Contemporary Themes

Old age in the sun

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This account of the care of the elderly in Australia is the third in a series looking at the ways different countries are proposing to cope with growing numbers of old people with a stagnant world economy.^{1 2}

In 1984 Australia's culture and its social structure are as much influenced by the United States as by Britain. The fast food restaurants, the drive in movie theatres, and the large, slowly driven cars give the visitor the impression that he might be in the American midwest (until someone starts speaking); and for many Australians the profusion of advertising and cut price promotions reflect the healthy virtues of capitalism. Yet the Labour party is in office, and successive governments have accepted responsibility for a wide ranging programme of social welfare. Australia's health system—and especially its arrangements for the care of the elderly—provide a prime example of the incompatibility of social welfare and entrepreneurial capitalism when brought together in a marriage of convenience.

The British influence seen in Australia should not be equated with attitudes found in contemporary Britain. Many Australian doctors emigrated from Britain after the second world war, disenchanted with socialism and austerity. They remain strongly opposed to any suggestion of socialised medicine on the NHS pattern: the Australian Medical Association speaks the same language (and has the same public image) as the American Medical Association. Doctors are seen by politicians and the public as rich, powerful, and greedy, though individual patients often have the same affection and respect for their family doctors as in Britain. At present the doctors and the government are enmeshed in bitter arguments about the financial implications for patients and doctors of plans for a new system of compulsory health insurance, Medicare. This is the context in which care of the elderly reflects the continuing conflict between society's aspirations for compassionate provision for their needs and the ingrained opposition of many doctors and businessmen to what they see as governmental interference.

Australia has not escaped the worldwide economic recession and its economists share the conviction of those in Europe and the United States that public spending should be cut—and that includes spending on the elderly. The current financial crisis has focused public attention on the rapid growth in the past decade of the numbers of nursing homes and other institutions for the elderly. Many of these institutions are run as money making businesses, but most of the occupants' fees are paid by the government. Attempts by the government to grapple with this drain on its finances have run into two obstacles: the conservatism of the medical profession and the Australian tradition that making money fast is a virtue. And to complicate the story

further for the overseas visitor Australia is made up of six autonomous states and two territories, each of which has a slightly different system for the care of old people while much of the money that pays for that care comes from taxation controlled by the Commonwealth (federal) government.

Geography and demography

Australia is a vast empty country, much of which is empty because it is virtually uninhabitable. Its area of 3 000 000 square miles is similar to that of continental Europe; the distance from Perth to Sydney (about 1750 miles) is of the same order as that from London to Istanbul. The population of 15 million is mostly crammed into the major coastal cities in the south east corner of the continent.

Much of the growth in the population this century has come from immigration—and migrants are mostly young. In 1901 only 3.8% of the population was aged more than 65 and as recently as 1981 the over 65s made up only 9.5%. By the end of this century Australia will still have only 11% of its population over 65, whereas in Britain the current figure is 13% and in Austria it is 15%. Aboriginals make up just over 1% of the Australian population, but 3% of the over 65s.

Financing health care

The Commonwealth (federal) government collects the major source of revenue, income tax, while leaving to the states and territories the responsibility for organising health care. An amendment made to the Australian constitution in 1946—at the request of the medical profession—specifically prohibited "civil conscription" and is thought to preclude the introduction of a national health service.

The health system that has evolved is a mixture of public institutions and private enterprise. The state and university hospitals provide 80% of the beds in the hospital sector, but the doctors who work in these institutions are mostly private practitioners paid on an item of service basis by their patients. The exceptions are the state psychiatric hospitals, which provide free care, and the states of Tasmania and Queensland, which have salaried doctors. General practitioners, too, are mostly private practitioners who charge their patients item of service fees, and many have hospital privileges in local hospitals.

Most Australian citizens, therefore, have become accustomed to paying for some sort of health insurance. The present government is in the process of introducing a national Medicare system with contributions based on the individual's taxable income. Many old people keep up their private insurance premiums so that they can continue to choose their doctors—but those with little income other than the national old age pension are eligible, in effect, for free medical care both in general practice and in hospital.

Pensioners admitted to nursing homes (whether state or private sector) have to make a contribution to their fees from their pensions but the bulk of the cost is borne by the Commonwealth government. Most sheltered housing, by contrast, is in the private sector and residents have to buy outright or find the rent, though rent rebates are paid to pensioners with low incomes.

Nursing homes, hostels, and flats

The current focus of attention in the Australian health system—at least as it affects the elderly—is the flourishing nursing home industry. Between 1963 and 1983 the number of beds in nursing homes rose from 25 000 to 68 000 or from 26 beds per 1000

FIG 1—Sheltered housing in South Australia.

people aged 65 and over to 47 beds per 1000. These 68 000 beds are mostly in private sector homes (33 000) or in “deficit financed” units (15 000), which are non-profit religious or charitable organisations. This rapid growth in the numbers of nursing home beds is directly attributable to legislation which has made the Commonwealth responsible not only for the fees of residents in nursing homes but also—in some circumstances—for capital subsidies for building new units.

In theory the aging Australian faces the same choices and has the same options as a pensioner in Europe or North America. Those who remain physically and mentally independent live in their own homes or may choose to move to a retirement village. Those who are too frail for independent living may be supported by home nurses, meals on wheels, etc, or may move into sheltered housing, hostels, or nursing homes.

What happens in practice is determined by some unusual features of Australian society. Firstly, most Australians approaching retirement age own their own homes. A recent survey found that 77% of 65 year old heads of households owned their homes outright. Relatively little private housing is available for rent. Most of the 94% of the aged who are not in institutions live with their spouses or other relatives (64%—including those in granny flats), 26% live alone, and around 3% live with non-relatives. But the traditional arrangement in Western society—old people being looked after by a daughter, usually unmarried—is becoming less common.

The pool of unpaid, unmarried women is drying up. Of women aged 45-59 in 1901, no fewer than 22% had never married. Today that proportion is 4.8%. Furthermore, many more of these single women now have jobs. Old couples often find nowadays that when one becomes frail the other has to provide support with little help from their children. When the

burden becomes too great the solution seen as proper by contemporary Australian society is admission to a nursing home.

If they are middle class, or at least reasonably affluent, the couple may make arrangements with one of the deficit financed, charitable organisations for one or both to move into one of the three tier complexes built in recent years. These are purpose built and provide sheltered flats, a hostel, and nursing home facilities, typically all on one site (figs 1 and 2). The client/patient pays a capital sum (actuarially calculated) as a contribution to the capital cost and will then be provided with whichever of the three levels of accommodation is required—and may move, for example, from nursing home bed back to hostel and vice versa in response to changing levels of dependence. Old people with little or no money apart from a pension may be accepted by a charitable deficit finance organisation without charge, but the numbers of such places are few.

Whatever the income of a pensioner, however, he can be certain that once under a deficit financed organisation's umbrella or in a state or private nursing home there will be no further financial problems. The Commonwealth picks up the bill.

For the family, too, the nursing home solution is attractive. If grandmother is in a caring institution (and the standards are high) they need no longer worry about her living alone, falling and injuring herself perhaps. Visiting need not be so frequent. Holidays no longer present a problem. And as a final bonus (Australians being realists and not too sentimental) once she is in a home the old lady's house may be sold.

So all the pressures in recent years have been encouraging the admission of old people to nursing homes early rather than late. In total 6.4% of the over 65s are in sheltered housing, hostels, hospitals, or nursing homes (table); but among the over 75s the proportion living in institutions is almost 20%. The striking figure, however, is the proportion of inmates of institutions who are very old: three quarters are aged over 75.

Where the elderly live in Australia (1981)

	Men	Women	Both sexes
Households	573 000	758 200	1 331 100
Nursing homes	10 800	34 100	45 000
Sheltered housing	7 700	24 300	32 000
Hospitals	5 200	9 600	15 000
Others	5 800	10 600	16 000

(Australian Bureau of Statistics.)

Australia's problems

Australia faces similar problems, then, to those I have described in Denmark and in the Netherlands: at a time of economic stagnation the Commonwealth government is looking for ways of curbing the rising costs of caring for the growing numbers of old people.

The distinctive features of the Australian scene are, firstly, the conviction of many experts that too many old people have been shunted into nursing homes; secondly, the determination of the government to halt what is seen as the nursing home growth bonanza; thirdly, the poor relations currently existing between doctors and government (owing to the long continuing wrangle about the Medicare scheme); and, finally, the constitutional complexities that have led to one set of politicians and civil servants in Canberra paying for the care of the elderly while another set—the state and territory governments—actually organise it.

The way forward may have been described in a detailed report, *In a Home or at Home*, produced in 1982 by the House of Representatives Standing Committee on Expenditure (known as the McLeay report).³ The committee spent two years examining the ways in which care has been organised, starting with the premise that too much emphasis has been given to institutional care.

Many of the McLeay recommendations are intended to simplify and unscramble the bewildering network of benefits,

grants, and subsidies payable by the government through a series of well intentioned laws dating back to 1947. In the new, simplified system these programmes will be reduced to nursing home care, extended care, and subsidised housing.

The proposals envisage a substantial growth in community services with senior citizens centres providing a base for extended care. At the same time the rate of admission of new patients to nursing homes should be reduced by the introduction of an assessment scheme—under which any patient wanting to be admitted has to be seen by an independent assessment team. At present a doctor has to certify that a patient needs admission; in practice general practitioners tend to go along with the wishes of the family. The proposed scheme would have the patient assessed by a team including a specialist geriatrician; the options might include admission to a hospital with facilities for rehabilitation and provision of domiciliary support services as well as admission to a nursing home.

Potential battles

The fate of the McLeay proposals seems likely to be determined by political rather than medical considerations. The first obstacle is the medical profession. Australian doctors (possibly more than most) resent any challenge to their clinical autonomy. Many general practitioners assert that they will not accept that an assessment team should be able to reverse their decision that a patient requires nursing home care. Yet assessment teams operate already in some parts of Australia—most often in association with academic geriatric units. In these circumstances the teams have shown themselves effective in rehabilitating patients (a function attempted by few nursing homes) and in mobilising and organising domiciliary services. Indeed, the McLeay Committee saw one of the important functions of assessment teams as identifying and advising on gaps and deficiencies in the range of services available in a community. The Department of Health would like to press ahead with the formation of teams but it faces widespread opposition from the Australian Medical Association.

A second problem stems from the ways in which different sorts of care are financed. In its evidence to the McLeay Committee the Australian Department of Health accepted that in the past community services for the elderly have been much cheaper than institutional care—but that the savings were explainable largely by the contribution made by voluntary workers and relatives. If these are to be replaced by paid workers—as seems likely if domiciliary services are expanded rapidly—the savings made by home care would be less. A change in policy along the lines recommended by McLeay might lead to savings in Commonwealth expenditure on nursing home fees, but the bill for the domiciliary services would necessarily rise. These bills are met by the state governments with “dollar for dollar” type support by the Commonwealth, and state governments are in no mood to spend more money on health. One solution favoured by some politicians and other experts is for the whole range of services for the over 65s to come under one budget in each community—so that savings made in expensive residential care could be transferred directly to the domiciliary services.

Conclusions

Health officials, geriatricians, and sociologists are all agreed that the government's provision of care for the elderly needs reform—to simplify the legislation and administration, to make the system more cost effective, to introduce tighter controls over the growth of the state financed private sector, and—finally—to provide old people with a better system of care.

Yet the average Australian citizen seems indifferent. The pensioners' own organisations campaign stridently for higher old age pensions while saying virtually nothing about care for the

FIG 2—Nursing home on the same site as the sheltered housing in fig 1.

demented and physically disabled. The main activities of the senior citizens clubs are bowls and bingo. If the system is reformed the handful of specialist geriatricians in each state will have to agree to devote a substantial proportion of their time to work on assessment teams. Plainly objective assessment will have to come—so long as the taxpayer is paying for the services. With assessment, and with its very large stock of mostly new, mostly purpose built institutions, Australia could have the world's best system for care of the elderly.

References

- 1 Smith T. Denmark: the elderly living in style. *Br Med J* 1983;287:1053-5.
- 2 Smith T. Care of the elderly in the Netherlands. *Br Med J* 1984;288:127-9.
- 3 House of Representatives Standing Committee on Expenditure. *In a home or at home: accommodation and home care for the aged*. Canberra: Australian Government Publishing Service, 1982.

CLINICAL CURIOS

Myxoedema and dark hair in old age

A 75 year old woman and four other elderly patients treated on separate occasions for myxoedema showed unusually dark hair and eyebrows for their age. Other doctors in the South Western region reported on similar patients, all aged over 65, with myxoedema, dark hair and eyebrows, and the considerable hair loss and receding frontal hair line that are characteristic of myxoedema.

Some association between retained hair pigment and myxoedema in old age is suggested, though myxoedema is often seen in white haired elderly women. Perhaps dark hair associated with myxoedema in old age is a sign that the patient concerned became hypothyroid before the time of life when his or her hair would naturally have turned grey.—W B WRIGHT, consultant physician, Cirencester.

Frozen insulin

A diabetic patient receiving continuous subcutaneous insulin infusion was fitted with an AS6C Autosyringe pump (Autosyringe, USA). The applied insulin, Actrapid (40 U/ml), was diluted with the appropriate diluting medium at a ratio of one to one. On being discharged from hospital on a cold (−25°C) February day he found that the insulin had frozen in the plastic catheter (Vygon Microflex 30 cm G 27). The complication was resolved by replacing the frozen syringe and plastic catheter with new ones.

Patients have subsequently been warned to protect equipment for infusion from the cold, and no similar complications have arisen.—J SALMI, consultant endocrinologist, H OKSA, senior registrar, H OKSALA, senior registrar, Tampere, Finland.