

### THINGS THAT OUGHT TO HAVE BEEN DONE

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In Australia today the emphasis in social gerontology largely tends to neglect the maintenance of independence in the aged in favour of rather vain effort to recover lost causes presented by medico-social break-down. If this aspect of gerontology continues to occupy our major effort then those medico-social agencies concerned with the study of ageing and the care of the aged will be increasingly involved in "geriatrics" and the numbers of prospective candidates for the services provided will always swamp facilities, statutory, voluntary and private, for their care. The physiological, public health and sociological approaches to the age problems of our modern community have too long been subjected to the pressing needs presented by the end processes of ageing and chronic disease. Every year, under these conditions, will the community be presented with a crop of elderly and chronic sick who can no longer cope with living in it, and who will demand care, therefore, apart from it. To provide adequate conditions for care will very soon overtax the community, not only in capital expense but also in maintenance and services costs.

Australia is a young country with a "younging" population mainly as a result of immigration. It has been estimated that Australia has some ten years of grace before the trend becomes oriented to an "ageing" population. Remember also that a good proportion of our ageing population will be represented by immigrants without the supportive family structure on which many native born Australians depend in their elder years.

The trend in all sophisticated societies examined in a recent world trip is most definitely towards preservation of health and social competence in the aged. It is only in this way, it is stressed, that care separate from the community can be kept within the bounds of reason from the socio-economic point of view. Socially emergent countries are beginning at the point where community conscience demands a standard of living for the socially and physically incompetent aged acceptable to these communities' awakening social conscience so that institutions provided at first by voluntary and later by statutory agencies are seen as the solution. In nations a little more socially mature a system of pension has been added, but in the most sophisticated societies it has been recognised that pensions and institutions alone can neither cope in quantity nor can standards be maintained in keeping economically or emotionally with the resources of that community. The trend, therefore, has been forced towards preventative medico-social activity and active restorative and maintenance services for those who break down. Some countries have approached this from the point of view of a total welfare state and some at the other extreme from a total private enterprise or charity solution.

Examine first the situation of a total welfare state. In this instance it is likely that an overall policy could be adopted and applied generally. Experts are more likely to be able to influence policy and social and public health measures may be better applied at a preventative level. Physical and capital resources are likely to be superior and anxiety, striving and suffering in the ideal situation should be reduced to a minimum.

To provide this total welfare requirement is expensive and the community generally must be prepared to be taxed heavily to pay for it.

However, people in such a welfare state have given over the activity of individual, or neighbourly planning in favour of state planning. The element of striving for one's personal safety, and the safety and welfare of one's family and neighbours, has been eliminated and the concept of contribution by the individual and the family group has been abandoned. Is this a good thing for the emotional health of the community or even a good thing for the physical and emotional well-being of the elderly themselves? It is my opinion that it is not. Those communities who have taken this way have suffered in numerous ways. Emotional health has suffered and in the inevitable event of death the process of mourning has been complicated in that no matter what the financial contribution in taxation has been there remains enhanced the natural guilt reaction in mourning that "those things that ought to have been done have not been done". In other words the personal contribution of the survivors has not been sufficient to compensate for the reaction to the loss of loved ones.

On the other hand the attitude of neglect by government to the needs of the ageing section of the community has been responsible in some countries for the evolution of charitable and privately financed

services to an extreme degree. In this situation it has been the responsibility of individuals to save and privately insure themselves against the cost of care in the event of disability through age or infirmity. When this has not been achieved the community has relied on charity to provide the care.

The increased standards of care demanded by the community have heavily taxed the insurance funds, private resources and charitable organisations to the point where the expenditure can be ill-afforded, or organisations have been forced to turn to government for financial aid.

In both cases, total welfare from taxation or exorbitant costs for private and voluntary care, the trend has had the taint of "pay off" of social conscience without any real satisfaction. In some countries what one pays to a nursing home for mother's care is taken as an accolade of social and moral rectitude.

Recognising the inability of private enterprise or voluntary or charitable organisation many countries have turned more and more to government for finance and although the identity of the voluntary associations has been preserved, more and more of their money comes from Government, linked of course, to advice and control of their activities. This is how a traditionally voluntary mechanism becomes absorbed in the welfare state trend and it is seen in Norway, Denmark, Holland, Great Britain, and in Christchurch in New Zealand, where traditional voluntary agencies continue to exist in the midst of national health programmes.

Where then does the road lie for Australia because Australia is truly at the cross-roads in social gerontology and geriatrics? Remember we have the unique opportunity of a period of grace before the enormity of the problem is truly felt. We have a European society still "younging" but knowing that within ten years we may follow all other similar societies and become an "ageing" one. There are certain well known facts and desirable aims. Let us examine the facts:

1. 1. An increasing number of people surviving to old age will increase not only the numbers but also the percentage of old people in our population.
2. 2. Neglect of preventative measures will increase the number of old people dependent on the community.
3. 3. Neglect of modern geriatric medicine will increase the number of old people remaining dependent who could and should be restored to and maintained within the general community.
4. 4. The capital and maintenance cost of preserving the dependent elderly in institutions will rise to a point where neither the individual nor the general community can afford the standard of care demanded.
5. 5. The application of modern geriatric medicine and the organisation of maintenance services for the dependent aged can stabilise these folk in the community and maintain the majority there.

Now the desirable aims.

6. 1. Access to modern diagnostic and therapeutic medical and social services should be made available to this section of the community.
7. 2. Assessment and direction of the contribution of the individual and the community through its existing agencies should be encouraged within professionally recommended limits.
8. 3. Co-ordination of government, community and individual contributions to the assessed need of the individual is the activity which produces the most economic and morally satisfying and scientifically ideal situation.

The provision therefore of such services aimed firstly at understanding the process of ageing, the maintenance of physical and social competence and the prevention of disability will ameliorate and lessen the problem of treatment when and if breakdown occurs.

To be able to find the individual at special risk, to examine his situation and to apply medical and/or social therapy will pay handsomely. At this stage the solution is correct even though cheap. If and when breakdown occurs we ought to have modern medico-social philosophy applied to the case so that restoration to the maximum possible can be achieved and maintained—not a "geriatric unit" where kindly neglect is practised; in the event of residual disability, to have a combined approach from medical, social and family sources applied to care in the domestic situation; to cope with the irreducible minimum of continued disability needing medical and nursing care in a manner socially and emotionally acceptable at a cost that the individual and the community can afford; and when death comes, as it will, to have the elderly citizen suffer this with dignity and peace, leaving a family and community satisfied not only in their head but also in their heart, that those things which ought to have been done have in fact been done.