HEALTH IN OLD AGE

AIM: To discuss the aims of healthy ageing policy, the services that support it, and related service management concerns.

AUSTRALIA'S AGEING POPULATION IN INTERNATIONAL CONTEXT

Measured by longevity, health is improving internationally but many nations, including Australia, now face problems providing support for the elderly, the disabled, the unemployed and poor. Health and education are recognized as primary drivers of productivity and the poor have the worst health and education. Later discussion of Australian experience is undertaken in an international context where free trade is increasingly embraced. In this competitive environment, comparative discussion of health and related social goals is vitally important for development across the economic and political spectrum. In agrarian nations without a developed welfare state, adults are normally expected to care for aged parents. Children may also have to work. Some nations, such as Nigeria and Pakistan, expect the school-age population to increase by two thirds during the next fifty years. In many others, however, it is expected to decline sharply. In China, for example, the combination of high levels of economic growth, comparatively good population health and the one child policy, have meant population aging is occurring faster than normal. By 2020 people over sixty will make up 16% of the population and the government is grappling with how best to provide for them.

For Australians born in the period 1901-10 life expectancy at birth was 55 years for men and 59 years for women. By 1995 life expectancy at birth had increased to 76 years for men and 81 years for women. However, the life expectancy of Indigenous Australians remains 15-20 years lower. The major increases in life expectancy in the first half of the century were mainly the result of rapid decline in infant and maternal mortality, particularly the lessening impact of childhood infectious diseases. Since the 1960s the gains in life expectancy have been concentrated among the middle-aged and older population due to dramatic decline in mortality from conditions such as cardiovascular disease. While life expectancy has been rising, fertility rates have been falling. As a result of this the Australian population is ageing. This has important implications for the nation's health and welfare systems which must be able to meet their needs. The proportion of the population aged 65 years or over is likely to increase from 12% in 1998 to 18% by 2021. In older age groups there are proportionately more women than men. In 1998, women comprised 70% of the population aged 85 or more. It is predicted that people from culturally and linguistically diverse backgrounds will comprise around 25% of the Australian population aged 65 and over by the year 2001. Australia's migrant population came from over 160 countries and speak over 100 languages. How their particular care needs can best be met is a major issue for policy consideration.

TOWARDS A HEALTHY AND PRODUCTIVE OLD AGE

Perceptions of what is old vary according to the social context, a person's state of mind, their age and their quality of life. Australians are choosing increasingly active lives, as

they get older, with many taking advantage of more time to undertake activities such as recreation, voluntary work and further education. There are many elements which impact on the opportunities of older people, including their relative health, wealth, their housing situation, their transport, retail opportunities, personal interests and safety at home and in the community. Income level has been shown to be significantly associated with poor health, even when factors such as education, workforce status and risk factors, such as smoking and age, were held constant. Older Australians living on low incomes experience poorer health and are more likely to suffer disability, serious chronic illness or report recent illness. The ability to drive or to access public transport is vital for older people to enjoy a happy and productive life. Many older Australians are at risk of experiencing social isolation. Their likelihood of spending large amounts of time alone increases with age, in association with the increased chance of living alone.

The aim of remaining healthy and independent in one's own home for as long as possible is shared by the elderly and governments alike. The National Strategy for an Ageing Australia identified a number of key areas in promoting healthy ageing and preventing illness. These include maintaining physical and mental health, engaging in physical activity, preventing falls and injury, maintaining adequate nutrition, detecting sensory loss early, managing incontinence and evaluating alcohol and other drug usage. It is vital to analyse how these aims might best be achieved through the effective combination of service provision, research and evaluation in any regional development context. Communication, recreation, community service and education are potentially vital for supporting all regional community development. The appropriate role for superannuation funds and taxation, particularly in regard to accommodation planning, should also be a major concern for government planners. Strategies to maintain wellbeing in old age must also centre on the development of more flexible employment patterns, and better coordinated and more effective provision of health and social services, including transport, to meet community need. The aim must be to assist people to make easier transitions as they age. Flexible employment and related services are required to meet a multiplicity of individual situations. They should assist everybody to maintain links with work, recreation and community service wherever this is considered beneficial.

MAIN REASONS FOR DISABILITY, HOSPITALISATION AND DEATH

The proportion of Australians with a disability is fairly high among the population aged 65 and over. However, this does not necessarily mean a need for assistance. For those aged 65-69 years only 7.8% of men and 9.2% of women have a profound or severe core activity restriction. The proportions rise markedly after 75, so that about 20% of men and 25% of women experience such problems. The major disabling conditions are arthritis, problems relating to the circulatory system and other musculoskeletal conditions. Sensory problems (diseases of the eye or ear) are the second most disabling set of conditions. Mental and behavioural problems are also comparatively common.

The main reasons for hospitalisation of people over 65 is dialysis, followed by cataract problems, and diagnoses associated with heart disease. The main causes of death for both men and women aged 65 and over are diseases of the circulatory system, malignant

cancers and diseases of the respiratory system. Together, these three categories account for well over three quarters of deaths. Older people may have a combination of conditions such as failing eyesight, osteoporosis and Parkinson's disease. Treatments such as tranquillising drugs can greatly increase their risk of falls or fractures. One in three Australians aged over 65 will fall at least once per year and falls are a serious health problem for older people. Around 40% of nursing home admissions are related to falls.

The prevalence of dementia increases with age. About 5% of people over the age of 65 and 20% over the age of 80 have some form of dementia. This will be an increasing problem as the population ages. Fortunately, the prevalence of mental disorders other than dementia generally decreases with age, although depression may be under-diagnosed and appears to be greatest in older people in residential care. Enhanced preventative care and early detection of problems in all the above areas are the major priority. It seems clear, however, that early government and personal action to prevent the problems related to smoking, alcohol, obesity, and disabling working conditions, can substantially improve peoples' health in old age.

AUSTRALIAN DEVELOPMENT OF AGEING RELATED SERVICES

Kendig and Duckett's research shows that in the period after World War II the Commonwealth government service provision for older people was limited to a small pension available to less than a third of the age group, and hospital-based services provided by the States, but funded under the 1951 Pensioner Medical Service. The prototype of later aged care accommodation systems was found in homes for independent older couples provided by churches to their members. It was virtually unquestioned that single people would live with their families, and 'sick' older people would go to hospital. The churches took an important lead in demonstrating to the public and governments the potential value of aged welfare accommodation and services. The National Health Act of 1963 provided substantial nursing home benefits to private as well as voluntary and government providers, virtually on demand. In general, the neglect of policy coordination with State governments ensured little or no Commonwealth interest in acute or community care until 1969 when legislation was passed for limited home care, paramedical services and meals services.

During the 1970s the major focus of Commonwealth attention was on national policy development for all, including pension increase, the introduction of Medibank, the development of community health centres and increased emphasis on public housing. However, by the 1980s a growing awareness of the future needs of the baby-boomers had generated a series of reports, which all focused on the importance of keeping aged and disabled people out of nursing homes and effectively supported in their communities. This led to the passing of the Disability Services Act and to the establishment of closer Commonwealth/State cooperation in setting up home and community care services. Standards for accreditation and monitoring of aged care facilities were also established. There was a gradual reduction in the proportion of Commonwealth money spent on nursing homes and an expansion of hostel places for more independent living, and community care funds.

The home and community care program jumped from $30 million in 1986 to over $60 million in 1987. Multidisciplinary aged care assessment teams were established to co-ordinate the care arrangements of aged people with a view to keeping them in their homes or independent living situations for as long as possible. Health assessment teams provided referrals for home and community care services, for accommodation in nursing homes and hostels and for other care packages funded by the Commonwealth and tailored for the needs of the aged client. A domiciliary nursing care benefit was also introduced. It is paid to people who care for frail older people who remain in the community rather than entering institutional care, when the carer and the person are living very close to each other, and if a medical practitioner certifies the need for full-time care. Health assessment teams are usually based at hospitals, geriatric centres or in community health centres. In general, many of their health management functions are similar to the work related functions of rehabilitation providers, whose role is discussed elsewhere.

Superannuation payments provide Australians with a new but enormously important provision for old age. Award based superannuation was introduced in the 1986 budget and was supplemented in 1992 by Commonwealth legislation which introduced a superannuation guarantee affecting all employers. They were henceforth required to provide superannuation entitlement for all employees. Industry managed superannuation funds have become huge new players in the financial services sector as a result of these developments. In a decade, superannuation funds grew to a point where they controlled about $12 billion in funds. They had $80 billion in assets by 2000. The issue of how these funds can best be managed in the individual and community interest is now of central concern. Ensuring that appropriate forms of accommodation and employment are available, including for the aged, are related major issues.

State anti-discrimination acts may forbid discrimination on the basis of age, and make automatic compulsory retirement at a particular age unlawful. Additional steps to promote the continuing employment of injured or ageing people occurred in 1992 when the Commonwealth passed the Disability Discrimination Act. The act states that a person discriminates on the grounds of disability if they treat the aggrieved person less favourably than they would treat a person without the disability under the same circumstances. The Act also places new onus on employers to make 'reasonable adjustment' to workplaces and job design to accommodate injured workers.' The aim of the legislation is to assist as many people as possible to attain greater personal independence and a reasonable living standard through appropriate work.

In the early 1990s the Council of Australian Governments called for the pooling of Commonwealth and State funding for aged care services, and for devolution of service delivery to the States within a broad framework of national guidelines. This was considered a necessary aspect of achieving more extensive and integrated services, improved access and social equity, and shifting the balance of aged care towards the community. From 1985 to 1995 the main changes in the balance of aged care funds were a relative decline from 80% to 64% in nursing homes; relative increases from 5% to 12%

for hostels and from 10% to over 20% for community care. Over the same period aged care funding increased by more than 50% in real terms.

In 1997 the Commonwealth government integrated nursing homes with hostels, which had previously provided separate accommodation for more independent living. A common funding instrument was developed where the care and funding support provided to each individual was based on his or her level of disability. An accommodation bond was proposed, on a means-tested basis, for incoming residents. There was considerable public protest about this because the necessity for the bond meant that elderly people might have to sell their houses to pay it. The government withdrew the bond requirement in favour of the requirement of a modest daily fee from residents. The government paid a $5 per day subsidy on behalf of those who could not pay.

Under the Aged Care Act 1997 the Commonwealth established the Aged Care Standards Accreditation Agency, which has responsibility for managing accreditation for all Commonwealth-funded residential aged care services. All residential aged care services required accreditation by January 2001. Standards are self-assessed, with a visit by assessors appointed by the agency. The quality management framework includes:

- Accreditation standards required by government
- Certification of the quality of buildings
- Concessional and assistant-resident ratios
- Prudential arrangements

The four accreditation standards specified by government include:

- Management systems, staffing and organisational development
- Health and personal care
- Residential lifestyle
- Physical environment and safe systems

THE CURRENT STRUCTURE OF AUSTRALIAN AGED CARE SERVICES

The private sector has a dominant role in residential aged care. The public sector and not-for-profit organizations dominate in most areas of community-based care. The provision of hospital services is a mixed responsibility. The system seeks to ensure that all care is provided to a minimum standard, that consumers have a choice about their level of accommodation, and that supporting payment will be received from government wherever appropriate. In 1995-95 the government spent $22 billion on health and welfare services for the aged, or about 5.1% of gross domestic product. Almost two thirds of government expenditure is for aged pensions, with the next largest component being expenditure on aged persons in hospital (15%). Residential care comprises 10% of the total and non-residential care 3%. Medical services are 6% of the total and pharmaceuticals are 3%. Expenditure on pharmaceuticals appears to be growing at the highest rate of 13% per annum, and medical expenses are next and growing at 8.5%.

HOME AND COMMUNITY CARE (HACC)

About 12% of people aged 70 and over receive HACC support. Sixty percent of the HACC budget comes from the Commonwealth, with the rest coming from State governments and user charges. The community care sector is characterised by a very large range of very small organizations. For example, in 1998 there were 2367 organisations in receipt of HACC funding. Almost 60% of all HACC funding is provided to organizations employing fewer than three staff for these activities. The major areas of HACC work and budget expenditures according to the Commonwealth Department of Health and Aged Care are outlined below. The high cost of program support, the insufficiently clear categories of provision, and the estimate that 64% of clients have their service needs met by more than one organisation suggest a substantial need for more effective coordination and needs based case management of service provision in this area.

- Community nursing 23%
- Home help 20%
- Other 22%
- Community respite care 13%
- Program support 12%
- Community options (high level care management for complex needs) 7%
- Delivered meals and food services 3%

RESIDENTIAL CARE

The likelihood of an older person being accommodated in residential aged care increases sharply with age. Contrary to a common belief, only a minority of the people who reach old age are ever likely to need residential care. For those who do enter a nursing home the average length of stay is between one and two years. The duration of stay has fallen considerably over recent years, as people have tended to enter care with higher levels of dependency. About one sixth of residents return to the community. Most nursing homes are mainly serving older people with serious illnesses in the last stage of life.

The resident's need for care is measured by an eight-point classification scale, which provides the basis for differential daily payments to the residential care facility. This funding system replaces an earlier one where funding for care provision was determined separately from housing and infrastructure. The current value scale is determined by a scoring system of 20 questions that take into account the resident's communication, mobility, personal hygiene, toileting, bowel management, whether they are physically aggressive, and medication requirements. Government supplements are paid on the basis of resident need and facility location. The resident pays a basic daily care charge and a contribution to the capital cost of the facility. The level of this charge depends upon the quality of the facility, the level of care and the resident ability to pay. All proposed an Aged Care Assessment Team must approve residents of aged care facilities.

CARER'S PAYMENT AND BENEFIT

In 1999 over 40000 Australians received the carer payment. Half of these people were caring for a relatively younger adult with a disability, 33% were for carers of aged persons, and the remainder were for carers of children. Carers may have access to a respite service in residential care and a small care allowance. It is interesting that these allowances, unlike other aged care policies, place the resources and choices directly in the hands of the carers themselves.

THE NEED FOR INTEGRATED CARE

Current program inflexibility can result in older people being discharged from one service and left to find their way to another. There is a major need for better linkages between hospital, residential, general practitioner and home and community care service provision. Investigation of how 'hospital in the home' type service provision might best be achieved is also necessary.

REGIONALLY POOLED FUNDS FOR ACCOMMODATION AND SERVICES

Kendig and Duckett have recently proposed that all Commonwealth and State funds for aged care services be pooled into a single fund to be managed at regional level. The funds pool would incorporate residential aged care, home and community care, community aged care packages, and relevant state-funded community health activities. A major advantage of this approach is that the supply of care can be tailored to local circumstances, especially in rural and remote areas. A funds pool could be managed regionally but with an advisory board of all stakeholders. Ideally, local government areas and health, welfare and disability planning regions would have common boundaries.

Kendig and Duckett also suggested that, as occurred in Britain, housing and aged care should be unbundled, with separate funding streams for accommodation on the one hand, and for living costs and care needs on the other. Care service provision should be based on personal needs, along the lines of the current resident classification system, irrespective of whether it is provided in residential care or in the home. This could provide more choice for older people by enabling them to meet their particular needs more effectively. It would also allow separate and continuing investigation by government of the best means of ensuring adequate and flexible accommodation of the ageing population in the future. This needs to be effectively coordinated with housing policy and provision throughout the life span, and with superannuation, taxation, education, employment, transport and related planning.

EVIDENCE BASED SERVICE PROVISION

The regional planning approach outlined above is generally necessary for the effective development of transparent, evidence based service provision. The current government planning framework aims to provide 100 residential aged care places and community care packages for every 1000 people aged 70 years in each planning region. The target for

Aboriginal people is 100 places for every 1000 Indigenous Australians aged 50 years and over. While not an indicator of need, this benchmark helps achieve a more equitable distribution of places to regions. The planning ratio applies in both city and country areas and helps achieve a more equitable distribution of places to regions. However, in order to assist decisions about what kind of planning and service provision is most effective for different needs, it is essential that a platform of information should be increasingly available for all those who plan or request new arrangements that affect the welfare of older people.

THE RIGHT TO DIE – A PERSONAL PERSPECTIVE

Data on suicide shows that older men commit suicide at similar rates to younger men, but older women very rarely commit suicide. Is this because women are more prepared to ask for others' help than men? The right to die is not an issue addressed in the current Commonwealth Government's National Strategy for an Ageing Australia. Nor is it addressed in the Australian Health Policy Institute paper on 'Directions in Aged Care' by Kendig and Duckett, which most of this lecture summarises. However, it is an issue which many in an ageing population will be unlikely to ignore.

The power of technology and drugs to prolong life, irrespective of its quality, is huge, increasing, and extremely costly for the community. Currently doctors tend to make decisions, in consultation with family members, about when treatment should be ceased. However, opinion polls show that in spite of the lack of effective and coordinated Commonwealth or state government policy on euthanasia, the majority of the population support the right for terminally ill people to choose their time of death themselves. Even if those who support the introduction of this right were in a minority, why should their wishes be ignored in regard to their own situation?

All choices about the deployment of community resources involve benefits and costs. The money spent in supporting a life, which is already comparatively long, but which is plagued by substantial physical and mental decline, represents resources which are not utilised in some alternative fashion, such as caring for the young, animals or the environment. At a personal level, and as a part of the largest population cohort of baby boomers, I definitely do not wish to be kept alive, demented and/or incontinent or in pain, as long as there is technology, drugs and money to sustain me. Having watched my parents suffer through their inability to control their own decline and death, I personally do not wish to experience the indignity and pain of such dependence, or burden my family and the community with the emotional and economic cost of preserving a shell. If any people who have already lived a comparatively full and happy life think this way, why should they not be more effectively supported by the community in regard to the planning of their own time of death?

In providing elderly people with the right and the means to end their lives when they choose to do so, government would be providing them with the right to choose what they think is best for themselves, significant others and the broader community. Death is a

moral choice which elderly people have surely earned the right to be allowed to make themselves. If it is not applauded, should it not at least be assisted?

CONCLUSION

Australians are living longer and healthier lives than formerly. The National Strategy for an Ageing Australia identifies major needs of the elderly as maintaining physical and mental health, engaging in physical activity, preventing falls and injury, maintaining adequate nutrition, detecting sensory loss early, managing incontinence and evaluating alcohol and other drug usage. Management of these problems should be discussed in the general context of community housing, education, employment and all related sustainable development needs. The aim of remaining healthy and independent in one's own home for as long as possible is shared by the elderly and government alike. People need to be able to make easier transitions as they age. Flexible services are required to meet a multiplicity of individual situations, whilst assisting each person to maintain links with work and the community wherever this is considered beneficial. Strategies to maintain wellbeing should centre on the development of more flexible employment patterns, and better-coordinated and more effective provision of accommodation, health, recreation and other social services, including transport, to meet community need. The appropriate role for superannuation in assisting attainment of accommodation and other aims will be a future concentration of government policy.

It has been proposed that all Commonwealth and State funds for aged care services be pooled into a single fund to be managed at regional level. The funds pool would incorporate residential aged care, home and community care, community aged care packages, and relevant State-funded community health activities. A major advantage of this approach is that the supply of care could be better tailored to local circumstances, especially in rural and remote areas. Housing and aged care might also be unbundled, with separate funding streams for accommodation on the one hand, and for living costs and care needs on the other. Care service provision should be based on personal needs, along the lines of the current resident classification system, irrespective of whether it is provided in residential care or in the home. The regionally managed implementation of national standards would assist the development of a more data driven, consultative and effective approach to improving services for the elderly and their communities.

FURTHER READING:

Kendig H. and Duckett S. Australian Directions in Aged Care: The Generation of Policies for Generations of Older People, Australian Health Policy Institute, University of Sydney, Commissioned Paper Series 2001/05.

Magnusson, R., Angels of Death: Exploring the Euthanasia Underground, Melbourne University Press and Yale University Press, 2002.

The Hon. Bronwyn Bishop MP, Minister for Aged Care, Attitude, Lifestyle & Community Support, The National Strategy for an Ageing Australia, AGPS, 2000.

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