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Political issues in the care of the aged

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Health and welfare provisions for the sick aged with episodes of illness, with continuing illness and with unresolved illness, for the well aged, and for the frail aged are outlined. Some political implications of the shape and type of services are discussed.

Introduction

Almost 9 per cent of the 4½ million people in New South Wales are over 65 and some 60 per cent of those of pensionable age do in fact receive a full or part pension. At the end of the 1970—71 fiscal year about 300,000 persons received the age pension in this State. About 100,000 did not own their own home and had "means as assessed" of less than $520; in other words, 100,000 aged pensioners were paying rent or living in someone else's place and would be reasonably classed as being below the poverty line according to most definitions in Australian surveys into the subject of poverty. These were the people who were found by, for example, Henderson's surveys in Melbourne[1] as having a major poverty problem, along with households headed by females, some of the chronically ill, and other problem individuals.

It is also known that there is a progressive rise in the prevalence of limiting chronic disease in the older age groups from the 10 per cent which applies to the population as a whole, to the 70 per cent of those who are 85 years and over. Thus it is reasonable to surmise that in addition to poverty, the 100,000 aged pensioners in question will number a goodly proportion of disabled people amongst them.

It may be opportune to point out here that chronic physical disability is reasonably independent of socio-economic class, so that services for the sick and frail non-pensioners will also have to be provided.

What is happening to these people? What are their needs? How are their needs being met?

Though obviously an oversimplification, with much overlapping, it is convenient to consider the vast range of our aged in the categories of "the sick", "the well", and "the frail".

The sick aged

These fall broadly into three categories, viz those with an episode of disease, those with terminal, lingering illness, and those with unresolved illness or disabilities who require prolonged rehabilitation or retraining.

Episodic illness

This may be a single episode of illness which is usually self limiting, that is, either ending in early cure or death and managed by traditional medical intervention on the part of the physician, surgeon, hospital and nurse.

Such episodes are, generally speaking, dealt with in the same facilities as similar episodes in the non-aged, even though the approach may have to be substantially different than if the episode were to occur in someone young. The good periatric physician or surgeon knows of the great likelihood of multiple pathology, of the need to wait longer for results, of the necessity to attend to the multitude of other factors that impinge on the health and welfare of the aged and need manipulation if the best recovery of functions is to be earnestly sought.

However, good management probably requires litle more than the commonsense utilisation of existing resources. Whether these in turn are adequate or not is beside the point — at least there is little reason to suggest any undue discrimination against the aged, even though there has not been enough deliberate provision made for special clinical facilities.

Terminal illness

This may be associated with feebleness, prolonged bedfastness and the need for bedside nursing and frequent assistance with the execution of the daily tasks of bodily maintenance. Though much of this may be done at home, given adequate support systems, it is in this type of case that nursing home admission would appear to be appropriate quite often. By and large, provision of nursing home beds is plentiful — for example, the 21,000 or so such beds in New South Wales gives us close to the highest such bed/population ratio in the world.

Financial aid in the form of the Commonwealth 's Nursing Home Benefit is available on a single medical practitioner's certificate, the national bill for this item alone having reached a staggering $80 million annually. Nevertheless, the care of many such patients at home, where willing and able relatives exist, is possible with the aid of home nursing services (where these are readily available) and medical aid which is subsidised by the Commonwealth.

Unresolved illness

These people present a more difficult problem in that they require the provision of services such as

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physiotherapy, occupational therapy, speech therapy and associated long term therapeutic devices.

These services are most conveniently delivered through a regionalised system, so as to make them accessible to the patient and appropriate in terms of his local geographic and human environment. The types of resources and general therapeutic approach bear much similarity to the types of services to be provided for the so-called frail aged and will be considered later under that heading.

The well aged

These do not require health services or rather disease services. A number of primary preventive measures, however, can legitimately be regarded as health intervention and, to obtain a total view, it might be appropriate to examine some of the more important aspects in the physical, the psychological and the social spheres.

Physical health maintenance

The high incidence of physical illness in the elderly is well known — the outstanding biological characteristic of the aged is the increasing likelihood of developing malfunction in the many physiological systems and, because of their more or less simultaneous degeneration, the prospect of multiple illness is quite high.

Much major breakdown, often with disastrous consequences, could be avoided by a program of "preventive maintenance". This would pre-suppose a regular health screening including the taking of a careful medical history, the performing of a physical examination, particularly the checking of blood pressure, respiratory and cardiac reserve, vision, hearing, composition of blood and urine and a check for the possible appearance of cancers. Early intervention in cases of symptomless disease could lead to not only prolongation of life but much longer maintenance of the person in a symptom-free state.

Such preventive maintenance measures are available only to the private citizen seeking them from his medical adviser, who at times may not be sufficiently attuned to this problem to in fact deliver such a service. Even if it were freely available, such a service would have to be cleverly "marketed" if it is to reach those for whom it is intended.

There is no extensive public health program in operation here for this purpose.

Retirement and illness

Compulsory fixed age retirement with its attendant problems of a vast increase in available leisure time but concurrent diminution of income, social status and, most importantly, major role change, can present insuperable problems to a person who is ageing and perhaps losing some of his flexibility or adaptability to changing circumstances.[2]

The problem of compulsory retirement has far-reaching implications and is raised here only as an illustration of the impact of political decisions on the health of individuals. Closely related is the question of money.

Money

The problem of compulsory fixed age retirement in the absence of a national superannuation scheme, because of its financial implications too, is a major consideration in any concerted attempt at improving the lot of the aged at large. There is a long and fascinating history involving a century of rapid social change and the debate of some weighty political and philosophical issues about the welfare state, the individual's responsibility for his own fate and the impact of technological advance on the human condition.

Though any progress in this field must have far-reaching political consequences, there is little doubt that the present situation which enforces idleness and income loss and endangers the pension where an individual makes any substantial effort to increase his income can hardly be regarded as therapeutic.

Housing

As already stated, 100,000 pensioners in New South Wales do not possess their own home and many of them might live with relatives who may see them as more or less of a burden. A lucky few have managed to obtain a unit from the Housing Commission. Some retain a rent-controlled flat in spite of various harassments. Many

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are forced to pay exorbitant rents for substandard accommodation and may have to make major dietary sacrifices in order to maintain payments. The majority are under fairly severe pressure to produce a solution to the housing problem which becomes more serious as they become older and more dependent.

There is one certain solution to a difficult housing problem and that is to be, or appear to be, sick enough to qualify for admission to a nursing home and hence for receipt of the Nursing Home Benefit — the first easily obtainable financial support the community is prepared to offer to the person with a housing problem. It has been estimated informally that up to 40 per cent of nursing home residents in New South Wales do not require nursing care.

Apart from attending to the central preventive devices of modifying the impact of retirement and attending to housing needs, there are certain more specific, perhaps more narrow in scope, but very important measures in the area of domiciliary care which require some scrutiny.

Another very important form of housing is that in the very slightly more sheltered setting of the retirement colony or villas where one sees the development of some communal facilities. These are often graded to the point where common dining facilities are provided and eventually nursing home beds are constructed for those who are most frail. Admission to any such homes has, as a rule, been confined to those who can become "founder donors" for anything from $4000 upwards.

Here again, New South Wales is rather struggling to keep up with demand for such facilities. The amount of subsidy provided by the Commonwealth for this purpose taken up in this State is comparatively small and less than 5,000 beds for 300,000 pensioners have been thus constructed so as to produce a bed/pensioner ratio of 1:62, by comparison with Victoria's 1:40 and Queensland's, South Australia's and Tasmania's 1:25. The interest of local government, or rather the lack of it, in this scheme has been particularly disappointing as this is an obvious agency that could enter the field as a major entrepreneur.

Local government, in fact, is in a very appropriate position to conduct a number of key services for the aged and disabled and there is ample precedent for this overseas and even interstate. The provision of Meals on Wheels, counselling and referral services, home aides and Day Centres could be arranged in a most appropriate way in relation to local needs, by local people through the agency of local government, yet we find many of these sadly lacking.

On the brighter side, one notes the fairly rapid proliferation in the last two or three years of municipal social workers, but there is the very clear impression that there are vast unexplored opportunities for rendering service to the frail and dependent. Thereby they could be enabled to survive at home, within their own social network and using their own or their family's assets, real estate and a close relative's contribution of time or labour, rather than become a charge on the nation.

The frail aged

These individuals are recruited either from those so-called "sick aged" who have a continuing illness as described above or, more commonly, progressively ageing men and women who very gradually become more feeble and dependent. Failing wind and limb, hearing and sight, mental agility and financial resources, or capacity to handle daily house-keeping tasks may gradually force older people to abandon the normal conduct of their original households.

Some cope with this by employing companions or housekeepers, others by moving in with their children or other relatives many by depending on friends, neighbours and relatives popping in and helping. As this frailty progresses, maintaining the old folk in their own home becomes an increasing burden which the old do not want to impose upon the families, and which families do not tolerate too well as a rule.

It is at this stage that the provision of the right kinds of supportive services will make all the difference between succeeding or failing to maintain the ageing individual in his own familiar setting. These services may include delivery of meals, laundry services, home aides, perhaps some home nursing, and probably a transport system to a neighbourhood Day Care Station. Those elderly ladies who might be living with their children could be helped remain there by the provision of a minding service, day hospitals and perhaps some financial subsidy.

However, few if any of the above services are available on anything like a large scale, yet one readily obtainable alternative looms very large. The patient, the relatives and the family doctor (who has usually been consulted to help face the solving of the housing, caring and financing problem of such a frail, dependent person) usually find that the Commonwealth's Nursing Home Benefit constitutes the easiest solution to their problem: there is little choice.

This then might be the explanation for the actual course which is largely embarked on — namely the wholesale diversion of the frail aged into nursing home beds, public, private or charitable. The facile answer is the provision of the Commonwealth Nursing Home Benefit, relatively easily obtainable, and operable (with the pension) at more or less break-even point, which offers a rapid solution to the placing of anyone who is old, difficult and dependent. Moreover, there is a number of other more subtle pressures and often vested interests which encourage the patient, the family and the referring doctor to utilise this resource.

Thus there is a system of subsidies and payments which will aid the person's extrusion into an institution — no matter how beautiful this is, it does represent an exile — but virtually no system of moneys or services designed to foster his survival as a member of the community within a normal social network.

It is this basic fault in our handling of this problem of caring for our aged which as a nation — through the agency of our legislators presumably — we must try and resolve or eliminate somehow.

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