

Ageing well, ageing productively: The essential contribution of Australia's ageing population to the social and economic prosperity of the nation

ABSTRACT

KEY WORDS

Ageing, preventive health care, self-management, service demand, sociology

In Australia we have become preoccupied with the potential adverse impact of our ageing population on our health and social systems. The projected cost of having increasing proportions of our population in the over 70s, retired, chronically ill category of the demographic profile is emerging as a major challenge for governments and private insurers: so much so in fact that the government is now urging older people to stay at work longer.

In America, new approaches to the management and self-management of chronic diseases have been invoked to encourage and support older people to improve their quality of life and reduce their recourse to and dependence upon health care technologies, clinical interventions and health care management systems. Unless this is achieved, it is argued, the cost of looking after this emerging 'bubble' of elderly people will become increasingly unsustainable as fewer and fewer (proportionately) younger people work to pay the taxes that support ageing, retired, sick and dependent populations. This paper argues that we are at real risk of having our economic wealth and productivity impeded and truncated by the financial burden of looking after high demand and high cost dependants at the aged end of the social demographic.

This paper offers an alternative view of our ageing population, as well as highlighting some of the assets we have in our elderly populations, and providing suggestions as to an alternative view of the phenomenon of ageing that incorporates elements such as flexible working arrangements and the application of new, enabling technologies. This approach to our ageing population dilemma is predicated on a concept of lifelong learning and social participation along with better preventive and early intervention systems of health care.

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Background

The ageing of the Australian population is now an important focus for research and social debate (Rowland 1997). A key question for health policy and social planning, however, is what will happen to our culture and social frameworks as the current population of ageing people continues to live beyond the

age for which our superannuation and welfare systems have been designed? What will our aged people do in the last 25 years of their lives after they cease formal, paid employment as it is currently known? Will our pension funds be sufficient to sustain this group in long-term retirement? Will our hospital and health systems become overburdened and ineffective or will elderly people find another way of living and contributing to society as they age well beyond the lifespan to which our systems and our society have become accustomed?

According to the Australian Bureau of Statistics (ABS) data, over the next 45 years the age structure of the Australian population will change markedly (Schofield and Earnest 2006:510):

In 2005, the baby boomer bulge from about the age of 40–60 years is pronounced and the population pyramid tapers away quickly from the age of 60 years. However, by 2050 the population pyramid takes on the distinctive ‘coffin shape’ as the population ages, longevity increases and fertility declines. People aged 65 and over will double as a proportion of the population increasing from 13% in 2005 to 27% by 2050.

Some authors predict an unmanageable increase in the number of hospital bed days required by older people with the projected proportion of bed days used by people over 65 years set to rise from 47% in 2005 to 67% in 2050. This upward pressure on hospital resources will also impact upon infrastructure and staffing numbers. Currently, there are around 90,000 FTE nurses and 20,000 salaried medical officers working in Australian public hospitals (Schofield and Earnest 2006:512–513):

With the demand for hospital bed days projected to almost double over the next 45 years, there will be a need for additional staff to cover this increase. However, at the same time as demand is rising, the health workforce is ageing, with high exit rates expected as doctors and nurses retire from the workforce.

However, even with this ‘ageing’ profile of the population to 2050, there is uncertainty as to whether this will mean increased demand for hospital bed days or whether these pressures will result in increased treatment and management of ageing patients in the community. Also, improvements in chronic illness management and self-management could have a significant moderating effect upon these trends, hence the massive investment currently in these programs (Commonwealth of Australia 2006) by Australian and other governments in the developed world as well as in other strategies to coordinate, integrate and manage health care and health services more efficiently across the system (Commonwealth of Australia 1999, 2001a, 2001b; Podger 1999).

There is now abundant evidence in relation to the onset of chronic conditions that much hitherto debilitating chronic illness is either ‘preventable or can be postponed and is therefore not an inevitable accompaniment of growing old’ (Khaw 1997:1829). With the doubling of life expectancy in the last century, it is now a realistic expectation that people not only will live to be much older than they have in the past, but that we now have the knowledge and health systems available to support a compression of morbidity into the last few years of life (Fries 2000; Fries *et al* 1993), making it realistic for people to expect, also, to be working productively well into their seventies and even eighties. Indeed, as Mirrlees suggests, in order to earn a ‘normal pension’ in future, ‘people may have to continue working till seventy’ (1997:1882). Recent events in relation to the global financial position may enhance the imperative for older people to continue in some form of paid employment as superannuation funds return less and less profit over time.

The myth of ageing

The archetypal view of elderly people is that they cease working and being productive in any real economic sense whilst at the same time becoming an increasing burden on the health care, social security and superannuation systems. Recent research on health care costs

and ageing has shown such myths to be just that, as Harper outlines in her recent book on the myth of ageing (Harper 2006:2):

It is not ageing populations that are the main explanatory factor for pressure on health care services, rather the wider effects of income, lifestyle characteristics and new technology. Similarly, the forecast dependency ratio is not due so much to the presence of large numbers of older people who are unable to work because of their age, but labour markets which have used retirement as a regulating mechanism in times of labour over-supply, and pension systems which have allowed healthy, active individuals to withdraw from economic activity.

Sperry identifies six key myths surrounding ageing (assuming that people over 65 years of age are considered 'old'): i.e. the current age of retirement is arbitrary, that most older people are in poor health, that older minds are not as bright as younger minds, that older people are unproductive, that they are unattractive and sexless, and that most old people are essentially the same (Sperry and Prosen 1996:4–5). He then proceeds to show how all six perceptions of older people are false and explains, in relation to the myth of older people being in poor health (Sperry and Prosen 1996:4), that:

While older persons may have chronic, controlled health problems as they age, they are not necessarily adversely affected or limited by them. Traditional notions about old age and health need to be re-thought. Definitions that have more to do with the functional abilities, levels of vigor and vitality, and an individual's own feelings of wellbeing will likely become the norm for health in the years to come.

The idea of people living effectively with chronic and complex illness and assessing their quality of life and wellbeing from their own perspective is central to the self-management work of Fries and Lorig (see Bodenheimer *et al* 2002; Fries 2000; Lorig *et al* 2000), and will be discussed later in this paper.

Sperry goes on to note that two major conclusions have emerged from the Baltimore Longitudinal Study of Ageing (BLSA), one of America's longest running scientific examinations of human ageing. These are that ageing cannot be linked to a general decline in all physical and mental functions and that standard or predictable patterns of ageing do not exist (Sperry and Prosen 1996:60). Furthermore, researchers have found that, almost paradoxically, ageing people rate their wellbeing, quality of life and psychological functioning as high as do younger people and elderly people even report higher levels of life satisfaction, morale and happiness and lower levels of depression and anxiety than younger adults (Heidrich and Ryff 1996:72). This is in spite of the general perception that ageing is an unpleasant, alienating and lonely process generally accompanied by illness and unhappiness. This may also be a result of changing perceptions about life and health as people age. In any event, the stereotype of ageing is certainly questionable in the modern context.

Whether or not this apparent paradox can be explained by the fact that self-rated wellbeing becomes skewed in older people and affected by the ageing process itself so that people overrate these aspects of their lives is not clear, but more and more work in chronic illness management, for example, points to the fact that people are able to feel well and happy in themselves even though they may be living with degenerative health conditions. In an existential sense, perception can be considered to be reality, and, following this train of thought, if people feel well they are well, irrespective of their physical condition. As Heidrich and Ryff (1996:75) note:

... both objective (physical reports, medical history) and subjective (perceived health, health self-rating scales) measures of physical health explain only a small proportion of the variance in psychological well-being. Furthermore, when subjective health ratings are compared with objective health ratings, the subjective ratings are the most important

in predicting mortality. Asking someone to rate his or her own health, from poor to excellent, is a better predictor of his or her own future physical health and morbidity than are 'objective' health reports. This is true even though older adults 'overestimate' their health (i.e. report they are healthier or better off than what physicians, nurses or other objective indices might indicate).

Let's examine these key constructs around our concept of our ageing society and the so-called 'risk' this poses a little further. Firstly, as outlined above, there is no reason why people should necessarily cease being productive in our economy or in our community once they pass the magical age of 60 or even 65 years (Harper 2006:19):

In contrast to much public health belief, many of us will live out much of the remainder of our lives in reasonable health, with limited disability. Indeed around 90% of individuals can expect to live out their lives without significant disability or need for help with daily activities.

Admittedly, some elderly people are not capable of working or volunteering in the community and need to be supported, but this is also the case for many younger people. However, aged people are quite capable of contributing to the community either as business people, professionals, volunteers or family supporters. Indeed, it has long been proposed that the sudden reduction of personal involvement, responsibility and intellectual stimulation that is apt to follow forced retirement and withdrawal from active life actually promotes ill-health and leads to early onset of health problems that might be avoided if people were able to continue an active life, albeit at a reduced level of demand.

Elderly people, *en mass*, therefore do not necessarily need to retire from work or active involvement in community life to live out their years on a pension, in whatever form that might take (Mirrlees 1997). Their contributions to society through partial or full employment after retirement age is one probable scenario (Sperry

and Prosen 1996:108) that would enable elderly people to continue to contribute to the economy if, in turn, they can be supported through preventive health care programs to remain active and productive for longer. The longer we keep people active and engaged, the more likely it is that they can continue to contribute to our economy whilst reducing the burden on our health care and social security systems. Indeed, Fries argues that this process compresses morbidity into the last few years of life, improving quality of life and reducing the cost of ageing to the health system (Fries 2000, 2003; Fries *et al* 1998).

Importantly, the current population of ageing people owns and controls significant capital and investments in the community. The longer these people are able to manage their assets productively, the more they will have to pass to the younger generation, hence reducing the burden on that generation of the cost of their education, housing and of raising healthy, happy and socially well-adjusted families. In economic terms, it is much better for a society to raise well nurtured and well educated children who can take their place in society and, in their turn, become productive and entrepreneurial than it is if large proportions of successive generations grow up in poverty and privation, which generally leads to poorer quality education, health and life experiences. By preserving the assets and prolonging the contribution to society of our ageing populations, we guarantee wealthier and healthier successive generations (McCain and Mustard 2002).

The alternative to this scenario is that society forces its ageing populations into retirement where they consume their assets (and the assets of their children) to pay for aged care, medical intervention and their increasing dependence on drugs and remedial therapy leaving them not only captives of the health system, but unable to contribute to future generations either in kind or in capital ways. Whilst this practice is now not an acceptable approach to ageing and workforce management, it has evolved over time and if left unchallenged, could threaten our vitality as a community and as a competitive nation in the global economy.

On the positive side, it is unlikely that the most well educated, wealthy, healthy and productive generation in the history of modern Western culture will allow this scenario to continue to play out without using its considerable resources and resourcefulness to create alternatives for ageing individuals and their families (Bodenheimer *et al* 2002). Indeed, not to do so would certainly contribute to a slowing of economic growth and downgrading of overall community wealth and wellbeing as a growing proportion of our national and personal capital is used in unproductive pension, social security and health care consumption. Whatever form of pension or retirement scheme a country runs, it cannot afford to spend more on looking after its aged population than has been saved by this group over time in preparation for this stage of their life (Mirrlees 1997:1886). To do so would adversely affect the overall economy and distribution of wealth in favour of those not working and at the expense of those who are. Beneath all of this debate, however, lies the fundamental premise, as Mirrlees suggests, that 'We may indeed prefer to work longer, and we should not be discouraged from doing so' (1997:1886).

The prescription for such alternatives may actually already exist in the subtext of the current ageing generation. This group has been raised on an ideology of lifelong learning, creativity, flexibility and opportunity and is therefore unlikely to succumb to forced repatriation into redundancy without a struggle. More likely, as is already being flagged by health system forecasters (PricewaterhouseCoopers 1999, 2002), the older generations will be called upon, as is implied by the current government policy of encouraging the ageing to continue to work rather than retire, to support (with social as well as economic capital) the middle-aged populations. Indeed, it has been argued that the subjective life reality of ageing and retiring people is already being reconstructed in some neo-liberal countries to ensure that aged people continue to live and work independently rather than becoming a burden on the State's resources (Rudman 2006). Rudman (2006:185) goes on

to insist that, whilst there may be positives in such an engineered scenario for older people:

Gerontologists and others should not therefore uncritically welcome contemporary constructions of retirement and 'retirees' because they promote individual freedom, but rather should examine critically what forms of old-age living are legitimized and de-legitimized ... there is a need to ask whether power is operating by proselytizing freedom.

There are also concerns associated with this concept of ageing in relation to those who might be unable to afford the well provisioned lifestyles upon which prolonged health are predicated and who may not have the skills or abilities to create new 'market driven' opportunities for themselves in their old age. As Rudman (2006:196) suggests:

For a person to adopt the 'ideal' subjectivities, fairly substantial health and financial resources are required. Given that in Western countries during the 20th Century, there was substantial improvement in the financial and health status of older people, there may be an increasing number who are able to participate in the practices associated with 'age-defying' and 'prudential' subjectivities, but a gap between well-off and poor seniors persists and is predicted to widen. Those without such resources are provided with few 'positive' options for subjectivity or lifestyles and, in turn, may be increasingly marginalized.

So whilst obvious benefits and opportunities abound today for some older people to enjoy prolonged health and wealth into their old age, others may not be so fortunate, especially as we increasingly move away from government interventions and support structures for health and aged care and embrace a market economy and the private provision of these services. As Marmot and others point out, good health and longevity correlate with social and economic advantage. Poorer people, communities and countries have significantly poorer health outcomes, whereas those individuals fortunate enough to be more in control of their lives, work

and economic support structures generally enjoy much better health outcomes (Marmot and Wilkinson 2006:43). These powerful ideological elements in modern neo-liberal society, it is argued, also promote ageism as people are schooled or socially engineered into resisting ageing in all its forms and are bound by the false reality of remaining 'forever young' (Rudman 2006:197).

Whilst the technologies now exist through which society can tap into the enormous wealth and knowledge of our ageing and retiring population, it is clear that some segments of this group may not, for economic reasons, be as well placed to avail themselves of these opportunities as others. We need to remain mindful of this reality when we generalise about future prospects of the aged population across the board. For example, some sectors of the working community such as teachers, health professionals and administrators might be much better placed to work on into older age because of their access to flexible working conditions, whilst other groups in the community may not have such luxury.

However, these considerations notwithstanding, the current group of people approaching retirement in Australia – the baby boomers – has been well nurtured, generally, on open education, social inclusion, teamwork and an endless diet of opportunity and variety. It has embraced the digital world and in recent years taken up the 'screen technologies' of computing in their various forms. This generation of ageing people is also better educated about health and lifestyle and is equipped, better than previous generations, to make informed decisions about its patterns of consumption, investment and leisure activities. This group is in control of its capital and social base to a greater extent than in previous generations and it is well equipped to evolve and invent ways to continue to contribute to the wider economy. Unlike in previous generations where people were forced by the impact of more prevalent hard and physical work, less advantageous diets and an ideology of fixed term retirement, members of the current cohort are better placed than ever to tackle the

issues and challenges of ageing in a much more creative manner.

With more structured self-management practices being encouraged across entire populations in Western countries today, we are also developing approaches and technologies that promote longer life and more active ageing, even for people with chronic and complex health conditions (Battersby *et al* 2007; Fries 2000; Fuller *et al* 2004; Harvey and Docherty 2007; Lorig *et al* 2000; Wagner 2000). These approaches assist people to live well and positively in older age rather than declining passively after an active working life as has been the case in the past. Although such approaches may be focused on the individual as being primarily responsible for their health and wellbeing (Harvey and Docherty 2007), and ignore some of the wider social and environmental antecedents of ill-health (Baum 1998; Marmot 1999, 2000; Syme 1998), they are making a positive difference for more and more people and helping them to live more productively beyond their formal working lives.

Another reason for having such an optimistic outlook for the future, in spite of the elements of social engineering and community control driving and conditioning us to rethink the impact of ageing and chronic illness, is that the nature of our economy appears to demand that ageing people not bow out of active service at the traditionally prescribed and premature time. Not wanting to miss out on the social and economic opportunities that will flow from their continued active service, in one form or another, people seem bound now, for whatever reason (*i.e.* social and economic engineering [Rudman 2006] or personal existential choice [Frankl 2004]) to continue to make opportunities for themselves in their ageing years. Certainly recent trends in global finance provide a major imperative for people to continue to participate in the community rather than relying solely on superannuation and other benefits in retirement. Whether these dramatic changes serve to enhance the abilities of ageing people to remain active contributors to society or whether these circumstances will conspire to constrain ageing people is yet to be determined.

The point remains, however, that many more people are better prepared than ever to cope with ageing well and ageing productively than has been the case in the past. Emerging trends in medicine and chronic disease management and self-management underwrite these trends and offer real hope to those who choose to continue to remain active and in control of their lives and their health for longer than has been possible in previous generations.

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