CHAPTER 6

HEALTH AND MEDICAL ISSUES

6.1 Life expectancy and health status in older age have altered significantly over the past century. The expectation of life for men and women reaching the age of 60 years has increased by three years over the past two decades, so that men reaching sixty in 1991 can expect to live to 78.3 years and women can expect to live to 82.8 years. As Table 6.1 shows, Australia rates fairly well by international (OECD) standards, although outstripped by several developed European countries and, most strikingly, Japan. Australia is slightly below the average rate of increase for life expectancy at birth among females between 1960 and 1989, and slightly above the average increase for males.

Table 6.1: Life Expectancy at Birth, Males and Females, for OECD Countries, 1960 and 1989

	WOMEN		MEN		Percent increase	
COUNTRY	1960	1989	1960	1989	WOMEN	MEN
Australia	74.0	79.6	67.9	73.3	7.6	7.9
Austria	71.9	78.6	65.4	72.0	9.3	10.0
Belgium	72.7	77.7	66.7	70.9	6.9	6.3
Canada	74.3	79.7	68.4	73.0	7.3	6.8
Denmark	74.1	77.7	72.3	71.8	4.8	–0.7
Finland	72.4	78.7	65.4	70.7	8.7	8.1
France	73.6	80.6	67.0	72.4	9.5	8.0
Germany	72.4	78.4	66.9	71.8	8.3	7.3
Greece	70.4	-	67.3	-	-	-
Iceland	75.0	79.9	70.7	75.2	6.5	6.3
Ireland	71.8	76.7	68.5	71.0	6.8	3.6
Italy	71.8	79.1	66.8	72.6	10.1	8.7
Japan	70.3	81.8	65.4	75.9	16.3	16.0
Luxembourg	71.9	77.9	66.1	70.6	8.3	6.9
Netherlands	75.5	80.0	71.6	73.7	5.9	2.9
New Zealand	73.9	77.1	68.7	71.1	4.3	3.5
Norway	75.9	79.9	71.4	73.3	5.3	2.7
Portugal	67.2	77.6	61.7	70.7	15.5	14.6
Spain	72.2	-	67.4	-	-	-
Sweden	74.9	80.6	71.2	74.8	7.6	5.0
Switzerland	74.2	80.7	68.7	73.9	8.7	7.6
Turkey	-	-	-	-	-	-
United Kingdom	74.2	78.1	68.3	72.4	5.2	6.0
United States	73.1	78.5	66.6	71.5	7.4	7.3
OECD Average					8.1	6.9

Source: OECD in Figures 1991, p 8-9.

6.2 The longer length of life means that there is now, and will be for future generations, a distinct and extensive third stage of life, retirement or post-employment, which for many will last for about 20 years - a period as long as or longer than that of the first stage of life, childhood. Health status during retirement and older age will be a significant determinant of the quality of life or older people and of their capacity to contribute to the community.

6.3 For much of the 20th Century, older age was experienced as a period of decline and disease. This perception is now changing rapidly, as a consequence of dramatically increasing life expectancy and improvements in public health. Present generations of older people generally rate their own health as good or excellent, and research during the 1980s indicates that, among older people, self-rating is a more accurate predictor of health than clinical assessment. This widespread experience of good health is an aspect of older people's health which has been overshadowed by an emphasis on the causes of death, disability and frailty.

6.4 One condition for the increased number of older Australians are improvements in health and survival during the 20th Century, as the tables on life expectancy in Chapter 2 make clear. From 1905 to 1966 the improvements in survival were concentrated among these aged below 60 years, while between 1966 and 1986 the survival chances for both men and women increased significantly at ages above 60.[1]

6.5 These improvements in life expectancy at older ages are historically unprecedented, and their effects on the lives of older people are yet to be studied. In the 1971-1981 period the life expectancy of those in their fifties increased by two years and that of those aged 60-plus by more than a year. Among males this improvement was greater than all improvements for these age-groups over the previous century. John McCallum suggests that the improvement may reflect the arrival of Mediterranean migrants (especially Greeks and Italians), whose diets contain less animal fat and who are thus less susceptible to cardiac and vascular problems, a proposal that is not inconsistent with Hugo's argument that the improvements in life expectancy are largely due to reduced deaths from ischaemic heart disease. Hugo cites the following figures for such deaths:

	Males	**Females**
1968	337 per 100 000	219 per 100 000
1982	250 per 100 000	177 per 100 000[2]

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1 John McCallum, guest editor of Chapter 7, "Health: the Quality of Survival in Older Age", in *Australia's Health 1990: The Second Biennial Report of the Australian Institute of Health* (Canberra, AGPS, 1990), p 211 (Hereafter McCallum AIH).

2 Graeme Hugo, *Australia's Changing Population: Trends and Implications* (Melbourne, Oxford University Press, 1986), p 21.

6.6 He attributes the reduction in the incidence of heart disease to lifestyle changes and medical advances. The former heading includes factors such as fewer men smoking, lower consumption of animal fats and more exercise. The medical advances include improved diagnosis of coronary disease, better information and screening programs, improved drug and surgical treatment and increased use of medical services (leading to earlier detection of problems). There is argument as to the relative weight that should be given to the medical and the lifestyle explanation, but a recent study by the Australian Institute of Health has concluded that about 75 per cent of the reduction is attributable to modification of high risk behaviour, such as smoking, poor diet and high blood pressure.[3] Such a conclusion has profound implications for the future development of health policy . There are obvious links between food, exercise, health and energy, on the one hand, and confidence and psychological well-being on the other (see below).

6.7 While circulatory diseases are still a major cause of death, the rate of death from cancers has increased for both men and women, and respiratory and digestive disease rates have increased for women aged 80 and above.[4]

6.8 With increasing longevity, the view of older people as a homogeneous group with specific health support needs has been challenged. Within the great cultural diversity which characterises the Australian population, there are three stages in older age which provide some predictors of health status.

6.9 First, there are the "young old", those between 65 and 74 years, who are most often physically healthy, functionally independent and mentally alert. Illness in this group frequently follows patterns observed in younger people, that is, acute conditions with a defined clinical course and a return to pre-illness functioning. As a result, preventive health services, primary health care and occasional access to acute hospital services are most relevant to this age group.

6.10 Second, there are the "middle old", those aged 75 years and above, who are increasingly likely to experience acute illnesses for which medical treatment is sought and for which hospital admission is more frequently required. This age group is also more likely to have functional, social and economic dependencies resulting from chronic illness and disability.

6.11 Third, there are the "old old", those aged 85 years and above, who are most likely to be affected by chronic diseases, multiple pathology, continuing and/or progressive disability and dependency. Most important for the delivery of health care are the specific physiological characteristics of older age which require appropriate treatment and management. Illness in a very old person tends to present different symptoms than are encountered in other age groups with clusters of non-specific symptoms being common manifestations of disease. Age specific medical care and treatment options are most appropriate to this age group.

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[3] National Better Health Program, Submission, p 19.

[4] Victorian Government, Submission, p 7.

6.12 The longer survival and greater numbers of the aged have implications for the demand for health services, and demand will shift from the acute ailments of the young to the chronic sickness of the aged. Much of Australian medical system was established in 1950s/60s, when the population was young, and was thus set up to provide the relatively short-term, very intensive specialised care suited to acute illness, but not the less intensive, long-term and less technologically sophisticated care appropriate to chronic illness.

6.13 The greater life expectancy of women has particular implications for age care provision. Women's greater longevity is due partly to inherent genetic and biological factors and partly to environmental factors such as:

- higher occurrence of heart disease among men, related to greater incidence of stress, smoking and alcohol consumption;

- men's greater workforce participation and the greater variety of their occupations, with consequent higher level of exposure to workplace hazards;

- men's greater incidence of motor vehicle accidents, especially in the 18-25 year age group.

6.14 Because of women's greater life expectancy, projected to stabilise at 6.5 to 7 years more than men's, 60 per cent of Australians over 65 and 75 per cent of those over 85 are women. This means that care of the very old is principally the care of elderly women, and increasingly so the later the age. Fewer men will need institutional assistance because married men are likely to have a wife to look after them, but the older women are the less likely they are to have a surviving husband.[5] It is therefore important that the forms of home and institutional care that are available for the very old take the gender composition of their clientele into account.

Disability

6.15 Although today's elderly are healthier than ever before, advancing age is inevitably marked by a rapid increase in the incidence of disability. There is normally a higher proportion of people with disabilities among the older age groups as a result of the ageing process. As people age they are more likely to acquire some disabling condition (hearing and visual disorders are an obvious example), and the risk of disabling resulting from normal everyday life compounds with increasing length of life. The ageing of the population will in itself produce a large increase in the number of people with dementia because the prevalence of this condition is exponential with age, doubling for every five years of life over age 60.[6]

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[5] Hugo, p 22-25.

[6] DCSH, Submission, p 2.

6.16 About 44 per cent of those aged 75 or more have some sort of disability, meaning that they are limited to some degree in their ability to perform tasks in self-care, mobility, communications, education or employment. Older people also have a higher incidence of severe handicap, meaning that they need personal help or supervision in performing or are unable to perform one or more tasks related to self-care, mobility or communication.[7] As the following table shows, the incidence of mild, moderate and severe handicaps is directly related to age.

Table 6.2: Incidence of mild, moderate and severe handicap among Australians, by age, 1981.

Age group	Mild handicap Rate per 1000	Moderate handicap Rate per 1000	Severe handicap Rate per 1000	Total Number ('000s)	Rate per 1000
5-14	0.37	0.45	1.60	97.0	3.75
15-44	0.73	0.80	1.41	158.6	2.30
45-54	2.43	2.71	3.61	157.8	11.65
55-64	5.43	4.69	5.75	260.7	19.25
65-74	8.46	5.45	9.61	220.5	23.53
75+	8.95	6.02	29.49	230.4	44.46
Total	1.98	1.70	3.44	1264.6	8.47

Source: Hugo, p 33.

6.17 This fact has profound implications for the quality of life among older people. One cannot assume that increasing longevity means better health or that reductions in mortality will necessarily be accompanied by corresponding reductions in morbidity. The DCSH points out that:

> *This is the theoretical position known as "compression of morbidity", but to date there is little evidence to support it. It is based on the argument that, as longevity increases, the period of final chronic illness, such as myocardial infarction or lung cancer, does not increase correspondingly.*
>
> *However, the measurement of morbidity should not be restricted to only the final serious illness, but should cover other less serious but disabling and dependency-inducing disorders. Disorders such as dementia and rheumatoid arthritis are age-related, and these result in disability and dependency. Their prevalence is increasing with longevity: between 1981 and 1988 there was an increase of 50% in the prevalence of disability in the 65-75 age group.*[8]

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7 Hugo, p 32.

8 DCSH, Submission, p 1.

6.18 This figure is based on the results of surveys of self-assessed disability which the ABS carried out in 1981 and 1988. The increase in the prevalence of disability over this period is so large for some age groups that it sparked a good deal of controversy as to whether the disability was mostly "real" or mostly an effect of greater public awareness and willingness to admit problems.

Table 6.3: Percentage of people with disabilities in the total population

Age group	0-14	15-24	25-59	60-84	85+	All
1981	5.3%	6.8%	15.8%	36.7%	63.6%	13.2%
1988	6.0%	7.1%	15.9%	44 9%	82.9%	15.6%
Variation +/-	+0.7	+0.3	+0.1	+8.2	+22.3	+2.4

Source: Preliminary Results: Disabled and Aged Persons Australia, 1988 Australian Bureau of Statistics

6.19 These surveys show that between 1981 and 1988 the number of Australians who reported that they were disabled rose from 1.9 million (13 per cent) in 1981 to 2.5 million (16 per cent). This included 9 per cent in 1981 and 13 per cent in 1988 who felt they were handicapped by their disabilities. The increase was most marked in older people.

6.20 Some of the increase in disability and handicap between 1981 and 1988 was due to the ageing of our population. To clarify the situation the Australian Institute of Health has analysed the data to determine the number of disability-free years theoretical groups of people of different ages can expect. According to this analysis, the years spent disabled and handicapped are increasing. From 1981 to 1988, Australians gained about a year of life expectancy from the age of 65 years, but lost two years in handicap-free life expectancy and about one year in disability-free expectation. This conclusion is consistent with the experience in other countries, since the overall picture from the international data is of rising total life expectancy and stationary or falling health expectancies.[9]

6.21 As the National Better Health Program observes:

> *The discovery that the number of Australians who considered themselves to be disabled had increased by 600 000 in seven years created a controversy. Some denied that the effect was 'real', suggesting that, rather than being caused by impairment from an increase in disease, it was merely due to a change in behaviour. Perhaps as a result of the International Year of the Disabled perceptions of disability were enhanced, or people were more willing to report disability and handicap.*

[9] National Better Health Program, Submission.

Others pointed out that, by definition, disability and handicap were not just measures of physical impairment, but contained mental and social dimensions.

Certainly in terms of demands placed on the health system, it is people's behaviour that is important. The World Health Organisation defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" over twenty years ago. It is only now that this concept is beginning to find expression in the mainstream health system.[10]

6.22 The DCSH considers that medical intervention was the most significant reason for the apparent rise in disability. It explains in its submission that, in addition to lengthening the lives of people with genetic or chronic disease or disability and enabling people to survive disabling accidents which were formerly fatal, medical technology is now ensuring that many infants who in the past would have died at birth or in their early years are living to old age, often with chronic health problems.[11] A comparison of the ABS's 1981 and 1988 Surveys of Disability and Handicap indicates that the most significant increase of disability has been in the 60-plus age group, where it rose by 9 per cent, or more specifically:

. 60 to 80 years - 8.2 per cent

. 85 years and over - 19.3 per cent.

6.23 There is a range of reasons for this, including the consideration that 55 per cent of the increase is because of total population changes; changing community attitudes towards disability; and the fact that people with disabilities live longer. It should also be noted that most of the increase in disability among the total population occurred in the mild and moderate groups, while the biggest increase in the severe disability group occurred in the 85-plus age group.

Preventive Health

6.24 As the argument about increasing disability suggests, increasing longevity can be regarded as a positive good only when the problems of associated ill-health are resolved. As Aldous Huxley implied in his novel *After Many a Summer* and Jonathan Swift so savagely illustrated in Gulliver's voyage to Laputa and Japan, there is nothing more dreadful than to be condemned to eternal life while suffering all the traumas of senile decay. Quality of life at older ages is most appropriately assessed in a variety of terms, such as level of function, ability to perform the normal activities of daily living, level of dependency on others and psycho-social well-being, not simply in terms of prolonged life.

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[10] National Better Health Program, Submission, p 4.

[11] DCSH, Submission, p 2.

The public and private cost of providing services to achieve social goals, such as maintaining the frail aged independently at home or providing long-term nursing home care to the most dependent, has to be considered alongside the quality of life gained.[12]

6.25 One of the biggest problems with modern clinical medicine is that the lengthening of life (by saving lives from disease) has taken priority over efforts to improve quality of life. Survival alone tends to be the criterion by which the achievements of the medical system are assessed, and this is an important source of the profession's prestige. John McCallum argues that the goal of many technological and pharmaceutical developments is the marginal extension of life at older ages, even though there appears to be little public or consumer support for such developments. The agenda of modernised medicine can also be criticised for failing to evaluate the cost-benefit ratios related to its achievements, or the persistent realities of death, loss of function and social isolation that continue to occur in older age.[13]

6.26 It is thus becoming increasingly recognised that, as John McCallum argues, health in older age is very dependent on the social and environmental context. The quality of housing is critical in maintaining daily activities. Income is important for adequate nutrition and allows options for transport and leisure that can prevent social isolation. The "new public health" stresses that these social and institutional structures are important in health outcomes, and they have added importance in older age because of the increasing risk of dependency. An extra dollar spent on the social and economic fabric, such as housing or pensions, may well have more impact on the health of older people than a dollar spent on hospitals, doctors and nursing homes.

6.27 Accordingly, the questions of preventive health and health promotion are high on the health policy agenda, even if little practical progress has been made so far. Many submissions to the inquiry emphasised the importance of preventive health strategies and deplored the lack of effort being directed towards them - for example, the Ethnic Communities Council of South Australia, which pointed out that Australia had been planning for the coming increase in aged population but that "the prevention of ill-health in older people has not been addressed sufficiently well". The submission added that older people themselves have identified illness prevention and health promotion as the key health issues and proposed that resources be diverted to expand health promotion programs which target the groups most likely to benefit from them.[14]

6.28 The importance of preventive health and the need to reform public health strategies to make it more central was emphasised by the National Better Health Program. In its submission the program contended that a "Paradigm shift is currently occurring in health" and went on to explain how this has occurred and why the change should be supported.

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[12] McCallum, AIH, p 199.

[13] ibid.

[14] Ethnic Communities Council of South Australia, Submission, p 2-3.

A New Meaning for Health[15]

6.29 A paradigm shift is currently occurring in health. The traditional medical model which emphasises the diagnosis and treatment of disease is in decline. Increasingly it is found to be costly, ineffective and unpopular.

6.30 *Too Costly:* Although Australia's health costs are favourable by international standards, the cost of modern health care is still considerable. Between 1960 and 1990 total expenditure on health in Australia grew from 4.9 per cent of GDP to 7.5 per cent, a final result right on the OECD average, but the second lowest rate of increase for all OECD countries except Iceland. Table 6.4 gives the details. In 1987-88 the total Australian health bill was over $23 billion.

Table 6.4: Total Spending on Health as a Percentage of GDP

	1990 % GDP		1990 % GDP
United States	12.4	Greece	5.3
Italy	7.7	Ireland	7.1
Switzerland	7.4	Finland	7.4
Japan	6.5	Denmark	6.2
Norway	7.2	Germany	8.1
Belgium	7.4	Canada	9.0
France	8.9	New Zealand	7.2
Netherlands	8.0	United Kingdom	6.1
Austria	8.4	Australia	7.5
OECD Average	7.5	Iceland	8.5
Sweden	8.7		

Source: OECD Press Release, 25 September, 1991.[16]

6.31 *Ineffective:* Despite this increased investment, there is concern that the health of populations is not improving. The traditional model has few cures for the new epidemics of chronic degenerative diseases such as strokes, arthritis, some cancers and Alzheimers disease. Furthermore, given its separation of mind and body, it has little to offer many common presentations of ill-health, including fatigue, stress and chronic pain. In fact, it has been estimated that in over 50 per cent of consultations, general practitioners can find no evidence of disease to explain symptoms.

6.32 *Unpopular:* The growth in popularity of alternative medicine in Australia and elsewhere can be seen as a protest against the traditional medical model. In 1984 the Victorian Government conducted an enquiry into alternative medicine, in response to

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[15] This section is largely based on the submission received from the National Better Health Program.

[16] See also Jenny Macklin, the National Health Strategy, Background Paper No 1, *Setting the Agenda for Change* (November 1990), p 6, where the figures are calculated slightly differently but carry the same message.

concerns about the safety of herbal medicine. A survey of 1202 people found that 22 per cent had used a form of alternative medicine in the previous 5 years, and this survey excluded manipulative therapists such as osteopaths and chiropractors.[17]

6.33 Although women are the heaviest users of conventional medical services, it is no coincidence that they have led the flight to alternative medicine. Consultations with women during the development of the National Policy on Women's Health revealed that they believed that ill-health should be seen, not simply as a set of symptoms, but as a condition inextricably intertwined with its social and economic environment.

6.34 Popular support for alternative medicine can also be seen as a growing desire to take greater personal responsibility for health.

6.35 *A new social health is emerging.* Under the banner of the World Health Organisation's Health for All Campaign, a new social health is emerging. In this model, health is a positive state of well-being. It is a reflection of the extent to which basic human needs have been met. Spiritual, economic and social needs for health are recognised, as well as physical. These have been described as the presence of:

- safe environments;
- the basic necessities of life (adequate food, adequate shelter);
- the basic amenities of life (transportation, recreation, beauty, stimulation);
- safe, rewarding and meaningful work; and
- companionship and involvement.

6.36 Theories have been proposed to explain how these factors may interrelate to influence health, although a better understanding of the new meaning of health, particularly with respect to alienation and powerlessness, is needed. Under this model, the role of the health sector is broadened from the treatment of disease to the provision of support to communities and individuals to enable them to create healthy societies and environments.

6.37 Healthy Cities Australia, funded by the National Better Health Program, is a program based on this model of health. Under its umbrella, local councils, health services, employers, school, governments and citizens in Canberra, Illawarra and Noarlunga (Adelaide), have co-operated in local forums to improve physical and social environments.

6.38 The submission from the National Better Health Program also offered comments on particular questions raised in the inquiry's terms of reference.

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[17] See also Parliament of Victoria, Joint Select Committee on Osteopathy, Chiropractice and Naturopathy, *Report* (1973-75).

How to maintain an active and healthy life into old age

6.39 A model of health using a social, as opposed to a disease, emphasis, health is maintained by creating physical and social environments which support health and personal development. Using the basic human needs identified earlier as a framework, examples of projects which aim to promote health to ensure an active and healthy life into old age are shown in Table 6.5.

6.40 Through the National Better Health Program, the National Aboriginal and Women's Health Strategies and the National Occupational Health and Safety Commission, social health frameworks are being used to create healthy environments and develop communities and individuals so that they can exercise greater control over their health. Of the total health budget, however, only 1-2 per cent is spent on effort to promote health. Naturally sick people will always need treatment. The challenge is to find a balance between the promotion of health and well-being and the provision of adequate care.

Table 6.5: Examples of current activities to promote an active and health life.

AIM	ACTIVITY
Create safe environments	Developing national guidelines and other resources for environmental health management planning. This will assist local governments to anticipate the health impacts of current and proposed activities.
Provide basic necessities, e.g. adequate food and shelter	Working with producers, retailers, consumers and others to develop a national food and nutrition policy and strategy. This will aim to ensure Australians will have access to a food supply which is safe, accessible and affordable.
Provide basic amenities, e.g. transportation, recreation, beauty, stimulation	The recently announced Better Cities Program will aim to improve urban design. For example, urban villages could be created with mixed housing types, set in traffic-calmed environments which are focussed around significant village centres, public transport facilities, generous open spaces and high quality public recreation facilities.
Provide safe, rewarding and meaningful work	Bringing together the principles of award restructuring, health promotion and occupational health and safety to develop new strategies for health promotion in the workplace.
Strengthen companionship and involvement	Successful Ageing A.C.T. is developing community action to counter isolation among all age groups. It emphasises the need for both independence and interdependence.

Source: Submission from National Better Health Program.

How to deal with the problems of extreme longevity and associated chronic illness

6.41 In Australia the problems of extreme longevity and illness are being considered in the context of the ethical allocation of scarce resources.

6.42 Little is known about the relative effectiveness of prevention and cure, but evidence is mounting that clinical medicine may have contributed less to improvements in the health of populations than has been assumed.

6.43 For example, a decline in circulatory diseases has been largely responsible for our increased life expectancy since the 1970s. At the same time as the rate of death from heart disease has been falling, there have been dramatic changes to treatment. By-pass surgery, which rectifies the immediate structural problem but does not address the underlying disease, has replaced the traditional pharmacological management. Costing some $10 000 per operation, such treatment has been very expensive.

6.44 As noted above, evidence would now suggest that the decline in mortality from heart disease is mostly due to a reduction in the incidence of the disease, and much less to the improved treatment. Australian studies have estimated that 75 per cent of the reduction in deaths from heart disease is due to modification of risk factors such as smoking habits, diet and blood pressure.

6.45 We can therefore no longer afford to assume that the highly specialised, highly technical treatment of disease is the most effective health intervention.[18]

Other Health Issues Affecting Quality of Life

6.46 While endorsing the thrust of the case for more emphasis to be placed on and more resources to be directed towards preventive health, the Committee notes that there are specific health issues that are also relevant to quality of life for older people. Health surveys have shown that the most common health problems among older people are chronic disabling conditions; a rising incidence of dementia; eye and ear disorders; arthritis and respiratory disorders. In addition, significant numbers of older people are known to have undiagnosed or untreated health problems which result in remediable conditions, such as incontinence or poor oral health.

6.47 It is now recognised that many of these conditions, once thought to be the inevitable consequences of older age, are preventable or at least capable of inhibition or amelioration. Australia's progress in such areas will have a significant impact on the quality of life of older people in the next century.

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[18] National Better Health Program, Submission, p 19-20.

Mobility and Safety

6.48 In view of the high incidence of accidental injury among older people, it is critical that emphasis be placed on the importance of promoting low risk home and urban environments for older people and of maintaining mobility and independence. Programs appropriate to meet these needs include safety and design promotion programs aimed at designers and developers of urban environments and housing and at older people and their service providers; and prevention and treatment programs for disabling conditions such as arthritis, osteoporosis, sight and hearing loss.

Diet and Oral Health

6.49 The diet of older people is increasingly recognised as essential to the maintenance of health and quality of life. Maintenance of an adequate diet requires a recognition of the social aspects of food and nutrition, and the fact that the oral and dental health needs of older people are closely connected with their health, appearance and self-confidence.

6.50 Diet can be adversely affected when the ability to purchase and prepare food is eroded by problems of physical mobility or widowhood. It can also be adversely affected by oral or dental health status. A newly emerging concern recently identified in Australian research is the extent to which older people require dental treatment for pain, infection or other acute problems. Up to 75 per cent of residents in geriatric institutions and 30 per cent of older, home-bound people have been shown to be in need of urgent dental treatment. This is largely a consequence of changing dental practices and health care which have resulted in increasing numbers of people retaining some or all of their teeth throughout life. There is an urgent and growing need for services appropriate for older people who have retained some or all of their natural teeth, including access to subsidised oral health care; and for appropriate oral health care services among the range of health services for older people.

Medication Management

6.51 Older people are the major users of prescribed and non-prescribed pharmeceuticals in Australia. Pensioner prescriptions under the Pharmaceutical Benefits Scheme (PBS) account for 25 per cent of all prescribed drugs and 55 per cent of psychotropic drugs. Pensioner prescriptions have shown an annual increase of 6 per cent, compared with a 2 per cent increase in the number of eligible pensioners. According to PBS records, in 1985 pensioners had an average of 26 prescriptions per person, compared with four per person among the non-pensioner population.[19]

6.52 While many older people derive great benefit from using appropriately prescribed and administered medications, the specific physiological changes and the effects of multiple interacting conditions or diseases in older age predispose older people to adverse drug reactions to the extent that 25 per cent of reported adverse drug reactions occur in people aged 65 years and older.

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[19] McCallum, AIH, p 228.

6.53 The prescribing practices of general practitioners and the amount of self-purchased medications taken by older people have recently been identified by older people's organisations as major health care issues affecting the well-being and quality of life of older people.

6.54 Recent recognition of the extent to which older people use and need medications and of the heightened risk they face of adverse drug reactions requires long-term strategies both to promote safe prescription and use of medications and to foster the use of other health care strategies where appropriate. Recent initiatives by the Victorian and the Commonwealth Governments in this regard have begun the development of increased community awareness of the risks associated with medication use. In Victoria, the Older Persons' Action Centre has been funded by the Victorian Health Promotion Foundation and the Health Department Victoria to provide a 12 month pilot education and information project on medications and older people. Future strategies, to ensure careful and appropriate use of medications and to enhance the quality of life of older Australians need to include:

- medication audits, medication self-management programs, and discharge plans providing medication information to older people and their medical advisers, in acute hospitals;

- community-based medication information programs; and

- current and regularly revised medication information in all community languages.

6.55 The Committee notes that the recent report by the House of Representatives Standing Committee on Community Affairs has recommended the inclusion of "a cautionary note on packages of unscheduled and Schedule 2 and 3 drugs advising older people to consult a pharmacist or doctor on appropriate dosage rates for their age, weight and state of health".[20]

Health Information and Education

6.56 The Victorian Health Promotion Foundation and the National Better Health Program have been established in recognition that the quality of life for all is enhanced by the promotion and maintenance of health and well-being. For older people, in particular, health promotion and maintenance is enhanced through local community-based health information and educational provision. Future strategies need to recognise the importance and education of community health centres, older people's organisations, general medical practices and local pharmacies in providing health information and education for current and future generations of older people.

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[20] *Prescribed Health: A report on the prescription and supply of drugs* (Part 1 - March 1992), Recommendation 7.

Health care strategies for the future

6.57 The Older Persons' Planning Office, Victoria, considers that the overall aim of health policies for older people should be to improve their quality of life. As the Office writes:

> *In an important sense, all older people are in need of special attention from Government policy. The human condition is such that old age brings problems common to all groups of people, irrespective of wealth, cultural background, sex or place of residence. These are problems of frailty, ill-health, limited capacity to earn an income and loneliness. Although by no means all older people will encounter these problems, they are sufficiently universal as concerns facing older people to warrant the special attention of government.*
>
> *Thus, Governments have a duty to ensure that older people, as a group, have access to good quality health care, a basically adequate income, decent housing, and access to those community services that are essential to the maintenance of an independent life.*[21]

6.58 Future strategies in health services need to recognise certain critical aspects of health in older age:

- that increasing longevity requires policies which will promote and maintain health in younger-old age, including recognition of the wish by many older people to remain in the workforce and appropriate programs to address emerging health issues;

- that health care services for advanced older age are adequate and appropriate to respond to the high levels of physical disability and mental impairment which occur in older age groups; and

- that changing social patterns require government health policy to recognise the burden of care placed on family support systems, particularly women, and that increasing longevity is already resulting in many carers themselves being among the young-old age group, and thus in need of greatly increased levels of support and assistance.

6.59 To ensure adequate planning and provision of services for future generations of older people, health strategies are needed which:

- are based on accurate information about the population for which services are planned;

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[21] Victorian Government, Submission, p 11.

- assume increasing demand for a wider range of services, in a budgetary context of relatively static resource availability;

- target available resources with optimum effectiveness, and eliminate service duplication; and

- ensure the development of effective linkages both within acute health care services and between those services and primary and community health and health promotion services and welfare support services.

6.60 Strategies may include the following:

- community-based health promotion and maintenance information and support to enable older people to be aware of their health needs and opportunities;

- local community health centres, providing a range of allied health and support services;

- low cost and free community-based public dental health, podiatry, optometry and hearing services;

- a network of high quality, free public hospitals providing easy access to older people, with specialist geriatric health care units where appropriate, and co-ordinated discharge services for older people which link with their local services and support;

- rehabilitation services to enable older people who have experienced illness, accident or diminished ability to return to a level of functioning which maximises their independence and quality of life;

- improved availability of psychiatric assessment and treatment services;

- expanded dementia diagnosis, treatment, care and carer support services, including appropriate community-based residential care services;

- geriatric centres which are centres of excellence in geriatric medicine, research and education;

- small-scale community-based residential services for those older people for whom living independently or alone is no longer appropriate or desirable or who need high levels of nursing care;

- integrated networks of community health, welfare and acute care services capable of providing adequate and appropriate support to older people with health care, frailty or disability support needs;

- adequate and current national and state-based data on the health and welfare needs of older people, capable of informing planning and policy development to meet the needs of future cohorts of older people; and

- respite services, including residential, day care and at home categories of respite care.

Palliative care

6.61 Many older people face a time of chronic illness, some a stage of terminal disease. Increasingly, health professionals recognise the limitations of modern medical treatment as a cure for all illness, and acknowledge the need for available palliative and other support services. Although palliative care programs have grown in the past few years, they still fall far behind the funding of other health services. There is a need to support programs which enable older persons to confidently remain in their homes through chronic and terminal illness.

Inequalities in Australia's Health

6.62 The amount of research which has been done on the relationship between socio-economic factors and health in Australia is small. Nevertheless, interest is growing, and there is evidence to support the shift to a social framework for health.

Socio-economic status

6.63 The relationship between poverty and health is well established. "The socio-economically disadvantaged have higher death rates than the socio-economically advantaged for all major causes of death", according to *Australia's Health 1990*, the Australian Institute of Health's second biennial report. The Health Targets and Implementation Committee to Australian Health Ministers (1988) indicated that poverty was the most powerful determinant of health when it commented that 'the greatest improvements are likely to occur in concert with reductions in poverty'. Income, occupation, education, employment and place of residence are all indicators of socio-economic status.[22]

6.64 A major project of the National Better Health Program has been the development of a Social Health Atlas for Australia. Due to be completed in 1992, this project is constructing a map of health status by postcodes. This will enable health promotion programs to be instigated where they are needed most, and will assist in their evaluation. Health Whiz, a software package, will allow communities to readily access the Atlas for information about their locality.

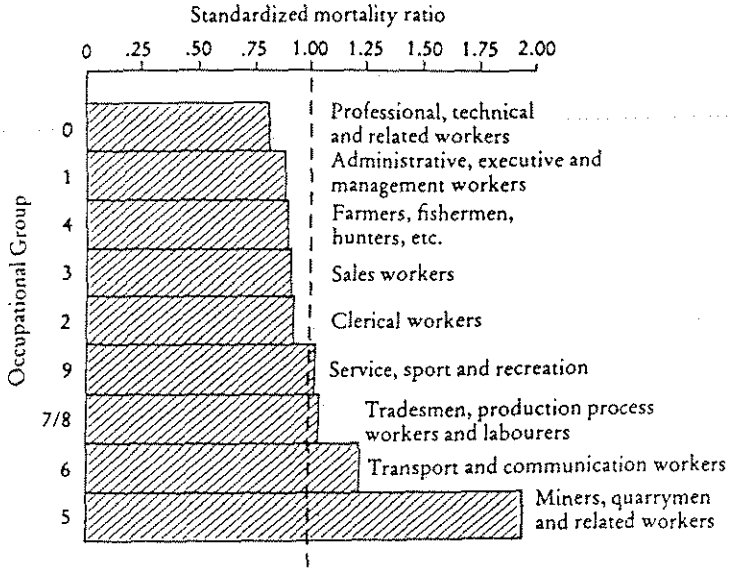
6.65 Given the unlikelihood of a blanket cure for poverty, the structure of poverty is worth closer examination. What emerges from such scrutiny is that Aborigines, women and the aged, who are mostly women, bear disproportionately large shares of poverty and consequently low health status. The mechanism by which poverty influences health is not clear, though there are basically two theories. One is that structural factors predominate: poorer people work in more hazardous jobs, live in more polluted and dangerous

[22] National Better Health Program, Submission, p 11.

environments, live in less adequate housing and eat less healthy food. The other view is that poorer people are alienated. If they have any work at all it is stressful and unfulfilling. They are isolated from support and information. These conditions could lead to poor health through high risk behaviour, and it is certainly true that socio-economically disadvantaged people smoke and drink more. The link could also be through some more indirect means, less well understood - for example those with less well developed social networks get sick more often and take longer to recover from illness.[23]

6.66 Hugo has also reported that recent (1980s) studies have confirmed the existence of strong occupational differentials in mortality, as the following chart makes strikingly clear.

Figure 6.1: Standardised mortality ratios by occupational groups for all causes of deaths in Australian males, 1968-78



Source: Hugo, p 28.

6.67 A submission from the manager of the Occupational Health and Safety Research Service of the NSW Workcover Authority reported that workers' compensation statistics showed that those from lower socio-economic groups were more likely to suffer from poor health as a result of accident and injury at work:

> *In the 1988/89 workers compensation statistics for New South Wales, for example, the occupation group Labourers and related workers incurred 36 per cent of all employment injuries, and occupations with the lowest number of employment injuries were Managers, Administrators and Professionals.*

[23] ibid. p 11-12.

In the case of both males and females, the most dangerous occupations were those in the lower socio-economic occupation of labourers and related workers. However, the hazards of work are not distributed equally between the sexes. The most dangerous industries are mining, construction, manufacturing, agriculture and transport, storage and communication. Employment levels in these industries are much higher for men than for women. The fact that women live much longer than men may reflect the much heavier concentration of men in hazardous industries and occupations during their working life.

The over-representation of migrants in the occupation of labourers and related workers suggests they experience health disadvantage not only in working life but that this advantage will also be reflected in their health during old age and their life expectancy.

Improved access to health and safe workplaces for those who are currently most at risk would mean a significant Australian step towards the World Health Organisation target of reducing the differences in health status between groups within countries by at least 25% by the year 2000. Steps taken at the workplace to reduce this inequality should have a significant effect on the situation of the aged as well.[24]

6.68 Dr Richard Taylor pointed out that socio-economic differentials in health and mortality were real, but hard to measure because of the lack of data on agreed standards of class in Australia. The ABS provided breakdowns by industry and occupation, but that was of limited value in assessing socio-economic status. There was also little information on death certificates: most say "retired", which reveals nothing about previous or spouse's occupations. Local government area or postcode is useful for analysing spatial differentials in health status when an area is homogenous, but many (especially inner city) areas are socially very diverse.

6.69 Dr Taylor suggested that improved collection of data in this area - for example by ABS and on death certificates - would greatly facilitate research in this field.[25]

Spatial Mortality and Health Differentials

6.70 As Hugo points out, differentials between different areas are largely a spatial expression of the socio-economic differentials mentioned above. That is, they reflect the relative distributions of the various socio-economic, birthplace and occupational groups which in turn are associated with differences among groups as to lifestyle, diet, behaviour,

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[24] Occupational Health and Safety Research Services, NSW Work Cover Authority, Submission, p 2-3.

[25] Dr Richard Taylor, Seminar Transcript, p 14-17, and paper prepared for seminar, "Differences in life expectancy: Social Factors in Mortality Rates", (with Dr Susan Quine).

work patterns and inequalities of access to health services, housing, education etc. In some cases, however, the environmental factors (such as types of pollution) or particular patterns of behaviour which are spatially concentrated may have an independent association with specific mortality patterns.[26]

6.71 Many surveys discussed by Dr Taylor have also found significant differences of health and longevity between rich and poor suburbs. One in Sydney, for example found that residents of Kuring-Gai had a considerably greater life expectancy than those of Sydney city (77 compared with 66 years) (See Figure 6.2). As Dr Taylor notes, the difference would be greater if the Australian-born and migrant components were separated out, since the Australian-born have the highest mortality and the Sydney area has many migrants.[27] A researcher, D R Wood, studied infant mortality rates (IMR) in Adelaide between 1970 and 1981. She found that IMR was significantly higher than average in the areas of lower socio-economic status and industrial suburbs to the north, west and south-west of city centre, and lower in the higher-status suburbs to the east of the city. She also found that the differentials between the less and more affluent suburbs increased over the decade.[28]

Aboriginality

6.72 The greatest inequality in health in Australia is between Aboriginal and non-Aboriginal Australians. Aborigines have a life expectancy which is 12 to 20 years less than that of other Australians, depending on the place of residence. Aborigines in the Northern Territory have the shortest life expectancy. Here, girls born in 1985 can expect to live to the age of 63 years and boys will die, on average, at 53 years. This effect is largely due to the increased death rates among the young and middle-aged. The death rate among Aborigines who survive to reach old age approaches that of non-Aboriginals. The death rates for the leading causes of death are between two and eight times that of non-Aboriginal Australians.

Table 6.6: Leading Causes of Deaths in Aboriginals

	MALES		FEMALES	
Rank	Cause	SMR	Cause	SMR
1	Circulatory system	2.1	Circulatory system	2.1
2	External injuries	3.0	Respiratory system	8.0
3	Respiratory system	6.2	External injuries	3.8
4	Neoplasms	1.0	Neoplasms	1.3
5	Genito urinary system	12.8	Infectious, parasitic	22.8

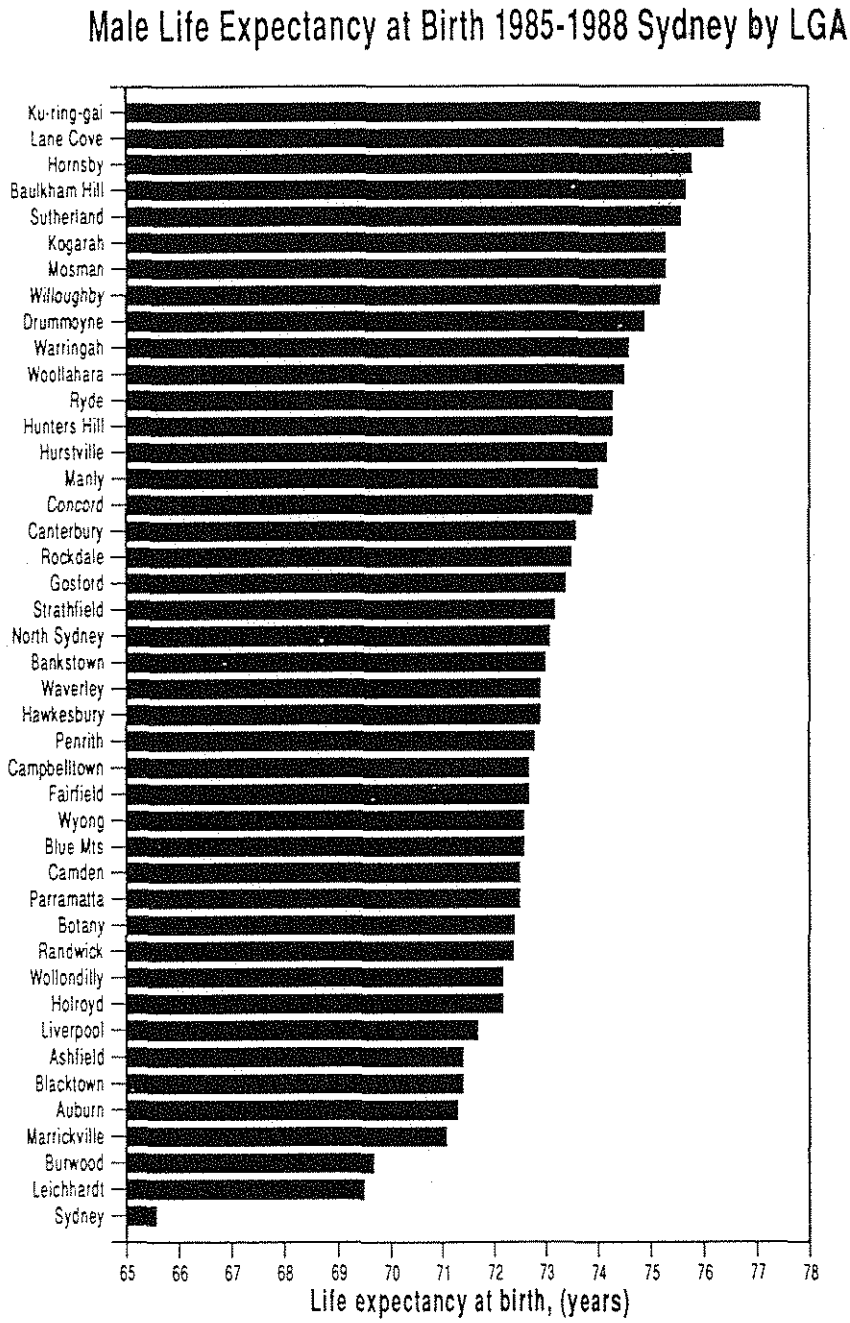
Source: A National Strategy for Aboriginal Health, 1989, quoted in National Better Health Program Submission, p 513.

[26] Hugo, p 28.

[27] Seminar Transcript, p 18.

[28] Hugo, p 29.

Figure 6.2



Source: Dr Richard Taylor, Department of Public Health, University of Sydney.

6.73 Aboriginal Australians have a double burden of ill-health, according to the National Aboriginal Health Strategy, both of infectious diseases common to developing countries. In addition, the poor underlying state of Aboriginal health is a measure of their social disadvantage within Australian society. Aborigines are poorer, experience greater unemployment, have lower educational attainment, lived in poorer housing and have lower access to facilities taken for granted by most Australia. The median annual income for Aboriginals is 65 per cent of that for all Australians, and 53 per cent of that income is received for social security payments, compared with 11 per cent nationally.

6.74 The National Aboriginal Health Strategy was launched in 1990, will provide a social framework for the delivery of health care to Aborigines. The strategy accepts that social and physical environments are major determinants of health status and aims for a community based health system in which the allocation of health resources is largely determined by particular communities.[29]

Gender

6.75 In 1988, life expectancy at birth was 73.1 years for Australian males and 79.5 years for Australian females. Of these years men can expect 14.7 years of disability and women 16. For men there will be 12.1 years of handicap, and for women, 14 years. Women thus live longer than men but experience more disability and handicap.

6.76 Such generalisations have been criticised. Kane[30] argues that they 'tend to obscure investigations of the ways in which women's health is genuinely different to that of men, and the causes and extent of ill-health in women'. She wants a more careful, disaggregated analysis of health data to determine the extent and cause of ill-health in women. Kane suggests that reproductive health problems may be underestimated and gives as an example the Australian Health Survey which found that menstrual problem shared seventh place with influenza in the list of the common health complaints reported by all females of any age. By failing to limit the denominator to women at risk of menstrual problems say, to those aged 12-49, the role menstrual problems play in the well-being of women has been underestimated. Furthermore, she suggests that women's health problems are poorly understood and misdiagnosed.

6.77 The feminisation of poverty is a factor in women's health status. Socio-economic status is largely determined by participation in the paid workforce. Women participate in the workforce less than men (50 per cent compared to 75 per cent). Those that do work fewer hours and in jobs with lower status. Both these factors contribute to their lower average weekly earnings, which in 1987 was 65 per cent of male earnings. Approximately 60 per cent of the Department of Social Security's clients are women, and many of these have sole responsibility for raising children.

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[29] National Better Health Program, Submission, p 12-13.

[30] P Kane, *Researching Women's Health: An Issues Paper*, Department of Health, Housing and Community Services, 1991.

6.78 The National Women's Health Policy released in 1989 provides a social framework for women's health. The policy has identified seven priorities:

- reproductive health and sexuality;
- the health of ageing women;
- women's emotional and mental health;
- violence against women;
- occupational health and safety;
- health needs of women as carers;
- health effects of sex role stereotyping on women.

6.79 The major role women play in health is increasingly appreciated. As stated by the Director General of the World Health Organisation, "Women are the key to achieving health for all".[31]

Age

6.80 It has already been established that older people experience ill-health to a greater extent than younger people. Once the age of 60, or thereabouts, has been reached, the proportion of expected disability-free years falls to approximately 50%. Older people use public hospital beds at four times the rate of the general population.[32]

6.81 The aged, of course, are not a homogeneous group but are themselves divided into many groups of differing socio-economic, education and other measures of status. If we recognised this and stopped talking about the "disadvantages" of the aged we would find, as one authority has asserted, that:

> *Those who have had high income and access to expensive forms of health care during life are also those who enjoy the same advantages during old age. Such sub-cultures also have different diet and exercise patterns. Generally, lower socio-economic groups are less receptive to exercise and have less healthy diets. It may also be that they suffer more passive stress than higher status groups. Thus, sub-cultures identified by different socio-economic status have different lifestyles partly determined by lifetime advantages or disadvantages. In our new interest in the aged as a group, we should not lose sight of the fact that much of what happens to the elderly is determined by lifetime patterns about which we do have the power to do something in our social welfare policies during younger years.*[33]

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[31] National Better Health Program, Submission, p 13-14.

[32] ibid. p 14.

[33] John McCallum, "Lifestyle implications of Australia retirement patterns", *Australian Journal on Ageing*, 4(4), 1985, p 11.

6.82 Arguing a related point, Dr Taylor considers that the main reasons for health and mortality differentials lie in cultural factors. These include such issues as:

- social transmission of health related behaviour;
- education;
- ability to get and use new health information; and
- degree of self-esteem and goal orientation.

6.83 Dr Taylor emphasises that social and educational factors were more important than improvements in medical treatment in achieving the big increase in average life expectancy between 1900 and 1950, and again since the 1970s. The big drop in infant mortality at the turn of century was due to (1) improved sanitation; and (2) more information for mothers, as those mothers were the first generation to have benefited from the compulsory education acts of twenty years before. As noted earlier, the drop in heart disease among males since mid-1970s was due to improved diet, more exercise and less smoking. Southern European immigrants have longer life expectancy because of diet: lack of a dairy industry around the Mediterranean means less meat and milk fat, which in turn means less heart disease and arterial deterioration.

6.84 Dr Taylor also asserted that social differentials increased in the 1970s because the rich had faster access to improved medical techniques and information about improvement in diet and lifestyle. The decline in deaths from heart disease was thus felt most strongly among those of higher socio-economic status and only filtered slowly down to those at lower levels.[34]

[34] Seminar transcript, Taylor's talk, passim, and paper.

Preventive Health

15 That the Minister for Health, Housing and Community Services initiate a review of national health spending in order to determine what proportion is spent on preventive health and health promotion strategies; analyse the costs and benefits of preventive (before illness) as compared with therapeutic (after illness) approaches to health care; and consider redirecting funds from treatment to prevention of illness.

16 That the Commonwealth Government, in consultation with the States (through the Australian Health Ministers' Conference) make preventive health strategies the main emphasis of any national health policy.

Oral Health

17 That the Minister for Health, Housing and Community Services make specific provision for older people to have access to subsidised oral health care.

Palliative Care

18 That the Commonwealth Government, in consultation with the States (through the Australian Health Ministers' Conference) support the provision of effective palliative care for older Australians.

Medical Education

19 That the Minister for Health, Housing and Community Services and the Minister for Employment, Education and Training conduct a review of medical education to determine whether more specialist geriatricians ought to be trained at medical school and whether other medical personnel, including GPs and nurses, receive adequate training in meeting the needs of elderly patients.

Collection of Statistics

20 That the Commonwealth Bureau of Statistics, in consultation with researchers and professional experts in the field, improve its collection of data on mortality, morbidity and socio-economic status in order to provide statistical information that is more useful to researchers studying the relation between health/mortality and socio-economic position.

21 That the Attorney General consult with the States with a view to having the information shown on death certificates more comprehensive and thus more useful for mortality studies.

CHAPTER 7

ACTIVE AT ANY AGE: FITNESS FOR ALL AUSTRALIANS

7.1 People of all ages can benefit from regular physical exercise, but it is of particular importance to older adults. In recent years it has been recognised that, just as mental deterioration may be the result of not using one's mind enough, many of the physical 'symptoms' traditionally associated with ageing are really symptoms of lack of exercise. Maintaining muscle strength, flexibility and cardio-vascular efficiency can mean the maintenance of capacity for independent living and the ability to engage in activities which make that independence rewarding and useful. As the then Department of the Arts, Sport, the Environment, Tourism and Territories (DASETT) points out:

> *if older adults are encouraged to be more physically active, there may be significant health care savings at both the community and residential levels, as well as an increase in personal self-sufficiency, health and well-being.*[1]

Health Benefits of Exercise

7.2 The health benefits of exercise are well documented. The human body evolved as a physically active organism, the parts of which improve with use and deteriorate with disuse. Muscles of unused limbs wastes away; heart muscle atrophies with prolonged bed rest; the incidence of thrombosis increases with inactivity; bones lose their density if not required to carry their normal load.[2]

7.3 A summary of the benefits of exercise in various physiological areas is provided in Appendix 6.

7.4 The physiological benefits of exercise apply to people of all ages, but there are particular reasons why they may be greater, in both personal and social senses, for the elderly.

1 Many physical failings that were previously regarded as characteristics of normal ageing are now seen as effects of physical unfitness brought about by an unnecessary lack of activity, eg. muscular weakness, frailty, lethargy, high blood pressure.

2 These characteristics of ageing lead to losses in functional independence (both social and physical) which increase the need for extra care.

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[1] Department of the Arts, Sport, the Environment, Tourism and Territories, Submission, p 6.

[2] Adapted from *Exercise in older adults: A national health care and quality of life issue*, DASETT January 1991 (Copy attached to DASETT submission).

3 There is an enormous social and personal cost for each individual who moves from independence to any degree of dependence upon others.

4 Small changes in physical capability can have major social effects. If an individual is already declining in functional ability (due to "age", but really due to lack of exercise), only a small change in physiological or mental function can have a profound influence on quality of life. For example, small losses in muscle strength can mean the difference between getting out of bed, having a bath or going to the toilet independently or requiring assistance. The need for assistance could spell the difference between living independently at home or having to be admitted to a nursing home.

7.5 At a social level, it is clear that a healthier population will not need as much medical attention as an unfit one. As the VRAA points out:

> *A healthy older population makes fewer demands on health, hospital, pharmacological, domiciliary and other services. Moreover, healthy retirees are able to make greater contributions to society.*[3]

7.6 Accordingly, there is growing pressure on the health system to place less emphasis on therapeutic and more on preventive approaches to health, with increased attention paid to diet, lifestyle and environment.

Medicine and Health Policy

7.7 Modern medicine has evolved over the past hundred years by developing systems which are primarily directed towards curing conditions which arise from disease or accident. This approach, combined with the fact that illness increases with age, has led to the situation in which the medical system may often virtually take over the lives of older people, whose existence comes to revolve around pills, prescriptions, regular visits to the doctor and increasing spells of hospital care. The end result of this "medicalisation" of old age is to confirm in the minds of the aged themselves the conviction that the inevitable features of old age are illness, frailty, weakness and uselessness.

7.8 This is a gross distortion of psychological, physiological and social reality, and an underestimate of the real capabilities of the aged. The paradox in the situation is that the conditions which society ascribes to the ageing process are in fact partly due to the inactivity that society encourages in older people. As the Tomaree Project (see below) and much other research have indicated, there is strong evidence that these conditions can be minimised and postponed.

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[3] VRAA, Submission, p 3.

Health Care Provision

7.9 One of the crucial areas in which social support for the aged is required is health care, on which the aged place disproportionately heavy demands.

7.10 There is likely to be an increasing need for significant changes to the health care system in response to this situation. The current system has been designed largely to cater for the needs of a relatively young population, who usually experience short-term and episodic illnesses, most of which are readily curable. The system is less well equipped to cater for the less severely but chronically ill who experience long-term and not necessarily curable conditions.

7.11 Two facts stand out in any consideration of health expenditure on the aged population:

- The number of people in the 75-plus age group is increasing as a proportion of the population and is the fastest growing sub-group of the aged population.

- Health expenditure for the 75-plus age group is 6.3 times the average per capita expenditure (1985 figures).

7.12 While there is no occasion for panic, it is necessary to consider ways in which this expenditure can be minimised and its increase contained if we are to maintain the provision of health care at current standards into the future. Three areas of concern are:

- The difficulties faced by public hospitals in meeting budgetary constraints in the face of increasing demand on their services. One example are the long lists of older people waiting for particular types of hospital treatment. There is obviously a limit to how long a hospital can postpone care (in order to keep within their budget) before people in the queue start to sicken or die.

- The increasing cost of drugs. In 1988 it was found that drug costs were rising as a proportion of health expenditure for the first time in fifteen years, a trend that had not been predicted. Cost increases in other areas are also possible.

  The extensive use of drugs among older age groups has been a major contributor to this cost increase - for example, the prescription of A.C.E. inhibitors for hypertension. There is reason to believe that this trend will continue, and perhaps accelerate as the numbers of the aged requiring treatment increase. The most common method currently used to contain the use of costly drugs has been to make them hard to get, but this policy has obvious flaws from an equity perspective and is therefore limited in its effectiveness.

- Cost increases in dependent care provision, that is, nursing homes, hostel accommodation and home aged care in its various forms. These services are sensitive to changes in population age composition and will be increasingly affected by the rapid growth of the 75-plus age group in the 1990s and by the trend to smaller families and more people living alone, with the consequent reduction in the number of family members available to share the responsibility for care.

7.13 It is therefore desirable that society establish programs which enable older people to maintain their capacity to function independently and healthily at home for as long as possible.

Cost of Dependence

7.14 While the aged themselves desire to maintain their independence for as long as they can, dependency imposes heavy burdens on the care providers. At the personal or family level, caring for a dependent individual can often be a full-time occupation which removes one, and sometimes several, people from other activities. At the social level, professional care for dependent people is labour intensive and very costly. There are now many organisations active in the field of aged care, and most of their operations are related to the inability of the aged to function independently. A non-exhaustive list of such organisations that may be active in any area includes:

- Meals on Wheels;
- home care;
- home nursing;
- Home Maintenance Scheme;
- community transport;
- hostel accommodation;
- nursing homes;
- hospital respite care;
- GP home visits;
- geriatric assessment teams;
- community occupational therapist;
- community physiotherapist; and
- domiciliary benefit scheme.

7.15 Any increase in older people's functional capability or mobility could lead to a decrease in their demand on these resources. There has been very little research on the usefulness of exercise in lowering the need for such services, but what has been done suggests that it does lead to decreased dependence on community support. Society should therefore foster independence and seek to maintain it for as long as possible. Increased exercise in the aged is one means of achieving this goal.

Prevention is Better Than Cure

7.16 Prevention is better than cure, but there is debate on the sort of preventive health programs that are needed to answer society's health needs. Some programs are better than others, which means that new programs should be analysed to determine their effectiveness, using both cost/benefit criteria and the degree of improvement to quality of life.

7.17 Programs to reduce ischaemic heart disease have already proved themselves in the cost/benefit stakes. A study by the Ballarat College of Advanced Education for the Sport and Recreation Ministers' Council between 1982 and 1984 concluded that the reduction in costs associated with ischaemic heart disease as a result of increased participation in exercise was $274 million by 1982 and that the saving would be around $400 million by the year 2000.

7.18 In addition to its value as a preventive measure, exercise has therapeutic benefits. As the National Heart Foundation's risk prevalence study of 1983 found, the low level of physical activity characteristic of those aged 60-plus could be seen as an "illness" with "symptoms" in many bodily organs. Such an illness has far reaching cost implications for both disease management and care provision:

1 It contributes to other pathological states, such as heart attacks, high blood pressure, stroke, osteoporosis, diabetes, depression, and many others;

2 It affects strength, fitness and flexibility and thereby has the potential to cause loss of independence.

7.19 The combination of preventive and therapeutic benefit is likely to give exercise for the aged a significant cost/benefit advantage over current approaches to aged health care.

Tomaree Peninsular Pilot Project

7.20 The Tomaree Peninsular is a coastal area north of Newcastle with a population of 11000, 60 per cent of which is more than 60 years old. A voluntary, community exercise program was started there by a local GP, Dr Arn Sprogis, in late 1987. The participants were recruited through his practice, with a small amount of local media advertising, word of mouth and self-referral. The project brought about measurable improvements in participants' health status, plus declines in drug use and hospital admissions. The project was entirely funded by small weekly fees paid by participants. At the time of writing, the exercise group was still active and growing.

7.21 The unexpectedly enthusiastic response to and extensive benefits from the Tomaree project reflect the existence of a desire in the older population for health programs that are in tune with their needs and style and which carry a positive message about their capabilities, rather than a negative one about their disabilities. The results of the project imply that if only 6 per cent of the 50-plus population were sufficiently active (a very moderate level of activity), over $77 million per year might be saved on hospital, nursing home, medical service and pharmaceutical expenditure.[4]

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[4] Much of the preceding material is based on the DASETT paper, *Exercise in Older Adults*.

The Future of Fitness

7.22 There is evidence that the number of older people who participate in active sports is increasing and that "a much more active later lifestyle is emerging". The authors of a report on the future of Australian sport, *Sport to the Year 2000*, consider this trend to be one of the major features of their projections, and they consider that it will have significant implications for the sort of facilities that will be needed in coming decades:

> *Sports planners will be faced with meeting the leisure and recreational activities of an older population which is still relatively active (50-64 years) and which will demand quite different sporting facilities from those currently demanded. Given the current trend towards more individualistic sports there is every likelihood that this will continue to be expressed in later life. There may be considerable dysfunction between existing sporting infrastructure and that demanded by this age group. The possibility of shorter working weeks and earlier retirement could be expected to exacerbate this situation.*
>
> *The very oldest age groups (75 years and over) will be increasingly represented in the total population. With the increased community emphasis upon self help and home care, rather than institutionalisation of the aged, sports planners should begin to consider seriously the needs of this burgeoning group.*[5]

7.23 Despite such possibilities, it is clear that at present there is a catastrophic decline in people's participation in physical exercise as they get older. A survey of Australian physical activity levels published in 1988 shows that the young are far more active than the aged. As shown in Figure 7.1, 87 per cent of 14-24 year olds were active, 70 per cent of 35-49 year olds but only 56 per cent of those aged 50 or more.

7.24 Not only does the general level of activity decline with age but, more seriously from a fitness perspective, the intensity of activity falls even more markedly. As Figure 7.2 illustrates, the proportion of people who engage in "High" level activity falls from 45 per cent at the 14-24 year age group to 15 per cent at 50-plus, while the number of people classified as inactive rises from 12 per cent to nearly 50 per cent for the same age groups.

7.25 The decline in activity holds good for nearly all types of sport. As Table 7.1 shows, the only activities in which participation increases with age are walking, golf and lawn balls, only the first of which has the potential to do much to improve aerobic fitness.

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[5] Australian Sports Commission, *Sport to the Year 2000*, (1987), p 6.

Figure 7.1: Participation in activity by age

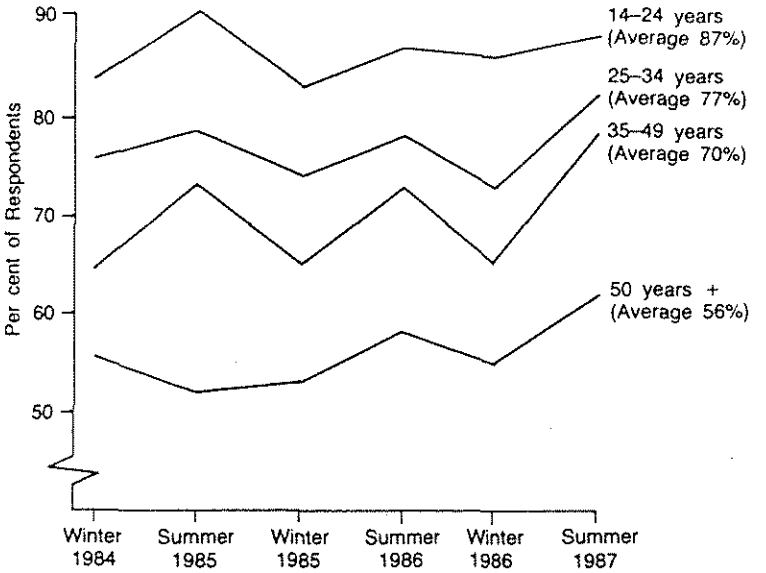

Figure 7.2: Level of activity by age

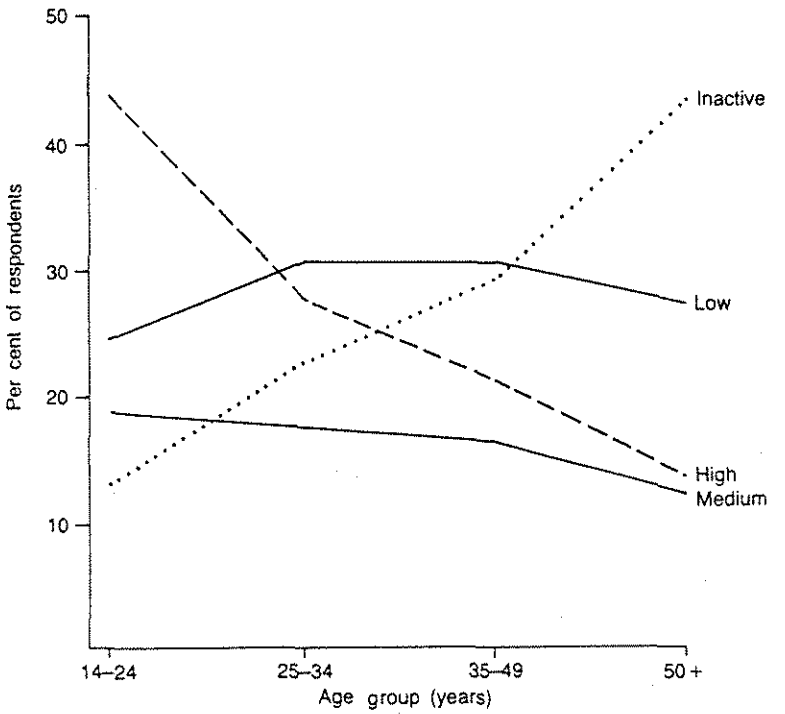

Table 7.1: Participation in activity by activity type and age (per cent of active respondents)

	Age Group (Years)			
Activity Type	*14-24*	*25-34*	*35-49*	*50+*
Walking	48	53	57	75
Swimming	30	25	24	12
Calisthenics/Aerobics	30	26	17	9
Jogging/Running	27	19	14	3
Bicycling	25	15	14	7
Cricket/Football	29	16	8	1
Tennis	13	11	13	5
Golf	8	10	10	12
Squash	10	10	6	1
Sailing/Boating	7	7	7	4
Table Tennis	7	5	5	2
Netball/Basketball	10	5	2	*
Lawnbowls	*	*	1	10
Athletics	5	1	1	*

Source: DASETT, Physical activity levels of Australians (AGPS 1988), p 19-22.

7.26 The authors of the report conclude that age is an important determinant of participation in physical activity and make the following observations that are relevant to this inquiry:

- although there is considerable interest and participation in exercise and activity at all ages, there is a need for fitness programs and opportunities to be tailored specifically to the needs of older people;

- people should be encouraged to maintain more strenuous levels of activity, particularly as they reach adulthood;

- although older people (50 years and over) who were active engaged in activity more often than younger adults (25-49), they lagged behind on the most important criterion of activity: its exertion level; and

- fitness programs should aim to increase participation in vigorous exercise among all people, but particularly among people aged 25 and onwards, since it is at this age that participation in, frequency of and level of activity start to decline.[6]

7.27 There is widespread conviction that peoples activity levels at all ages should be increased, but that it is difficult to achieve this goal. As the authors of *Sport to the Year 2000* point out, age and geographic access are important considerations:

> *Age - Australians see sporting participation as essentially a 'young' activity. Participation declines with age, and this seems to be the result of attitudes ('age and sport don't mix') rather than physical incapacity.*

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[6] DASETT, *Physical Activity Levels of Australians* (AGPS, 1988), p 19-22.

Geographic access - Access to facilities may be denied through lack of facilities planning and lack of mobility, especially for the old and young (i.e. non-vehicular).[7]

7.28 The submission from DASETT agrees:

Participation must be positively encouraged through information and access at specific points in time when people are likely to 'drop out', for example, teenage girls, people who consider themselves too old, people with disabilities who are excluded from mainstream activities.[8]

7.29 Speaking at the Committee's seminar, Anne Thurley suggested that to encourage older people's participation in sport, leisure and recreation, it was necessary to:

- ensure that children's play is an accepted part of life that provides enjoyment and skills, and which sets a pattern of active, healthy behaviour that people can follow all their lives;
- encourage teenagers not to drop out by providing school activities that are more varied and stimulating than the old "physical education" classes;
- provide workplace health, fitness and recreation programs; and
- provide opportunities for people not in the workforce.

7.30 Such measures are necessary because you cannot expect people at 60 suddenly to take up activities that they have never done before.[9]

7.31 DASET runs a number of programs intended to increase participation in exercise under its Sport and Recreation Program, the aim of which is to "improve the health, fitness and well-being of the nation by encouraging and facilitating opportunities for participation in safe and satisfying sport, recreation and fitness activities". It also conducts research and produces publications with the same objective. These include *What's age got to do with it?*, *Safe Exercises for Older Adults* (these two publications have been translated into a number of community languages), resource books for women in rural Australia (*You can Beat the Country Blues* and *Doing it for Ourselves*), *Bush Experience for Young Migrants*, *Recreation in Nursing Homes*, and a directory of Aboriginal recreation, cultural and related studies.

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7 *Sport to the Year 2000*, p 11.

8 DASETT, Submission, p 4.

9 Seminar Transcript, p 52.

7.32 As well as producing a range of resource materials the Sport and Recreation Branch of DASET conducts research which is aimed at providing information to underpin program and increase its success. A major research project currently underway is the Survey of Physical Fitness which encompasses an extensive questionnaire examining factors such as socio-demographic influences, attitudes, lifestyle, physical activity patterns and barriers to participation in physical activity patterns and barriers to participation in physical activity. A group of physical tests will provide comprehensive information on the physical capabilities of participants.

7.33 The Sport and Recreation Branch has also conducted a workshop into the issue of age and recreation, undertakes research into participation in physical activity and other recreations and provides resources such as "What's age got to do with it?". The aim is to encourage people to reject the stereotypes and to continue to participate in activities with which they have been involved in the past, to take up new activities without embarrassment and to value themselves and what they do.

7.34 A video produced by DASET, *Challenging Age*, is aimed at recreation workers and is designed to promote awareness amongst recreation workers of the attitudes and capabilities of older Australians. It examines ways in which recreation workers can best provide opportunities for older Australians. It is important that older Australians have an understanding of the value of recreation and that those in a position to provide facilities, programs and activities understand their clients needs and interests.

7.35 Other projects conducted by the Sport and Recreation Branch are also aimed at encouraging a professional workforce which can facilitate rather than program people. These include a study on Recreation Education at the Tertiary Level, a Study of the Recreation Industry, production of a guide to recreation education etc.

7.36 It is particularly important to treat older Australians as a diverse group of individuals rather than one homogenous group. Old age depending on its definition, can encompass some 30 or 40 years. With this in mind, the Department has looked at providing information to facilitate recreation provision for those older Australians in residential care. Three publications have been produced so far. These are:

- *National Directory* of agencies, services and resources available to recreation workers in the aged field. This provides addresses of government departments, non-government organisations and education institutions providing courses in recreation and quality of life fields.

- *A Guide for Recreation Workers in Nursing Homes.* This is a guide for people involved in the provision of recreation for residents of nursing homes and provides them with ideas and suggestions for recreation activities and planning.

- *Volunteer Resource Manual.* This is designed to assist in the management of volunteer services, and to encourage a wider range of recreational activities and opportunities, which could be provided by nursing homes through the increasing involvement of volunteers.[10]

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[10] DASETT, Submission, p 3 & 5-6.

7.37 DASET also considers that workplace fitness and recreation programs are a way to encourage employees toward regular involvement in fitness activity and thereby reduce differences in life expectancy between high and low status occupations. (In this context it is noteworthy that the Physical Activity Levels survey shows lower participation among those of lower socio-economic status.[11]) Such programs may also provide a forum for imparting information about safer work practices, nutrition, and thereby reduce socio-economic mortality differentials.

7.38 Despite such initiatives and the volleys of fine words, it is clear that insufficient notice has been taken of the vast evidence for the health benefits of exercise, and equally that its implications for social policy and Commonwealth spending in preventive health and the community sport and recreation field have not been seriously considered. The most striking evidence for these contentions is the DASET sport and recreation budget. According to the Portfolio Program Estimates for 1991-92 (1991-91 Budget Paper No 3) there are three major sub-programs : 5.2, Facilities, with a budget of $10 716 000 in 1991-92; 5.3, Recreation and Fitness, with $3 173 000; and 5.4, the Australian Sports Commission, with $59 222 000. The last item clearly has the lion's share of the funds. Although its stated objective is to "enrich the lives of all Australians through increasing participation in sport and encouraging excellence in elite sports performance", nearly all the money is spent on an elite of competitive sportsmen and women. The only "enrichment" that goes to ordinary Australians is any inspiration towards a more active lifestyle that may seize them while they watch the stars on television. It could be considered that, far from encouraging participation in sport, these funds were fostering couch-potato-ism among most people.

7.39 Sub-program 5.2, Facilities, sounds more promising. Its objective is to "increase opportunities for access for all Australians to recreation and sporting activities through the provision of facilities in selected communities with a demonstrated high priority need". But $10 million is a lot less than $60 million, and much of what there is in fact goes to competitive and semi-professional sport - such as suburban football clubs.

7.40 There are really two problems. First, the money is directed at organised sport, which is necessarily a team and competition-oriented activity. If people are not involved in the clubs and associations which receive the money, they obviously cannot benefit from it; yet there are many people who could profit from increased exercise but who will never associate themselves with organised sport. (Dr Sprogis's exercise group on the Tomaree peninsular is a perfect example of this). Secondly, the Committee wonders what criteria are used to assess "high priority need". Too often such "needs" are asserted by good submission writing and lobbying skills, again activities which favour the organised clubs over individuals who would benefit from taking exercise more regularly. The Committee feels that the whole system of sports funding needs to be critically reviewed, and its real contribution to the community's well-being assessed.

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[11] *Physical Activity Levels of Australians*, p 28-34.

7.41 Finally, perhaps Sub-program 5.3, Recreation and Fitness fits the community health bill. Its objectives sound hopeful:

- To maximise the contribution to a healthy lifestyle that increased appreciation of and participation in recreation and fitness activities can make through the collection and dissemination of information and the effective and efficient delivery of programs.

- To contribute to the safety of Australians participating in sport, recreation and fitness activities by supporting water safety activities and examining opportunities for involvement in other sport, recreation and fitness activities.

7.42 Yet even here there are the same problems. These days $3 million does not go very far, and nearly half of that ($1.25 million) goes to water safety organisations like the Surf Life Saving Association of Australia.

7.43 No doubt these funding destinations are perfectly worthy in their own right, but they are contributing little to the goal of encouraging mass participation in sports and particularly fitness activity. Models which DASET should consider when developing national programs that really will fulfil the stated objectives of Sub-programs 5.2 and 5.3 are the very successful "Life; Be In It" campaign, with its everyday role models, and the ongoing Victorian "Health At Any Age" campaign, with its stress on exercise for the elderly. The Committee would gladly trade a few Olympic medals for a more active and healthy population at large.

COMMITTEE RECOMMENDATIONS - FITNESS

Community Fitness

22 That the Minister for the Arts, Sport, the Environment and Territories initiate a review of the Department's sport and recreation budget in order to redirect funding from organised and competitive sport towards community fitness and mass participation health and fitness activities.

National Recreation Strategy

23 That the Departments of Health, Housing and Community Services and the Arts, Sport, the Environment and Territories develop a national recreation strategy, linked with a health promotion campaign along the lines of the "Life. Be In It" campaign, targeted particularly at those who are reluctant to take adequate exercise.

Workplace Fitness

24 That the Commonwealth Government investigate the possibility of introducing deductibility of fitness-related expenses from taxable income.

25 That the Commonwealth Government encourage the provision of work-based health and fitness facilities and the introduction of programs on health and fitness and safety education.

26 That the Minister for Industrial Relations, in consultation with relevant employer and union bodies, develop policies by which access to health and fitness opportunities are part of employee benefits.

CHAPTER 8

EDUCATION, CULTURE AND THE ARTS

EDUCATION

8.1 It is commonly believed that people have less need for or less right to education as they get older. Such views are normally based on the outdated expectation that people will have a single career or the same job for life, on the assumption that education is synonymous with training, and on the misconception that intellectual capacity and learning ability decline with age.

8.2 To take the last point first, there is considerable evidence that the capacity to think and learn does not decline significantly with age, or not at least until people are very old. An important Australian study was conducted at the University of Queensland by Drs Harwood and Naylor, who tested a panel of 155 people aged 60 to 90 over a ten year period, beginning in 1965. Although the study showed differences between age groups, it concluded that "effective deterioration is confined to the period beyond the age of 70 and does not become appreciable in magnitude until the beginning of the ninth decade". The study showed that improvement can occur in intellectual functioning during old age and that this improvement is associated with vigorous intellectual and social stimulation. The authors concluded that such stimulation is essential to enable people to remain self-sufficient, and probably to enjoy themselves more, in their old age. Recent overseas studies also suggest that important developmental changes occur throughout life and that many personal characteristics, long assumed to be more or less fixed by late adolescence and young adulthood, change considerably and frequently throughout adulthood.[1]

8.3 An important point which emerged from this and other studies is that the mental deterioration sometimes seen with advancing age may be the result of intellectual inactivity, not the weight of years. As Dr Elsie Harwood stated recently:

> *Without the stimulation of thinking, reasoning, calculating, design, handcraft, reading etc, brains fall into disuse and independence is gradually diminished. We found that mental deterioration after 15 to 20 years was less in those who engaged in our disciplined learning than in those of our panel who took neither learning activity.*[2]

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1 New South Wales, Anti-Discrimination Board, *Discrimination and Age* (Sydney, ADB, 1980), p 64.

2 University of the Third Age, Brisbane, Submission, p 2.

8.4 Many submissions to the Committee's inquiry emphasised the importance of lifelong or continuing education in older people. The Ethnic Communities Council of South Australia, for example, stated:

> *We know that contrary to outmoded perceptions, adults can continue learning throughout their lives. Our society needs to shed the blinkered view that education is only for the young. Policy should recognise the importance of providing mental stimulus for older people to delay or avoid the undesirable dependencies of older age. Continuing education will also have economic benefits by reducing the use of health and welfare services in later life. Finally, the sharing of knowledge, skills and experience gained by older people can greatly enhance the lives of others through continuing education and inter-generational sharing.*[3]

8.5 The VRAA argued along similar lines:

> *Further education options need to be made available to older persons as well as the rest of the society. The mental stimulus of learning combined with the socialisation opportunities which it provides reduce the feelings of isolation and loneliness experienced by mature age people once they have left the mainstream of society. The need to experience feelings of achievement which come from learning something new do not disappear when the date on the calendar decrees that individuals are of no further use.*[4]

8.6 Education for older people is really of three distinct types:

1 Education as a form of recreation: for pleasure and personal interest.

2 Education as vocational training: with employment possibilities in mind.

3 Education as preparation for the demands of the Third Age (retirement) lifestyle.

Education as Recreation

8.7 As Ann Whyte, President of the Australia Council for Adult and Community Education explained at the Committee's seminar, the main purpose of adult education in the first sense is to give people the opportunity of:

- never being bored or boring, and to remain an interested and interesting person;
- never succumbing to a feeling of futility; and

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[3] Ethnic Communities Council of South Australia, Submission, p 3.

[4] VRAA, Submission, p 9.

- not deciding that they have come to the end of what is worth having (i.e. that there is nothing left to live for).

8.8 Even though adult education is largely non-vocational and does not normally teach work skills, it offers great benefits in promoting the intellectual and emotional capacities of participants and keeping their minds alert and active. Studies have shown that attendance at such courses promotes an increased sense of purpose and achievement and generally improved self-esteem and capacity to cope with everyday life. Some courses, such as writing classes, may benefit society by causing old people to record their experiences for others to read.

8.9 One of the projects undertaken by the Victorian Council for Adult Education was the Learning for the Less Mobile Project. This was a program aimed at reaching elderly people who were not able to travel to attend classes. The benefits assessed as deriving to participants included:

- improved health, skills and family relationships;
- more to talk about with friends; and
- more developed inter-personal relationships.

8.10 Ms Whyte considered that there were five necessary conditions for adult education to be a success:

- participants must themselves plan course programs (the University of the Third Age does this in a big way);
- the courses must be financially affordable;
- they must be held in attractive venues;
- there must be adequate access; and
- the classes must be in daytime.[5]

8.11 Despite, or perhaps because of, its lack of vocational orientation, the demand for this sort of education is large and growing. As the Victorian Government points out in its submission:

> *The changing enrolment pattern for the Council of Adult Education, the rapid development of the University of the Third Age (U3A) in this State, and the growth of neighbourhood adult learning programs all demonstrate that the demand for ongoing education for older adults is very high. One third of the students in the CAE's Victorian Certificate of Education*

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[5] Anne Whyte, Seminar Transcript, p 65-76.

program are over 50, responding to both the competitiveness of the workplace for older workers, and demonstrating interest in building for future tertiary studies. Over 30% of all the daytime students in the CAE hold age concession cards, and 15% of the total Autumn 1990 enrolment (2018 students) hold age concession entitlements. For the group discussion program, a distance learning program, 66 people in the 1991 enrolment of 8000 are 85 years or older, and 312 are between the ages of 75 and 84. All these categories are increasing.[6]

Universities of the Third Age

8.12 A sign of the times is the rapid development of the Universities of the Third Age (U3A) in Australia, which have grown from a small group of committed volunteers in 1985 to over 6000 participants and 28 campuses by 1990. U3A is well established in both urban areas and provincial centres, and it is making a significant impact with respect to both the numbers of people involved and the development of linkages with other educational and community endeavours.

8.13 The rapid development of the University of the Third Age is also a significant indicator of two factors - namely, the readiness of older people to volunteer their experience and teaching capacity, and the attractiveness of a very low cost educational opportunity. Education programs and courses are offered on the basis of an exchange of skills, thus providing an unparalleled model of co-operation and participation.

8.14 Universities of the Third Age offer people aged 50 years and over the opportunity to continue learning in conditions better suited to their needs than those offered by formal institutions. The submission from the University of the Third Age, Brisbane, contended that U3A activities improve the quality of life of retired people, and postpone or prevent dependence on family or institutional care by providing continued mental stimulation which prevents brain deterioration and reduces the incidence of dementia and similar problems.

Costs

8.15 Naturally there are costs associated with the future expansion of recreational or general interest adult education, which will face an increasingly difficult battle for survival if the limited resources for adult learning are directed more specifically towards vocational training, the more so if vocational education is seen as the special preserve of the young. Despite such problems, the institutions themselves are doing what they can to maximise participation by the aged.

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[6] Victorian Government, Submission, p 21-22.

8.16 For older people as students, the cost of further education is significant. The Victorian Council of Adult Education has addressed this issue by extending its pensioner concessions. In an attempt to increase the opportunities for all older people as well as those on lower incomes, it offers a 15 per cent discount on its courses to holders of the Victorian Seniors Card. This incentive has only recently been introduced, but it is expected that it will encourage even more older people to make use of the Council's programs.

8.17 In the same context, eleven TAFE Colleges in Victoria are offering discounts to Seniors Card holders on various courses and materials. These developments are indicators of the recognition of demand by major providers, and also of the issues involved in extending adult education to older people.

8.18 The Council of Adult Education concluded its submission to the 1991 Senate Inquiry into Adult and Community Education as follows:

> *The development of a more tolerant, humane, equitable, informed and just society is an obligation of adult education drawn from its origins in the philosophical societies and mechanics institutes of early nineteenth century Britain. It is still among its most fundamental objectives and will continue to be so - for the complexities of our society, the increasing inter-dependence of global socio-economic systems, the maintenance of a sound and safe environment and the survival of democratic principles necessitate it.*
>
> *Active and intelligent citizenship requires continued information and the social skills to apply what is learned. This is not just a requirement for a functioning democracy; it is also a necessity of a sure and stable world, not only where individual rights and freedom are enhanced but where people can live safely and securely.*[7]

8.19 If this is relevant now, it will be even more critical in the 21st Century - when the pace of change and impact of technology will present significant pressures on an ageing population seeking "active and intelligent citizenship".

Vocational Education

8.20 While vocational education is all the rage for the young, its relevance to the older citizen is not widely understood. Yet the implication of a period of rapid social and technological change is that a person's existing formal qualifications may become obsolete and that an increasing proportion of the workforce may need to train for new jobs or update old qualifications. In other instances, people may have made ill-informed subject or career decisions in their youth because of lack of opportunity or expectations resulting from family circumstance, social class or sex-role conditioning and may not become fully

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[7] Quoted in Victorian Government Submission, p 24.

informed of career choices until they are adults. People's interests may change during their life, and they may seek to move from a job or career in which they are no longer interested; retraining will usually be necessary for such a move. As the population ages, educational institutions are likely to find themselves under increasing pressure to accommodate 'mature age' students.

8.21 Education can play a significant role in the extension and diversification of work opportunities for older people. Through re-training and multi-skilling strategies developed by training institutions, older workers can be provided with sufficient skills to enable them to make a significant contribution in work areas which may differ from their initial and possibly longstanding occupations or careers. These programs can be in areas of work which are less physically taxing, adjusted to the emerging labour market demands, particularly in service industries, and both satisfying and challenging for older age groups.

8.22 As Professor Sol Encel pointed out at the Committee's seminar, developments next century may well mean that there will be a need for retraining throughout a person's lifetime. If there is going to be an older workforce next century, as is likely, people will need training and retraining throughout their careers. Professor Encel claimed that there were in fact tougher obstacles to developing this sort of adult education than the recreational variety, despite its utilitarian potential, because:

- it is more expensive and is in competition for resources with education of the young;

- governments find it difficult to provide adequate funds for the TAFE system, the most flexible means of achieving these objectives.[8]

Education for the Third Age

8.23 John McCallum has argued that education for retired (or soon-to-be-retired) people is an important means for teaching them leisure options, health, domestic life skills and practical matters generally, and a way of learning about and defining desirable qualities in aged (or retired) lifestyles and the social supports needed to sustain it.[9] The University of the Third Age, Victoria, agrees, asserting in its submission that:

> *Education for leisure should form part of the curriculum at either secondary or tertiary level of education. This should make the individual better prepared for his/her period of retirement; at the same time it may change the current negative attitudes towards retirement, old age and unemployment.*[10]

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8 Seminar Transcript, p 79-80.

9 McCallum, "Lifestyle implications of Australian retirement patterns", p 12.

10 U3A Victoria, Submission, p 3.

8.24 A relatively new idea, the desirability of education as preparation for the Third Age is probably even less widely accepted than job training for the aged, yet the proposal should be taken seriously. In its submission to the inquiry, the Victorian government was firmly of the view that a positive focus for the preparation for retirement and a productive third age of life can be achieved by developing educational policies and strategies which emphasise the need to plan for all major life changes, including the passage to retirement, and the third age.

8.25 Educational strategies can be developed which not only cover the broad range of existing needs, but also provide new options which assist individuals to anticipate and plan for a more active and productive life style in their later years. As has already been indicated, the University of the Third Age is one example of older people finding their own solutions through enterprise and cost efficient organisation. Through the network of further education already available, older people can also be encouraged to develop and plan programs suitable to their own needs and aspirations. Examples of role modelling of new careers can be found in the work of older men and women in primary school help programs, and also in the skills exchange which often occurs in community based providers of further education, also mentioned above.

8.26 Development of role models and in effect new career opportunities for older people constitute an important and significant part of education directed towards preparation for the third age.

8.27 Work in these areas is still in its infancy. It is significant that the three Victorian community based organisations that have been established to assist people to prepare for retirement have seen their focus as very specifically around the transition from paid work to leisure. These organisations, the Early Planning for Retirement Association, the Victorian Retirement Advisory Association and the Australian Retirement Advisory Association have placed particular emphasis on financial planning and the economic issues around retirement. They have conscientiously addressed the major issues of concern to retirement workers. With little support they have picked up part of the needs, and have done this work well.

8.28 Effective preparation for the third age has to take on a much broader perspective than the more established approach to preparation for retirement from full time work. The basis for this is clear cut. First, not all those people who are entering older age see themselves as making a transition from work to retirement. There are many different situations which are relevant, including of course women whose life work has been committee to family and caring responsibilities, paid workers who have retired from work early for a variety of reasons, and people who are phasing out of the work force and who do not experience the radical break traditionally associated with retirement. Second, those workers who have been in full time work for many years may be in greater need of a broadly based preparation for the third age then those who have not. Traditionally male workers who have not established good links with their local community, who depend greatly for their status and image on their work, find the transition from work to retirement extremely difficult.

8.29 Consequently, there are sound reasons for undertaking quite different approaches to preparing people for the third age. Up to now, educational institutions have not undertaken a major role, and the retirement planning organisations have not won a great deal of support or interest from such institutions. Considerable work needs to be undertaken to provide constructive, significant and relevant approaches to preparing for the Third Age.[11]

CULTURE AND THE ARTS

8.30 Related to the possibilities for increased participation of older people in education are opportunities in culture and the arts, whether as practitioners or consumers. It has been suggested to the Committee that culture and the arts constitute the very model of a Third Age activity. Such a view may appear paradoxical when one considers the number of writers and artists who never retire but go on working until the very end, but Peter Laslett[12] would point out that, because of the nature of their employment, they have been enjoying their Third Age (the period of personal fulfilment) throughout their working lives. As the submission from DASETT argues,

> *Arts and cultural pursuits offer an area of the economy where retirement is almost irrelevant. Even in strict economic terms many participants develop arts and heritage skills continually throughout their lives. Moreover they tend to be productive (in an economic sense) both before and after they are members of the "workforce". Many members of the workforce are productive artists etc in their leisure time. Cultural pursuits then already bridge the rigid separation into periods of education, work and retirement. The expectations are based more on ability and available time, and much less on financial considerations.*[13]

8.31 Not everybody can be a creative artist, but the opportunities for participation in the arts as a spectator or consumer are very wide. The Australia Council considers that:

> *Arts and cultural participation can be vital to the mental, physical and emotional well-being of people in general. Developing the arts and related cultural participation of older people can engender a sense of worth and encourage a creative, healthy and productive life.*[14]

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[11] Victorian Government, Submission, p 24-26.

[12] Peter Laslett, *A new map of life: The emergence of the Third Age*, (London 1989).

[13] DASETT, Submission, p 7.

[14] Australia Council, Submission, p 8.

8.32 Older people's participation in the arts can be increased in a number of ways, perhaps most significantly by education programs. As the Australia Council argues, the arts are now an accepted part of schooling, with approximately 29 per cent of school students studying creative and performing arts.[15] A strong case exists, however, for developing non-vocational, adult education in the arts and related cultural activities to promote and develop participation.

8.33 This could be achieved by utilising and developing existing resources, including schools, providing more community centres for close-to-home arts education in informal settings and utilising existing and developing communications technologies and networks for in-home and distance arts education programs.

8.34 Older people could be encouraged through such programs to participate more in the arts and related cultural activities, play a productive role as volunteers in arts organisations and convey their knowledge and skills to younger people.

8.35 The development of non-vocational, community outreach and distance arts education programs is essential if we are to build on the increasing arts and related cultural interests of an educated and active ageing population.[16]

8.36 Participation could also be increased by the removal of a number of barriers. For example, a DASETT Recreation Participation Survey revealed that many aged 55 and over people would have liked to visit museums and art galleries more often, but found transport and access too severe a problem. Other barriers identified by the Australia Council are:

- architectural: buildings are too hard to enter;
- proximity: facilities are too far away;
- lack of transport;
- lack of discretionary income;
- unsuitable scheduling of arts events: daytime sessions are preferred;
- ineffective marketing and promotion of events; and
- inadequate or inappropriate education.[17]

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[15] DEET, *National Report on Schooling*, 1989.

[16] Australia Council Submission, p 10-11.

[17] ibid, p 8-9.

8.37 Time of day is a very important consideration for older people because many do not wish to go out at night. Some are nervous about driving after dark. Some are fearful for their safety on public transport and in the streets, and some probably just like to get to bed early. As a consequence, George Fairfax informed the Committee's seminar, daytime performances of musical and theatrical events are very popular:

> *Presenters of events find matinees popular, not only for older people, but also for shift and part-time workers. "Morning Melodies" is a program at the Melbourne Concert Hall (similar shows are presented in most states) held at 11am. People can come for $6 ($5.50 for groups of 20 or more) for a popular light entertainment program, including a cup of tea or coffee. The sessions are almost invariably sold out. Great pleasure can be had on these mornings, watching the looks of delight on peoples' faces as they come into the hall. You can be sure that those tickets, clutched in hands as people enter, have been resting on mantelpieces and dressing-tables, and contemplated with eager anticipation each day as the even draws near. A fine counterpoint to the often blase and half-interested attendees to some regular performances.*
>
> *The Victoria State Opera gave a performance of "Don Pasquale" recently - tickets - $10; time 11.30am. I need hardly say that those who attended are waiting for the next one.*
>
> *Daytime performances are popular with older lonely people. Many women come on their own to matinees where they would feel unsafe at night. Without question women are far better attenders than men at cultural events, and are happy coming in the daytime with friends or on their own.*
>
> *In recent times local councils - Melbourne, Prahran, St Kilda to name three - have arranged with major arts organisations such as the Melbourne Symphony Orchestra and the Victoria State Opera, free daytime performances in their Town Halls for citizens in their municipalities. It would be splendid to see these types of events continue and increase. Partnerships between government and business groups within the communities could well be directed towards such programs.*[18]

8.38 The most popular home-based recreation activities among the 55-plus age group are:

- watching television;
- reading;
- gardening; and

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[18] George Fairfax, "Access to Culture and the Arts", paper prepared for Committee's seminar.

- listening to music.[19]

8.39 Enjoyment of these activities would seem pretty straightforward, but each has its own potential problems. Older people would like more arts programs on TV,[20] but the most likely broadcaster for these, the ABC, has been forced to become more market (and thus youth) oriented in recent years and thus less likely to screen the sort of arts programs that older people would probably like. The commercial stations are largely ruled by their advertisers, which naturally want to see the programs which will attract the biggest spending viewers. Whether because of reduced income or satisfied needs, the retired are not generally big spenders and are thus without an important means of getting what they want, for in the electronic media it is not just ratings that matter, but the purchasing power and willingness to spend of the viewing audience. Of course this situation may change in the coming decades. The questions for the future are whether the increasing number of the aged will outweigh this financial weakness and whether their affluence will increase sufficiently (with the spread of superannuation) for advertisers to treat them with new respect.

8.40 The capacity of older people to read widely is dependent on public libraries, which are heavily used by old people - proportionately more than their number in the community would warrant. Public libraries are also a vital social, recreational and educational resource for all ages, but their use by older people will increase disproportionately as their number increases. A survey at the Fremantle City Library found that people aged 55 and over accounted for 19 per cent of the population but 34 per cent of users.[21] It is thus vital, as the Committee's report on Australian libraries stressed, that resources and funds for public libraries be increased along with the growth in demand to ensure that an adequate level of services is maintained.[22]

8.41 Gardening is the most popular of all Australian hobbies. The National Recreation Participation Survey (October 1987) found that 53 per cent of men and 51 per cent of women aged 55 and over worked in the garden, compared with 35 per cent and 39 per cent respectively for men and women of all ages.[23] Yet even this innocent pastime is threatened in a number of ways:

- by the declining affluence which makes it necessary for retired people to sell a suburban home and move into a flat without a garden;

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19 Australia Council Submission. More detailed figures in DASETT, Recreation Participation Survey, October - November 1987, analysed in Earle, "Recreation Patterns..."

20 Australia Council Submission, p 5.

21 Ms Betty McGeever, Librarian, City of Fremantle, Submission.

22 House of Representatives Standing Committee for Long Term Strategies, *Australia as an Information Society: The Role of Libraries/Information Networks* (September 1991).

23 Leon Earle, "Recreation Patterns Among Older Australian Adults (55-plus years)", p 4.

- by the necessity to move into some sort of institutional or commercial accommodation where care of the grounds is the responsibility of paid professionals;

- by any sort of urban "consolidation" program that increases residential density at the expense the gardens in existing homes.

8.42 Our national fondness for a garden of our own should be considered in any planning which relates to the three areas above.

8.43 Apart from records, CDs and tapes, the main source of music for the elderly is over the radio, and here the same sort of considerations apply as were mentioned above in relation to television. Perhaps the big question for the future here is whether the coming generation of the elderly will want to listen to the pop songs of their youth, or whether they will turn to the classics as they get older.

8.44 The Australia Council expects the following developments on the arts and cultural front in the near future:

- an increase in arts and cultural activity;

- increased spending on books, videos, cassettes and CDs;

- a decline in attendance at spectator sports;

- an increase in active, participatory forms of leisure, particularly arts and cultural tourism;

- an ageing population that will be more educated and technologically literate, that will have more free time and will possibly have (comparatively) more discretionary income.[24]

8.45 The Council made a convincing case that the arts and other cultural industries and associated activities contribute to national economic growth and community development, stimulate creative use of time and provide meaningful, diverse and satisfying leisure and cultural experiences. It notes that there is evidence of increases in activity in these areas but urges that there are points at which the arts need assistance if growth is to continue:

- the provision of facilities and resources for non-vocational, community outreach and distance arts and related cultural education programs;

- support for folklife, heritage development and amateur arts activities as vital avenues for preserving and transmitting our cultural heritage and for encouraging and utilising people's untapped creative talent and stimulating creative time use; and

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[24] Australia Council, Submission, p 7.

- the development of access to and the use of existing and developing communications technologies for the distribution of, and education and information about the arts and related cultural activities, particularly the development of home-based and distance arts education programs, public access broadcasting activities and both broad and 'narrow' casting of arts programs and events.

COMMITTEE RECOMMENDATIONS - EDUCATION, CULTURE AND THE ARTS

TAFE

27 That the Minister for Employment, Education and Training provide additional federal funds for the TAFE system in order to increase its capacity to offer courses that appeal or are useful to older people.

Lifelong Education

28 That the Minister for Employment, Education and Training work with the States to develop programs for lifelong education so that adults can continue to educate themselves and learn new skills throughout their lives.

Cultural Facilities

29 That the Minister for the Arts, Sport, the Environment and Territories -

- consult with the States with a view to increasing the accessibility of cultural facilities (especially theatres, concert halls, art galleries, and museums) to old people by taking steps to overcome the barriers identified in Para 5.36.

- take note of and act upon Australia Council's suggestions for increasing general, and particularly older people's, participation in cultural activity.

Public Libraries

30 That the Commonwealth Government make a commitment to providing financial support for public libraries, as already recommended in the report of the Committee for Long Term Strategies, *Australia as an Information Society: The role of libraries/information networks* (September 1991).

Public Broadcasting

31 That the Commonwealth Government recognise the importance of public broadcasting, with its wide range of program material, to the quality of life among the retired and the elderly and accordingly strengthen its commitment to public broadcasting services so that they can offer the necessary diversity of program material.

CHAPTER 9

HOUSING AND THE URBAN ENVIRONMENT

9.1 Older people place a high value of the quality of the physical and social environment in which they live - their community. As part of the "Successful Ageing" project, its director, Dr Alice Day, surveyed the attitudes of older (60-plus) residents in a number of inner Canberra suburbs. On the physical side of the question, she found that the matters they raised as a particular concern to them were "related to conditions that affected their autonomy of movement, of getting around in the community and of being able to manage on their own. Public transport was a very important issue.... Other concerns were the condition of the footpaths, heavy traffic that make it difficult to get across roads to do their own shopping, and improvements in street lights so that they could walk at night".[1]

9.2 On the other side of the ledger, there is no single ideal notion of "community" but older people themselves clearly articulate a number of common features which they want in their community and which, in their view, will help to maintain their involvement in its daily life. The community they desire is one in which:

- they can feel safe;
- they feel part of a network of friends, neighbours and family, with all the benefits and responsibilities that entails;
- the details of urban design (pavement services, pedestrian crossings, the provision of physical facilities and so), take account of their needs and limitations;
- the environment is friendly and benign;
- they can get around without undertaking strenuous exercise, or a major public transport expedition to get from A to B;
- they have ready access to services to meet their changing needs for personal care or various forms of help at home over time;
- they play a significant part in the assessment of those needs;
- they are able to exercise some freedom of choice in how the services are provided and by whom. The services need to assist the business of getting on with daily life, not dominate it; and
- they are heard when they express their opinions and treated with respect.

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[1] Seminar Transcript, p 34.

9.3 These aspirations for what the Commissioner for the Ageing, South Australia, calls "user-friendly communities"[2] are not held only by older people. The Adelaide Metropolitan Planning Review launched by the South Australian Government in 1990 with the aim of devising draft policy objectives for metropolitan Adelaide for the next 20-25 years, has already undertaken around 70 consultations with people of many backgrounds and generations, and these have revealed that people of all ages share the same vision. At the same time, the Review has underscored the difficulty of achieving the kind of community living to which many aspire. This is because:

- the dictates of economic efficiency do not lend themselves to small-scale and low density community living that has long been the Australian urban norm;

- whether in housing development, job creation, or transport, competing social, economic and political interest make urban planning an exercise in compromise rather than ideals;

- the complexity, internal contradictions and - in some areas - the in-built competition between service delivery arrangement for older people are making the goals of simplicity, accessibility, adaptability to individual needs and consumer choice, increasingly difficult to reach.

9.4 Even in the country, where residents have known and have understood the concept of a "user friendly community" all their lives because they themselves have helped to create it, things are changing. The rural crisis, in its various forms, is eroding the self-sufficiency which has for so long been the backbone of so many country towns. Particular difficulties are faced by rural families and their elderly members who have spent years in their home community, often contributing materially to the local hospital or day care centre (for example) in expectation of being able to spend their last years in familiar surroundings. Increasingly, it appears, the frailer aged in the country are having to move elsewhere in search of the services and support they require.[3]

9.5 The search for means to create "user friendly communities" will be one of the challenges facing policy makers in the 21st Century.

Housing

9.6 Housing is crucial to the quality of life of older people. The type and standard of housing affects independence, health, feelings of well-being and security. Lack of or inappropriate housing can induce poverty, cause distress and ill-health and adversely affect life cycle changes. In recent decades there has been public and private sector recognition of the significance of housing for older people.

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2 Commissioner for the Ageing, South Australia, Submission, p 22.

3 ibid, p 23-24.

9.7 As John McCallum points out in his chapter from a recent report from the Australian Institute of Health[4], taxation incentives from the 1950s led to a rapid increase in the rate of home ownership from which present cohorts of older people are now benefiting. About three quarters of older Australians were living in their own homes on the night of the 1986 Census.

9.8 The 1950s also saw the introduction of public sector housing specifically for older people, usually in the form of bed-sitters and high-rise accommodation. The inadequacy of this type of housing was recognised in the 1970s, and one or two bedroom, unit-type accommodation was introduced by public housing authorities. The private sector responded to increasing demand for age-specific housing design with the introduction of retirement villages and other types of retirement lifestyle developments in the 1980s.

9.9 The high rate of home ownership and the relative availability of public housing for older people has enabled the Australian commitment to a minimum flat-rate pension to be sustainable.

9.10 Although the number decreases with advancing years beyond age 65, the vast majority of the aged prefer to live and in fact remain in private households. Very few make the move to assisted accommodation, though the number that does increases sharply after age 75. As Table 9.1 shows, the majority of elderly people remains in private households rather than assisted accommodation. The loss of a partner does not automatically mean a move into such accommodation, though increasing frailty or ill health and changing household structures can mean that the house bought as a family home may no longer be manageable as people age.

Table 9.1: Percentage of older age groups living at home

Age Group	60-64	65-69	70-74	75+
Percentage of each age group living at home	99.1%	98.2%	96.5%	82.7%
Percentage of each age group living alone at home	15.8%	19.8%	27.5%	32.9%

Source: Australian Bureau of Statistics, Disabled and Aged Persons Australia 1988.

9.11 In its submission to the inquiry, the DCSH points out that such independence is an important part of older people's quality of life and that the thrust of Commonwealth Government policy is to help people maintain their independence for as long as possible. The Home and Community Care (HACC) program and other support mechanisms are designed to help achieve this goal.

[4] McCallum, AIH, p 206.

9.12 Another important measure to assist people to live with maximum independence within the community is the redesign of buildings and transport services, particularly pedestrian and public transport facilities, to improve their accessibility for people with visual or mobility defects. An increasing number of elderly people may also mean that design standards for private housing and public buildings may need to become more prescriptive, particularly in the following areas: pedestrian safety, building access, lighting, pathway networks, directional signs and building identification.[5]

9.13 The preference for people to remain in familiar surroundings as they get older - their own home and neighbourhood - has implications for proposals to redevelop such areas. As DASETT points out, "Many older people feel strongly about their heritage, and there is likely to be increasing pressure to preserve and maintain heritage buildings". There should thus be less destruction of such buildings and more emphasis on "recycling" them for new uses.[6] These points were strongly supported by Dr Alice Day, who reported that her survey had found that "environment and heritage values were very important to them. There were many places in Canberra that they did not like to see changed ... and places that meant something to them".[7]

9.14 There are, however, problems in achieving such objectives. At an everyday, almost banal level, is the frequent difficulty found by the elderly in carrying out or paying for the necessary maintenance on their property. Although the HACC program, and the Victorian Government in particular, allows for home repairs, the allowance is not always adequate and might not meet the needs of every structure. At a more complex level, because Australian household size is declining there is likely to be pressure to increase dwelling density, particularly in capital cities. While there were 3.15 to 4 persons per household in the 1950s, the figure is expected to be 2 to 2.5 persons in the 1990s. Increased urban density could benefit the aged if it were accompanied by improved street design and public transport, but in themselves more dwellings just mean less green space and more cars on the road. In addition, the pressure toward greater density will, if the redevelopment entails replacement of homes by flats or similar structures, put pressure on the elderly to relocate, either to less sought-after (outer suburban) areas or perhaps to age-specific accommodation. If such a move results, as it must, in the dislocation of people from their community base and established networks, their sense of personal loss and isolation will be severe. Such a dislocation would also destroy many of the inter-personal links that would otherwise allow people to retain community status and continue to lead useful lives.

9.15 The challenge is therefore to develop suitably approachable and flexible urban neighbourhoods which permit people of all ages and household types to be adequately housed without the need for relocations consequent upon age or household type.

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5 Comments from National Capital Planning Authority, p 10 of DASETT Submission.

6 DASETT, Submission, p 7.

7 Seminar Transcript, p 34.

9.16 The vital need here is to understand the nature of the urban environment in which most people will grow old in the first twenty years of the 21st Century. As the submission from the Victorian Government points out, this is the environment that was created for the young families of the latter half of the 20th Century. It is an environment which was largely planned on the assumption that people had easy access to a car and that they could use their car to access even the most basic goods and services. The design of these suburbs does not recognise that many of the old people who will inhabit the outer and fringe suburbs in the next 20 to 30 years, will be prevented from driving by failing sensory faculties long before they need, or want, to give up their independence.

9.17 The urban environment can be modified but it is a slow process. The failure to recognise in the past that the young of today are the old of tomorrow, means that we will need a range of imaginative and flexible social solutions if the old of the 21st Century are to be able to maintain options for activity, participation in social networks and independence.

9.18 Most people grow old within the neighbourhoods where they now live. Consequently, as the rapid growth in Melbourne in the past decades has been in the outer and fringe suburbs of those times, the ageing of the population within the next ten years will be most intensely felt in those suburbs, which will then be in population decline. "Of the estimated 138 000 increase in the 60 plus cohorts between 1986 and 2001, 84% or 115 000 will be located in the outer and fringe municipalities".[8]

9.19 So the estates built for the mobile and commuting young of past generations will become the domain of the settled and non-working aged. The nature of these suburbs will have significant impact on the way their residents approach their later years.

9.20 In a different context, but with similar consequences, the provincial centres will also become the preferred places of residence for the rural aged - and some metropolitan people as well. The decline of small towns, the breakdown of social networks and the difficulty of isolated living means a steady increase in the drift to provincial centres. Some of these have considerable advantages as urban environments for older people, because of well established services arising from the hospitals and institutions established earlier this century, or even last century. However, the urban environments of either metropolitan Melbourne or the provincial centres have not been planned around the needs of a older population in the 21st Century.

9.21 The basic needs of old people are broadly the same as those of the rest of the community : adequate and appropriate housing, security, health, access to goods and services and a safe environment. Because of their life stage, however, new barriers emerge which are different to those experienced by young people.

9.22 The fringe suburbs of the 1970's and particularly the fringe suburbs of the 1980's are quite different residential environments from the inner city areas. Consequently they present different, and probably greater, problems for those growing old than are experienced in the inner suburbs.

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[8] Victorian Government, Submission, p 29.

9.23 While the housing stock is relatively young, and therefore is not likely to require extensive renovation and maintenance in the medium term, these suburbs have been designed to be low density, car oriented, and services are often dispersed or lacking.

9.24 This may not be a problem for the "young old" persons, the 65 to 74 year old, for the vast majority of them can and do drive. As long as they can afford a car, for the young old person who is relatively fit this type of urban environment does not present any problems greater than for any other younger age group. For the older old and very old, however, the very nature of such suburbs may become a problem. The older a person becomes the more likely that they will no longer be able to drive and the more likely they are to find themselves alone through the death of their spouse. This means that the provision, quality and design of flexible and appropriate public transport, and the possibility of reaching basic services on foot, is extremely important in enabling older people to retain their independence.

Low Densities and Public Transport

9.25 Low density development makes the provision of a frequent and easily accessible public transport system more difficult. For a public transport system to be efficient and effective it requires a minimum density of 17 dwellings per hectare.[9]

9.26 The outer and fringe suburbs have a density of around 10 dwellings per hectare. A service may be provided, but it is likely to be infrequent and geared towards peak travel times, that is before 9am and between 4pm and 7pm. Such a timetable is of little use to an older person whose movements are not linked to employment.

9.27 The layout of many subdivisions developed during the 70's and 80's also effectively reduces the older person's access to public transport. "Spaghetti" style road layouts were designed to reduce the speed of local traffic but have the effect that large buses cannot penetrate such subdivisions. Another negative effect from an older person's point of view is that the pedestrian path between any two places is usually substantially longer than when the road layout follows a grid.

9.28 Traditional public transport, even when available, if often not used by the aged, given the perceived access difficulties and lack of flexibility. Perceptions of insecurity may also discourage older people from travelling at night, despite the fact that the actual risks are relatively low. More personalised public transport may increase in popularity, particularly given potential capacity to pay for such flexibility. Transport authorities have also introduced measures in response to the security concerns of their more vulnerable users, including women and older people.

9.29 Awareness of car dependence and its environmental effects has resulted in the inclusion of plans for bicycle and pedestrian paths at the planning stage in Melbourne's newest areas. Although such from an environmental view point, in many cases these paths are meant to serve both cyclists and pedestrians and some of them are located on

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[9] Victorian Government, Submission, p 30.

the shoulder of roadways. This economy of planning may, however, make such paths, which should be an asset, unsafe for some older pedestrians.

Open Plan Subdivisions and Lot Size

9.30 Some outer and fringe suburbs have been designed on an open plan with no front fences and limited footpaths. This also adds to the difficulties for the elderly as they must either walk on the grassy surface, which may be uneven, or on the edge of the road. The edge of the road presents problems for the older person with failing sensory faculties and slower reaction times.

9.31 The size of the average lot, which of course creates the low densities in outer and fringe suburbs, will also become a problem for older people. Frailty can make a large garden a burden rather than a joy.

Access to Basic Goods and Services

9.32 For many old people, a large number of whom are women living alone, easy access to local shops is important. Being able to purchase basics, such as bread, milk or the paper, is important not only because it helps people to maintain a sense of independence and self reliance, but also because it brings them into regular, possible daily, contact with other people. A regular walk to the shops can be an important part of maintaining links with immediate surroundings. In the outer and fringe low density suburbs, however, local shopping centres are more widely spaced than in older, high density suburbs and tend to be located on main roads. Even local milk bars are more widely spread and may only be reached by a comparatively lengthy, circuitous route.

9.33 A variation on the theme of difficulty of independent access for the elderly is access to hotels. Older suburbs have many local hotels. They can play an important social role, particularly for older men who live alone, but in the outer and fringe suburbs hotels are very large, dispersed and orientated to major roads to cater exclusively to a car driving public.

9.34 Access to sporting facilities is also difficult in low density suburbs. For example, in 1987 there were 192 bowling greens, 34 indoor pools and 8 bocce alleys in the small area of the core and inner ring suburbs of Melbourne. At the same time there were only 84 bowling greens, 40 indoor pools and 29 bocce alleys in the huge area covered by the outer and fringe suburbs.[10]

9.35 The capacity of older people to effect changes in these areas will increase over the next few decades. Past and current planning decisions, however, will have sustained impact on the ability to adapt these urban environments to a different population mix.

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[10] Victorian Government, Submission, p 32.

9.36 If a frail older person is able to overcome the immediate difficulty of reaching and using public or community transport, then some aspects of recent urban development are beneficial.

9.37 For example, effective district centre or activity centre policy, which fosters the availability of a full range of goods and services within a district, should assist in maintaining the independence of the elderly.

9.38 The development of self contained, fully enclosed shopping centres also has some benefits for older persons. Such centres protect shoppers from the elements, generally provide seating within the mall and eliminate the danger of conflict between pedestrians and vehicles.

9.39 For the older persons to be able to benefit fully from either of these developments there are a number of other areas that need to be considered. The transport network must be flexible and integrated with district centres and freestanding shopping centres. Given the difficulties with carrying goods on public transport, delivery services suitable for all types of streets and medium density housing will assume considerable importance.

Difficulties of Change

9.40 Changing the urban environment in the outer and fringe suburbs is a long term proposition. In the short term it is impossible to change the layout of the roads, or to alter the density of the whole area to ensure easier access to transport, shops and other facilities.

9.41 Policies have been introduced which will modify over time the environment in the outer and fringe suburbs. Policies relating to urban consolidation, as-of-right dual occupancy and, in the future, probably as-of-right medium density housing, will have some effect. The requirement that future development in Melbourne's growth corridors be at a density of 15 dwelling units per hectare and offer a variety of housing types will give older people indeed all people, more choices of housing type in the outer areas in the future.

9.42 However, such changes take time. In the short term it is necessary to devise a range of programs (small, flexible community buses, neighbourhood level visiting programs, neighbourhood co-operative stores) to tackle the problem of isolation of older people in outer areas. This need for support is borne out by the experience of the Older Persons Housing Branch of the Victorian Office of Housing and Construction. The OHC currently provides one bedroom self-contained units for eligible elderly applicants and is involved in joint venture agreements with local councils, churches and community groups to provide similar facilities. Portable flats which can be located on the land of families and friends are another positive measure. The OHC are experiencing increasing pressure to provide support services in conjunction with the housing itself, particularly when the general community service infrastructure is not well developed.

9.43 The need for funding for such services, however, highlights one of the other major problems that will confront such areas within the next ten years - namely the issue of competing demands. Not only with 84 per cent of the expected increase in the 60 plus age group occur in the current outer and fringe suburbs between 1986 and 2001, but at the same time the new fringe suburbs will be experiencing considerable growth in the 0-29 age cohort Victoria.[11]

9.44 Victoria faces sustained pressure on its social as well as physical infrastructure, in order to sustain both ageing population and urban growth.

Purpose Built Housing

9.45 The difficulties arising from the potential unsuitability of the outer and fringe suburbs to meet the needs of the frail aged might be partially resolved for some by relocating to purpose built accommodation in areas of their choice, such as retirement villages, elderly persons units, hostels and nursing homes. Relocation, however, is often an inappropriate, unwanted and expensive solution, both for the individual and the community, unless the individual is genuinely in need of the specialist care provided by such institutions. Retirement homes and elderly persons units must be carefully sited if they are to avoid the very same pitfalls that make low density housing inappropriate for many older persons.

9.46 Elderly persons units must be sited to enable people to maintain their independence and self reliance for as long as possible. Thus such units should be close to a local shop and within 150 metres of public transport with direct access to activity centres offering a range of cultural and social activities. Access to sporting and educational facilities should also be considered.

9.47 With larger retirement villages some services are likely to be available within the village itself, but it is still necessary that villages have good transport links that can be accessed by frail older persons, so that people maintain their sense of independence, choice and control in their lives for as long as possible.

9.48 An accommodation alternative which is being explored in Victoria is the purchase of adjoining blocks within streets with concentrations of older people. Multiple older persons units would then be developed on the consolidated site. The idea is to relieve old people of the worry of larger, inappropriate housing while enabling them to remain in the same immediate neighbourhood. It also would free under-utilised housing enabling families to enter the area and thus assist in population retention.

9.49 In future development in the South Eastern and Werribee growth corridors of Melbourne it is required that development be at a minimum density of 15 dwelling units per hectare and that there be great variety in housing type. The required increase in density, particularly along transport routes, and more varied housing types should lead in a general improvement in access and choice available to all people, not just the elderly.

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[11] Victorian Government, Submission, p 34.

9.50 As it is recognised that the community lacks examples of well designed three or four storey medium density housing, a number of demonstration projects are currently being planned. Factors such as good lighting, inclusion of functional open areas, efficient layout, use of space and the need for personal security and privacy, which are important to all age groups, are being considered at the design stage.

9.51 The housing needs of the frail older population differ, however, in some aspects from the population as a whole. Some of the factors that need to be considered are older people are best accommodated at ground floor level; floor treatments should exclude ceramic tiles; housing should either incorporate, or be easily modified to include gentle ramps as an alternative to steps; where steps do occur banisters should be provided; bathrooms and entry areas should be roomy.

9.52 The upper levels of three and four story walk ups are not suited to elderly persons but there is no reason why the ground floor of such developments cannot be adapted for their use. At least a percentage of the ground floor units in such developments could be designed with the needs of the disabled and frail in mind. If well incorporated, such variations need not reduce the appeal of the units to others, but would ensure that the choice of suitable housing was available to older people.

COMMITTEE RECOMMENDATIONS - HOUSING AND URBAN ENVIRONMENT

Representation on Planning Bodies

32 That the Minister for Health, Housing and Community Services, in consultation with the Minister for the Arts, Sport, the Environment and Territories, where appropriate, and representative organisations of the elderly, take steps to ensure that people representing the interests of the elderly are appointed to planning, consultation and decision-making bodies with responsibility for urban planning and housing issues (for example, the Better Cities Program).

Living at Home

33 That the Minister for Health, Housing and Community Services consult with the States to develop policies which will make it easier for the elderly -

- to remain within familiar neighbourhoods.

- to continue living in their own homes (for example, by considering the provision of carers' pensions rather than funds for institutions; development of home maintenance, repair, advisory and cost assistance programs).

Design Standards

34 That the Minister for Health, Housing and Community Services consult with the States and appropriate professional associations with a view to ensuring that Australian design standards, especially in relation to pedestrian safety, building access, lighting, pathways and signs, are more prescriptive on the needs of the aged, and especially the frail and handicapped.

Public Transport

35 That the Minister for Health, Housing and Community Services consult with the States and local government with a view to modifying pedestrian and public transport provision to facilitate their use by the elderly.

CHAPTER 10

SUMMARY AND PROSPECT: THE PROMISE OF THE THIRD AGE

10.1 In his recent book, *A fresh map of life: The emergence of the Third Age*,[1] the English historian and sociologist, Peter Laslett, considers the effects of the demographic revolution which lies behind current concern at the ageing of the populations in most developed countries. Laslett is not concerned with details of policy, but with the broad sweep of demographic change that has occurred over the last five hundred years, though particularly the past century, and the implications of such change for our way of life. He puts forward three main arguments:

- that the late twentieth century has seen the emergence of the "Third Age", a lengthy period of active life following retirement, as a distinct and significant phase in most people's lives;
- that this is a new development in human history; and
- that we have not yet learned to cope with the consequences.

10.2 The aim of this chapter is to summarise Laslett's ideas and to indicate their relevance to Australia in general and this inquiry in particular.

10.3 To appreciate Laslett's ideas it is necessary to understand some of the terms he uses. These will become clearer in the exposition that follows, but the vital term to understand immediately is "Third Age", an expression increasingly used in Australia for the active elderly (as in Universities of the Third Age). The term arises from Laslett's proposed new classification of the Ages of Man:

. First Age:	Immaturity, dependence, socialisation and education;
. Second Age:	Maturity, independence, responsibility, earning and saving;
. Third Age:	Era of personal fulfilment;
. Fourth Age:	Final dependence, decrepitude and death.

10.4 Laslett considers that the Third Age is the age of greatest freedom, when the pressures imposed by work and family responsibilities have been lifted, but physical and mental health remain good. Those in the Third Age have control over their own time. With a rethinking of the way society operates, the Third Age could become the age of personal achievement and the crowning glory of an individual's life. There are two main obstacles to this aim: the poor economic position of many old people; and the demeaning way in which society (especially those in Second Age) view and treat the aged.

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[1] London, Weidenfeld and Nicolson, 1989.

10.5 The first point to emphasise is that the arrival of the era of the Third Age is not a phenomenon of the 1990s, but a long term transformation over the whole 20th Century, with complex social, economic and medical causes, and equally far-reaching effects.

10.6 The second vital point is that the Third Age is a new feature in human history. Before our own period (or at least until the 1920s) the vast majority of people moved directly from the Second Age (responsibility and earning) to the Fourth Age (decrepitude and decline) and, in the process, gave the impression that all retired people were senile and incapacitated and thus old age its bad image. Even in earlier times there was plenty of evidence that not all elderly people were in such a situation, whatever the horror of old age expressed in so many literary accounts. Today, when most people lead healthy and disability-free lives until well into their seventies, there is no excuse for such attitudes.

10.7 As Laslett writes: "Those in advanced societies today are the first population ... to exist in which almost every individual has a chance of full experience of the world, full in the sense of being in it for as long as they are capable of living. At all times before the middle of the twentieth century ... the greater part of human life potential has been wasted by people dying before their allotted time was up". The vital question he asks is: "How are we going to use this sudden, unprecedented, unanticipated release from mortality?". The answer so far is that, far from rejoicing as might have been expected, we have responded with fear and alarm: "Instead of so rearranging our affairs ... that we can begin to realise the full potential human experience for the fist time in history, we have taken fright. ... Ageing is seen as a burden on society at large because resources have to be found to give older people incomes, provide for their ever-failing health, to maintain institutions for those who cannot be supported otherwise". Laslett is thinking largely of Great Britain, but, as we have seen, the story in Australia is mostly the same.

10.8 Laslett argues that modern life expectancy and retirement practice mean that most traditional assumptions about age are wrong. The fundamental error is a survival from the past, the error of "taking the minority of the problematic elderly, the chronically sick, those who cannot look after themselves, those who have to live in institutions, those about to die, for the whole body of the retired" - in other words, confusing the Third Age with the Fourth Age. As a result, expressions in language, institutions and instruments have all become obsolete, and we need, in the words of his title, a new map of life.

How Long Can Anyone go on Living?

10.9 Considering the question of biological life expectancy, that is, the natural span of life that humans would run in the absence of accident and disease, Laslett concludes that, while odd individuals will continue to live beyond a hundred years, average life expectancy will not increase significantly beyond what has already been achieved. In summary:

- life expectancy as projected from now until 2050 is about the maximum that people can expect;

- most people will live until age 75 and die between the ages of 75 and 85;

- the conquest of most diseases of youth means that most people will live out their natural human span.

The "Age" of Countries

10.10 There are many metaphorical usages of the word "age", and Laslett makes a number of comments on its application to countries rather than people. He points out:

- The "age" of a nation is an abstraction that has no connection with the age of the population in the demographic sense.

- Countries may consider themselves "young" - e.g. the United States or Australia in comparison with Europe - and be correspondingly more alarmed at their "greying".

- There is no connection between economic innovation, progress etc and a youthful population. Sweden made rapid economic progress when it already had the oldest population in Europe, and Japan today has the most rapidly ageing population of any industrial country.

10.11 There is thus no reason to think that the "greying of Australia" will in itself have any harmful effects on our economic or technological capacity.

The Rectangular Survival Curve

10.12 Laslett's assessment of the long-term changes in life expectancy that have occurred over the past hundred years begins with the "rectangular survival curve", a model developed by two United States researchers, James F Fries and Lawrence M Crapo. As life expectancy improves, it approximates more closely to life-span (the biological limit to life). Illustrating this development, it is possible to draw a graph which shows the percentage of a given population surviving at successive ages. As life expectancy has increased, the graph line has become more like a right angle, showing that there has been a steady decline in the proportion of people who die at young ages and a steady increase in the proportion who die in an increasingly narrow range of advanced years. Survival curves for the United States from 1890 to 2050, and for Australia at selected years are shown on the following pages.

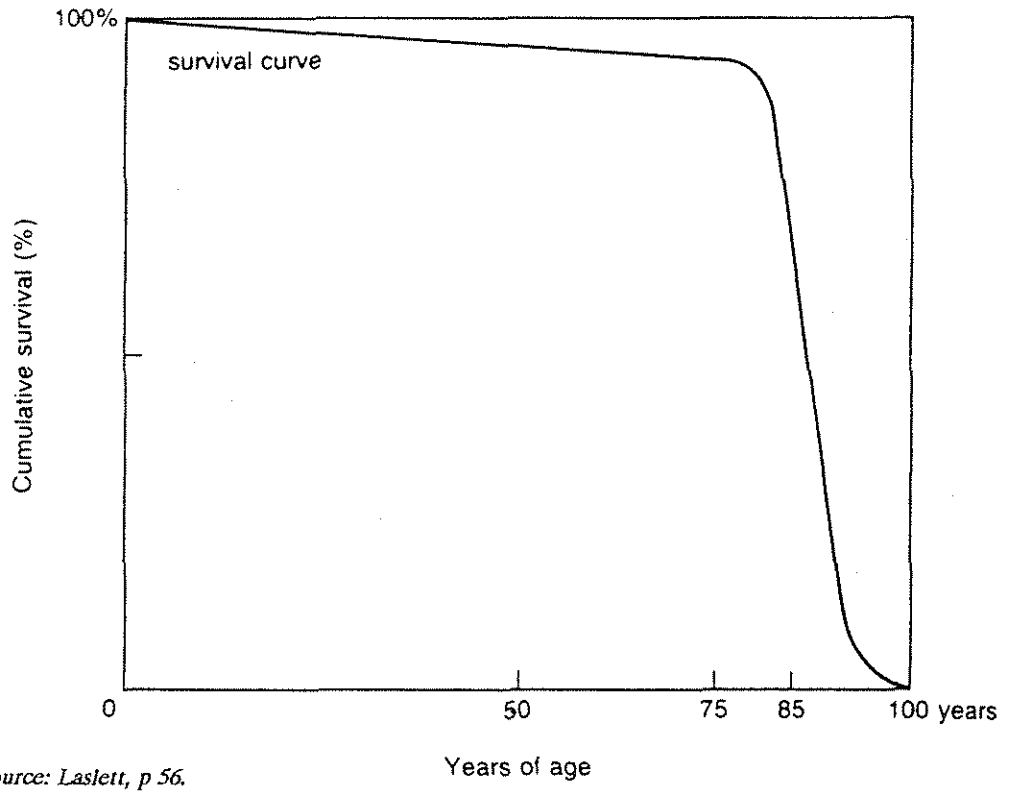
10.13 As we have seen, there is uncertainty among the experts as to whether increasing longevity will be matched by what is called "compression of morbidity", that is, a shortening of the period of illness and decline which Laslett terms the Fourth Age. On the one hand, the rectangular survival curve implies such a trend; on the other, figures on illness and disability among the aged raise doubts. In Australia it has been stated that, "from 1981 to 1988 Australians gained about a year of life from the age of 65 years, but lost two years in handicap-free life expectancy and about one year in disability-free life

expectation".[2] Speaking of the survival curves for England from 1541 to 1981, Laslett observes that the "rectangular" claim is an exaggeration, but notes that the curves show:

- the disappearance of infant and child mortality;
- increased child and youth survival after the development of penicillin in the 1940s; and
- the ending of the transition to increased longevity as the lines get closer together towards the end of the century.

10.14 Similar conclusions may be drawn from the survival curves for Australia.

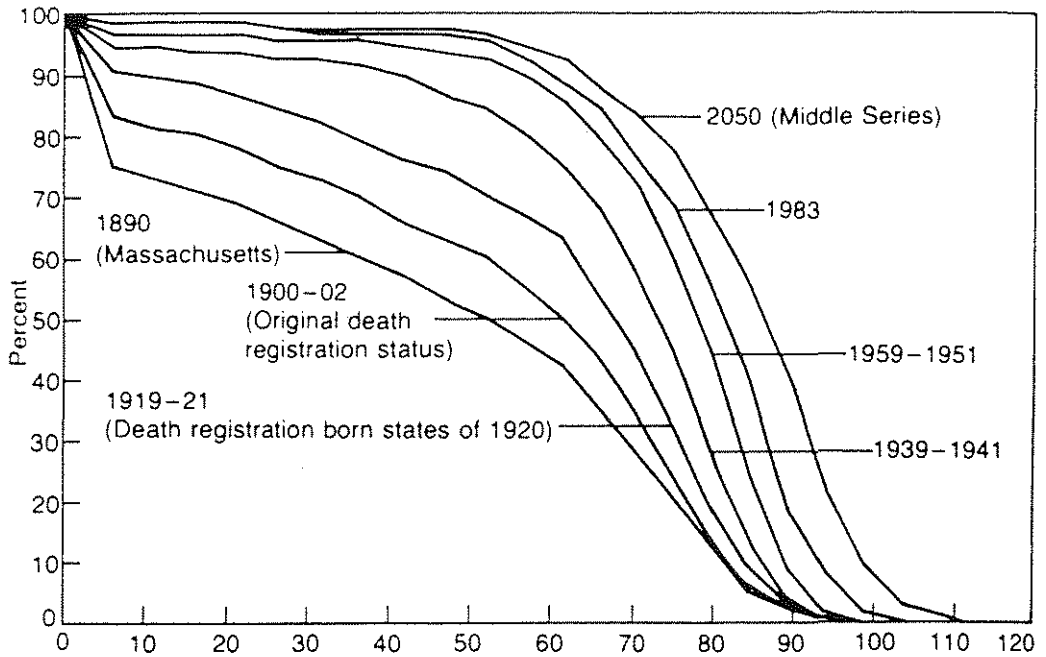
Figure 10.1: The ideal rectangular survival curve



Source: Laslett, p 56.

[2] National Better Health Program, Submission, p 4.

Figure 10.2: Survival curves in the United States, 1890-2050



Source: Laslett, p 60.

Figure 10.3: Survival curves for Australian males, 1905-1986

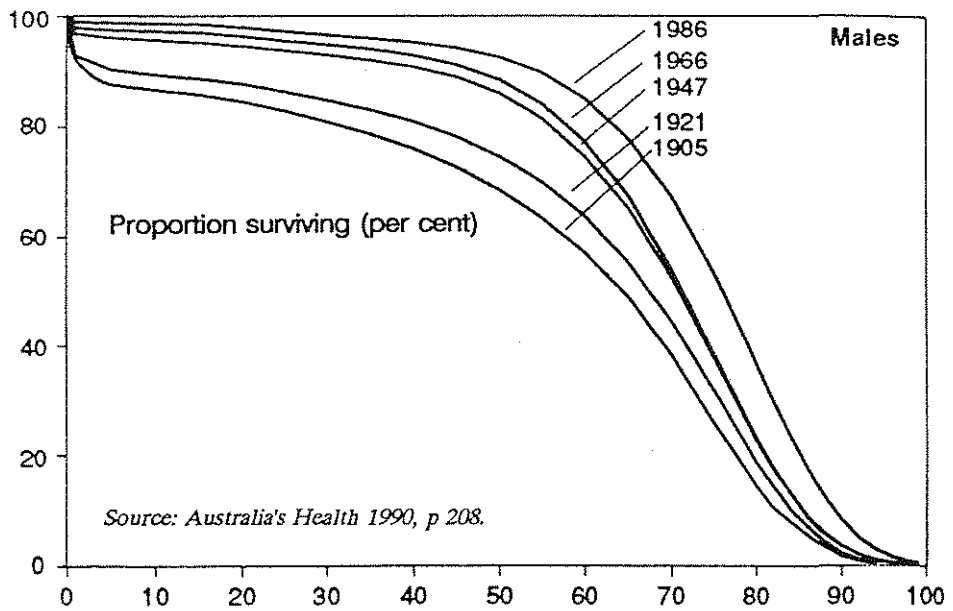
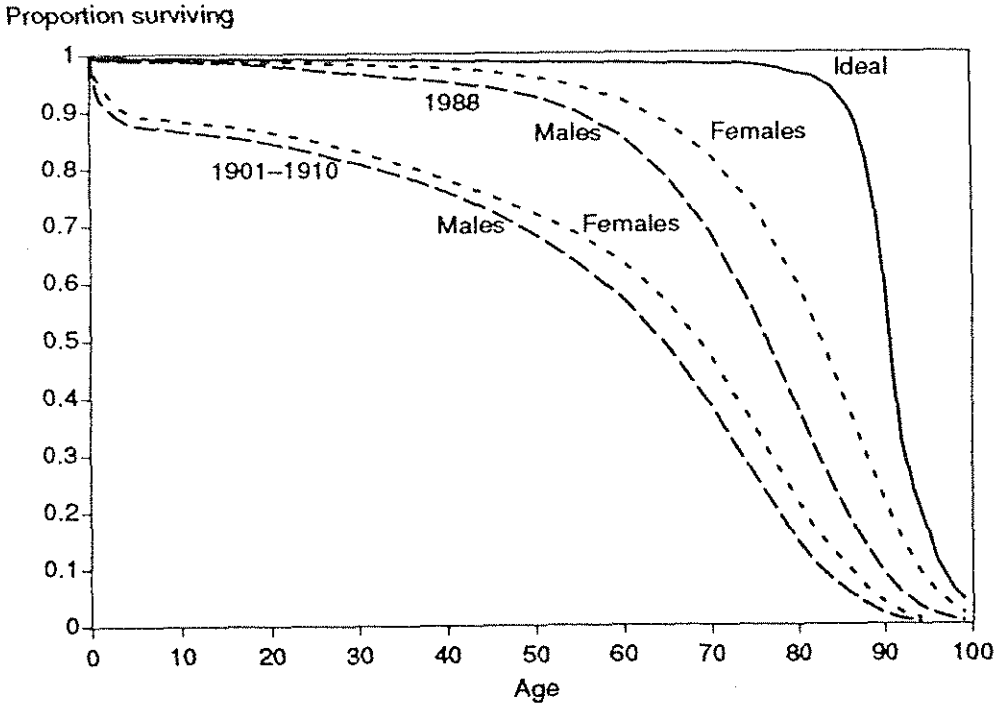


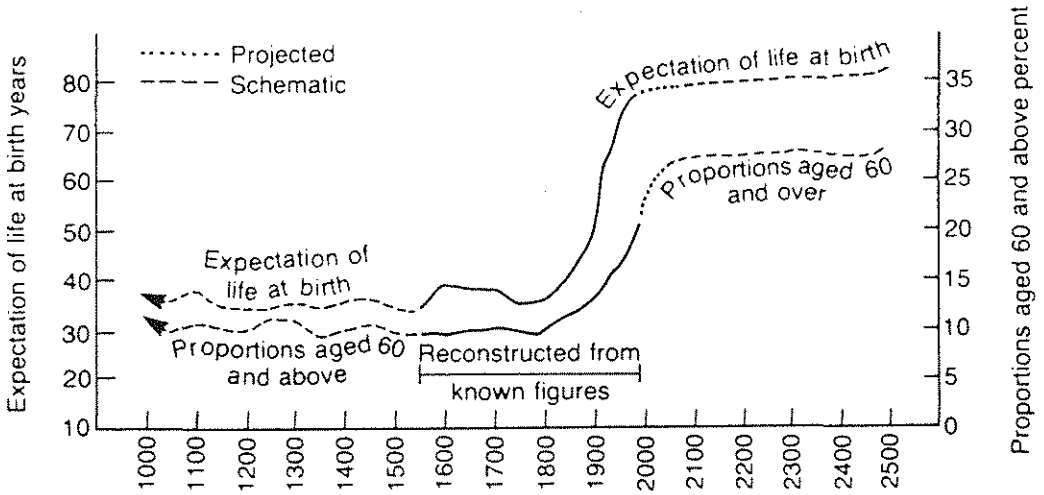
Figure 10.4: Survival curves for Australia, 1902-10 and 1988



Source: Australia's Health 1990, p 10.

10.15 Laslett's second major exhibit is a striking graph which illustrates what he calls the "secular shift in ageing". The graph shows life expectancy and the proportion of the population aged 60 and over for the millennium from 1000 to 2050. From this graph Laslett concludes that ageing is a twentieth century phenomenon. There is a long period (from the year 1000 to the 1880s) with very little change in either life expectancy or the proportion of the population aged 60-plus; there is a dramatic increase in both from the 1890s to the 1990s; and a new plateau at a higher level stretching onwards from the year 2000. Because the early plateau could be extended indefinitely back, and the later one indefinitely forward, Laslett argues, "A change took place ... between the 1890s and the 1980s which was so fundamental that it can ... be conveyed only in geological metaphors". In other words, such a striking change in the demographic characteristics of society represent an upheaval like an earthquake or the emergence of a new mountain range.

Figure 10.5: The secular shift in ageing in England



The Emergence of the Third Age

10.16 Laslett emphasises that the emergence of the Third Age is (historically) a recent development. Before the twentieth century there was no Third Age (except for a privileged elite, who enjoyed a Third Age for their whole lives) because most people went straight from employment to their Fourth Age: most people worked for as long as they could, then fell into incapacity or died. Only during this century, with its increased life expectancy and the increased industrial productivity that makes it possible for people to stop working at an earlier age, has there emerged a definite period between a person's ceasing work and reaching the phase of decrepitude, and only after World War II has this phase become long enough for the Third Age to become a mass phenomenon. As Laslett puts it, a man who leaves work at 55 can look forward to spending as much time in retirement as he can expect to spend at work from age 35. So little has society been able to cope with the promise of this increased leisure that it has insisted on regarding it as the problem of the multiplying aged.

Character of the Third Age

10.17 The Third Age is not defined chronologically. It is the period when individuals realise their full human potential. Accordingly, some creative people (most notably artists) can live their Third Age along with their Second, and some athletes, in these days of child sports stars, must live at least some of it along with their First. Because it must be experienced with others, the Third Age is an attribute of a whole population, not just of an individual. The emergence of the Third Age requires:

- life expectancy to have risen to the point where there is a significant stretch of time to be spent after retirement;

- social productivity and age care provision is such that people can afford to retire (i.e., will have enough to live on);

- the country must be rich enough to finance the incomes necessary for Third Age living - a GNP of at least $7000 per head, according to Laslett (in Australia today it is about $12,000 per head);

- the existence of the concept of retirement and a definite (if variable) point at which people leave paid work; and

- people in the Second Age must expect to live after retirement and therefore plan for those years.

10.18 On the last point Laslett comments that "until recently it was not only possible, but in some ways sensible, for people ... to ignore the possibility of living long after leaving active life and their work. This was particularly so for men. The chance of their surviving into the seventies and eighties was small enough to be regarded as unlikely - even as a piece of bad luck - an eventuality to be coped with if it should ever arise". Studies have found that working people in Victorian and Edwardian Britain did not save for old age, and a survey of elderly poor in London in 1930 found that only 10 per cent of those aged 65 or more had any income beyond earnings, their pension or letting rooms in their house.

Demographic indicators of the Third Age

10.19 Laslett suggests a formula for recognising Third Age societies. The conditions are:

- that a person of 25 has a more than 50 per cent chance of living until 70; and

- when more than 10 per cent of the population is aged 65 or more.

10.20 Laslett calls the first condition the "Third Age Indicator". To put it another way, if a 25-year old has 500 chances in a 1000 of living to 70, it also means that 500 people out of 1000 will survive to that age.

10.21 In Australia, 1921 was the year when men at 25 years first had a 50 per cent chance of surviving until 70, and 1986 the year when the 65-plus population reached 10.5 per cent. By Laslett's definition, Australia thus became a Third Age society in 1986.

Issues and Implications

10.22 Defining a demographic model for the Third Age is the central concern of Laslett's book. In addition to this, he has interesting things to say on a variety of relevant issues, some of which are discussed below.

Work and retirement

10.23 It might have seemed logical that the retirement age should have followed the rise in life expectancy, but the opposite has happened: as life expectancy has risen, the retirement age has fallen. Although Laslett does not give it the same attention, the latter trend is as much responsible for the emergence of the Third Age as strictly demographic changes.

10.24 The words "retire" and "retirement" are fairly new in the history of the English language. The Oxford English Dictionary's first citation of "retire", in the sense of withdrawing from an office or official position, is from Samuel Pepys in 1667, but with the implication that it still carried the older sense of retiring to a country seat, something that only the aristocratic elite could do. The first recorded use of "retire" in relation to business is from 1781. "Retirement" as a noun is even younger. The first OED citation is from 1648 in the sense of leaving the army, and it is not until 1818 that the word is used in the sense of retirement from a business. If the word is relatively new, it is likely that the phenomenon it designates is only slightly less so.

10.25 Laslett points out that retirement in today's absolute sense is quite new and that, in the past, retirement was often partial and gradual. He gives the example of the philosopher and politician John Locke, who "retired" at age 58 to a country house, but who still spent a third of the year in London working at official duties. The position of most working people was less privileged, but not so terribly different because they also kept working until invalidity. Before the introduction of old age pensions in the 20th Century, the English Poor Law operated as a de facto pension system. In the 18th and 19th Centuries it regarded 70 as a pensionable age because most people were not considered capable of work beyond that age. The criterion was not just age, however, but the chronic disablement (which could strike at any age) that prevented a person from continuing to earn a living. The question was judged by local officials at a time when the small size of communities meant that the true circumstances of most members were well known. The contrast with today's centralised social security system, in which universal suspicion stands in the place of personal knowledge, is striking.

Family support

10.26 Contrary to popular myths about the supportive nature of the "traditional" family, Laslett (an expert in this field) points out that family support for the aged has always been inadequate. Old people have always tended to live separately from their family, a trend that has become stronger in recent times because women bear fewer children at later ages (largely because of contraception) and are thus less likely to have sons or daughters still living at home when they are old. A survey of elderly people in London in 1929-31 found:

- a preference for independent, and usually solitary, living;
- minimal role of family support;
- that government pensions were the main form of income;

- that 40 per cent of men and 18 per cent of women between ages 65 and 74 earned income from paid work;

- that the family provided informal care if close enough, but little financial support.

10.27 It is thus unlikely that governments today will be able to persuade the family (that is, adult children) to make a significantly increased contribution to the care of their aged parents, nor the aged themselves to accept it.

Low status of the elderly

10.28 One of the factors which transforms the challenge of the Third Age from an opportunity into a problem is the low status of the aged in western society generally and their particularly low status since the youth cult of the 1960s. Laslett observes that the western literary heritage is banal and negative on the question of old age, odd passages in Shakespeare, Browning and Tennyson notwithstanding, and that myths of perpetual youth have inspired poets and artists far more than the pleasures of old age. In the stories of Methuselah, the Fountain of Youth, the Greek legend of Tithonius and the city of Shangri-La we see the desire, not for eternal life, but for more time spent in the full sensual vigour of youth. The most horrifying literary reference is Swift's bleak vision of the Struldbruggs, miserable people condemned to an eternal Fourth Age hell.[3]

10.29 The science of gerontology was founded in the 19th Century by the French scientist Michel-Eugene Chevreul (1786 - 1889), and appropriately, as he lived himself to the remarkable age of 103 and thus had an extraordinarily accessible subject for study!

10.30 Around 1900, Laslett writes, many doctors classified old age as a disease, and he quotes a contemporary UK gerontologist on the effects of this: "Translating senile dementia into Alzheimer's Disease has undoubtedly produced support for research. ... If dementia had not for so many years been categorised as normal ageing, the relevant research might have started years ago". The problem throughout is the failure to distinguish the Third Age from the Fourth Age.

10.31 The low status of the elderly has had disastrous effects on their employment prospects since the end of the post-war economic boom. As Laslett writes, "when the recession came in the 1970s traditional attitudes were strong enough to ensure that 'natural wastage' - the reduction and remodelling of the workforce - should be carried out as far as possible by dispensing with older workers". Few objected to this policy. Laslett adds that one of the main reasons why labour force participation rates for older people have fallen so dramatically since the mid-1970s is because "successive governments have seized every opportunity possible to classify as much redundancy as possible as 'natural wastage', in order to play down unemployment figures .... The treatment of people as 'natural wastage' is the most obvious and definite sense in which very large numbers of elderly have been forced to be indolent in the last few decades."

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[3] Gulliver's voyage to Laputa and Japan, in Jonathan Swift, *Gullivers Travels* (Penguin English Library edn), p 252-260.

10.32 It is no doubt the baby boom which led to the youth cult, and the affluence of the 1960s which saw the emergence of the youth and teenage markets as significant targets for advertisers. The conditions for this syndrome will probably disappear as the baby boom generation turns into the elderly, but in the meantime we have the problem that the youth cult poses for the status of the aged. As Laslett puts it:

> *The exultation of the prowess of youth at sport of all kinds grows ever more important in our cultural life, and it cannot but affect the self-esteem of those no longer able to compete. The exertions and achievements of the [sportspersons]... almost dominate television programs, which in their turn almost dominate diversion in the contemporary world. ... But youthfulness is not only dominant on TV, it monopolises the market and the media, obsessively devoted as they now are to youthful looks .... Not only is each particular of dress and facial appearance subject to the imperial measures set by those in their teens and early twenties, but every least sign of a decline from those standards with the normal ageing process is singled out for comment and reproach.*

10.33 These attitudes will change as advertisers realise that the retired constitute a market potentially as great as the teenage world, but this will occur only if the retired have sufficient spending power (and thus income) to be an economic force.

Promise of the Third Age

10.34 Laslett concludes with a statement of the promise of the Third Age and a plea to stop regarding it as a problem: "Time, or leisure rather - and a means to use it - has ceased to be the monopoly of an elite made up of hundreds, thousands or, at most, tens of thousands of persons. It is becoming a commodity of millions of our citizens, our elderly citizens, those in the Third Age." He considers that there are six key issues relevant to the achievement of such a goal:

- Lack of awareness of what has happened and failure to adapt to it.
- Finding the means to support more people defined by society as no longer required within the workforce.
- The attitude and morale of old people in the face of prejudices about their capacity and worth.
- The development of institutions, organisations and outlook to give purpose to the additional years being given to us.
- How to deal with the Fourth Age, the phase of decrepitude, decline and true dependency.

- Questions related to justice between age groups and generations, for example: the just limit of resources to be devoted to the care of the incapacitated; the just arrangements for deciding to end life support; the general question of a fair go from one generation to the next.

10.35 Laslett's book is a particularly comprehensive statement on the preconditions and nature of the Third Age, and it is for this reason that the Committee felt his ideas should be summarised in such detail. That many people in Australia are thinking along the same lines is indicated in the submissions received by the Committee, one of which was adamant that retirement **was** "the most efficacious way for people to spend a quarter of their lives" because "this is the age when men and women should be able to do those things they have always wanted to do".[4]

10.36 Other material presented to the Committee argued along the lines laid out by Laslett. Mr Jim MacBride, retirement counsellor for the RSL, rejoiced in the fact that most people today are able to retire, pointing out that "It is not so long ago that only the minority were able to retire. The surge in early retirement when 'normal' retirement has only just become accepted borders on the revolutionary."[5] Not that early retirement is in any way a consequence of demographic change. The clear acceptance of relatively early retirement (and even at 65 men can expect another 15 years of life) as a leisure lifestyle (without paid work) is not a necessary consequence of an ageing society, but a cultural creation which emerges from Australian history, values and economic realities.[6]

10.37 MacBride considers "retirement" to be the wrong word and suggests "Age of Living and Enjoyment". Such a phenomenon is new and carries its own problems. As he writes:

> *For thousands of years men and women worked until they were physically unable to continue. Retirement was known only to the very wealthy. Even when retirement became more widely accepted, relatively few people were perceptive and far-sighted enough to plan adequately for truly happy and satisfying later years. Many, unfortunately, were willing merely to drift into inactivity and boredom.*[7]

10.38 The pleasures and promise of retirement are greater than the problems, but the latter are real and will be worsened by lack of planning. They include:

- time formerly occupied by work can create emotional and family problems if not used constructively;

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4 Mr R E Taplin, Submission, p 2.

5 Mr Jim MacBride, retirement counsellor for the RSL (Victoria), Submission, p 1.

6 MacCallum, "Lifestyle implications of Australian retirement patterns", p 12.

7 MacBride, Submission, p 5.

. savings and buying power are eroded by inflation and rising taxes;

. surviving spouse could be in trouble if will not drawn up properly;

. poor health could result from physical inactivity and lack of mental stimulation.

10.39 Despite the promise of the Third Age, there is much dissatisfaction among retired people in their 60s with limited options for activity: one survey in Melbourne and Adelaide found that 20 per cent of the 65-plus wanted to take up activities but, for a variety of reasons, could not, and 30 per cent in the 60-64 year age group. Decreasing participation in work by men would be less a concern if there was a parallel increase in active leisure. Between ABS surveys of time use in 1974 and 1987 the time spent by older men in domestic tasks increased, paralleling the decreasing time spent at work. Unfortunately, the pattern is that as Australians age their participation in social activity declines, and from age 50 their home leisure activities (e.g. watching television) increase. Older people report "health" as a reason for not undertaking new activities more frequently from age 50 years. They are also less likely to report that they have activities they would like to do but are unable to. An increasing fear of crime and decreasing average income compared with people at younger ages suggests that there is a syndrome of under-use revealed by these patterns of attitudes and activity in older age. More activity would be possible and desirable, but appears to be prevented by the social and economic constraints experienced disproportionately by older people. This has implications for health outcomes because level of activity is one of the few common risk factors for a number of diseases and is important for psychological well-being.[8]

10.40 It has been suggested that there are three general ways in which retirement opportunities could be expanded:

. By improvements in retirement income.

. By greater opportunities for work.

. By increased access to leisure and recreation activity.[9]

10.41 In response to these problems, MacBride proposes that:

> *A whole social and welfare reform action plan must be developed which effectively integrates with occupational/national superannuation. Implementation must seek to provide for an effective transition of people from a mainstream workforce lifestyle into a second career of "living" [for] the last fifteen or twenty years of our lives. This will necessitate a major*

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8 McCallum, AIH, p 208.

9 McCallum, Lifestyle, p 10.

public education program ...[10]

10.42 And he suggests that there is a role for government in developing such a program:

- It can examine the whole scope of preparation for the Age of Living as a part of Adult Education and life long learning. Consultation with all involved parties, including employer and employee groups, would provide the forum for communication and derivation of an agreed Australian "Age of Living" scenario.

- Government departments, organisations and companies could then adapt their present programs to come in line with uniformity in direction and guidance. Individuals and organisations seeking policy to develop new programs would have something authoritative from which to work. Colleges specialising in education for mature persons should conduct appropriate courses for both interested individuals and counsellors.

10.43 He proposes a number of specific and relatively inexpensive measures which governments could implement in the near and mid-term future:

- Prepare an Adult Education Policy for the Age of Living, a basic document on which to establish training programs and counselling.

- Set an example by providing special superannuation benefit statements automatically to public servants who come within five years of the earliest retirement option date of their scheme. Reminder benefit statements should then continue until a decision on retirement is made. From the five year mark provide a quarterly journal and produce special articles for its own and Company Newsletters or Magazines on retirement subjects and preparation for the Age of Living. Invite registration of specialist counsellors in various areas of activity to make sure employees do get sound advice no matter where they live. Organise in-house or selected external seminars on preparation for all employees and staff within five years of termination of career employment.

- Provide for formal Adult Education for individuals and counsellors for all retirement education subjects.

- Ensure effective inter-departmental co-operation on all aspects of the Age of Living.[11]

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[10] MacBride, Submission, p 2.

[11] MacBride, Submission, p 11-12.

10.44 Mr Lange Powell also felt that governments had a role in realising the promise of the Third Age - and that it was not something that could confidently be left to the mysterious operations of the invisible hand. Speaking at the Committee's seminar he noted that there were three essential ingredients for "successful ageing":

- A "private safety net": the external supports for the older person, including income, housing, health and personal care, mobility, social and family networks, educational, recreational and work opportunities.

- The capacity for independent activity: the older person retaining sufficient physical and mental health to manage the tasks of daily life and make use of these supports.

- Perceived personal well-being: the psychological predisposition to remain in control of one's life, and to feel confident, independent and generally satisfied with oneself.

10.45 The role of public policy makers was thus:

- To foster the first two ingredients of successful ageing, by

  (a) providing a broad, flexible and adequately resourced net of services;

  (b) enabling Australians to lead lives in which they are able to prepare themselves financially, educationally, in health, etc, for a successful old age. Obviously, those who are now poor, homeless or unemployed have little chance of an old age that is any more successful than their youth or maturity.

- Support the third ingredient by fostering a climate in which old age is recognised as a stage through which nearly all of us pass, not a separate chamber of life on which the door is slammed as soon as we enter.[12]

10.46 Whether these moves can succeed depends partly on whether the aged in our society are seen as a burden or a resource. Only in the latter case will we be able to agree with Dr Don Edgar[13] that:

> *The ageing of our society is a cause for celebration it is recognised as an extension of opportunities. It means maintaining tremendous skills and resources with the wisdom of experience. It provides a spreading pool of competence and human help to be drawn upon with enthusiasm.*

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[12] Seminar transcript, p 143-4.

[13] Edgar, "Ageing - Everybody's Future".

10.47 It is essential that we get away from the idea of "statutory senility" - the mandatory retirement age, accompanied by the all-too-familiar belief that the aged are away with the fairies and can make no useful contribution. We should point to the extraordinary accomplishments of many great people in extreme old age. In addition to Chevreul mentioned earlier, other examples include the painters Titian, Hokusai and Picasso and the musicians Verdi, Richard Strauss, Stokowski, Stravinsky, Arthur Rubinstein, Mieczyslaw Horszowski (still performing at 100!) and Horowitz. Regrettably, few women spring to mind: the painters Georgia O'Keefe and Grandma Moses, the poet Mary Gilmore, and the musicians Nadia Boulanger and Lily Laskine, and Australia's own octogenarian rock climber, Dot Butler. The wealth of experience of the aged must be used as an asset rather than having the aged generally characterised as a liability. A major public debate needs to be generated on this subject.

BARRY O JONES
Chairman

April 1992

APPENDIX 1

CONDUCT OF THE INQUIRY

The Committee adopted terms of reference for the inquiry and placed newspaper advertisements which called for submissions in November 1990. The Committee decided to conduct its investigations principally by means of research and did not hold public hearings. It did, however, hold a seminar at which invited speakers and other participants spoke on a range of relevant topics. The Committee is most grateful to the speakers and participants for their contribution on this occasion and would like to record its warm appreciation of their efforts. The speakers and other participants are listed in Appendix 3.

The Secretariat carried out a substantial volume of research in relevant published literature, the range of which is indicated in the content of the report and the bibliography. The Committee received 60 submissions to the inquiry which were also of great value in the preparation of the report. The submissions are listed in Appendix 2.

APPENDIX 2

LIST OF SUBMISSIONS

1	Mr Alfred Ashbrook QLD
2	Mr John Lodewijks Department of Economics University of NSW NSW
3	Dr John Tomlinson Director ACT Council of Social Service ACT
4	Mr John Brooks National Trainer Australian Association for Marriage Education NSW
5	Mr Craig Bradshaw President Phoenix Alliance (Inc) WA
6	Mr R E Taplin NSW
7	Ms Joan Lysaght WA
8	Mr Harry Beveridge QLD
9	Mr P D Mantle QLD
10	Mr Dennis Bates WA
11	Mr Alan Wilson Secretary Pinnaroo & District South Australian Senior Citizens' Club SA

12 Dr John Ward
Director
Dickinson Unit for Aged Care
The Prince of Wales Hospital
NSW

13 Ms Gillian Macfarlane
Director
Social Work
Hollywood Hospital
WA

14 Ms Vivienne Rowney
General Secretary
The Country Women's Association of WA (Inc)
WA

15 Mr Jim Macbride
Retirement Consultant
The Returned Services League
VIC

16 Mr Graham Wilson
Director
WA Council on the Ageing Inc.
WA

17 Mr John Smith
Manager
OH&S Research Services
Workcover Authority
NSW

18 Mr R E Taplin
NSW

19 Mr Bob Holderness-Roddam
TAS

20 Mr Douglas Goudie
QLD

21 Prof S Encel
Social Policy Research Centre
The University of NSW
NSW

22 Mrs Margaret Carter
Chairman
Silver Power Action for Reform Inc
VIC

23 Miss Elizabeth Ayling
WA

24 Mrs Val Atkins
NSW

25 Mrs Barbara McKenzie
President
U3A University of the Third Age
QLD

26 Mr Colin Grenfell
Superannuation Committee
The Institute of Actuaries of Australia
VIC

27 Mr Jason Grossman
Dept of Community Medicine C24
University of Sydney
NSW

28 Ms Janet Greenwood
Study Area Consultant
Women's Interests Unit
Department of TAFE
WA

29 Mr Bruno Krumins
President
Ethnic Communities Council of SA Inc
SA

30 Ms Betty McGeever
City Librarian
City of Fremantle
WA

31 Mr P C Alexander, CMG OBE
National Secretary
The Australian Veterans and Defence Council
NSW

32 Mrs Margaret Hector
WA

33 Mrs Jean Tom
National President
The Country Women's Association of Australia
VIC

34 Ms Merryanne Sumner
Director - Client Service
Volunteer Centre of NSW
NSW

35 Mr Stuart Hamilton
Secretary
Department of Community Services and Health
ACT

36 Ms Kay Frost
Victorian Retirement Advisory Association (Inc)
VIC

37 Mrs Barbara Fitzgerald
Hopkins District Health Council
VIC

38 Mrs Mary Miller
President
SA Council of Pensioner & Retired Persons Associations Inc
SA

39 Mr Lynden Esdaile
Director
Strategic Development
Australia Council
NSW

40 Ms Alison Carlson
Convenor
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The U3A Network - Victoria
VIC

41 Ms Marjorie Molyneux
Convenor
Elderly Working Group
The Parks Community Health Service Inc
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42 Mr Ian Gollings
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The Returned & Services League of Australia
ACT

43 Mr Vincent McMahon
Assistant Secretary
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44 Ms Val Marsden
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45 Ms Lisa Wallenius
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Department of the Arts, Sport, the Environment, Tourism & Territories
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46 Mr Lange Powell
Commissioner for the Ageing
SA

47 Mr John Bowdler
Acting Secretary
Department of Social Security
ACT

48 Mr Jon Stanhope
President
The A.C.T. Hospice Society Inc.
ACT

49 Mr Andrew Moorhead
Director
Parliamentary Liaison Section
Department of Veterans' Affairs
ACT

50 Ms Peta Borthwick
NSW

51 Mr Allan McDonald
QLD

52 Ms R L Matchett
Director-General
Department of Family Services & Aboriginal and Islander Affairs
QLD

53 Hon Dr C Lawrence MLA
Premier
Office of the Premier
Department of the Premier and Cabinet
WA

54 Mr Basil E Castleton

55 National Better Health Program
Department of Community Services and Health
ACT

56 Department of the Arts, Sport, the Environment, Tourism and Territories
(Supplementary Submission)
ACT

57 MatureSTAFF
NSW

58 Victorian Government
VIC

59 Department of Industrial Relations
ACT

60 Aged Services Association of NSW & ACT Inc
NSW

APPENDIX 3

SEMINAR SPEAKERS AND PARTICIPANTS

Speakers

Ms Kathy Sanders
Law Reform Commission of Victoria
Quality of Life for Older People: Ethical Issues in Ageing

Dr Richard Taylor
Department of Public Health
University of Sydney
Differences in Life Expectancy: Social Factors in Mortality Rates

Ms Ann Thurley
Recreation Development Section
Department of Arts, Sport, the Environment
Tourism and Territories
Fitness and Recreation for Older Australians

Mr George Fairfax
Chairman
Arts Action Australia
Access to Culture and the Arts

Ms Ann Whyte
President
Australian Council of Adult Education
Lifelong Education: Learning Opportunities for Older People

Ms Kathy Patston
Evaluation and Monitoring Branch
Department of Employment, Education and Training
Jobs for Older Workers: A Question of Attitudes

Professor Sol Encel
Social Policy Research Centre
University of New South Wales
Flexible Employment Practices: Increasing the Options for Work and Leisure

Mr Robert Bowring
Victorian Retirement Advisory Association
Towards Less Rigid Retirement Patterns

Mr Lange Powell
Commissioner for the Ageing
South Australia
Successful Ageing: Our Common Future

Dr Hal Kendig
Director
Lincoln Gerontology Centre
Melbourne
Summing up the Issues: Policies for an Ageing Australia

Participants

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Mr Paul Free
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Mrs Wyn Tate
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Day Respite Centre
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Mr John Richmond
Office of Seniors' Interests
Western Australia

Mr David Green
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Ms Karen Byatt
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Australia Council

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APPENDIX 4

FLEXIBLE RETIREMENT AND OVERSEAS PROGRAMS TO INCREASE JOB OPPORTUNITIES FOR *OLDER AND RETIRED WORKERS*

(1) *Edited from talk by Professor Sol Encel at Committee's seminar, 24 September 1991*

Flexible retirement is a largely unresearched subject. That is the first thing that strikes you when you start looking at it. It is not nearly as well researched as other aspects of ageing, retirement and so on. In fact, the literature on ageing is dominated by considerations about health, not work. The only country in the world where we have got any kind of substantial data series is the United States where, since the mid-1950s, there have been seven or eight major longitudinal studies, some of them lasting as long as 20 years, which give us a great deal of information about the transition to retirement and to old age. However, even there these surveys too have been concerned more with health and with adaptation to old age than with working life after the formal age of retirement.

But there are now a large number of articles describing the policies of individual companies and government agencies which are actively trying to employ and make use of the experience and skills of older people. I will mention some of these later on. Most recently, the subject has attracted the attention of two major international organisations, the OECD and the World Health Organisation. In 1988, the OECD published a report called *The Future of Social Protection*, which argued in favour of what it calls an "active society" where better use is made of human resources, both for economic and welfare reasons. The interest of the World Health Organisation goes back to about 1980 and is now incorporated in the program called "Healthy Ageing". The general objective of this program is to ensure equity in health by reducing inequalities between countries and also between different group within countries, which includes inequalities and inequities between younger and older age groups. This includes the full use of physical and mental capacity to derive full benefit from life, the reduction of disease and disability, and adding years to life by reducing premature deaths, which includes the examination of work opportunities after retirement. This might be the answer you might give to the Department of Finance. What is the bottom line of your project? The bottom line is that if you keep people healthy you will reduce the cost of Medicare. That argument should appeal to even the hardest nosed economic rationalist in that Department.

Apart from contributing to the health and well-being of the individual, arguments in favour of retaining the services of older workers are well known. These arguments have in principle been accepted by a number of governments, but in most cases their actions in support of these principles have been pretty minimal. Last year the International Labour Office made a study of ten industrialised countries, and the

report concludes that there was some evidence of rethinking at the government level but not much in the way of action. Action has, however, involved raising the retirement age, for example in Germany, which is somewhat ironic because the modern concept of retirement comes to us from Germany. In case people have forgotten, it was Bismarck who introduced the first national retirement scheme, the first national pension scheme, in the 1880s and it is worth noting that Bismarck himself wanted this to start at the age of 65. He thought that was a good age, obviously because it would be very cheap since it would involve very few people and they were not going to live very long. He was, however, frustrated by the German Reichstag which insisted that the age be raised to 70. Most people date the adoption of 65 as a kind of sacred figure, almost a fetishistic figure, for retirement from that period.

So 65 has really only been the normal retirement age for men for just over 100 years; previously it did not exist. It may be that the history of the compulsory retirement age will not be very long, particularly in view of the action of both State and Federal governments in the United States which have abolished compulsory retirement, the action of the Canadian Government which has increased a scheme of flexible retirement up to the age of 70 and, of course, now legislation in Australia. But, as John McCallum points out, American legal changes since the 1960s have had very little effect on stimulating work after the official retirement age, and so the changes in Australia will probably have less effect than some people might have thought. I think this is important because, if we are talking about action, that is not the kind of action that is likely to produce much of an effect. It comes back to the point already made about the attitudes of employers which seem to be extraordinarily resistant to arguments of the sort I have already mentioned.

As far as the Federal Government is concerned, the Human Rights and Equal Opportunity Commission was given authority since in 1991 to investigate complaints of age discrimination, but so far there is no sign of interest in flexible retirement. Indeed, the Minister for Industrial Relations, Senator Cook, stated in November 1990 that there did not seem to be much case for flexible retirement and that the Government was not under much pressure to act on the issue; by which he meant, I think, that he was not under much pressure from the State governments.

Sweden

Sweden, as we might expect, has gone furthest in this respect. The Swedes have been thinking about this problem since the 1950s, and since 1976 they have introduced a number of schemes to encourage people to retire gradually, instead of simply leaving the work force at the age of 60. As early as 1959 the pension scheme was reformed to allow free choice in the use of pension entitlements. This meant that people could choose the age at which they retired, from 55 onwards, with actuarial adjustments to pension levels and also the right to withdraw up to one third of accumulated entitlements at earlier ages. In 1976 the flexible pension was introduced which enabled people to move freely back and forth from the work place, carrying part of their pension with them between the ages of 60 and 70. Part-time pensions were also

introduced for workers between 60 and 65 years on a sliding scale basis. According to the Swedish studies, although the evidence is a bit skimpy, the people who stay on at work have a significantly better health record than the people who retire and just give up work completely - which is another argument you might give the gentleman from Department of Finance.

United States

In the United States, quite apart from the issue of the abolition of compulsory retirement, the subject has attracted a lot of attention both at state and local government levels, and from federal government agencies and private companies. The main legislative support for this kind of thing comes from an Act of the US Congress, the Job Training Partnership Act, which provides that 3 per cent of the funds allocated for this program, which is designed to improve work skills - like similar programs in this country - are set aside for the training and placement of older workers, by which is meant people aged 55 or over. For example, in Denver, Colorado, there is a program called the Older Worker Employment Program, in which the major private public utility which provides electric power in that town has hired 25 people over the age of 55 to conduct home energy use audits. They contract privately with the company. The Bell Telephone Company in Denver also took on 26 temporary older workers to deal with the results of a survey of their clients. Both of these projects were supported by the Job Training Partnership Act. In 1985 a report was published detailing 650 separate training programs which were funded by money coming from that three percent allocation available to economically disadvantaged workers over the age of 55.

The Environmental Protection Agency in the US, a Federal government agency, runs something called the Senior Environmental Employment Program which it operates jointly with the biggest single organisation of seniors in the United States, the American Association of Retired Persons. That association has 30 million members and has produced a great deal of very good research information on the whole subject. The EPA employs older people to assist in administration, to wash glassware, to do graphics and to act as telecommunication operators. Other federal agencies which have followed this example are the Federal Communications Commission, the Forest Service, the US Department of Agriculture, the Army Engineers, the Census Bureau and the Customs Service. There are similar projects at State level.

Some large companies in the US are also well known for their work in this area. For example, one of the big hotel chains has a program of recruiting older people, not 55-plus but 65-plus. Twenty-five per cent of the staff which it now employs to deal with reservations and sales are people aged 65 and over. They have discovered that the annual turnover among these older people is 2 per cent compared with 70 per cent for younger employees. The result of that has been that their recruitment and training costs have been cut by 40 per cent.

We could go on; there are quite a number of others. For example, there is a study of a large machinery manufacturer which operates a partial retirement and part time-work program which is open to workers who have been with the company for 30 years or, if they are over 60, that is reduced to 10 years. Each worker negotiates an individual contract with the company. For example, in some cases they work 60 per cent of what a full time worker would work, and they receive 60 per cent of their money in salary and 40 per cent in pension benefits through a company pension scheme. Pension benefits continue to accrue on a pro rata basis.

A bank in California runs what it calls an annuitant pool of workers who are employed as required by the bank up to a maximum of 20 hours per week. The bank employees are recruited into this pool before they retire and the company continues to pay retirement benefits while they are working.

Britain

One interesting program, a very large program in Britain this time, not in America, is described by an Australian public servant, Ann Kern, who was formerly a senior official of the Department of Community Services and Health and who is now working in Queensland. She did this as part of the WHO program on healthy ageing. She studied the second largest supermarket chain in the United Kingdom, Tesco Limited, which is well-known for its interest in employing older people. They now employ more than 5,000 people aged 55 years and over. They have found in a series of studies that the health and morale of these people has improved. Sixty-seven per cent of the men they employed were pensioners when they were taken on and 45 per cent of the women they took on were pensioners. Thirty per cent of them had been unemployed or made redundant before joining Tesco.

McDonalds

An internationally known firm which has also given a lot of publicity to its success in recruiting older people is McDonalds. McDonalds, of course, has an image of recruiting younger kids, and it has been frequently criticised for exploiting them. In fact, the pool of younger people has been drying up in the United States, so McDonalds has introduced a program which, in true MacDonald's style, is called the McMaster's Program. It has apparently been a great success. There are recruiting notices all around the United States in their restaurants encouraging older people to apply at their neighbourhood McDonalds for jobs which, to quote the company's blurb, "offer a convenient workplace, flexible hours, training with pay, the opportunity to make new friends, meal benefits" - that sounds a bit of a double-edged one - "and the chance to earn money without affecting social security benefits". They have produced a national television commercial called "The New Kid", and these kids, of course, are over 65, and some other videos which deal with the problems of older people re-entering the work force, and they run national training programs and national seminars for supervisors.

McDonalds in Australia does not run this program, but they went through their records and discovered that they employ eleven people aged over 60 in their own restaurants. There are only about 35 McDonald's restaurants in Australia which are actually run by the company itself; the others are let out on franchise. We do not know anything about the franchised ones, but we were given access to their eleven older employees in their own restaurants and we have sent them our questionnaire, with the company's assistance.

We had a chat with the personnel manager of McDonalds in Australia, who said that they are recruiting older people. What they are not doing in Australia is that elaborate McMasters program which I described which is being done in the United States. That is a purely American thing. He made several observations about the situation in this country.

One of them was that the average age of McDonalds' work force was increasing, partly because the pool of young people that they used to rely on is shrinking. They cannot rely on those young people in the way they could. In spite of youth unemployment, it is not as easy to get young kids to work in McDonalds as it used to be.

The second thing he mentioned was that the turnover among executives has decreased. McDonalds executives used to leave the firm at a relatively young age because they found the job rather stressful, but because of the labor market they are now staying on, so the average age of their executives is also rising. Their champion exhibit is a gentleman aged 75 who works for them now, but they are also finding that they are recruiting older women.

He pointed out that one of the advantages in America of recruiting older people is that it encouraged older customers to come into the restaurants because they prefer being served by older, polite, attentive, considerate persons and not by young kids who just throw the food at them and forget about them. It also encourages the grandparents. Possibly the grandparents would not have been seen dead at a McDonalds restaurant before, but now they come in with their grandchildren and the meal becomes a family occasion. Because the recruitment is on a neighbourhood basis, they get to know the people who work there and it becomes a very chummy affair. I do not know whether all that is transferable to Australia, but I think one can say that some of it would be. He did not explain why they do not operate a more elaborate program in this country, but presumably if they are recruiting older people they do not really need to.

Conclusion

This subject was investigated a few years ago by the Centre for Studies and Social Policy in London. The author of this report, Michael Fogarty, who has written a lot on the subject, makes a suggestion for a four-point approach to this subject which I think is worth quoting to you. First, he suggests that the minimum age of retirement for both men and women should be 62 and that it should range up to 70. This range

would be also relevant to the payment of pensions; they would be payable at a half-rate from age 62 onwards, depending on how much time you spent working. There would be no restriction on earnings and no pressure to stay on. At age 70 you would be eligible for your full pension and fourthly - and he suggests a topic that has been mentioned here today - that there should be positive encouragement to people on pensions to become more involved in voluntary social service. That is a very quick run through of the sorts of options that already exist or have already been discussed.

I cannot resist ending with a French quotation. The French, of course, like to dignify these things with great philosophical generalisations. In a recent article by one of the leading students of ageing in France, Anne Marie Guillemard, of the National Centre for Scientific Research in Paris, describes the inevitable outcome of current trends as what she calls `dechronoligisation'. If you have not heard that word before, I make you a free gift of it. It means of course that you give up the notion that life is divided into three bits; youth, maturity and old age and never the three shall meet. She says that we have to get away from this, that it is already happening, but government policy and employer attitudes have not yet caught up with the fact. I think that is true in Australia also.

(2) *Reprinted from Appendixes A and B of the submission from the Department of Industrial Relations*

The United States of America

The Congress of the United States of America enacted the *Age Discrimination in Employment Act of 1967* to prohibit discrimination in employment on account of age in such matters as hiring, job retention, compensation and other terms and conditions of employment. The Act and its later amendments prohibit discrimination by employers, employment agencies and labor unions against workers aged 40 to 70.

This act has become the most important mechanism for protecting the employment rights of older workers. A study in 1984 found that 55 per cent of all notifications under the Act were from employees between the ages of 50 and 59. As two American researchers comment,

> That fact suggests that the Act is being used most extensively by those employees likely to be in greatest need of its protection: older workers who have reached the end of their career path with a particular organisation, who are paid more than younger workers, who find it difficult to start over in a new job, and who are not yet old enough for retirement benefits.[1]

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[1] Schuster M. & Miller C.M., 'An Empirical Assessment of the Age Discrimination in Employment Act', *Industrial and labour Relations Review*, Vol. 38, No. 1, October 1984, p 69.

In addition, the long standing anti-age discrimination legislation has meant that a significant number of North American workers have switched to second careers after their 'normal' retirement.

In 1983 widespread reforms were made to the US social security scheme. The scheme is important in that it covers all Federal civilian employees and all employees of private tax-exempt non-profit organisations. Further and law prohibits states and local governments from withdrawing from social security schemes. Under the new law, the retirement age will increase from 65 to 67, after 2000.

A number of innovative working arrangements have been introduced by American corporations. At Polaroid Corporation, 'rehearsal retirement' is available to employees, who may take unpaid leave to assess whether they are ready to retire. Employment benefits are frozen during this period. Polaroid also allow employees to gradually reduce their working hours until they retire.[2]

Job reassignment is another concept that is used by some companies in the US to ease transition to retirement or allow employees to continue working. It involves employees transferring to jobs with less responsibility, stress, pay and status. Xerox Corporation uses the term 'strategic repositioning'.[3]

Xerox has a program that allows older production workers to move into less strenuous jobs. Under a union contract people who are 55 or over and have been with the company at least 15 years can move to less demanding jobs that do not involve rotating shifts. The employees earn an hourly rate between their old rate and the rate for the less arduous job.[4]

The use of retired pools of labour is developing as a cost effective method of retaining skills be companies. In the US a number of companies have kept a bank of former employees. These employees can be brought in to work when production or work requirements demand extra staff. The advantage is that the former full-time employees are experienced in the particular operation: that is, they have "institutional knowledge". The Travelers, in Connecticut, started what it called a job bank for its retirees in 1981, from which it hires people for temporary jobs.[5]

A contingent labour force, such as pools of retirees carries some risks. Employers may become dependent on such sources of labour without investing in the training of new recruits. For the retirees themselves the uncertainty of work and limited control may give rise to unnecessary stress.

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2 Parnes, H. S., (ed.), *Policy Issues in Work and Retirement*, The W.E. Upjohn Institute for Employment Research, Michigan, 1983, p 114.

3 *ibid*, p 115.

4 *Australian Financial Review*, 28 May 1990.

5 *ibid.*

Japan

Reform of the Japanese public pension scheme was enacted in April 1985. The reform was to raise the age of eligibility for old age benefits for women from 55 currently to 60 between now and the year 2000 in the Employees Pension Insurance scheme. Following the results of the 1988 Basic Survey on National Life by the Ministry of Health and Welfare, which showed the progressive graying of Japanese society, "...the eligible age for employee's pensions is going to be raised to 65". In addition the Ministry of Labor has decided to promote "...the policy of assurance of employment for elderly people until they reach the age of 65."[6]

Notwithstanding the current retirement age, it has been common practice for Japanese workers to retire at 55 and search for another job, normally less well paid than their previous work.[7] A survey by the Ministry of Labor in June 1989, found that of the elderly (aged 55-65) questioned, 73.8 per cent of the males and 41.4 per cent of females were working. Of those surveyed not working, 50.9 per cent of the males and 32.2 per cent of the females desired to work.[8]

Europe

A number of European countries have agreements that allow employees to reduce their hours of work, or change shift patterns prior to retirement. This has the effect of smoothing the transition from work to retirement, rather than the general Australian practice of permanently exchanging the collar and tie or overalls for gardening gloves in 24 hours.

Control over their own retirement age, or flexible retirement, is available to many European workers. Germany allows pension claimants with 35 years of contributions to retire and draw a pension anytime between ages 63 and 67. They give the insured worker the freedom to determine unilaterally the upper limit of his or her work life. 'In spite of fairly generous inducements to work beyond age 63, the result has been for German workers to retire at the earliest possible moment, 63. The upper limit - 67 - of flexibility has rarely been used. For all practical purposes, flexible retirement has mostly changed into early retirement for long-service workers.'[9]

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6 *Japan Labor Bulletin*, 1 August 1989, p 2.

7 Inagami, Takeshi, 'Worker's Life after Compulsory Retirement' *Japan Labor Bulletin*, 7 July 1978, p 5-8.

8 *Japan Labor Bulletin*, 1 August 1989, p 2.

9 Rix, S.E. & Fisher, P., *Retirement-Age Policy An International Perspective*, Pergamon Press, New York, 1982, p 65.

The Swedish insured worker can choose to either retire with a full pension at age 65; continue working beyond that age until age 70 with an increased pension; retire between 60 and 64 at a reduced pension; or take advantage of the partial pension program. Partially disabled or prematurely aged and long-term unemployed workers may retire at a full pension five years before age 65.

The Swedish Partial Pension Insurance Act of 1975, amended in 1979 is designed to encourage a reduction in work activity on the part of insured workers between the ages of 60 and 64 who had earned 10 years of credits under the earnings related government pension layer after age 45, were employed for at least 5 out of the last 12 months, and had worked at least 22 hours per week immediately before making a claim.

If a worker reduced working hours by a least 5 hours, to not less than 17 hours of paid employment, the government undertook to replace 50 percent of the wage loss without reducing the size of the regular earnings-related pension available to age 65.[10]

There is no age discrimination legislation in Britain. Following Marshall v. Southampton and South West Area Health Authority (Teaching), however, a 1986 case involving the involuntary retirement of a 62 year old female employee, moves are being made to amend the Sex Discrimination Act to make it unlawful to dismiss a woman on the grounds of age when men of comparable circumstances would not be dismissed. This would effectively extend women's retirement age to 65, but would not challenge compulsory retirement itself.

Developments in the Australian States

A number of state governments have been actively investigating the need for anti-age discrimination legislation in both employment and in the provisions of goods and services.

South Australia

In March 1989 a South Australian Task Force to monitor age discrimination reported to the Government of South Australia. The Task Force was to monitor age discrimination in the areas of employment, finance, advertising and accommodation. Amongst others the Task Force Recommended that:

> Age be included as a ground of discrimination under the Equal Opportunity Act in all areas covered by the legislation.

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[10] *Ibid*, p 66.

> Existing legislation which contains age related provisions be exempt from the Equal Opportunity Act amendments for a period of two years.[11]

Acting on these recommendations the South Australian Government has passed legislation addressing the issue of age discrimination.

New South Wales

The New South Wales Parliament recently passed the *Anti-Discrimination (Compulsory Retirement) Amendment Act 1990.* From 1 January 1991, compulsory retirement was outlawed in most parts of the New South Wales public Sector. This includes employees of NSW Government Departments, NSW public authorities (where a Minister has a degree of control), and Government educational institutions.

Employees so far exempted include people employed in fire fighting or fire prevention, people employed at a State coal mine, judges, police officers, statutory office holders, and any others exempted by Regulation. Local government employees will be covered from 1 January 1992, and people employed in the private sector and in fire fighting or fire prevention from 1 January 1993.

In New South Wales the Office on Ageing is attached to the Department of Community Services. In addition, the Office of the Minister Assisting the Premier on the Aged has also been established. The Office on Ageing has had some co-ordinating and policy-advising responsibilities, although its main involvement has been the organisation of Senior Citizens Week.

Victoria

In January 1989, the Victorian Attorney-General directed the Law Reform Commission to review the Equal Opportunity Act 1984. This Act prohibits discrimination on specified areas of activity - such as employment, education and the provision of goods and services. Age as a criterion of discrimination was investigated. The Commission in October 1990 presented its report to the Victorian Government and recommended:

> ...that age should be a prohibited ground of discrimination in much the same way as other grounds. The prohibition should apply in the same areas - such as employment, education, the provision of goods and services and accommodation.

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[11] Tiddy J.M., Graycar A. & Edwards P.G., *Report to the Government of South Australia from the Task Force to Monitor Age Discrimination*, March 1989, p 12.

The Commission also recommended that exemptions should apply:

> where the basis for the decision was a genuine occupational requirement (e.g., a young actor to play Hamlet) or the provision of a welfare program (e.g., a nursing home for elderly people) ... (and) ... age is a reasonable basis for discrimination, if only where the alternatives are impracticably complex... These includes segregation by age in competitive sporting activities, and allowing service providers to provide age-based concessions - for example, cheaper entry prices for young and old patrons.[12]

Western Australia

The Western Australian Government is also considering the question of compulsory retirement and anti-age discrimination legislation. In February 1988 the Commissioner for Equal Opportunity was requested to investigate age as a discrimination and in 1989 it was recommended that age be included as a ground of discrimination in the *Equal Opportunity Act.*

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[12] Law Reform Commission of Victoria, *Review of the Equal Opportunity Act,* Report No. 36., October 1990.

APPENDIX 5

DEPARTMENT OF HEALTH, HOUSING AND COMMUNITY SERVICES EXPENDITURE PROJECTIONS

Actual and projected Commonwealth Outlays by Dependency Status, 1988 to 2021

	Dependent Young	Dependent Aged	Total Dependent Categories	Persons of Workforce Age	Total
1988 Actual					
Population ('000)	4 553.5	2 218.1	6 771.6	9 630.5	16 402.1
Per Capita ($)	1 730.9	7 082.2	3 483.7	1 559.4	2 353.9
Outlays ($m)	7 881.3	15 709.0	23 590.3	15 018.3	38 608.4
1991 Projected					
Population ('000)	4 635.1	2 353.9	6 989.0	10 320.2	17 309.2
Per Capita ($)	1 738.4	7 131.5	3 554.8	1 563.1	2 367.3
Outlays ($m)	8 057.9	16 786.8	24 844.7	16 131.6	40 976.2
1996 Projected					
Population ('000)	4 705.6	2 584.2	7 289.8	11 192.7	18.482.5
Per Capita ($)	1 724.0	7 190.6	3 661.9	1 551.9	2 384.1
Outlays ($m)	8 112.6	18 582.1	26 694.7	17 369.5	44 064.1
2001 Projected					
Population ('000)	4 609.2	2 783.1	7 392.3	11 933.0	19 325.3
Per Capita ($)	1 726.3	7 170.3	3 775.9	1 550.9	2 402.0
Outlays ($m)	7 957.0	19 955.6	27 912.6	18 506.7	46 419.3
2011 Projected					
Population ('000)	4 409.3	3 496.9	7 906.2	12 827.1	20 733.3
Per Capita ($)	1 747.8	7 068.9	4 101.3	1 569.1	2 534.7
Outlays ($m)	7 706.4	24 719.4	32 425.8	20 127.4	52.553.2
2021 Projected					
Population ('000)	4 315.9	4 573.3	8 889.2	12 957.1	21 846.3
Per Capita ($)	1 731.6	7 132.1	4 510.0	1 574.5	2 768.9
Outlays ($m)	7 473.4	32 617.1	40 090.5	20 400.7	60 491.2
Per cent increase or decrease	-5%	+107%	+70%	+36%	+57%

Source: Department of Community Services and Health, *The impact of population ageing on Commonwealth and State social outlays*, (Canberra 1990) p 10.

Actual and projected State Outlays by Dependency Status, 1988 to 2021

	Dependent Young	Dependent Aged	Total Dependent Categories	Persons of Workforce Age	Total
1988 Actual					
Population ('000)	4 553.5	2 218.1	6 771.6	9 630.5	16 402.1
Per Capita ($)	1 903.5	1 318.6	1 711.9	369.7	923.8
Outlays ($m)	8 667.6	2 924.7	11 592.3	3 560.1	15 152.3
1991 Projected					
Population ('000)	4 635.1	2 353.9	6 989.0	10 320.2	17 309.2
Per Capita ($)	1 904.3	1 358.3	1 720.4	370.7	915.7
Outlays ($m)	8 826.8	3 197.2	12 024.0	3 826.0	15 850.0
1996 Projected					
Population ('000)	4 705.6	2 584.2	7 289.8	11 192.7	18.482.5
Per Capita ($)	1 903.0	1 380.6	1 717.8	367.7	900.2
Outlays ($m)	8 954.6	3 567.8	12 522.4	4 116.0	6 638.4
2001 Projected					
Population ('000)	4 609.2	2 783.1	7 392.3	11 933.0	19 325.3
Per Capita ($)	1 903.2	1 375.4	1 704.5	367.7	879.0
Outlays ($m)	8 772.1	3 827.9	12 600.0	4 386.2	16 986.2
2011 Projected					
Population ('000)	4 409.3	3 496.9	7 906.2	12 827.1	20 733.3
Per Capita ($)	1 905.2	1 346.6	1 658.6	372.7	862.9
Outlays ($m)	8 400.6	4 709.0	13 109.6	4 780.8	17 890.4
2021 Projected					
Population ('000)	4 315.9	4 573.3	8 889.2	12 957.1	21 846.3
Per Capita ($)	1 903.7	1 365.5	1 626.8	374.3	883.9
Outlays ($m)	8 216.1	6 244.9	14 461.0	4 849.6	19 310.7
Per cent increase or decrease	-5%	+113%	+25%	+36%	+27%

Actual and projected Commonwealth and State Outlays by Dependency Status, 1988 to 2021

	Dependent Young	Dependent Aged	Total Dependent Categories	Persons of Workforce Age	Total
1988 Actual					
Population ('000)	4 553.5	2 218.1	6 771.6	9 630.5	16 402.1
Per Capita ($)	3 634.3	8 400.6	5 195.6	1 929.1	3 277.7
Outlays ($m)	16 548.9	18 633.4	35 182.3	18 578.4	53 760.7
1991 Projected					
Population ('000)	4 635.1	2 353.9	6 989.0	10 320.2	17 309.2
Per Capita ($)	3 642.8	8 489.8	5 275.2	1 933.8	3 283.0
Outlays ($m)	16 884.6	19 984.1	36 868.7	19 957.7	56 826.3
1996 Projected					
Population ('000)	4 705.6	2 584.2	7 289.8	11 192.7	18.482.5
Per Capita ($)	3 627.0	8 571.3	5 379.7	1 919.6	3 284.3
Outlays ($m)	17 067.1	22 150.0	39 217.1	21 485.6	60 702.7
2001 Projected					
Population ('000)	4 609.2	2 783.1	7 392.3	11 933.0	19 325.3
Per Capita ($)	3 629.5	8 545.7	5 480.4	1 918.5	3 281.0
Outlays ($m)	16 729.2	23 783.6	40 512.8	22 892.8	63 405.6
2011 Projected					
Population ('000)	4 409.3	3 496.9	7 906.2	12 827.1	20 733.3
Per Capita ($)	3 653.0	8 759.5	5 759.5	1 941.9	3 397.6
Outlays ($m)	16 107.1	29 428.5	45 535.6	24 908.4	70.443.9
2021 Projected					
Population ('000)	4 315.9	4 573.3	8 889.2	12 957.1	21 846.3
Per Capita ($)	3 636.3	8 497.6	6 136.9	1 948.8	3 652.9
Outlays ($m)	15 689.5	38 862.2	54 551.7	25 250.5	79 802.2
Per cent increase or decrease	-5%	+108%	+55%	+36%	+48%

APPENDIX 6

HEALTH BENEFITS OF EXERCISE

Strength

Strength is a prime requisite for optimum function at any age, and it becomes more critical as a person gets older.

It is possible to increase strength at any age. The traditional view of older people as weak or frail is a direct observation of the loss of strength which is normally seen to occur with age. Loss of muscle bulk is interpreted as loss of strength. Although loss of muscle bulk is a normal part of ageing, much of the observed loss is caused by lack of use. Such losses have been shown to be reversible through weight training, with gains of the same order at all ages.

There is nothing "special" about training older muscle, only that there is less of it to begin with. When the gains in muscle strength are related to changes in functional ability, it is clear that, the older the person, the smaller are the gains needed for improvements in capacity and quality of life. The average walking speed of a 70 year old man is 4 km/h, but to cross a busy street he needs to walk at 6 km/h. An achievable increase in strength and speed would not only improve his capacity to get out and about, but would reduce his risk of vehicle accident.

The unhealthy heart

Clinical studies of people who have suffered heart attacks have shown that quality of life in people with diseased hearts is dramatically improved with exercise and rehabilitation programs. The improvement is expressed in greater physical capacity and enhanced sense of well being. This evidence is relevant to older age groups because many older people have undiagnosed heart disease.

The healthy heart

Improvements in cardio-vascular fitness arise from the effects of exercise on the heart, with consequent improvement in its efficiency and increased capacity to supply blood (therefore oxygen) to organs and limbs, with an associated improvement in the capacity of the muscles to extract and use oxygen.

Fitness is achievable at all ages in much the same way - through aerobic exercise. Cardio-vascular fitness is a desirable goal for the older person in particular, and it should be seen as an integral part of their well being. It is fitness which allows an individual to do more for the same expenditure of energy. In the older population, any increase in fitness would permit greater function for less energy cost.

Lack of fitness is often the underlying reason why older people say they are too tired to do anything, a situation which leads to decreased mobility, boredom and depression. Increased fitness will decrease the feelings of exhaustion that may arise from any level of work. The effect will be to diminish the feelings of exhaustion which may arise from the effort of daily living.

Respiratory system

Both in health and disease the respiratory system is relatively unaffected by exercise. In chronic lung disease there may be some benefits from exercise in its effect of reducing oxygen demand by skeletal muscles for a given workload. Since there are many older people with chronic lung disease, often caused by smoking, exercise has a place in their treatment.

Mental functioning

Exercise has very substantial effects in countering depression, anxiety and insomnia, and in promoting alertness and a sense of general well being.

It has long been assumed that the increase in depression, insomnia, lassitude etc are a normal feature of ageing, but it is now believed that many such symptoms may be the effect of inappropriately reduced activity. Improvement in these areas through exercise would improve the quality of older people's lives and reduce their need for drugs - the latter in itself a major problem.

Hypertension

High blood pressure is one of the great health problems in our society because of its relationship to strokes and heart attacks, and also because of the substantial cost of treating it. The cost lies in both the drugs needed to lower blood pressure and the medical treatment of the severe medical conditions it can provoke. Since the incidence of hypertension increases with age, the costs increase as the proportion of the aged goes up.

There is strong evidence that exercise will reduce blood pressure and that the quantity of exercise needed for significant changes to occur may be quite small.

Diabetes

Non-insulin dependent diabetes is the most common type of older age groups. Evidence suggests that the condition can be significantly improved with exercise.

Blood

There is evidence that there is less accumulation of "debris" along the artery walls in those who do regular exercise. The consequently reduced risk of clotting and occlusion reduces the likelihood of stroke and heart attack.

Weight reduction

The general consensus is that a reduced diet is essential for significant weight loss and that this should be combined with exercise. In the older population the reverse is more likely to be appropriate: increased exercise is preferable to radical changes in diet. Obviously, older people needing to lose weight should aim to eat less fat and sugar, more fibre and more water, but these dietary changes should follow the introduction of an exercise program.

Bone

The density of bone decreases with advancing age, an effect that is most severe in women who have passed the menopause. The effect of this decrease is to weaken the bones and make them more vulnerable to fractures, the incidence of which increases markedly with age.

There is evidence that exercise can slow the reduction in bone density and help the bone to maintain its strength.

Flexibility

There are certain ranges of movement of the joints that are necessary for a person to function effectively without assistance. Joints which have become less flexible as a result of disuse (eg. a sedentary lifestyle) can be made more mobile by exercise. This can make the difference between independence and dependence, since the inability to bend over far enough to wash the lower parts of the body or to put on clothes makes a person dependent on others.

Recent evidence suggests that exercise can greatly improve joint flexibility, and also that it can reduce the pain of arthritis.

Peripheral vascular disease

Exercise can significantly counteract the symptoms of peripheral vascular disease, and often reduce the need for surgery.[1]

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[1] The above was adapted from the DASETT paper, *Exercise in older adults: A national health care and quality of life issue.*

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