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Social Welfare Research Centre
THE UNIVERSITY OF NEW SOUTH WALES

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CONTENTS

EDITOR's NOTE

In March 1982, as a contribution to Senior Citizens' Week, the University of New South Wales sponsored an open symposium under the title "Age Care - Whose Responsibility?". The symposium was attended by approximately 200 people and the papers presented that evening were both informative and provocative. Considerable interest was generated and the speakers have since received many requests for copies of the papers. All four speakers have strong links with the Social Welfare Research Centre, and thus it seemed appropriate for the Centre to put the proceedings of that evening between covers as a contribution to current debates. The papers are not definitive statements about research findings, but rather reflect interests and concerns of the authors, and they highlight a small part of contemporary debates in social gerontology. As four papers given by four individuals there was, of course, no attempt to develop a unified theme.

This is evident, for example, in the way in which the political dimensions of public allocations are discussed. The opening paper makes the point that if ageing is seen as a problem, it is a political problem, first and foremost, and we have not yet understood how to legitimize the claims made by elderly people and find a political resolution of allocative mechanisms. The second paper points out that allocations are the result of partisan political debate and as such are subject to uncertainty, which can breed fear among aged people whose options are limited. Jamrozik suggests as a possible solution the establishment of an Income Maintenance Commission which would operate outside party political boundaries. In the third paper, Peter Sinnett goes a step further and argues strongly for the depoliticization of provisions in health and welfare. He argues that the strongest groups, the most articulate and those able to express their interests win in the political stakes, at the expense of the most

disadvantaged and also at the expense of equitable co-ordinated services. What we need, says Sinnett, is moral leadership, not political leadership.

Ian Webster's paper examines the creation of dependency, and his inverse law of need again highlights the political dimension of resource allocation. The "law" states that (a) for the individual, access to services decreases with increasing needs (unmet need is compounded), (b) for communities, the number of aged persons in need is inversely proportional to services provided.

The four papers illustrate some of the issues of concern to those working in service provision for elderly people. Social gerontology in Australia is not a well established discipline, and only now are we beginning to see the development of a workable data base. This data base must be blended with theory about social allocation, for data without theory is not particularly informative. These symposium papers demonstrate some of the interests in ageing which have been developed in the University.

AGEING IN AUSTRALIA : OVERVIEW AND SOCIAL POLICY

by Adam Graycar

Between July 1, 1980 and June 30, 1981, 111,220 Australians turned 65 - that is 305 per day. Approximately 73,000 people over 65 died in the same period, that is 200 per day. Thus our "aged" population increased by around 38,000 in the year or by 105 per day. When translated into goods and services and social facilities and supports, this warrants careful policy attention. Elderly people require a wide range of supports, especially income support, health services, housing support and social services. Public resources which are allocated are substantial, yet the range of incomes, access to services and housing situation of elderly people is probably wider than for any other population category.

While demographers argue about the extent to which the population is ageing, and about dependency ratios in years to come, the key issue is really why ageing is seen as a problem in the first place. In the second place, the question of for whom is it a problem must be raised; and third, what interventions are appropriate to deal with the situation.

Ageing is seen as a problem because a situation of dependency can be identified. In earlier times when life expectancy was lower and the proportion of older people smaller, it was regarded as quite an achievement to have survived to old age, and status and prestige were accordingly granted. To-day, with one in ten over sixty five and the prospect of one in seven over sixty five within two generations, prestige is diminished and novelty value has disappeared. The older person's reputation as a repository of knowledge and fount of wisdom has been eroded by modern education and technology. The Henderson Report found that before housing costs were taken into account, almost one quarter of elderly income units were "very poor". (The high rate of home ownership among elderly people reduces this proportion to about 8%, but this still represents many tens of thousands of people falling below Henderson's very stringent line).

About 65% of those over 65 are under 75, that is most elderly people are of an age where people are usually physically healthy and mentally alert. Their main problems relate to adjusting to retirement, and in most cases the associated income reduction. Income maintenance and preventive health

services are of great importance. 35% of people over 65 are over 75, and thus of an age where most people need more than average levels of support from the community. In addition to economic and social dependencies, physical limitations and disabilities become part of the lives of many people.

Ageing therefore can be seen as a problem if transitional periods are used as a means of creating, for elderly people, and for the society they live in, a situation of exclusion from the mainstream of life. To maintain high rates of inclusion requires a substantial public intervention, and of course there is a price to be paid. If we turn to the second question, for whom is ageing a problem, we can identify three parties whose situations are affected. This is not to say that ageing actually is a problem for all concerned. First of all there are the elderly people who are excluded from the mainstream of life; second there are the relatives who may find themselves in time consuming and expense producing caring arrangements; third there are taxpayers and politicians who maintain that elderly people cost too much.

Our third question, what interventions are appropriate to deal with the situation, is primarily a political question. There has been no shortage of political controversy lately about the degree to which government should provide support to elderly people. Arguments about whether age pensions should be provided on a universal basis, whether elderly people should receive health care and housing support at less than market rates are perpetually in the political arena. Age pensions, for example, are paid to women over 60 and men over 65 - almost 1.4 million people (including 30,000 who receive wife's allowance). This is about three quarters of the population in the eligible age groups. The cash cost is around $4.5 billion per annum - slightly under half of the social security budget and about 11% of the whole of the Commonwealth Government's budget. In addition there are expenditures on social, housing and health services.

As the rate of economic growth slows down, competition for resources becomes more fierce and the legitimacy of the "non productive" sector is increasingly questioned. Accepted and potential interventions come under greater scrutiny and the politics of backlash is evident amidst arguments about "responsible government spending", "excessive taxation", "system overload", "family responsibility" and so on. One long running argument is to suggest that the government is replacing the family as a primary care agent. To rectify this situation and to save public funds, one solution offered is a

diminution of publc services and a thrusting upon the family of greater responsibility for a primary caring function. It can be argued that many of the "problems" associated with ageing are largely political.

Defining what we mean by "old age" or "aged people" usually involves drawing an arbitrary chronological line. The first social scientist to publish a comprehensive study of aged persons in Australia, (Bertram Hutchinson) did so as recently as 1954, and in that study he developed a working definition which went like this :

> "old age begins at the point in an individual's life when he ceases to perform all those duties, and enjoy all those rights, which were his during mature adulthood, when he begins to take over a new system of rights and duties. There is no particular year at which this process begins for all individuals, for its onset will vary quite considerably according to the family setting of each person".

From a policy or planning perspective this makes for a fairly amorphous target, and any specification of targets involves making a judgement on who is to be included and who is to be excluded.

Social policy is about interventionist activities which attempt to alter life chances. It is about a theory of benefits and their distribution, and in determining the distribution or redistribution of our social resources a conflict situation develops, and with it arguments about the relative responsibilities of "the state" "the taxpayer" "the family" "individuals" as if they were all discrete categories rather than integrated entities.

The basic social policy issues of how targets are set, of how strategies are planned, of how resources are allocated and of how results are assessed are primarily questions of values. Rarely does a (Federal) parliamentary sitting day go by without some Members telling us that we in Australia can not afford our welfare bill - that the taxpayer is being bled dry by people who cannot or will not provide for themselves and who thus have become dependent on the state. Yet dependency is not something that people seek out - people do not choose to become dependent - rather dependency is socially structured and created, and the social consequence of ageing is cumulative exclusion of a significant number of people from income, jobs and meaningful roles in society.

We must note however that physiological and psychological changes do not occur consistently in the aged population, but as they do occur, they are sequential, and irreversible. The dependencies associated with ageing are chronic rather than transitional, and it is the way in which our socio-economic and socio-medical system affect these dependencies which tells us how effective our social policy is.

Through the Departments of Social Security, Health, Veterans Affairs, and Housing and Construction the Commonwealth Government allocates somewhere between $5.8 billion and $7.3 billion per annum for services for elderly people. This is between 15% and 18% of Commonwealth budget outlays. Now, some critics might argue that elderly people who constitute 9.6% of our population, yet receive 15 - 18% of Commonwealth budget outlays, are getting more than their fair share. Any analysis of the data which illustrates the mantle of disadvantage which envelopes elderly people, in particular elderly women, will show that this is not so. But this is the very crux of social policy - planned intervention to allocate and redistribute resources in society. A political battle of competing interests - against a backdrop of social values, stated and unstated goals, and specific resources,determines our social policy outputs.

After a White House Conference on Ageing in the United States ten years ago, Richard Nixon announced a new national policy towards ageing and the aged. He specified four major goals :

1. assuring an adequate income
2. assuring appropriate living arrangements
3. assuring independence and dignity
4. assuring institutional responsiveness and a new attitude towards ageing

Having these goals spelt out does not guarantee political action. It does, however, contrast with the situation in Australia where we have never had clearly articulated national policy goals, nor any overall national policy on ageing. The Americans have legislation in the form of an Older Americans Act which attempts to deal comprehensively with the elderly population. The Act, passed in 1965,was initially designed to stimulate the development of needed services for the elderly. Massive co-ordination problems have since emerged with eighty federal programs providing or financing services. These involve twenty three different federal agencies in seventeen departments each having

separate authorizations and appropriations. The U.S.A. of course, is not alone in having co-ordination headaches, as Peter Sinnett's comments below indicate.

Despite our lack of national policy goals, we do have a plethora of services delivered by quite a range of instrumentalities.

- Income maintenance services are designed to ensure a basic regular income. In the public sector there are age pensions, fringe benefits, and various allowances and concessions. In the private sector there are private pension schemes and also certain concessions.

- Health services are geared, not only to elderly people, but to the whole population. Elderly people, however, are greater users of medical services than all others except children under 5, and they are the greatest users of hospital services. Health services cover a wide spectrum of government provided services, services provided by non-profit bodies, services provided on a commercial basis; and the debates about financing health services have filled our Hansards and our newspapers for much of the past decade with no sign of easing up.

- Accommodation services have been developed to provide both residential institutional and self-contained accommodation. Government funds provide self-contained accommodation directly through Housing Commissions, and residential care facilities in certain nursing homes; government subsidises non-government welfare agencies in their provision of self-contained units, nursing home beds and hostel beds; about 8% of elderly people rent in the private market, and for developers there seems to be a boom in building for the affluent elderly. A significant number of elderly people (see below, p. 10) live with relatives.

- Domiciliary services are provided to support people who wish to live in their own homes. If successful, the services will help keep people in a familiar environment, keep them out of more expensive institutional care and improve their quality of life. Services such as home help services, home nursing services and meals on wheels are provided under a wide variety of auspices - sometimes by government, sometimes by non-government non-profit welfare agencies, sometimes by commercial enterprises and sometimes by volunteers, neighbours, friends and family.

I have outlined these services, not so we can now assess them in terms of adequacy, equity, or efficiency, but rather to illustrate that provision cuts right across our social institutions and right across our society. In the rough description just given we can note four major systems which deliver services to elderly people.

First, there is the statutory system. This comprises government provided and operated services. They may be costly, but in their favour is the argument that they can provide on a universal basis - they are publicly supported by the majority of the population who are not in need, so that a minority of the population, who are in need, can receive services.

Second, there is the commercial system. There services are bought and sold at a price that the market will bear. Apart from most housing, there are few pure commercial services - most medical and hospital services are subsidized, though at the top end, private nursing home and private nursing services have a commercial market.

Third, there is the non-government welfare sector - sometimes called the voluntary sector. This is a large and complex web of organizations varying in size, scope, activity and interest. It is too diffuse to be regarded as a unified sector. Our research has identified 37,000 NGWOs in Australia, of which 4,000 deal with aged people. There are complex funding and service arrangements between NGWOs and government.

Fourth, there is the informal system of social care. The help and support that family, friends and neighbours give one another is so often just taken for granted that it seldom enters discussions of service provision. We have no way of estimating the extent of informal help, but we are presently conducting studies on family care of elderly people and on volunteer activity. Informal supports include provision of care in the home of dependent and disabled people, young and old; transfers of material resources within families; provision of advice and psychological support in coping wih difficult situations.

These four systems, the statutory, the commercial, the non-government agencies, and the informal, intervene to provide supports, primarily to limit dependency. There are, of course, important value questions about where the responsibility lies. Should individuals be responsible for their own health and welfare?

How far must a situation deteriorate before government should step in? Should the state be primarily responsible for all risks? Should families care for their dependent members? What if elderly people have no family, or if their family does not have the resources to play the caring role?

Responsibility is a matter of balance, and can be discussed only in the light of the characteristics of the population in question and the nature and extent of their dependency.

If we just look at the Australian population for a moment we find that about 1.4 million people are aged 65 or more - 9.6% of the population. 50 years ago the proportion was 6.5% - in 50 years time it will be around 13.5% - about the rate which prevails in most of Europe to-day. Over this century life expectancy at birth has increased from 47 to 70 for males and from 51 to 77 for females. Elderly people have less income than people in the population at large. 72% of elderly men earn less than half average weekly earnings, 92% of elderly women earn less than half A.W.E. For most (82% of those over 70) the main source of income is the age pension. One quarter of their income goes on food, 15% on transport and 12% on housing. Elderly people however travel less, make fewer daily journeys and one could argue that this is a form of exclusion from many activities. 70% of elderly people own their own homes and this proportion is declining. In the past 5 years the proportion renting in the private market has doubled - from 4% to 8%. On the health front, 77% of elderly people report one chronic condition, 50% report two. A very small number are bedridden, but 6% are housebound and a further 10% need assistance in getting out of the house. There has been a dramatic shift in labour force participation rates and in the past 15 years the percentage of males aged 65 and over in the labour force has declined from 23% to 11% - this applies to both full time and part time participation rates, and it is important when one considers the important role that part time work can play in the lives of elderly people.

As noted earlier, 35% of those over 65 are aged 75 or more. At the turn of the century the proportion was 25%. Most old people are women, of those over 75, 60% are women, 40% are men - as ages go up so does the proportion of women. Most men have a spouse. Most women do not. 65% of men over 70 have a spouse, but only 27% of women over 70 do. Widowhood and living alone are of greater significance for the more numerous female population.

Around 89% of males and around 82% of females aged 75 or more in Sydney live in private dwellings. The remainder live in nursing homes, homes for the aged, or hospitals. Of those in private dwellings living arrangements of males and females differ dramatically.

Percentage distribution, persons aged 75+
in private dwellings in Sydney (approximates)

	living alone	living with spouse	living with relatives
Males	20	60	20
Females	42	16	42

Slightly more people over 75 live in institutional settings than with relatives. Before jumping to conclusions that families no longer care for their elderly it is important to note that families often simply do not have the capacity to provide adequate care.

Care is needed if elderly people find themselves in a state of dependency. As I said before, dependencies of ageing are chronic rather than transitional and in our society they are seldom legitimized.

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

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

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

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

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

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

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

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

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

AGEING AND INCOME SUPPORT

by Adam Jamrozik

In this paper, I will consider four aspects of income support for the aged: the significance of income in retirement and old age; the allocation of funds by the Commonwealth for the assistance to the aged; the issue of equity in the allocations; and the possible options for change in the present system of allocations.

Conventionally, we speak of income as so many dollars a week or a year. Such perception of income is rather truncated, for weekly income accounts for only one aspect of income, although for some people this may be the only or the most important aspect. Income consists of a flow of resources, a stock of assets, and the access to goods and services. For this reason, weekly pension as a measure of income is not the only dimension of income support for the aged any more than weekly earnings are the only dimension of income a person derives from employment.

These three aspects of income are more important for the aged than for other age groups because the aged have reduced options for finding alternative sources of income; for example, they cannot easily find a job, and even if they physically could do this they are not expected or allowed to do it. In considering income support for the aged it is therefore necessary to include the three aspects of income. Furthermore, because of the reduced options available to the aged, the issue of income for the aged has to be seen in time dimension so as to identify the antecedents of the conditions experienced by the aged. For in our society the notion of preparing oneself for retirement has now been imprinted in people's minds. However, the question whether everyone is capable of doing so, especially in terms of financial security, receives less attention.

Income for people who can no longer work in paid employment, that is no longer "produce", is significant in that their social role is essentially reduced to one dimension, that of consumers. The possession of means to consume goods and services determines the kind of life the aged person will have, other aspects such as health being equal. The consumption pattern of the aged is somewhat different from that of other age groups. They may consume less food but more health services and pharmaceutical products. They use public transport. Those who have the means become consumers of

profit-making ventures in the tourist industry, retirement villages, private nursing homes. Now, it seems, the aged have become an attractive proposition for investment industry (not to mention the tax avoidance industry). Last week the Sydney Morning Herald ran a five-day series of articles as a "comprehensive guide for people receiving pensions or who are about to retire". On the same pages were 24 advertisements: five advertised accommodation for purchase or rent in retirement villages; the remaining 19 advertised investment opportunities, usually framed in the mode of "how to minimise tax and keep the pensions and concessions".

I will return to some of these issues later. Now, I want to consider some specific issues of income support. Adam Graycar has identified four sources of support; statutory, commercial, non-government welfare organisations, and informal. These sources of support are not discrete mutually exclusive categories: some people may have access to all four, others may be reduced to two or only one. The important thing to note is that the state through the instrument of government can provide income support - in all its three dimensions - not only directly through statutory provisions but it can facilitate or directly finance provisions through any or all of the other three sources. The government does this in many ways: it provides the concessions for superannuation contributions and earnings thus allowing employers and self-employed persons to count the contributions to their own or their employees' retirement income as production cost. It provides tax concessions of all kinds. It supports non-government welfare organisations by funds and by tax concessions.

Comparatively little is being done to facilitate income support for the aged through the informal source, that is through the family and kinship networks. Yet, there are numerous possibilities for provisions through that source. For example, it would cost as much, or often less, to build a "granny flat" as to build a comparable flat in a "home for the aged", and the cost of nursing at home may be in some cases cheaper than nursing in a formal nursing home.

It is true that the aged find it difficult, and sometimes impossible, to live with their families. But we seem to accept this proposition with an attitude akin to fatalism. Possibilities here could be considered as alternatives. Some answers would be found by giving more attention to the conditions of living experienced by contemporary families rather than focussing attention on the aged

in isolation from the rest of society. It would not be necessary to go as far as the government of Singapore is proposing to do - to make it compulsory for families to take care of their aged parents - but options could be facilitated if people wanted to take care of their parents personally.

Time does not allow me to explore all possible options in the provision of income support for the aged in this country. As the statutory constitutional responsibility for income support for the aged in Australia is that of the Commonwealth Government, I will curtail my remarks mainly to that sector.

Much has been said and written about the "rising" welfare bill. An editorial in a daily newspaper described it recently as a "herculean problem" which the government would ultimately have to face in order to avoid bankruptcy. How big, then, is this problem? How much is much, or too much, on income maintenance?

First, income maintenance allocations made by governments are not, strictly speaking in economic terms, a cost but a transfer, a redistribution. Second, they are an income transfer, not a wealth transfer. Third, income maintenance transfers perform a vital function in modern economies of maintaining and regulating cash flow and thus enhancing the flow of goods and services; they are an important part of tertiary sector, or rather quaternary sector, of the economy, along with banks and other financial institutions. The recipients of income maintenance rarely keep the money; they act as "middlemen" of financial transactions, holding the money for a few days and returning it to the economy via grocers, butchers, supermarkets, landlords, and energy suppliers. It is a recycling process of money supply not a permanent transfer of wealth. How important this process is has been well demonstrated by the experience of the Scandinavian countries where income maintenance transfers are among the highest in the world and the economies among the most stable and providing high standard of living.

The fear about the "rising welfare bill" is not fear about cost but fear about re-distribution. Ironically, most of those who express those fears are usually the biggest recipients of income transfers, although they do not see themselves - and are not usually seen - as such. For income maintenance or welfare, does not mean only pensions and benefits; it includes tax rates and tax concessions, allowances, subsidies, and legal (and not-so-legal but

condoned) tax avoidance schemes as well as other artifacts such as "paper" partnerships and family trusts. The attack on welfare allocations is sometimes due to genuine belief in the validity and truthfulness of various authoritative statements but more often than not it is a protective stance; an effort to maintain a narrow perspective on welfare as a kind of necessary public charity that has to be dispensed to the unfortunate "needy", while at the same time maintaining one's privileged position and benefiting from welfare allocations dispensed under another name.

There are limits, of course, in the extent to which re-distribution of income maintenance allocations can be carried out; economic limits as well as social and political limits. It needs to be pointed out, however, that Australia is not in the forefront among the industrially developed countries in that respect, at least not in the level of allocations in the visible part of the transfer system conventionally perceived as social welfare. The fiscal and occupational parts of the welfare system may be another matter.

There is something of a myth about the "rising welfare bill" in the Commonwealth sphere. Taking the last decade as a period for comparison, most rises in income maintenance allocations had occurred in the first half of the 1970's. The reason for this adjustment was not only the political change of 1972 but also the continuous under-allocation to social security in the 1950's and 1960's. True, allocations for income maintenance since then have risen but not in relation to the overall levels of Commonwealth allocations, or in relation to the Gross Domestic Product. Therefore, income maintenance allocations have to be seen in relation to those areas; when they are quoted in isolation they are usually misunderstood or, deliberately or not, misrepresented.

Let me present some examples which I have taken from the Commonwealth Budget Papers for 1981-82. First, total Commonwealth Budget outlays in 1971-72 amounted to 24.2 per cent of the Gross Domestic Product. They rose to 29.1 per cent in 1974-75 and to 30 per cent in 1975-76; since then they have gradually come down to 27.9 per cent in 1980-81 (Table 1).

Second, allocation to social security and welfare in 1971-72 amounted to 4.3 per cent of the GDP and 17.7 per cent of total Budget outlay. The allocation rose to 8.2 per cent and 27.8 per cent respectively, in 1977-78; and has since then fallen to 7.6 per cent and 27.3 per cent, respectively, in 1980-81.

Some of the increase is only apparent because in the early part of the 1970's there were taxation concessions for taxpayers' children which have since been removed.

Third, with regard to age pensions it is true that the numbers of persons receiving age pensions have been rising. From 1972 to 1981 the numbers had risen from 840,207 to 1,376,671 (both figures include wives' pensions) - a rise of 63.8 per cent, or as a proportion of total population, from 6.4 per cent to 9.3 per cent. The increase has been due partly to the gradually ageing population but more to the changes in eligibility. In 1972, 60.1 per cent of persons of pensionable age (men 65; women 60) received age pensions but in 1981 the proportion has risen to 76.6 per cent - a rise of 27.5 per cent. That proportion fell somewhat in the last three years from a peak of 78.2 per cent in 1978 (Table 2).

What is interesting is the changes in the numbers of new pensions granted each year. In 1970, 112,771 new age pensions were granted. The numbers fell down to 70,582 in 1972, rose sharply to 140,002 in 1973 and have been falling each year since then to 69,002 in 1981 - a decrease of 50.7 per cent since 1973. Also the majority of age pensioners have been women but the men-women ratio has been narrowing throughout the decade, both in the numbers receiving pensions as well as in new pensions granted each year. (Department of Social Security, Annual Report 1980-81 and Ten Year Statistical Summary 1972-1981). The significance of these trends, I think, has yet to be assessed.

In terms of Budget allocations, in 1971-72 pensions and other assistance to the aged accounted for 1.9 per cent of the GDP and 7.8 per cent of total Budget outlay; in 1980-81 the corresponding amounts were 3.1 per cent and 11.1 per cent, respectively. Again, the highest levels were in 1978-79 when the respective amounts were 3.4 per cent and 11.4 per cent. As a proportion of Social Security and Welfare allocations, assistance for the aged has fallen from 44.5 per cent in 1971-72 to 40.6 per cent in 1980-81.

The rate of increase in the numbers of persons receiving age pensions over the last decade (63.8%) has been the lowest of all categories of pensioners and beneficiaries receiving income maintenance from the Commonwealth. The reason for this has been the rise in the numbers of persons receiving unemployment benefits, invalid pensions and supporting parents benefits. The total number of people receiving Commonwealth pensions and benefits has doubled

over that period from 1,132,990 in 1972 to 2,302,926 in 1981, and this number does not include dependent children of pensioners and beneficiaries (Table 3). In 1972, 4.0 per cent of children under 16 years of age were children of pensioners and beneficiaries; in 1981 that proportion was 13.7 per cent - a rise of 243 per cent. Thus, if there is a "problem" in social security and welfare in Australia the problem appears to lie in rising dependency on public income support among people of working age, families and their children. The significance of this trend should be of greater concern than the relative position of the aged.

I do not mean to imply that the aged are enjoying a life of luxury. Far from it. There is enough evidence to show that many of them live in poverty. But the issue of income support for the aged is not so much one of the overall allocation of income and access to resources but one of inequality. As a population group the aged may be income poor but they are asset rich. There are no data on the distribution of wealth in Australia but some people have estimated that at least 40 per cent of all wealth is held by people over 60 years of age.

In relation to other categories of pensioners and beneficiaries the age pensioners have the highest rate of home ownership. In 1980-81, 60.9 per cent of age pensioners owned their homes, wholly or partly, as against 35.3 per cent of A Class widow pensioners and only 12.2 per cent of women receiving supporting parent benefits. We have no data on the ownership of other assets by the aged, but if the interest in the welfare of the aged shown by investment firms, banks, and tax consultants is of any indication the assets of some of the aged must be substantial.

It seems, then, that at present some age pensioners have few assets and have to rely almost entirely on pensions for their income while others have assets which they want to preserve and claim pensions as well. In some cases the assets come from lump sum superannuation payments. Considering the fact that the Commonwealth contributes substantially to superannuation provisions by taxation concesssions on contributions as well as earnings and payouts, a person who collects superannuation and age pension as well collects twice and to a certain extent from the same source - a practice referred to as "double dipping". The practice has been facilitated by the Commonwealth's decision in 1976 to replace the means test by an income test. The outcome was predictable, and the complaints of abuse that are now made

by some people in government are tantamount to complaints about a self-inflicted injury.

The main issue in income support for the aged is the issue of equity and fairness. This issue will become more pressing, for two reasons. On the one hand, there has been a significant increase in superannuation coverage in recent years. On the latest survey, conducted in 1979, 42 per cent of employees are now covered by superannuation, a rise of 31 per cent since a similar survey was taken in 1974. On the other hand, there has been an increase in the withdrawal from the workforce by men of 55 years and over and a substantial increase of invalid pensioners in that age group. This suggests that many people who withdraw from the workforce do so for health reasons and among them are those who do not have other sources of income than a pension. These people will in due course become age pensioners, relying entirely on pensions for their incomes.

So to achieve a degree of equity and fairness the policy on income support for the aged must take into account Commonwealth's contribution to superannuation provisions, and the two parts of the system - age pensions and superannuation - will need to be seen together as one. At present, the Commonwealth allocates funds to both and does so on principles which negate each other. Age pensions are paid on a uniform rate but superannuation is related to person's earnings. Hence the higher a person's earnings the higher the Commonwealth contribution. There are other inequities in superannuation coverage which would be too numerous and complex to mention here.

One advocated remedy is a return to means testing, on the grounds that every dollar paid by the Commonwealth to the better off people means a dollar less for the needy. The remedy is tempting but the argument seems to me to be fallacious and also difficult to sustain on many grounds.

First, the argument implies that the Government has only a limited amount of money to allocate and to only one area of allocation.

Second, in any means testing, people who know how the system works are able to "fit in" their claims into the criteria of entitlement, either by themselves or now with the assistance of expert advice. The experience with income testing is the best example of this.

Third, means testing on the basis of "need" leads to attitudes of old-fashioned charity and for this reason it is socially divisive. There is only a small step from the "needy" to the "deserving" and "undeserving", with all the moralistic judgments such a system incorporates.

Four, the more rigid, the more specific, means testing is devised the more cumbersome and administratively costly it becomes.

Finally, it is fairly evident that most people in Australia - the "average" persons - regard entitlements to government allocations as a right, not as a charity for the poor. We have to accept the fact that to-day the person or the social group who make claims on the state are not the poor people but the "average" and the well off people. This is evident in all areas of claims, whether we speak of pensions, benefits, wages, taxation, health and welfare services, or child care. The poor are left behind because they do not have the means to have their claims heard. We hear of their plight only indirectly from the people who provide personal welfare services, such as social workers, and from some journalists.

The Minister for Social Security has recently stated that :

> Recent surveys have suggested that many Australians want everyone, however well off to get social security benefits. The argument is they have paid taxes so they should get benefits. That wish and that argument are not consistent with the simultaneous demands for lower taxes. (Press Release, FC 82/1, 11.1.82)

Thus it appears that the issue of income support for the aged is political rather than economic. The dilemma for governments (or, rather, for political parties) is how to reconcile social and economic allocations with the need to stay in power (or gain power). As a result, parties in power often negate their proclaimed policy goals by political expediency aimed to achieve the support from the majority of the electorate. This means attempting to ensure the votes of those who are made to believe that the government cares for them as well as the votes of those who <u>know</u> that the government cares for <u>them</u>.

One cannot achieve at the same time the objectives of helping the poor while pursuing policies designed to safeguard or even to enhance the interests of the well off and the rich. Yet in recent years we have seen such contradictory policies. On the one hand, the Government has been re-affirming

its commitment to the "needy" while on the other hand, allocations through fiscal and taxation policies, such as concessions, incentives, and a passive attitude to the growing field of tax avoidance have contributed to the inequalities in incomes and wealth generated by the market rather than attenuating these inequities.

The inequalities in income support for the aged have been exacerbated by the ease with which income can be converted to assets and assets to income. This has made the income test rather irrelevant to the problem and it is unlikely that a modification to the income test or return to the means test will improve the situation. To come to grips with the problem a new measure of income and wealth needs to be devised that would take account of the current operations of the finance market. Unless this is done - not only in relation to pensions and benefits but also in relation to the overall distribution of income and wealth - we will have an increasingly unequal society.

Because most people expect income support in retirement as a right the inequalities would be more easily overcome or better attenuated with a policy of selectivity or positive discrimination within a system of universal provisions, rather than by a system of complete inclusion or exclusion. Provided the government allocations for income support were made within the overall system of allocations, that is, including taxation and other fiscal measures as well as superannuation, such a system would be economically more rational, socially more equitable, and politically more acceptable to the majority of the electorate.

Income support for the aged, like income support for other dependent groups, has in recent years become subject to much political debate, promises, and changes with each change in political or economic climate. Such a situation cannot but increase uncertainty and fear, particularly among the aged whose options are limited. I would venture, therefore, to suggest that perhaps we should consider the possibility of removing this particular issue from the area of party politics and placing it in the hands of a statutory body such as an Income Maintenance Commission that would operate along the lines of the Conciliation and Arbitration Commission, not necessarily with the same powers but with the power to determine feasible and appropriate rates of income support for various dependent groups and recommend the means for their implementation. I would like to think that

we, as a society, have reached the necessary social and political maturity to consider such a proposition.

TABLE 1

COMMONWEALTH BUDGET OUTLAYS 1971-72 to 1980-81
(from Budget Statements 1981-1982)

YEAR	71-72	72-73	73-74	74-75	75-76	76-77	77-78	78-79	79-80	80-81	Change Ratio 71-72 75-76	75-76 80-81	71-72 80-81
GDP ($M)	37,389	42,538	51,034	61,260	72,702	83,176	90,275	101,661	114,347	130,029	1.94	1.79	3.48
Total Budget Outlay	9,047	10,190	12,229	17,839	21,861	24,123	26,738	29,012	31,660	36,274	2.42	1.66	4.01
as % of GDP	24.2	24.0	24.0	29.1	30.0	29.0	29.6	28.5	27.7	27.9	1.23	0.93	1.15
Outlay on Soc. Security & Welfare	1,597	2,101	2,487	3,712	5,030	6,367	7,425	8,095	8,783	9,917	3.15	1.97	6.21
as % GDP	4.3	4.9	4.9	6.1	6.9	7.7	8.2	8.0	7.7	7.6	1.60	1.10	1.77
as % Budget	17.7	20.6	20.3	20.8	23.0	26.4	27.8	27.9	27.7	27.3	1.30	1.19	1.54
Assistance to the Aged	710	922	1,181	1,675	2,236	2,562	3,025	3,311	3,593	4,023	3.15	1.80	5.67
as % GDP	1.9	2.2	2.3	2.7	3.1	3.1	3.4	3.3	3.1	3.1	1.63	1.00	1.63
as % Budget	7.8	9.0	9.7	9.4	10.2	10.6	11.3	11.4	11.3	11.1	1.31	1.09	1.42
as % S.S. & W.	44.5	43.9	47.5	45.1	44.5	40.2	40.7	40.9	40.9	40.6	1.00	0.91	0.91
Assistance to Veterans & Dependents	264	301	360	475	565	659	795	855	960	1,187	2.14	2.10	4.50
as % GDP	0.7	0.7	0.7	0.8	0.8	0.8	0.9	0.8	0.8	0.9	1.14	1.13	1.29
as % Budget	2.9	3.0	2.9	2.7	2.6	2.7	3.0	2.9	3.0	3.3	0.90	1.27	1.14
as % S.S. & W.	16.5	14.3	14.5	12.8	11.2	10.4	10.7	10.6	10.9	12.0	0.68	1.07	0.73
Assistance to the Handicapped	148	197	242	337	469	581	687	793	901	1,006	3.17	2.14	6.80
as % GDP	0.4	0.5	0.5	0.6	0.6	0.7	0.8	0.8	0.8	0.8	2.25	1.33	2.00
as % Budget	1.6	1.9	2.0	1.9	2.1	2.4	2.6	2.7	2.8	2.8	1.31	1.33	1.75
as % S.S. & W.	9.3	9.4	9.7	9.1	9.3	9.1	9.3	9.8	10.3	10.1	1.00	1.09	1.09
Assistance to Widows & Single Parents	111	150	229	324	462	542	652	752	846	1,069	4.16	2.31	9.63
as % GDP	0.3	0.4	0.4	0.5	0.6	0.7	0.7	0.7	0.7	0.8	2.00	1.33	2.67
as % Budget	1.2	1.5	1.9	1.8	2.1	2.2	2.4	2.6	2.7	2.9	1.75	1.38	2.42
as % S.S. & W.	7.0	7.2	9.2	8.7	9.2	8.5	8.8	9.3	9.6	10.8	1.31	1.17	1.54
Assistance to Families	226	263	237	244	294	1,057	1,075	1,037	1,054	1,000	1.30	3.40	4.42
as % GDP	0.7	0.6	0.5	0.4	0.4	1.3	1.2	1.0	0.9	0.8	0.57	2.00	1.14
as % Budget	2.5	2.6	1.9	1.4	1.3	4.4	4.0	3.6	3.3	2.8	0.52	2.15	1.12
as % S.S. & W.	14.2	12.5	9.5	6.6	5.8	16.6	14.5	12.8	12.0	10.1	0.41	1.74	0.71
Assistance to Unemployed/Sick	72	181	119	477	776	748	951	1,076	1,121	1,256	10.78	1.62	17.44
as % GDP	0.2	0.4	0.2	0.8	1.1	0.9	1.1	1.1	1.0	1.0	5.50	0.91	5.00
as % Budget	0.8	1.8	1.0	2.7	3.5	3.1	3.6	3.7	3.5	3.5	4.38	1.00	4.38
as % S.S. & W.	4.5	8.6	4.8	12.9	15.4	11.7	12.8	13.3	12.8	12.7	3.42	0.82	2.82
Other Outlays	66	85	118	179	228	218	238	271	308	376	3.45	1.65	5.70
as % GDP	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.3	1.50	1.00	1.50
as % Budget	0.7	0.8	1.0	1.0	1.0	0.9	0.9	0.9	1.0	1.0	1.43	1.00	1.43
as % S.S. & W.	4.1	4.0	4.7	4.8	4.5	3.4	3.2	3.3	3.5	3.8	1.10	0.84	0.93

TABLE 2

SOCIAL SECURITY PENSIONERS AND BENEFICIARIES AS A PROPORTION OF THE POPULATION AND THE LABOUR FORCE, AUSTRALIA, 1971-1981
DEPARTMENT OF SOCIAL SECURITY, CANBERRA, DECEMBER 1981

	1971 %	1981 %	Change 71-81 %	Peak Year	%
Age Pensioners :					
All female age pensioners as a % of the female population aged 60 years or over	63.3	77.8	22.9	1978	79.4
All male age pensioners as a % of the male population aged 65 years and over	52.9	74.4	40.6	1978	75.9
All pensioners as a % of the population of pensionable age (M-65; F-60)	59.8	76.6	28.1	1978	78.2
Age pensioners (incl. wives pensions) as a % of the total population	6.3	9.3	47.6	1980/81	9.3
All Pensioners of Age Pension Age :					
Persons aged 70 years and over as a % of the population aged 70 years and over	75.7	99.4	31.3	1980/81	99.4
All pernsioners of age pension age as a % of the population of age pension age	64.8	87.0	34.3	1980	87.1
All Social Security Pensioners and Beneficiaries :					
Social Security pensioners as a % of total population	8.2	13.0	58.5	1981	13.0
- for 100 persons in labour force	18.7	28.8	54.0	1981	28.8
Social Security pensioners and beneficiaries as a % of total population	8.5	16.2	90.6	1981	16.2
- per 100 persons in labour force	19.5	35.8	83.6	1981	35.8
Dependent Children :					
Dependent children of Social Security pensioners and beneficiaries under 16 years of age as a % of population under 16 years	3.7	13.7	270.3	1981	13.7

Source : Department of Social Security
Social Security Pensioners and Beneficiaries as a Proportion of the Population and the Labour Force:
Australia, 1971-1981

TABLE 3 INCOME SUPPORT RECIPIENTS 1972-1981 (June 30)

Pensioners or Beneficiaries	1972		1981		Change/Ratio 1972-1981	
	N	%	N	%	N	%
Age (incl. wives pensions)	840,207	74.2	1,376,671	59.8	536,464	1.64
Invalid (incl. wives pensions)	154,994	13.7	279,043	12.1	124,049	1.80
Widows (all classes)	92,784	8.2	165,661	7.2	72,877	1.79
Supporting Parents Benefits	26,286 (1)	-	106,631	4.6	80,345	4.06
Unemployment Benefits	29,110	2.6	310,000	13.5	280,890	10.65
Sickness Benefits	11,927	1.1	44,500	1.9	32,573	3.73
Special Benefits (excl. migrants)	3,769	0.3	19,550	0.8	15,781	5.19
Special Benefits (migrants in accommodation centres)	199	0.0	870	0.0	671	4.37
					(1,143,650) (2)	
All Income Support Recipients	1,132,990	(100)	2,302,926	(100)	1,169,936	2.03

Source : Department of Social Security, Annual Report 1980-81

(1) Introduced in 1974 (used here for comparison purposes)
Not included in total for 1972

(2) Total of increase 1972-1981 including Supporting Parent Benefit since 1974

FIGURE 1

TOTAL BUDGET OUTLAYS AND SOCIAL SECURITY & WELFARE ALLOCATIONS AS % OF GROSS DOMESTIC PRODUCT. 1971-72 to 1980-81

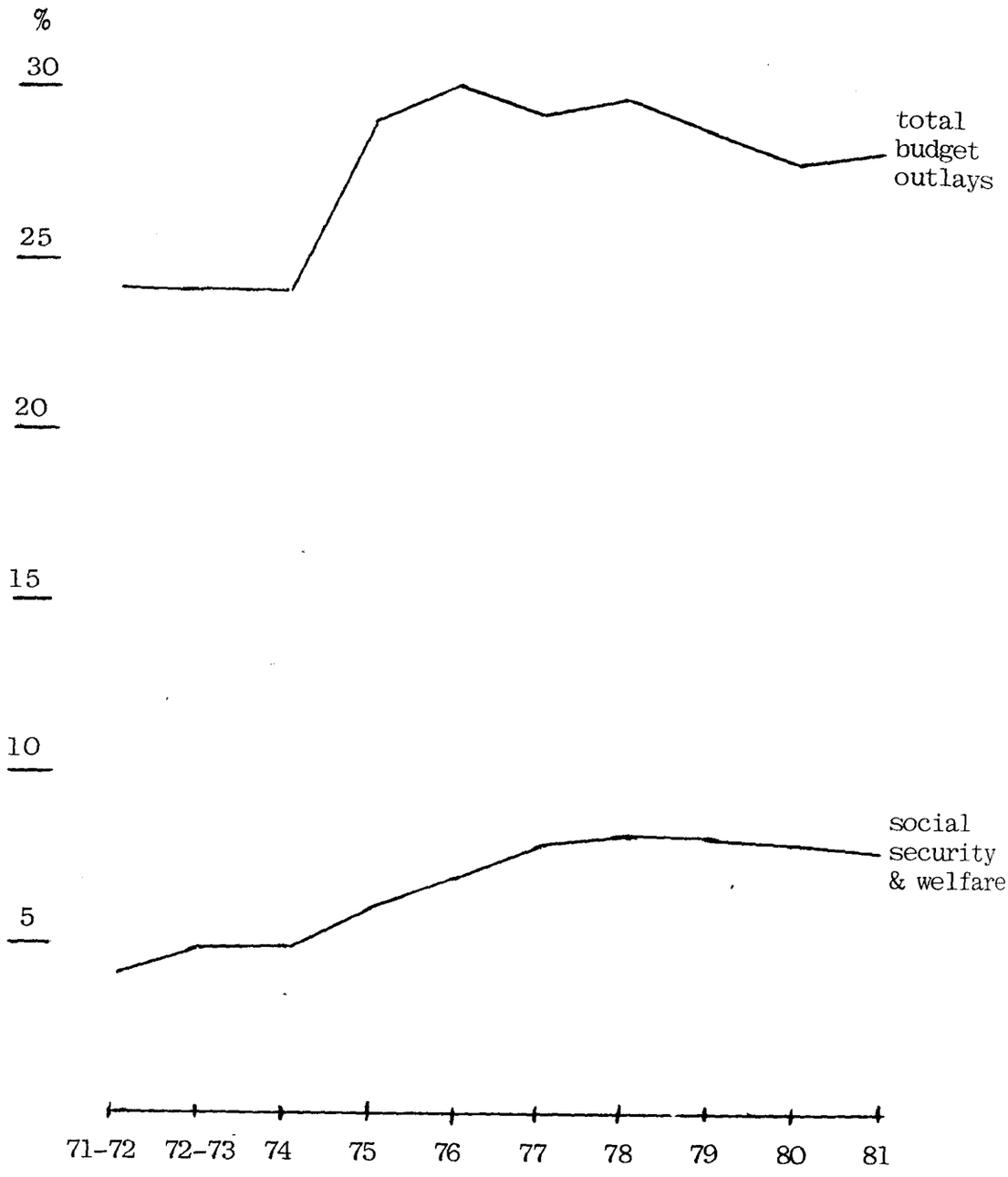


FIGURE 2

Allocations to Social Security and Welfare
as % of Total Budget Outlays 1971-72 to 1980-81

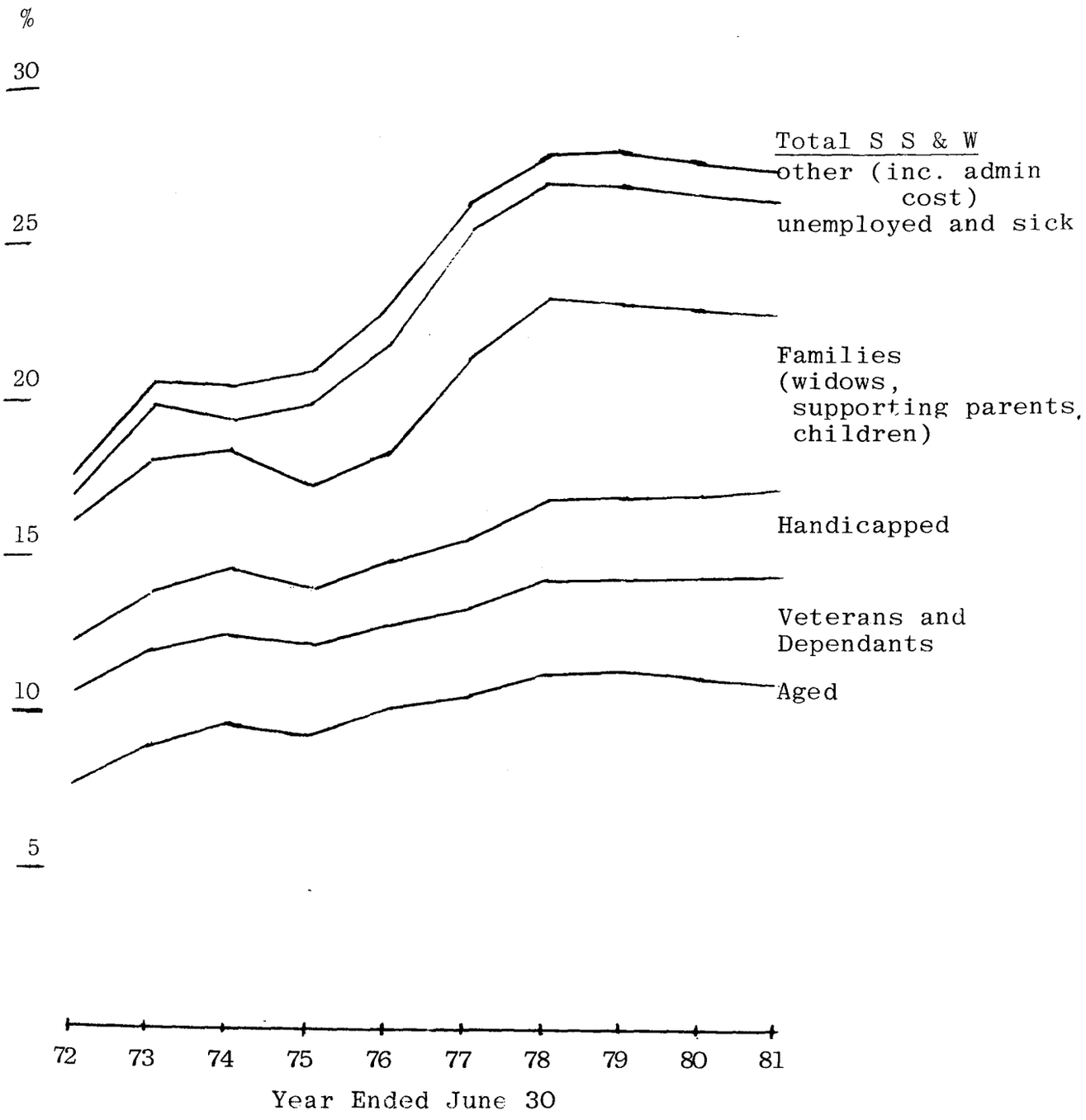
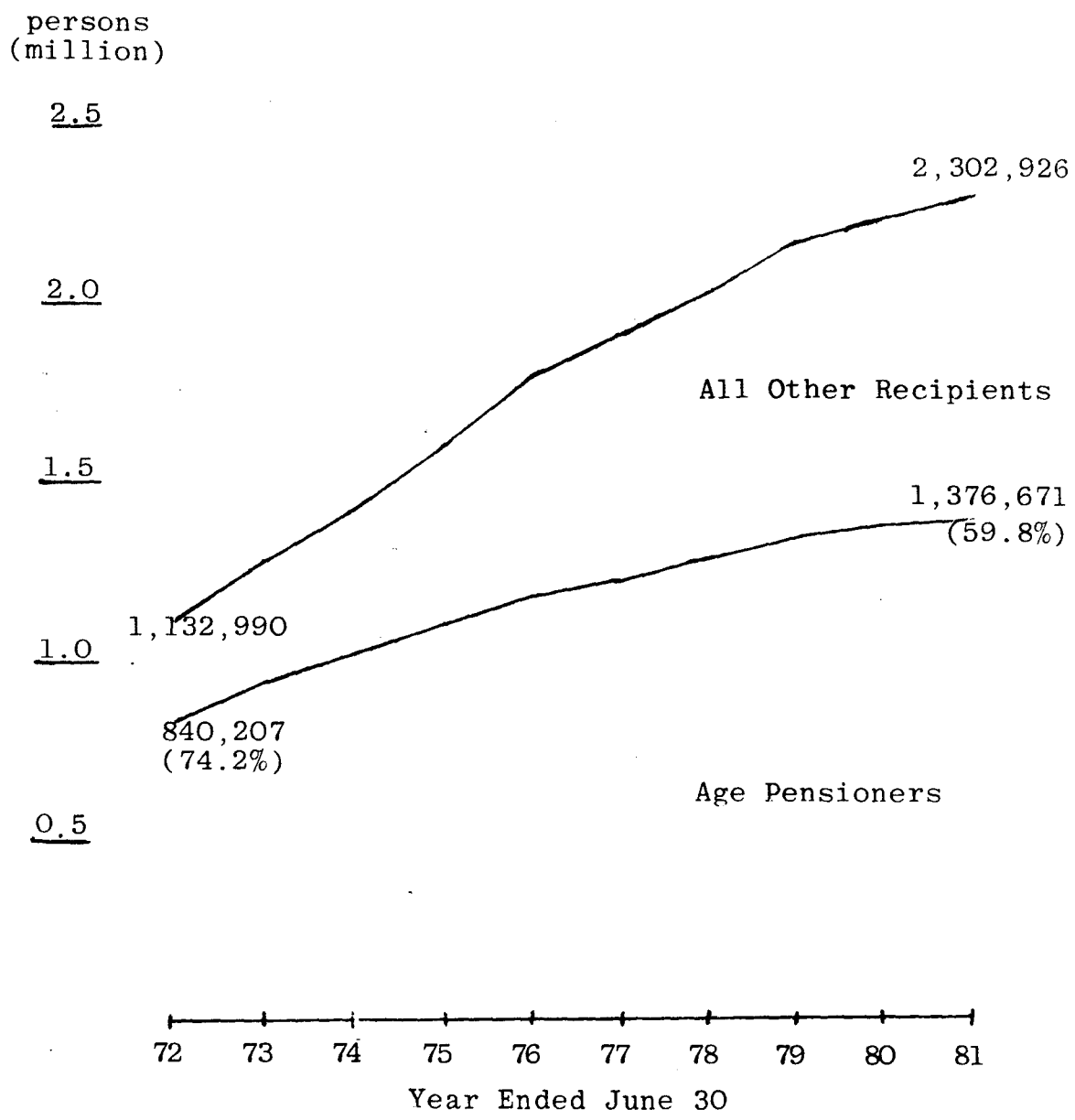


FIGURE 3

INCOME SUPPORT RECIPIENTS 1971-72 to 1980-81



HEALTH AND SOCIAL SERVICES FOR THE ELDERLY

by Peter Sinnett

Welfare and health expenditure directed at elderly people comprises between 15 and 18 per cent of total Commonwealth Government outlays. The largest single expenditure area is in income maintenance, where approximately $4.5 billion goes annually into age pensions. It seems inevitable that there will be considerable growth in the level of this expenditure in the future as the Government is under pressure to increase the age pension. At the same time there are moves to lower the age of retirement and this will increase the number of persons in receipt of pensions and benefits.

Faced with this increased financial burden it would seem essential for the Government to develop an overall policy for the care of the Elderly Australian; so that priorities for expenditure can be established on a rational basis and the cost effectiveness of the services funded can be assured.

Needs of the Elderly

Who are the elderly and what are their needs? The elderly in our community do not represent a homogeneous group. The health and welfare requirements of a person aged 65 years differ significantly from those of a person aged 95 years. This is so because ageing is associated with a marked increase in the prevalence of chronic illness and in the level of dependency. Some 27% of people aged between 65 and 74 years suffer from some chronic condition that limits their physical activity and independence. By contrast 42% of people over the age of 75 years are so affected. In consequence advancing age is associated with changing requirements for health and welfare services. 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 effects 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. As one ages the burden of illness increases and with it the need for acute hospital admission which must not be denied simply on the basis of the patient's age. The provision of an adequate level of care for the elderly demands the development of a co-ordinated range of health and welfare programs. The achievement of such an integrated care program is presently inhibited by difficulties in the administration of health and welfare services in Australia.

Present Difficulties in the Administration of Health and Welfare Programs for the Elderly

In Australia health and welfare services for the elderly have developed in an ad hoc fashion, largely as a result of demands by voluntary, private enterprise and professional groups involved in the provision of aged persons' care. In response to demands by such groups governments have tended to rely heavily on fiscal control directed by political expediency to regulate the growth of services and benefits. This is unfortunate, as administration based on fiscal control of policy initiatives, generated by diverse community groups gives no assurance that the resulting range of services will be balanced, comprehensive, equitable or cost-effective.

The random growth of health and welfare services for the elderly is responsible for the large body of poorly co-ordinated Commonwealth and State legislation which controls the use of funds for aged persons' programs. Thus Nursing Home proposals compete against each other for funds under the Aged or Disabled Persons Homes Act. Hostels proposals compete against each other for funds provided under both the Aged Persons Hostels Act and the Aged or Disabled Persons Homes Act. Independent living units may be funded by either the Housing Assistance Act Part III or the Aged or Disabled Persons Homes Act. Community programs compete against community programs for funds provided under the States Grants (Home Care) Act, the Delivered Meals subsidy Act, the Aged or Disabled Persons HOmes Act and the National Health Act. Hospital based geriatric services now depend for funds on State Governments. Destitute elderly are provided for under the Homeless Persons Assistance Act. Elderly returned service personnel are supported by a separate range of legislation administered by the Department of Veterans' Affairs. Finally income maintenance schemes for the elderly are funded under the Social Services Act.

The body of legislation that comprises the Commonwealth Government's health and welfare programs for the elderly is administered separately at the Federal level by four autonomous departments, Social Security, Health, Housing and Construction, and Veterans' Affairs. Thus administrative complexity is added to legislative fragmentation. Nowhere is there an overview which would enable assessment of aged persons' services and their funding arrangements. Of necessity decisions are taken in isolation by the various departments without full awareness of their impact on the efficiency and cost structure of the overall program. The absence of a single body responsible for the co-ordination of aged persons' programs has adversely affected program planning, program implementation and program evaluation and control.

A further difficulty arises from the fact that there is no one-to-one relationship between legislation and service provision. A given service is often funded under more than one Act. As an example Home Nursing Services within the (now defunct) Southern Metropolitan Health Region of New South Wales are funded under three separate instruments. The Sydney Home Nursing Service is treated as a Schedule 4 hospital. The Rockdale Community Nursing Service, the Kogarah Community Nursing Service and the Hurstville Home Nursing Service are each funded under the Home Subsidy Act, Home Nursing carried out by the staff of the New South Wales Health Commission is supported by the Commonwealth Government under the Community Health Program.

Home Nursing Services provided by the Chesalon Homes do not attract a subsidy from the Government. Hence it is extremely unlikely that the Commonwealth Government is fully aware of the extent to which it is supporting home nursing services in this health region. In consequence, it would be difficult for the Government to respond adequately to requests for additional funds for nursing services or to defend the present level of support for nursing services in this region. The capacity of governments to respond appropriately to requests for increased services is further weakened by the absence of agreed statutory "norms" which would serve as a basis for the regulation of the supply of services on a regional basis.

Day centres present a similar problem to home nursing services since these are funded under two Acts, The States Grants (Home Care) Act and the Aged or Disabled Persons Homes Act. It is however in the field of aged persons'

accommodation that administrative difficulties are most obvious. Hence, three levels of accommodation, Nursing Homes, Hostels and Self-contained Units, are funded by the Commonwealth Government. Two Commonwealth Departments are involved in the provision of capital funds, Social Security and Housing and Construction. Excluding provisions administered by Veterans' Affairs, three separate acts are involved, The Aged or Disabled Persons Homes Act, the Aged Persons Hostel Act and the Housing Assistance Act. Finally expenditure of capital funds on nursing homes commits the Department of Health to an ongoing expenditure under the Nursing Home Benefit provisions of the National Health Act, or deficit funding under the Nursing Homes Assistance Act.

Further complexities arise at the level of Commonwealth/State/Local co-ordination. In the case of nursing homes, approval for new accommodation is recommended by the Commonwealth/State Co-ordinating Committee on Nursing Homes. Regional need is measured against an arbitrary norm of 50 nursing home beds/1000 of the population over the age of 65 years. The Commonwealth Government approves homes for purposes of Commonwealth funding (benefits or deficit funding) but the nursing home is licensed by the State Health Authority. In the case of other forms of aged persons' accommodation approval of new facilities does not at present require the recommendation of a Commonwealth/ State or local Co-ordinating Committee and there is no agreed norm to regulate the level of service provision. Further, in New South Wales licencing of hostels is the responsibility of the State Department of Youth and Community Services.

At the level of service delivery there is further fragmentation as facilities are provided by a range of agencies which include religious and charitable bodies, some of whom have entered into deficit funding arrangements with the Commonwealth, private gain organisations, local councils and State governments. As there are no agreed criteria or assessment procedures for admission to nursing homes or hostels the Commonwealth Government has no assurance that funds are being used to assist those in greatest social or medical need. As there are no defensible staffing norms for nursing homes the Government has no assurance that the services funded provide a satisfactory level of care, or that they are cost effective.

Regional Services Required for Effective Aged Persons Care

Clearly the provision of an adequate level of care for the Elderly Australian demands the development of a co-ordinated range of health and welfare programs.

Central to any such group of programs is the provision of an adequate pension scheme indexed to the cost of living so that the elderly person can remain a viable economic unit in the Australian Community and can purchase those services which enable him to live independently and to enjoy doing so. To prevent such a scheme becoming an inordinate burden on the Australian tax payer it would be advantageous to introduce compulsory contributory superannuation for all members of the Australian workforce. Inadequate income provision in the post retirement period leads to social alienation and invites a heavy dependence on government financed welfare services. There is a clear nexus between the level of post retirement income and the need for Government expenditure on welfare. The higher the income the greater are the individual's chances of remaining as an independent member of society exercising his/her own choice in the purchase of those services which s/he considers necessary. The lower one's income the less one's chances of remaining independent and the greater one's reliance on services provided by the State.

In addition to income maintenance programs, a range of integrated community, hospital based and institutional services as well as adequate accommodation is required for effective aged persons' care. Integration would be assisted if all Commonwealth/State and Local government departments were to select the same demographic unit to serve as the basis for planning, accounting and statistical reporting. Failure to agree on such a demographic base is currently inhibiting the planning implementation, control and evaluation of services. It is suggested that the Health Region used by State government is a suitable population unit.

It is the responsibility of government, having taken appropriate advice to define the range of services it is prepared to fund in order to assure the provision of a comprehensive geriatric service. It is stressed that the service components in aged persons' care are in large measure interdependent and that a deficiency in one area will be associated with inappropriate use of a related facility. Thus if home nursing and home laundry services are deficient it is likely that an incontinent patient will be placed in an institution.

In Australia at the present time there is a lack of "norms" which could be used for health and welfare planning at a regional level. Indeed there is no general agreement as to the range of services required for effective aged

persons' care. Such deficiencies seriously inhibit planning and rational resource allocation. As a result the impact of fluctuations in financial support on service provision is largely a matter of chance.

Major Problems Identified

1. Absence of a single body within the Commonwealth Government charged with the responsibility of co-ordinating programs and monitoring expenditure on aged persons' services.

2. Relevant legislation is administered independently by four autonomous Commonwealth Government departments.

3. Many aged persons' services are funded under more than one Act.

4. Lack of comprehensive aged persons' care programs organised on a regional basis.

5. Lack of statutory "norms" to regulate the level of service provision on a regional basis.

6. Lack of agreement between Government departments as to a suitable demographic unit to serve as a basis for accounting and service provision.

7. Interdependence of geriatric services is not considered when funds are allocated.

8. Lack of adequate Commonwealth/State/Local co-ordination of services. Nursing homes are reviewed by a Commonwealth/State Co-ordinating Committee on Nursing Homes. However, a similar committee does not exist for the review of other forms of accommodation or indeed for the review of any of the other aged persons' services funded by the Commonwealth.

9. Lack of standard licencing requirements for aged persons' accommodation.

10. Lack of adequate assessment procedures for admission to aged persons' accommodation.

11. Lack of Commonwealth government initiative in determining location of Nursing Homes and other forms of accommodation. Geographic distribution of facilities is left to the initiative of the applicant.

12. Lack of hospital based services specialising in the assessment, treatment and rehabilitation of geriatric patients.

Consequences of Ad Hoc Service Provision

I believe that the present administrative difficulties are inhibiting the provision of adequate aged persons care in Australia and further are preventing those services from being cost effective. It is well known that the standards of care for aged people vary markedly not only throughout Australia but within separate States of the Commonwealth. Often the level of service provision does not parallel social need. This situation is illustrated in three diagrams (pages 38 - 40) which relate the provision of nursing home accommodation, pensioner housing and Day Centres to social need within one of Sydney's Metropolitan Health Regions. As can be seen nursing home provision is negatively related to need. Provision of Housing Commission Units is positively related while the provision of Day Centres bears no relationship to social need.

General Recommendations

1. Define a demographic unit, such as the State Health Region, which will provide all relevant Commonwealth government departments with a common basis for the financing of services and for accounting procedures.

2. Define the range of services considered essential for the adequate care of the elderly in our community and support funding of these services. Commonwealth financial support will thereby be translated into a comprehensive and integrated program of aged persons care organised on a regional basis.

3. Establish statutory "norms" to regulate the level of service provision required to provide an adequate program of aged persons' care organised on a regional basis.

4. Establish on a regional basis a register of services, including those funded both directly and indirectly by the Commonwealth government. Services registered should be classified according to function, i.e. income maintenance programs, day centres, home nursing services, nursing home accommodation, etc. The register would enable the Commonwealth to relate the level of financial support to the level of service provision and thus to undertake service evaluation.

5. Establish an interdepartmental committee of the Commonwealth government charged with the responsibility of co-ordinating information on a regional basis as to the level of funding and service provision in the area of aged persons' care. The maintenance of regional funding and service registers should be the responsibility of this committee. The integrated regional

information would be supplied to relevant Commonwealth government departments with advice as to areas in which funding was either above or below the level required to meet agreed "norms" of service provision. Information would also be supplied to Commonwealth/State Co-ordinating Committees to assist them in formulating advice to appropriate Commonwealth and State Ministers.

6. Expand the role of the Commonwealth/State Co-ordinating Committees on Nursing Homes initially to include the development of recommendations on all forms of aged persons' accommodation. Later this role should be expanded to include recommendations on all regionally based aged persons' services. This would ensure that Commonwealth and State governments received uniform advice and that a balanced program of community, hospital and institutional services resulted.

7. Establish a working party to advise on possible rationalisation of aged persons' health and welfare legislation.

8. Establish standard licencing procedures for all forms of subsidised aged persons' accommodation.

9. Establish adequate assessment procedures for admission to all forms of subsidised aged persons' accommodation.

10. Establish architectural guidelines to be adhered to in the construction of all new nursing homes.

11. Extend the range of the extensive care nursing home benefit to include patients requiring constant supervision due to intellectual impairment.

12. Encourage the establishment of hospital based services specialising in the assessment, treatment and rehabilitation of geriatric patients.

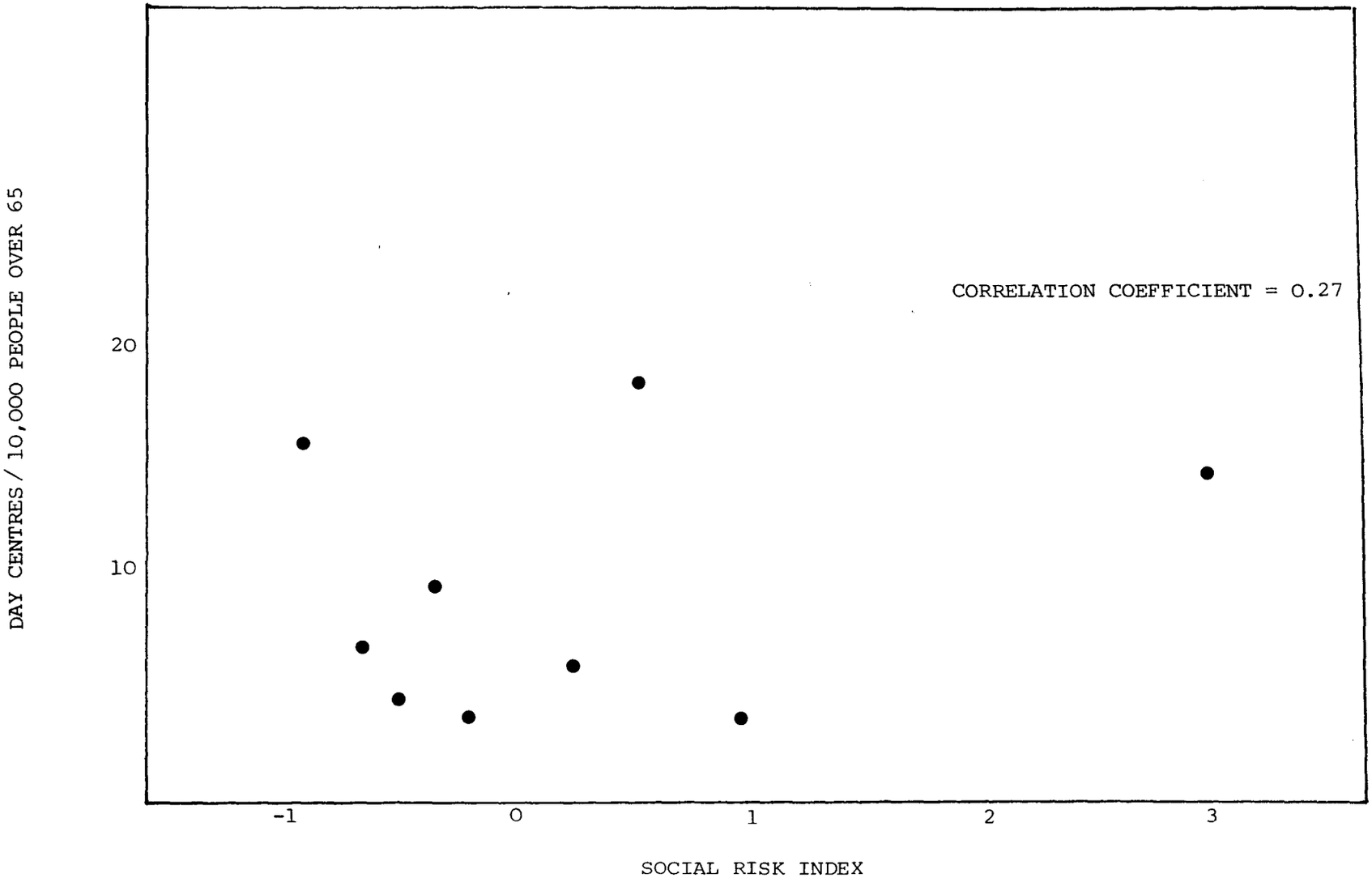
The practice of politics is concerned with the acquisition and exercise of power. In the acquisition and exercise of power these individuals who are capable of organizing themselves into pressure groups on the basis of shared self interest are more effective than those individuals who remain isolated.

The resulting struggle between competing self interested pressure groups for political power and for a community's resources does not necessarily result in the well being of individual members of a society or in social equity. For to be successful a politician must acknowledge the demands of the strongest self interested groups in a society and must allocate resources accordingly.

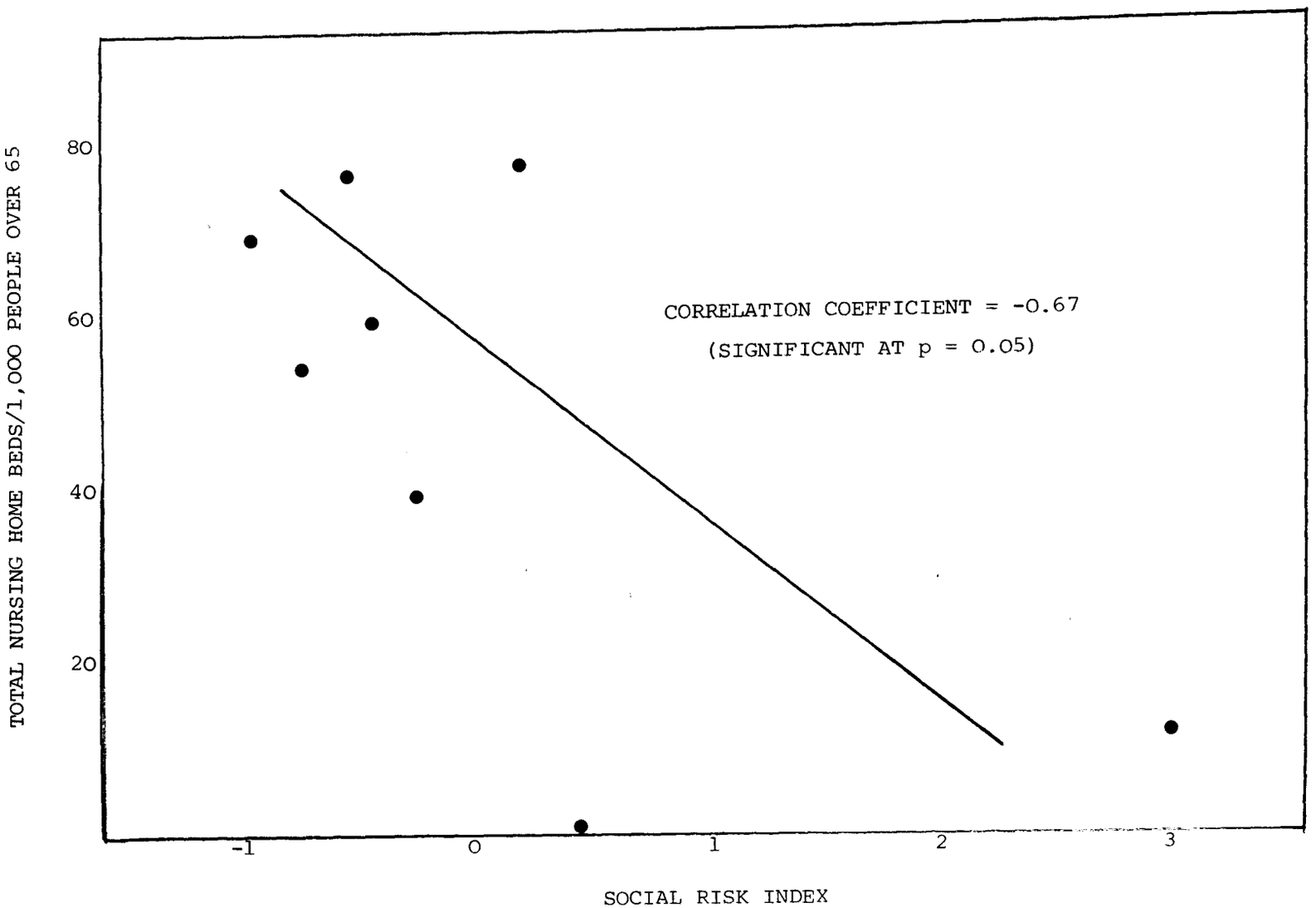
Political success is not encouraged by distributing resources from powerful groups in favour of weak isolated individuals. In short, concepts of equity and social justice can rarely be incorporated into the political process.

Surely the answer to the plight of disadvantaged individuals is not to form a separate pressure group whenever they develop the strength to be audible but rather to depoliticize as far as possible the provision of health and welfare services: an objective that demands the development of an ethical consensus on the part of the Nation to serve as a basis for the national planning of our health and welfare services. The leadership we need is moral not political. For as long as resources for health and welfare are provided on an ad hoc and arbitrary basis determined by the interests of political expediency there will be no social justice. The interests of the strong will prevail against those of the weak. The self interest of the organized pressure groups will prevail against the needs of the isolated individual.

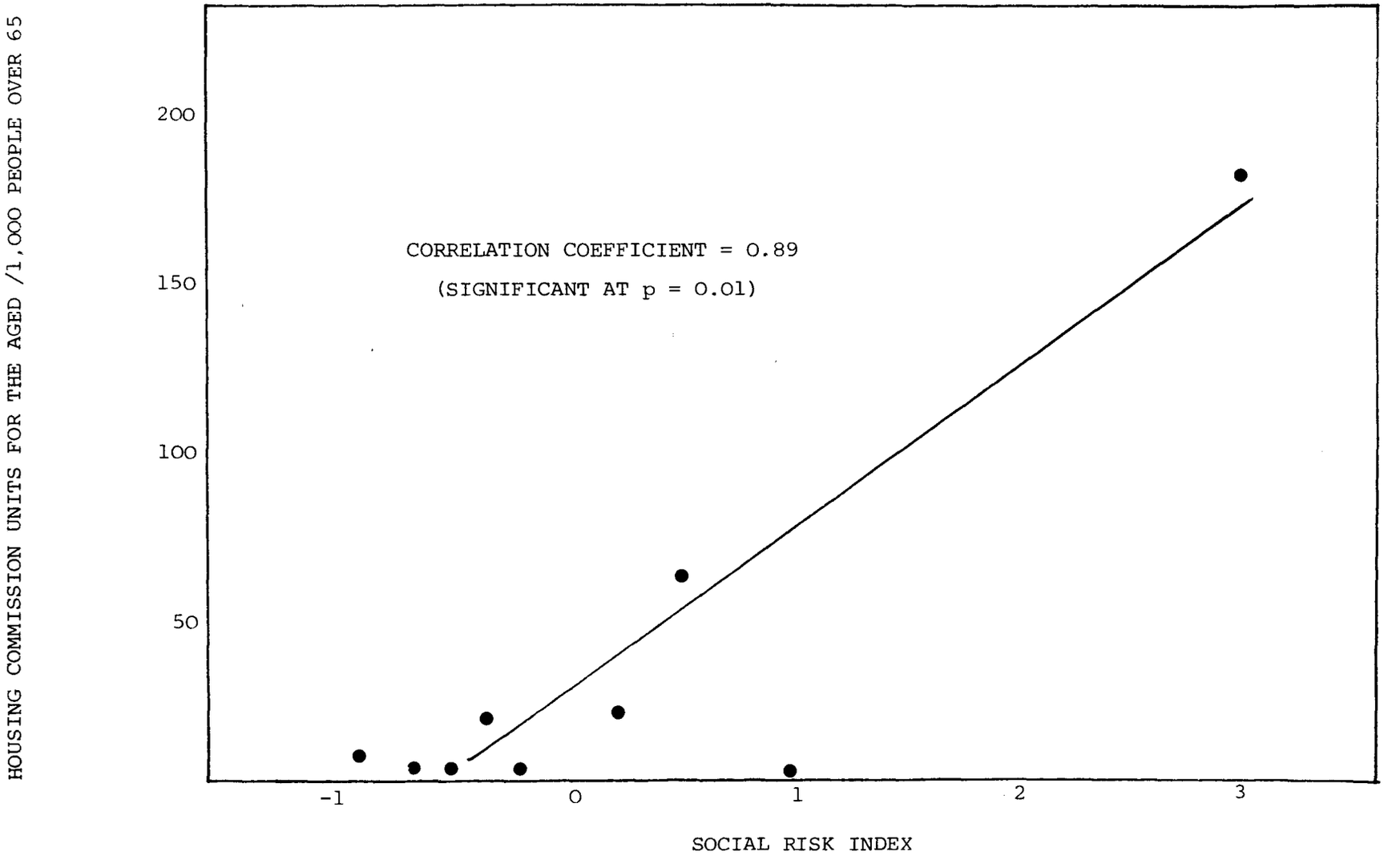
RELATIONSHIP BETWEEN SOCIAL RISK INDEX AND DAY CENTRE PROVISION



RELATIONSHIP BETWEEN SOCIAL RISK INDEX AND NURSING HOME PROVISION



RELATIONSHIP BETWEEN SOCIAL RISK INDEX AND HOUSING COMMISSION UNITS FOR THE AGED



OLD PEOPLE WHO MISS OUT

by Ian W. Webster

A person with health and social problems is less likely to have these dealt with when there are multiple needs, or complex needs, or both. Because institutions respond selectively to human need, unmet need compounds as the number of needs increases: the gap between met and unmet need widens. So are the needs of aged persons characterised, especially of dependent aged persons. Their health problems are always multiple; and these problems interact with social status and context and are presaged by the person's resources and available community resources.

Thus, when independent services are organised to meet specific needs of aged persons, for example meals on wheels or institutional care, these may not be the most appropriate societal response for aged persons who require co-ordinated services and wider social provision. These are negative but powerful reasons why geriatric health services are necessary: to reduce the extent of unmet health need caused by the sectorial and organ specific organisation of health care services.

For old persons dependency is usually conceived as the need for external care or support in daily living activities in which mental and physical incapacities dominate; especially confusion, incontinence, physical limitation and reduced mobility. But dependency extends beyond the personal support network to the wider social provision of income maintenance, accommodation, health and social services, transport, and to the prescription of social roles. In essence, the problem of dependency is the severity of the equation: intrinsic disabilities plus social disadvantage produce handicap. The addition of secondary disabilities, for example, mental depression, poor nutrition or general deterioration of health, compounds these effects, as disabilities themselves compound with age.

I propose that handicap, as I have defined it, is the principal reason why old people miss out on appropriate services. In old age there is an inverse law of need:

- for the individual, access to services decreases with increasing needs (unmet need is compounded),

(b) for communities, the number of aged persons in need is inversely proportional to services provided.

Whether one takes a limited economic criterion of poverty or equates poverty with relative deprivation, the state of poverty is central to our appreciation of the medical and social services required by aged people. Here the social security systems, the health services and support services designed for the normal working population, fall down. At a national level this was signalled by the Poverty Inquiry, in 1974, which demonstrated for the aged that poverty was due to social/structural factors and not to be explained by reason of personal inadequacy or maladjustment. The community impact of the social and biological processes of ageing simply cannot be explained by personal choices and reckless behaviour; variations in outcome may be related to life style and environmental factors but ageing is beyond social and biological control.

To exemplify the unresolved problems of dependency, I shall examine: dependency through social disadvantage, dependency through intrinsic impairments and severe long-term dependency.

Creating Dependency Through Social Disadvantage

Communities differ in their age structure and the degree to which old, and disabled persons, are supported. In a Melbourne study of aged persons, Howe[1] showed that local government areas could be grouped into a number of main categories based on:

social risk,
mortality;
Mediterranean origin;
aged density;
North/Central European origin.

Certain inner city suburbs were found to have high levels of social risk and others of mortality, and there was a poor correspondence between support services and apparent need, and of services to each other.

Kane and Anderson[2] found that about half the aged living in the inner city of Sydney and near Eastern suburbs were isolated, one in five extremely so. About 1,700 aged people lived upstairs, between 1,000 to 2,000 required help

with cooking and household activities, and 1,650 needed assistance with walking (half of these people lived upstairs). Generally, old people, reported in this study, knew very little about available services and made little use of what was available.

On the other hand, in South Sydney, Guy Marks found that few people lived alone, and that there was a high level of support by family members and friends. The older residents of this municipality made good use of health services and community activities[3]. Compared with the adjacent Inner City area, this community supports its older citizens and its social services meet their needs.

South Sydney has a continuing history and a sense of community, and amongst the long-term residents there is stability and coherence. On the other hand, the geography of the Inner City has been broken and it has become a refuge for the young and for others who have lost their roots. Old people are trapped by these events in a hostile environment, amongst fearful people.

Social disadvantage has long-term effects on dependency through exposure to health risks, and through structuring the person's resources and support network. For me, this is most clearly portrayed by what happens in long-term destitution, for example, amongst homeless men[4]. As children, these men have been uncared for, and unloved. Home life for many was a corrective institution and school was unsuccessful. In work they were not valued, being unemployed for long periods. Their social relationships and work experiences have been transient and itinerant, and they have rarely married. Physical or mental incapacity has determined the biography of others amongst them.

In the end, such lifelong disadvantage and superimposed disabilities, and secondary reactions, overwhelm the person who then becomes dependent for basic necessities of food and shelter, for social and economic support and for medical care. Many poor ageing men and women end their lives dependent on marginal city accommodation, on charities and night shelters. Their levels of mental and physical incapacity and disease rates are much higher than the rest of the community and yet they are relentlessly excluded from the State's health and welfare services. Perhaps this could be put differently - as health and welfare services are cut, so as to cost less,

those most in need are affected most. An example of another "inverse law": broad cuts in government funding have most effect on least popular services.

In disadvantaged communities ageing is characterised by higher rates of dependency, and social disadvantaged persons have higher risks of dependency as they grow old.

Old Before Their Time: Physical and Mental Incapacity

As death is postponed by modern health care, the time from the onset of dependency to the age of death becomes critical to a persons' quality of life and to the community's load of dependency. Whether the compression of death into old age will mean a delayed onset of dependency is problematical. Demographers have shown that old people will increase in number - and so the community load should rise from this factor alone, but will this be a more or less healthy population group than at present? The critical biological link is whether the factors which cause premature loss of life are similar to those causing disability, and the extent to which these factors are inter-related. Vascular disease is a major cause of death and of population disability, but beyond this the association between mortality and disability is weak: cancer incidence has a minimal effect on the prevelance of disability, and chronic respiratory disease, arthritis and mental illness are more significant as disabling conditions. Especially to be noted is the severe impact of brain failure in the old which is rarely recorded as a cause of death.

Thus the onset of disabling conditions in adult life compounds the dependencies of old age. Because these are often the same conditions, it would be more appropriate in our social and health services to be responding to the functional disorders of ageing and their handicaps rather than to the chronologically "aged" as such.

The framework of ageing, as a process of change, can be extended to preventive medicine. It entails the notion that ageing takes place in cultural and ecological contexts and that it is a multi-dimensional phenomenon affected by extrinsic and intrinsic factors. It can have both positive and negative attributes. This is not to deny that ageing may be applied to cellular biology or to intrinsic genetic mechanisms, no more than other concepts such as development or adaptation are exclusive of these processes. Most people are aware of certain communities such as the Hunza,

Georgia and Ecuador where ageing appears to be very different from our own - biologically and socially[5]. Much research in developing countries has shown that many of the characteristics of Western degenerative diseases are not to be found there[6]. Peter Sinnett has shown that ageing in a traditional Papua New Guinean community is very different from our own - in body structure, physiological changes and in disease incidence[7].

Within our own society variations exist also. Higher status social groups have lower rates of degenerative disease; health conscious groups, such as Seventh Day Adventists, have lower rates of degenerative disease[8]; and old people who survive have fewer biological and social risk factors[9]. Conversely other groups have higher rates of degenerative disease. In a sense, then, there are groups who show "premature ageing" characteristics. Premature ageing has been found among analgestic abusers, and cigarette smoking accelerates many degenerative changes. Perhaps the extreme in this regard are the chronically destitute - they show the characteristics of old men (and women) while still young and their rates of disability and dependency are equivalent to the very old[4].

Thus the societal response to the social distribution of dependency should not only be based on existing needs and services but should also be concerned with those factors which cause dependency in the first place. Herein lies a principal challenge to modern public health, and that is *how, in the face of an ageing population can we maintain health so as to lessen the community load of dependency through chronic degenerative disease?*

Beyond Dependency

Community services. As so often happens it takes an advocate organisation for disadvantaged persons to "blow the whistle" on the inadequacy of health and social services. The Council of Social Service of New South Wales has shown that there is a crisis in home support services in New South Wales[10].

They found, through the experience of 239 organisations, that home support services were overwhelmed:

> Home and community nursing services were not able to cope with demands;
>
> Meals on Wheels services were less able to accept new clients and the standard of service was declining;

> Home Help Services were being reduced, with many people not receiving services, and the costs to individuals rising.

These effects were being felt especially by aged persons and handicapped persons, and a high level of stress was affecting family members and other carers. All service providers believed that their services were being overloaded by too early discharge from hospital and that many people would need institutional care because they could not be cared for at home.

The interdependence of community services and institutional and acute hospital services is too well known to be stated again, and has been reported in many studies[11,12,13]. However, it is worth stating an obvious but easily forgotten fact: a bed is not a service. A service is based on the activities of people a bed may or may not facilitate this.

The NCOSS report noted that both Federal and State Governments acknowledge the role of home support services and that the Australian Labor Party Policy Platform in New South Wales states:

> "(should) Give priority to the development of domiciliary services, which will reduce the over-reliance on institutional care, and establish home maker and home help services, on a long term basis where necessary, particularly for the following groups: the aged, the handicapped adult, the younger chronically sick and families threatened by imminent breakdown."

Dependent aged persons are at risk when, as is occurring at present, philosophies of community care are used to justify the closure of institutions and when resources are not allocated to support people in their homes.

Institutional Care

Severe dependency justifies institutional care when family and community support services fail but decisions about who should be admitted and who should be discharged and when, are often inappropriate. Acute general hospitals resist admitting old people to their beds, few assessments are

made on discharge from hospital to arrange appropriate support care and admission to nursing homes is arbitrary.

A conversation with any nursing home matron will reveal how little information is given about patients discharged from hospital to a nursing home and how little regard is given to continuing medical care in these environments. It seems that nursing homes are not to be trusted and yet they carry a massive burden of aged person care.

Nursing homes are in the vice of their origins, government subsidy of private initiative, and government regulation of their funding. As a result they are inadequately staffed to either provide heavy nursing care or rehabilitation for those who might be returned to their homes. Their nursing establishment permits six minutes in every two hours to be allocated to those with high dependency needs.

It might reasonably be expected, as no control on admission to nursing homes is exercised, that having been admitted some people could be discharged to more appropriate circumstances, or that others could be rehabilitated to do so. But, because of inadequate community services and of services within nursing homes, this does not occur. Various studies show that about 25% of persons in nursing homes could well be cared for at home[13]. The chance of being admitted to a nursing home in old age is several times that of the number of old persons in homes at any one time: probably about 1 in 5 compared with 1 in 20 bed occupancy per aged population.

Whatever our views of the quality of life in a nursing home, there are some for whom this type of care is less accessible. Stephen Duckett has shown that hostels and nursing homes are located in affluent areas and their residents tend to come from poorer areas[14]. One could reasonably believe that services generally are better co-ordinated in these areas than in deprived communities; certainly the regional supply of services is inter-related[12].

At one time the State provided institutional care for the destitute and sick aged. Such a tradition had an unhappy origin, arising our of poorhouses and workhouses of last century and led to public revulsion of putting the poor and sick aged together.

The "Old Men's Home" at Lidcombe has now become an acute hospital and its custodial function has decreased. Where are the destitute old to go? Some eke out a borderline existence in guest houses and single rooms (mainly women), others end up in the city's night shelters and if mad enough they may be lucky to find their way to a mental hospital.

Private nursing homes are unable or unwilling to shelter the difficult person, the confused or the "misfit". If the State does not respond, as it does not, many live their last years in terrifying insecurity, marginally supported by the charity of the Churches.

Co-operation

A bed is not a service, and a service is only worthwhile if it meets the needs of aged persons. To meet these needs services have to be connected and be prepared to co-operate together.

This is not happening. Firstly, geriatric services have been established to a limited degree in New South Wales. Secondly, as resources are constrained, organisations and individuals will defend themselves from being overloaded. They may regard a referral as a "slough-off" and not a considered option by the referring agency.

Thirdly, very often the referral is a "slough-off" as prestigious health services unload their social problems and less worthy patients to the "welfare" sector.

And, fourthly, the Federal and State Governments have not exercised their authority to plan or co-ordinate services, nor has funding of services been condition on these attributes. Re-classifying hospital beds as geriatric beds will be of symbolic value only when measured against the needs for comprehensive services linked to community health and welfare services. The voluntary sector is being expected to fill the gaps of public neglect - and that is not good enough.

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