



LABOR'S GOALS FOR AN AGEING AUSTRALIA

ACTIVITY, QUALITY AND SECURITY

Ageing Policy Discussion Paper

'In itself, population ageing should not be seen as a problem as it reflects the beneficial effects of improved life expectancy and voluntary control over fertility. However, it will give rise to economic and fiscal impacts that pose significant policy challenges.

Population ageing can only be conceived as a crisis if we let it become one.'

Economic Implications of an Ageing Australia, Productivity Commission, April 2005.

Senator Jan McLucas

Shadow Minister for Ageing, Disabilities and Carers

September 2006

CONTENTS

PURPOSE	3
SETTING THE SCENE: PAST, PRESENT AND FUTURE POLICY APPROACHES	4
Labor's record	4
Principles	4
Scope and strategic approach of ageing policies	4
Recognising stakeholders	5
Timelines	5
SETTING THE SCENE: POPULATION AGEING, SOCIAL AND ECONOMIC IMPACTS	6
Past and projected population ageing	6
Ageing of Baby Boomers	6
Social and Economic Impacts	7
Australia in international context	7
Ageing of the workforce	7
Expenditure on health and aged care	8
<i>HEALTHY AGEING PROGRAM</i>	9
The current scene	9
Potential policy options	9
<i>QUALITY CARE IN THE COMMUNITY</i>	12
The current scene	12
Potential policy options	14
<i>QUALITY CARE IN RESIDENTIAL CARE</i>	17
The current scene	17
Potential policy options	20
<i>SECURITY FOR OLDER AUSTRALIANS</i>	24
The current scene	24
Potential policy options	24
APPENDIX	27

PURPOSE

Labor believes that healthy and positive ageing must be an achievable goal because older Australians deserve the best our nation can provide.

The purpose of this paper is to encourage discussion to improve the futures of, services for and care of older people in Australia.

The Ageing Portfolio encompasses more than just aged care but includes a number of other significant issues that are associated with ageing such as housing, older workers, and living healthy and happy lives.

We have included a wide range of policy proposals from stakeholders and are seeking input for the issues and potential solutions identified in this paper. I encourage you to take the opportunity to contribute your ideas which will deliver positive outcomes for older Australians.

Contributions can be sent to: heather.witham@aph.gov.au or to: Office of Senator McLucas, The Senate, Parliament House, Canberra ACT 2600, by 10 November.

Senator Jan McLucas, September 2006

'Despite the challenges that face aged care, there should be considerable optimism about the future. The aged care sector is full of bright ideas, and there are plenty of people enthusiastic enough to put them into action. As long as we are not distracted by the doom and gloom philosophy, and as long as we are able to utilise currently favourable economic conditions to push ahead with feasible plans for our future, then Australia's aged care system has the potential to deliver excellent outcomes'

Warwick Bruen, former Assistant Secretary, Community Care Branch, Department of Health and Ageing, *Australasian Journal on Ageing*, September 2005.

SETTING THE SCENE: PAST, PRESENT AND FUTURE POLICY APPROACHES

Labor's record

Labor achieved a great deal through its Aged Care Reform Strategy in its previous term of office and extended policy development to cover other areas of ageing. This record means there are high expectations in the field.

There have been many changes over the last decade that mean Labor cannot simply pick up the old reins. Changes have come not only from the Howard Government's policy measures, but from wider social trends. These trends are encapsulated in the UN policy shift from a *Plan of Action on Ageing* in 1981, to *A Society for All Ages* in 2001, built around an intergenerational perspective. While the cost of aged care and its close relationships to health care and social security policies mean it must remain at the centre of Labor's policies on ageing, this paper puts aged care in the wider perspective of intergenerational policies.

Principles

Labor's responses to ageing now and into the future are built on four principles:

- Promoting social inclusion and relationship building between generations;
- Working in partnership with state and local government, community organisations and service providers in all sectors;
- Providing funding that is responsive to need and responsible to past, present and future generations of taxpayers; and
- Giving priority to key programs.

Scope and strategic approach of ageing policies

After a decade of reviews and upheavals, Labor's strategy will focus on:

- Taking action in areas which address emerging issues as well as addressing identified weaknesses and gaps in existing programs. New initiatives will be taken in partnership with a range of stakeholders, and the priority areas will be reviewed regularly to take account of social changes and the changing health status and well-being of older Australians.
- Charging the Ageing Portfolio with responsibility for developing a coherent "all of government" approach to ageing policy, and identifying the complementary actions to be taken in other portfolios – such as health, income security and housing.
- Consolidating the strengths of Australia's aged care system and related services.

Labor will support policy development exercises and research focused on critical issues, but will *not* launch yet more expensive mega-reviews that end up on dusty bookshelves.

Labor's principles and approach can be put into practice in three broad program streams that build on existing program structures:

- Active ageing.
- Quality care in the community and in residential care, and in acute and post acute settings.
- Security for seniors.

This paper focuses on the Ageing Portfolio but also puts forward complementary initiatives presented by stakeholders that are needed in health, education, housing and income support.

Recognising stakeholders

The policy initiatives presented in this document draw on numerous research reports and submissions that stakeholders have made to government reviews and inquiries and also directly to Labor's Ageing spokesperson. In turn, Labor's policies will aim to engage these stakeholders and involve them in implementing the priority initiatives.

Timelines

Respondents to the Discussion Paper may wish to consider an appropriate timeline for policy implementation. Three obvious time frames are evident:

1. Initiatives that can proceed immediately.
2. Initiatives linked to developments that will occur mid 2007 to mid 2008 which provide grounds for reviewing current policy and program provisions:
 - The results of the 2006 Census will be available by late 2007.
 - The restructuring of the aged care sector to meet the higher building standards for certification should be virtually complete from the start of 2008.
 - The new Aged Care Funding Instrument (ACFI) for residential care is due to be introduced mid 2007.
 - The Government's response to the Hogan Review of pricing arrangements in residential aged care has been completed for almost a year and must be published to allow discussion on funding a sustainable residential aged care sector.
3. Initiatives that need to be put in place soon but have longer term time frames for policies to mature.

SETTING THE SCENE: POPULATION AGEING, SOCIAL AND ECONOMIC IMPACTS

Past and projected population ageing

Population ageing in Australia is not new. Declining birth rates and increasing life expectancy from the early 1970s have resulted in increases in both the number and proportion of Australia's population in older age groups. Over the last 35 years, the number of people aged 65 and over increased by 143%.

Over the next 35 years, the aged population will grow at a slightly lower rate, increasing by 134% from 2006 to 2041 (see appendix, Table 1). The shift in the proportion of aged, from 13.1% to 24.8%, will be more marked than in the past due to relatively lower growth of younger age groups, but will occur most rapidly after around 2015 rather than in the immediate future.

The source of greatest pressure on programs for older Australians comes from the rapid growth of the 80 years and over population in the immediate future.

There are very wide variations from one geographic area to another in the size and proportion of the population that is aged.

The main message about population ageing is that there are no surprises ahead – the trends are well known in advance. The policy challenge is to prepare for the changes. Some policy areas have relatively short time frames while others, notably superannuation, will take decades to mature.

Ageing of Baby Boomers

Much has been made of the impending ageing of Baby Boomers. Many of these claims are sweeping generalisations. Despite the view that all retirees are going to be richer in future, there are wide variations in economic and social status among Baby Boomers, ranging from well superannuated married men who are home owners, to single women who have had only marginal involvement in the paid workforce, who are renters and who are totally reliant on the Age Pension.

Higher incomes among younger retirees highlight the increasing disadvantage of those who are already very old, particularly very old women, and it remains to be seen how well those who do have higher incomes and assets at age 65 can make these resources last over what is likely to be at least 20 years in retirement.

The main message is that older people have and will have diverse personal circumstances. The ageing of baby boomers will see increasing differences between these new retirees, the young old, and the old old who are now already in their 80s. There is also increasing diversity among the young old.

Social and economic impacts

Australia in international context

Australia is now and will remain young over the foreseeable future compared to almost all other OECD countries (see appendix, Table 2). Many countries of northern Europe and Japan are now almost as old as Australia will be in 2050. None of these already older countries have collapsed under the burden of their ageing population, and OECD reports document a great variety of policies that have been adopted to address the social and economic issues of ageing societies.

Ageing of the workforce

Long term trends and current research indicate that few older Australians wish to work past age 65. Workforce participation has remained around 10% for men aged 65 and over, and around 3% for women aged 65 and over for the last 20 years and shows little sign of changing.

In contrast, increasing participation over the pre-retirement years suggest that mature age workers want to remain in the workforce until they have sufficient savings for retirement. Over the last 10 years, participation has increased for those aged 55-59 and the 60-64 age group; these increases are all the more significant given the increase in size of these age groups.

Against these positive trends, the situation of older workers who cannot find employment are all the more stark. Mature age workers who lose their jobs are likely to experience longer periods of unemployment than any other age group, and many of those with part time jobs want more hours of work.

The main message of these trends are that effort to maximise participation in the 50-65 age group will deliver greater return to individuals and society as a whole than pursuing policies that attempt to extend participation beyond 65.

Expenditure on health and aged care

The most common concern associated with population ageing is that it will bring massive and unsustainable increases in expenditure on health and aged care that will impose a burden on the rest of the population. This view is as common as it is mistaken. It is especially contradictory to suggest that because the tax system will not be able to meet these costs, more costs should be borne by individuals: all costs have to be met from the same GDP.

While per capita health care expenditures are higher for older people, upswings in expenditure over time are associated with policy changes, new technologies and rising demand for health care at all ages associated with rising living standards rather than population ageing.

In a review of 27 analyses, the Productivity Commission comments on the lack of correlation between population ageing and health expenditures. In line with many health economists, the Commission concluded that the effects of population ageing are swamped by the effects of demand for health care associated with rising standards of living and health technologies, including increasingly costly pharmaceuticals. Efforts to control expenditure on health care have to focus on measures that control costs at the same time as maintaining access, and not on ageing per se.

Australia's experience is in common with other OECD countries that have universal health care systems that enable them to exercise strong controls on health care costs. Given that these controls have been effective in the past, there is no reason to expect they cannot continue to be effective at the same time as delivering high quality health care to the whole population.

HEALTHY AGEING PROGRAM

The current scene

A variety of initiatives in healthy and positive ageing have been progressively implemented. Most recently, these initiatives have taken up themes from the UN program *A Society for all Ages* released in 2002.

Among the state and territory initiatives, Victoria's *Forward Agenda for Seniors* and Western Australia's *Active Ageing Strategy: Generations Together* are well developed. The summary of these two states' initiatives in Appendix 2 illustrate the 'whole of government' approaches that have been taken, with actions in virtually all areas of state responsibility. Similarly, wide arrays of actions taken been taken in other states, and have involved many stakeholders, particularly local government in some states.

However, implementation has been inconsistent between regions and local areas, and different priorities have been unevenly pursued over time and from state to state. Some recognised priorities, such as falls prevention, have been tackled with evidence based interventions. However, in other areas actions have been largely by way of softer, although still necessary, options such as providing information, resource kits and consultation. It also needs to be recognised that many of the trends that come within the scope of healthy and positive ageing, such as increasing use of computers, are proceeding without any particular policy or program support.

Commonwealth initiatives in healthy ageing have been very fragmented and past efforts to develop a national approach to healthy ageing have not been marked by a high level of leadership from the Commonwealth, nor have they produced significant outcomes. Other Commonwealth initiatives such a free flu immunisation for the over 65s and the health assessment for the 75 and overs have had more success in achieving more clearly defined goals.

Maintaining and enhancing the independence of older people is fundamental to ensuring that seniors play an active part in the lives of their communities. There is a close relationship between advancing age and increasing restrictions in ability to live independently, and the growth of the aged population, and especially the oldest old, will see an increasing prevalence of chronic illness and disability. The most effective way of addressing this prospect is through a national healthy ageing program that focuses on the major factors associated with disability and that are amenable to early intervention.

POTENTIAL POLICY OPTIONS

Given the number of healthy ageing initiatives that have already been taken at state level, policy could contribute to better ageing outcomes by taking a small number of national initiatives through a healthy ageing program established in the Ageing Portfolio and with complementary action taken through the Housing and Local Government portfolios.

Actions that could consolidate existing initiatives are:

Volunteering: Increased funding for *Volunteering Australia* for activities that promote exchanges between different age groups, whether older people as volunteers in all age activities, or younger people volunteering to support older people.

Accessible and adaptable housing: Build on the foundation that has been laid by the 'Building a community for all ages' seminar series across all states over the last two years. Complementary action could be taken with the Housing Portfolio to promote the provision of

accessible and adaptable housing through the *Commonwealth-State Housing Agreement* and the *Building Code of Australia*.

Inclusive communities: Incentives to promote inclusive town planning principles and practice that would result in vibrant mixed age communities with dividends for young and old alike. The Australian Local Government Association has undertaken some work in this area which can be developed further.

Social inclusion: Loneliness and isolation of older Australians is becoming an increasing challenge for the future. Unsurprisingly, research has found a connection between interaction with others and levels of self-esteem and overall well-being. Additionally, lonely individuals who lack social support are significantly less inclined to undertake healthy practices. It is acknowledged that the majority of older Australians are not socially isolated. However, given the already growing rates of Australia's ageing population, the importance of this issue is likely to grow. Potential policy options to tackle this issue include:

- The introduction of intergenerational community projects, promoting a positive perception of Australia's ageing population.
- The instigation of initiatives that focus on integration. Volunteering schemes are an effective avenue through which elderly citizens can not only gain new circles of friends and new skills, but also boost their sense of accomplishment and self-esteem.
- Befriending schemes to encourage older people to interact with the wider community to a greater extent - particularly involving older people with young people.
- Greater support for programs such as the University of the Third Age and TAFE courses for older people.

Continence Scheme: A person's capacity to fully enjoy life can be dramatically affected by incontinence, as well as its associated stigma and monetary costs. Given that the frequency of incontinence increases with age, the majority of the economic burden imposed by incontinence is borne by residential aged care.

Currently, the Continence Aids Assistance Scheme (CAAS) ceases when an Australian turns 65, unless he/she continues to work a minimum of eight hours a week, a requirement that cannot always be met due to other conditions or commitments. Also, CAAS does not account for older people undertaking volunteer work. Policy options include:

- Extend the CAAS to volunteers and to those beyond the age of 65 who volunteer more than eight hours a week.
- Invest in educational resources and clinical continence facilitators, including physiotherapy, to establish specific practice guidelines.

Senior Service Awards to recognise the contributions that seniors make to communities across Australia. The aim could be to recognise many individuals and groups, not just one Australian Senior of the Year. This could provide many opportunities to celebrate the contribution of older Australians at a local level.

Ageing and dementia research. In 2006, over 200,000 people will have been diagnosed with dementia. By 2050, that number is expected to surpass 730,000, 2.8% of the total estimated population. The Australian Health Ministers have jointly agreed to the development of a *National Framework for Action on Dementia* and the Commonwealth has recognised dementia's significance with a \$320.6 million package of support over five years. Potential policy options include:

- All jurisdictions to work with providers and consumers to expedite the finalisation and implementation of a Framework to assist people with dementia.
- The Commonwealth Government to significantly contribute towards creating an environment in which more research can be undertaken into understanding the causes, diagnosis techniques and possible prevention of dementia.
- Support for those with dementia in their own homes, particularly those who live alone and do not have access to carers, as well as easy access to quality community care services.
- Information dissemination mechanisms to be implemented in community-based structures such as pharmacies to allow for greater awareness and better decision making.
- Provision of psychogeriatric services along with an analysis of the effectiveness of psychogeriatric care units.

POTENTIAL ACTIONS TO ADDRESS KEY PRIORITIES IN OTHER PORTFOLIOS

Health Portfolio:

Dental care is a recognised priority and demand will increase as improvements in dental care over the 20th century mean that those reaching old age increasingly have more of their own teeth. Labor is committed to reintroducing a Commonwealth Dental Scheme.

A prevention and early intervention program which covers the population overall and which carries through with people as they age. Consideration also needs to be given for programs that address eyesight, hearing loss, falls, osteoporosis, better management of chronic conditions, nutrition and exercise, and medication reviews.

Health care reform in partnership with the states and territories potentially leading to better integration of community care, acute care, rehabilitation and community and residential care that would benefit older people.

Family and Community Services Portfolio:

Caring for carers: In 2005, over one in eight Australians, or 2.6 million people were estimated to be providing informal care. Of those carers, there is an increasing proportion of women aged between 35 and 54 who are required both in the workforce and to provide informal care for the young and the old. Women comprise nine out of every 10 Australians younger than 65 who care for a frail aged parent or spouse. Potential options include:

- Increased provision of centre-based day care programs that offer flexible times, high quality of service and greater accessibility could significantly assist those carers who wish to undertake paid employment.
- Increased funding for respite services across the board, but also particularly for respite services which assist people with mental health issues.

Grandparenting: Providing practical support to grandparents who look after their grandchildren. Labor has already announced that it will support new playgroups especially for grandparents who care for children and extra support and information for grandparents by funding existing community organisations and local government to reach out to more grandparents in the community.

QUALITY CARE IN THE COMMUNITY

The current scene

Funding trends

Community care has been at a stalemate for some years now in both the balance of aged care expenditure and policy and program development. Despite a continuing commitment to community care, it accounts for just over 25% of total aged care outlays, a share that has not changed in a decade.

Aged care expenditure, 2003-04 (from AIHW Australia's Welfare, 2005)

Commonwealth only funding	\$m	% of total	% of community care
Residential care - subsidies	5150.6	72.9%	
- resident and provider support	19.7	0.3%	
Accreditation	6.3	0.1%	
Community care			
Carer Allowance	315.5	4.5%	16.6%
Community Aged Care Packages	297.2	4.2%	15.7%
National Respite for Carers	98.0	1.4%	5.2%
Veterans' Home Care & DVA in-home respite	87.9	1.2%	4.6%
Multi-purpose and flexible services	58.6	0.8%	3.1%
Day Therapy Centres	30.5	0.4%	1.6%
Flexible care pilot projects	16.9	0.2%	0.9%
Extended Aged Care at Home	14.9	0.2%	0.8%
Commonwealth Carelink Centres	13.4	0.2%	0.7%
Other	25.7	0.4%	1.4%
Joint Commonwealth/state funding			
Home and Community Care	885.2	12.5%	46.7%
Assessment	46.7	0.7%	2.5%
Total	7067.1	100.0%	100%

Different growth factors built into each program have resulted in shifts within community care:

- The Home and Community Care (HACC) program now accounts for just under half of all expenditure on community care.
 - HACC's share of total aged care and community care outlays has been shrinking, not because states have failed to match Commonwealth funding but because the Commonwealth has put more resources into other, Commonwealth-only funded programs, and also into residential care.
 - Allocation of HACC funds to the states is also converging to an equitable per capita basis that will see each state receive a share of total funding in proportion to its share of the population with moderate, severe or profound disability and who are living in the community, as determined by the *ABS Survey of Disability, Ageing and Carers*. This equalisation strategy will achieve convergence in 2010-11.

Community Aged Care Packages (CACPs) have expanded due to the interaction between an increase in the ratio of provision to 20 per 1000 aged 70+ and growth of the aged population. CACPs now account for 4.2% of all aged care expenditure, up from 2.7% in 1998-99, and some 16% of all community care expenditure.

The Carer Allowance (CA) accounts for a similar share of funding as CACPs and has grown strongly in recent years due to increased take-up, not to increases in the amount of CA.

The balance of outlays on community care are divided between four programs that account for between 3-5% each, and a string of very small programs that together account for only around 5% of expenditure; the category of "other" includes three dementia initiatives, the continence program and assistance with care and housing.

Recent policy directions

Policy directions aimed at addressing the fragmentation of community care programs were set out in *The Way Forward* released in August 2004. Attention has focused on two main areas:

- two large scale projects are underway to develop systems for intake assessment and comprehensive assessment; and
- developing common arrangements for administration of all the Commonwealth-only funded programs.

While there have been few major outcomes from *The Way Forward* on the ground to date, more progress should be expected by mid 2007. The slow pace of progress and the apparently complicated systems that appear to be emerging have led to a sense of frustration in the sector. This situation calls for action that will simplify program administration for providers and for clients. In taking such action, the two limitations that appear to be stalling *The Way Forward* could be addressed.

First, recognition needs to be given to the funding that state and territory governments also contribute to a range of state-only funded community care programs that run parallel to the Commonwealth-only programs, notably for carer support and dementia care. The states and territories could be given an opportunity to put these cards on the table for consideration in any discussions of future program structures and funding, and the Commonwealth could also provide some incentives for them to do so.

Second, the Commonwealth could work with small service providers to reduce the confusion experienced by care recipients in choosing from the array of service providers and to achieve efficiencies in administration costs. This may lead to the consolidation of some services. Any strategy adopted must retain the full range and diversity of services.

Community care for younger people with disabilities

While Health and Community Care (HACC) and other carer programs serve both younger and older client groups, Community Aged Care Packages (CACPs) and Extended Aged Care at Home (EACH) packages serve only older people, and older people dominate the populations served by the other Commonwealth-only programs and Aged Care Assessment Teams (ACATs).

A key question that remains unresolved despite many years of debate is whether HACC should be split along the lines of the "frail aged" and "younger disabled" target groups. The main sticking point has been the share of funding that would go to the "younger disabled". While people under 65 years account for around two thirds of all those in the HACC target population (those with moderate, severe or profound restrictions who are eligible to receive HACC services), they account for just under 25% of HACC clients. Because those under 65

have somewhat higher care needs, they account for a slightly higher share of HACC expenditure - around 30%.

Younger people with disabilities also have their care needs met through general programs such as Medicare and Disability Pensions as well as through services provided through the Commonwealth State/Territory Disability Agreement.

This critical issue would have to be resolved in liaison with the Family and Community Services Portfolio and with HACC and community care providers.

The Senate Inquiry, *Quality and Equity in Aged Care*, handed down in June 2005, stated that the accommodation of young people in aged care facilities is unacceptable in most instances. The Committee recommended that all jurisdictions work cooperatively to:

- assess the suitability of the location of each young person currently living in aged care facilities;
- provide alternative accommodation for young people who are currently accommodated in aged care facilities; and
- ensure that no further young people are moved into aged care facilities in the future because of the lack of accommodation options.

The COAG announcement in February 2006 that from 1 July 2006, governments will implement a new joint Commonwealth, state and territory program to further reduce the number of younger people with disabilities living in nursing homes is a welcome start towards tackling this issue. This initiative should be well advanced by late 2007, and a check on progress in early 2008 will indicate the scale and nature of further action required.

POTENTIAL POLICY OPTIONS

Although the progress from *The Way Forward* is not yet clear, whatever progress has been made could be taken further along with new initiatives advanced through a potential Community Care Partnership Program (CCPP).

The CCPP is proposed with just two sets of arrangements for funding and accountability, and providers could enter into one or both of:

- a single service agreement to deliver specified services under the Commonwealth-only part of CCPP reflecting national priorities. All current Commonwealth-only funded programs and some new initiatives could be included in this. This part of the program could include Multipurpose Services (MPS) in which funds from different programs could be pooled;
- a joint service agreement to deliver services under the jointly funded part of CCPP, comprising HACC and the parallel services that states and the Commonwealth agree to bring into this part of CCPP.

The CCPP could:

- build on the limited progress made with implementing *The Way Forward* and set a timetable for phasing in over three years to ensure a smooth transition;
- aim to bring community care funding up to 30% of all aged care funding over three years; and
- provide a range of options for consolidating both small Commonwealth programs and small state programs that in some cases run parallel to a Commonwealth program. The options that could be negotiated with the states and territories include:
 - matching Commonwealth and parallel state and territory programs, such as carer initiatives and dementia support services provided by some governments into a

- shared partnership program with the cost sharing approximating the current HACC formula, 60% Commonwealth: 40% state;
- bringing relevant state and territory services into CCCP as trade-offs for other services currently in HACC that states want to realign with health services, notably the small component of allied health services provided through HACC; and
- consolidation of smaller services which mirror more viable services, and
- consideration of a viability supplement in community care as operates in residential aged care.
- link funding to program consolidation and redesign through proposed mechanisms such as:
 - bringing CACPs and EACH into the CCPP, meanwhile retaining these places as part of an appropriate overall ratio of places.
 - promoting more MPS in rural areas, linking up small programs and including small residential aged care facilities, and bringing together the Flexible Aged Care Services for indigenous communities.
 - initiating new Integrated Service Delivery Projects in metropolitan areas in collaboration with states and territories. These pilots could build on the cooperation that already exists between providers in many regions by formalising and strengthening this cooperation. Unlike MPS, these pilots would not involve pooling of funds. Examples of initiatives that are already underway are the comprehensive assessment arrangements being developed in several states, and collaboration between generic and ethno-specific services of the kind being promoted in Victoria's *Culturally Equitable Gateways Strategy*.

A Community Care Card. A Community Care Card (CCC) could solve problems with multiple referrals and assessment that occur in HACC. The CCC could build on the high levels of acceptance of Seniors Cards, the Medicare Card, DVA Gold Card, etc. The CCC could serve as a means of registering clients in the CCPP when they are first assessed. Clients could be registered with one provider, and the Card could hold only basic client details, as Medicare cards do. Having a CCC could serve as a key to accessing a community care database shared between providers - only when activated by the client. Providers could enter care transactions to the database.

An Assistive Technology Benefits Scheme (ATBS). An ATBS could be implemented as a national initiative through the CCPP. It could also mesh with the current provision of aids and equipment in HACC and in Veterans Home Care. Aids and equipment are immensely valued by individuals as they make them more independent. They are particularly valued by carers as their use reduces direct care time allowing more time for more positive activities. Aids and equipment are effective in delaying progress of disability and that those using assistive technology are less likely to be admitted to residential care. Aids and equipment are widely used, but there is still unmet need.

Rather than a model of direct reimbursement to individuals, the ATBS could operate using selected CCPP providers. A specified list of aids and equipment could be provided through central purchasing from suppliers.

The effect of the ATBS could be to transfer current expenditure on AT (10% of HACC expenditure at most) from the shared component of the CCPP budget to the Commonwealth funded component and free the shared funds for other agreed services.

The primary focus of the ATBS could be on supporting independence in daily living and duplicate the rehabilitation services provided through other programs.

These above initiatives must be undertaken considering the particular needs of indigenous people, people of Culturally and Linguistically Diverse heritage, and those living in rural and remote areas of Australia.

POTENTIAL ACTIONS TO SUPPORT THE CCPP IN OTHER PORTFOLIOS

Health Portfolio:

Integrated Geriatric Medical Hospital Services

Initiatives to promote geriatric medical services in public hospitals began in the late 1980s with the Medicare Incentive Packages (MIPs) under the Hawke Government.

Commonwealth initiatives continued through a focus on ageing in several rounds of the National Hospitals Demonstration Program (NHDP). The NDHP was where hospitals each took on one initiative and proved very successful at promoting best practice for a very modest outlay. More recently, further initiatives have been pursued through the Australian Health Ministers Advisory Council (AHMAC) Working Group on Health Care of Older Australians.

Many initiatives have also been taken by state governments, and the Medicare Agreements now provide the most suitable vehicle for an initiative that consolidates and furthers developments that have occurred to date. The proposed integrated geriatric medical hospital services that could build a number of components around the core of the Aged Care Assessment Teams is outlined in Appendix 3.

Education, Training, Science and Research Portfolio:

Aged Care Workforce Development Strategy

The Aged Care Workforce Strategy, released in 2005, covered only the residential aged care workforce. Most initiatives taken to date have focused on increasing the supply of qualified nurses for residential care. Three sets of actions could be undertaken to extend the scope of community workforce development:

The strategy could be extended to cover the community care workforce, in particular to recognise the mobility of the current workforce across different sectors of care and the increasing cross sector role of many providers. For example:

- Expansion of the role of Nurse Practitioners and Practice Nurses in aged care, including in Multipurpose Services and Integrated Geriatric Medical Services in public hospitals as well as in residential care and community care.
- Increased training positions for geriatricians, rehabilitation specialists, allied health practitioners and nurses, including Aged Care Nurse Practitioners, through a training component in Integrated Geriatric Medical Services.

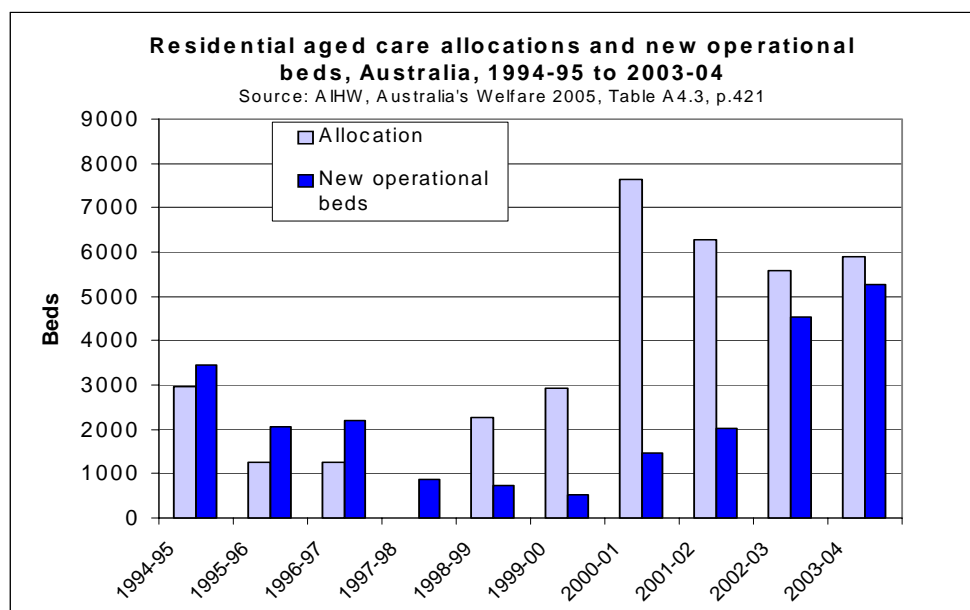
QUALITY CARE IN RESIDENTIAL CARE

The current scene

Compound growth of expenditure in residential aged care is expected to continue through increases in bed numbers in line with population growth and reclassification of residents upwards to higher levels of funding in line with increasing dependency over their stay.

Access to residential aged care

The growth of bed allocations and new beds coming on line is shown in the graph below taken from the Australian Institute of Health and Welfare report *Australia's Welfare 2005* (p.174).



This graph tracks the growth of aged care bed allocations and beds coming into operation and shows that:

- The drought of allocations that occurred in the five years to 2000 came to a sudden end in the 2000-01 Aged Care Approvals Round (ACAR) when over 7,000 bed licences were allocated.
- Bed allocations have continued at around 4-5,000 per year.
- Beds come into operation at about a two to three year time lag; a big jump occurred in 2002-03 when nearly 5,000 new beds came into operation compared to barely 2,000 new beds the year before and even fewer new beds in the preceding years.
- The 2006-07 ACAR announced an allocation of 4,600, and higher numbers in 2007-08 and 2008-09.
- New beds should continue to come on line at around 4-5000 a year.
- There will always be a gap between the number of approved beds and the number operating due to the time taken for construction. The Government states that it will meet its target of 88 beds for 1000 people aged 70 years and over in 2006, and we wait to see if this occurs.

Vacancy rates in Australian Government funded residential aged care services from 1998-9 to 2004-05 for each state and territory

	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05
NSW	3.9%	3.9%	3.6%	3.3%	3.6%	3.9%	4.8%
VIC	6.3%	5.7%	4.7%	4.5%	5.3%	5.6%	5.9%
QLD	3.4%	3.8%	3.3%	3.1%	3.6%	3.5%	3.8%
SA	3.1%	2.5%	2.1%	2.1%	2.7%	2.8%	2.5%
WA	4.9%	4.9%	4.6%	4.8%	4.4%	4.3%	5.2%
TAS	5.4%	5.6%	2.0%	1.9%	2.2%	2.5%	3.1%
NT	- #	4.2%	3.7%	3.8%	5.3%	9.1%	6.1%
ACT	5.0%	5.3%	3.8%	2.4%	2.3%	2.0%	1.7%

not available (Budget Estimates 2006-2007, 31 May-1 June 2006, E02-082)

Residential aged care vacancy rates fell overall between 2000-2003 and started rising slightly from 2003.

Waiting times for access to residential aged care have grown over the past five years. In 2000 15% of people who are assessed as requiring residential aged care waited over three months to access that care. In 2005, over 28% of people waited three months or more.

(Report on Government Services, Productivity Commission.)

Transition care

Every night, a significant number of older people are being cared for in hospitals who should be in alternative care/accommodation settings. A report developed on behalf of the Australian Health Ministers' Advisory Council (AHMAC) in July 2004 found that in April 2002, 1663 hospital patients were recommended for residential aged care by the health professionals caring for them. Of these, 1341 also had an Aged Care Assessment Team (ACAT) assessment recommending residential aged care. This report noted that at any one point in time, approximately 2,000 older people nationally are waiting in hospital beds for residential aged care. (From *hospital to home: Improving care outcomes for older people*, AHMAC, July 2004.)

AHMAC qualified these statistics by recognising that circumstances of the patient change over the hospital stay and recommendation for residential aged care may be premature.

However, it is generally agreed that over 1000 people on any one night will be in hospital inappropriately.

State and territory governments have strong motivation to address this issue with the cost of providing care in hospital estimated at \$800 per day out of the states and territories budgets compared with the average of \$270 a day in residential aged care.

Action by the Commonwealth to date in developing transition care strategies has been limited and more work needs to be undertaken.

Availability of beds is an issue that comes into play for these people.

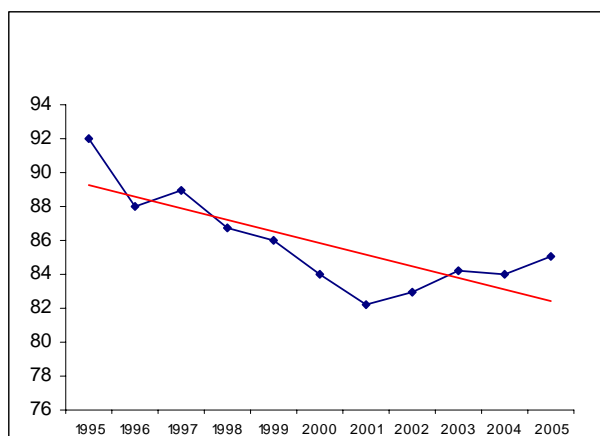
From hospital to home: Improving care outcomes for older people provides sound analysis of the situation along with a set of sensible proposals.

Further, there are a number of extremely successful transition programs operating in various locations which can be used as models.

Decline in availability

It should be noted that when Labor left Government, there were 92 residential aged care beds for every 1000 people aged 70 years and over. As at 30 June 2006 there were 85.3 beds for every 1,000 people aged 70 years and over.

The graph below shows the decline in the provision of operational residential aged care beds for every 1000 people aged 70 years and over since 1995. The ratio was reduced from 90 beds for every 1000 people aged 70 years and over to 88 in 2004.



Changing issues of concern

Some providers and Aged Care Assessment Teams state that access to beds will be satisfactory when provision reaches the ratios, which the Government predicts will occur in 2006 - data is awaited to verify this.

The table below is from a report prepared by Aged and Community Services Australia and shows the projected growth in beds. Between 2006 and 2011 alone, there is a 20% growth predicted in low care beds and 5% growth in high care in beds. Expenditure per bed is much higher in high care than in low care, so the expenditure impact will be considerably greater than the overall increase of 11% in total bed supply over five years. An added impetus to further growth in expenditure will come from the proportion of residents in places designated as low care who are classified to receive high care in line with ageing in place.

	2006	2011	2021	2031
High care places	80,509	83,612	117,307	158,450
Low care places	88,547	104,515	146,634	198,062
Total	169,056	188,127	263,941	356,512

Concerns are now:

- how well new beds are distributed in relation to the aged population and the level of frailty of entrants into residential aged care through the ACAR;
- the need to overhaul the planning ratios which have been in place for 20 years with only minor modifications, and including the adequacy of access for concessional residents;
- the impact of the new Aged Care Funding Instrument;
- ensuring sustainability in the sector;
- strengthening the quality assurance process; and
- ensuring that recurrent funding for care is spent on care and workforce development.

POTENTIAL POLICY OPTIONS

Policy proposals for residential aged care address a wide range of issues of concern to the sector through five broad strategies in the Ageing Portfolio.

Streamline the Aged Care Approvals Round (ACAR) process

Although the ACARs and planning processes have somewhat evened out provision across regions, access to residential care remains problematic for those living in regions where provision remains markedly below the planning ratios. At the same time, the ACARs are over-subscribed by providers by varying degrees for different regions.

The pressures from redevelopment to meet the 2008 building certification standards should abate as all facilities are expected to have reached the standards.

An assessment of the appropriateness of the planning region boundaries.

A restructure of the ACAR process could be undertaken with a view to streamlining the process, in consultation with provider and consumer bodies. The restructure could give attention to, but not be limited to aspects of the ACAR process already identified as problematic, including:

- Imbalances between provision and submissions to ACARs;
- The reasons for persisting shortfalls in regions of low provision;
- The reasons for high levels of submission above allocations available, with a high rate of unsuccessful submissions and wasted effort;
- Consider advertising bed allocations three or four years in advance to promote a steady flow of allocations so providers involved in developing residential aged care facilities can be assured of an even level of activity.

Options for developing a system of 'reserve' applications for runners-up in any ACAR who could be given a head-start for resubmitting an updated proposal in a future year, subject to bed allocations still being available. The advantages of a reserve approach are savings to providers, a reduced number of excess applications making more time available for fuller assessment of suitable applications, and timely announcement of new bed approvals.

A potential initiative to allow funding for approved, but not operational bed licences to be made available as temporary CACPs until the beds became operational. The pros and cons of such a step need to be considered carefully in any proposal as part of the CCPP.

Adjust the planning ratios

The current planning ratios were introduced in the mid 1980s, with only relatively minor adjustments since then. The prime need is to bring all areas up to the same level.

There are strong grounds for adjusting the population based planning ratios to take account of changes that have occurred and likely future trends, including:

- Increases in life expectancy over the 20 years since age 70 was introduced as the basis for planning in the mid 1980s.
- Trends in prevalence and severity of disability in older age groups.
- Availability of the results of the 2006 Census and new population projections.
- The changing balance between high and low care, including recognition of the growth of alternative forms of retirement accommodation that can approximate the lower levels of hostel care as well as the expansion of community care.
- Changing patterns of use with ageing-in-place; the role of small, stand alone low care facilities that are not linked to high care facilities requires special consideration in this context.

- The impact of use of residential care beds for respite and transition care on overall levels of demand.
- The adequacy of the Concessional Resident Ratio overall and from region to region, taking account of variations in the characteristics of the population over the older age range rather than just age 70 and over as a whole.

Review the Aged Care Funding Instrument (ACFI)

Labor recognises the considerable effort the sector has made in the development of the ACFI and does not intend to put providers through another exercise of this kind. Labor will make a commitment to monitoring the outcomes of the ACFI and to review the processes two years after its implementation. Review of the ACFI will also provide the opportunity to address outstanding issues in other areas of recurrent funding, including:

- Funding of transitional residents;
- Assessing the continuing need for a number of current 'supplements' that complicate present funding and that if not incorporated into the ACFI, could be incorporated into an ACFI Mark 2 and so simplify funding and documentation of resident care;
- Adequacy of Commonwealth Own Purpose Outlays (COPO) and examination of alternative indexation models;
- Conditional Adjustment Payments; and
- Viability supplements for rural and remote facilities.

Subject to the findings of the ACFI review, an assessment of the need to recalibrate the instrument and funding levels at regular intervals to take account of the changing profile of residents in aged care facilities, would be undertaken.

It is anticipated that the outcomes of the ACFI review will provide a basis for establishing best value benchmark models of care. By defining best practice models of care, benchmarking could ensure that the funding made available through the ACFI was allocated to care provision. Benchmarking could provide incentives for best practice and best value in delivery of efficient and effective care, including adoption of assistive care technologies and computerisation in administration, and enable care funding to be linked to resident outcomes in the accreditation process.

Sustainability in the sector

In 2004, Professor Warren Hogan handed down his report *Review of Pricing Arrangements in Residential Aged Care*. The Government's allocation to residential aged care in the 2004/05 Budget was recognised as a short term response to his report. Consequently, \$1.3 million was allocated to facilitate consultation with the sector and the development of the so called "Long Term Response to Hogan". It is understood that the report was developed during 2005 and handed to the Minister for Ageing around August of that year.

However, to this point it has not been released. In the policy vacuum that has been created, the sector has become increasingly frustrated at the inability to engage in any informed way about proposals to ensure the long term sustainability of the residential aged care sector.

In order to encourage further discussion on the issues, the Aged Care Association released "Capital Contribution: Policy Options Paper" in March 2006. In September 2006 the National Aged Care Alliance released "A Summary of Options for Long Term Financing of Community and Residential Aged Care", also a discussion paper. Options canvassed in these contributions include:

- Increase the daily accommodation charge;
- Changes to the periodic payment of refundable accommodation deposits;

- Differential charges for varying accommodation quality;
- Changes to Deeming Provisions;
- Refundable accommodation deposits:
 - draw down proportion,
 - extension to high care;
- Regulate income stream;
- Separate care and hotel/accommodation services.
- Aged Care Capital Pool;
- Nominated investment account.
- Reverse mortgages.
- Treatment of short term residents.

(ACAA, 2006)

- Increased Government contribution;
- Increase Medicare Levy;
- Increase consumer contribution;
- Increase means and asset testing for eligibility for subsidy;
- Bonds for High Care;
- Unbundling costs of care;
- Long term care insurance;
- Equity release scheme;
- Changes to regulation of residential aged care.

(NACA, 2006)

Labor concurs with the view that it is essential that the Government release its long-term response to Hogan so the discussion about sustainability in residential aged care started by Professor Hogan can be re-invigorated and consensus about directions found.

Strengthening quality standards

Policies which could strengthen the quality standards for aged care include:

- Giving the Aged Care Complaints Commissioner the capacity to investigate the operation of and delivery of care in homes about which complaints are made.
- Enhancing the role of the Aged Care Standards and Accreditation Agency include:
 - Considering the implementation of the recommendations from the Senate Inquiry Quality and Equity in Aged Care handed down in June 2005, outlined in Appendix 4:
 - Extending its role to monitoring standards of community care. This action recognises that many providers of residential care are also providers of community care and that having a single agency carry out standards monitoring will bring advantages of consistency across all care sectors for consumers and providers.

Tackling workforce shortages

The aged care sector is suffering from a lack of qualified nurses and care staff. Reasons include the relatively poor pay and conditions of those working in aged care along with the perennial complaints about paperwork. With nurses in aged care being paid on average around \$200 a week less than their counterparts in acute hospitals, aged care is seen as a less attractive career option. Workforce shortages are compounded by increasing workload leading to disillusionment and burn out among staff. Policy options could include:

- The training of care workers for community and residential aged care to be seen as a national priority.
- Incentives to provide minimum training for care staff of Certificate III or IV in aged care, to improve quality of care and the self worth of the care staff.
- The development and implementation of a benchmark of care in consultation with aged care consumers, providers, care workers and community representatives.
- Linking the level of care subsidies to the benchmark of care with subsidies being indexed against changes in component costs to ensure that care funding in maintained in real terms.
- A national nursing recruitment strategy.
- The allocation of additional undergraduate nursing places at universities in line with the recommendations from the Hogan *Review of Pricing Arrangements in Residential Aged Care* and the recommendations from the Senate Inquiry *Quality and Equity in Aged Care*.
- Increasing Undergraduate and Postgraduate Scholarships in aged care nursing.
- The national health workforce strategy to encompass all health professionals including medical and allied health professionals and all areas of the aged care sector, including the community care sector.
- Improving conditions and career structures to stem the flow of nurses and care staff from residential aged care facilities.
- Incentives for staff to work in aged care settings in remote and rural areas.
- The creation of the position of National Chief Nursing Officer with responsibility for nursing workforce planning. Labor's Shadow Minister for Health has already announced Labor's commitment to implementing this strategy.
- The consideration of the introduction of national standards and harmonised registration of health care professionals which allow greater movement of qualified staff.

Young people in nursing homes

In Australia there are about 1000 young people (aged under 50 years) and about 5000 middle aged adults (aged 50-64 years) with disability living in residential aged care facilities because no other suitable accommodation is available. For these people, residential aged care facilities can be totally inappropriate for their medical, social or support needs. The importance of getting young people into accommodation more suited to their needs cannot be overstated.

There were funding announcements at the February 2006 COAG meeting regarding this issue, and a Senate Inquiry into the Commonwealth, State, Territory Disability Agreement is due to be tabled in December 2006 which will inform the debate.

SECURITY FOR OLDER AUSTRALIANS

The current scene

Notwithstanding the generally satisfactory standard of living of older Australians, underpinned by Medicare, the PBS, the Age Pension, and increasingly the returns from the Superannuation Guarantee, there are a number of older people who experience multiple disadvantages and who are excluded from much of what constitutes a good quality of life in old age. A gradient of disadvantaged groups can be identified as follows:

- Older Australians who, for a variety of reasons but commonly mental illness and drug and alcohol abuse, are homeless or at risk of homelessness. While relatively small in number, this group must be included in strategies for older Australians.
- Those who enter old age as renters living in private sector rental housing, who have generally experienced a lifetime of low incomes, broken employment and fragmented social networks. The high cost, low quality and insecurity of housing place constraints on the wider well-being of these individuals that are likely to endure and increase as they grow old. This group constitutes around 4-5% of older Australians.
- The very old, particularly very old women, who are most likely to be living alone, totally reliant on the Age Pension, to have their daily activities restricted by disability, and to be most in need of community care or residential care. While well below 10% of the population aged 70+ are in residential care, the likelihood of spending some time in residential care before the end of life is 25% for the older population overall and increases to about 80% for this group. This group gains virtually no benefits from cuts to income tax rates as very few are paying any income tax, yet they bear considerable costs of increased charges for services even with concessions. Those aged 85+ account for some 10% of the total population aged 65 and over.
- The norm can be taken as those who are home owners and who receive a full or part pension, who are entitled to various means tested concessions, and who have reasonable social networks, including family support. There is considerable variation in this group who account for around two thirds of all older Australians.
- Self-funded retirees are generally younger and better off than individuals in the above groups. They account for around 20% of all older Australians, and their numbers will increase as the baby boomers retire. Many in this group will have modest incomes, often only marginally above the Age Pension, and consider themselves to be disadvantaged compared to full Age Pensioners, especially with regard to access to pensions. Their feelings of exclusion, and anxiety about their ability to maintain their living standards, are at least as important as their actual financial status.

POTENTIAL POLICY OPTIONS

The focus on equity in the measures proposed in the Healthy Ageing Program and Quality Care policies will ensure that the greatest benefits accrue to the most disadvantaged; three further measures in other portfolio areas are proposed below to complement these initiatives.

Elder abuse prevention

Abuse of older people manifests in many forms: neglect, financial abuse, psychological abuse, physical and sexual abuse. International research shows that around 3-4% of people

over 65 suffer abuse in some form and the majority of abusers are family members either a spouse, adult child or other close relative - and they usually live with the victim.

By focussing solely on abuse in residential aged care facilities, the Government has simply reinforced community misconceptions about how and where elder abuse occurs. Potential policy options include:

- In the same way that governments have educated and informed the community about domestic violence, a community campaign could be developed to inform and empower the community to withstand abuse of older people in all its forms.
- The introduction of Whistleblower Legislation to protect staff in residential aged care and in community care who witness and report abuse.
- The development and introduction of policies and procedures for staff education about recognising and reporting of elder abuse in residential aged care within a culture of dignity and respect for older Australians.

POTENTIAL ACTIONS TO SUPPORT KEY PRIORITIES IN OTHER PORTFOLIOS

Housing Portfolio:

Secure housing for seniors

An initiative through the Commonwealth State Housing Agreement to improve access to affordable housing for low income older people. The scheme could target areas with high numbers of private renters receiving Rent Assistance in areas with rapidly growing older populations but limited access to social housing.

Family and Community Services Portfolio:

A Community Support Allowance for those aged 85 and over living in the community

A person who is living on the Age Pension, about \$12,000 a year, receives about twice as much Commonwealth funding if they move into a low care facility and receive the lowest level care, around \$12,000 a year – with the pensioner also contributing the majority of their pension towards their care.

This proposal could go some way to redressing this imbalance and enabling more very old people to remain living in the community (including in various forms of supported accommodation) instead of seeking admission to aged care facilities.

The proposed community support allowance could be paid at a rate equivalent to the Carer Allowance (currently \$84 per fortnight). The Community Support Allowance (CSA) could be paid to those aged 85 and over, who are living in the community but without a carer or with a carer who is not receiving CA. Rationales for this proposed initiative are:

- Those aged 85 and over have the lowest incomes of all the older age groups.
- Remaining in the community carries extra costs for these individuals due to their high levels of disability and restrictions on daily living, for example, the need to use taxis, purchase of over the counter medications and related supplies.
- The CSA would not be taken into account in determining fees to be paid for community care services (the Carer Allowance is not).

Financial security: A comfortable retirement is one where we have 60-65% of the income we had before we retired. The National Information Centre on Retirement Investments Inc (NICRI) was established in 1989 to provide an independent source of information to retirees and pre retirees about investments and the financial planning process. It is funded through

the Department of Families, Community Services and Indigenous Affairs. NICRI's annual grant for 2005/06 was \$479,000.

NICRI is currently developing a DIY financial planning guide, a self planning tool to assist in making financial decisions. It is designed to help people understand the issues that need to be considered in planning for retirement.

NICRI could be funded to extend the reach of their information and education services to younger people so that important financial decisions are well advised at a younger age rather than just pre-retirement and retirement.

Health Portfolio:

Advance care directives: The Australian Medical Association defines an Advance (Health or Care) Directive (AD) as a statement that allows patients to understand the implications of their choices to state in advance how they wish to be treated when they are no longer capable, as a consequence of physical or cognitive incapacity, of making such health care decisions in a particular circumstance. (AMA, *The Role of the Medical Practitioner in Advance Care Planning*, Released 24 August 2006)

There have been calls for greater consistency across states and territories and a requirement to enact consistent legislation to establish ADs as legally enforceable instruments.

ADs have great potential to empower older people and there is a role for the Commonwealth to facilitate this harmonisation.

Appendix 1: Demographic trends

Table A1: Ageing of Australia's population, 1971-2041

Year	Pop 65 + (000)	Pop 80+ (000)	Total pop (000)	% 65+	% 80+	80+/65+%
1971	1,091.1	180.0	12,937.2	8.4%	1.4%	16.5%
1981	1,455.0	257.0	14,576.3	10.0%	1.8%	17.7%
1991	1,728.8	312.4	15,575.4	11.1%	2.0%	18.1%
2001	2,403.1	582.9	19,421.3	12.4%	3.0%	24.3%
2006	2,653.4	712.2	20,278.1	13.1%	3.5%	26.8%
2011	3,036.0	819.9	21,288.8	14.3%	3.9%	27.0%
2021	4,220.4	997.0	22,926.4	18.4%	4.3%	23.6%
2031	5,405.1	1,518.2	24,254.4	22.3%	6.3%	28.1%
2041	6,213.2	2,046.7	25,033.6	24.8%	8.2%	32.9%

Source: 2001-2041 Series II projections, ABS, *Population Projections for Australia 1999-2101*. ABS Catalogue No. 3222.0. 2000.

Table A2: International comparisons of proportion aged and Aged Dependency Ratio, 2000 and 2050.

Country	% aged 60+ in 2000	Aged Dependency Ratio 2000	% aged 60+ in 2050	Aged Dependency Ratio 2050
Italy	24.1	40/100	40.6	88/100
Japan	23.3	38/100	42.4	95/100
Sweden	22.3	38/100	33.6	66/100
Canada	16.7	26/100	32.3	62/100
USA	16.1	26/100	25.5	45/100
Australia	16.4	26/100	29.9	56/100
Korea	11.0	16/100	36.9	75/100
China	10.1	16/100	30.0	56/100

Source: Productivity Commission.

Appendix 2: Summary of healthy ageing strategies in Victoria and Western Australia

Forward Agenda for Victoria's Seniors, 2002	Western Australia's Active Ageing Strategy: Generations Together, 2004
The age to be active	Health and well-being
Falls Prevention programs	Falls prevention
Promote physical activity through three seniors initiatives and involving seniors in VicFit programs for all age groups	Carer support
Grandparenting program for older women migrants	Promoting value and respect for older people
Three Oral Health Promotion Grants	Help line for grandparents
Ageing Well forums in Seniors Festival	Research into transitional life events
Promote seniors tourism opportunities	
Promote seniors discounts in recreation facilities	
The age to be productive	Employment and learning
Funded support for mature age workforce participation through six employment programs	Promote sustained workforce participation by mature age workers and phased retirement
Enforced anti-discrimination legislation	Workplace gender discrimination/ women retirees
Funded lifelong learning programs, U3A	Promote retirement planning
Funded Volunteering Victoria and Resource Centres, including in regional and rural areas	
The age to be valued	Community awareness and participation
Ministerial Advisory Council, Seniors Festival, Premiers Awards	Active Ageing Officers and Consultative Committee
Intergenerational mentoring, involving seniors in schools	Support volunteers/Volunteering Secretariat
Koori Elders initiatives	Promote active ageing in indigenous communities
Positive portrayal of seniors in the media	Grandparenting initiatives, including resource kit
Enhance government information services	
The age to be consumer wise	Protection and security
Concessions	Address elder abuse
Expand Seniors Card	Crime and safety information
Information and advocacy services	Information on state services
Legislative Reviews e.g. Retirement Villages Act	Consumer advocacy for seniors
The age to be involved	Planning and the built environment
Seniors Information Victoria, guides including multicultural directories	Improve transport
Public transport: improve access and safety, more low floor trams etc.	Review residential design codes/promote universal design
Crime prevention and safety initiatives, including Confident Living for Older Victorians Handbook	Protection for residents of caravan parks
Falls Prevention Projects	Develop housing alternatives for an ageing population
Research initiatives	Active ageing research
Increase on-line access for seniors	

Appendix 3

Integrated Geriatric Medical Hospital Services in public hospitals - Initiative in Medicare Agreements, through AHMAC

The scope of Integrated Geriatric Medical Hospital Services (IGMHS) is focused on Aged Care Assessment Teams and related services in public hospitals. The focus is on services that only public hospitals with specialist geriatric medical staff can provide, and for the selected segment of the aged population that needs these services. This segment of the aged population especially need more focused attention within acute care and post acute care.

Some proposals put forward a much wider scope of integration, across aged care, community care, community health and primary health services. This wider range of services not only cover the whole of the aged population, but also serve other age groups, reducing the rationale for integration. These proposals extend into areas that are well provided by agencies other than public hospitals, and they do not accord well with state initiatives to integrate different sets of services. Other agencies tend to see such proposals as empire building by hospital based services.

A well-established, if uneven, foundation now exists for an initiative for IGMHS through the Medicare Agreements, following negotiations with AHMAC. The components proposed for inclusion in this initiative are:

1. Aged Care Assessment Teams

ACATs are at the core of IGMHS in public hospitals. ACATs have received additional funding in recent years for an expanded role in assessment in the community, but this role can only be carried out effectively if ACATs have access to inpatient assessment beds, a committed presence in emergency departments for 'front end' management, and in post acute inpatient to provide 'back end' management by way of rehabilitation and transition care in bed-based services, in day hospital and outpatient clinics.

This component needs to be accompanied by a review of the role of ACATs to focus their activities on functions that cannot be carried out by other services, and to develop effective working relationships with other agencies.

2. Emergency department and discharge support

There are now a number of good practice models for enhancing the focus on aged care in emergency departments (EDs), with attention to forestalling presentation to the ED and prompt return to the community as well as facilitating needed inpatient admissions. These models include specialist aged care nursing presence in the ED and close liaison with community nursing services to avoid duplication and overlap with existing services, and extend to enhancing the role of ambulance services. One specific care for attention is the development of protocols to guide residential aged care staff in making decisions about sending residents to hospital, and include contact with a geriatrician before initiating an admission and possible on-call visits by a geriatrician.

3. Rehabilitation/Transition care

Despite several efforts over the years, there has been very limited success with developing rehabilitation and transition care services in residential aged care facilities. The very exceptional nature of the few who have tried and succeeded, but not always for a long time, point to the difficulties of generalising from their experience. Rather than expecting more residential aged care homes to take on these functions (with a consequent reduction of beds for usual residential care), the preferred option is for each IGMHS to establish relevant

services, within public hospitals or public sector nursing home beds, or by contracting to private hospitals with excess capacity, or to carefully selected residential aged care facilities. A bed day funding level would have to be established, probably commensurate with RCS 1, but with additional support provided through the IGMHS.

IGMHS could also provide a solution to the Day Therapy Centre program by enabling them to opt in and upgrade to Day Hospital status, or to opt out and become a Day Care Centre in the Community Care Partnership Program.

4. Community Geriatricians

The extension of the role of geriatricians in the community could best be achieved by a combined strategy of rotation from the ACAT to a designated community service, and by on-call arrangements by which geriatricians could attend residential aged care facilities instead of sending residents to emergency departments.

5. Palliative care

There is growing attention to developing palliative approaches in residential aged care. This development could be supported by making specialist aged care nurse practitioner consultants available through the IGMHS, and able to support staff and clients in community care services as well as in residential care.

6. Psychogeriatric services

Psychogeriatric care is a critical component of IGMHS that can be built on integration of the existing small Commonwealth initiatives for psychogeriatric and dementia assessment. The ACFI will stimulate a need for increased psychogeriatric involvement in assessment and management in residential care.

7. Hospital in the home

Most HITH services focus on a highly selected group of patients undergoing short term treatment such as intravenous antibiotic treatment. Older patients needing such care are included if they need this treatment. In expanding HITH for older people, there is a need for caution to avoid overlapping and duplicating community nursing services that currently operate under HACC. These existing services already have hospital liaison staff and protocols and their client load already includes many who are receiving care post acute discharge. Expansion of these services through the CCPP and enhancing interaction with IGMHS to provide a 'fast track' discharge service is preferable to adding a duplicative element.

8. Medication review

IGMHS could boost the medication review work that is currently done by pharmacists.

Appendix 4

Recommendations from Senate Inquiry: Quality and Equity in Aged Care June 2004

The Accreditation Agency, Accreditation Standards and complaints resolution

3.37 That the Agency ensure that the training of quality assessors delivers consistency in Agency assessments of aged care facilities.

3.38 That the Agency publish data on the accuracy of assessors' decisions in conducting assessments against Agency benchmarks and that this data be provided in the Agency's annual report and on its website.

3.55 That the Agency further develop and improve information provided to residents and their families about the accreditation process, including those from CALD backgrounds and Indigenous people, and more actively involve residents and their families in the accreditation process.

3.56 That the Agency develop a rating system that allows residents and their families to make informed comparisons between different aged care facilities. The Committee notes that work is being done on a web-based prototype; however it considers that the rating system should not be limited to a 'star rating' but should include easily understood descriptions of a range of attributes, such as type and range of services provided; physical features of homes; staffing arrangements; costs of care; and current accreditation status.

3.74 That the Agency ensure that all facilities be subject to a minimum of one annual random or targeted spot check and at least one site visit with notification over its accredited period.

3.93 That the Agency, in consultation with the aged care sector and consumers, develop a benchmark of care which ensures that the level and skills mix of staffing at each residential aged care facility is sufficient to deliver the care required considering the needs of the residents. The benchmark of care that is developed needs to be flexible so as to accommodate the changing needs of residents.

3.125 That the Commonwealth, in consultation with industry stakeholders and consumers, review the Accreditation Standards to define in more precise terms each of the Expected Outcomes and that this review:

- address the health and personal care needs of residents, especially nutrition and oral and dental care; and
- include specific consideration of the cultural aspects of care provision, including the specific needs of CALD and Indigenous residents.

3.126 That the Agency make greater use of interpreters during accreditation visits to aged care facilities, especially those facilities that cater for specific or predominant numbers of CALD or Indigenous residents; and that assessors be trained in cultural competency as part of their formal training courses.

3.154 That the Commonwealth review the operations of the Aged Care Complaints Resolution Scheme to ensure that the Scheme:

- is accessible and responsive to complainants;
- provides for a relaxation of the strict eligibility criteria for accepting complaints;
- registers all complaints as a complaint, with the complaints being categorised by their degree of severity, such as moderate level of complaint, complaints where

- mediation is required or where more significant levels of intervention are required;
and
- provides that the mediation process is responsive and open and that sufficient support for complainants is provided in this process.

3.155 That the Commonwealth examine the feasibility of introducing whistleblower legislation to provide protection for people, especially staff of aged care facilities, disclosing allegations of inadequate standards of care or other deficiencies in aged care facilities.

3.173 That the Commissioner for Complaints conduct an investigation into the nature and extent of retribution and intimidation of residents in aged care facilities and their families, including the need for a national strategy to address this issue.

3.187 That the Agency's role in promoting 'best practice' continue and that it:

- develop a standard evidence-based approach to defining 'best practice' in aged care;
and
- provide regular aggregated information to the industry on methods for achieving 'best practice' in the provision of aged care services.

The Committee further recommends that the Agency consider ceasing its direct role in providing direct staff training given the potential conflict of interest that this entails.