

ACCOMMODATION POLICIES FOR ELDERLY PEOPLE

by Adam Graycar

Issues

Family, income, health, and housing conditions are the major interlocking pieces in the kaleidoscope of well being of elderly people. Housing and accommodation, the subject of this symposium is concerned not only with physical structures, but also with issues of dependency, functional ability, choice, affordability and access.

Accommodation policies for elderly people in Australia are splattered across an expansive canvas and the major players pop up all over the place with policies and regulations, constraints and limitations, aspirations and hopes. Accommodation policies for elderly people involve activity by all three levels of government, non-government welfare organisations (of whom about 8,000 in Australia are involved with the welfare of elderly people), private entrepreneurs, developers, and professionals, to name a few. At the Commonwealth Government level we have four main departments deeply concerned with accommodation policies for elderly people - Social Security, Health, Housing and Construction, and Veterans Affairs. Several others are marginally concerned with these issues. It would be trite of me to list the various roles of the numerous State and local government involvements.

Where and how people live is very important. For elderly people the importance is heightened because if incomes are limited or if mobility is limited more time is spent at home than at any other time since infancy. Large numbers of elderly people may not leave the house at all during the course of the day, and when they do leave the house, many are out for only short periods. Physical amenity and a comfortable environment therefore are of crucial importance.

The author gratefully acknowledges the contribution of Chris Rossiter in the preparation of this talk. The material contained here is essentially the background to a longer piece to be written jointly by Chris Rossiter and Adam Graycar.

Housing is a major expenditure item in most family budgets. Although, on average, elderly households spend a smaller proportion of their incomes on housing costs than do younger families, many still face financial difficulty in this area. Elderly people who are not home owners have the highest incidence and risk of poverty; those who are home owners face council rates and maintenance costs which are often difficult to meet out of fixed and limited incomes. Approximately 12 per cent of an elderly person's income, on average, goes in housing, but elderly private tenants spend a lot more - up to 19 per cent - on rent.

Housing however occurs within a matrix of transportation, shopping, recreation, health services, and social and other opportunities, and these are every bit as important as the individual dwelling unit. Successful housing occurs where these matrix needs are met. It is important to note that this matrix should be part of all housing policy, for if it is, dislocation, which may result from an ageing locality will be minimised. Elderly people who move away from a familiar neighbourhood may find the experience most unsettling. This applies both to moves to residential or institutional environments and to retirement migration moves. Most disoriented of all are those who move into institutional settings where their possessions and mementoes are reduced to what one can fit into a locker.

Most elderly people in Australia live in private residences. 93.6 per cent of people aged 65 and over live in private households, and only 6.4 per cent live in institutions (nursing homes, hostels, homes for the aged, etc). Institutional rates vary by age and sex: 2.1 per cent of men aged 65-74; 2.4 per cent of women 65-74; 8.1 per cent of men 75+; 17.2 per cent of women 75+ live in institutions of various types (see table 1, page 11). Of elderly people in private households, three quarters own or are purchasing their homes. About three fifths of age pensioners in private households own or are purchasing their homes. At all ages home ownership rates are higher for men than for women. However, the majority of elderly people are women. Approximately 20 per cent of elderly female household heads are tenants, whereas approximately 12 per cent of elderly male household heads are tenants (see table 2, page 12).

Comprehensive national data on housing satisfaction are limited but a 1974 national survey of Aged Persons Housing (published by the former Department of Environment, Housing and Community Development in 1976) obtained

data on whether single elderly people would like to remain where they were or would they like to move. Of those responding, most were happy with their housing and 13 per cent indicated a desire to move. Data from the 1976 Census show the variability in living arrangements of older people in the Sydney urban area (see table 3, page 13).

Some people like where they live, some don't. Some people can comfortably afford their housing, some can't. Some need better access to community services, some don't. Most live in private independent accommodation but around 100,000 live in institutions and a further estimated 150,000 (half as many again) live with younger relatives, usually adult children. Levels of dependency vary with income and mobility limitations and community formal and informal supports. Put all of that against a backdrop of a privatised, individualised, federal system, and accommodation policies border on the incoherent and incomprehensible.

The issues to be addressed then are what types of interventions should take place by governments to ensure appropriate and satisfactory accommodation for elderly people; for whom should intervention take place - those heavily dependent?; what should the product be?; given that costs will be involved, should buildings be subsidised, should services be subsidised, should people be subsidised? Most elderly people, at any time live in satisfactory and suitable accommodation, yet a substantial number either live in unsatisfactory housing or are highly vulnerable. Because of the high degree of vulnerability, governments cannot ignore the fact that accommodation after retirement has an undeniable place on the policy agenda.

Targets

When developing post-retirement accommodation policies four target groups are readily identifiable - independent elderly people, elderly people in need of some support, dependent elderly people, and those who provide care for elderly people.

People who have just retired find themselves at home a lot more and find that their social networks may have changed. If income has been reduced their greatest need is for housing that is affordable and which has low maintenance costs. As a target group for policy intervention not much

attention is focused here as home ownership rates are very high, and in general housing causes no major problem. There is a problem, however, for those who are not home owners and who do not rent from housing commissions. Perhaps the most urgent need among the independent elderly can be found in those renting in the private market. 8.9 per cent of households with elderly heads are private renters (see table 4, page 14). Of elderly people living alone in private households 12.5 per cent or nearly 50,000 are private tenants. These are among the must vulnerable people and three quarters of them are women (calculated from table 5, page 15).

Elderly people who need some assistance can be supported to live in their homes often with simple and low-cost aids, minor adaptations to ease physical limitations, and certain basic communications equipment. In addition a balance of support services, both of a formal and informal nature can be constructed comprising, where appropriate, home help, meals on wheels, home nursing, home cleaning, handywork, gardening, shopping, meal preparations, etc. Sometimes the smallest amounts of these can make all the difference between satisfactory and unsatisfactory accommodation.

When one talks about dependent elderly people there are different types of dependency which must be noted. Those having major physical or mental disability are frequently accommodated in some form of institution. The largest part of accommodation policy for elderly people has been concerned with institutional care. Debates have raged on the desirability of such accommodation, and on whether it is being administered effectively and efficiently.

Many elderly people with chronic conditions do not live in institutions but live at home with limited or non-existent support. Their lives are characterised by lack of choice and a strong case can be made for policy intervention to provide for alternatives. Approximately 150,000 elderly people in Australia live with their adult children. Not all are fully dependent, but a great many are, and their accommodation circumstances are a result of a lack of choice and/or an utter abhorrence of institutional care.

One group often not considered in this issue are families who care for their elderly relatives. In our research in the SWRC we have found that these families are under enormous pressures in providing care and that their accommodation circumstances deteriorate along with their social and emotional

state. Few households go through the hassles of making major adaptations, especially if they involve planning regulations, local council and the building industry - not to mention costs. Our research has found that there are few support services for such families, thus making accommodation very difficult, not only for the elderly person, but for whole families.

The other carers who need to be mentioned as policy targets are those who provide care in a formal sense - the proprietors of nursing homes, hostels and boarding houses. To the extent that the care they provide can be judged, there needs to be regular and adequate surveillance to ensure satisfactory conditions for elderly residents.

Responses

The response of the Commonwealth government, which last year allocated approximately $8.5 billion for elderly people has been to provide considerable financial support for those in institutional accommodation. Almost three-quarters of this expenditure goes in pension payments, but of the remainder, for every dollar the Commonwealth Government spends on services for elderly people at home, it spends approximately 10 dollars for elderly people in institutional care. Yet almost 15 times more elderly people live at home than live in institutions.

Between 1975 and 1983 the response of the Commonwealth Government has been to increase the proportion of funding on support for aged people which goes to nursing homes from 6.7 per cent to 8.7 per cent (from $160 million to $740 million). However, expenditure on accommodation other than nursing homes over the same period has fallen from 3 per cent to 1.8 per cent of the total Commonwealth expenditure on aged people (the dollar amounts are $71 million to $154 million); this proportion does include some expenditure on other forms of institutional accommodation, such as hostels (see table 6, page 16). Expenditure on self-contained housing, rent relief and homeless persons' accommodation declined from 1.0 per cent to 0.8 per cent of the Commonwealth expenditure on elderly people over the same period.

The Commonwealth, however, directly or indirectly provides a roof over the heads of approximately 200,000 elderly people at any one time, or 13.7 per cent of those aged 65 or more. 32,205 independent units have been funded under the Aged or Disabled Persons Homes Act; 30,737 under the

Commonwealth State Housing Agreement, 70,574 Nursing Home beds have been funded, 34,741 Hostel beds, and a further 30,555 elderly people spent census night 1981 in a hospital.

When we consider the various target groups, varying policy responses can be identified. For independent elderly people, for example, the Commonwealth pays supplementary assistance of up to $10 per week to 208,000 age pensioners who are tenants (14.9% of age pensioners). For home owners, approximately 820,500 or 62 per cent of pensioners receive local government rate rebates at an average annual value of $62.80. These, together with concessions for water, sewerage and electricity are underwritten by State governments.

For elderly people needing some support, the response is more varied. The Commonwealth provides funding to non-government organisations on a 2:1 basis for self-contained units under the Aged or Disabled Persons Homes Act. 750 units were funded last year, and 32,205 since the program was started in 1954. For those requiring assistance to remain in their own homes $17.7 million was spent in 1982/83 under the States Grants Home Care Act for home help services.; $4.8 million under the Delivered Meals (Subsidy) Act for 764 services to provide 9.8 million meals and $16.5 million to Home Nursing Services. These three services are chronically underresourced and the quality of life of elderly people at home suffers accordingly.

The dependent elderly are the target group of most Commonwealth service expenditure. Nursing Home Benefits, deficit financed Nursing Homes, Personal Care Subsidy and accommodation assistance from the Department of Veteran's Affairs accounted for over $900 million in 1982/83. The response clearly is the heaviest here, in the institutional sector which accounts for around 6.4 per cent of Australia's elderly people. Apart from an allocation of $22.8 million for the Domiciliary Nursing Care Benefit, the response to families caring at home for dependent elderly people is negligible.

Futures

In some circles the increase in life expectancy which has characterised the twentieth century is seen as a social calamity - but it would be more reasonable to regard it as a major achievement. One implication of greater longevity is that accommodation arrangements must become more flexible and more adaptable. The great proportional growth in the elderly population in

the near future will be in the 75+ age bracket, which will comprise almost half of the aged population by the year 2001. This will place great demands on housing and accommodation services both in the private household sector and in the institutional sector, as physical and mental disabilities tend to be concentrated in the "old-old" age group.

Our research indicates that aged people in the future will probably look more towards the formal system of care and less to their families. This does not suggest that the answer lies in more institutional care, but rather in more variety and support in home care, which then makes accommodation more suitable. Responsibility for accommodating elderly and dependent elderly people can be identified across the spectrum, and the argument changes with different socio-political phases.

The family was seen, at one time, as the sole provider for elderly people but recent times have been characterised by greater involvement of statutory, commercial and voluntary agency provision. We have seen, however, attempts in the recent past to place more responsibility on families. Yet while families play an important emotional role they are generally not equipped to provide for the accommodation needs of elderly relatives.

In some scenarios the private market is seen as the solution, both in the general independent housing field and in the care field. In retirement housing, the private market is within the reach only of those who have built up assets over a lifetime. Even then, with entrepreneurs moving quickly into the retirement housing market there may be the need for some organised consumer protection to ensure adequate quality and fair terms. For those not able to buy, or participate in equity schemes, the market usually has little to offer.

Public housing is not to everybody's liking, nor is it appropriate for most. Yet, in view of declining rates of home ownership in the population at large, it may become an increasingly important aspect of housing for elderly people and as such must represent a significant policy option for future accommodation planning.

Assistance with maintenance for home owners is also essential to keep housing operational and satisfactory. If home help is taken to its broadest interpretation, rates of institutionalisation could well decline. Government

responses to date have been unbalanced and have emphasised institutional care at the expense of general public housing support and at the expense of home-based support services. There is a great danger that unless clear priorities are established inappropriate housing will considerably diminish the quality of life in Australia's growing elderly population.

One might ask why there should be what might appear to be disproportionate support for housing and accommodation for elderly people? A community which has benefitted from the endeavours of its population cannot in conscience abandon those requiring social care and argue that their needs are not sufficiently legitimate for the allocation of public resources. To date, social welfare provision has not responded well to rapid socio-technical and demographic changes. The community cannot default on its obligations to its citizens.

TABLE 1. PROPORTIONS OF ELDERLY PEOPLE LIVING AT HOME AND IN INSTITUTIONS, BY AGE AND SEX, AUSTRALIA 1981.

Percentages

Living Arrangement	65 - 74 years		75+ years		All 65+		
	Men	Women	Men	Women	Men	Women	Total
In private households	97.9	97.6	91.9	82.8	96.0	91.8	93.6
In institutions	2.1	2.4	8.1	17.2	4.0	8.2	6.4
Total number ('000) = 100%	414.7	501.1	181.7	324.8	596.8	825.8	1,422.6

Source: Australian Bureau of Statistics, Handicapped Persons, Australia, 1981. Cat.No. 4343.0 Canberra, 1982.

TABLE 2. HOUSEHOLDS WITH ELDERLY HEADS : PROPORTION IN MAJOR TENURE TYPES, BY AGE AND SEX OF HOUSEHOLD HEAD, AUSTRALIA, 1981.

Percentages

Tenure	65 - 69 years		70 - 74 years		75 - 79 years		80+ years		All 65+	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
Owner-occupation	80.4	71.0	78.8	69.6	76.8	68.6	75.7	68.9	78.7	69.6
Rental	11.7	19.8	12.1	19.8	12.6	20.0	11.7	18.9	12.0	19.6
Other tenure type	4.9	5.3	5.7	6.1	6.6	6.9	7.9	7.5	5.8	6.3
Tenure not stated	3.0	4.0	3.5	4.5	4.0	4.5	4.8	4.7	3.5	4.4
Total ('000) = 100%	201.0	103.6	140.2	99.4	80.4	76.6	49.9	73.3	471.7	352.8

Source: Australian Bureau of Statistics, 1981 Census of Population and Housing, Table 87.

TABLE 3. LIVING ARRANGEMENTS OF ELDERLY PEOPLE : PROPORTION IN EACH TYPE OF ARRANGEMENT, BY AGE AND SEX, SYDNEY, 1976.

Percentages

Living Arrangement	65 - 74 years		75+ years		All 65+	
	Men	Women	Men	Women	Men	Women
Living with spouse	69.4	37.6	49.2	12.6	63.0	27.1
Living alone	11.3	30.4	16.3	32.4	12.9	31.2
Living with others	6.8	24.1	17.5	31.5	12.7	27.2
Non-family members						
- in private dwellings	2.7	2.8	2.9	2.9	2.7	2.9
- in hospitals or nursing homes	3.6	3.5	10.4	16.2	5.7	8.8
- in hotels or boarding houses	1.7	0.6	1.4	0.7	1.6	0.6
- in homes for the aged	0.3	0.6	2.2	2.7	0.9	1.5
- other non-private dwellings	0.4	0.5	0.5	0.8	0.5	0.7
Total = 100%	66,571	90,210	32,062	65,749	96,633	155,959

Source: D. Rowland, "Vulnerability of the Aged in Sydney", Australian & New Zealand Journal of Sociology, Vol.8(2), July 1982, Table 1.

TABLE 4. HOUSEHOLDS WITH ELDERLY HEADS : AGE OF HOUSEHOLD HEAD BY TYPE OF TENURE, AUSTRALIA 1981

Percentages

Age of household head	Outright Owner	Purchaser	Owner/ Purchaser not specified	Public tenant	Private tenant	Landlord not specified	Other tenure	Tenure not specified	Total = 100%
65 - 69	65.2	9.1	2.9	5.9	8.2	0.3	5.1	3.4	304,610
70 - 74	66.2	5.6	4.0	6.1	8.8	0.4	5.9	3.9	239,514
75 - 79	65.8	3.5	3.4	6.1	9.7	0.5	6.7	4.3	157,068
80 +	65.6	2.5	3.5	5.5	10.0	0.5	7.7	4.7	123,196
All aged 65+	65.6	6.0	3.4	5.9	8.9	0.4	6.0	3.9	824,388

Source: Australian Bureau of Statistics, 1981 Census of Population & Housing, Table 87

TABLE 5. ELDERLY PEOPLE LIVING ALONE IN PRIVATE HOUSEHOLDS : PROPORTION IN EACH TYPE OF TENURE, BY SEX, AUSTRALIA 1981

Percentages

Sex of Household head	Owner	Purchaser	Owner/ Purchaser not specified	Public tenant	Private tenant	Landlord not specified	Other tenure	Tenure not specified	Total = 100%
Men	59.0	4.2	2.8	5.6	13.2	0.7	8.4	6.1	91,790
Women	60.2	4.0	3.6	8.5	12.2	0.6	6.4	4.6	282,322

Source: Australian Bureau of Statistics, 1981 Census of Population and Housing, Table 87.

TABLE 6. COMMONWEALTH EXPENDITURE ON ELDERLY PEOPLE INCLUDING ACCOMMODATION-RELATED EXPENDITURE, AUSTRALIA 1975-83

Year	A Total C'wealth expenditure on aged persons ($ '000)	B A less individual income maintenance[2] ($ '000)	C C'wealth expenditure on nursing homes[3] ($ '000)	D C as proportion of A %	E C as proportion of B %	F Other C'wealth expenditure on accommodation[4] ($ '000)	G F as proportion of A %	H F as proportion of B %
1975	2,393,650	518,531	160,064	6.7	30.9	70,973	3.0	13.7
1976	3,327,174	836,928	193,350	5.8	23.1	95,753	2.9	11.4
1977	4,491,685	1,539,051	232,848	5.2	15.1	69,135	1.5	4.5
1978	5,025,605	1,719,605	253,853	5.1	14.8	78,028	1.6	4.5
1979	5,538,216	1,873,007	268,543	4.8	14.3	82,598	1.5	4.4
1980	6,092,038	2,058,105	312,422	5.1	15.2	81,385	1.3	4.0
1981	6,999,752	2,377,470	381,659	5.5	16.1	109,847	1.6	4.6
1982	7,489,734	2,175,268	571,435	7.6	26.3	113,943	1.5	5.2
1983[5]	8,518,700	2,613,200	739,900	8.7	28.3	154,100	1.8	5.9

Notes:
1. Includes payments to individuals, States, local government, non-government welfare organisations in respect of elderly people and 'other' payments (i.e. to ex-servicemen; aged persons in programs such as health benefits, hospital services; administration).
2. Age pensions; service pensions.
3. Includes deficit funding of nursing homes, nursing home benefit paid to individual residents.
4. Includes payment for pensioner dwellings (to States); homeless persons' accommodation, aged persons' housing, personal care subsidy, aged persons' hostels (to local government and NGWOs).
5. ACIR estimate

Source: Advisory Council for Inter-government Relations (ACIR) Report 6, The Provision of Services for the Aged: a report on relations among governments in Australia, Canberra; AGPS 1983, Tables 10,22,23,24,25 and 26.

BRICKS AND MORTAR

by Clive Stevens

Abstract

There are many social and psychological theories which could be used by designers as a guide when they develop aged care accommodation. The theories are generally ignored because architects do not know of their existence, do not understand them, or find it difficult to put theories into a concrete form. If a supportive environment is essential for elderly people, then those environments should not be the province only of the architectural designer but the result of a multi disciplinary team.

In Australia, as well as in most Western communities, care for the ageing population has become an expanding problem. As a nation we project the image of youth with its vibrancy and aggressiveness, yet demographically we are becoming a greying assemblage. The age shift has caused concern about the growing need for aged care and accommodation. Individuals, entrepreneurial organisations and governmental bodies argue so as to apportion responsibility for care of elderly people.

In our society all three are concerned and committed and their activity varies, whether it be sustained care at home, whether it be entrepreneurial activity developing speculative housing estates for aged persons, or total care through four avenues of accommodation as offered by charitable organisations, viz:- self care, hostel care, frail aged care and sustained care in nursing homes.

Within this paper individual and family care will not be discussed as it is difficult to comment on the physical environment of a committed family providing physical sustenance for an aged relative. Likewise informed comment on speculative housing for aged persons is beyond this paper's ambit. In this milieu the paramount motive is profit and the appeal of the development is determined by the market place. The aged purchaser of a dwelling unit is generally influenced by location, standard of accommodation, terms of amortisation and the selling potential of the property when it becomes time to move on, or perhaps part of their 'deceased estate'. In this case, as in all cases, the more affluent a person, the greater the freedom of choice.

The third category is addressed by this paper, that is the charitable organisations and their attendant building programs for total aged care. It is within this area of their continued involvement in a tiered structure of care, that it becomes essential to develop strategies that go beyond the concrete fabric of a building and accompanying fiscal policies. It is necessary that organisations become cognisant of the nexus between the physical, social, and psychological environment, for these three items are the building blocks of a successful environment for aged persons. It has been claimed (Clough, 1981) that residents of old age homes do not grow senile in spite of institutions, but because of them.

Planning, designing and constructing a physical setting for aged people is not a matter of room sizes, grab rail locations, wheel chair clearances or even the height of window sills. A successful building program must be based on a theoretical maxim that leads to the understanding of the individual and assures that older people may retain, for as long as possible, their independence, individuality and dignity. If a conceptual approach is adopted it can be assured that the designer's motivations will not be directed only to the bricks and mortar aspect of the design. There is a hope that a theoretical approach towards the projected environment will result in offering the congregate aged community as individuals, expansion of mind, foster the opportunity towards self help and self determination, and finally maintain or raise their level of actualisation.

In many studies dealing with housing satisfaction, (e.g. Morris et al., 1976) it has been ascertained that the highest contentment is the propensity of the elderly. They may have, over a lifetime, achieved satisfactory accommodation norms, and prefer to remain as long as possible in the house they have purchased, and lived in, during their life cycle. Why do they decide to move into caring establishments?

Attitudes expressed on the desire to move are limited, vague and not as clear cut as satisfaction levels. Yet the main factors given in relevant studies for desire to move, were dissatisfaction with the current dwelling, complexity of house maintenance, and the state of the neighbourhood. Further there was a desire to pre-empt physical decline and to be in a situation where care is offered. It has been shown that the main causal decision to move is when the physical and emotional needs of the elderly become restricted (Montgomery, 1965). According to Montgomery (1965) the decision to move from

the family home is caused by the onslaught of physical disability, either through deterioration of health or an accident, both of which lower the level of independence. Failing independence has deleterious effects on the individual and his or her mobility. Previously their environment was supportive, but with reduced mobility their neighbourhood was assessed as a barrier to daily living. At this point in their lives, individuals decide to congregate and often this decision may have been encouraged by family, or be the result of family pressure.

With the loss of mobility, or the death of a spouse, the social milieu changes for the individual, and notably their environment contracts. The main result of social contraction is role loss and this leads to disengagement from social interaction. During a lifetime the individual has been tied into the social fabric of beliefs, values and actions of one's society, and gradually the isolated elderly are excluded from their social microcosm. Isolation is often accompanied by psychological degeneration, dejection and lowering of self esteem. When the elderly are in their lowered state of existence it becomes important that congregate accommodation provides maximum opportunity for interaction with peer groupings in the new circumspect community.

When people move into institutional care there is the tendancy to promulgate the community attitude that the elderly are all the same except for physical disabilities. People at this juncture of their life are as different and diversified as any non-aged community except that they are more dependent. Havinghurst (1963) believes that the aged can be psychologically categorised into the following personality states:-

Reorganisers	They reorganise their lives to substitute new activities for lost ones.
Focused	They are well integrated, with medium levels of activity, and select one or two role areas.
Successful disengaged	They have low activity levels with high satisfaction - a contented 'rocking chair' position.
Holding on	They hold on as long as possible to the activities of middle age, and have high satisfaction as long as this works.

Constricted	They have reduced their role activity but are less integrated personalities than the *focused* group.
Succourance-seeking	They are successful in getting emotional support from others and thus maintain a medium level of role activity and of life satisfaction.
Apathetic	They have low role activity combined with medium or low life satisfaction. Presumbaly they are people who have never given much to life and never expected much.
Disorganised	They have deteriorated thought processes and poor control over their emotions. They barely maintain themselves in the community and have low or, at the most, medium life satisfaction.

The inability of many elderly to survive in the external community is in itself a sign of low satisfaction (Clough, 1981). Yet the above personality patterns are usually indicative of a past life style. People are not neatly slotted into the categories as suggested by Havinghurst but exist within the state of several groupings. To cater for the diversified states of the aged persons within the environmental setting, that setting must not be simplistic but complex, wherein the individual can relate to the environment without undue conflict.

Havinghurst (1963) postulates that successful ageing within an institutional confine depends on whether and the extent to which the individual

(a) finds satisfaction in every day life,

(b) accepts the good and bad of the situation,

(c) feels that one has succeeded in achieving major goals,

(d) has a positive image of self,

(e) maintains happy optimistic views of self.

Havinghurst has offered a structured approach to ageing. Firstly he categorises the psychological variants of the aged and secondly states that successful ageing can be created by the elderly maintaining a degree of self actualization through social/psychological achievements. It has, however, been argued by Porkaj (1972) that there is not a simple relationship - as suggested by Havinghurst - between disengagement from the community and activity within the confines of an institution.

Porkaj concludes that successful ageing is measured as an expressed satisfaction of current life situation. To achieve a measure of satisfaction the elderly person must be within an environment that is conducive to their

needs. That setting must have minimal physical and administrative barriers thus allowing them to have control over their immediate environment. It should facilitate maximum voluntary participation or withdrawal from activities, and allow for the individual to adjust gradually to the psychological changes that take place during ageing. Within this environmental orbit, the architect should be able to influence the successful outcome of ageing without relying on preconceived deterministic planning.

The physical form of the environment within aged housing complexes is usually dictated by managerial policy and subsequently interpreted by the architect. The manifest concern is with economics and the greatest energy imput is expended in solving construction costs related to maximum accommodation return. The ensuing design philosophy is extremely introverted and the emphasis is placed on good middle class values - whatever they may be!

Hardly any architectural design work is based on social science theories; theories are generally ignored because architects do not know of their existence, do not understand them, or find it difficult to put the theories into a concrete form. The majority of design solutions are approached through prototypes, with undue emphasis given to visual qualities; for it is within the visual field that the architect is judged by his or her peers. In designing a built environment the architect uses a process called the 'central idea' which is centrality of thought and the design is directed to this concept. If one idea is followed, the result should be a building having complete harmony and unity.

Little credence is given to information theory (Cherry, 1966), as in this concept the user refers to the building as a source of information and demands predictability. With the information theory the architect builds in information redundancy, which is prior knowledge for the user. A small portion of the design is given to innovation which provides the major source of stimulus; this contains the 'news' value of the theory. Buildings designed within the information theory concept should have their resources drawn from the past environment of the elderly. In this instance the transfer from a community environment to a caring congregate environment has less psychological impact on the new elderly. They are not entering an 'aged care establishment' only transferring to an extended community setting. There should be a continuity of building shapes and building materials existent in their past settings. The environment should be known and predictable.

There are three other theories which may be used in the design field when considering environments for the aged. Theories have been offered by Lewin (1936) in the concept of 'life-space', Barker (1968) on 'behavioural settings' and Altman (1975) has developed theories dealing with topology of privacy, territoriality, propinquity and overcrowding.

Lewin's life-space concept is comprised of three states. Firstly there is the physical state of space - this is the geographic area in which the individual moves. Secondly there is a social life-space, which is the social network of the individual. The third deals with the psychological life-space, which refers to the individual's personality and construct system.

The life-space theory emphasises the importance of movement of the individual and the variety of spatial scope and action that can be offered in order that the person can enact their various roles. In the case of the elderly, their environment is contracting and it becomes essential that they are offered maximum opportunities for interaction in order to sustain movement and opportunities for role enactment. If barriers are placed on movement within the environmental setting they will result in the inability of elderly people to act on their immediate setting and will eventually lead to passivity and helplessness in the individual (Barnes, 1981). The individual's adaptation level to stimuli must be encouraged to as high a level as possible. Hebb (1949) reveals that perceptive deprivation may be of greater consequence in societal withdrawal, than a decline in sensory powers.

The Michigan State Housing Development Authority (M.S.H.D.A., 1976) has extended Lewin's theory in a publication which states that perception and information processes should be made easy for the elderly by providing an environment that is conducive to interaction. Making the setting comprehensible allows the individual to relate to their mental map of the visual world. The setting should have a variety of physical forms, shapes and colours so people may easily orientate themselves, although if the environment is overly predictable the elderly may not become stimulated or even bother with it. Also it is equally important that the same environment should have a variety of spaces that caters and stimulates the propensity for social interaction.

Barker's behavioural setting theory should be considered by designers as

it emphasises the need for the individual to be encouraged in social interaction within structured physical settings. In his research writing Barker (1968) states that the greater the number of behavioural settings provided within the built environment, the greater will be the individual's satisfaction. Each behavioural setting offers the potential for establishment of role playing, role choices, interaction and development of rules.

Retirement brings about loss of role and loss of societal membership, and opportunities for social interaction become eroded. The diversity of role play opportunities should be optimised in the aged persons' environment, as the greater the number of roles an individual can play can offset social disengagement. Barker's studies also reveal that the more opportunities and diversity of roles a person is offered, the greater will be their life satisfaction. Bechtel (1977:10) reinforces Barker's work and adds

> the greater number of settings that are provided within an aged person's environment create greater pressures to participate and generate role possibilities through undermanning, thus offering the potential for greater satisfaction.

To further implement Lewin's life-space concept Altman (1975) uses the theories of privacy as devised by Westin (1970). In essence privacy mechanisms are used to define boundary limits of self. Boundary limits may either be reinforced by body language or territorial behaviour. The concept of privacy is that the individual has the opportunity to use mechanisms of the environment either to socially interact or withdraw. If privacy is obtained the individual has the opportunity to be introspective in reassessing self esteem, self respect, personal goals and self freedom. When the controls of boundaries are able to be manipulated by the individual a sense of individuality develops. Privacy is the central regulatory process that ensures that the individual can obtain seclusion and can decide when they may slowly reveal themselves in a structured manner.

The concept of privacy is an umbrella covering behavioural relationships, and it provides the linkages between concepts of behaviour, territoriality and overcrowding. Crowding and social isolation occur when the desired level cannot be personally manipulated within the environmental setting.

Successful ageing within a caring environment is not based on activity theory but is placed directly onto the individual to achieve life satisfaction at their desired level. In order to achieve this satisfaction four broad social/psychological theories have been propounded in this paper as a simple and introductory guide to better environments for the aged. Within this framework it becomes evident that environmental design for the aged is complex and should not be the sole domain of the architect.

If meaningful supportive environments are to evolve, a greater need exists for extension of social theories and refinement of existing concepts. Until questions are asked about the suitability of an environment for the elderly, architects will still be designing in a vacuum, purpetuating a 'bricks and mortar' solution that has no solid theoretical foundation. A totally designed conducive caring environment for the elderly should be the product of a multi disciplinary specialist team comprising, for example, an administrator, an architect, a psychologist, a sociologist, and of course consumers.

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CHEAPER ISN'T ALWAYS LESS COSTLY

by Tim Philips

INTRODUCTION

The subject of accommodation after retirement is a challenging one because it suggests some basic questions about the kind of future society towards which we are heading, not only in terms of where and how people live, but also in terms of the kinds of social and inter-personal relations they will experience. Bernice Neugarten (1979) and others have suggested optimistically that the process of breaking down distinctions based on race, gender, and economic and social class will continue in the sphere of age until we arrive at a society where age is largely irrelevant. Neugarten (1979) argues that "not age alone, but retirement is the important factor affecting people over the life cycle. And retirement age is lowering while an increasing proportion of the aged are retaining good health in the retirement years, and entering those years with increasingly high levels of education and economic security. Therefore the old are becoming increasingly like the young, and we are moving towards an age-irrelevant society".

Others, (e.g. Shepherd and Rix, 1977) have suggested a "worst case scenario" which sees the current trends towards earlier retirement, ageing of the aged population and increases in the non-working population, as well as rising demands for better retirement incomes and living standards, leading to greater age segregation. The effect then, is further exclusion of the aged from the rest of society, and thus greater conflict over who should get what. I would prefer the more moderate and hopeful scenario as described by Canadian gerontologist, Victor Marshall (1981) in which we will have a more balanced and humane society which recognises that older people (as well as younger ones) are not all alike, and takes proper account of differences in their health needs, social and economic resources, leisure orientation and preferences. Which scenario is the more likely to come true in the decades ahead could be debated at length.

The important point is that many of the major decisions which are being made about accommodation and care for the present generation of retired persons will either bring us closer to a more integrated and harmonious society or a more divided and conflict-ridden one. One of these core issues is how to

resolve the growing conflict between the needs, demands and aspirations of the growing number of retired persons and the much more slowly growing capacity of society to meet these needs with the finite resources available, and without violating the accepted values and rights of individuals (e.g. to exercise choice about where and how they live). In essence, it is the old economic problem, in that demands appear to be rising faster than the economy's ability to produce income and wealth, and thus the taxation revenue to meet those demands. In addition, it has been suggested that the capacity of the non-market sector to supply voluntary or unpaid family labour may not be growing fast enough.

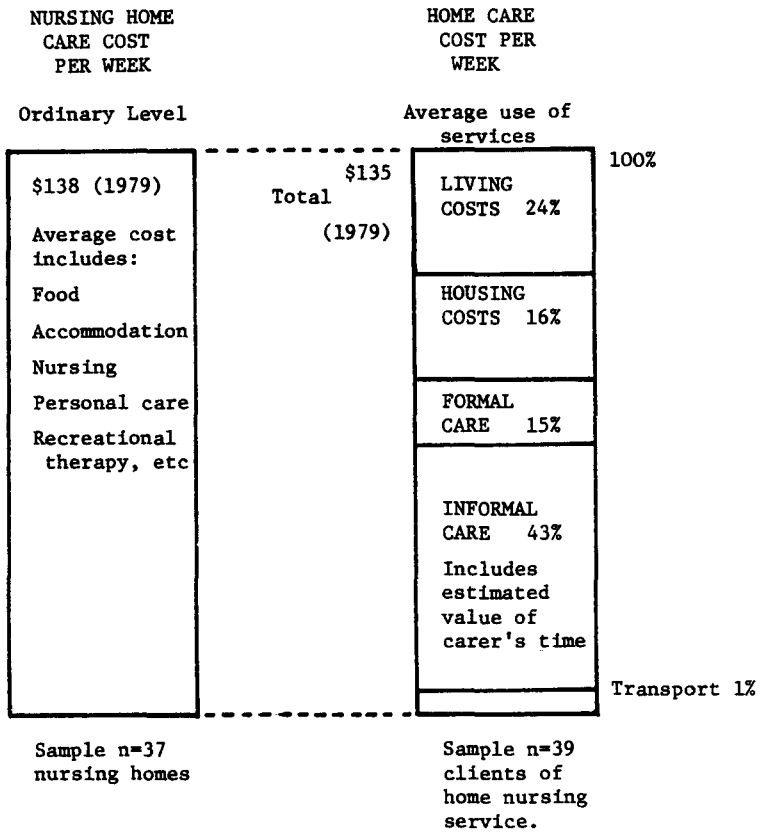
In this context it is natural for public policy-makers to seek to resolve the conflict by attempting to use the limited public resources in the way which would promise to do the most good for the greatest number of politically influential people, if not for those who need it. Reductions in the heavy commitment of resources to extended institutional care for the small minority (3.2%) of those aged 65+ in nursing homes and expansion of home care and community based services is seen as one way to achieve a better balance of accommodation services for frail aged people. But it is the contention of this paper that some aspects of this kind of solution may be misfounded on rather inaccurate estimates of the relative costs of the various forms of care. Here I will use as an illustration, confusion about the true cost of care for those people with relatively great needs for health care and accommodation. The title given to this paper sums it up well: "Cheaper isn't always less costly".

WHY CHEAPER ISN'T ALWAYS LESS COSTLY

There have been many recent reports concerned with care of the aged, and in several it has been admitted that if home care for some groups of individuals is cheaper than institutional care in nursing homes or hospitals, it is so because only the cost to government is being considered (McLeay, 1982; Mowbray, 1983). In other words it is beginning to be accepted that when the other elements of the cost of home care services, such as the domestic labour of spouses or other relatives, as well as the formal services (meals on wheels, home care and nursing) are included, together with housing costs, the cost advantage of home care may be much less than is often assumed. It is clearly obvious that the cost to government is not the whole cost to society. So cheaper to government is not always less costly to society.

Unfortunately none of these same reports appears to have faced up to the implications of this fact. Certainly the Richmond Report in New South Wales was reluctant to acknowledge the considerable costs borne by families and others caring for developmentally disabled or psychiatrically ill relatives. To illustrate the argument, consider the relative cost of an "average" package of home care for frail elderly people compared with the estimated cost of nursing home care for people of comparable dependency.

FIGURE 1 : THE COST ICEBERG



Source: Philips, T.J. (1981).

Note:

This is intended to demonstrate that when the cost of informal care is included, even though at an admittedly arbitrary value, the cost of home care is for some dependent elderly people, much closer to the average cost of nursing home care. No account is given of the variation in cost associated with variations in the clients' dependency, housing or living arrangements.

There are several points to be made about this comparison. It was made on the basis of certain assumptions about the types of people receiving this care and reflects the average of the actual use of certain services by a small sample of people living at home. There are dangers in using such data to make generalisations about home care being more or less costly than institutional care either for all older people, or specific individuals or groups. Average data must be carefully interpreted for reasons which have been well discussed elsewhere by Bennett and Wallace (1983).

Anyone attempting to obtain a more accurate picture of the comparative costs of what are supposed to be alternative forms of care would be wise first to give careful answers to the following questions.

(1) Whose costs are we talking about - those of governments, the providers of formal services, their clients, carers or society as a whole?

(2) What is included in the benefits of packages of services being compared? Are they really comparable? e.g. are meals and accommodation included in each package?

(3) Who is receiving the packages of services under consideration? Is it an average of a sample which is representative of a population, or a "marginal individual" or group? (i.e. one who is on the margin of transfer from one setting to another). (see Table 1, page 31).

(4) How are the costs being met or paid for - in cash or in kind? Who bears what share of each?

SOME FINDINGS ON COMPARATIVE COSTS

In the first Australian study which has attempted to answer many of these questions (Philips, 1981) it was found that the actual cost of home care depends on the level of care provided in each private home. This is always in a sense a unique situation, and depends on the characteristics of the housing occupied, the clients and their family arrangements and on the level of support available. As the recent Report of the Advisory Council on Intergovernmental Relations (1983) noted "domiciliary care is not necessarily cheaper than institutional care for all individuals or for all classes of need".

Detailed costing comparisons by the author as well as others have shown that it is more costly (in terms of resource cost) to care for some relatively heavily impaired individuals in their own homes than in nursing homes. (see Table 1 for more detailed comparisons).

TABLE 1. AVERAGE COST OF VARIOUS HOME CARE PACKAGES AS A PERCENTAGE OF THE AVERAGE FEE FOR ORDINARY NURSING HOME CARE, 1978, NSW.

Client's situation	Minimal[1] Package of Home Care %	Average[2] Package of Home Care %	Intensive[3] Package of Home Care %
Lives alone in:			
bed sitter Flat	78	99	108
1 BR Flat	87	109	116
3 BR House	92	113	119
4 BR House	95	116	122
2 BR Flat	99	120	124
Lives with spouse only in:			
1 BR Flat	61	95	128
3 BR House	64	97	129
4 BR House	68	101	132
Lives with family in:			
4 BR House	47	73	95
3 BR House	56	82	144
Range	52	47	49

Source: Philips, T.J. (1981).

Notes:

1. The cost of home care packages was based on the lowest levels of actual use of services by a sample of 39 clients in the study.
2. The average package was based on estimated average (modal) use of services by a larger sample of 275.
3. The intensive package was based on actual use by the biggest users in the micro sample of 39.

Many other possible packages can be generated when factors other than housing/ living arrangements are varied. Not all services used could be costed but all these packages include some estimates of the value of the time spent in caring by the relative carer in the home and volunteers in formal care services.

It is recognised that any full evaluation should consider the benefits as well as the costs. In this study it was assumed that rather similar benefits are being compared in each situation. To the best of my knowledge, no serious attempt has been made in Australia so far to estimate or value the benefits of different forms of extended care in Australia because of the considerable difficulties involved.

Similarly the very real psycho-social costs experienced by many people who are institutionalised have not been measured. The costs of institutional care are therefore likely to be understated. In the same way, it can be argued that including the costs of carers at home, in terms of wages or leisure opportunities forgone, may overstate these costs unless the benefits to the carer as well as the recipient of care are also brought into the picture.

These criticisms are accepted and it is stressed that there are many challenging tasks to be undertaken in this area before a more accurate picture of the costs and benefits of different forms of care can be obtained. Some writers have even argued that it is neither desirable nor possible to fully measure both costs and benefits, and that we should therefore abandon any such attempts, and simply try to understand what people do in respect to these factors.

It has been argued in the same vein that the sheer preponderance of informal caring in the community supports the view that the social costs of informal care are not as high as those of agency provision. Challis and Davies (1981) argued that if this were not so there would be irresistible political pressure to institute different arrangements. But my contention is that the mechanism by which this pressure can bear on the decision makers is imperfect and may be unresponsive to the preferences and needs of carers and clients and the true net costs they bear. The continuing heavy demand for nursing homes is an expression of this pressure. This is why further attempts to measure these costs are needed.

IMPLICATIONS

What are some of the implications of these research results about the hidden part of the cost iceberg? Firstly, they suggest that, while difficult to estimate, the potential cost savings to be obtained by government

as a result of shifting frail elderly people out of institutions and back into the community are likely to be much smaller than is often assumed. This is partly because the number of people who are able to be returned safely and humanely to the community is likely to be relatively small. Research in 1978-9 showed that the proportion of those in institutions who could return home was more likely to be about 9 per cent rather than the 25 per cent, which has been widely quoted in many reports (Philips, 1981). On the other hand, on average 20 per cent of those at home who were receiving home nursing care were considered as suitable for institutional placement. Given these estimates, those now in nursing homes who could be cared for at home would be replaced by others of equal or greater dependency, and it is likely that the average cost of institutional care might rise rather than fall.

Secondly there is the question of how the potential substitute services in the community might be provided and financed. Because the real cost of informal care is underestimated, as recent research has shown, simply expanding the level of support for home carers in the form of an attendant care allowance may create other complications. This is in spite of the fact that such an allowance is a most commendable move which could do a lot to help relieve the financial strain on many relatives. It is not clear whether this kind of support would be sufficient to induce more people to make the sacrifices experienced by carers in order to care for their elderly relatives, and thus possibly ease the demand for institutional care. A clearer picture of the behaviour of home carers over time and under different rewards and cost situations is only beginning to be obtained.

Thirdly, if additional government funds are provided for formal home care services, it appears from overseas experience that this would most likely increase the demand for these services and be a straight addition to the total costs of extended care. This may be what is desired to redress the huge imbalance, but it will only exacerbate the resource problems rather than reduce them. In particular if the additional funds increase the numbers eligible for home care services they may cause substitution of formal for informal care. Unless there is a big improvement in assessment and targetting so that the services get to those at greatest risk of being placed in institutional care, the net result may be increased use of public resources but little or no overall improvement in the health or well being of people.

I am not arguing that less should be spent on home care, but simply

suggesting that because home care is not necessarily less costly for all, it may be unwise to expect too much either in the way of public expenditure savings or reduceduse of nursing homes as a result of putting more resources into home care.

Both home care and institutional care should be expanded together in a balanced and more effective way because they are really complementary. Only for relatively few people are they direct alternatives at a given time. Thus what is needed is a better balance of facilities and services so as to provide greater choice, particularly for those with fewer assets and resources at the point when their needs and preferences indicate a change is appropriate. The main problems is that to ensure such scope for choice will deepen the conflict with policy objectives of containing the level of resources provided by the general taxpaying public. This brings me to the final issue of possible solutions for resolving this basic conflict.

ENSURING CARE IS AVAILABLE

Many people facing the prospect of retirement are going to face an increasing range of choices and hence uncertainty. Some available evidence suggests "that only a very small proportion of them have realistic expectations about the amount of income security they will receive in the retirement years, or about how long they might be expected to live. In other words, many people about to retire have no accurate understanding of the insecurity of their economic positions" (Marshall, 1981).

Those with substantial assets seek out a greater range of options than those who do not own the family home or some other assets. Apart from prospective changes in government policies on pension eligibility there are many other reasons people may feel uncertain. Much of this may be due to ignorance about entitlements or a feeling of stoic independence and natural pride or to a too-ready acceptance of the myths and stereotypes about old age which may be false or irrelevant to many people at the point of retirement.

Many of the responses people make to this uncertainty can be viewed as attempts to gain some sense of security by insuring against the worst happening - that they will become heavily dependent on others and need extended personal and health care. Some forms this insurance can take, using the term very broadly, include the following:

1. reliance on reciprocal caring by family members. This is the most frequently used form of support and care. It works reasonably well where relationships are firm and enduring. For the growing numbers whose family has been through restructuring on one or more occasions, the chain of reciprocal care may become tangled and strained, if not completely broken;

2. waiting lists or some form of limited right to admission to institutional care. This may be used as "insurance" which is unlikely to be appropriate or very effective; (Howe, 1981), (Hicks, 1983).

3. advance deposits or buying shares or formal rights in a retirement complex or "life care" arrangement. This is a growing form of "insurance" for those able to afford it or in an eligible group for schemes now being developed but with numerous problems;

4. financial investment using the savings of a lifetime, a superannuation lump sum or the family home. This aims to ensure a stream of income out of which the cost of living and supportive care may be paid as necessary;

5. reliance on the state to provide access to needed services. This is usually a last option for the poorest and when resorted to, invariably an only option;

6. social/health maintenance organisations. These are being developed in several places in the USA in return for fixed annual contributions to the scheme. Individual retired persons receive services as needed and even placement in institutional care arranged by a comprehensive community based organisation specifically caring for elderly people. Early evaluation of several of these spheres have found mixed results. (Diamond and Berman, 1981)

While all of these types of insurance have problems, there is one further type of insurance which is worthy of further study.

7. a self-help voucher system (or "Care Credit Union") is one type of arrangement which has been proposed in the USA (Drob et al, 1980) and illustrates the possibilities for tapping people's self interest as well as their caring and altruistic motivation.

In this latter arrangement retired volunteers who belong to community groups such as clubs, lodges and churches would be able to accumulate vouchers or markers representing the amount of care they had contributed to the benefit of another member. These saved results of volunteering could be spent at will by the caregivers or their families when they need care. The value of the vouchers would be guaranteed by the club or church or other guarantor of the scheme.

While there are numerous problems to be overcome with such a scheme and some may react in horror at the idea of utilising self-interest in this way, as well as utilising volunteers, this type of approach may have the essential ingredients for helping overcome the growing resource scarcity problem. The main advantage of such a scheme is that it would help mobilize one of the more abundant resources which the retired population have, and that is time. It would also have attractions for those who believe in the 'fair go' but are not prepared to volunteer their services in the usual way. The large number of community organisations already in existence, which could provide the needed continuity and administrative services is also a strong favourable basis for starting such a scheme.

New ideas could be tried out in some of the newer retirement areas along the coast where a great deal more formal and informal care and support services will be needed. This will occur because many people will have moved away from relatives, and a "care credit union" may be just the kind of approach required to complement but not replace the traditional publicly financed services.

CONCLUSION

Much of what has been said in this paper has been about clarifying the true costs of various alternatives which may or may not be potentially available at either the personal level on one hand or the societal level on the other. None of the suggested solutions represents a "costless fix" to very complex problems. Thus providing more public (tax) resources, whether they are used for increased support for home care, more subsidies for sheltered housing units, hostels or other styles of congregate living, may not be the solution, although it may provide a considerable amount of relief in the short term. In the end, the issue of accommodation of the aged requires a confrontation with the true costs and benefits in human terms of each kind of solution. Jerome Kaplan (1983) has aptly expressed the more basic problem in these terms:

> The ethical construct of the unique humaness of the ageing gives us a clue to those costs. Foremost among the problems we must face are the ageing person's welfare, the person's right to know about his or her situation, whether others should be able to coerce a person for what is presumed to be his or her benefit. What is at stake in such conflicts is perhaps the most basic feature of moral relationship between human beings - (that is the recognition that people exist as ends in themselves and not as entities to be used to fulfil the wishes of others).

> The compulsive race to provide more nursing home care beds (or hostels or whatever), unless rationally assessed in the light of the full armamentarium of services, puts us into conflict with our moral relationship. The answer may not be money, as important as it is. In the long run money will flow only as our ethic will permit it to flow.
>
> While sporadic public achievements may take place without a change in social values, permanent progress will eventuate only as the value base becomes firm and solid. Such firmness is dependent upon our willingness to provide the elderly at least what we provide others.
>
> The social implications of ageing in America and Australia are inherently related to the values of our society. Apart from an occasional, unusual planner and practitioner, what we create and how we utilize what we create, will depend on how we value ageing and the elderly retired person (now) and in the years ahead.
>
> The true cost of the institutions for our ageing humanity will be decided by our ethical values.

So whichever option is truly more or less costly depends on what has to be sacrificed not only in the way of material resources but also in even more valuable possessions such as humaness, independence, dignity and self worth to obtain the potential gains or benefits. For the cost, even if carefully measured in dollar terms, is a useful, but eventually imperfect indicator of these true costs of accommodating the dependency of the growing number of very elderly people.

However, I remain optimisic that necessity will drive us as a society towards inventing new ways of coping with the rising costs. For in a revised form of the old maxim, "necessity is the mother of invention" and (David Rockefeller has added) if this is not so, "discontent is the father of progress".

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AGEING AND DEPENDENCY - MYTHS AND REALITY

by Peter Sinnett

When we speak of issues which are of concern to the elderly in our community, there is a tendency to simplify matters by creating a stereotype of the elderly person, which is in essence negative, evoking an image of physical and intellectual disability and dependency. Such an image is both misleading and unfortunate: misleading in that the image has no general application; unfortunate in that the image often engenders a paternalistic approach to aged persons issues, stressing separateness, and encouraging an element of social rejection.

It is important to remember that the age of retirement is arbitrary and is determined by political and socio-economic expediency and is not based on any sound biological evidence of physical and intellectual decline. Indeed the recent history of the American Presidency and the Soviet Politbureau would tend to support the reverse proposition.

People in the post retirement age group cannot be reduced to a single stereotype. The aspirations as well as the welfare requirements, including accommodation, of a person aged 65 years will differ significantly from those of a person aged 95 years. Between the ages of 65 and 74 years, adequate pensions and other income maintenance schemes are the primary requirements together with community programs aimed at lessening the effect of displacement from the workforce and social isolation. Between the ages of 75 and 84 years there is an increasing requirement for community services in the form of home maintenance programs, home nursing services, meals on wheels, day hospital facilities and holiday accommodation to assist the elderly person as well as her supporting relatives. This age group has an increasing need for purpose built accommodation and for institutional care. After the age of 85 years, although there is a continuing demand for community based services, there is an increasing requirement for nursing home accommodation and for other forms of institutional care.

Quite clearly, effective aged persons care involves the provision of an integrated range of health and welfare options including accommodation. Australians of all ages place a high priority on home ownership and few elderly Australians would voluntarily exchange their homes for rental accommodation or for institutional living. For most Australians the home is

seen as providing the physical and emotional setting against which we live our lives. It is the place from which we set out in the morning to meet the tasks and challenges of the day and to which we return in the evening for rest and companionship. It may be made of bark, or canvas, or corrugated iron, or of brick or stone. It may be large or it may be small. It may be located in the urban crush of the inner city or in the endless sprawl of the suburbs, in a rural hamlet or on an isolated farm. But whatever its construction, whatever its size, whatever its location, a home must provide for the psychological aspirations, social values and biological needs of the individual. It is our responsibility as a society to see that the elderly in our community are given the greatest possible opportunity of achieving their personal aspirations,whatever they may be.

RISK FACTORS FOR DEPENDENCY

For each of us, whether young or old, the choice of accommodation becomes a compromise between our aspirations and our liabilities. In the case of the elderly, diminished economic circumstances, loss of family and social isolation, intellectual and physical disability are the major factors which restrict their freedom of choice in relation to accommodation.

(a) Social Change and Isolation

In Australia as in other industrial urban societies the development of technology by minimising the requirement for physical exertion, skill and experience, has progressively created greater opportunities for employment for younger and less experienced individuals. At the same time the associated development of consumerism has demanded that each individual should earn an income. Thus the individual has replaced the family group as the basic economic unit of society and the family's capacity to care for its members, including the elderly, has diminished. In spite of these limitations 12 per cent of the elderly living in the community live in the homes of their children and family[1].

The capacity of an elderly couple to remain self reliant without the support of their family is limited by the significant differences in life expectancy between the two sexes. At birth women have a life expectancy eight years greater than their male counterparts and even at age 80 there is still a difference of 1.6 years. In consequence women can anticipate a

prolonged period of widowhood and isolation towards the end of their lives. In the age group 74-85 years, 39.5 per cent of males and 78.8 per cent of females have no spouse and in the age group 85 years and over the percentage of persons without a partner has risen to 60.3 per cent for males and 92.3 per cent in the case of females[2].

The effect of the social isolation which results from the death of a spouse is perhaps reflected in the percentages of the two sexes seeking institutional placement. 8.1 per cent of males and 17.2 per cent of females over the age of 75 years reside in institutions.

(b) Economic Factors

Growth in the Australian economy has been extremely modest over recent years and difficulty has been experienced in providing employment opportunities for an expanding workforce. Faced with competition from school leavers and younger women, the older worker has had difficulty securing employment and has been encouraged to seek early retirement.

In 1966, 57.3 per cent of males over the age of 55 years were in the labour force, by 1981 the level of participation of this group had fallen to 40.1 per cent, a drop of 17.2 percentage points. Similar, but less marked reductions have occurred in employment of older women. By contrast, over the same period there has been an increase in the order of 50 per cent in the participation rate in the workforce of women aged between 25 and 44 years[2].

Although 42 per cent of all employees are members of superannuation schemes, such schemes provide the principal source of income for only a small percentage, in the order of 5 per cent of persons in the post retirement age group. Meanwhile 78.6 per cent of the aged population are dependent on government pensions for their principal source of income[2]. As single government pensions are currently set at less than 25 per cent of the average weekly male wage, retirement in the majority of cases involves a significant loss of economic security and the elderly find themselves financially and socially disadvantaged in relation to other age groups in the community. This is especially so if at the time of retirement the elderly person is living in privately rented accommodation and has not achieved the security of home ownership. Further, the relative economic dependency of the older Australian restricts her consumer capacity and limits her contribution to

domestic economic growth. The interests of social equity would be better served if the present government pension scheme was replaced by a national, contributory superannuation scheme.

(c) Disease and Disability

It appears that the socio-economic status of a society determines significant aspects of its life style including nutritional intake, physical activity, standards of housing and hygiene and the level of health and welfare services. In turn these factors influence the patterns of biological ageing and as a result determine the disease prevalence and disability level of the population[3].

Thus we find that the lifestyle of wealthy communities such as our own is characterised by high levels of nutritional intake, low levels of physical activity, satisfactory standards of housing and hygiene, and adequate health and welfare services. Biological ageing in such groups is characterised by progressive obesity, hyperlipaemia, hypertension and glucose intolerance. In consequence disease prevalence is dominated by high levels of degenerative vascular disease and low levels of infective illness.

Indeed increasing national affluence is associated with a progressive increase in degenerative disease and disability. Figure 1 (page 45) compares per capita Gross National Product with death rates due to ischaemic heart disease. As can be seen from this figure, wealthy nations pay a penalty for their affluence by having an increased prevalence of degenerative vascular disease in old age which manifests as stroke, coronary artery disease, aortic aneurysm and peripheral vascular disease. These diseases which are environmentally determined and thus potentially preventable are a major cause of the high levels of disability and dependency among the elderly in our community. There is every indication that they are not inevitable consequences of the ageing process since the level of these conditions varies markedly between communities with identical life expectancies.

It is this association between age and disability which is a major cause for our concern in relation to the care of the elderly. As is illustrated in Figure 2 (page 46), disability increases progressively with age. For while 9 per cent of the total population have some limiting disability this figure increases to 27 per cent of the population between the age of 65-74 years and

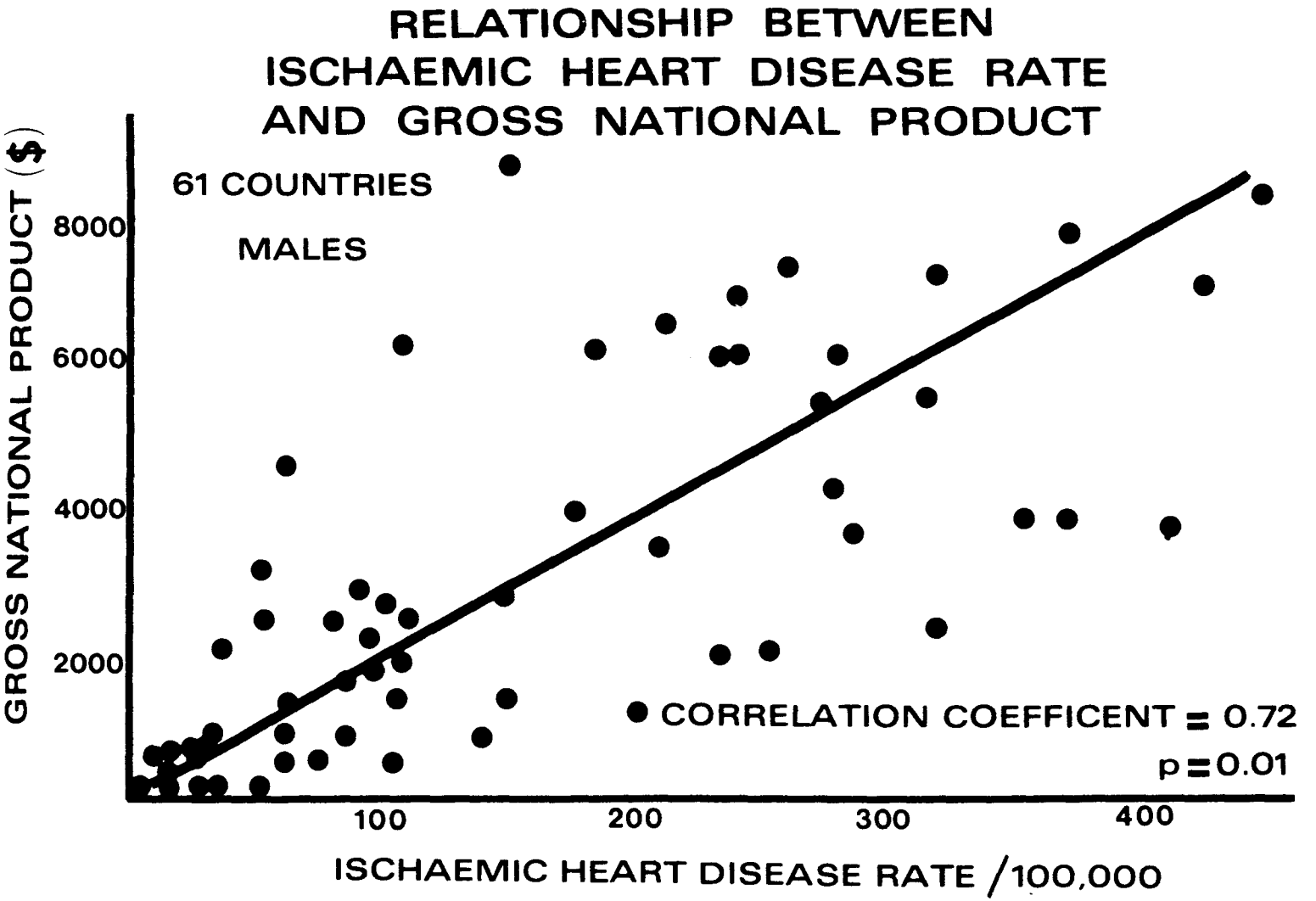
RELATIONSHIP BETWEEN
ISCHAEMIC HEART DISEASE RATE
AND GROSS NATIONAL PRODUCT
61 COUNTRIES
MALES
GROSS NATIONAL PRODUCT ($)
8000
6000
4000
2000
CORRELATION COEFFICENT = 0.72
p = 0.01
100
200
300
400
ISCHAEMIC HEART DISEASE RATE /100,000

FIGURE 1

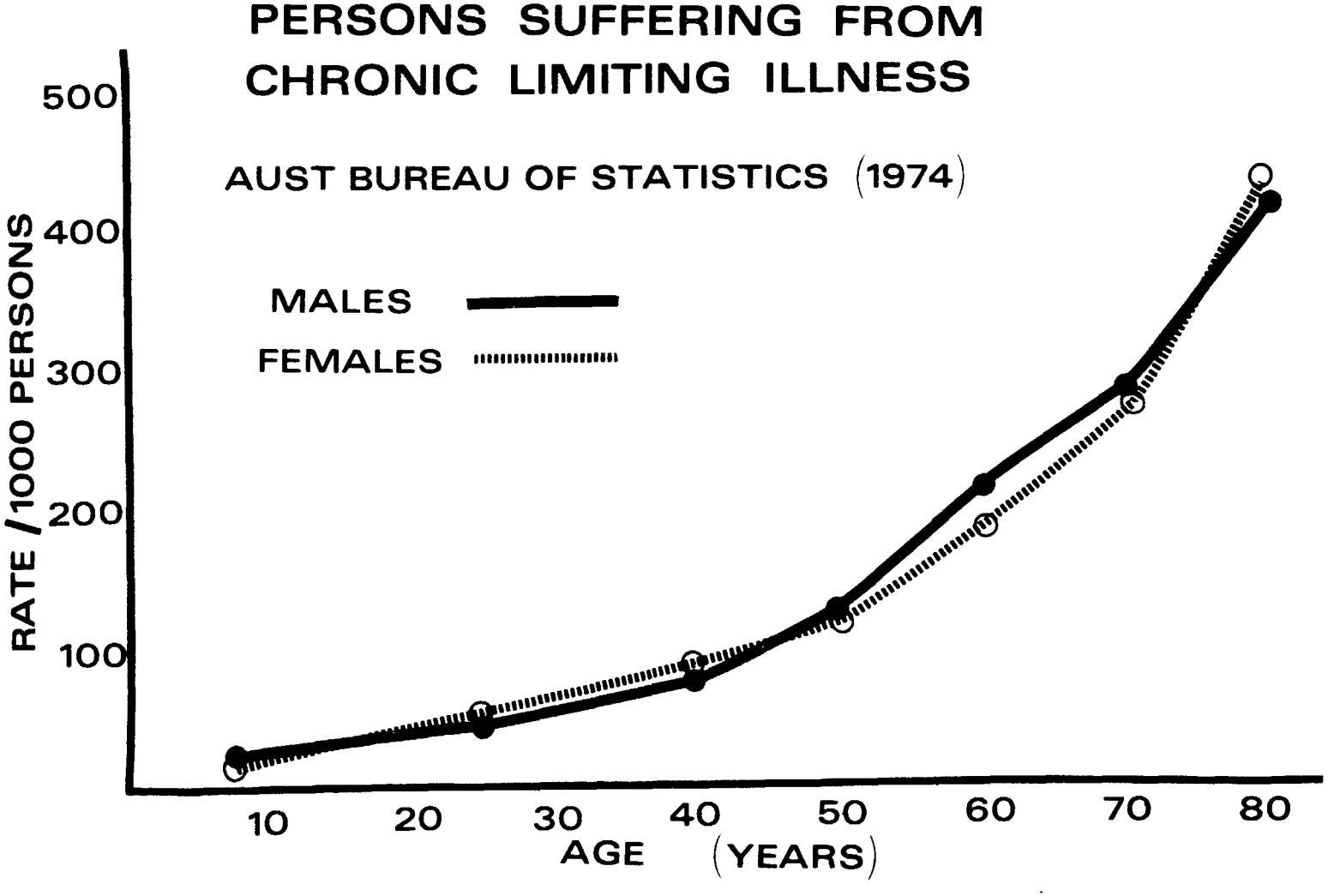
PERSONS SUFFERING FROM
CHRONIC LIMITING ILLNESS
AUST BUREAU OF STATISTICS (1974)
MALES
FEMALES
RATE /1000 PERSONS
500
400
300
200
100
10
20
30
40
50
60
70
80
AGE (YEARS)

FIGURE 2

a staggering 42 per cent of the population over the age of 74 years.

Although this disability figure appears high, I do not believe that physical disability on its own is usually the dominant factor in forcing people to seek institutional care. Intellectual impairment is a much more significant cause for institutional placement. The prevalence of Alzheimer's disease increases with advancing age from 3 per cent in the 65-74 age group to 26 per cent over the age of 85 years. Some 40 per cent of nursing home beds in Australia are currently utilized by people suffering from moderate to severe dementia and it is hard to see how community care can represent an effective alternative for such patients. At the present time it is estimated that there are some 98,000 Australians suffering from this condition and 26,000 nursing home beds are required for their care. As a result of the anticipated increase in the aged population, it is expected that by the year 2000 there will be 184,000 cases of Alzheimer's disease in Australia and we will require 49,000 nursing home beds for their management[4].

CONSEQUENCES OF THE RISK FACTORS

How successful are the elderly in avoiding dependency in relation to accommodation? A survey entitled "Australia's Aged Population, 1982" carried out by the Australian Bureau of Statistics[2] showed that older Australians have been largely successful in maintaining themselves in the general community. As is shown in Table 1, (page 48) the survey revealed that 93.6 per cent of people over the age of 65 years lived in independent households, 2.2 per cent were residents of hostels and retirement villages, while 4.2 per cent occupied accommodation in nursing homes and hospitals.

However, far from being reassured, governments and their advisors point out that these figures indicate that 6.4 per cent of elderly Australians are institutionalised. By contrast it is claimed[5] that 4.5 per cent of elderly people in England and Wales live in institutional settings (Table 2, page 48). Such international comparisons form the basis of the assertion that our use of institutional facilities in the care of the elderly is excessive and by extension that 20-25 per cent of our nursing home admissions are inappropriate and do not require the level of care they receive.

TABLE 1 PERSONS 65 YEARS AND OVER LIVING IN HOUSEHOLDS AND INSTITUTIONS (PERCENTAGE)

ACCOMMODATION	MALES	FEMALES	TOTAL
HOUSEHOLDS	96.0%	91.8%	93.6%
AGED PERSONS HOMES	1.3%	2.9%	2.2%
NURSING HOMES	2.0%	4.3%	3.4%
HOSPITALS	0.7%	0.9%	0.8%

TABLE 2 ACCOMMODATION OF PEOPLE AGED 65 AND OVER AUSTRALIA vs ENGLAND AND WALES (PERCENTAGE)

ACCOMMODATION	AUSTRALIA	ENGLAND & WALES
HOUSEHOLDS	93.6%	95.5%
AGED PERSONS HOMES	2.2%	1.7%
NURSING HOMES & HOSPITALS	4.2%	2.8%

Professor Brocklehurst[5], the British geriatrician, has commented on the English figures in the following terms.

> "It is interesting that the figure of 4.5 per cent is lower than that in other advanced societies". He continues, "there is no doubt at all that a proportion of younger members of the population in the United Kingdom are suffering almost intolerable stresses, mental and physical, in trying to cope with aged, disabled relatives, especially those who are mentally disordered. A demented old woman who hardly realises what is night and what is day, who turns on gas taps and forgets about them, who is likely to wander out into the streets in the day time and get lost, or into her grand-children's bedrooms at night and frighten them, may well be more than any individual person should have to try and cope with for months or years on end. The stress which may be engendered in this situation may indeed lead to breakdown involving not only the chief carer of the mentally disordered old lady but of the whole family and indeed of the marriage. In view of the extent of dementia it may be argued that the figure of 4.5 per cent institutionalised old people in Great Britain signifies greater hardship in this way than is apparent in other countries".

Similar concern regarding the level of use of institutional and hospital facilities by Australians has been expressed by Ford in his book The Elderly Australian[6]. He has pointed out that by international standards Australia has a high provision of hospital and nursing home beds. He has cited figures from 9 industrialized countries, Australia, Canada, Finland, France, Germany, New Zealand, Sweden, United Kingdom and the United States of America. However, when Ford's data on hospital and nursing home provision were analysed along with United Nations data on other economic and social variables from these countries, it was found that two variables, the Gross National Product and the percentage of the population living in urban areas, between them accounted almost entirely for the differences observed between countries in the level of hospital and nursing home provision. Indeed multiple regression analysis showed that these two variables, percentage of the population living in urban areas and Gross National Product, gave a correlation of 0.91 with hospital and nursing home provision in these countries according to the equation:

Hospital and Nursing Home Beds/1000 of the population

$$= 1.75 \times 10^{-1} \times \text{percent urban population}$$

$$+ 5.54 \times 10^{-4} \times \text{per capita GNP}$$

$$- 11.54$$

Thus the level of provision of institutional care in Australia may not be excessive by international standards given our level of affluence and our degree of urbanization.

In spite of the many problems faced by the elderly as a result of poor economic circumstances and social isolation as well as from high levels of physical and intellectual disability 94 per cent of the aged population continue to live in our community. It seems to me that if the government is anxious to reduce the level of institutional care provided for Australians, rather than seeking to block inappropriate admissions to nursing homes they would be well advised to examine the extent to which inadequate community and hospital based geriatric services are responsible. Large waiting lists for nursing home admission reflect anxiety on the part of the elderly and their relatives and a lack of confidence in the capacity of the existing health and welfare system to cope with a crisis if and when one should arise. To avoid being left without support at a time of crisis, many elderly people are persuaded to prematurely sacrifice their independence for the security offered by institutions which provide continuity of care. Improved services rather than increased control is surely the path to the future.

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