The Parliament of the Commonwealth of Australia

FUTURE AGEING

Report on a draft report of the 40th Parliament:

Inquiry into long-term strategies to address the ageing of the Australian population over the next 40 years

House of Representatives
Standing Committee on Health and Ageing
41st Parliament

March 2005
Canberra

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Foreword

In the 40th Parliament, the House of Representatives Standing Committee on Ageing inquired into *the long-term strategies to address the ageing of the Australian population over the next 40 years*. The election was called in 2004 before a report was completed for tabling.

The House of Representatives Standing Committee on Health and Ageing, formed in the 41st Parliament, resolved to table the draft report from the inquiry without amendment or reopening the inquiry. Recommendations are not made in this publication, and thus a Government Response is not anticipated. To aid readers and future researchers, the committee inquiry process details are summarised and some conclusions are shared.

During the 40th Parliament inquiry a total of 192 submissions and 88 exhibits were received. The committee held 18 public hearings across the country (Adelaide, Alice Springs, Brisbane, Broken Hill, Canberra, Central Coast, Coffs Harbour, Darwin, Dubbo, Lake Macquarie, Melbourne, Perth, Sydney, and Western Sydney), undertook six site inspections to aged care facilities, a respite centre, the University of the Third Age, and four organisations at Tullamore NSW involved in work with aged people. From the public hearing program, the committee took evidence from 100 witnesses representing 88 organisations or themselves.

To maximise community opportunities for contributions to the inquiry, the committee also held six community forums associated with five of the public hearings (Gold Coast, Norah Head, Charlestown, Coffs Harbour, Alice Springs, Broken Hill). A total of 127 statements were made. The committee also received 17 private briefings. A report was drafted.

Since the report was drafted last Parliament, and the election announced in August 2004, there have been a number of Government policy announcements and the new committee acknowledges these initiatives might supersede some conclusions made in the earlier drafted inquiry report.

On 13 August 2004, the Minister for Ageing Julie Bishop announced a new taskforce to ensure full delivery and oversee the remaining aged care Government initiatives that were part of the $2.2 billion Budget package, including:

- A new Internet-based service to provide information on the quality of care in aged care homes, as well as information on fees, services and workforce;
- An e-commerce platform for residential aged care payments and simplified resident classification scale, reducing paperwork for aged care staff and increasing efficiency in the information exchange between government and providers; and
- A provider-funded guarantee fund to further protect residents' bonds.

On 9 November 2004, the Minister for Ageing Julie Bishop announced the Government was taking applications for funding to train the aged care workforce:

- $7.4 million for education providers to provide up to 5,250 Enrolled Nurses with training to administer medication; and
- $56 million for vocational education and training opportunities for up to 15,750 aged care workers to upgrade their qualifications to Certificate III, Certificate IV and Enrolled Nurse level.

These measures were part of $150 million funds the Australian Government was spending on education and training opportunities for aged care workers, including scholarships for rural and regional Australians wanting to study aged care, and new undergraduate nursing places at university.

On 18 November 2004, the Minister for Ageing Julie Bishop also announced and introduced legislation to enable older Australians to have more choice in health care and to make private health insurance more affordable. The private health insurance rebate is to be increased to 35% for people aged 65-69 and to 40% for people aged 70 and over, thus making private health insurance premiums $100 to $200 per year cheaper for approximately one million older Australians.

In the Governor-General's speech at the opening of the 41st Parliament, it was also announced that GP rebates would be increased from 85% to 100% of the Medicare fee for all consultations, and there would be greater access to mental health care especially with the burden of depression. While these issues affect all Australians, they are especially relevant to the ageing population.

The committee in the 41st Parliament considers it important to share with the community the evidence, developments and conclusions of the previous committee in the 40th Parliament. Parliamentary committee members are challenged throughout an inquiry process, balancing the electorate demands with burning parliamentary committee inquiry work. The previous committee members were committed to producing outcomes to vexed issues that all Australians will eventually face in the future. Thus, central to future progress is the need to make public any pertinent explorations.

Hon Alex Somlyay MP

Chair

Membership of the Standing Committee on Health and Ageing - 41st Parliament

Chair	Hon Alex Somlyay MP	
Deputy Chair	Ms Jill Hall MP	
Members	Mr Alan Cadman MP	Mr Michael Johnson MP
	Mrs Justine Elliot MP	Ms Catherine King MP
	Mrs Kay Elson MP	Mr Malcolm Turnbull MP
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The Parliament of the Commonwealth of Australia

UNTITLED

Report on the inquiry into long-term strategies to address the ageing of the Australian population over the next 40 years

House of Representatives
Standing Committee on Ageing
40th Parliament

August 2004
Canberra

Contents

Membership of the Standing Committee on Ageing - 40th Parliament

Chair	Mr John Cobb MP (from 5/11/03)	
	Dr Andrew Southcott (to 4/11/03)	
Deputy Chair	Ms Jill Hall MP	
Members	Ms Ann Corcoran MP	Mr Greg Hunt MP
	Ms Annette Ellis MP	Mrs Margaret May MP
	Ms Teresa Gambaro MP	Mr Frank Mossfield MP
	Mr Luke Hartsuyker MP	Mr Tony Smith MP

Terms of reference

On 26 June 2002, the Minister for Ageing, the Hon Kevin Andrews MP, asked the Committee to inquire into the long-term strategies to address the ageing of the Australian population over the next 40 years.

List of abbreviations

ABS	Australian Bureau of Statistics
AHMC	Australian Health Ministers' Conference
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
ASFA	Association of Superannuation Funds of Australia
ASIC	Australian Securities and Investments Commission
AWT	Australians Working Together
BCA	Business Council of Australia
CACP	Consumer Aged Care Package
CBP	Community Business Partnership
CDEP	Community Development Employment Program
COTA	Council on the Ageing
CSIRO	Commonwealth Scientific and Industrial Research Organisation
DEST	Department of Education, Science and Training
DEWR	Department of Employment and Workplace Relations
DIMIA	Department of Immigration, and Multicultural and Indigenous Affairs
ENEPRI	European Network of Economic Policy Research Institutes

FaCS	Department of Family and Community Services
GDP	Gross Domestic Product
HACC	Home and Community Care
ICV	Indigenous Community Volunteers
IEP	Indigenous Employment Policy
ISFA	Investment and Financial Services Association
ISO	International Standards Organisation
IYOP	Year of the Older Person
NATSEM	National Centre for Social and Economic Modelling
NHMRC	National Health and Medical Research Council
NOM	Net Overseas Migration
OECD	Organisation for Economic Co-operation and Development
PBS	Pharmaceutical Benefits Scheme
PMSEIC	Prime Minister's Science, Engineering and Innovation Council
SISFA	Small Independent Superannuation Funds Association
TAFE	Technical and Further Education
TBL	Triple Bottom Line
U3A	University of the Third Age
VET	Vocational Education and Training
WESROC	Western Suburbs Regional Organisation of Councils

List of conclusions

2 Age friendly communities

Conclusion 1

The Committee concludes that the Department of Health and Ageing should ensure that the proposed quality assurance system for Australian Government funded community care programs covers the support provided to carers both directly by the National Carer Respite Program and through the provision of Community Care Packages. (para 2.56)

3 Ageing with dignity

Conclusion 2

The Committee concludes that in further developing the *National Strategy for an Ageing Australia*, the Australian Government should include a statement of the underpinning the Strategy. In the first instance, the values would promote a basis for debate. Subsequently as a goal /vision against which further development should be tested and measured.

The Committee concludes that in further implementing the *National Strategy for an Ageing Australia,* key messages and information must be developed in such ways as to engage people of all ages, of different backgrounds and relevant to the contexts in which people are living and working. (para 3.76)

Conclusion 3

The Committee concludes that the Community Services Ministers' Advisory Council should direct the Positive Ageing Taskforce to broaden the scope of their work on elder abuse to identify and develop guidance on ways in which older people can be assisted to maintain control over their lives and affairs.

The Committee further concludes that guidance be implemented by all State and Territory Governments to provide a consistent approach across Australia to protecting the dignity of all older Australians. (para 3.79)

Conclusion 4

The Committee concludes that the Attorney General should work with the State and Territory Attorneys General to review, streamline and unify the legal instruments used for planning end of life decisions relating to management of affairs and assets, protection from abuse and care preferences. (para 3.82)

4 Housing and transport

Conclusion 5

The Committee concludes that the Australian Government through the Health and Community Ministers' Council and the Housing Ministers' Conference should lead the development of longer term strategies to address the housing needs of an ageing Australia that:

- build on the research being undertaken by the Australian Building Codes Board;
- promptly action any national building standard recommended by the research being undertaken by the Australian Building Codes Board;
- facilitate the development of a national 'age friendly home standard' which must be included in all rental and sales advertisements for domestic dwellings; and
- entitle purchasers 65 years and over to reduced transaction costs for the purchase of a freehold title domestic dwelling (with registrable and transferable interests) that qualifies for the national 'age friendly home standard'. (para 4.46)

Conclusion 6

The Committee concludes that the Australian Transport Council identify older people's transport needs and develop a national action plan to improve the safety, accessibility, availability and affordability of public transport to support older people's independence and participation in their communities. (para 4.51)

5 Healthy ageing

Conclusion 7

The Committee concludes that the Australian Government fund research to establish reliable baseline data on obesity and longitudinal studies to track changes over time and the impact of changes on health status. (para 5.46)

Conclusion 8

The Committee concludes that the Department of Health and Ageing ensure that the expanded role of Aged Care Assessment Teams in case management include early identification and management of nutritional problems.

Nutritional problems should be included in the Aged Care Assessment Program National Minimum Data Set and reported against annually. (para 5.48)

6 Workforce participation

Conclusion 9

The Committee concludes that the Prime Minister's Community Business Partnership should explicitly advocate improving employment opportunities for older people as a component of corporate social responsibility and triple bottom line reporting by Australian employer organisations. (para 6.78)

Conclusion 10

The Committee concludes that employer organisations including government departments should voluntarily demonstrate their commitment to the employment of older people by :

- developing indicators for and reporting on improving employment opportunities for older people within their own organisations; and
- extending their corporate social responsibility activities to improving employment opportunities for older people more generally. (para 6.79)

7 Financial security in later life

Conclusion 11

The Committee concludes that a comprehensive study of the impacts of demographic compression on the capacity of families to save for retirement be undertaken jointly by the Department of Family and Community Services and the Treasury. (para 7.73)

8 Aged care and health services

Conclusion 12

The Committee concludes that the Department of Health and Ageing liaise with the state and territory agencies so that:

- the new dementia care supplement should be set at two levels, consistent with the rates for the new medium care and high care RCS categories; and

- the medium care level supplement should also be made available for the care of people with challenging behaviours who are still living in the community. (para 8.273)

Conclusion 13

The Committee concludes that, to provide a better incentive for aged care providers to provide respite care, including for people with complex high care needs, the subsidy for respite care in residential aged care facilities should be set at two levels, consistent with the rates for the new medium care and high care RCS categories. (para 8.274)

Conclusion 14

The Committee concludes that Australian Health Ministers, through the Australian Council for Safety and Quality in Health Care, should identify the care of older people while in hospital as a safety and quality priority and recommend specific actions to improve the standard of their care. (para 8.276)

9 Aged care and health services: Looking to the future

Conclusion 15

The Committee concludes that the Australian Government actively monitors funding for National Health Priorities research to ensure that by the end of 2005, at least one third of the funding priority is directed to research related to Ageing well, and ageing productively. (para 9.16)

Conclusion 16

The committee concludes that, in the next funding round, the NHMRC should give priority to research aimed at gaining a better understanding of nutrition for people aged over 65 years. (para 9.18)

Conclusion 17

The Committee concludes that the Department of Education, Science and Training should work with the Committee of Deans of Australian Medical Schools to increase the focus of the health of older people in the curriculum for under-graduate medical education. (para 9.23)

1

Introduction

The context of the inquiry

1.1 On 26 June 2002, the then Minister for Health and Ageing, the Hon Kevin Andrews MP, referred the terms of reference for the inquiry as follows:

> …to inquire into the long-term strategies to address the ageing of the Australian population over the next 40 years.[1]

1.2 Interest in the ageing of Australia's population has steadily increased since the early 1990s release of the Bureau of Immigration Research's *Australia's Ageing Population- Policy Options,* and the House of Representatives Committee for Long Term Strategies' report, *Expectations of Life*: *increasing the options for the 21st century*.[2]

1.3 In February 2002, the then Minister for Ageing, the Hon Kevin Andrews MP, released the *National Strategy for an Ageing Australia* following wide community consultation and expert advice.[3] Each State and Territory now also has an ageing strategy in place.[4]

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1 House of Representatives Standing Committee on Ageing, viewed 10/05/2004, <http://www.aph.gov.au/house/committee/ageing/strategies/index.htm>.

2 Young C, *Australia's ageing population – policy options,* Melbourne, Bureau of Immigration Research, 1990; House of Representatives Standing Committee for Long Term Strategies, *Expectations for life, increasing the options for the 21st century,* Canberra, 1992.

3 Department of Health and Aged Care, *National Strategy for an Ageing Australia: An Older Australia, Challenged and Opportunities for all*, Canberra, 2001, viewed 10/05/2004, <http://www.ageing.health.gov.au/ofoa/agepolicy/nsaa/nsaa.htm>.

4 ACT, viewed 11/05/2004, <http://www.ageing.act.gov.au/documents/pdf/macastrat.pdf>; NSW, viewed

1.4 The National Strategy was complemented by the release in the 2002-03 Budget context of the first *Intergenerational Report*. As required by the *Charter of Budget Honesty Act 1998*, the *Intergenerational Report* assesses 'the long term sustainability of current Government policies over the 40 years following the release of the report, including by taking account of the financial implications of demographic change'.[5]

1.5 During 2002 and 2003, the Senate Select Committee on Superannuation considered a wide range of matters relating to superannuation, including 'Superannuation and standards of living in retirement: the adequacy of the tax arrangements for superannuation and related policy to address the retirement income and aged and health care needs of Australians'.[6]

1.6 The Myer Foundation released *2020: A vision for aged care in Australia* in November 2002, and together with the Australian Housing and Research Institute supported a conference on 'Housing Futures in an Ageing Australia' to explore issues that need to be addressed if appropriate housing options are to be available in 2020.[7]

1.7 The National Review of Nurse Education coordinated by the Department of Education, Science and Training, included studies of the nursing workforce, including the critical issue of supply nurses for the care of the aged.[8]

6/05/2004, <http://www.maca.nsw.gov.au/pdf/strategicplan2003-4-2005-6.pdf>; NT, viewed 5/05/2004, <http://www.nt.gov.au/dcm/senior_territorians/ strategy.shtml>; QLD, viewed 5/05/2004, <http://www.communities.qld.gov.au/seniors/ publications/ index.html>; TAS, viewed 5/05/2004, <http://www.dpac.tas.gov.au/ divisions/seniors/>; VIC, viewed 6/05/04, <http://www.seniors.vic.gov.au/council.htm>; WA, viewed 5/05/2004, <http://osi.wa.gov.au/index2.htm>.

5 *Intergenerational Report 2002-03*, Budget Paper No 5, Department of the Treasury, Canberra, 2002, p iii.

6 For this report and other Senate superannuation reports see Senate Select Committee on Superannuation, viewed 10/05/2004, <http://www.aph.gov.au/senate/ committee/ superannuation_ctte/reports/index.htm>.

7 The Myer Foundation, *2020: A vision for aged care in Australia*, November 2002; Housing Futures in an Ageing Australia Conference, Melbourne, November 2002, both viewed 10/05/2004, <http://www.myerfoundation.org.au/main.asp?PageId=238>.

8 National Review of Nursing Education, jointly commissioned by the Minister for Health and Ageing and the Minister for Education, Science and Training, viewed 6/05/2004, <http://www.dest.gov.au/highered/programmes/nursing/public.htm>.

1.8 In June 2003, the Prime Minister's Science, Engineering and Innovation Council (PMSEIC) considered a paper on 'Promoting health ageing in Australia'.[9]

1.9 More recently, Emeritus Professor Warren Hogan has assessed whether the current arrangements for residential care will adequately support the Australian Government's commitment to its objectives for aged care in the future. The Australian Government responded to the *Hogan Report* in the context of the 2004-05 Budget with a $2.6 billion dollar package targeting the concerns identified by Professor Hogan as requiring immediate action.[10]

1.10 Arrangements for community care were reviewed separately and the Australian Government. The review included wide community feedback on the Government's long term vision for community care as set out in *A new strategy for community care.*[11]

1.11 In February 2004, the Treasurer, the Hon Peter Costello MP, released a discussion paper, Australia's Demographic Challenges, as the basis of community consultations. This paper proposes that improving productivity and labour force participation are key priorities in addressing ageing. It canvasses improvements in the capacity for work, through better education and health; better incentives for work; and improved flexibility in the workplace. The Treasurer also released a policy paper focussing on *A more flexible and adaptable retirement income system.*[12]

1.12 Drawing on the reports of the Senate Select Committee on Superannuation, the Investment and Financial Services Association (ISFA) and the Australian Securities and Investment Commission, the Minister for Revenue and Assistant Treasurer, Senator the Hon Helen Coonan, has established a high-level taskforce Consumer and Financial Literacy Taskforce. The Taskforce will coordinate a national approach

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9 'Promoting healthy ageing in Australia' was prepared by an independent working group of PMSEIC, viewed 15/05/2004, <http://www.dest.gov.au/science/pmseic/meetings/10thmeeting.htm>.

10 Hogan WP, *Review of Pricing Arrangements in Residential Aged Care*, Summary report, February 2002, Final report, April 2004, Canberra, viewed 11/05/2004, <http://www.health.gov.au/ investinginagedcare/summary/index.htm>.

11 Department of Health and Ageing, New Strategy for Community Care Consultation Paper, Canberra, March 2003, viewed 10/05/2004, <http://www.health.gov.au/acc/research/ commcare.htm>.

12 Department of the Treasury, *Australia's Demographic Challenges,* 2004, Canberra; Department of the Treasury, *A More Flexible and Adaptable Retirement Income System,* 2004, Canberra, both viewed 10/05/2004, <http://demographics.treasury.gov.au/content/default.asp>.

to the provision of consumer and financial information and education, which will benefit aged Australians now and in the future with simple financial decisions.[13]

1.13 Of equal importance is the thinking and planning that many community, professional and other groups are doing to help position Australians and the nation to manage the challenges and opportunities of an ageing Australia. Evidence to the Committee highlighted these contributions.

Australia's ageing population

> Ageing in Australia … is going to be big between 2020 and 2040. Why does this happen? Primarily it is because of the difference between the number of births in the 1930s and the 1940s compared to the 1950s and 1960s. That is a hundred-year timeframe we are talking about. Ageing is a long-term issue.[14]

1.14 By international standards Australia's population is still relatively young, or at most, 'middle aged'. In 2002 almost 13% of the population was aged 65 years and over. By 2042, it is expected that the proportion of people aged 65 years and over will have almost doubled to around 25%.[15]

1.15 This ageing of the population is caused by two factors: decreasing birth rates and longer life expectancy. Australian families are having fewer children. During the 'baby boom' of the early 1960s the birth rate peaked at 3.6 babies per woman but decreased steadily to 1.73 in 2001. This is well below the world's average but similar to other developed countries. Australian mothers are now around 30 years at the birth of their children – five years older than in 1971, which 'stretches out' each generation and results in fewer children over time.[16]

1.16 Should a fall in fertility to a level of 1.3 occur and happen quickly over a ten year period, as has happened in some OECD countries (Austria, Iceland, Italy, Spain and Sweden all have fertility rates of

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13 Minister for Revenue and the Assistant Treasurer, Press release, *Skilled People are the key to* success, February 2004, viewed 10/05/2004, <http://assistant.treasurer.gov.au/atr/content/ pressreleases/2004/007.asp>.

14 McDonald P, transcript 7/02/2003, p 67.

15 Australian Bureau of Statistics, *2004 Year Book,* Canberra, p 87.

16 Department of Family and Community Services (FaCS), sub 90, p 18.

approximately 1.3 children per woman[17]) there would be a profound effect on the rate of Australia's population ageing.

1.17 Australians are also living longer. Over the past century the average life expectancy of a new-born boy has increased from 55 to 77 years, and for girls from 59 to almost 83 years. By 2042 they are likely to live to around 83 and 88 years respectively.

1.18 This pattern of ageing does not apply to Indigenous Australians, nor does it apply evenly across Australia. In sharp contrast to the general population, only 3% of Indigenous people are aged 65 years and over and more than half (57%) are under 25 years of age, compared to 34% in the general population.

1.19 Within the next ten years, Tasmania will be the oldest state, replacing South Australia. One third of its population will be aged 65 years or more and the over 85 years population is likely to double by 2021 – and double again in the following 30 years.[18]

1.20 The Northern Territory, on the other hand, has a younger population, but the rate of ageing is faster with the number of people 65 and over increasing by nearly 5% in the 12 months to June 2002. Some 29% of the population is Aboriginal. Both the population as a whole and especially the Aboriginal population are highly dispersed, occupying only one-sixth of Australia's land mass.[19]

1.21 Within states, rates of ageing are influenced by the migration of certain are groups. In-migration of retirees from metropolitan or inland areas moving to coastal areas or major regional cities, from colder areas to follow the sun north, or from the mainland to Tasmania seeking lower cost housing. Out-migration of younger people and families seeking education and employment opportunities.[20]

Why is population ageing important?

1.22 Australia's total population will continue to grow even though the rate of growth is expected to fall. There will be more older people with around 6.2 million aged 65 years and over in 2042 compared to 2.5 million in 2002. Growth in the number of Australians aged over 85 years will be even more rapid, increasing from around 300,000 in 2002 to 1.1 million in 2042.

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17 Department of Immigration, Multicultural and Indigenous Affairs, sub 117, p 4.

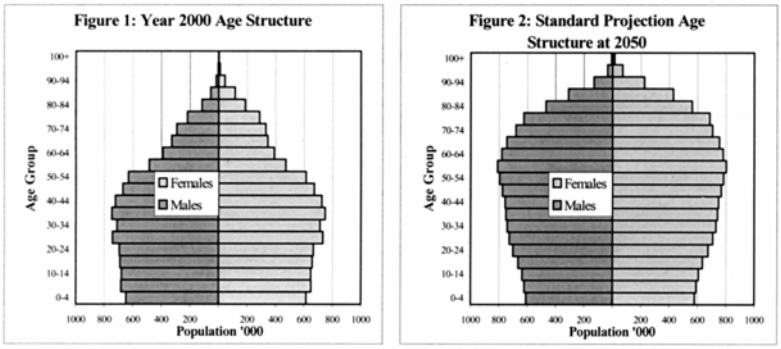
18 Tasmanian Department of Premier and Cabinet, sub 171, p 20.

19 Northern Territory Department of Health and Community Services, sub 177, p 1.

20 National Rural Health Alliance Inc, sub 131, pp 10-11.

1.23 Figure 1.1 shows the growth within respective age groups for Australia's population between 2000 and 2050. The increases in the age groups above 55 years are enormous, with some groups exhibiting more than a 200% increase over the fifty year period.

Figure 1.1: Australia's Population by Age Groups, 2000 and 2050



Source: Department of Employment and Workplace Relations, submission 164.

1.24 Traditionally, 65 has been regarded as the retirement age, the time when people shifting from earning incomes and paying taxes to living on retirement savings and/or taxpayer funded pensions. At present there are around five people of working age supporting each person aged over 65. Statistically, this is known as the 'potential support rate' and although there may be some debate around the validity of its underlying assumptions it provides a useful way of looking at the implications of an increasing number of older people.[21] By 2042, the number of people of working age supporting each person over 65 will have dropped to around 2.5.

1.25 The vast majority of older people now live healthy active lives and it is expected that future older Australians will do so too. No all people aged 65 years and over have 'retired'. Further, in 2002-03, for example, only about 10.5% of people aged 70 years and over (184,095 people) were in permanent residential aged care. With the overall projected increase in the number of older Australians over 70 years this alone could mean a significant increase in the demand for residential aged care services.

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21 The potential support rate assumes that people over 65 are not participating in the labour force and therefore require support. This assumption of dependency has been challenged: eg, McDonald P and Kippen R, 'Ageing: the social and demographic dimensions', in *Policy implication of the ageing of Australia's population*. Productivity Commission and Melbourne Institute of Applied Economic and Social Research, Melbourne, 1999, pp 47-50.

1.26 With more older people preferring to live at home with family and community support, more carers and care services will be needed. Informal care at home depends on the availability of carers: usually family members living in the same household or nearby. However, modelling by the National Centre for Social and Economic Modelling indicates that the ratio of primary carers compared with the number of older persons needing care is likely to fall significantly.[22]

1.27 With the increasing number of older people, the costs to government for age related spending such as pensions and aged care will also increase. The *Intergenerational Report* concluded that by 2041-42 Australian Government spending could exceed the amount it raises in taxes by around 5%.[23] This assumes that no changes would be made to the policies in place in 2002.

1.28 Costs will also increase for other spheres of government but data on this is not readily available.[24]

Can population ageing be changed?

1.29 Unless there is a very significant increase in the birth rate or drop in life expectancy the population will continue to age.

1.30 Increasing migration could also make a difference and, unlike the birth rate and life expectancy, immigration can be directly influenced by Government policy. However, the Committee is aware that there are differing views on the extent to which immigration can make a difference: immediate benefits to the workforce through young skilled migrants may be undercut by impacts on the environment and, in the longer run, further contribute to population ageing.[25]

1.31 Current Australian Government policy supports annual net overseas migration of between 80,000 and 100,000 of largely skilled young migrants.[26] The Department of Immigration, and Multicultural and

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22 National Centre for Social and Economic Modelling, *Who is going to care? Informal care and an ageing population*, Report prepared for Carers Australia, 2004, p 30. See further Chapter 2, Supporting carers in the community.

23 *Intergenerational report 2002-03*, Budget Paper No.5, 2002, pp 6-7; see also, *Australia's demographic challenges*, p 24.

24 Tune D, transcript 7/02/2003, p 39.

25 Department of Immigration, Multicultural and Indigenous Affairs (DIMIA), sub 117, p 4; Department of the Treasury, *Australia's Demographic Challenges,* p 20; McDonald P and Kippen R, *The impact of immigration on the ageing of Australia's population,* Discussion Paper, May 1999, p 3; Sustainable Population Australia (Canberra Region), sub 55, p 3; Catholic Health Australia, sub 94, p 19.

26 DIMIA, sub 117, p 4. Net overseas migration (NOM) equals permanent and long term arrivals minus permanent and long term departures.

Indigenous Affairs (DIMIA) referred to research showing that this level of net overseas migration makes a worthwhile impact on population ageing while higher levels are increasingly less effective.[27]

Population ageing in other countries

1.32 Australia ranks well outside the world's top ten oldest countries in terms of the median age of their populations of which Japan and Italy are the most rapidly ageing. Projections of the oldest ten countries in 2050 indicate that Australia will still remain well below the median age of these countries.

1.33 The ways in which countries respond to population ageing varies widely as do the actual impacts. The Governor of the National Bank of Belgium, in an address to the European Network of Economic Policy Research Institutes, noted that any viable solution to the population ageing crisis will be blend of three ingredients: governments getting 'their fiscal houses in order'; economic policy being geared towards increasing productivity growth and the employment rate; and careful analysis of health care spending and individual pension entitlements, both public and private. At the same time he stressed that:

> …it would be very easy, for instance, to offset the upward pressure on government spending coming from the rising number of elderly by simply reducing the average pension to a basic-needs level and to turn the health care system into a two-tier one, where public insurance is very limited and only the richest part of the population has access to new technologies via private schemes, but that would simply amount to a hollowing out of the welfare state, which our fellow citizens and myself do not wish.[28]

1.34 A recent study has shown that population ageing does not necessarily result in straightened living conditions, as is shown in Table 1.1.[29]

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27 McDonald P and Kippen R,*'The impact of immigration on the ageing of Australia's population,* Discussion Paper, May 1999, p 3.

28 Quaden G, Governor National Bank of Belgium, *Ageing and welfare systems: what have we learned?*, Introductory speech to the conference organised by CEPS in the Framework of the European Network of Economic Policy Research Institutes (ENEPRI), Brussels, 24 and 25 January 2003, viewed 14/05/2004, < http://www.enepri.org/PapersENEPRIfinalconference/ speechbyGuyQuaden.pdf>.

29 Healy J, *The Benefits of an ageing population,* The Australian Institute, Discussion Paper No 52, March 2004, viewed 14/05/2004, < http://www.tai.org.au/Publications_Files/DP_Files/ DP63%20summary.pdf>.

Table 1.1: Ten oldest countries, 2000 and 2050 (median variant)

2000			**2050**	
Country	*GDP per capita US $*	*Median age*	*Country*	*Median age*
Japan	37.544	41.2	Spain	55.2
Italy	18.500	40.2	Slovenia	54.1
Switzerland	33.303	40.2	Italy	54.1
Germany	22.814	40.1	Austria	53.7
Sweden	25.822	39.7	Armenia	53.4
Finland	23.453	39.4	Japan	53.1
Bulgaria	-	39.1	Czech Republic	52.4
Belgium	22.225	39.1	Greece	52.3
Greece	10.722	39.1	Switzerland	52.0
Denmark	30.057	38.7	Macao China	51.9
Australia	20.225	35.2	Australia	43.7

Source: UN Population Division 2001 Tables 8.14; OECD Health data 2002 (2002a) as cited in The Australia Institute, The benefits of an ageing population, 2004, p7.

The conduct of the inquiry

1.35 The chair of the Committee issued a media release launching the inquiry on 26 June 2002. The inquiry was also advertised in *The Australian* on 26 June 2002 with the closing date for submissions promoted as 30 November 2002. In addition, letters were sent to approximately 180 individuals and peak bodies, including State and local council organisations inviting them to make a submission to the inquiry.

1.36 A total of 192 submissions were received (see Appendix A) and 88 exhibits were received (see Appendix B). Submissions came from a wide-ranging representation of the nation. Contributions came from many areas: health and aged care service providers, unions and professional bodies, employers and business groups, academics, individual researchers and research organisations, lobbyists, financial institutions and financial advisers, church and religious groups, cultural and Indigenous groups, human rights and war veteran advocates, and many private individuals. All State and Territory governments, 14 Commonwealth government departments and several local governments also contributed.

1.37 To further involve the people of Australia in the parliamentary inquiry, the Committee held 18 public hearings across the country (Adelaide, Alice Springs, Brisbane, Broken Hill, Canberra, Central Coast, Coffs Harbour, Darwin, Dubbo, Lake Macquarie, Melbourne, Perth, Sydney, and Western Sydney). Some six site inspections were undertaken to

aged care facilities, a respite centre, the University of the Third Age and four organisations at Tullamore NSW involved in work with aged people (see Appendix C).

1.38 From the public hearing program, the Committee took evidence from 100 witnesses representing 88 organisations or themselves at 18 public hearings. The hearings were held between 7 February 2003 and 24 February 2004. Details of the public hearings program and the list of witnesses are at Appendix C.

1.39 Copies of the transcripts of the public hearings are available from the Committee's website or from the Secretariat.[30]

1.40 As a special feature of the inquiry and to maximise community opportunities for contributions to the inquiry, the Committee also held a total of six community forums associated with five of the public hearings (Gold Coast, Norah Head, Charlestown, Coffs Harbour, Alice Springs, Broken Hill). This allowed 127 statements to be made by members of the public, some invited, and some people volunteered. Over the course of six community forum segments, a total of 127 statements were made.

1.41 The Committee also received 17 private briefings from various Commonwealth agencies, individuals and a number of academics working in relevant fields.

1.42 During the course of the inquiry, Committee members also attended two conferences relevant to the issues. These details, together with those for the public hearings, community forums and private briefings appear in Appendix C.

Scope and structure of the report

1.43 The terms of reference for this Inquiry are very broad. In view of this and the wide-ranging activity noted above, the Committee has considered ways to focus this Report while acknowledging the wealth of information and concerns put to it for consideration.

1.44 Evidence put to the Committee fell into two broad categories: discussion of strategies for the longer term and concerns about matters affecting older Australians now.

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30 House of Representatives Standing Committee on Ageing, <http://www.aph.gov.au/house/ committee/ageing/strategies/index.htm>.

1.45 The Committee decided that it would be timely to focus the report on assessing whether individuals and communities are aware of the various long term strategies being promoted through such activities as those listed above, and whether more needs to be done before there are strategies that are widely owned and acted on.

1.46 The Committee appreciates that the problems identified as facing older individuals and communities here and now are real problems and greater efforts to address them must be made by all sectors of society.

1.47 The following chapters deal with the strategies put forward in evidence to the Committee and in other sources available to the Committee

- Age friendly communities
- Ageing with dignity
- Housing and transport
- Healthy ageing
- Workforce participation
- Financial security in later life
- Aged care and health services
- Aged care and health services: looking to the future

1.48 Within these chapters, three additional themes are covered: Indigenous and rural and remote issues, and the need for research across the spectrum of issues relevant to the ageing of the Australian population.

1.49 Throughout the report the Committee has sought to emphasise that preparing for the challenges of the next forty years is a shared responsibility. Governments and communities have responsibilities to remove barriers to maximising the benefits of an ageing population, and to foster positive environments in which individuals and their families can continue to make a positive contribution. Each individual, too, must plan for their future as part of Australia's ageing population – planning that encompasses health ageing, continuing engagement in work and the community, and financial security in later life.

2

Age friendly communities

> We should not be penalising people for ageing, but rather emphasising what they can do.[1]
>
> …we should be harnessing the goodwill and energy of the community to contribute to an effective partnership of shared responsibility …[2]

2.1 The Committee heard evidence stressing the importance of the social networks that foster age friendly communities, kinship and family networks, neighbours and friendship groups, and formal and informal community groups more broadly.

2.2 This is demonstrated by the approach being developed by a group of local government authorities in the western suburbs of the Perth Metropolitan Area:

> Positive ageing is…very much related to the creation of an a*ge-friendly community*, or the creating of a community which facilitates older people's participation and involvement in the community.
>
> … an *age-friendly community* is one in which the broad environment (structures, facilities, services, and attitudes) is supportive and enables people to develop and maintain strong community ties and participate at the level of their choosing.[3]

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1 Voloschenko S, transcript 7/03/2003, p 260.

2 Warn P, sub 26, p 28.

3 Western Suburbs Regional Organisation of Councils (WESROC), *Building strong communities through positive ageing,* Report of the WESROC Seniors' Needs Study, A project to encourage positive ageing in place, Exhibit 8. The report is also available at: <http://www.claremont.wa.gov.au/wesroc_senior_study.html>, p 6.

2.3 The Committee agrees that approaches encompassing individuals, families and their communities are necessary – with 'communities' being seen as including the built environments in which they live, their workplaces, businesses and social environments.

2.4 A wealth of information was presented to the Committee indicating the breadth, complexity and inter-relatedness of the issues involved. The evidence also gives insights into the ways in communities for an older Australia are being planned for and fostered right now.

2.5 In this chapter the Committee considers:

- the strategies that are being adopted to foster age friendly community environments;
- the increasing importance of lifelong learning and whether provision is adequate for future needs; and
- the contribution carers make to the community and the support given to carers by their communities.

2.6 The role of age friendly housing and transport in supporting the independence of older people, and the ongoing challenge of ensuring that older Australians continue to age healthy and are treated with dignity, are examined in subsequent chapters.

Promoting age-friendly community environments

2.7 The Committee was impressed by the role some local governments are playing in creating community environments that foster connectedness and social networks that contribute to well-being. Dr Silcox pointed out that local government is '…looking at creating social capital in their own area…' through '…communities that are well networked and well linked'.[4]

2.8 This is typified by the *Building strong communities through positive ageing* study developed by the Western Suburbs Regional Organisation of Councils (WESROC) and its constituent councils in the western suburbs of the Perth Metropolitan Area.[5] As representatives of participating Councils put it to The Committee, the WESROC report had crystallised for them

4 Silcox S, transcript 29/04/2003, pp 420-1.

5 Lee Phillips and Associates, *Building strong communities through positive ageing*, Report of the WESROC Seniors' Needs Study: A project to encourage positive ageing in place, July 2002, Exhibit 8, <http://www.claremont.wa.gov.au/wesroc_senior_study.html>, p 2.

that what is good for the community is good for older people – and that older people are 'actually part of society'.[6]

2.9 The Kingston City Council sees local government as having a major role in ensuring 'liveability' for all age groups through the design of their urban landscapes:

> We will be particularly concentrating on the older age groups and saying: 'What is it about a particular community or a particular area that makes it more or less liveable and how do we [improve liveability], through the provision of infrastructure, through simple things like making what they call pram crossings on footpaths accessible so there are no tripping points?'[7]

2.10 Not all issues are easily solved as they can be caught in conflicting policies involving different levels of government. Mr Burgess stated:

> Our engineers build wonderful roundabouts, but they have no regard for the aged person who will eventually walk across a flow of traffic which is possibly travelling at high speed. … we need integrated transport planning strategies taking a whole of government approach.[8]

2.11 Another innovative approach is being taken by the Central Coast Quality Ageing Planning Consortium, NSW, building on input from the community. Rather than waiting for the State Government or the Australian Government to initiate action, the Consortium is facilitating more responsive transport arrangements, improving information and how it may be accessed and actively exploring ways to integrate funding, coordinate services and care, providing support for carers, and enhancing living environments.[9]

2.12 Community input to the Consortium demonstrated clearly that many people are ill-prepared for life in retirement and this may be exacerbated by shifting locations at the time of retirement. Stress can arise from missing work, concerns about personal health, and relationship issues.[10] Central Coast Quality Ageing Planning lays much emphasis on retirement planning, on preparing for 'Starting Life Over After Work' -- not the

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6 Turner S and Silcox S, transcript 29/04/2003, pp 423-4.

7 McCullough T, transcript 31/3/03, p 339.

8 Burgess E, transcript 24/02/2003, pp 110.

9 Central Coast Area Health, sub 125, p 16; Blackwell J, transcript 24/02/2003, p 88.

10 Davies M, 'The impact of relocation following retirement on well-being', in *Maximising the Impact on Policy and Practice,* Proceedings of ERA 2003, Conference for Emerging Researchers in Ageing, Australasian Centre on Ageing, The University of Queensland, Brisbane, 2003, p 17.

financial side but about 'what you are going to do … and how your relationships … are going to be affected…'. [11]

2.13 The Aboriginal and Torres Strait Islander Commission (ATSIC) stressed to the Committee the importance of improving capacity building in Indigenous communities where people may not have opportunities to contribute in a meaningful way. ATSIC suggested that, in areas where there is effectively no labour market, CDEP could be better focussed to foster community participation, to focus on 'How do you contribute to what is happening in your community'. The Peninsula Regional Council, Cape York, is taking this approach looking for increased school attendance, and addressing issues such as family violence and looking after houses. [12]

2.14 In this respect, the Committee notes the House of Representatives Standing on Aboriginal and Torres Strait Islander Affairs has recently tabled its report into Capacity Building in Indigenous Communities, a report that made several recommendations on the subject of community programs and service delivery to Indigenous Australian communities. The recommendations recognise, among other things, the need for, and value of, training and mentoring programs in building capacity in Indigenous communities. The report recommended that:

> … the Commonwealth Government:
>
> - promote and further develop initiatives such as Indigenous Community Volunteers to enhance mentoring and skills development in Indigenous communities and organisations; and
> - take a leadership role in encouraging partnerships and joint ventures between the private/corporate sector and Indigenous communities, organisations and individuals. [13]

2.15 Older Australians from culturally and linguistically diverse backgrounds (CLDB), may feel socially isolated due to the communication problems which result from low levels of English language proficiency, loss of acquired English language skills with increasing age, or in some cases illiteracy in their own language. The Federation of Ethnic Communities Councils of Australia stressed to the Committee that more culturally and

11 Blackwell J, transcript 24/02/2003, pp 86-103; Burgess E, transcript 24/02/2003, pp 106-8; Health & Aged Care Roundtable, Isaacs, sub 105, p 4.

12 Gooda M, transcript 7/03/2003, pp 203-4.

13 House of Representatives, Standing Committee on Aboriginal and Torres Strait Islander Affairs, Many ways forward: Report of the inquiry into capacity building and service delivery in Indigenous communities, Canberra, 2004, p 163. For further information of the Community Volunteer Program see Chapter 6.

linguistically appropriate community planning and services would better serve the needs of CLDB people.[14]

2.16 Older people themselves play a critical role in fostering social networks and connectedness. The Committee heard many stories of the two-way benefits flowing from older people's engagement in mentoring, 'grandparenting', volunteering (discussed in chapter 6), and active involvement in University of the Third Age (U3A).[15]

2.17 At school in the small farming community of Lock on the Eyre Peninsular history comes to life:

> In our school we have a senior farmer who is still living on his property at …94 I think he is. He has been in the area sever since he was a very young man … and he goes and tells stories. It is like a history lesson to the children, once a week, and it is great interaction. They just love the day that Mr Mellor comes to tell of the history of the area and the advances that have been made in those 70-odd years. [16]

2.18 Centrelink staff have personally contributed to social activities within their community to help aged Australians overcome isolation. Some have become involved in supporting community agencies, assisting with daily calls to check on the well-being of elderly people, and activities that assist older people to bridge the digital divide.[17]

2.19 Community interaction assists older people to maintain social links, stay physically active and stay mentally, emotionally and physically healthy. Older Australians who are actively engaged in their community and have purpose and meaning in their life are healthier on average and, according to the Dubbo study, may be less at risk of entering residential aged care.[18]

Encouraging lifelong learning

> [Lifelong learning] is not just related to specific vocational training or education, which of course is important—as the nature of work

14 Federation of Ethnic Communities Councils of Australia, sub 140, p 2.

15 Cross J, transcript 28/04/2003, pp 382- 388; Burgess E, transcript 24/02/2003, p 113.

16 Lally P, transcript 28/04/2003, p 377.

17 Centrelink, sub 78, p 24.

18 McCallum J, Simons L and Simons J, 2003, *The Dubbo Study of the Health of the Elderly*, Australian Health Policy Institute, Commissioned Paper series 2003/06, pp 42- 46.

> is changing, people do need opportunities to learn and develop new skills and knowledge—but also related to what effect learning has in relation to general engagement, health and maintenance of your participation. Learning assists in that whole process and assists in making you remain part of the community.[19]

2.20 Evidence to the Committee indicated a strong understanding of the need for lifelong learning and the contribution it can make to building people's capacity for economic and social participation.

2.21 The need for lifelong learning was promoted by organisations concerned with maintaining workforce participation,[20] agencies from all spheres of government,[21] adult learning and University of the Third Age organisations,[22] community organisations and individuals.[23] The learning needs mentioned in evidence varied from wanting to feel more confident using computers and ATMs, to subjects that help older people grapple with the meaning of life.[24]

2.22 The sense of achievement to be gained through lifelong learning was demonstrated by the man who sent to the Committee his first letter created after learning to use a computer, saying how he had found it 'mentally stimulating'.[25]

2.23 Evidence to the Committee emphasised the need for wide-ranging opportunities from the informal and opportunistic, to activities that help bridge gaps or open up new experiences and structured learning leading to formal qualifications. In each of these contexts the value of older people passing on their learning from experience was raised. At the same time the need for better articulation of these opportunities was identified, with more emphasis to be laid on the recognition of prior learning and experience.[26]

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19 Reeve P, transcript 20/05/2003, p 518.

20 Australian Industry Group, sub 110 p 6; Australian Council of Trade Unions, sub 107, pp 5-7.

21 Lgov NSW, sub 89, p 11; Department of Family and Community Services (FaCS), sub 90, pp 39-40.

22 University of the Third Age (U3A), City of Melbourne Inc, sub 44, p 2; Cross J, transcript 28/04/2003, pp 382-87; Adult Learning Australia Inc., sub 100, pp 1-4.

23 Bertram L, transcript 28/04/2003, p 375.

24 Reeve P, transcript 20/05/2003, pp 518-19; Bertram L, transcript 28/04/2003, p 368; Cross J, transcript 28/04/2003, p 384.

25 Coleman R, sub 190, p 1.

26 Council on the Ageing (COTA), sub 91, pp 25-26; FaCS, sub 90, p 13; Lgov NSW, sub 89, p 11; Bertram L, transcript 28/04/2003, p 375; ACTU, sub 107, p 7; Australian Industry Group, sub 110, p 6.

2.24 The critical role of lifelong learning in helping to maintain workforce participation will be covered in Chapter 6 and the need for improving and maintaining financial literacy in Chapter 7.

2.25 Initiatives to promote lifelong learning vary across each State and Territory and include partnerships and linkages with educational institutions and private sector employers. A major partner in theses activities is the network of University of the Third Age (U3A) organisations.[27] The Council on the Ageing (COTA) suggested to the Committee that the Australian Government should place much stronger and explicit policy emphasis on lifelong learning and education for older people.[28]

2.26 The Committee notes that there is a growing interest in lifelong education policy at the national level and that, given the nature and scope of lifelong education, policy development is multi-pronged:

- Research on lifelong learning has been commissioned by the Department of Education, Science and Training and national consultations have sought to gain a better understanding of the needs of adult learners.[29]
- In relation to vocational education and training, Shaping Our Future: Australia's National Strategy for VET 2004-2010, acknowledges the need to 'balance the focus on training young people for work with the retraining needs of existing and older workers', with greater emphasis on lifelong learning.[30]
- The Minister for Education, Science and Training in November 2003, released a discussion paper, titled 'You Can Too: Adult Learning in Australia. The paper seeks views and recommendations on how governments, business and the wider community can work together to

27 University of the Third Age, Hobart Inc, sub 3, p 1; University of the Third Age Incorporated, Sydney, sub 10, p 1; University of the Third Age, City of Melbourne Incorporated, sub 44, p 5;

28 COTA, sub 91, pp 25-6. COTA's submission was received in November 2003.

29 Research reports commissioned by the Department of Education, Science and Training (DEST) include: Chapman J et al, *Lifelong Learning and Teacher Education*, Executive summary, viewed 6/05/2004, <http://www.dest.gov.au/highered/eippubs/eip03_4/default.htm>; Watson L, *Lifelong Learning in Australia*, viewed 6/05/2004, <http://www.dest.gov.au/highered/eippubs/eip03_13/default.htm>. Information on the consultations may be accessed at <http://www.dest.gov.au/ucan2/Default.htm>.

30 Australian National Training Authority, *Australia's National Strategy for Vocational Education and Training 2004-2010*, viewed 29/05/2004, <http://www.anta.gov.au/images/publications/national_strategy.txt>, p 3.

support adult learning and to coordinate Australia's efforts for the benefit of all involved.[31]

2.27 Information and communications technology is rapidly changing the way we look at and participate in education and training. The Department of Education Science and Training (DEST) is conducting a review into Australia's Future Using Education Technology. The review will examine the current users and providers of education technology as well as examining future applications. A particular focus will be placed on the needs of Indigenous Australians as well as access for remote/regional Australians. This review may be useful if it could be further examined in an ageing context.[32]

2.28 Educational technology is emerging as an important part of lifelong learning. The Unlimited Potential Programme[33] aims to support more than 75 technology learning centres located in rural and urban areas throughout Australia. The programs objective is to help improve lifelong learning opportunities for disadvantaged Australians by providing people with access to computer technology, education and training irrespective of age, background, education, location or socio-economic status.[34]

2.29 Recent research commissioned by DEST, examined the shifting emphasis of national lifelong learning policy. In the late 1990s focus was on the contribution of lifelong education to the nation's economy. Then on the contribution to the economic well-being of the individual, and most recently, to the notion that lifelong learning also contributes to the social well-being of individuals and the community.[35] The Committee considers that all three of these perspectives, together, should inform lifelong learning policy as the Australian population ages.

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31 Department of Education, Science and Training, *You Can Too: Adult learning in Australia, November 2003,* p 3.

32 Department of Education, Science and Training, *Australia's Future Using Education Technology,* viewed 28/06/2004, <http://www.dest.gov.au/afuet/default.htm>.

33 Developed as a community partnership between Microsoft, the Smith Family, Australian Seniors Computing Clubs, Work Ventures, Yarnteen and the Inspire Foundation.

34 Microsoft Australia, *Unlimited Potential Programme,* viewed 29/06/2004, <http://www.microsoft.com/australia/corpaffairs/corpcit/community/up.aspx>.

35 Chapman J, et al, *Lifelong Learning and Teacher Education*, Executive summary, viewed 6/05/2004, <http://www.dest.gov.au/highered/eippubs/eip03_4/default.htm>.

Supporting carers in the community

> Older people are encouraged to remain in their own homes for as long as possible rather than be admitted inappropriately into residential care. Informal carers take on the main impact of that care in the community. They provide an invaluable service to the community, with very little recognition.[36]

2.30 Evidence to the Committee shows that some 2.3 million people, family members, friends and neighbours provide unpaid care at home. Of these, an estimated 125,300 primary carers provide help to people aged 65 years and over. In the Northern Territory, for example, around 4,700 people have primary caring responsibilities though this is thought to be much lower than the actual number of carers. In Indigenous communities there may be up to three times the number in the general community given the high rate of morbidity.[37]

The demands of caring

2.31 Carers Australia referred to research which indicates that while care giving can reduce the well being of carers, strong personal and social networks together with greater economic resources can help offset the impacts. Negative effects on wellbeing were more likely for carers aged under 50 and for women. Indigenous carers face the same issues as other carers but with the issues intensified by isolation, poverty, language, lack of services, family breakdown, and cultural confusion.[38]

2.32 The demands of caring are becoming more complex. As families are having children later, an increasing number of women (in particular) are simultaneously caring for children and for ageing parents or other older people. Many carers themselves are ageing so that they find caring more arduous especially if, for example, they are caring for an ageing son or daughter with disabilities, or someone with dementia and challenging behaviours – a trend that may increase in the future as the population ages.[39]

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36 Lusty E, transcript 2/02/2004, p 714.

37 Carers Australia, sub 77, p 1; NT Carers Association Inc, sub 179, p 2; Simmons L, transcript 3/02/2004, p 771.

38 Carers Australia, sub 77, p 8; NT Carers Association Inc, sub 179, p 2; Older Women's Network (Australia) Incorporated, sub 59, p 2.

39 Waverley Council (NSW), sub 73, p4; Australian Institute of Health and Welfare (AIHW), *The future supply of informal care 2003 to 2013*, AIHW catalogue no. AGE 32, October 2003, pp 2, 32; Flanagan K, transcript 7/02/2003, p 16.

2.33 Other evidence to the Committee pointed to a reluctance to use 'outside' help, whether from outside the family or, in cultures where cultural taboos are involved and/or children feel a strong obligation to personally look after parents, the assistance of people from other cultures.[40]

Future availability of carers

2.34 In attempting to model the availability of primary carers in the future, the Australian Institute of Health and Welfare (AIHW) concluded that the interplay of factors likely to influence availability is 'substantially more complex than is often thought'. Taking into account the contributions of additional carers and the relationships between primary carers and additional carers increases the complexity. It also highlights the importance of extended informal support networks, which in turn are 'dependent on the availability of relevant formal services and programs and on policies that facilitate broader community support'.[41]

2.35 Modelling by NATSEM calculated a ratio of older persons needing care (ie, persons aged 65 and over, with a severe or profound disability *and* living in private dwellings) to persons likely to provide care. This ratio projects a fall in the ratio between 2001 and 2031 from 57 primary carers for every 100 persons needing care to 35 carers for every 100 persons (see Figure 2.1). In consequence, by 2031, the percentage of older persons in private dwellings needing care but without a primary carer is projected to grow from 43% (152,000 persons) to 65% (573,000 persons).[42]

2.36 The availability (or lack) of carers can depend on factors specific to some locations. In the Northern Territory and Broken Hill, for example, there is an increasing number of older people without family: single men who may have worked out bush or in the mining towns; couples whose children have moved to the city.[43]

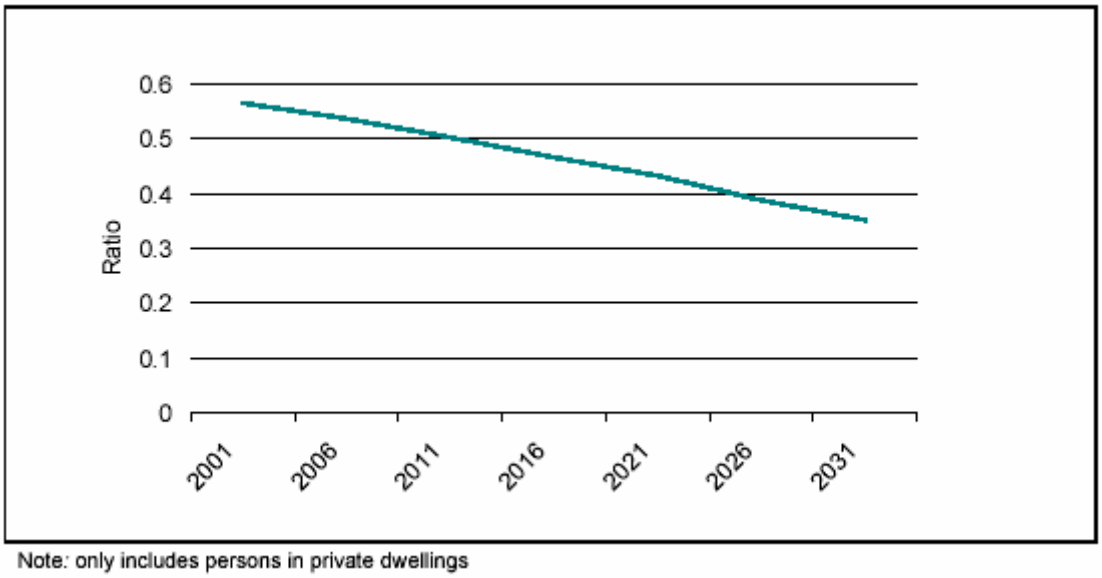
40 Ross I, transcript 4/07/2003, p 659; Waverley Council (NSW), sub 73, p 4; Mahajani S, transcript 3/02/2004, pp 791-2.

41 AIHW, *The future supply of informal care 2003 to 2013,* AIHW catalogue no. AGE 32, October 2003, pp 31-32, 34; Carers Australia, sub 77, p 10; Lusty M, transcript 2/02/2004, p 715.

42 NATSEM, *Who's going to care? Informal care and an ageing population,* pp 30-31.

43 McKell J, transcript 3/02/2004, p 774; Phillips C, transcript 3/02/2004, p 778; Flecknoe-Brown S, transcript 24/02/2004, p 840; Carter A, transcript 24/02/2004, p 848.

Figure 2.1: Projected ratios of carers to persons aged 65 and over with a severe or profound disability and living in private dwellings, Australia 2001-2031



Source: NATSEM, Who's going to care? Informal care and an ageing population, p30.

2.37 NATSEM also noted recent research indicating that the supply of carers may be limited due to people's desire to remain in the workforce. [44]

2.38 In light of evidence on the ageing of the population, the need to increase workforce participation and the growing number of people caring for both young children and elderly relatives, the Committee is concerned that it might not be possible to continue to be caring communities to the same extent as now.

2.39 Carers wanting to return to the workforce are supported by the Transition to Work program. This program is available to carers who have been unemployed for at least two years and aims to assess skills and identify training needs of carers. Arrangements for the Carer Payment also encourage continuing participation in work, study or training. Recipients can be involved in these activities for up to twenty hours a week without their access to the Carer Payment being affected. Ms Austin suggested that the twenty hour limit may need to be reviewed.[45]

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44 NATSEM, *Who's going to care? Informal care and an ageing population,* p 10.

45 Centrelink, Returning to work when you stop being a carer, viewed 6/08/2004, <http://www.centrelink.gov.au/internet/internet.nsf/individuals/carer_work.htm>; Commonwealth Carer Resource Centre, transition to work, viewed 6/08/2004, <http://www.carernse.asn.au/infosupport/facts/Other/fstransitionwork.htm>; Austin J, transcript 7/03/2003, pp 255-256.

2.40 Comparisons were drawn in evidence between the different attitudes and policy responses to parenting and child care on the one hand, and caring for the elderly which appears to be regarded as 'a private matter [to be] managed within families'. In this context, the attention of the Committee was drawn to the need for attitudinal changes in workplaces to allow flexibilities for people with caring responsibilities (see further, chapter 6).[46] Another area of comparison related to elder abuse: physical, mental and financial. While there are now mandatory reporting requirements in each State and Territory for child abuse, there are no similar arrangements for elder abuse (see further 'Ageing with dignity').[47]

2.41 Attention was repeatedly drawn to the importance of carer payments and carer support programs such as the Carer Respite Program, and the support provided by Community Aged Care Packages and Home and Community Care services. Even so, the adequacy of these measures was questioned:

> …we urge you not to fall into the trap of considering family carers as an unlimited and free work force. They are there and they are happy to provide care to family members, but they need support.[48]

2.42 The Committee notes that Australian Government funding and the range of supports have been substantially increased in recent years. In the 2004-05 Budget, funding is being provided for the development of a quality assurance framework for community care programs including the National Respite for Carers Program. The carer allowance is being extended to people who provide at least 20 hours of daily-personal-care per week, but do not live with the person for whom they care. It is estimated that this will provide assistance to an additional 13,270 carers.

2.43 At the same time, there is a danger that as the range of support services increases they are poorly integrated, adding to the confusion and frustration already experienced by many carers.[49]

2.44 The Committee is concerned that there is very little in the way of training for carers. Some training is provided by Carers Australia but availability varies considerably from state to state. Alzheimers Australia also provides

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46 NT Carers Association Inc, sub 77, p 10.

47 Mahajani S, transcript, 3/02/2004, p 791; Australian Institute of Health and Welfare, *Child Protection Australia 1996-97*, Appendix 4, pp 80-81, viewed 13/07/2004, <http://www.aihw.gov.au/publications/welfare/cpa96-7/>.

48 National Aged Care Alliance, sub 88, p 6; Halliday G, transcript 3/02/2004, p 769.

49 Malak A, transcript 7/03/2003, p 259; *Budget Measures 2004-05*, Budget Paper No.2, p 160, viewed 20/07/2004, <http://www.budget.gov.au/2004-05/bp2/download/bp2.pdf>.

training in dementia care. The Committee notes that Carers Australia is developing a training program for new carers and the NT Carers Association Inc is developing a training program for Indigenous carers. Another promising move is that the National Health and Medical Research Council (NHMRC) is beginning to direct more funding to ageing research, with a current study assessing how well health and community services support people with dementia and reduce the burden on their carers.[50]

2.45 Indigenous carers in communities in Central Australia may not get the support possible from such services and initiatives. In a town camp it is almost impossible to get help at home so informal carers carry the load. At Utopia where the traditional custom of taking care of each other continues, the people who need support 'are the grandmothers and grandfathers who are taking care of the 30- to 40- year-old aimless people' in the community.[51]

2.46 Communities in various ways are also putting in place supports for carers. For example, providing day care for dementia patients; support groups for carers; and Legacy and the local RSL helping to care for war widows and single returned soldiers. The NT Carers Association Inc has demonstrated that innovative and culturally appropriate approaches to support for remote Indigenous carers are possible. The Responsive Respite Program involves 'two Toyota troop carriers with a trailer and camping gear going to communities' for a month's stay. In addition to respite, education and information are provided, and carers or their families are taken to ceremonies, camping, fishing or on back-to-country camp outs.[52]

2.47 The Committee concludes that appropriate support is critical to maintaining the willingness of people to be carers and the quality of care they provide. The development of quality assurance system for community care programs, and the development of training for carers should both contribute to better support for carers.

2.48 Increasing reliance on care in the community makes it all the more imperative that the proposed quality assurance system for community care programs is developed and put in place as a matter of priority. The Committee considers that the quality assurance system must address the

50 Jones D, transcript 24/02/2004, p 858; Simmons L, transcript 3/02/2004, p 772; National Health and Medical Research Council (NHMRC), sub 130, p 3.

51 Dennis L, transcript 2/02/2004, p 729-30; Kunoth-Monks R, transcript 2/02/2004, p 737.

52 Kennedy M, transcript 23/02/2004, p 820; Waverley Council (NSW), sub 73, p 4; Vickers W, transcript 24/02/2004, pp 859-61; Simmons L, transcript 3/02/2004, p 771.

support provided to carers both directly by the National Carer Respite Program and through the provision of Community Care Packages.

Summing up

2.49 Positive ageing is very much related to the creation of age friendly communities that facilitate people's participation and involvement in the community.

2.50 The Committee was impressed by the role some local governments and communities are playing in reassessing their community environments in light of the aging of the population. Many are realising that what is good for older people is good for the community: improving 'liveability', brokering more responsive transport arrangements, improving information and how it may be accessed, and exploring ways to integrate funding, coordinate services and care, encouraging lifelong learning, and enhancing living environments.

2.51 Involvement in the community assists older people to maintain social links, stay physically active and stay mentally, emotionally and physically healthy. Older Australians who are actively engaged in their community and have purpose and meaning in their life are healthier on average and may be less at risk of entering residential aged care.

2.52 While the value of lifelong learning is actively encouraged in many communities, the Australian Government has been slow to provide support. Recent initiatives are promising but are still in their early stages.

2.53 The Committee concludes that appropriate support is critical to maintaining the willingness of people to be carers and the quality of care they provide – especially as the demands of caring are becoming more complex

2.54 The development of a quality assurance system for community care programs, and the development of training for carers should both contribute to better support for carers.

2.55 Increasing reliance on care in the community makes it all the more imperative that the proposed quality assurance system for community care programs is developed and put in place as a matter of priority. The Committee considers that the quality assurance system must address the support provided to carers both directly by the National Carer Respite Program and through the provision of Community Care Packages.

Conclusion 1

2.56 **The Committee concludes that the Department of Health and Ageing should ensure that the proposed quality assurance system for Australian Government funded community care programs covers the support provided to carers both directly by the National Carer Respite Program and through the provision of Community Care Packages.**

3

Ageing with dignity

> Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.
>
> Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.[1]

3.1 Evidence to the Committee raised issues around people's fears of losing control of their lives – of no longer being able to maintain their sense of personal dignity. The Committee also heard about the ways in which families, communities and governments may contribute to such fears, or respond to them.

3.2 The issues put before the Committee are complex and sensitive. They range from the practice and impacts of discrimination on the basis of age, to the personal, ethical, moral and legal aspects of end of life issues. Facing these issues can increase older people's fears of losing their dignity and result in distress for families, carers and professionals providing aged care and health services. It also provokes community and legal debate about who has the right to make decisions on behalf of those older people who can no longer make their own decisions.

3.3 This chapter first looks at the community and professional attitudes held about ageing and older people and the discrimination directed at older people which, in their more extreme forms, constitute elder abuse. Issues raised about age discrimination, safety in the

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1 United Nations Principles for Older Persons 1999, viewed 24/05/2004, <http://www.un.org/esa/socdev/iyop/iyoppop>. Also cited in Older Women's Network (Australia) Inc, sub 58, p 21; Australian Medical Association Ltd, sub 86, p 11.

community and elder abuse are then discussed. Finally, evidence regarding the practical steps people can take to protect their assets, their person, and respect of their wishes is presented.

Are attitudes to ageing changing?

> I teach speech pathology students, and every semester I have about 100 speech pathology students sitting in front of me. I start off by putting the word 'ageing' on the board and I ask them to freely associate with the word ageing. Every word is negative: wrinkles, grey, senile, forgetful—there are no positive words that come through their mouths.
>
> … These are speech pathology graduates who are going to be in management positions and who will be employing people…[2]

3.4 Some positive indications of changes in attitudes to ageing and older people were included in the previous chapter on 'Age friendly communities' among others, the joy of children listening to living history stories from a district pioneer; and the realisation that seniors are actually part of society.

3.5 But the Committee also heard that the attitudes of speech pathology graduates referred to above are typical of those still held by many Australians and many health aged care professionals. Negative attitudes to older people and reluctance to address the ageing of the population persist among individuals of all ages, within organisations and within governments.

3.6 The issue of attitudes is broad, encompassing attitudes to the ageing process, attitudes to the older population, attitudes to older individuals as well as individuals' attitudes to their own ageing.

3.7 Only some small progress appears to have been made since research on community attitudes to ageing and older people was undertaken as part of the development of the *National Strategy for an Ageing Australia*. That research showed:

- the public perception of older people is fairly negative;
- older people by and large are felt to lack value and potential;
- media portrayal is often unfair and unkind to older people; and

2 Worrall L, transcript 20/05/2003, p 507.

- the expectations of the future for older people (and for younger people when they become older) are relatively bleak and pessimistic.[3]

3.8 These impressions of older people by all ages of Australians have been diagrammatically represented as follows:

Figure 3.1: Impressions of older people, by all ages of Australians

Source: http://www.seniors.gov.au/nacoa/attitudes.htm

3.9 The research for the development of the *National Strategy* also emphasised that images of ageing are presented as a matter of extremes, with older people being portrayed as extremely active or as dementia suffers (frail and mentally fading). In reality, neither is a true picture of most older Australians.[4]

3.10 Evidence to the Committee made clear that there is continuing concern about the impacts of negative attitudes on the Australian community and on older people's desire to maintain their sense of personal control and dignity.

3.11 Dr Silcox, of the City of Nedlands WA, was concerned that in the face of strident expressions of inter-generational envy, older people found it difficult to put forward their views:

> …it was not an environment that seniors felt comfortable in to stand up and say: this is what I want and these are the reasons I want it, when they have an aggressive young person standing there demanding: 'They have had the luxury of

3 Di Marzio W, *A research report on community attitudes towards ageing and older people,* 1999, viewed 27/05/2004, <http://www.seniors.gov.au/nacoa/attitudes.htm>.

4 Di Marzio W, *A research report on community attitudes towards ageing and older people,* 1999, viewed 27/05/2004, <http://www.seniors.gov.au/nacoa/attitudes.htm>.

> bringing their children up on quarter acre blocks. We should have the same luxury.'[5]

3.12 That negative attitudes can erode older people's sense of worth, replacing it with fear of being a burden was emphasised by the Social Issues Executive of the Anglican Diocese of Sydney:

> … Perceptions that aging is an illness or that people reach a 'use by date' are unhelpful. … the elderly are fearful of becoming a 'burden' on those around them. This is a sad indication of the unhealthy attitudes held about what makes life worthwhile. [6]

3.13 Negative attitudes may in part arise from lack of understanding and fear of ageing. Even so, they can further diminish the dignity and worth of older people:

> Ageism … has generated and reinforced fear and denigration of the aging process, and has given rise to negative stereotypes and presumptions regarding the incompetence and dependence of older [people]. …the dominant stereotypes which imply that ageing equals debility, have largely eroded the images of wisdom, power, benevolence and respect which were once associated with elders.[7]

3.14 In contrast, Mrs Kunoth-Monks, told the Committee of the respect in which her community elders are held:

> … We have a group of elders who to us are priceless. I am happy to say I am included as one of them. These elders hold together the age-old songs, the land and the ceremonies through their continuing knowledge, which was handed to them verbally and not in written form …[8]

3.15 Despite negative community attitudes to ageing, the research for the development of the *National Strategy for an Ageing Australia* found that most older individuals have a positive attitude to their own ageing. This finding was echoed in evidence to the Committee.[9]

3.16 Professor Andrews reminded the Committee that there is a long way until there is a general shift in attitudes:

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5 Silcox S, transcript, 29/03/2003, p 426.

6 Social Issues Executive, Anglican Diocese of Sydney, sub 67, pp 3-4; see also Morrison R, sub 189, p 4.

7 The Aged-care Rights Service, sub 87, p 10; see also Lgov, sub 89, p 4.

8 Kunoth-Monks R, transcript 2/02/2004, p 734.

9 Di Marzio W, *A research report on community attitudes towards ageing and older people,* 1999, viewed 27/05/2004, <http://www.seniors.gov.au/nacoa/attitudes.htm>; Jones D, transcript 24/02/2004; Holmes B, transcript 4/07/2003, p 650.

> …The National Strategy for an Ageing Australia is a step in the right direction – no doubt about that – but it is more about words than action, and we need to explore steps that can be taken in terms of shifting public perceptions and understanding.[10]

3.17 While negative attitudes continue, there is a danger that older people will be treated like second-class citizens. The worse manifestations of negative attitudes give rise to discrimination and elder abuse.

3.18 The Centre for Ageing and Pastoral Studies referred the Committee to research which reported that fear and no longer being in control are major issues for many older people. People want to have control of their life, including their end of life:

> We have now added years of life, but for numbers of older people, these added years may have no meaning. Fear of future vulnerability and no longer being in control were major issues for many of the independent living older people interviewed.[11]

3.19 Concerns about loss of control may be triggered or increased by acts of discrimination just because a person is getting older.

3.20 As people age and become more dependent on others, they may have less control over their destiny and are more open to being taken advantage of, or becoming the victim of abuse by others. It should be borne in mind however that Australian and overseas studies, indicate older people are less likely to be a victim of crime (robbery, theft, fraud, rape and homicide), than are younger people.[12] Even so older people's concerns and their fear of losing control over their personal dignity are real.

3.21 Families and the community have a responsibility to support older people's desire for dignity. As a society, Australia is only beginning to grapple with these issues. As Dr Mahajani stated to the Committee:

> We have postponed dealing with end of life issues as being too difficult but increasingly healthy elders are coming forth wanting to ask questions and [seek] information.[13]

3.22 To date, public debate has often focussed on euthanasia and this was raised with the Committee (see below). However, the issues are much

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10 Andrews Prof, transcript, 28/04/2003, p 357.

11 Centre for Ageing and Pastoral Studies, sub 167, p 2.

12 Noble J, transcript 2/02/2004, p 711; Australian Institute of Criminology 1996, James M, 'Crime and older people', paper presented at conference 23-25 February 1993, p 1.

13 Mahajani S, sub 181, p 3.

broader and more complex. These include assisting older people to make known their preferences for the safe handling of their assets and affairs and for their own care as they become frail. They also include supporting and protecting older people against abuse of their wishes and directions, and against physical, sexual, financial, psychological/ emotional, social and neglect.[14]

Age discrimination

3.23 The Committee heard evidence of age discrimination including difficulties that mature aged people experienced in finding employment and the age-restrictions imposed by some insurance companies. The U3A reported a 'relatively new' age restriction by insurance companies on personal accident policies for those 85 and over. This means that over 85s involved in U3A activities – activities which 'cannot be classified as high risk' – are not covered for injury or disability and, if problems do arise, U3A organisations could be exposed to substantial compensation claims.[15]

3.24 As a nation, action had already been taken to discourage age discrimination through legislation.

3.25 Age discrimination laws were introduced by each State and Territory by 1998. In an employment context the federal Workplace Relations Act 1996 also specifies anti-age discrimination objectives and provisions. However the coverage of the state and territory legislation did not extend to Commonwealth laws, employment in the Commonwealth public sector or acts done under Commonwealth laws and programs.[16] To cover these gaps the Australian Government passed the Age Discrimination Act No. 68 of 2004, which was assented to 22 June 2004. This is used to ensure a person is treated fairly in areas such as employment, education, access to goods and services as well as the administration of Commonwealth laws and programs.

14 Aged Rights Advocacy Service, 'Preventing abuse of older people', viewed 23/08/2004, <http://www.sa.agedrights.asn.au/prevent/forms.html>.

15 Polich T, sub 43, p 1; Department of Family and Community Services, sub 156, pp 11-14; Venner R, sub 168, pp 1-3; University of the Third Age, City of Melbourne Inc, sub 44, p 7-8.

16 Explanatory memorandum for Age Discrimination ACT 2003, p 10.

> The legislation means that, for the first time, there will be an enforceable remedy in federal law for people who suffer discrimination on the basis of their age.[17]

3.26 The Australian Age Discrimination Act 2004, is not a substitute for State anti-age discrimination laws or a replacement for the federal workplace law.

3.27 Recent court cases indicate that there is still room for improvement despite the legislative protections.

Safety in the community

3.28 The Committee received evidence about community initiatives addressing older peoples' fears about safety in their homes and communities. Some of these initiatives are equally relevant to making homes more age-friendly (see further, Chapter 4, Housing and transport).

3.29 The Institute of Chartered Accountants in Australia (ICAA) advised the Committee of a free home safety inspection service for older people, facilitated through their ElderCare service in collaboration with the Victorian Government and Archicentre. Home inspections by architects have identified hazards that could cause falls or other injuries:

> …Many homes inspected by Archicentre architects had slip and trip hazards, including slippery steps, poorly lit steps, rugs on slippery floors, moss on outside steps and paths which became like ice when damp.[18]

3.30 Mrs Noble mentioned a local council in Darwin that makes early morning calls to people who might be at risk. She also expressed concern about initiatives intended to improve safety that prove to have unintended consequences. Older people were encouraged to install deadlocks. However, if something goes wrong the deadlocks mean that nobody can get in to give assistance, so now a spare key arrangement is being put in place.[19]

3.31 As a result of the Community Liaison and Advisory Safety Project (CLASP), older residents in the ACT have free access to a home Safety

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17 Human Rights and Equal Opportunity Commission, 'Human Rights Commission welcomes age discrimination laws', Media release, 17/06/2004, p 1.

18 Institute of Chartered Accountants in Australia, sub 30, p 9.

19 Noble J, transcript 2/02/2004, pp 706, 711.

and Security Review which provides comprehensive personal advice on crime prevention, improved security, fire safety and personal safety. The Safety and Security Review team consists of officers from the Australian Federal Police, the ACT Fire Brigade and the ACT Ambulance Service. The Review is free and people on Centrelink Aged Pensions may access vouchers to help cover the costs of changes needed and for the installation of smoke alarms. The Community Liaison and Advisory Safety Project, instigated by the Council of the Ageing (ACT), also produced a handbook on home safety and security which covers aspects of general safety, medical safety, fire safety, and security.[20]

3.32 Organisations such as Neighbourhood Watch, and the Community Safety Council in Tasmania (in conjunction with governments) also play a role by promoting practical advice designed to enable older people to live confidently and safely. *Confident Living for Older Victorians*, for example, states that:

> Confident living is a state of mind. It is an attitude which recognises possible threats but encourages older people to fully participate in their personal life and their community. …
>
> Responsibilities change with age. By planning and making the most of community resources, [age] can be a time of enjoyment, company and new experiences. …[21]

3.33 One source of information and practical advice which takes into account the needs of people from culturally and linguistically diverse backgrounds is the New South Wales Department of Health website. Information sheets (in 13 or more languages) cover a range of topics including the prevention of elder abuse, strategies to stop fear limiting life, and dementia.[22]

3.34 The Committee commends initiatives such as these, and is aware that they are just a few of many making a difference in the community.

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20 Home Safety and Security Handbook, viewed 12/08/2004, <http://www.cota-act.org.au/safety_handbooks/ clasp_handbook/clasp_handbook_toc.htm>. See also, Flint P, Council on the Ageing, 'The CLASP partnership: we can all benefit', paper presented at the conference Partnerships in Crime Prevention, convened jointly by the Australian Institute of Criminology and the National Campaign Against Violence and Crime, Hobart, 25-27 February 1998.

21 'Confident living for older Victorians', 2000, viewed 10/08/2004, <http://www.neighbourhoodwatch.com.au/>. See also, eg, 'Safe and secure living: your personal handbook', viewed 10/08/2004, <http://www.police.tas.gov.au/police/police2001.nsf/ W/Resources/CCAS-56TUKG/?Open>.

22 New South Wales Department of Health, viewed 23/04/2004, <http://www.mhcs.health.nsw.gov.au/health-public-affairs/mhcs/publications/3435.html>.

Elder abuse

> The other thing which is really a neglected problem in our area is abuse of the elderly. We find it so often. It burns out the people like us who are looking after the elderly; it burns out the other people who are identifying the abuse. But there is nothing mandatory we can do about abuse of the elderly. We just have to sit on it and do nothing a lot of the time.[23]

3.35 Elder abuse has been defined as:

> …wilful or unintentional harm caused to a senior by another person with whom they have a relationship implying trust.[24]
>
> …any pattern of behaviour by a person or persons that results in physical or psychological harm to an older person.[25]

3.36 Elder abuse is not confined to particular groups: it may affect all classes, races and cultures, and both men and women. While the frail and dependent may be affected, the physically and mentally fit may also be abused. Elder abuse can take place in the family home or in residential care. Carers can be stressed by the responsibility and difficulty of coping with the physical, emotional and economic costs of caring. Sometimes abuse may be a continuation of domestic violence.[26]

3.37 Harm may include physical, sexual, and emotional mistreatment, financial exploitation, or neglect of basic needs (see Table 3.1).[27] Neglect can include inadequately assisting with personal hygiene, food, clothing, shelter, medical care, health and safety hazards, and failing to prevent malnutrition.[28]

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23 Mahajani S, transcript 3/02/2004, p 790.

24 The Aged-care Rights Service, sub 87, p 15 (adapted from Hailstones, 1992); COTA (NT) and National Seniors, sub 178, National Policy Document 2003, p 26.

25 Australian Institute of Criminology 1996, Roberts J, 'An analysis of situations of elder abuse and neglect in Brisbane, and other Australian studies', p 3.

26 Australian Institute of Criminology 1996, Kingsley B and Johnson S, 'Elder abuse: the ethical dilemma', paper presented at Conference 23-25 February 1993, pp 7-8.

27 The Aged-care Rights Service, sub 87, p 15; COTA (NT) and National Seniors, sub 178, National Policy Document 2003, p 26. See also Australian Medical Association (AMA), sub 86, p 11.

28 Combined Pensioners and Superannuants Association of NSW Inc, Policy Discussion Paper, No 8, May 2002, p 2.

Table 3.1: Forms of elder abuse

Abuse Forms	Behaviour	
Financial	• Forgery • Reluctance to pay for accounts/debts • Unwillingness to bring items in for the older person • Forced will changes	• Embezzlement • Withholding funds form the older person • Enduring Power of Attorney's refusal to provide info about financial affairs
Neglect	• Not providing adequate clothing and personal items • Unwillingness to allow adequate medical or dental care or personal care	• Over, under or inappropriate use of medication • Refusal to permit other people to provide adequate care, eg food or drinks
Social	• Includes being discouraged or stopped from seeing other people eg family or friends	• Prevented from joining in any activities in or outside the residential care facility
Physical	• Hitting • Burning • Pushing • Punching • Slapping • Forced confinement in room, bed or chair	• Biting • Arm twisting • Cutting • Hair pulling • Pinching
Sexual	• Rape • Indecent assault	• Sexual harassment • Sexual interference
Psychological/ Emotional	• Humiliation • Blaming • Intimidation • Insults • Treating the older person like a child • Threats of punishment of abandonment	• Name calling • Silence • Shouting • Emotional blackmail • Threats of restricting access to others • Witnessing family arguments

Source: www.Agedrights.sa.asn.au/prevent/forms.htm

3.38 Enforced isolation is a less obvious example of abuse of older people. Over the next 40 years, increasing numbers of older people are likely to live alone, or to be isolated and lonely because of inability to drive, being fearful of going out at night, or because their families are 'too busy' to help them maintain social activities. Such social isolation often leads to declining health. [29]

3.39 Recent research identified practices which 'at best place the older person at risk of financial abuse and at worst constitute financial abuse':

29 Centre for Ageing and Pastoral Studies, sub 167, p 6; Country Women's Association of Australia, sub 121, p 3; Wellbeing of Older Men, Hunter Retirement Living/Uniting*Care*, sub 189, p 4.

- inadequate or no accountability procedures particularly for cash payments;
- appointing attorneys who may lack the required personal or financial skills to take on the responsibility, or who may be subject to influence by a spouse or other significant person whom the donor feels hesitant about;
- asset managers taking over full control – supposedly to make it easier for the older person – but effectively denying the level of control over money sought by the older person;
- asset managers being overly generous with an older person's money – for example, by using a gifting option excessively;
- fraudulent use of authority such as falsifying a signature or continuing to use an Enduring Power of Attorney after the donor has died or revoked the document in order to get important paperwork done while in a transition period.[30]

Community action against elder abuse

3.40 The Committee heard of preventive, community support and legal initiatives to assist older people to maintain control over their life and affairs.

3.41 Dr Mahajani (quoted above) expressed frustration at the absence of clear protocols in the Northern Territory for handling elder abuse. Dr Richardson suggested that if mandatory reporting of elder abuse was introduced, this could be a way of collecting research data.[31] There are no mandatory reporting laws for elder abuse in Australia.[32] The Legislative Assembly inquiry into Elder Abuse in the ACT concluded that mandatory reporting may deprive older people of control over their destinies and making their own decisions about their futures, and represents an invasion of privacy.[33]

3.42 Prevention, rather than reporting, was suggested to the Committee as a more powerful tool. Prevention should focus on the concerns of

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30 Setterlund D et al, 'Financial abuse within families: views from family members and professionals', p 2. Paper presented to the 8th Australian Institute of Family Studies Conference, Melbourne, 12-14 February 2003.

31 Richardson S, transcript 7/03/2003, p 222.

32 Aged Rights Advocacy Service, Preventing Abuse of Older People, viewed 23/08/2004, <http://www.sa.agedrights.asn.au/prevent/law_mandatory.html>

33 Legislative Assembly for the Australian Capital Territory, Standing Committee on Health and Community Care, Report No 11, *Elder Abuse in the ACT,* August 2001, p 40; Kurrle and Sadler cited in Weeks, Elizabeth and Sadler, Paul (1997 '*Elder Abuse and Dementia*' a discussion paper for the NSW Advisory Committee on Abuse of Older Persons, p 15.

older people and their caregivers, and what can be done to support and educate carers in their role. The ACT Government favours a broad based community education campaign to increase general public awareness, establishing education and training standards for workers in aged care institutions, and implementing a campaign to educate professionals working in the field of elder abuse or those likely to have contact with victims. As part of this approach, an Elder Abuse Prevention Information Line has recently been launched. The ACT Government is also committed to consulting with the ACT Division of General Practice to develop strategies to address elder abuse issues. [34]

3.43 A training kit has already been produced by the NSW Ageing and Disability Department, *Dealing with Elder Abuse of Clients and their Carers*, which the ACT Legislative Assembly could be easily adaptable to another jurisdiction. Such initiatives are encouraging to the Committee and should be shared across the States.[35]

3.44 The Committee notes that consideration of addressing elder abuse is a responsibility of the Positive Ageing Taskforce (a subcommittee of the Community Services Ministers Advisory Council), and a part of the implementation of the Commonwealth, State and Territory Strategy on Health Ageing. The Positive Ageing Taskforce is yet to provide guidance on how this issue might be tackled.

Guardianship

3.45 One way of assisting and protecting older people who are being abused, exploited or losing control of their mental capacities, is to seek the appointment of a guardian.

3.46 Each State and Territory has a Guardianship Board or Tribunal which can appoint a guardian or administrator. Major advocacy groups such as Carers Australia and Alzheimer's Australia provide information about the roles of these bodies. [36]

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34 Legislative Assembly for the ACT, Standing Committee on Health and Community Care, Report No 11, *Elder Abuse in the ACT*, August 2001, p 37.

35 Legislative Assembly for the ACT, Standing Committee on Health and Community Care, Report No 11, *Elder Abuse in the ACT*, August 2001, pp 37-38; ACT Government Response to the Standing Committee on Health and Community Care, Report No 11, *Elder Abuse in the ACT*, 26/09/2002, pp 15-16; *Canberra Times*, 21/06/2004, p 3. City of Joondalup Elder Protection Network website, launched 24/10/2001 by Western Australia Minister for Seniors Interests, Media Release, 13/09/2001.

36 The Aged-care Rights Service, sub 87, p 14.

3.47 However, evidence from Broken Hill and the Northern Territory indicated that arrangements on the ground may not always enable timely protection:

> …They are very keen that the patients' rights are very carefully managed. We think the average wait for a guardianship hearing is about one to two years. An urgent guardianship application gets done in about two weeks. I think there is a very small office with just a few people and they have something like 300 guardianship orders at any one time [37]

3.48 Ms Jones advised the Committee that the processes involved can put aged care workers in remote areas at risk:

> … we have remote workers in remote communities having to put their name on application forms to the Guardianship Tribunal and then the tribunal or the person who is reporting it having to hand these documents over to the alleged abuser with their name and contact details on them. We are putting our staff at risk.[38]

3.49 Dr Lowe emphasised the need for improvement of the Northern Territory arrangements and standardisation and coordination of the various arrangements across the States: '…I would like to plead that we get some Commonwealth standardisation of these, as they are better done in other places'.[39]

3.50 In this respect, the Committee notes the role of the Australian Guardianship and Administration Committee (AGAC) which provides a national forum for all relevant state and territory agencies associated with protection through guardianship and administration. Major functions of AGAC include developing consistency and uniformity, a collaborative focus and consistency of nomenclature in relation to guardianship and administration. [40]

3.51 Recent work has focused on interstate recognition of orders of tribunals, interstate recognition of enduring powers of attorney (financial) and interstate recognition of enduring powers of guardianship. The Committee notes that, on the basis of the status

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37 Lowe M, transcript 3/02/2004, p 793. See also, Lowe M, transcript 3/02/2004, pp 788, 795; Sneesby K and Burfoot C, transcript 19/05/2003, p 475.

38 Jones D, transcript 24/02/2004, p 869.

39 Lowe M, transcript 3/02/2004, pp 788, 793.

40 Australian Guardianship and Administration Committee, sub 194, pp 1-2 and attached status reports at April 2004, re interstate recognition of Enduring Powers of Attorney (Financial) and Enduring Powers of Guardianship.

reports provided by AGAC (see Box/Appendix), while encouraging progress is being made there is still much work to be done to achieve cross-jurisdictional consistency and uniformity in relation these matters.[41]

Planning for end of life issues

> There is a wish volunteered by almost all patients whom I meet in the course of my medical practice, regardless of their intellectual or social background, that they want to have control of their life, and implicitly, their end of life. Most have not thought through the practicalities of how this can be achieved for themselves or their family. On the contrary, there seems to be a view that unnecessary suffering or prolongation of life is due to some medicolegal requirement that if there is something which can be done to maintain life, then it has to be done.[42]

3.52 This statement by Dr Glover raised for the Committee a complex set of medical, ethical and legal issues around the concepts of 'dying with dignity', 'voluntary euthanasia' and/or 'right to die'. Other evidence also stressed the need for older people to plan for end of life and to make known in advance their preferences for the safe handling of their assets, affairs and their own care as should their capacity to make their own decisions be diminished by dementia or other causes.

3.53 As stated by Dr Mahajani (above) thinking about, and planning for, end of life issues it too often postponed as being 'too difficult'. In part this is because there is a lack of understanding about the family, medical and legal matters that should be planned for, and about the ways in which older people can plan to protect their wishes.

3.54 Mrs Teltscher stated that:

> The issue of the rights of aged patients to refuse treatment will become more important as an ageing population considers [its] future 'style of dying'. Many may not wish to spend years in a nursing home, doubly incontinent, totally dependent on others for their feeding and toileting, with no physical or mental capacity.[43]

41 Australian Guardianship and Administration Committee, sub 194, pp 2-3.

42 Glover A, sub 5, p 2.

43 Teltscher B, sub 27, p 1. See also, Rey P, sub 62, p 1; Voluntary Euthanasia Society of Victoria Inc, sub 22, p 5; Kearney J, sub 34, p 1.

3.55 Both Dr Glover and Mrs Teltscher drew the Committee's attention to the *Medical Treatment Act 1988* (Vic), and the fact that many health professionals do not understand patient's rights under its provisions, or disregard them. The Act allows a patient (or legally appointed agent) to refuse treatment or interventions which the patient considers no longer appropriate or beneficial. A guardian can refuse medical treatment on behalf of a patient, but cannot refuse palliative care. Where a refusal of treatment certificate is in place, medical practitioners and persons acting under the direction of a medical practitioner must comply. The Act protects medical practitioners and people working under their direction who comply with refusal of treatment certificates.[44]

3.56 In addition to Victoria, medical treatment legislation is in place in South Australia and the Northern Territory. Legislation is being considered by the Western Australian Government. Some states have both medical treatment legislation and enduring powers of guardianship provisions which potentially both cover end of life decision making around personal care. [45]

3.57 The Committee was urged to recommend that patients and health workers in all jurisdictions be given protection by:

> [changing] the Federal and State laws so that medical and nursing professionals who assist a mentally competent person to implement a well-documented decision to end their life, are not legally or professionally compromised.[46]

3.58 In contrast, the Social Issues Executive of the Anglican Diocese of Sydney argued that euthanasia 'should continue to be outlawed in Australia'; instead, there should be increased resources for palliative care.[47] Although legislation differs across jurisdictions, euthanasia is a criminal offence throughout Australia.

3.59 The contrasting evidence put to the Committee indicated strong beliefs about who should have the right to decide whether older people should have the right to make their own end of life decisions.

3.60 The Committee is concerned that there appears to be wide-spread confusion about end of life care options, leading to inadequate and inappropriate treatment and diminished trust in arrangements to

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44 Glover A, sub 8, p 2; Teltscher B, sub 27, p 1; AMA (Vic), The Medical Treatment Act 1988, viewed 12/08/2004, <http://www.amavic.com.au/downloads/dec03MTA.rtf>.

45 Australian Guardianship and Administration Committee, sub 194, p 3.

46 Glover A, sub 5, p 3.

47 Anglican Diocese of Sydney, Social Issues Executive, sub 67, p 4. See also, Kearney J, sub 34, p 1; Right to Life Australia Inc, sub 36, p 1; Mirabella C, sub 41, p 1.

protect patients' rights to make end of life decisions. This confusion extends to palliative care. Further, where medical treatment legislation is in place there is ignorance among medical practitioners of what the legislation entails.[48]

3.61 In May 2003, the Victorian Supreme Court was asked to determine whether artificial feeding and hydration (percutaneous endoscopic gastronomy or PEG) via a tube is medical treatment or palliative care.

3.62 The Court decided that PEG feeding is 'medical treatment' within the meaning of the *Medical Treatment Act 1988* (Vic), not 'palliative care'. The decision 'carefully balanced the competing moral and ethical values of the sanctity of life and the right to self-determination and dignity'. It helps to clarify the intent of the legislation and give doctors and other health professionals legal certainty with regard to the protection it provides.[49]

3.63 As the population ages, more individuals and families will face the practical and moral dilemmas considered by the Victorian Supreme Court. Dr Glover, among others, stressed the need for widespread, objective public education and debate by all age levels, about end of life issues and decision making:

> …education and information should be encouraged and actively promoted by government as occurs with other major public health issues. It should not be left to editorial decisions by media where the emphasis is inevitably on dramatic crisis situations.[50]

3.64 In this respect, the Institute of Chartered Accountants in Australia drew the Committee's attention to developments in Elder Law at the University of Western Sydney.[51] The Centre for Elder Law contributes to the advancement and awareness of the legal rights and responsibilities of older people in Australia through undertaking sponsored research, contributing to discussion, debate and

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48 Cartwright C, 'End-of-life decision-making: practical and ethical issues for health professionals', *Australasian Journal on Ageing,* vol. 19-2, May 2000, p ??;

49 AMA (Vic), 'The Medical Treatment Act 1988', viewed 12/08/2004, <http://www.amavic.com.au/downloads/dec03MTA.rtf>; Phillip Fox, Health e-Update 29 May 2003, 'Does artificial feeding constitute medical treatment or palliative care – the Victorian Supreme Court makes a declaration'; Victorian Government Health Information, 'Supreme Court decision on the Medical Treatment Act', viewed 12/08/2004, <http://www.health.vic.gov.au/mta/decision.htm>.

50 Glover A, sub 5, p 3. See also, Mahajani S, transcript 3/03/2004, p 790; Voluntary Euthanasia Society of Victoria Inc, sub 22, p 5; Trustee Corporations Association of Australia, sub 106, p 5; AMA, sub 86, p 18.

51 Institute of Chartered Accountants in Australia, sub 30, p 8. See also, ??????

publications, and developing and delivering programs for community and professional education and training, including for aged care workers. The Centre publishes a new journal, the *Elder Law Review*.[52]

3.65 The Committee considers that community education is essential to enable better understanding of the issues and the avenues available for safeguarding end of life decisions regarding both care and financial matters. Developments such as the Centre for Elder Law and the *Elder Law Review* will help focus much-needed attention on defining and protecting the rights of older people.

3.66 Practical advice on planning for end of life issues was offered to the Committee by, for example, the Trustee Corporations Association of Australia, including:

- making a will clearly setting out intentions with respect to one's estate; and
- creating an enduring power of attorney to enable a third party to make financial (and possibly other) decisions on behalf of a person who is no longer able to manage their own affairs.[53]

3.67 The Committee notes the complex range of the legal instruments that may be used to plan end of life affairs including: will, living will, power of attorney, enduring power of attorney, anticipatory direction, and advance directive. Further, for example, there are several types of powers of attorney and in Victoria only the enduring power of attorney (medical treatment) allows an agent to make decisions about medical treatment.[54] Alzheimer's Australia points out that while an advance directive allows specification of future treatment, requirements (the right form; the witnesses specified etc) are substantially different across the states and territories. In addition they may also be referred to as 'advanced health directives', 'advanced health care directives', 'anticipatory grants' or 'anticipatory directions'.[55]

3.68 The Trustee Corporations Association of Australia suggested to the Committee ways in which wills and enduring powers of attorney

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52 University of Western Sydney, Elder Law at USW, viewed 14/08/2004, <http://www.uws.edu.au/about/acadorg/clb/sl/research/elderlaw>. The *Elder Law Review*, may be accessed online at this address.

53 Trustee Corporations Association of Australia, sub 106, p 2.

54 AMA (Vic), 'The Medical Treatment Act 1988', viewed 12/08/2004, <http://www.amavic.com.au/downloads/dec03MTA.rtf>.

55 Alzheimer's Australia, Legal planning and dementia, glossary, viewed 14/08/2004, <http://www.alzheimers.org.au/content.cfm?topicid=263>.

could be improved and safeguards strengthened. Overall, the Association proposed that:

- relevant legislation should be unified across Australia, to overcome the difficulties that frequently arise with wills and powers of attorney outside the region in which they are drawn, … and
- in situations where elderly people are unable to look after themselves and a Court appoints a financial manager and/or a personal carer, the body charged with reviewing their performance should be independent of those parties.[56]

Summing up

3.69 The Committee considers that there is still much to be done before negative attitudes and age discrimination are replaced by attitudes that accept the universality of the ageing process and value and are supportive of older people. Old stereotypes may be being shaken but many are yet to tumble. Too frequently references to older people being a 'burden', the 'problem', or 'bed blockers' are still heard.

3.70 Successfully addressing the ageing of Australia's population is an ongoing task. In large part success will depend on changing the mindsets of the nation and of individuals. Even so there are some actions that should be taken immediately.

3.71 The Australian Government, State and Territory Governments, and a growing number of local governments have developed ageing strategies. The Committee concludes that these strategies should be evolving documents, reflecting community engagement with the issues and responding to debate on the values the community considers should underpin them.

3.72 A vision of the sort of society Australians want in the future is lacking in the *National Strategy for an Ageing Australia* and should be included in further development of the Strategy.

3.73 The Committee concludes that much greater effort must be put into developing key messages and information in such ways as to engage people of all ages, of different backgrounds, and relevant to the contexts in which people are living and working. The work being undertaken by Treasury is a vital component of the Government's

56 Trustee Corporations Association of Australia, sub 106, p 2. See also, ACT Government Response to Standing Committee on Health and Community Care, Report No 11, *Elder Abuse in the ACT,* 26/09/2002, p 11, which identifies similar problems and responses.

overall strategic approach. However, it is perceived by many people as focussing solely on the Budget bottom line, disconnected from work being undertaken in other government departments, and perpetuating the notion that older people are a burden.

3.74 New approaches are needed, together with a diversity of leadership to help make these messages 'click' with more people.

3.75 The Committee concludes that in further developing and implementing the *National Strategy for an Ageing Australia*, the Australian Government should ensure better integration of the relationships between the social, human, fiscal and economic components and a more constant focus on the 'human faces' of ageing Australia.

Conclusion 2

3.76 **The Committee concludes that in further developing the *National Strategy for an Ageing Australia*, the Australian Government should include a statement of the underpinning the Strategy. In the first instance, the values would promote a basis for debate. Subsequently as a goal /vision against which further development should be tested and measured.**

The Committee concludes that in further implementing the *National Strategy for an Ageing Australia*, key messages and information must be developed in such ways as to engage people of all ages, of different backgrounds and relevant to the contexts in which people are living and working.

3.77 The Committee commends the initiatives being taken to make older people feel more safe in their communities and to take action against elder abuse.

3.78 The Committee concludes that the development of national guidance on tackling elder abuse can no longer be delayed. The Community Services Ministers' Advisory Council should direct the Positive Ageing Taskforce to give this matter high priority. In view of the fact that elder abuse is often symptomatic of wider problems, the Committee concludes and that the scope of their work should focus more broadly on ways in which older people can be assisted to maintain control over their lives and affairs.

Conclusion 3

3.79 **The Committee concludes that the Community Services Ministers' Advisory Council should direct the Positive Ageing Taskforce to broaden the scope of their work on elder abuse to identify and develop guidance on ways in which older people can be assisted to maintain control over their lives and affairs.**

The Committee further concludes that guidance be implemented by all State and Territory Governments to provide a consistent approach across Australia to protecting the dignity of all older Australians.

3.80 The Committee considers that wide-spread objective education around understanding and planning end of life decisions is essential. These are complex and sensitive issues. While many organisations are already engaged in this, their efforts are made more difficult by the plethora of legal concepts and variations across jurisdictions.

3.81 A concerted effort must be made to bring greater uniformity to the types of legal instruments used to plan for the full range of end of life decisions, and the administration of these. In this context the work of the Australian Guardianship and Administration Committee is noted. However, the Committee concludes that more comprehensive and urgent action is needed.

Conclusion 4

3.82 **The Committee concludes that the Attorney General should work with the State and Territory Attorneys General to review, streamline and unify the legal instruments used for planning end of life decisions relating to management of affairs and assets, protection from abuse and care preferences.**

4

Housing and transport

4.1 Housing and transport are both vital aspects of ageing healthily. Maintaining independence requires easy access to services, facilitated by a good transport network and advanced planning of housing needs. Housing that is age-friendly inside but located well away from services and transport does not support the overall needs of an older person.

Homes for independence

4.2 The Committee is concerned that the development of cohesive policy around housing in an ageing society is lagging. Policies are fragmented across several Australian Government departments and the States and Territories. In the main, policies focus on public housing, building standards and, in the State/Territory context, retirement villages. There is also growing policy interest in the realisation of housing assets to fund home modifications, to enable the purchase of housing more suited to life stage, or to fund residential care facilities.

Home ownership by older Australians

4.3 Older Australians are strongly in favour of living in their own home for as long as possible, with only 7% of Australians aged more than 70 years living in residential care.[1] However, the design of their home may make it impossible to continue to live there. Staircases, bathrooms without support railings, narrow hallways and doorways can make living almost

1 Aged and Community Services Australia, sub 101, p 3.

impossible once a person has reduced mobility and strength, let alone if they are confined to a wheelchair.[2]

4.4 Consistent with Australia's tradition of home ownership, 77% of people aged 60 and over are home owners compared to 24% of those aged 15–59. Taking into account those purchasing their own homes, ownership among older people is substantially higher (82% compared to 54%). The Department of Family and Community Services (FaCS) stated to the Committee that there has been a decline in home ownership, especially in the 25-34 and 35-44 year age groups. FaCS suggests that there is a need to monitor this trend to gain a better understanding of the causes and impacts on future retirement security and demand for rental property.[3]

4.5 Home ownership not only provides a financial asset, it provides a sense of security, familiarity and continuity important for maintaining self-esteem and social interaction as people age. At the same time, property rates and maintenance costs can be a challenge particularly for people living on the basic age pension who are likely to be living in older homes. Older people who rent have relatively higher recurrent costs. They are also more at risk of insecurity and lower housing quality.[4]

4.6 Increasingly, Australia's older population is migrating to the coastline and this tends to increase prices for purchasing land and/or housing in such areas.[5] Some housing industry commentators suggest that measures, possibly by relevant governments, to slow the increasing costs of land and housing in such areas may be necessary.[6]

4.7 Rural and remote areas also suffer from a shortage of housing to suit the needs of the aged. The range of housing available in these locations is limited, many existing houses are old and as such are not adaptable to age-friendly accommodation.[7]

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2 Department of Premier and Cabinet of Tasmania, sub 171, p 59; Carter A, transcript, 24/02/2004, p 865.

3 Department of Family and Community Services, sub 90, p 31; Centrelink, sub 78, p 19; Shop, Distributive & Allied Employees' Association, sub 7, p 5.

4 *Promoting Health Ageing in Australia*, p 49, paper presented to the Prime Minister's Science, Engineering and Innovation Council, 10th meeting, 23 June 2003, viewed 7/05/2004, <http://www.dest.gov.au/science/pmseic/documents/Promoting%20Healthy%20Ageing%20report.pdf>.

5 National Rural Health Alliance, sub 131, p 21; Spearritt P, *Unhappy Valley: housing options for the over 60s*, viewed 21/07/2004, <http://www.brisinst.org.au/resources/spearritt_peter_agedcare.html>.

6 Spearritt P, *Unhappy Valley: housing options for the over 60s*, viewed 21/07/2004, <http://www.brisinst.org.au/resources/spearritt_peter_agedcare.html>.

7 National Rural Health Alliance, sub 131, p 21.

Making homes more age friendly

4.8 Evidence was put to the Committee that home modifications, and aids and appliances can assist older people to continue living in their own homes, improve their quality of life and reduce injuries. Yet the Myer Foundation has found that by far the majority of older people who could benefit from such assistance have not had home modifications and only 40% have access to aids and equipment.

4.9 In Victoria, under a joint initiative by the Department of Human Services and Architecture, older people can access a free service providing advice on hazards and maintenance matters. Analysis of data relating to close to 4,000 inspections each year since 1988 provides insights into the safety of older people's housing and the modifications that should be made. The findings are reported in *In pursuit of health and independence: A housing profile of Victoria's older population*.[8]

4.10 The 25% of older Victorians living in homes built before World War 2, were assessed as being at significant risk of falls (trip and slip), electrical problems and hazards associated with rising damp. The report notes that:

> Every year, thousands of older Victorians need medical care following a fall, while and average of 280 of these falls result in accidental death. Health care costs alone exceed $600 million. The most common trip and slip hazards were obstacles like protruding thresholds, shower bases, defective floor finishes and dangerous staircases. [9]

4.11 Safety concerns also include fire hazards which are not only dangerous but constantly detract from the resident's peace of mind.[10] Poor drainage affected 11% of the houses inspected resulting in:

> …slippery footpaths, deteriorated building components and timber rot, rising damp, rotted stumps, and termite attack.[11]

4.12 The Committee heard that home modification assistance is provided to veterans, and limited assistance with home maintenance, home modifications, and aids and appliances is provided through such services as Home and Community Care (HACC).[12] Queensland's department of housing provides home maintenance services (in addition to HACC

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8 The report may be accessed at <http://www.archicentre.com.au/html/downloads.html>, viewed 1/09/2004.

9 *In pursuit of health and independence: A housing profile of Victoria's older population,* pp 7, 8.

10 *In pursuit of health and independence: A housing profile of Victoria's older population,* p 10.

11 *In pursuit of health and independence: A housing profile of Victoria's older population,* p 20.

12 Myer Foundation, *2020 A Vision for Aged Care in Australia*, p 24; [Gray R, transcript 17/09/2003, p 703; Lgov NSW, sub 89, p 13.

service) through its Home Assist Secure scheme. Beneficiaries of this scheme can have age-friendly maintenance to their homes, including home security installations (see further 'Ageing with dignity').[13]

4.13 The Committee heard that opinion varies on how best to meet the changing housing needs of people as they age. Arguments were put for introducing adaptable, accessible, visitable or universal standards for all new dwellings, or at least for all new public housing.[14]

4.14 In part such proposals are based on decreasing the impact of the high costs associated with converting existing homes. On the other hand, as most older people wish to continue in their own homes, mandated standards for new buildings would not necessarily help them, or reduce the cost and effort required for maintaining a home that is now too large. Nor would standards address housing issues for the homeless or remote Indigenous communities.

4.15 Currently there is no Australian Government policy that would require the development of such standards. The Committee notes, however, that the Australian Building Codes Board is funding research to better define the possible standards noted above and undertake modelling to assess the feasibility and costs of the approaches. The research will also consider the feasibility of non-regulatory solutions.[15] This research will inform any future consideration of the introduction of national standards.

4.16 FaCS suggested that the ageing of the population may bring pressure on the housing industry to be more responsive to the needs of older people.[16] Other arguments favoured influencing the industry through encouragement, planning processes, federal tax incentives, or the management of development applications. The Salisbury Council, SA, has

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13 Home Assist Secure Program Information, <www.public-housing.qld.gov.au/building/assistance/home_assist_secure.htm>, viewed 22/07/2004.

14 Disability Information Australia Pty Ltd, sub 8, p 5; UnitingCare Australia, sub 104, p 4. 'Universal *housing* design is intended to: meet the housing needs of people across a range of abilities and ages; be economically adaptable to meet the changing needs of people throughout their lives and providing people with the choice to remain in their own home; ensure usability and aesthetics are mutually compatible and achieve wider market appeal; and increase safety.' See, Herd D, Ward M and Seeger B, *Included by design: a national strategy for accessible housing for all*, paper presented to National Housing Conference, Adelaide, November 2003, viewed 7/05/2004, <http://www.pwd.org.au/anuhd/national_housing_conference03_paper.html>. This paper also provides a useful summary of universal design initiatives overseas, and in state/territory and local government spheres.

15 Heath J, transcript 28/04/2003, p 392; Herd D, Ward M and Seeger B, *Included by design: A national strategy for accessible housing for all*, paper presented at the National Housing Conference, Adelaide, November 2003, p 9; viewed 16/05/2004, <http://www.pwd.org.au/anuhd/national_housing_conference03_paper.html>.

16 Flanagan K, transcript 7/02/2003, p 17.

selected parcels of land for development specifically for housing for older people. The Wyong Shire Council suggested that under planning processes, developers of land stocks should be required to provide up to 10% of assisted housing.

4.17 Some governments are addressing this issue by legislating to encourage the planning of new housing with the needs of the ageing population in mind. In 2004 the New South Wales Government implemented the State Environmental Planning Policy (SEPP) – Seniors Living 2004 legislation. This legislation aims to encourage development of housing that is ideal for the aged and people with a disability, while at the same time using the existing infrastructure more effectively. The legislation effectively overrides certain local planning measures which hinder the development of age-friendly housing. [17]

4.18 While the Wyong Shire Council has considered (and does promote) adaptable housing, it notes that as yet the market has little interest and suggests that to change this situation will need education around what good adaptable housing can look like. In this respect, the Department of Health and Ageing drew the Committee's attention to their sponsorship of the Master Builders Australia National Lifestyle Housing for Seniors Awards for purpose built dwellings (including town houses and high rise apartments), and extensions and modifications.[18]

4.19 While the housing industry may respond to demands for age-friendly housing in future, the current industry focus is on the investment market. Developers build on the premise of obtaining the best possible return rather than providing appropriate and affordable housing for a particular age group, such as the elderly.[19]

4.20 The transaction costs (such as stamp duty and property transfers) involved in moving to a more suitable house can be substantial and act as a disincentive to older people seeking more suitable homes. The FaCS suggests that consideration could be given to reducing these costs on the purchase of an 'age friendly' home.[20] While this may mean that State and Territory Government forgo some revenue, there would be benefits to

17 New South Wales Department of Planning, Infrastructure and Natural Resources, *Housing for Seniors and People with a Disability,* (State Environment Planning Policy – Seniors Living 2004), p 3, viewed 20/07/2004, <http://www.planning.nsw.gov.au/settingthedirection/pdf/seniorsguide_may04.pdf>.

18 Burgess E, transcript 24/02/2003, p 115-16; Department of Health and Ageing, transcript 7/02/2003, p 8. For information on the design awards, see <http://www.ageing.health.gov.au/ofoa/awards/natlifestyle.htm>.

19 Spearritt P, *Unhappy Valley: housing options for the over 60s*, viewed 21/07/2004, <http://www.brisinst.org.au/resources/spearritt_peter_agedcare.html>.

20 Department of Family and Community Services, sub 90, pp 28, 30.

individuals and to governments through reductions in health costs due, for example, to falls, and occupational health and safety injuries to CACP and HACC providers. Reduced transaction costs could be applicable to dwellings that qualify as 'age friendly homes' against a rating along the lines of energy efficient ratings.[21]

4.21 The growth in retirement villages in most states has provided a real alternative for many people, one which has helped to reduce social isolation. However retirement villages do not necessarily suit the lifestyle of all older people and there appears to have been little innovative thinking around a wider variety of housing models (for example, to suit older women without close family).[22]

Overseas initiatives

4.22 In this context the Committee notes that in Denmark radical policy changes were made to facilitate older people living independently. A freeze was put on the building of new nursing homes. Significant investment was made in the development of housing suited to the living and care/home help needs of older people, backed up by 24 hour access to integrated health care services.[23]

4.23 Japan's 'Gold Plan' aims to have 40% of the housing in the country supportive of 'ageing in place' by 2015. The Japanese Government aims to have half of this 40% newly built and the other half through adapted housing. To this end, the Ministry of Health and Welfare is providing second mortgages at a 1% lower-than-market interest rate for adaptable or age-friendly.[24]

4.24 Evidence to the Committee has also shown that Scandinavian nations have highly secure and supportive housing environments for their aged citizens. A majority of the aged in Sweden have access to 24 hour home care, while the aged in Denmark are entitled to housing that allows them to change the level of home care services they receive, instead of having to move house in order to change the level of service.[25]

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21 Disability Information Australia Pty Ltd, sub 8, p 2.

22 Howe A, 'Housing and older Australia: More of the same or something different?', keynote address to the Housing Futures in an Ageing Australia Conference, Melbourne, November 2003, viewed 6/05/2003, <http://www.myerfoundation.org.au/GroundControl/SiteContent/UserFiles/0000000238.pdf>; Boldy D, transcript 29/4/03, pp 408-9.

23 Review of Pricing Arrangements in Residential Aged Care, *Long term aged care: International perspectives,* Background Paper No 3, 2003, pp 67-68.

24 Brink S, sub 49, p 4.

25 Brink S, sub 49, p 6.

4.25 Catholic Health Australia informed the Committee that in some nations there is an emerging practice of adapting buildings such as former office blocks to make housing for people over the age of 50. The major improvements to the buildings generally include ramps, handrails, grab-rails, improved lighting in stairways and security systems to ensure the safety of the residents. This method can also be utilised to convert existing housing for the same purpose.[26]

4.26 Professor Boldy stressed the need to look at housing in conjunction with the neighbourhood – the ease of access to shops and user-friendly transport.[27]

4.27 While the standards, costs and levels of adaptability of housing are undoubtedly important, if residents can not safely and easily access services and amenities from their home then regardless of the standard of the home itself, it is not suitable for aged people.

> Adequate housing must also be set within an adequately supportive community environment…the ability to access public transport, to move about independently and safely within the community and have safe and ready access to resources (eg. Shops, pharmacies, medical facilities, churches and recreational facilities).[28]

4.28 The location of housing also plays a large role in the social inclusion. Should it be too difficult for someone to make it to a local club or recreational facility on a regular basis, they may become prone to social isolation and possibly depression. [29]

4.29 Hence while age friendly housing is a vital aspect of ageing, its interaction with services such as transport is of equal importance.

Transport: the key to independence and involvement

4.30 A repeated theme in evidence put to the Committee stressed that transport systems appropriate to the needs of people as they age are not optional but essential. Transport is essential to supporting daily living including

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26 Catholic Health Australia, sub 94, p 31.

27 Waddington E, transcript 28/04/2003, p 370; Burgess E, transcript 24/02/2003, pp 115-16; Boldy D, transcript 29/04/2003, p 402.

28 Uniting*Care* Australia, sub 104, pp 3-4.

29 McCullough T, transcript 31/03/2003, p 342; Disability Support and Housing Alliance, sub 122, p 1. McCallum J, sub 132, p 3; Wellbeing of Older Men, Hunter Retirement Living/ Uniting*Care*, sub 189, p 4

work or volunteering, accessing services (eg, health, dental) when they are needed, and critical to countering the possibility of social isolation.[30]

4.31 The Committee notes that the availability of transport is variable, and timetabling can be quixotic, and older people can find the physical environments in which public transport operates discouraging. Older people will not contemplate continuing to work if dependent on transport accessed in unsafe physical environments. Even where there may be adequate transport arrangements access for older people can be inequitable: pensioners are entitled to concessional fares for public transport but not necessarily for private transport.[31]

4.32 The Aged Services Learning and Research Health Collaboration stated that the private provider of public transport in the Coffs Harbour region does not charge the concession price that is standard in other major centres of New South Wales such as Sydney, Newcastle and Wollongong.[32] The Wyong Shire Council also told the Committee of problems with transport that greatly disadvantage the older people in their shire:

> Of concern to council is that public transport systems are inadequate now…state regulation does not foster competition between the bus companies. We have some buses that take three hours to go from Tacoma (one of our suburbs) out to our Westfield shopping complex…aged people just will not make the trip. It is impossible.[33]

4.33 Evidence was put to the Committee demonstrating that innovative approaches are possible through the better coordination of the total transport infrastructure (eg, public, private and dedicated buses such as the Rotary bus), and brokerage arrangements for transport services that give older people door to door service.[34]

4.34 Health-related transport is one area where door to door service would be ideal. Early discharge, attendance as outpatients, day treatment at doctors' surgeries mean that older people must travel more frequently for health care, often under circumstances when they require support while travelling. Older people in small rural towns may have to travel some

30 The Aged-care Rights Service, sub 87, p 43; Liddle J, 'Transport and lifestyle issues for older people: Implications for policy and practice', in *Maximising the Impact on Policy and Practice*, Proceedings of ERA 2003 Conference for Emerging Researchers in Ageing, 2003, pp 106-11.

31 Silcox S, transcript 29/04/2003, p 428; Lgov NSW, sub 89, pp 20-21; Lake Macquarie City Council, sub 68, p 3.

32 Aged Services Learning and Research Health Collaboration, sub 151, p 15.

33 Burgess J, transcript 24/02/2003, p 100.

34 Blackwell J, transcript 24/02/2003, pp 88-9.

distance for health services they often depend on the dwindling availability of volunteer transport and drivers - which makes keeping healthy even more difficult.[35]

4.35 In the Committee's view, access to transport is critical to personal independence, continued participation in the workforce, and to maintaining family and community networks.

4.36 The provision of transport is the responsibility of the states and private enterprise. State and Territory Governments already facilitate concession fares in various ways. Less attention seems to be paid to making transport age-friendly. Accessibility and reliability are one of the greatest concerns.[36] While the operations of public transport (routes, timetables etc) are formulated through a 'population wide' analysis, particular attention must to be paid to the needs of ageing people and their ability to access the transport.[37] This includes not only the timeliness of the transport, but also the physical facilities being convenient for those with restricted mobility and, most importantly, safe for their boarding.

4.37 The Municipal Association of Victoria referred to the fact that changes are being made to assist those with reduced mobility. Demonstrating the important interaction between housing and transport for ageing Australians, the Association targeted trams that travel through suburbs with older populations. Trams on these routes were modified to remove entry steps making it easier to get on board. Because the trams pass through several suburbs, a number of local councils as well as the Victorian Government cooperated in coordinating the modifications.[38]

4.38 While transport and housing are individually important to the ageing population, the combined planning and interaction of these elements will play a major role in providing appropriate infrastructure for our aged population in the future.

Summing up

4.39 Age friendly housing and transport are both vital to the independence of Australia's ageing population in the future.

4.40 Action can be taken to improve the safety and accessibility of existing housing and transport as is demonstrated by the innovative approaches

35 The Aged-care Rights Service, sub 87, p 43; Lally P, transcript 28/04/2004, pp 371-2.

36 The Aged-care Rights Service, sub 87, p 43.

37 MacKinlay E, transcript 25/06/2003, p 544.

38 Edwards T, transcript 31/03/2003, p 288.

being put in place by some local and municipal governments. The housing and private transport industries have been slower to respond to the ageing of the population.

4.41 While older Australians are strongly in favour of continuing to live at home for as long as possible, the Committee concludes that this is seriously impeded by the inappropriateness of many homes.

4.42 The Committee is concerned that the development of cohesive policy around housing in an ageing society is lagging. In the main, policies focus on public housing and, in the State/Territory context, retirement villages. There is also growing policy interest in the realisation of housing assets to fund home modifications, to enable the purchase of housing more suited to life stage, or to fund residential care facilities.

4.43 Australian Government policies support older people's strong preference to remain independent and not enter an aged care facility unnecessarily. Support is often couched in terms of 'staying in their own homes' rather than encouraging and facilitating older people to live in homes suited to their lifestage and lifestyle.

4.44 The Committee concludes that there should be a greater emphasis on homes that support independence and or making it more acceptable – and easier – for older people to shift to more suitable dwellings.

4.45 The Committee considers that there is merit in exploring the possibilities of new building codes for all new dwellings however solutions must also come from a variety of sources including the financial sector and housing industry. Various incentives are given to first home owners. It may now be time to give serious thought to incentives for 'later life home buyers'.

Conclusion 5

4.46 **The Committee concludes that the Australian Government through the Health and Community Ministers' Council and the Housing Ministers' Conference should lead the development of longer term strategies to address the housing needs of an ageing Australia that:**

- **build on the research being undertaken by the Australian Building Codes Board;**
- **promptly action any national building standard recommended by the research being undertaken by the Australian Building Codes Board;**
- **facilitate the development of a national 'age friendly home standard' which must be included in all rental and sales**

advertisements for domestic dwellings; and

- **entitle purchasers 65 years and over to reduced transaction costs for the purchase of a freehold title domestic dwelling (with registrable and transferable interests) that qualifies for the national 'age friendly home standard'.**

4.47 A repeated theme in evidence put to the Committee stressed that transport systems appropriate to the needs of people as they age are not optional but essential.

4.48 The Committee concludes that transport is essential to supporting daily living including work or volunteering, accessing services when they are needed, and critical to countering the possibility of social isolation. Innovative approaches are possible through the better coordination of the total transport infrastructure and, for example, brokerage arrangements for transport services.

4.49 To date transport policy for older Australians for older people appears to have been considered largely in terms of concessions. Overseas research demonstrates that other factors must be taken into account.

4.50 The Committee concludes that re-thinking the transport needs of older people, and planning for the increasing numbers of older people who will be dependent on public transport is a matter of priority.

Conclusion 6

4.51 **The Committee concludes that the Australian Transport Council identify older people's transport needs and develop a national action plan to improve the safety, accessibility, availability and affordability of public transport to support older people's independence and participation in their communities.**

5

Healthy ageing

5.1 Healthy ageing is the normal experience of most Australians. As Professor Julie Byles informed the Committee: 'Ageing is not all downhill.'[1]

5.2 Australia rates highly by international health standards. Australians enjoy one of the highest life expectancies in the world, slightly higher than countries such as Canada, Norway and Spain, and well ahead of countries such as the USA, New Zealand and the United Kingdom. Australians also rate highly in terms of healthy life expectancy, or the expected number of years to be lived without reduced functioning due to ill health. Australia's levels of healthy life expectancy are 69.6 years for men (sixth in the world) and 73.3 years for women (third in the world).[2]

5.3 Most older Australians feel positive about their health, rating it as good, very good or excellent. Even though older age is generally associated with increasing levels of disability and illness, only 30% rate their health as fair or poor. Women tend to rate their health more positively then men. These 'self-ratings' of how people feel about their health are regarded as providing a reasonable measure of health status. They seem to reflect the complex nature of 'being healthy' including such factors as '…psychological wellbeing, aspects of health behaviour, social support and self confidence'.[3]

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1 Byles J, sub 103, p 3.

2 Department of Health and Ageing, *Chief Medical Officer's Report 2001-2002*, Canberra, 2003, pp 62, 64, viewed 3/05/2004, < http://www.health.gov.au/pubs/cmo/cmo0102/cmo2002.pdf >.

3 Australian Institute of Health and Welfare (AIHW), *Older Australians at a glance,* Third edition 2002, AIHW cat.no. AGE 25, p28; Bartlett H, transcript 20/05/2003, p 499.

5.4 While Australia's health levels are good, there are certainly areas in which their health could be improved:

> …one disturbing trend is that Australians are getting fatter, which has serious implications for the health of our population. In addition, statistics are now reflecting increasing numbers of tobacco-related deaths in women from lung cancer; youth suicides; deaths from drug overdoses; and higher mortality rates in Aboriginal and Torres Strait Islander people.[4]

5.5 The life expectancy of Indigenous Australians is around 20 years less than non-Indigenous people and mortality rates between two and four times higher. The low levels of health of many Indigenous people are exacerbated by poverty, unemployment, poor housing and education and incarceration.[5]

5.6 Evidence to the Committee shows additional reasons for the lower health levels of Australia's Indigenous population. Indigenous Australians are more likely to live in rural and remote communities than non-Indigenous Australians. Rural and remote communities struggle to maintain an adequate health infrastructure and there are few Indigenous health and allied health practitioners, leading to alienation for some Indigenous people. Indigenous people also have higher incidences of diseases which are largely controlled in the general population, and higher incidences of diseases caused by poor environmental health or poor nutrition.[6]

The top 10 health problems

5.7 Although there have been significant improvements in preventing and managing chronic diseases, their prevalence continues to increase with age so that older people are likely to be living with more than one chronic disease: 12% of people aged 59 years or younger have an impairment compared to 51% of people aged 60 and over. As shown

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4 Department of Health and Ageing, *Chief Medical Officer's Report 2001-2002*, Canberra, 2003, p 62, viewed 5/05/2004, <http://www.health.gov.au/pubs/cmo/cmo0102/cmo2002.pdf >.

5 Department of Health and Ageing, *National strategic framework for Aboriginal and Torres Strait Islander health*, 2003, p 1; Lester R, transcript 7/02/2003, p 47, Lipscombe J, transcript 7/03/2003, p 241; Gregory G, transcript 7/03/2003, pp 237-238.

6 Gregory G, transcript 7/03/2003, p 241; Emerson F, transcript 7/03/2003, pp 206, 208; Lester R, transcript 7/02/2003, p 47; Gooda M, transcript 7/03/2003, pp 203, 210.

in Table 5.1, for people 65 years and over the diseases most likely to affect their ability to lead healthy lives are dementia, adult hearing loss and stroke.

Table 5.1: Top 10 causes of healthy years of life lost due to disability for females and males aged 65 and over, 1996[10]

Disease category	Females	Males	Persons	
	Years of life lost due to disability (*YLD)s*			*Per cent*[a]
Dementia	33, 976	20, 232	54, 208	16.7
Adult-onset hearing loss	10, 871	15, 404	26, 275	8.1
Stroke	10, 160	13, 587	23, 747	7.3
Vision disorders	15, 591	4, 343	19, 934	6.2
Osteoarthritis	11, 942	7, 691	19, 633	6.1
Coronary heart disease	9, 593	9, 734	19, 327	6.0
Parkinson's disease	9, 969	5, 392	15, 360	4.7
Diabetes mellitus[b]	4, 288	5, 541	9, 829	3.0
Benign prostatic hypertrophy	..	9, 690	9, 690	3.0
Chronic Obstructive Pulmonary Disease	3, 698	4, 506	8, 204	2.5
Top 10 Disorders	*110, 088*	*96, 120*	*206, 207*	*63.6*
Total	170, 730	152, 995	323, 725	100.0

a) Per cent refers to percentage of total YLD for persons. b) Includes Type 1 and Type 2 diabetes

Source: AIHW Older Australia at a glance p 32.

5.8 The causes and means of preventing dementia are still unclear. While many acute illnesses may be cured and chronic diseases managed over time, the effects of dementia are irreversible. Alzheimer's Australia suggested that the rate of neuro-degenerative disease is likely to increase over the next forty years to the point where it may become the primary disease of ageing. There are some promising medications that may slow progress of dementia but there are no miracle cures in view.[7] (See further, chapter 8).

5.9 Associate Professor Linda Worrall informed the Committee that loss of hearing is of major concern to older people as it affects their ability to communicate effectively and to participate in their communities. If this loss of hearing occurs in conjunction with a visual impairment,

7 Alzheimer's Australia, *Promoting healthy ageing in Australia*, p 13; Bruen W, transcript 7/02/2003, p 8; Pollard D, transcript 20/05/2003, p 523; Alzheimer's Australia, sub 79, pp 6-7; Woodward M, 'Prevention and cure of dementia', Public Lecture, September 2002 (accessed at http://alzheimers.org.au/content.cmf?infopageid=940).

such as cataracts, then communication becomes progressively more difficult and social isolation more likely.[8]

5.10 The number of people living with disability who reach 70 years or more is increasing. However, increasing age can mean that they are also affected by the diseases common among older people generally, which can further impact on their capacity to manage daily living.[9]

5.11 The extent to which the various behavioural and biomedical risk factors are linked to the common chronic diseases is shown in Table 5.2.

Table 5.2: Relationships between various chronic diseases, conditions and risk factors

Condition	Behavioural				Biomedical		
	Poor diet	Physical inactivity	Tobacco use	Alcohol misuse	Excess weight	High blood pressure	High blood cholesterol
Coronary heart disease	✓	✓	✓	✓	✓	✓	✓
Stroke	✓	✓	✓	✓	✓	✓	✓
Lung cancer			✓				
Colorectal cancer	✓	✓			✓		
Depression		✓	✓	✓	✓		
Diabetes	✓	✓			✓		
Asthma			✓		✓		
Chronic obstructive pulmonary disease			✓				
Chronic renal diseases	✓				✓	✓	
Oral diseases	✓		✓				
Osteoarthritis		✓			✓		
Osteoporosis	✓	✓	✓	✓			

Source: AIHW Chronic diseases and associated risk factors, Canberra, AIHW, 2002

Prevention, not reaction

5.12 While acknowledging the prevalence of chronic disease, the Department of Health and Ageing advised the Committee that such diseases are in many instances preventable:

> Modifiable risk factors such as smoking, alcohol misuse, poor diet, physical inactivity, overweight and obesity and chronic stress have been shown to account for up to a third of the total disease burden in Australia. Hence preventive action that targets a particular risk factor or condition can provide

8 Worrall L, transcript 20/05/2003, p 506.

9 COTA NSW, sub 157, p 2; Disability Information Australia Pty Ltd, sub 8, p 2.

> benefits in terms of prevention of a range of conditions simultaneously.[10]

5.13 The Committee heard that a number of preventive actions can contribute to healthy ageing such as regular physical activity and maintenance of functioning,[11] good nutrition,[12] adequate support for daily living, adequate financial resources,[13] reducing the adverse effects of air pollution,[14] access to appropriate infrastructure,[15] social connectedness,[16] and 'training' for old age.[17] An approach focusing on smoking, nutrition, alcohol, and physical activity (known as SNAP) has produced positive results in increasing health and well being across the Australian population.[18]

5.14 The value of preventing poor health rather than treating it is stressed in evidence to the Committee. Preventing poor health ensures better quality of life and reduces health costs.[19]

5.15 Catholic Health Australia noted that preventative approaches are being adopted internationally:

> 'Healthy ageing' – at the lowest cost while ensuring quality – is becoming an international catch-cry, resulting in public policy campaigns for injury prevention, healthy eating, smoking cessation and physical activity. Multi-faceted approaches to enable healthy ageing include re-orientations within the health care system (emphasising self-help strategies), translation of information into action by creating supportive psycho-social environments, involvement of

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10 Department of Health and Ageing, sub 119, p 24.

11 Australian Physiotherapy Association, sub 118, p 6; Hunter Health, sub 46, p 2; National Private Rehabilitation Group, sub 53, pp 14-15; Lake Macquarie City Council, sub 68, p.2; Lgov NSW, sub 89, p 19; Dunn L, transcript 25/02/2003, p181; Bartlett H, transcript 20/05/2003, p 499; Telford B, transcript 7/02/2003, pp 29-30.

12 CSIRO, sub 35, p 3; Head R, transcript 28/04/2003, pp 361-66; Smith M, transcript 2/02/2004, p 744; Byles J, transcript 24/02/2003, p 160.

13 Central Australian Aboriginal Congress Inc, sub 176, p 7.

14 CSIRO, sub 35, pp 7-8.

15 McCullough T, transcript 31/03/2003, p 339; Worrall L, transcript 20/05/2003, p 502.

16 Australian Institute of Family Studies, sub 115, p 5; Department of Health and Ageing, sub 119, p 14; Waverley Council, sub 73, p 5.

17 Isaacs Health and Aged Care Round Table, sub 105, p 5; Cheah V, transcript 23/02/2004, p 835.

18 O'Donoghue R, transcript 7/02/2003, p 3.

19 Catholic Health Australia, sub 94, p16; Older Women's Network, sub 58, p 3; Council of the Ageing, sub 91, p 20; Hunter Area Health Service, sub 46, p 3.

> seniors at all levels, emphasis on diversity and sustainability and policies that combat age discrimination.[20]

5.16 This evidence indicates that healthy ageing requires not only a pro-active attitude from individuals but also a supportive infrastructure that promotes preventative health measures.

Obesity

5.17 Obesity is a significant risk factor in preventable health problems such as Type II diabetes, cardiovascular diseases, stroke and hypertension. An 'alarming rise' in the prevalence of overweight and obesity across all socio-demographic groups is shown by data from the 1989-90, 1995 and 2001 National Health Surveys with around a 25% increase in just over 10 years. If this trend continues, by 2010 least 60% of adults will be overweight or obese, and this could increase to 65% by 2020.[21] As the surveys are based on self reporting they are likely to under estimate the problem.

5.18 While the tendency to be overweight is inherited, lifestyle factors, in particular nutrition (diet) and the level of daily physical activity, influence the tendency. Ms Maxine Smith, from the Yuendumu Old People's Project, told the Committee of some of the factors contributing to the poor health status (including diabetes) and high mortality rate of Indigenous young people and people in their middle years.

> We see lots of young people buying Coca-cola and iceblocks for breakfast …The cost of food … is very exorbitant in community stores … Things like fruit and fresh vegetables are often beyond what people can afford.[22]

5.19 Some Indigenous communities in remote areas have, or would prefer to have, stores with more healthy food but transport costs can undercut their intentions.

5.20 Apart from the effects on people's health, there are significant economic costs relating to obesity. The Pharmacy Guild of Australia noted that increasing obesity contributes to Pharmaceutical Benefits

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20 Catholic Health Australia, sub 94, p 16.

21 O'Donoghue R, transcript 7/02/2003 p 3; NHMRC, *Acting on Australia's weight: A strategic plan for the prevention of overweight and obesity*, summary report, 1997, p.2; AIHW, *Are all Australians gaining weight?* AIHW Bulletin No 11, 2003. These studies are based on self-reporting. The AIHW considers that the data are likely to under-report prevalence. See also *About overweight and obesity*, viewed 9/05/2004, <http://www.health.gov.au/pubhlth strateg/hlthwt/ obesity.htm#prevalence>.

22 Smith M, transcript 2/02/2004, p 744.

Scheme (PBS) expenditure which is projected by the *Intergenerational Report* to rise from around 0.6% of GDP in 2001-02 to 3.4% by 2041-42 unless there are changes in utilisation rates.[23]

5.21 In the Committee's view, reducing the incidence of obesity is a priority area in supporting healthy ageing. The children, adolescents and young adults of 2004 are the adults and older adults of 2042. They must be encouraged to adopt good nutrition and patterns of physical activity now, to give themselves the best opportunity for healthy ageing in the future.

5.22 The Committee notes that all levels of government have recognised the need for action. A National Obesity Taskforce was established by the Australian Health Ministers' Conference (AHMC) to consider what should be done to tackle obesity, including in the Aboriginal and Torres Strait Islander population.[24]

5.23 The work of the Taskforce resulted in the AHMC agreeing to the need for a long term, whole of government approach. The AHMC stated:

> …families, schools, child care centres, general practitioners, food manufacturers, retailers, sporting groups, urban planners, the media, community health centres, workplaces and many other groups all have a role to play and should be the focus of sustained programs to reduce overweight and obesity and the harm it causes.[25]

5.24 A National Action Agenda for Children and Young People and their Families, *Healthy weight 2008 – Australia's future*, has been developed and the Taskforce is to lead implementation of the strategies it sets out. Cathy Freeman has been named patron and ambassador.[26]

5.25 Although implementation is yet to formally commence, some stakeholder groups (such as the advertising industry) are already making changes within their own responsibilities relating to obesity. AHMC has also requested the Taskforce to undertake further consultation to develop similar action agendas designed for adults and older people. Complementary initiatives include the publication

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23 Department of the Treasury, *Intergenerational Report 2002-03,* Budget Paper No 5, pp 8-9.

24 National Obesity Taskforce, *Aboriginal and Torres Strait Islander Workshop: Outcomes*, September 2003, pp 10-11, viewed 13/05/2004, < http://www.healthyactive.gov.au/docs/ indigenous_obesity.pdf>.

25 Australian Health Ministers' Conference, Joint Communiqué, *Obesity a national epidemic*, 28 November 2003, viewed 7/05/2004, <http://www.health.gov.au/mediarel/yr2003/jointcom/jc002.htm >.

26 The Herald Sun, 5/05/2004.

of *Clinical practice guidelines for the management of overweight and obesity* by the National Health and Medical Research Council.[27]

5.26 The Committee commends the significant attention that is being focussed on the issue of obesity and agrees with Mr Ross O'Donoghue that, in addition to wide stakeholder involvement:

> …we very much have to ask people to take some responsibility as well for taking the initiative to have an influence on their own health.[28]

5.27 The Committee considers that the success of these strategies will depend on their effectiveness in gaining the active support of diverse stakeholders so that there is a multi-faceted and cohesive attack on the problem. Active encouragement and close monitoring of the outcomes will be necessary.

5.28 As the effectiveness of these initiatives will be not be demonstrated for many years, a commitment to longitudinal studies will be necessary. Critical to this will be establishing more reliable baseline data than provided by self reporting. The Committee notes that the National Obesity Taskforce recommended a program of evidence and performance monitoring and that the Australian Government is yet to respond to this recommendation.[29]

Physical activity and falls prevention

5.29 Evidence from local governments and communities also stressed the importance of physical activity and recreation. Input to the community consultations conducted for the Western Subregional Organisation of Councils (WESROC) Regional Seniors' Needs Study suggested a vision for recreation in an age-friendly society, one which has affordable recreation facilities open to everyone to encourage participation as a community, and which also recognises the need for some age-specific facilities and activities (see Box 5.1).[30]

5.30 The Committee recognises the growing importance of exercise and strength programs specifically designed for older people. These help

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27 Australian Health Ministers' Conference, Joint Communique, *Obesity a national epidemic*, 28 November 2003, viewed 12/05/2004, <http://www.health.gov.au/mediarel/yr2003/jointcom/jc002.htm>.

28 O'Donoughue R, transcript 7/02/2003, p 4.

29 *Healthy Weight 2008 – Australia's Future,* The National Agenda for Children and Young People and their Families, p 10, Evidence and performance monitoring, viewed 8/05/2004, <http://www.healthyandactive.health.gov.au/docs/healthy_weight08.pdf>.

30 Western Suburbs Regional Organisation of Councils, *Building Strong Communities through positive ageing*, pp 139-44.

tackle osteoporosis and arthritis through maintaining flexibility and mobility. They also assist in preventing falls which can result in older people being hospitalised, entering aged care or even death. [31]

Box 5.1: Facilities for recreation in an age-friendly community

In my vision of an age-friendly community …

… space and facilities for all ages – recreation within easy access.

- Has easy-access, low-cost social facilities for entertainment, sport, hobbies for all income groups.
- There would be a sports and gym complex with gentle activities for the aged and a swimming pool, spa etc.
- Facilities for a variety of recreational activities ranging from various kinds of sports and hobbies to more passive activities would be available at low cost in local centres, parks and sports grounds.

…

- More participation and occupation in keeping fit and well i.e. programs in hostels, retirement villages and even community gyms.
- Affordable recreational activities. Many people in their own home are receiving pension, so cannot afford club fees etc…[32]

5.31 The Department of Health and Ageing drew the Committee's attention to the National Falls Prevention for Older People Initiative. This initiative aims to increase understanding of the causes and prevention of falls, and to encourage individual, professional and community action to decrease the incidence and costs of falls. Research, information, training and community demonstration projects are funded under the initiative.[33]

5.32 The Committee commends this initiative but considers that sustained investment and effort over time will be necessary before falls prevention is seen not just as a medical issue but also a workplace, housing and community responsibility. Local government authorities, such as the Kingston City Council, already see it as their

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31 Australian Physiotherapy Association, sub 118, p 6; Department of Health and Ageing, sub 119, p 30; Malone D, transcript 31/03/2003, p 322.

32 Western Suburbs Regional Organisation of Councils, *Building Strong Communities through positive ageing*, p 139.

33 Department of Health and Ageing, sub 119, p 30; Moller J, *Projected costs of fall related injury to older persons due to demographic change in* Australia, 2003, p 4; National Falls Prevention for Older People Initiative, viewed 16/05/2004, <http://www.health.gov.au/pubhlth/strateg/ injury/falls/index.htm>.

responsibility to ensure that are no tripping points in their footpaths.'[34]

The role of community Pharmacists

5.33 An important aspect of support for healthy living is the network of community pharmacies throughout Australia.

5.34 Community pharmacists provide a wide range advisory and preventative services including cholesterol testing and early detection and prevention of conditions such as diabetes and asthma. They also advise patients on issues such as effects of medication, and refer them to expert medical attention where necessary.[35]

5.35 Given their close relationship with the community, pharmacists play a significant role in provision of health services in rural and remote regions, facilitating wider delivery of health services.[36] Community pharmacies have been prominent in providing health services in predominantly Indigenous communities such as the Tiwi Islands by utilising methods such as telepharmacy to dispense prescriptions remotely.[37]

5.36 Many older people take multiple medications and may need help to ensure that they use them safely and effectively. Community Pharmacists advise and assist them through programs such as the Quality Care Pharmacy Program and the Home Medicine Review in relation to the National Strategy for Quality Use of Medicines. This includes such practical help as safely disposing of outdated or unrequired medicines, assisting older people to use dose administration aids and to know how to store medicines safely.[38]

5.37 Evidence from the Pharmacy Guild shows that services provided by community pharmacists:

> …lead to improved patient compliance, reduced inappropriate medication use, fewer preventable adverse drug effects and interaction, reduced hospitalisation, reduced

34 McCullough T, transcript 31/03/2003, p 339.

35 Pharmacy Guild of Australia, sub 75, p 10.

36 Pharmacy Guild of Australia, sub 75, p 6; Crockett J, sub 165, p 37.

37 Crockett J, sub 165, p 37.

38 Pharmacy Guild of Australia , sub 75, p 4, attachment 2; Department of Health, The National Strategy for Quality Use of Medicines, Canberra, 2002, 36 p.; Department of Health, Checklist for using medications wisely, viewed 8/08/2004, <http://www.health.gov.au/pbs/general/check_wise.htm>.

GP visitation and a better quality of life for the Australian community.[39]

Nutrition

5.38 For older people, good nutrition is important in relation to both obesity and malnutrition. Evidence to the Committee indicated that 30% to 50% of older people entering hospital are undernourished and that older people's nutrition is under-researched. Malnourishment is also a factor in older people entering residential aged care. Malnourishment may be associated with poor dentition, forgetfulness because of advancing dementia, nausea related to drugs, depression, poor mobility and social isolation.[40]

5.39 The Committee also notes that the role of Aged Care Assessment Teams is to be expanded to include case management. The Committee considers that this means Aged Care Assessment Teams will be well placed to identify people who are at risk of malnutrition and assist them to access practical help.[41]

Summing up

5.40 Ageing healthily requires that individuals take an active role in keeping themselves healthy, but just as importantly, communities and the health care system have a responsibility to provide appropriate infrastructure and encouragement.

5.41 The Committee is concerned that despite the fact that most Australians age healthily, there continue to be high levels of preventable diseases, including what is now an obesity epidemic affecting all age groups.

5.42 The Committee concludes that support by the Australian Health Obesity Taskforce for action agendas involving responsibilities for all stakeholders is a creative and promising approach. As the full

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39 Pharmacy Guild of Australia, sub 75, p 7.

40 Byles J, transcript 25/02/2003, p 160; Head R, transcript 28/04/2003, p 363; Malnutrition and hip fractures, research project being undertaken by Hunter Health, viewed 9/05/2004, <http://www.newcastle.edu.au/faculty/health/nletter/archive/2002_12/p6.pdf>; Whitehead C, 'Malnutrition in elderly people', in Ashford Community Hospital, *Clinical Practice Bulletin,* No 3, viewed 8/05/2004, <http://www.joannabriggs.edu.au/services/ durdin/ashdec98.htm#anchor142909>.

41 Department of the Treasury, Budget Paper No 2, <http://www.aph.gov.au/budget/2004-05/bp2/html/ expense-12.htm>; In Victoria assessment is the responsibility of Aged Care Assessment Services.

effectiveness of these initiatives will not be demonstrated for many years, the Committee concludes that the Australian Health Ministers' Conference should commit to jointly funding research to establish reliable baseline data on obesity and longitudinal studies to track changes over time and the impact on health status.

5.43 The Committee also concludes that the Australian Health Ministers' Conference should direct that the next agenda to be developed by the National Obesity Taskforce should be that for older Australians. Where necessary the Australian Health Ministers' Conference should commission research to fill the gaps in knowledge of nutrition for older people and the medical and social reasons for malnutrition. This research should include specific consideration of older Indigenous people, and older people from culturally and linguistically diverse backgrounds.

5.44 The Committee considers that the success of these strategies will depend on their effectiveness in gaining the active support of diverse stakeholders so that there is a multi-faceted and cohesive attack on the problem. Active encouragement and close monitoring of the outcomes will be necessary.

5.45 As the effectiveness of these initiatives will be not be demonstrated for many years, a commitment to longitudinal studies will be necessary. Critical to this will be establishing more reliable baseline data than provided by self reporting.

Conclusion 7

5.46 **The Committee concludes that the Australian Government fund research to establish reliable baseline data on obesity and longitudinal studies to track changes over time and the impact of changes on health status.**

5.47 For older people, good nutrition is important in relation to both obesity and malnutrition. The Committee is concerned that 30% to 50% of older people entering hospital, are undernourished and that older people's nutrition is under-researched. The Committee concludes with the proposed expansion of their role to include case management, Aged Care Assessment Teams will be well placed to

identify people who are at risk of malnutrition and assist them to access practical help. [42]

Conclusion 8

5.48 **The Committee concludes that the Department of Health and Ageing ensure that the expanded role of Aged Care Assessment Teams in case management include early identification and management of nutritional problems.**

Nutritional problems should be included in the Aged Care Assessment Program National Minimum Data Set and reported against annually.

42 Budget Measures 2004-05, Budget paper no. 2, p 188; In Victoria assessment is the responsibility of Aged Care Assessment Services.

6

Workforce participation

6.1 Maintaining and increasing the number of older people in the workforce is of interest to the inquiry from both social and economic perspectives.

The Challenge

6.2 The changing demographic profile of the Australian population will impact upon labour participation due to a higher proportion of the population reaching retirement age. While Australia's population is projected to increase by 16% or 3 million people by 2012, 94% of this growth will be in people aged 45 years and over, resulting in decreasing workforce participation over time.[1] This in turn could reduce annual growth in Gross Domestic Product (GDP).

6.3 The last 40 years have seen significant changes in the way in which Australians work with a dramatic increase in the number of women joining the workforce. The increased rates of female participation between 1982-83 (44.6%) and 2002-03 (56%) are partly explained by the increased instances of part-time work. In 1973, 12% of all work was part-time, by 2002-03 the proportion had increase to 28.5%.[2]

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1 Australian Bureau of Statistics, Labour Force Projections Australia, Canberra, 1999, Catalogue No 6260.0, p 7.

2 Australian Bureau of Statistics, *2004 Year Book*, Canberra, 2004, Catalogue No 1301.0, p 133; Australian Social Trends 1994 Work – Paid Employment: Trends in Part-time work, Canberra, 1994, p 1-2.

6.4 As noted in chapter 1, potentially the ageing of the population could be offset by changes in fertility or mortality (which are unlikely) or by changing immigration policies. There is general agreement in the evidence put to the Committee that immigration may moderate the fall in employment growth but increases in immigration alone will not be sufficient to reverse declining workforce participation.[3]

6.5 At present the participation rate for the older people is significantly lower than for other age groups (Table 6.1).

6.6 The Department of Family and Community Services (FACS) indicates that Australia has participation rates below the OECD average, for men and women alike in the mature age (55 to 64 years) group. In 2002, Australia's participation rate for this group was 48.6%, whereas Canada had 51.3%, United Kingdom 54%, United States 60.2%, and New Zealand 62.93%[4]. As a consequence, Australia is at a significant disadvantage in accessing and retaining the expertise of mature age workers.

Table 6.1: Labour Force Participation Rates, by age group

	Males		**Females**	
Age Group	*1982-83 (%)*	*2002-03 (%)*	*1982-83 (%)*	*2002-03 (%)*
15-19	63.6	58.4	59.2	60.7
20-24	91.2	85.1	71.0	77.5
25-34	95.6	91.2	54.0	70.8
35-44	95.0	90.6	58.4	72.6
45-54	90.6	88.1	48.2	73.8
55-64	64.4	63.1	20.3	40.2
65 and over	9.7	10.0	2.3	3.2
All Age Groups	**77.1**	**72.0**	**44.6**	**56.0**

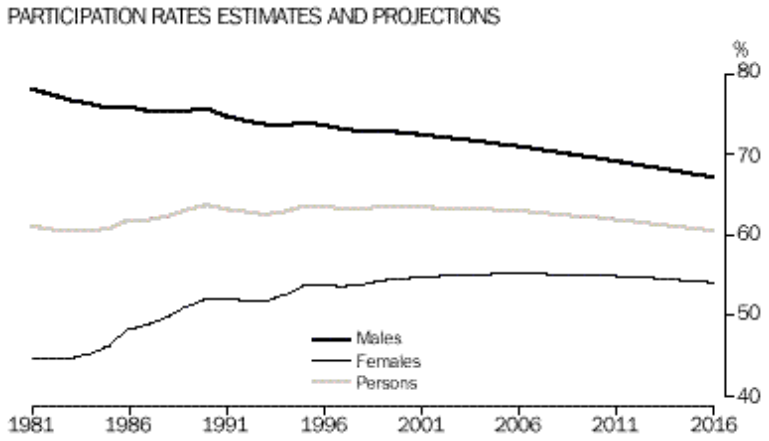
Source: ABS, 2004 Year Book, p 133.

6.7 Although female participation rates have increased over the last twenty years, this trend could flatten over the future years. Ausralians overall participation rate is expected to decrease over time as shown in Figure 6.1.

3 Department of Immigration and Multicultural and Indigenous Affairs, sub 117, p 3; Betts K, Swinburne University of Technology, Victoria, sub 92, p 1; Sustainable Population Australia, Canberra Region, sub 55, p 3.

4 Department of Family and Community Services, sub 90, pp 10-11.

Figure 6.1: Workforce participation rates to 2016



Source: Australian Bureau of Statistics, Labour Force Projections, Australia, 1999-2016, catalogue 6260.0

6.8 The low participation rate also affects Australia's aged dependency ratio by decreasing the number of working aged people (between 15 and 65 years) supporting the number of people aged over 65 years. Table 6.2 shows that while Australia's aged dependency ratio is expected to rise from 18.2 in 2000 to 32.3 in 2030 (177% increase), it will still be well below the 2030 projected international average of 41.2. Countries such as Switzerland and Japan are expected to experience an increase in their aged dependency rates of respectively 23.8 to 53.0 and 25.2 to 51 (a 200% increase).[5]

Why older people leave the workforce

6.9 The reasons why mature age workers leave the workforce are complex and interrelated. They include: early retirement (voluntary and involuntary); reluctance among employers to recruit mature aged people; and low demand for the skills or expertise mature age workers possess.[6]

6.10 Older employees may leave the workforce as a result of company policy, culture or the attitudes of individual managers. Employer attitudes form one of the most significant barriers to mature age employment. Stereotypical assumptions about the merits of older workers include low productivity, inefficiency, and mental and physical incapacity. Professor Helen Bartlett advised the Committee:

5 Gittins R and Tiffen R, *How Australia Compares*, 2004, Cambridge, England, Chapter 6, Work and the labour force, p 67.

6 Department of Health and Ageing, sub 119, p 26.

The challenges that still remain are concerned with negative attitudes around ageing and how we can break down some of the stereotypes.[7]

Table 6.2: Aged dependency ratio

Country	1980	2000	2030
Switzerland	20.8	23.8	53.0
Japan	13.4	25.2	51.7
Italy	20.4	26.7	47.3
Austria	24.0	22.9	46.4
Germany	23.7	24.1	46.3
Sweden	25.4	27.1	46.0
Finland	17.7	22.3	45.7
Belgium	21.9	25.9	43.4
United Kingdom	23.5	24.1	40.4
Denmark	22.3	22.5	40.0
France	21.9	24.5	39.8
Netherlands	17.4	20.1	39.6
Norway	23.4	23.7	39.1
Canada	13.9	18.5	37.5
New Zealand	15.7	17.9	33.7
United States	16.9	18.6	32.9
Australia	**14.7**	**18.2**	**32.3**
Ireland	18.3	16.9	26.3
Mean	***19.7***	***22.4***	***41.2***

Source: Annex to OECD Society at a Glance: OECD Social Indicators (2nd Edition, 2003) Table 2.1.A, as cited by R Grittins and R Tiffen, Work and the labour force, p 67.

6.11 The Committee notes that increasing the rate participation of older workers in the paid workforce has the potential to contribute significant opportunities towards productivity and social wellbeing in Australia.

Barriers to workforce participation

6.12 Mature aged people can face disadvantages and barriers when seeking work or wishing to remain in the workforce: the attitudes of employers, their duties as carers, a lack of relevant skills and experience and perhaps their own health. [8]

7 Bartlett H, transcript 20/05/2003, p 498.

8 The Country Women's Association of Australia, sub 121, p 1.

6.13 The Department of Family and Community Services drew the Committee's attention to research undertaken by Drake Personnel surveying discrimination against older workers. Of the group of 500 organisations surveyed, 62% choose their staff from the 31 to 40 years age group. None preferred to select managers and executives in their fifties and 65% indicated the over 50 age group are more likely to be identified for retrenchment. In evidence to the Committee Professor Helen Bartlett pointed out that most of human resources staff are likely to be in their 30s. This may be a contributing factor in employing younger people instead of older people.[9]

6.14 Other evidence indicated that there are implicit incentives to discriminate against older workers. Mr Venner stated that '…older workers have low status and low status workers have low status managers. Low status managers do not get promoted.' Older workers are also far more likely to be denied workplace training or promotion. [10]

6.15 Mature aged people often find it may take longer and be more difficult to find employment. This is reflected in the fact that mature aged people have the highest levels of long term unemployment. While the rate of mature age unemployment is lower than for other groups, mature age workers face increased rates of long term unemployment.[11] Figure 6.2 illustrates that the proportion of people whose last job was two or more years ago increases with age, with those aged 55 years and over making up 51% of the long term unemployed.[12]

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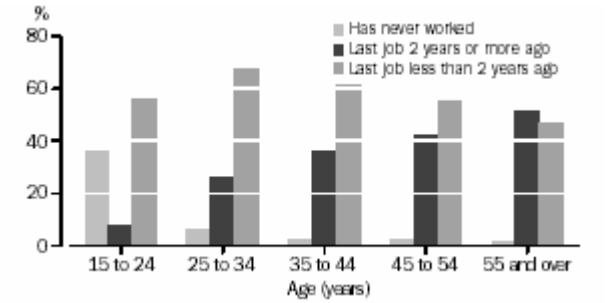
9 Department of Family and Community Services, sub 156, pp 11-12; Bartlett H, transcript 20/05/2003, p 507.

10 Venner R, sub 168, pp 1-2.

11 In November 2003, the unemployment rate for 45-64 year olds was 3.5% compared with an overall unemployment rate of 5.4%; Australian Bureau of Statistics, *Australian Labour Market Statistics, Job search experience: methods and barriers in finding jobs*, Canberra, April 2004, catalogue no 6105.0

12 Australian Bureau of Statistics, *Australian Labour Market Statistics, Job search experience: methods and barriers in finding jobs*, Canberra, April 2004, catalogue no 6105.0

Figure 6.2: Unemployed Persons with prior work experience



Source: Australian Bureau of Statistics, Australian Labour Market Statistics, Job search experience: methods and barriers in finding jobs, April 2004 catalogue no. 6105.0.

6.16 Reasons for leaving the workforce vary by age. In 1997, people under 60 years most commonly retired because of ill health or injury, particularly among those retiring before the age of 55 years where more than half of retirees gave this as the reason. Retrenchment was also given as a common reason for those aged under 60, particularly among those aged between 55 and 59 years (19%). However, most of those who had retired between 65 and 69 years had done so because they felt they had reached an appropriate age for retirement or because they had reached the compulsory age for retirement in their job and were 'considered too old by employers' (82%).[13]

6.17 Until recently, superannuation arrangements may also have acted as an incentive for individuals to retire at an age where they could still have contributed to, and received benefits from, the workforce. The Australian Government announced in 1997 that the preservation age for superannuation would be increased from 55 to 60 for anyone born after 1 July 1964.[14] Other superannuation measures to encourage increased workforce participation are detailed in chapter 7.

6.18 An ageing community means that there is an increasing number of carers including older people. Many people, particularly in regional and rural centres, find it necessary to leave work to provide care for a partner or relative. Options such as flexible working arrangements and parental care should be considered so that carers have a more realistic chance of combining caring and workforce participation.[15]

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13 Australian Bureau of Statistics, Australian Social Trends 2000, *Retirement and retirement intentions,* Canberra, catalogue no. 4102.0 pp 112,131; ACTU, sub 107, p 4; Reeve P, transcript, 20/05/2003, p 513.

14 FaCS sub 156, p 6; Australian Taxation Office, *Self-managed superannuation funds – preservation rules*, viewed 4/05/2004, <http://www.ato.gov.au/super/content.asp?doc=/content/19132.htm>.

15 Halliday G, transcript 3/02/2004, pp 767-9.

6.19 Recent research into the barriers facing older workers examined ways to reduce age-related stereotypes and discrimination, and to increase fairer performance ratings and provision of training. The research recommended:

- providing training to managerial staff on the ageing process;
- retraining older workers to enhance their career opportunities, especially within companies undergoing substantial organisational change;
- providing older workers with opportunities to enhance motivation and learning by undertaking job rotation and job transfers; and
- carrying out career planning programs to avoid skill obsolescence and increase the commitment and productivity of the employee. [16]

Sharing responsibility for improving workforce participation

6.20 Increasing workforce participation is a shared responsibility. Governments, employers, the community and individuals are all responsible for encouraging and increasing levels of workforce participation and together need to develop strategies that meet the needs of all parties.

6.21 The role of Government is to provide an environment, through legislation, policies and services, which encourages participation. It is also that of encouraging choice for those who could possibly enter or exit the labour force:

> The key issue is not to mandate particular labour market behaviour for this group. Rather it is to create the environment in which those people, particularly women with child rearing or other caring responsibilities can balance those responsibilities with the demands of work should they choose to enter or return to the labour force.[17]

6.22 The Australians Working Together (AWT) welfare reform package, introduced by the Australian Government in September 2002, encompasses a range of initiatives to help people on income support gain work or participate in their communities in ways which best suit

16 Department of Education, Science and Training, Report into the Barriers to Training for Older Workers and Possible Policy Solutions, pp 171-219, 001, viewed 17/05/2004, <www.dest.gov.au/archive/iae/documents/olderworkers/olderworkersv4.pdf>.

17 Department of Employment and Workplace Relations, sub 164, p 10.

them.[18] The Transition to Work component focuses on parents, carers and people 50 years and over who are starting work for the first time or are returning to work after an absence of 2 years or more. The program offers mature age people practical help and training to develop their skills including: help with writing a resume or job application; courses to up-grade skills; career counselling; and driver training.[19]

6.23 The Indigenous Employment Policy (IEP) focuses on increasing employment opportunities, particularly in the private sector, for Indigenous people. The IEP consists of a number of programs including the Community Development Employment Program (CDEP).[20] While supporting the desirability of older people maintaining workforce participation, the Aboriginal and Torres Strait Islander Commission explained that in some communities, CDEP can make only a limited contribution to assisting people with workforce participation. There may be 'a couple of generations without any work experience.' Even where CDEP does assist in acquiring skills, there may be very few labour market opportunities.[21]

6.24 Governments are not solely responsible for increasing levels of workforce participation. The Business Council of Australia (BCA) recognises the role business (inclusive of government employers) at all levels must play:

> While change will initially need to be led from the top, it must flow through all levels of business if new strategies and policies are to have a meaningful impact.[22]

6.25 The notion of sharing responsibility underpins the Community Business Partnership (CBP). The CBP recognises that communities are stronger and more cohesive when individuals, not-for-profit organisations, governments and business work together, combining their resources and skills to develop creative solutions to local and regional problems and to strengthen community ties. The focus of the

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18 Australian Chamber of Commerce and Industry, *Mature Age Employment Changing Culture,* May 2003, viewed 19/05/2004, <http://www.acci.asn.au/text_files/issues_papers/Employ_Educ/ee27.pdf>.

19 Australian Government website, viewed 19/05/2004, <http://www.together.gov.au/whoIsInvolved/peopleOverFifty/default.asp>.

20 Department of Workplace Relations, *Indigenous Employment Policy,* viewed 16/07/2004, <http://www.workplace.gov.au/indigenous>.

21 Gooda M, transcript 7/03/2003, p 202.

22 Business Council of Australia, *Age Can Work: A Business Guide for Supporting Older Workers,* August 2003, p 3, viewed 16/07/2004, <http://www.bca.com.au/content.asp?newsID= 91720>.

CBP includes measuring employment participation for older workers. The Prime Minister has requested the CBP inquire into ways for government and business to encourage the private sector to employ more mature age workers. The Partnership is expected to present its findings and recommendations to the Prime Minister for consideration in mid 2005.[23]

6.26 State and Territory Governments in their strategies to address the ageing of the population all acknowledge the importance of encouraging workforce participation. Encouragement to participate in the workforce is given through targeted programs, including:

- in NSW, the Mature Workers Program, run through the Department of Employment and Training;
- the South Australia Government's workforce development strategy targets older workers and Indigenous people and has a focus on job opportunities in regional communities; and
- in Queensland the Back to Work Program and the Experience Pays Program focus on people aged 45 and over who have been unemployed for at least 3 months.[24]

The benefits of employing older workers

6.27 Evidence presented to the Committee reinforces the value of mature age workers and the positive contribution they make to the workforce, including:

- in many activities, productivity may increase with age in part because continuity and stability combined with experience reduce training and recruitment costs;
- mature workers produce work of high quality; and

23 Community Business Partnership, viewed 12/07/2004, <http://www.partnerships.gov.au/social/social_policy_mature_age_workers.shtml>.

24 Encel S, *Age can work: The case for older Australians staying in the workforce,* A report to the Australian Council of Trade Unions and the Business Council of Australia, April 2003, viewed 28/05/2004, <http://www.bca.com.au/upload/AGEDOCfinal22.04.03.pdf>, p 25-28; ACT, viewed 11/05/2004, <http://www.ageing.act.gov.au/ministinfo/>; NSW, viewed 6/05/2004, <http://www.maca.nsw.gov.au/pdf/strategicplan2003-4-2005-6.pdf>; NSW Mature Workers Program, viewed 28/05/2004, <http://www.det.nsw.edu.au/eas/mature/index.htm>; NT, viewed 5/05/2004, <http://www.nt.gov.au/dcm/senior_territorians/strategy.shtml>; QLD, sub 129, p 8; QLD website, viewed 5/05/2004, <http://www.communities.qld.gov.au/seniors/publications/ index.html>; SA, viewed 27/05/2004, <http://www.saworks. sa.gov.au/>; TAS, viewed 5/05/2004, <http://www.dpac.tas.gov.au/divisions /seniors/>; VIC, viewed 5/05/2004, <http://www.seniors.vic.gov.au/index.htm>; WA, viewed 5/05/2004, <http://osi.wa.gov.au/htmlfiles/active.htm>.

- older workers may have more experience and maturity, a stronger work ethic and higher commitment to their jobs. [25]

6.28 Negative stereotypes need to be countered with positive messages which highlight the contribution older Australians can make to the workforce and to the community. [26] There is considerable scope for organisations to improve mature age participation in the workforce by addressing misconceptions about older workers.

Practical initiatives to encourage participation

6.29 The Department of Employment and Workplace Relations (DEWR) suggested to the Committee initiatives to encourage people in the workforce to stay at work longer and encourage those who have left the workforce to re-enter the workforce as soon as possible. Possible initiatives include building upon workplace relations reforms by increasing flexibility in working conditions such as the opportunity to access permanent part-time work, flexible working hours, job sharing, home-based work, career breaks and family friendly policies. [27]

6.30 Already some organisations have introduced more flexible working arrangements to support the employment of older workers including Alcoa Kaal Australia Pty Ltd, ANZ Banking Group Ltd, Australia Post, the Department of Family and Community Services, Geoscience Australia, National Australia Bank and Westpac.[28] Flexible working arrangements introduced by these organisations include job sharing, parental care, purchased leave arrangements and part time work.

6.31 DEWR emphasised to the Committee that, along with these initiatives, there needs to be a change in employer culture to recognise the value of investing, retaining and retraining older staff.[29]

6.32 Some organisations are encouraging programs to assist their workers to stay healthy. Health and wellness programs adopted include the 10,000 steps a day initiative, fitness programs, providing health

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25 Bartlett H, transcript 20/05/2003, p 507; Australian Council of Trade Unions, sub 107, p 5.

26 Local Government Association of NSW, sub 89, p 9; Australian Industry Group, sub 110, pp 5-6.

27 Department of Employment and Workplace Relations, sub 164, pp 10-11.

28 Australian Public Service Commission, *Flexible working arrangements for older workers,* Canberra, 2003, pp 18-20, viewed 11/05/2004, <http://www.apsc.gov.au/publications03/ maturedewr.pdf>; Australian Financial Review, Hepworth A, *Older workers needed to avoid labour shortage*, 5 May 2004, p 10; The Age, O'Rourke J, Lang M & Nuefeld S, *Big firms get friendlier with families,* 18 January 2004.

29 Department of Employment and Workplace Relations, sub 164 pp 10-11.

services such as vaccinations, skin cancer screening and stress management seminars.[30]

6.33 Increasingly it is being recognised that older people's preference is to be serviced by staff of a similar age and experience, who are more likely to understand their viewpoint and issues. Recently reported examples of the recruitment of older people to service the needs of older customers include Westpac, which set a target of recruiting 900 older workers by 2005, Bunnings Warehouse which has recruited experienced tradesmen over the age of 50, Hertz and Australia Post. Centrelink employs older people to become personal advisers, providing career guidance and helping clients develop career plans.[31]

6.34 More people may stay in the work force longer and go on contributing to savings for later life if there is a general acceptance of phased retirement. FaCS explained the benefits of phased retirement:

> Phased or transitional retirement allows for a gradual transition from full-time work to no paid work, providing flexibility to accommodate other responsibilities or interests, for example, caring responsibilities and volunteering. There is also potential for retirement incomes to be supplemented by earnings for those people who can and wish to work beyond Age Pension age, perhaps on a part-time or casual basis.[32]

6.35 Evidence to the Committee shows that some organisations encourage phased retirement to help make the transition from working easier for the individual. Employees may phase in their retirement by working more flexible hours or by changing their roles in the workplace, perhaps shedding management responsibilities in order to focus on project or mentoring work. Phased retirement would give people time to adjust to the transition of working to retirement. [33]

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30 10,000 steps – one at a time, viewed 17/05/2004, < http://www.smartstate.qld.gov.au/smartstories/ss_project/ssproject_e1y.shtm>; Bannister L, Human Resources, *A healthy helping hand: Corporate health and fitness programs,* 24 February 2004, viewed 28/05/2004, <http://www.humanresourcesmagazine.com.au/articles/0B/0C01D90B.asp?Type=60&Category=881>; Work Solutions Group, Corporate Health Solutions, *Solutions for Human Resource Managers*, viewed 28/05/2004, <http://www.worksolutions.com.au/corphealth.htm>.

31 Centrelink, sub 78, pp 17-18; McCallum J, sub 132, p 3; The Sydney Morning Herald, Long C, *A wiser approach to older workers,* 5 May 2004.

32 Department of Family and Community Services, sub 90, p 16.

33 Council on the Ageing (Australia), sub 91, pp 24-25; Council on the Ageing (Australia), sub 157,p 8; COTA NT & National Seniors, sub 178, p 11; Lgov NSW, sub 89, p 9; Deans D, transcript 20/05/2003, p 510.

6.36 Phased retirement may assist in making people's retirement incomes last longer, enabling them to delay using their superannuation. To encourage phased retirement, the Australian Government has enabled superannuation to be accessed whilst working part time once a worker has reached preservation age, thus allowing people to supplement their retirement income by continuing their participation in the workforce.

6.37 The Council on the Ageing suggested to the Committee that phased retirement will become the norm rather than the exception over the coming years, with beneficial effects for both individuals and the community.[34]

6.38 As the population ages, it is expected that most people will make several career changes before they retire.[35] Significant structural change has already taken place in traditional industries over the past twenty years and mature workers have increasingly been required to embrace new technologies.

6.39 Older people may need to rethink their career paths, and possibly move from one industry to another. Many may require training or retraining to give them the skills and confidence to seek work in different jobs. This also requires a change of attitude by employers:

> …employers need a bit of encouragement to do that and there might be some retraining needed, so we have been talking about the possibility of encouraging employers to retrain these very skilled workers to work in a different role.[36]

6.40 People aged 55 or over are far less likely to have used a computer than young people – indeed only 32% have. This places them at a disadvantage as many jobs now require computer literacy.[37] Professor Helen Bartlett explained to the Committee:

> It is very clear that if you are in a professional career there may be possibilities to adopt more flexible working as you age…But in other professions or in unskilled work, individuals will not necessarily have that choice.[38]

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34 Council on the Ageing (Australia), sub 91, p 25.

35 *Age Counts: An inquiry into issues specific to mature-age workers*, House of Representatives Standing Committee on Employment, Education and Workplace Relations, June 2000, pp 134-135.

36 Noble J, transcript 2/02/2004, p 710.

37 Australian Bureau of Statistics, *Use of internet by householder,* Catalogue no. 8147.0, Canberra, 2001, p 5.

38 Bartlett H, transcript 20/05/2003, p 505; see also Robinson C, Department of Employment and Training, *Employment Opportunities and Needs for the Future*,

6.41 If labour force participation is to be maintained and increased as the population ages, there will be pressure on people to acquire new work skills and abilities. An ageing population will need to engage in ongoing education and training to improve labour force competitiveness.

Lifelong learning for workforce participation

6.42 Evidence to the Committee stressed the role of lifelong learning in maintaining workforce participation. Lifelong learning fosters adaptability and responsiveness to change.[39]

6.43 The Australian Industry Group noted that there is considerable scope to increase the workforce participation of older people through innovations in education and training, such as:

- greater recognition by managers, individual workers and unions of the importance of life-long learning and its incorporation into the institutional arrangements governing work;
- improved access to more flexible learning arrangements – particularly through short courses relevant to job requirements and through more widespread use of e-learning; and
- improved procedures for more thorough recognition of prior learning and current competencies (including competencies and learning acquired or developed on-the-job).[40]

6.44 The Business Council of Australia recognises that lifelong learning is not entirely dependent on the employer, but on the interaction between the individual and his or her employer or organisation:

> Individuals must take responsibility for maintaining skills and training and their overall employability. At the same time business must encourage and support individuals in their efforts.[41]

6.45 Evidence presented to the Committee emphasises the need for employers to encourage the retraining of people and to provide

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presentation to the Skilling Australia Forum, Gold Coast, 10-12 September 2003, pp 20, 27, 28, viewed 19/07/2004, <http://www.skillingaustralia.com/skill_aust_forum/pdf/chris_robinson_notes.pdf>.

39 Lgov NSW, sub 89, p 11; Adult Learning Australia Inc, sub 100, p 1.

40 Australian Industry Group, sub 110, p 6.

41 *Age Can Work: A Business Guide for Supporting Older Workers*, Business Council of Australia, August 2003, p 7, viewed 19/07/2004, <http://www.bca.com.au/content.asp?newsID= 91720>

opportunities for life long learning so as to provide flexible, well trained, and motivated employees. [42]

> … a lot of [mature workers] are very articulate and will be able to contribute to society for a long time to come. They do not tend to get to the age of 60 or 65 and say 'It is time to hang up my hat.' That is where the educational aspects need to kick into gear to say, 'You are of worth. You can still contribute.'[43]

6.46 Mentoring programs are a means of contributing to a more skilled workforce.[44] Organisations such as Golden Circle and Wyong Shire Council have introduced mentoring so that mature-age workers can transfer knowledge to colleagues and foster intergenerational links with younger generations:

> …harnessing those people with mentoring programs – as business mentors and school mentors …we are harnessing those people and their worth within the community.[45]

6.47 Vocational Education and Training (VET) should have the potential to play a major role in lifelong learning, especially given its wide network of service outlets. Vocational Education and Training is delivered by around 4000 providers through secondary schools and Technical and Further Education (TAFE) institutes.[46]

6.48 However, the number of mature aged participants in the Vocational Education and Training scheme has been lower than other age groups, representing only 14% of participants in 2002. The Vocational Education and Training National Strategy, launched in 2003, in part aims address this through increased focus on enhancing the skills of mature age workers and increasing heir chance of achieving and/or maintaining involvement in the workforce. [47]

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42 Department of Family and Community Services, sub 90, p 13; Department of Employment and Workplace Relations, sub 164, p 11; Douglas K, transcript 7/03/2003, p 191; Council of the Ageing (Australia), sub 91, p 23-24; Flanagan K, transcript 7/02/2003, pp 17-18.

43 Burgess E, transcript 24/02/2003, p 113.

44 Deans D, transcript 20/05/2003, p 510.

45 Burgess E, transcript 24/02/2003, p113; McCallum J, sub 132, p 6.

46 Australian National Training Authority, *VET – What is it*, viewed 2/06/2004, <http://www.anta.gov.au/vetWhat.asp>.

47 Australian National Training Authority, *VET – What is it*, viewed 2/06/2004, <http://www.anta.gov.au/vetWhat.asp>; Australian National Training Authority, *Increasing the Vocational Education and Training Participation and Achievement of Mature Age Workers*, Ideas for Action, viewed 8/08/2004, <http://www.anta.gov.au/images/publications/mature.pdf>, p 3; Australian Bureau of Statistics, 2004 Year Book,

6.49 The importance of lifelong learning is also acknowledged by the Senate Employment, Workplace Relations and Education Committee. In March, 2004 this Committee commenced an inquiry into future policies to support life long learning of Australia's ageing population. The Committee is scheduled to table the report in November, 2004.

New employment opportunities

6.50 The Committee notes that while there is general acceptance of the need to increase workforce participation, less attention is being given to valuing work related to older people. There is still much scope for new business and employment opportunities servicing the needs and preferences of older people. Future employment opportunities will not just be related to the aged-care sector. Indeed there is already growing demand for products and services tailored to meet the needs of the older population. [48]

6.51 Businesses and governments are expected to concentrate on improving existing services and programs which seniors use and value. These include primary health care, hospitals, pharmaceuticals, employment services, utilities, public transport, residential care, social support, in-home therapy, housing and community care. [49]

6.52 Future services to meet the needs of older people include:

- personalised home and lifestyle services from medical, diet, natural therapy and massage specialists;
- multilingual translators for aged care providers
- accommodation and entertainment specifically designed for seniors;
- financial advisors for superannuation and other investments
- travel and educational tours; and
- education and lifelong learning providers.[50]

Education and Training, Vocational Education and Training (VET), 2004, Catalogue No 1301.0.

48 Bartlett H, transcript 20/05/2003, pp 503-504; Reeve P, transcript 20/05/2003, p 512.

49 Mason B, CPA Australia, *Business opportunities in the non-profit sector – an aged care perspective*, Edition 1 2004 CPA Australia's Public Sector News, viewed 19/07/2004, <http://www.cpaaustralia.com.au/01_information_centre/26_tbl/1_26_0_0_tbl_index.asp>; NSW Department of Health, sub 160, p 12.

50 Mason B, CPA Australia, *Business opportunities in the non-profit sector – an aged care perspective*, Edition 1 2004 CPA Australia's Public Sector News, viewed 19/07/2004, <http://www.cpaaustralia.com.au/01_information_centre/26_tbl/1_26_0_0_tbl_index.

6.53 The projected shortfall of informal carers, as noted in chapter 2, may also open up niche business and employment opportunities. Some families may prefer to purchase support services from private suppliers, rather than access government controlled services provided through CACPs and HACC funding.

Supporting workforce participation through corporate social responsibility

6.54 The Australian Government's Community Business Partnership encourages corporate social responsibility activities and public accountability for the outcomes of such activities through Triple Bottom Line (TBL) reporting. The Committee notes that the Partnership has a leadership role in:

- …encouraging companies to identify and generate opportunities for people with disabilities, older workers and parents returning to the workforce … tak[ing] forward a national approach to triple line reporting…[51]

6.55 The Department of Family and Community Services, (FaCS) in 2003, undertook the first TBL report of its kind for an Australian Government agency. The Committee notes that while in this report FaCS records having already put in place flexible working arrangements and an Indigenous recruitment and retention strategy, the Department has since published the *FaCS Mature Workers' Strategy*.[52]

6.56 The Committee also notes that Standards Australia has developed a world-first standard to provide a framework for organisations to establish and maintain a corporate social responsibility program. Australian Standard *AS 8003-2003, Corporate governance – Corporate social responsibility*, is equally applicable to public and private

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asp>; NSW Department of Health, sub 160, p 12; Burgess E, transcript 24/02/2003, pp 105-06.

51 Community Business Partnership, viewed 14/04/2004, <http://www.facs.gov.au/internet/ facsinternet.nsf/aboutfacs/programs/esp-welreform_whatshappening_ pmcbp.htm>.

52 Department of Family and Community Services, *Triple bottom line report: Our commitment to social, environmental and economic performance,* 2003, Canberra, viewed 23/04/2004, <http://www.facs.gov.au/tblreport_2002-03/_lib/pdf/tbl02_03.pdf>, p 3.; *FaCS Mature Age Workers' Strategy,* viewed 5/05/2004, <http://www.facs.gov.au/internet/ facsinternet.nsf/VIA/matureworkers>. Westpac also undertakes a form of triple bottom line reporting in its Social Impact Report, viewed 12/05/2004, <http://www.westpac.com.au/internet/publish.nsf/Content/WISPSI+Downloads>, p 16.

organisations, government departments and not-for-profit organisations. The International Standards Organisation (ISO) is also considering a corporate social responsibility standard.[53]

6.57 The Committee considers that these developments – corporate social responsibility and associated reporting through triple bottom line reporting and/or standards – have considerable potential to foster an environment conducive to better, and more appropriate employment opportunities for older people. However, there is a need for more explicit connections between the two approaches. Organisations should:

- develop indicators for and report on improving employment opportunities for older people within their own organisations; and
- extend corporate social responsibility activities to assisting with improving employment opportunities for older people more generally.

6.58 The Committee concludes that, in taking forward a national agenda for triple bottom line reporting, the Prime Minister's CBP, in promoting a culture of corporate and individual social responsibility, should encourage corporate social responsibility and associated reporting through triple bottom line reporting or through complying with corporate social responsibility standards.

Voluntary work - unpaid work

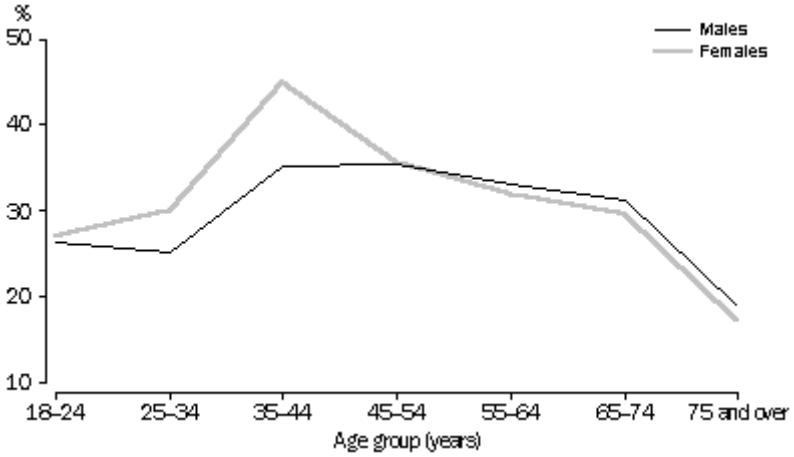
6.59 The Committee heard wide-ranging evidence about the increasing importance being placed on volunteering and the associated benefits to individuals, communities, businesses, other employer organisations and the economy. The evidence also throws light on the evolving nature of the relationship between paid work and volunteer work.

6.60 In 2000, there were around 4.4 million adult volunteers – 32% of the population over 18 years. Volunteer rates varied across age groups. The highest rate of volunteering was among people aged 35-44 years

53 Standards Australia, *AS 8003-2003: Corporate Governance – Corporate Social Responsibility*, viewed 23/05/2004, <http://www.standards.com.au/catalogue/script/Details.asp?DocN=AS871065609029>; BSD Global.com, *Business and Sustainable Development: A Global Guide,* viewed 21/05/2004, <http://www.bsdglobal.com/issues/sr.asp>; United States Council for International Business, *ISO to Debate International Standard on Corporate Responsibility,* viewed 3/05/2004, <http://www.uscib.org/index.asp?documentID=2847>.

(Figure 6.3) however the median hours worked by volunteers tended to increase with age to peak at 2.5 hours per week for ages 65-74.[54]

Figure 6.3: Voluntary work in Australia in 2000, showing age and sex



Source: ABS Voluntary Work Australia June 2001 (Cat No. 4441.0)

6.61 The most common types of volunteer activity that Australians aged 65 and over, took part in were: fundraising/sales (51.9%); clerical/ administration /recruitment (38.9%); and management/committee work/co-ordination (38.9%). Volunteering can be a way of updating skills and gaining the confidence and connections to re-enter the workforce. Sometimes, a volunteer position leads to paid employment.[55]

6.62 The work of volunteers contributes to both social capital and the economy – a contribution that is now being measured more systematically. The economic value of volunteer work was estimated to be $8.9 billion in 1999-2000.[56]

6.63 Over recent years, an increasing number of organisations, both private and public, have encouraged the involvement of volunteers in their activities through volunteering programs. Volunteer work

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54 Department of Family and Community Services, sub 156, p 24; Australian Bureau of Statistics, Year Book Australia 2002, *Income and Welfare Voluntary work in 2000*, Catalogue no 1301.0, 2002, Canberra.

55 Australian Bureau of Statistics, *Voluntary Work Australia,* 2000, Catalogue no 4441.0, 20 June 2001, Canberra, p 29; Recreation Training Queensland, *Volunteer your time and gain some valuable experience,* viewed 26/05/2004, <http://www.rtq.com.au/CareersGuide/getexp-volunteer_body.html>.

56 Mayer P, *The Wider Economic Value of Social Capital and Volunteering in South Australia,* November 2003, p 1, viewed 28/05/2004, <http://www.ofv.sa.gov.au/pdfs/mayer_report.pdf >; Australian Bureau of Statistics, Media Release, *Non-profit institutions contribute 3.3% to GDP*, 28 November 2002, 1 p.

provides organisations with additional resources which may be used to support ongoing activities or to undertake activities not possible within budget resources.[57]

6.64 Some organisations are encouraging their own paid staff to be involved in corporate social responsibility programs with the aim of assisting people or groups in the community. Westpac, the ANZ Bank and the Department of Family and Community Services encourage their staff to take be active in such programs.[58]

6.65 The Australian Government funds programs to assist volunteers and volunteer organisations including Voluntary Work Initiative; Participation through Volunteering (Australians Working Together); National Skills Program for Volunteers; Volunteer Management Program; Volunteer Small Equipment Grants 2004; Indigenous Community Volunteers and Volunteering Australia.[59]

6.66 The Volunteer Management Program funds Volunteer Resource Centres across Australia to provide volunteer matching services and training of volunteers. In 2002-03, a total of 19,399 volunteers were referred to 26 member organisations including 17 regional agencies. Under the program 6,701 training hours were provided. In 2004-05, FaCS is increasing the number if Volunteer Resource Centres to 27 at a total cost of $1.649 million. [60]

6.67 The Indigenous Community Volunteers (ICV), a program under the Department of Employment and Workplace Relations, provides avenues for corporate social responsibility or individual volunteering. The scheme links skilled volunteers with Indigenous communities and organisations to encourage skills transfer and the development of

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57 Volunteering Australia, website, viewed 21/07/2004, <http://www.volunteeringaustralia.org/sheets/corporate.html>

58 Westpac, *Westpac in the Community,* viewed 27/04/2004, <http://www.westpac.com.au/internet/publish.nsf/Content/WIWC+Our+Community+Involvement>; ANZ website, viewed 27/04/2004, <http://www.anz.com/aus/careers/Wheretobe.asp>; Department of Family and Community Services, *Triple bottom line report: Our commitment to social, environmental and economic performance,* 2003, Canberra, viewed 23/04/2004, pp 26-28, <http://www.facs.gov.au/tblreport_2002-03/_lib/pdf/tbl02_03.pdf>.

59 Department of Family and Community Services, sub 156, p 25-26; Department of Family and Community Services, *Volunteering*, viewed 14/07/2004, <http://www.facs.gov.au/internet/facsinternet.nsf/aboutfacs/programs/communities-volunteering.htm>

60 Department of Family and Community Services, *Annual Report 2002-03 Volume 1,* p 128, viewed 14/07/2004, < http://www.facs.gov.au/annreport_2002-03/_lib/pdf/facs_ar_full.pdf>. Department of Family and Community Services, Family and Community Services Portfolio, Budget Related Papers No 1.8, Commonwealth of Australia 2004, pp 166, 177.

longer term strategic relationships between communities and the private sector.[61]

6.68 The Committee was made aware of concerns that volunteers may be exploited, or exposed to liability and safety problems.

6.69 Professor Byles explained that:

> There is a need to consider current financing, accreditation and liability issues as they impact on the quality and quantity of volunteer resources across the community.[62]

6.70 Other organisations stated that difficulties getting insurance for older volunteers can limit volunteering activities.[63] Volunteers should not be seen as replacing paid workers or constituting a threat to the job security of paid workers. Volunteering is not a substitute for paid work.

6.71 The Aged-care Rights Service also cautioned against organisations exploiting volunteers by placing unrealistic expectations in them:

> … there is a tendency to load volunteer workers with unreasonable responsibilities, to expect more with greater personal liabilities. [64]

6.72 These difficulties have been recognised by volunteering Australia has developed a set of National Standards. These provide a best practice guide to ensure volunteer's rights are protected and that they work in a safe and healthy environment:

> The National Standards have been written with the explicit intention of protecting the volunteer, the volunteer-involving organisation and customer of the organisation.[65]

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61 Department of Employment and Workplace Relations, 2004-05 Budget, *Budget Fact Sheet Indigenous Community Volunteers*, viewed 21/05/2004, <http://www.dewr.gov.au/ministersandmediacentre/budget2004/factsheets/budgetfactsheeticv.doc>. Examples of projects include: the Horticulture project that have led to accredited training jobs; pottery project that has resulted in increased sales revenues; and community benefits from a sport and recreation project.

62 Byles J, sub 103, p 4.

63 The Country Women's Association of Australia, sub 121, p 1; The Aged-care Rights Service, sub 87, p 45; National Rural Health Alliance Inc, sub 131, p 26; University of the Third Age, City of Melbourne Incorporated, sub 44, pp 7-8.

64 The Aged-care Rights Service, sub 87, p 44.

65 Volunteering Australia, viewed 20/07/2004, <http://www.volunteeringaustralia.org/>, and <http://www.volunteeringaustralia.org/punlications/stndards.html>.

Summing up

6.73 The challenge of maintaining productivity and living standards in the context of a diminishing number of adults of working age is not to be underestimated. Equally important is valuing the skills and experience of older Australians and enabling them to contribute to the wealth of their families, communities and the nation through paid employment and unpaid volunteering.

6.74 Many older Australians will prefer to continue in the workforce and their participation should be encouraged and facilitated. Improving opportunities for continued workforce participation by older Australians must be a shared responsibility, one in which industry, business, and public sector employers play a more proactive role.

6.75 The Committee considers, however, that there is a need for further research and analysis to test the assumptions around the extent to which increased participation of older people could offset the effects of population ageing. Research is also needed to gain a better understanding of how older workers can participate in ways that provide them with quality employment opportunities.

6.76 The Committee commends the growing involvement of employer organisations. The Prime Minister's Community Business Partnership has the potential to significantly influence their involvement and to encourage employer organisations to take a wider perspective than their own workforce needs. The Committee concludes that the Prime Minister's Community Business Partnership should explicitly advocate improving employment opportunities for older people as a component of corporate social responsibility and triple bottom line reporting by Australian employer organisation.

6.77 The Committee considers that major employer organisations including government departments should voluntarily demonstrate their commitment to the employment of older people (within their own organisations and through engagement with the community) through adopting triple bottom line reporting or achieving Australian Standard AS 8003-2003 with an explicit focus on the employment of older people.

Conclusion 9

6.78 **The Committee concludes that the Prime Minister's Community Business Partnership should explicitly advocate improving employment opportunities for older people as a component of corporate social responsibility and triple bottom line reporting by Australian employer organisations.**

Conclusion 10

6.79 **The Committee concludes that government agencies should voluntarily demonstrate their commitment to the employment of older people by :**

- **developing indicators for and reporting on improving employment opportunities for older people within their own organisations; and**
- **extending their corporate social responsibility activities to improving employment opportunities for older people more generally.**

6.80 While some industries and professions are moving to value work which services the needs of older people, others are lagging. The undervaluing of understanding the processes of ageing and caring for frail elderly is of continuing concern.

6.81 There is no doubt that many older Australians will wish to volunteer their skills and experience to support community activities, service provision, business and other organisations. The work of volunteers contributes to both social capital and the economy – a contribution that is now being more systematically measured. Volunteering can also be a way of updating skills and gaining the confidence and connections to re-enter the workforce. The Committee is concerned that these contributions are not adequately recognised by governments at all levels when weighing up the costs of population ageing.

6.82 The Committee concludes that there may be a need to guard against creating expectations that older people will, in effect, become a secondary workforce, unpaid and without protections. Successful use of volunteers requires sustained investment in managing

participation, protecting rights including through indemnity insurance, and continuing to grow their skills and capacities.

6.83 The Committee welcomes the recently announced Productivity Commission inquiry into the implications of population ageing including the implications for unpaid work such as caring and volunteering.

7

Financial security in later life

> Staying in the work force for an extra two years can extend the 'life' of your superannuation savings by seven years. Working for an extra five years can give you over 20 years of additional superannuation income.[1]

7.1 The matter of financial security in later life will become increasingly important over the next forty years as Australians continue to age healthily and live for longer. Retirement incomes will need to be greater and more flexible, to provide financial security for longer periods of time.

7.2 Australia utilises a 'three pillars' retirement income system, consisting of government aged pension support, compulsory employer superannuation contributions and private savings including private superannuation. This 'three pillars' concept is recognised internationally as a high standard model of retirement income system.[2]

7.3 While the model is considered sound, in light of Australia's ageing population, the adequacy of retirement incomes that the system currently provides has been questioned in evidence to the Committee. This chapter examines the issues raised, together with recent initiatives aimed at addressing them and possibilities for increasing private savings and for releasing equity to provide an income stream. Compulsory saving schemes, as used by other nations and suggested in evidence, are also considered.

7.4 As with all other aspects of preparing for an older Australia, making financial provision for later life requires lifelong learning. Being able to

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1 Business Council of Australia, *Age Can Work: A Business Guide for Supporting Older Workers* August 2003, p 27.

2 Association of Superannuation Funds of Australia (ASFA), sub 72, p 12; Sass, S (Centre for Research Retirement, Boston College), viewed 23/07/2004, <http://www.bc.edu/centers/crr/gib_2.shtml>.

make effective use of existing retirement income arrangements requires competency in financial literacy. In the final section of this chapter, the Committee considers the need for concerted efforts to improve the financial literacy of Australians of all ages.

Superannuation

7.5 The Committee received evidence from sources such as superannuation funds, actuaries, Centrelink and investment advisors on perceived flaws in the superannuation system. The major issues that have been identified relate to adequacy, equity, level of complexity and a lack of incentives to invest in superannuation.

7.6 The general level of complexity of superannuation was drawn to the attention of the Committee. Superannuation is obviously a complex subject but its complexity is compounded by the interaction with taxation and periodic changes to the legislation in this area.[3]

Adequacy

7.7 Much of the evidence relating to the issue of retirement income adequacy indicated that the 9% level of the superannuation guarantee was not sufficient, particularly in lower paid industries or where there are no defined benefit funds for the industry's workers.[4]

7.8 Even when combined with the aged pension, the 99% Superannuation Guarantee is not regarded as significant to ensure adequate retirement income. The Association of Superannuation Funds of Australia (ASFA), Investment and Financial Services Association (IFSA), the Institute of Actuaries of Australia and the Research Centre of Ageing and Retirement of the University of New South Wales all testified to this effect.[5]

7.9 Since the commencement of this inquiry, the attention paid to these issues has increased significantly. Wide ranging inquiries were undertaken by the Senate Select Committee on Superannuation throughout 2002 and

3 Smith P, transcript 3/07/2003, p 584; Kirk A, transcript 3/07/2003, p 635.

4 Smith P, transcript 3/07/2003, p 583; Institute of Actuaries of Australia, sub 138, p 9; Olsberg, D, transcript 3/07/2003, p 639.

5 Smith P, transcript 3/07/2003, p 583; Gilbert R, transcript 3/07/2003, p 614; Institute of Actuaries of Australia, sub 138, p 8; Research Centre on Ageing and Retirement (University of New South Wales), sub 84, p 5.

2003. Reports from these inquiries include *Superannuation and Standards of Living in Retirement* and *Planning for Retirement.*[6]

7.10 The Australian Government is making significant changes to the superannuation system to encourage and assist Australians to better prepare for retirement. Treasury has released *A More Flexible and Adaptable Retirement Income System* which introduced some changes in the retirement income system. Concurrently, Treasury released *Australia's Demographic Challenges*, to highlight the challenge that ageing presents to Australia now and in the future.[7]

7.11 To varying degrees, these initiatives will address the issues of incentive and adequacy raised in evidence to the Committee. Since the release of these documents, the Federal Budget has also addressed issues central to retirement incomes.[8]

Equity

7.12 Equity issues on superannuation refer to the matter of all workers being able to accumulate a similar level of retirement income for later life when working in the same or similar industries. Evidence to the Committee that two people can be employed to carry out similar duties, yet because one is employed on a contract basis or has less time in the workforce due to child bearing they accumulate far less superannuation than the permanent employee.[9]

7.13 The issue of equity relates particularly to those who have intermittent or limited participation in the workforce. Women who leave the workforce temporarily to have children, casual or contract employees, divorcees and those who have not lived in Australia all their life are likely to have insufficient retirement income.[10] Similarly, Indigenous Australians with only short periods in the workforce and/or dependence on the Community Development Employment Program (which is not subject to the Superannuation Guarantee) are not in a position to provide for later life.[11]

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6 Senate Select Committee on Superannuation, viewed 2/03/2004, <http://www.aph.gov.au/Senate/committee/superannuation_ctte/reports/index.htm>.

7 Department of the Treasury, *A more flexible and adaptable retirement income system* and *Australia's Demographic Challenges*, viewed 25/02/2004, <http://www.treasurer.gov.au/tsr/listdocs.asp?doctype=0&year=2004>.

8 *Budget Strategy and Outlook 2004-05*, Budget Paper No 1, Statement 1, p 13; *Budget Measures 2004-05*, Budget No 2, pp 17-21.

9 Olsberg, D, transcript 3/07/2003, p 639.

10 Olsberg, D, transcript 3/07/2003, p 638.

11 Gooda M, transcript 7/03/2003, p 203.

7.14 Workers in certain professions are more susceptible to inequitable superannuation than others. Nursing is one such profession. Casual and contract employment are common, the majority of nurses are female and are likely to be absent from the workforce for considerable periods in the event of child bearing. Not only does this make saving for later life more difficult, but it also effects the industry's capacity to attract and retain staff, especially in aged care.[12]

7.15 ASFA has noted that superannuation strategies were originally formulated on the basis of 40 years unbroken participation in the labour force.[13] Clearly this is not the case for many in the workforce today and to ensure that the groups outlined above are able to accumulate adequate superannuation the basis for superannuation needs to change to reflect the modern workforce. As the workforce becomes more flexible, superannuation will need to become similarly flexible.

Lack of Incentives

7.16 Evidence to the Committee regarding incentives to invest in superannuation centred on the fact that both high and low income earners had little reason to make contributions to superannuation beyond minimum requirements. Whether it is a case of a high income earner who incurs the superannuation surcharge, or a low income earner who would have to sacrifice valuable disposable income in favour of retirement savings (which will not benefit them for some time), Australians generally are not willing to contribute more superannuation than they have to.[14]

7.17 In terms of adequacy of retirement income levels, the Australian Government has moved to introduce changes to the notional earnings basis of superannuation. These changes are to ensure that workers will only receive superannuation contributions that are based on notional earnings since the inception of the superannuation guarantee. As a result, employees will receive superannuation based on more recent notional earnings levels.[15]

7.18 The Association of Superannuation Funds of Australia (ASFA) suggested that the government co-contribution scheme is the key to encouraging people to invest more in their superannuation. Government plans for enhancing this scheme have since been announced. To encourage people

12 Australian Nurses Federation, sub 97, p 16.

13 Smith P, transcript 3/07/2003, p 582.

14 Gilbert R, transcript 3/07/2003, p 614; Smith P, transcript 3/07/2003, p 584.

15 Department of the Treasury, *A more flexible and adaptable retirement income system*, p 11; All employers must comply with this regulation by 1/07/2010; Department of the Treasury, *A more flexible and adaptable retirement income system*, p 11.

to invest savings in their superannuation, the government has enhanced its 'co-contribution' scheme, with the government now contributing 150% of lower income earners private superannuation contributions.[16]

7.19 While the enhancement of the superannuation co-contribution increases incentives for lower income earners to invest in their retirement income, the Australian Government also aims to improve the incentives for retirement saving of those in higher income tax brackets. Superannuation contributions from employer and employee are subject to a surcharge of up to 14.5% for high income earners, which is to be reduced gradually until reaching 7.5% in 2006 - 2007.[17] Employees at this income level as a result will gain more retirement income through their pre-income tax superannuation contributions.

7.20 One of the chief concerns born of the ageing population, is that retirement incomes will have to last significantly longer given improving life expectancy. By remaining in the workforce for longer, not only is there the benefit of further adding to superannuation savings, but the consumption of superannuation is delayed as well. The Business Council of Australia predicts that by remaining in work for two years longer, the life of a person's retirement income would be prolonged by up to seven years.[18]

7.21 As an incentive to extend time in the workforce and further preserve people's retirement incomes, the Australian Government announced that from July 2005 superannuation could be used to supplement a part time income once a worker has reached superannuation preservation age. Further, superannuation contributions can now be made up until the age of 75, allowing people more time to generate an ultimately greater retirement income.[19]

The Aged Pension

7.22 The aged pension effectively represents the 'safety net' of the three pillars retirement income scheme. The full aged pension is available to men at the age of 65 and to women at the age of 62, although the age requirement for

16 ASFA, sub 72, p 62; Department of the Treasury, Budget Paper No. 1, 2004 – 2005 (Part 1); Previously the co-contribution scheme entailed government contributions on a "dollar for dollar" basis.

17 Minimum income level to be liable to surcharge is $94, 691; Department of the Treasury, Budget Paper No 1, 2004 - 2005.

18 Business Council of Australia, *Age Can Work: A Business Guide for Supporting Older Workers* August 2003, p 27.

19 Department of the Treasury, *A more flexible retirement income system*, p 10.

women is set to rise to 65 by the year 2013. The aged pension is provided subject to a means test, to ensure that the pension is used to provide adequate income rather than accumulate wealth.

7.23 According to FaCS, 82% (2.1 million Australians) of Australians over 65 years of age are in receipt of some level of the aged or service pension. Approximately two thirds of those receiving the pension are receiving the maximum rate of payment.[20]

7.24 The number of people to be supported through aged pension is projected to reach 5.1 million by 2051.[21] This suggests that by 2051 spending on the aged pension would be more than double its present level.

7.25 Concern over future increases in aged pension outlays was raised by the Australian Government in the *Intergenerational Report*.[22] The predicted increase in government spending on aged pension in future will be offset, however, by factors such as the future benefits of the superannuation guarantee policy and planned changes to aged pension qualification age.

7.26 The superannuation guarantee policy is still relatively new. Over time, as more people benefit from the superannuation guarantee policy, far fewer older Australians will be reliant on aged pension support, or their reliance will be reduced.[23]

7.27 Raising the age requirement for women from 62 years to 65 will further offset the increase in the amount the spent on aged pension in the future.[24]

7.28 Evidence presented to the Committee indicates more immediate issues with the aged pension at hand. The means test that determines eligibility for the aged pension has been the subject of criticism from Centrelink, and financial institutions claim the test is unnecessarily complex and inconsistent.[25] Centrelink claims that not only is the aged pension system poorly understood by those reliant upon it but that the changes to rules also cause problems for their staff in administering the aged pension.[26]

7.29 Centrelink has also suggested that many retirees (and those approaching retirement) focus solely on maximising the level of their pension, as opposed to maximising the level of their overall retirement income. This approach will not ensure adequate retirement income and Centrelink

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20 Department of Family and Community Services, sub 90, p 18.

21 Department of Family and Community Services, sub 90, p 10.

22 Department of the Treasury, *The Intergenerational Report,* Budget Paper No 5, May 2002.

23 Smith P, transcript 3/07/2003, p 583.

24 Department of Family and Community Services, sub 90, p 20.

25 Clare R, transcript 3/07/2003, p 586; Centrelink, sub 78, p 15.

26 Centrelink, sub 78, pp 9 - 12.

considers changing people's attitudes on this matter to be vital if retirement incomes are to be sufficient in future.[27]

7.30 At the same time this approach has flow on effects to other government payments where access to programs is targeted to pensioners, such as health cards, travel concessions and residential aged care concessional supplement.

7.31 Rural and remote regions of Australia are particularly affected by the application of the pension means test. Although farmers may effectively retire, their eligibility for social security benefits may be affected if they are still in possession of farm and agricultural equipment (despite little or no income being derived through possession of these items).[28] The relative value of social security benefits such as the aged pension is highly dependent on the costs of living, which in rural and remote areas are often higher than in metropolitan areas. The National Rural Health Alliance suggests that the aged pension needs to account for the high costs of living and the lower value of capital in rural and remote regions compared to metropolitan areas.[29]

Private Savings

7.32 The third pillar of Australia's retirement income system, private savings, includes a wide range of options to generate retirement income. Private savings can be voluntary superannuation contributions and assets such as the family home. However, the scope for investment of private savings is wider than these two options and includes shares, bonds, property and numerous other investment options.

7.33 Evidence to the Committee indicated that savings levels in Australia are historically low and that the level of savings could be crucial to the adequacy of retirement incomes in future. IFSA reported that Australia's levels of household savings, while difficult to measure with great accuracy, are lower than they were 25 years ago. Further, the National Centre for Social and Economic Modelling (NATSEM) stated that this low level of savings is responsible for a greater level of reliance upon government support via the aged pension.[30]

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27 Centrelink, sub 78, p 18.

28 Crocket J, sub 165, p 17.

29 National Rural Health Alliance, sub 131, p 17.

30 Gilbert R, transcript 3/07/2003, p 621; IFSA, sub 51, p 7; National Centre for Social and Economic Modelling, *Self Provision in Retirement? Forecasting Future Household Wealth*, p 2.

7.34 A recurring issue in evidence to the Committee was the level of taxation on private superannuation contributions. Organisations such as ASFA and IFSA see this as a major deterrent to investment and consider that the contributions tax scheme should be simplified and the rate lowered. The Small Independent Superannuation Funds Association (SISFA) argued that such a reduction could assist in reducing the Australian Government's aged pension outlays.[31]

7.35 A factor which may be contributing to low savings levels is the effect of 'demographic compression.' Family events such as completing tertiary education, finding a partner, child rearing and acquiring a home are taking place in a much shorter time frame than in previous generations.[32] The costs of education and the debts incurred in home ownership may still be a significant burden when approaching retirement. Demographic compression effectively shortens the time available for families to save for their retirement.

7.36 The Committee is concerned that there appears to have been little research on the effects of demographic compression on families over time and their capacity to save for retirement. While the Productivity Commission and FACS have undertaken preliminary research into demographic compression, the Committee notes that the issue is not well understood and more research is required to allow policy makers to plan on an intergenerational level.[33]

7.37 The challenge of saving for retirement can be more difficult in rural and remote areas of Australia. Evidence from the National Rural Health Alliance showed that in every state of Australia, average levels of household income are higher in metropolitan areas than in non-metropolitan areas. Lower income levels and the income fluctuations of seasonal industries common to rural regions such as agriculture allow a lower capacity for saving. To compound this, people in non-metropolitan areas are concerned by the rising cost of living.[34]

7.38 Dr Judith Crockett's evidence to the Committee also raised these problems as well as intergenerational problems presented by inadequate provisions for retirement by farm owners:

> Few farmers make adequate provision for retirement, either by default and inaction, or by choice. This will impact greatly upon

31 ASFA, sub 72, p.6; ISFA, sub 51, p 3; Small Independent Superannuation Funds Association, sub 69, p 3.

32 FaCS, sub 90, p 10.

33 Productivity Commission, *Policies Governing Aged and Child Care,* 1999, p 307; FaCS, *The Policy Maker's Guide to Population Ageing: Key Concepts and Issues*, June 2001, p 34.

34 National Rural Health Alliance, sub 131, p 15.

> the decision of if and when to retire, having implications for the primary and succeeding generations. Where finances are lacking, a second generation family can face a heavy financial burden if required to support the first generation in retirement.[35]

7.39 Indigenous Australians are at a severe disadvantage in building sufficient retirement incomes. The Indigenous have more health problems than non-Indigenous Australians, poorer access to health and ageing services, lower employment levels, lower skill levels due to poorer access to education and generally are ageing at a far greater rate.[36]

Voluntary savings

7.40 Evidence to the Committee canvassed the possibilities of greater emphasis on specific types of private savings vehicles such as long term care insurance or designated savings for health or aged care purposes. Mr Francis Sullivan suggested that, if future funding of health and aged care is to be a mix of public funding and user charges, then some form of health or long term savings vehicle would be necessary, even though to that date health savings accounts in the United States had not proved successful. The Institute of Actuaries Australia argued for a wide-ranging set of private savings products (medical savings accounts, medical catastrophe insurance, pre-funding of residential care through superannuation related products) combined with changing requirements for the design and pricing of private health insurance products.[37]

7.41 Reverse mortgages were also proposed as a way of releasing savings held in assets. It is anticipated that over the next forty years those seeking access to aged care and those seeking to fund retirement will have significant equity in property. The Institute of Actuaries noted that 'reverse mortgages' and other equity release products may be one way of providing an income stream without needing to dispose of the asset.[38]

7.42 Such products have been proposed as a means of paying for aged care or of enabling older people to afford the necessary services that will allow

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35 Crockett J, sub 165, p 17.

36 Gooda M, transcript 7/03/2003, pp 201-204; Emerson F, transcript 7/03/2003, p 202

37 National Aged Care Alliance, sub, 88 p 38; Sullivan F, transcript 17/09/2003, pp 693-4. Institute of Actuaries Australia, sub 138, pp 19-20. See also Sullivan F, transcript, 17/9/03, p 6949; In late 2003, the US Government introduced new tax deductible Health Savings Accounts as an added incentive for people covered by qualifying high deductible health insurance plans to increase their savings, viewed 26/05/2004, <http://www.usatoday.com/money/industries/health/2003-11-30-hsa_x.htm>.

38 Institute of Actuaries, sub 138, p 10; Kirk A, transcript 3/07/2003, p 628.

them to continue living in their own home.[39] A reverse mortgage allows the owner of an asset such as a family home, to borrow funds through the equity built up in the asset, to be paid back upon the house being sold or the death of the owner. Generally, home owners can borrow up to $100,000 against the equity of the home.[40]

7.43 In relation to home equity conversion FACS advised the Committee that while these products have been available for some time there has been little use made of them:

> We have been trying home equity and sale lease-back and many schemes for many years, there still seems to be an attitude, with the current generation in particular, that they have saved all their lives for a house and finally paid it off and they are reluctant to remortgage it or re-encumber it. Also, there is a design issue in that we found very few financial institutions prepared to pay for, or bear the risk of, longevity.[41]

7.44 Financial institutions risk the possibility of the sale of the asset not being enough to cover the repayment of the loan, in which case, the lender loses a significant amount. Accrued interest can be substantial and if the owners are unable to meet their repayments for any reason, then financial institutions are faced with the prospect of evicting elderly people from their homes, which may have a negative public relations impact.[42]

7.45 Reverse mortgages have had some success in the United States, however there have also been some problems in the form of legal complications in individual states.[43]

7.46 In the United Kingdom the Royal Commission on Long Term Care considered reverse mortgages and other financial products that might be used to finance aged care. The Commission concluded that while some individuals may find them worthwhile, they were not likely to offer a 'universal solution'. To ensure that those people who wish to make use of these products can do so with confidence, the UK Government is introducing legislation under the *Financial Services and Markets Act 2000*, governing reverse mortgages and long term care insurance.[44]

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39 Services such as Home and Community Care, Meals on Wheels etc could be funded through the income these products provide.

40 One lender, the Commonwealth Bank of Australia, does however, offer a loan of up to 35% of the value of the home, if the borrowers are over 70 years of age.

41 Flanagan K, transcript 7/02/2003, p 27.

42 Reed R & Gibler K, *The Case for Reverse Mortgages in Australia: Applying the USA Experience*, 9th Annual Pacific Rim Real Estate Society Conference, Brisbane, January 2003, p 5.

43 Reed R & Gibler K, *The Case for Reverse Mortgages in Australia: Applying the USA Experience*, p 5.

44 Review of Pricing Arrangements in Residential Aged Care; International Perspectives, 2003, pp 26-27, viewed 10/03/2004, <http://www.ageing.health.gov.au/ rescare/acprtask.htm>.

7.47 The Committee notes that the Australian Securities and Investments Commission (ASIC) are aware of regulatory issues overseas. ASIC is monitoring such products and seeking feedback on any problems.[45]

7.48 Despite the apparently cautious approach of financial institutions in Australia, more lenders are now offering such products.[46]

7.49 The Committee considers that the higher profile being given to these products by the financial sector and the media will alert more people to recognise the possibility of using such products.

Compulsory Savings Schemes

7.50 The Committee received suggestions that the sorts of compulsory savings or long term care insurance schemes used in other countries could be introduced in Australia.[47]

7.51 The National Aged Care Alliance provided the Committee with an overview of arrangements in the United Kingdom and Germany.[48] Other evidence referred to the financing arrangements in Denmark, Japan and Singapore.[49] The complex, inter-related schemes in Singapore (which require contributions of anywhere up to 40% of a worker's salary dependent on their age and income) allow contributors to access funds for medical and other purposes and include a safety net for low income earners. Features of the Singaporean arrangements include:

- compulsory national employee savings through the Central Provident Fund and Medisave;
- health and long term care insurance through MediShield, ElderShield and private insurance;
- national endowment funds – Medifund and ElderCare Fund; and
- consumer co-payments and/or gap payments.[50]

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45 Australian Securities and Investments Commission, *Financial Tips and Safety Checks*, <http://www.fido.asic.gov.au/fido/fido.nsf/byheadline/Reverse+ mortgages? openDocument>.

46 Commonwealth Bank of Australia, Media Releases: <http://about.commbank.com.au/group_display/0,1922,CH2071%255FTS9798,00.html>; StateWest: <http://www.statewest.com/financial-services/home/homeloan.shtml>; Police and Nurses Credit Society: <http://www.pncs.com.au/pncs/borrow/borrow_ easy_ living_loan.html>.

47 Howe A, sub 128, p 7-10; Institute of Actuaries Australia, sub 138, pp 18-20; Sullivan F, transcript 17/09/2003, p 694.

48 National Aged Care Alliance, sub 88, p 39; Olsberg D, sub 84, p 32.

49 National Aged Care Alliance, sub 88, p 48; Association of Superannuation Funds of Australia, sub 72, p 34.

50 World Bank, *Singapore's Innovative Health Financing System,* viewed 23/05/2004, <http://www.worldbank.org/wbi/healthandpopulation/oj_singapore.doc>; Pricing Review

7.52 The Myer Foundation proposed compulsory savings for aged care costs attached to the Superannuation Guarantee, and a compulsory Medicare style levy to fund a long-term care social insurance scheme.[51]

7.53 The Committee notes that while there is a range of possible funding mechanisms, what works in the social and policy context of one country may not be as effective in another. It is the 'fit' of any mechanism with the total social and policy context that matters.

7.54 Any proposal to introduce, for example, compulsory long term care insurance or dedicated health savings through superannuation would need to include an assessment of whether these products would actually achieve increased savings over all, or simply result in one form of savings being substituted for another. A requirement to establish a dedicated health savings account may simply substitute for discretionary private health insurance.

7.55 The Committee also notes that encouraging multiple, special purpose savings vehicles, can result in inflexibility and possibly waste. Only a small proportion of older Australians actually enter residential aged care. Savings accounts for aged care could mean that the money (or a substantial portion of it) is 'wasted'.

7.56 ASFA argued that considerable progress has been made because superannuation (compulsory and discretionary) is focussed on building substantial retirement income which individuals can then use to meet their particular retirement circumstances. ASFA also cautioned against diverting savings from superannuation into specific purposes:

> Superannuation is not a magic pudding from which additional slices can be taken without compromising the core goals of retirement savings.[52]

7.57 As evidenced by much of the work since the publication of the *Intergenerational Report*, Australia's 'three pillars' approach is still immature and, as discussed below, the capacity of many people to benefit from the options already available is limited by a lack of financial literacy skills.

7.58 The Committee concludes that there is a need for a period of consolidation, including concerted effort to improve financial literacy, rather than introducing further compulsory savings arrangements at this stage.

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of Pricing Arrangements in Residential Aged Care, *Long Term Care :International perspectives*; p 82-83.

51 The Myer Foundation, *2020: A Vision for Aged Care in Australia*, pp 34-35.

52 Association of Superannuation Funds of Australia, sub 72, p 13.

Improving financial literacy

7.59 The complexity of retirement income arrangements and options were raised with the Committee by individuals, government departments, and representatives of financial organisations.[53]

7.60 Making effective use of the options available – even with professional help – requires a fairly sophisticated level of financial literacy. Simply encouraging people to save does not work. As it was put to the Committee:

> Smiling suntanned silver haired couples enjoying houses at the beach and overseas holidays are just not the norm.[54]

7.61 There is growing awareness of the need to improve the financial literacy of all Australians. As around 12% of 15 year olds and 20% of adults have very poor general literacy skills, improving their financial literacy will mean first providing assistance with developing their literacy and numeracy skills.

7.62 Centrelink offers a free Financial Information Service as an educative and information brokerage service. There are approximately 120 Financial Information Service officers across Australia to provide investment information regarding superannuation, banking and financial services, taxation issues and social security payments.[55]

7.63 In general, education and information services provided by financial institutions, have assumed that people already have basic skills and a fair degree of financial literacy.

7.64 In the past year or so, however, some financial institutions have been taking the lead in promoting the issue of financial literacy and exploring what can be done to improve it. The ANZ Bank's financial literacy survey is helping to inform their own consumer and community programs and initiatives being developed by other financial organisations. ASIC has investigated the need to make financial literacy a core skill for young Australians and the Financial Planning Association has released a CD designed for 12-15 year olds.[56]

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53 Olsberg D, sub 161, p 9; Olsberg D, sub 84, p 18; Centrelink, sub 78, p 15; Association of Superannuation Funds of Australia, sub 72, p 5.

54 Clare R, transcript 3/07/2003, p 587; Research Centre on Ageing and Retirement, sub 161, p 4.

55 Department of Family and Community Services, submission to Senate Select Committee on Superannuation: Inquiry into Planning for Retirement, p 14, viewed 20/05/2004, <http://www.aph.gov.au/Senate/committee/superannuation_ctte/retirement/submissions/sub38.doc>.

56 ANZ Bank, *ANZ Survey of Adult Financial Literacy in Australia,* p 10. The ANZ report and information about its other initiatives may be accessed through <http://www.anz.com/

7.65 The Australian Government has set up a National Consumer and Financial Literacy Taskforce to develop a national strategy to raise levels of consumer and financial literacy in Australia.[57] The Taskforce released a discussion paper in June 2004 which calls for public submissions.

7.66 The issue of financial literacy skills is of considerable concern to the Committee as it underpins the capacity of individual Australians to improve their financial provision for later life. The Committee concludes that responsibility for improving financial literacy must be shared between government, financial services, educators, and consumer and community groups. The Committee notes that the objectives of the strategy being developed by the Consumer and Financial Literacy Taskforce include a national approach which fosters collaborative and joint efforts in nationally consistent ways.

7.67 The matter of financial security in later life is complex in itself and is more confusing to those who may not have numeracy and financial literacy skills. Further work building on the outcomes of the Consumer and Financial Literacy Taskforce's discussion paper will be critical, together with a concerted effort across all sectors of the community.

Summing up

7.68 Increasing the capacity of Australians to achieve financial security in later life is undoubtedly essential. The Committee agrees that Australia's three pillars approach provides a sound policy framework: a tax-payer funded means-tested age pension; a minimum level of compulsory employer superannuation contributions; and private superannuation and other savings.

7.69 Evidence before the Committee indicates the complexity of the relationships between the three pillars, and between them and the retirement income system, the tax system, health and aged care funding,

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aus/aboutanz/community/Programs/finlit.asp>; Media release: 'ASIC Chairman calls for action on financial literacy problems, 2 May 2003 , viewed 22/05/2004, <http://www.asic.gov.au/asic/asic_pub.nsf/byheadline/03142+ASIC+Chairman+calls+for+action+on+financial+literacy+problems?openDocument>; Senator the Hon H Coonan, Minister for Revenue and Assistant Treasurer, Address to the Financial Planning Association Conference, 6 May 2004, viewed 22/05/2004, <http://www.assistant.treasurer.gov.au/atr/content/speeches/2004/005.asp>.

57 Senator the Hon H Coonan, Media Release*: Skilled People Are the Key to Success*, viewed 22/05/2004, <http://www.assistant.treasurer.gov.au/atr/content/pressreleases/2004/007.asp>. Information on the Taskforce and its terms of reference may be viewed at <http://www.cfltaskforce.treasury.gov.au/content/default.asp>.

and private health insurance. The Committee notes that overseas experience shows that these relationships, and the weight given to each particular component, are a matter of ongoing debate and adjustment.

7.70 The Committee agrees that more needs to be done to encourage savings. However, there is also a need for research to look more closely at the opportunities individuals and families actually have to make adequate savings depending on their life course, circumstances and location.

7.71 The Committee notes the efforts of the Australian Government to raise awareness and action by individuals to better provide for later life. The financial sector has also responded enthusiastically. However, while there continue to be regular and prominent advertisements lauding the goal of early retirement, the Committee has doubts the extent to which the sector has adjusted its practices and products.

7.72 The setting up of the Consumer Financial Literacy Taskforce is an innovative – and sensible – approach to a major challenge. The magnitude of the task before it should not be underestimated. The Committee notes that for many workers of all ages, limited literacy and numeracy skills restrict both current employment opportunities and possibilities for making the transition to new types of employment as they grow older. The success of the Consumer Financial Literacy Taskforce will in part be judged by the strategies it develops for assisting people with basic literacy and numeracy skills so that they can gain more benefit from financial literacy training.

Conclusion 11

7.73 **The Committee concludes that a comprehensive study of the impacts of demographic compression on the capacity of families to save for retirement be undertaken jointly by the Department of Family and Community Services and the Treasury.**

8

Aged care and health services

> Older people receive care services across acute, aged, primary and community care sectors. Wherever older people interact with these systems and associated interfaces there is a risk of harm to the older person, a risk of functional decline and altered quality of life. It is no longer possible to consider one sector without the impact of the other.[1]

8.1 While there is growing awareness of the need for longer-term strategies to foster health ageing, much of the evidence the Committee received focussed on concerns about current aged care and health service. Wide ranging evidence was received from individuals, service providers, professional associations, peak bodies, researchers and research institutions, state and local governments, and lobby groups.

8.2 Projections in the *Intergenerational Report* identified health and aged care as accounting for much of the expected rise in Australian Government spending over the next four decades. Not surprisingly, subsequent debate has largely focussed on who should pay for health and aged care services.

8.3 This chapter surveys evidence received by the Committee providing on-the-ground perspectives on aspects of aged care and health services and related policies. The Committee notes that in relation to residential aged care, the evidence is consistent with that in submissions to the Hogan Review.

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1 Australian Nursing Federation (SA Branch), sub 93, p 4, citing DHS SA, *Moving Ahead*, 1999.

8.4 The chapter is rather lengthy. The scope is broad covering: services to maintain healthy functioning; community care; care in diverse setting for people with dementia or other mental health problems, respite and palliative care; residential care; the need for age friendly hospitals; GPs and older people; fragmentation and lack of cooperation; and workforce shortages.

8.5 A consistent thread throughout the chapter is the need for more flexible, integrated policies and services delivered through far greater collaboration and team work than is demonstrated by today's workforce. Hence, the Committee has resisted the obvious approach of shorter chapters reinforcing traditional fiefdoms.

Funding for aged care and health services

8.6 Funding for aged care and health services comes from governments at all levels, private individuals, health insurance funds and other non-government institutions.

8.7 The Australian Government provides the majority of funding for aged care services overall: $5.6 billion in 2002-02, expected to rise to $6.5 billion in 2003-4 and $6.7 in 2004-05. The bulk of this funding is directed to residential aged care.[2] The states and territories make a substantial contribution to the funding of Home and Community Care providing $434.1 million of the total $1.1 billion in 2002-03. They also provide some funding for public sector residential care beds and for Aged Care Assessment Teams.[3]

8.8 Older Australians who can afford it pay fees for community care services and residential aged care, and accommodation bonds or charges for residential aged care. Reliable data on the total contribution older Australians make to community care services and residential aged care fees is not readily available. In relation to accommodation bonds and charges, the Pricing Review of Residential Aged Care found that, as at June 2003, an estimated $2.7 billion in

2 Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997,* 1 July 2002 to 30 June 2003, pp 21, 23, viewed 5/07/2004, <http://www.ageing.health.gov.au/reports/ acareps/rep2003.pdf>. This includes $4.6 billion in the Health and Ageing Portfolio and $630 million for the residential care of veterans funded through the Department of Veterans' Affairs. The expectation for 2003-04 does not include expenditure announced in the 2004-05 Budget but to be paid to residential aged care providers before 30 June 2004.

3 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2004*, vol. 2, p 12.11

bonds was held by the industry. In addition, residents had paid providers approximately $124 million in accommodation charges. In 2002-03, providers deducted around

8.9 $90 million in retention amounts form bond holdings and refunded bonds to the value of some $733 million. [4]

8.10 The *Report on the Operation of the Aged Care Act 1997* for the period 1 July 2002 to 30 June 2003 provides details of the numbers of older Australians (including Indigenous people aged 50 years and over) who received assistance from aged care services:

- 184,095 people received permanent residential care;
- 34,025 people received residential respite care, of whom 14,792 were later admitted to permanent care;
- 31,186 received care through a Community Aged Care Package, including some who also received permanent or respite residential care during the year; and
- an estimated 700,000 people received services through the Home and Community Care program.[5]

8.11 The proportions of people from the targeted special needs groups receiving aged care services may be summarised as follows:

- 0.5% of Indigenous people aged 50 years and over received residential care;
- 3.9% of Indigenous people aged 50 years and over received CACP services;
- 2.5% of Indigenous people aged 50 years and over received HACC services;
- 12.7% of residents from a non-English speaking country aged 70 years and over received residential care;
- 19.5% of residents from a non-English speaking country aged 70 years and over received CACP services; and
- 16.3% of residents from a non-English speaking country aged 70 years and over received HACC services.[6]

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4 WP Hogan, *Review of Pricing Arrangements in Residential Aged Care, Final Report,* 2004, p 161. Information based on, Department of Health and Ageing, *Census of Aged Care Homes 2003,* Commonwealth of Australia, 2003.

5 Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997*, 1 July 2002 to 30 June 2003, p 3, viewed 5/0/2004, <http://www.ageing.health.gov.au/reports/acareps/rep2003.pdf>.

6 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2004*, Supporting Table 12A.18, Aged care recipients from special

8.12 Comparable information on the proportion of health funding directed to the care of older Australians is not available. Some information relating to the high cost areas of acute care, Medicare and pharmaceutical benefits was provided to the Committee by the Department of Health and Ageing.

- In 2000-01, people aged 65 years and over accounted for approximately one third of all hospital separations but accounted for approximately 41 per cent of the cost. This was attributed to the complexity of health issues for older people and the compression of morbidity into the last few years of life.
- In 2001-02, expenditure on the Pharmaceutical Benefits Scheme was $4.2 billion of which people aged 65 years and over accounted for 47 per cent. This was attributed in part to the fact that over 90% of these people have a concession card and therefore pay only the concessional co-payment.
- In 2001-02, expenditure on the Medicare Benefits Schedule was $7.8 billion. People aged 65 years and over accounted for 26.4% of services and 27.4% of cost but comprise only 13% of the total population. [7]

8.13 The Australian Government has introduced a range of health measures specifically designed to focus on the health of older people, such as enhanced primary care multidisciplinary case planning, access to medical care for residents of aged care homes, and promotion of the wise use of medicines. Experiences with some of these initiatives were raised with the Committee.

Issues raised in evidence

8.14 The issues raised, sometimes passionately, were many and varied reflecting the scope of the services accessed by older Australians and the concerns of service providers and other stakeholders. Several broad themes emerged, demonstrating that there are areas of common concern in aged care and health services:

needs groups, June 2003. Indigenous data includes only people who identify as Indigenous.

7 Department of Health and Ageing, sub 119, pp 34-35.

- inadequate focus on services aimed at maintaining healthy functioning: physiotherapy; podiatry; nutrition advice; speech pathology; oral health services; and podiatry;
- confusion caused by multiple community care services, and issues around the quality of community care services;
- need for further development of the potential enabled under flexible care funding;
- the availability and quality of care for people with dementia or mental health problems, and for those needing respite or palliative care – care which may be provided at home, in the community or in an institutional setting;
- the availability, quality and viability of residential care;
- hospitals that are seen as becoming increasingly unfriendly to older people and poorly integrated with other care services for older people;
- the need for changes in general practice and the ways GPs work with other health professionals to provide better care for people as they grow older; and
- workforce shortages, especially nurses and other residential care staff.

8.15 The evidence also made clear that three overarching matters are seen as critical to addressing these issues, together with related funding issues:

- a workforce more attuned to the needs of older people and more appropriately skilled to provide services: not just solving the shortage of nurses, but changing the attitudes and work practices of the other health professionals and better utilising services to maintain functioning;
- increased focus on research to gain a better understanding of ageing and the care of the aged; and
- better integration of services at all levels: from genuine cooperation between the states, territories and the Australian Government, to a far greater willingness by health and care professionals to work together to provide person-centred care.

8.16 These concerns are not inconsistent with containment of costs that was the primary concern of the *Intergenerational Report* – especially costs driven by the demand for new technologies and treatments. Indeed the Committee considers them critical to achieving cost containment even though some ongoing investment will be needed.

8.17 This chapter discusses, at some length, the concerns presented to the Committee. Proposals for addressing the overarching issues are covered in Chapter 9, Aged Care and Health Services: Looking to the Future.

Services to maintain healthy functioning

> The main emphasis in aged care needs to shift from providing care towards the end of life, to providing better health programs before mobility and independence begin to deteriorate….[8]

Maintaining physical function

8.18 Ageing and the diseases associated with age are, for example, contributing to an increasing number of older people experiencing swallowing and communication difficulties. Swallowing difficulties can arise from stroke, Parkinson's disease, dementia and respiratory conditions resulting in difficulty organising and coordinating muscles for swallowing.[9] The Committee heard of the distress swallowing problems caused one resident:

> … the difficulty [he] was experiencing in swallowing tablets ... he could not manage to swallow a large antibiotic tablet unless it was crushed…[10]

8.19 Factors seen as contributing to poor access include workforce shortages (physiotherapists, podiatrists) and the limited number of health professionals in rural areas. In Broken Hill, for example, the hospital's rehabilitation facilities (including a hydrotherapy pool and gymnasium) are not fully utilised because rehabilitation staff numbers are down 'at least one in every department'; nor are there enough staff and funding to keep up with the need for rehabilitation services in people's homes.[11]

8.20 Overall the evidence put to the Committee makes clear that these services tend to 'fall into the cracks' at the interfaces between acute

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8 Australian Physiotherapy Association, sub 118, p 7.

9 Speech Pathology Australia, sub, 52, pp 1-2

10 Warn P, sub 26, p 20.

11 Australian Physiotherapy Association, sub 118, p 16; The Aged Care Rights Service, sub 87, p 35; National Rural Health Alliance, sub 131, p 131; Speech Pathology Australia, sub 52, p 4; Peck M, transcript 19/05/2003, p 480; Kennedy M, transcript 23/02/2004, p 823; Flecknoe-Brown S, transcript 24/02/2004, p 844

care and community and residential aged care or between Australian Government and state/territory responsibilities. These health professionals may not be included in Aged Care Assessment Teams and while it could be assumed their services (such as assistance with communication and swallowing difficulties) are provided in aged care homes this is not necessarily be standard practice.[12]

8.21 The services are also at the interface of various funding mechanisms where professional groups protect their access to funding streams. It was suggested to the Committee that hospitals attuned to casemix funding place higher priority on early discharge than rehabilitation.[13]

8.22 Under the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995*, health funds are required to cover private psychiatric, palliative care and 'rehabilitation services' under hospital tables. The National Private Rehabilitation Group suggested to the Committee that these arrangements are not working well, in part because health funds compliance with this requirement is variable.[14] Services not related to hospital care may be covered by private health ancillary tables. Consequently, older Australians who do not have private health insurance may not be able afford access to support of the sort that could significantly assist them to maintain healthy functioning.

8.23 In addition, there is growing use of purchasing contracts between health funds (or organisations such as the Department of Veterans' Affairs) and service providers. The National Private Rehabilitation Group noted that these are premised on a medical model – 'episode of illness' – which does not necessarily assist with preventative maintenance of functioning. Further, payment is made to the acute care provider or general practitioner with flow on distribution of payments to other providers being dependent on the acute provider.[15]

8.24 The National Private Rehabilitation Group and the Australian Physiotherapy Association stressed the need for more suitable and consistently applied funding models: '… governments need to untangle funding…' and develop transparent patient-centred funding models. Options put forward include:

12 Speech Pathology Australia, sub 52, pp 3, 4.

13 Australian Physiotherapy Association, sub 118, p 9

14 It should be noted, however that the Private Health Insurance Ombudsman has received no complaints on this matter.

15 National Private Rehabilitation Group, sub 53, executive summary pp 3-4; Australian Physiotherapy Association, sub 118, p 9.

- restricted coverage through Medicare for targeted groups such as Enhanced Primary Care patients;
- implementing blended payments as a single industry-wide model for private medical rehabilitation services; and
- replacing 'episode of illness' contracts with a single level of purchasing for private medical rehabilitation services.[16]

8.25 The Committee notes that a new health initiative allows chronically ill people who are being managed by their GP under an Enhanced Primary Care (EPC) plan, access to Medicare rebates for allied health services. Five services per patient per year may be claimed for services provided by an eligible allied health professional following referral by a GP as part of care provided under a multi-disciplinary care plan. Allied health professionals covered are Aboriginal health workers, audiologists, chiropodists, chiropractors, dieticians, mental health workers, physiotherapists, occupational therapists, osteopaths, podiatrists, psychologists and speech pathologists.[17]

8.26 The Committee sees this as a positive step towards involving allied health professionals in care that will potentially contribute to maintaining health functioning. However, the Committee considers that the actual contribution will be limited as the initiative is still premised on waiting until the patient is significantly affected by one or more chronic conditions.

8.27 The Committee also notes that further consideration is needed of how best to find increased access to preventive allied health services.

Oral health

8.28 Oral health continues to be a concern with the cost of services being seen as far beyond the means of many pensioners. COTA stated that:

> One of the worst examples of poor health policy is in divorcing the oral health of individuals from all other aspects of their health care. … Many older people are missing out on basic dental care and are subject to long delays in receiving treatment.
>
> Poor dental health can contribute to deterioration in overall health and can lead to premature admission to a nursing

16 National Private Rehabilitation Group, sub 53, p 7.

17 'Expanded Medicare services for the chronically ill', Joint Media Release, The Hon Tony Abbott MHR, Minister for Health and Ageing, and Senator Meg Lees, Senator for South Australia, 24 June 2004.

> home or death. Early intervention for dental problems is important in preventing further deterioration…[18]

8.29 The National Rural Health Alliance stressed that poor dental health is sometimes seen as a 'relatively trivial issue' yet it is closely linked with such major health problems as cardiovascular disease, stroke, diabetes, endocarditis, and nutritional deficiencies in older people. In remote Aboriginal communities, there is a strong link between oral health and diabetes.[19]

8.30 As with other services for maintaining functioning, evidence to the Committee indicated that funding is inadequate and affected by being at the interface of various funding arrangements. Evidence suggested the need for a national dental policy, with increased funding provided by the Australian Government and greater cooperation between the Australian Government and the states and territories. Funding mechanisms suggested included inclusion of oral health in the Australian Health Care (Medicare) Agreements, or a jointly funded program managed in a similar way to HAAC, with the mechanism to include innovative approaches to funding for rural areas and remote Aboriginal communities.[20]

8.31 The Committee notes that in the 2004-05 Budget, funding was confirmed for an MBS item to cover:

> … up to three dental consultations each year where dental problems are significantly exacerbating chronic medical conditions being treated under a Multidisciplinary Care Plan.[21]

While this initiative is a welcome step, the Committee considers that it falls short of providing access to preventive dental care to maintain good oral health for older people.

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18 COTA, sub 91, p 21.

19 National Rural Health Alliance, sub 131, p 33.

20 National Seniors Association, sub 81, pp 10-11; Superannuated Commonwealth Officers' Association, p 57, p 18; COTA, sub 91, p 21, National Rural Health Alliance, sub, 131, p 33; The Aged-care Rights Service, sub 87, p 35.

21 *Budget Measures 2004-05*, Budget Paper No. 2, p 208. For conditions of access, see <http://www.health.gov.au/pubs/mbs/mbsjul04/MBS_Updated_July_2004_HTML/MBS_Updated_July_2004_755.htm>, viewed 30 July 2004.

Community care services: coordination and quality

8.32 Quality community care is a critical factor in a positive experience of ageing for the 93% of those over aged 65 years of age who live in the community and want the choice of remaining at home.[22]

8.33 While there is wide acknowledgement of the significant contribution community care programs make to enabling older people to live at home, evidence to the Committee indicates concerns about the adequacy of some aspects of current arrangements.

8.34 Mrs Sneesby, a member of the ACAT team for the Mid-North Coast Area Health Service informed the Committee:

> Some of the concerns we have in relation to services at home are that older people generally are unaware of them, quite often support is not initiated early enough, the guidelines for entry leave some people ineligible, some services have extended waiting times, some older people find it too difficult to negotiate their way through the system and some older people have the capacity to pay for private services but there is no way of ensuring their safety.[23]

8.35 Consistent with this, lack of coordination resulting in fragmentation and confusion, quality and safety, access to respite and palliative care, and funding were the most frequently raised issues. While the need for better coordination between community services and health services was also raised, especially in relation to hospitals, this is covered in the section on 'The need for age-friendly hospitals' below.

Confusion or coordination?

8.36 The Committee heard that fragmentation and confusion are caused by:

- all levels of government having policy and funding responsibilities;[24]
- an absence of coordinated planning across levels of government and across services; [25]
- multiple funding, eligibility and accountability requirements;[26]

22 National Aged Care Alliance, sub 88, p 6.

23 Sneesby A, transcript 19/05/2003

24 Aged and Community Services Australia, sub 101, p 2

25 Lgov NSW, sub 89, pp 17-18; Moreland City Council, sub 37, p 4; Aged and Community Services Australia, sub 101, p 2;

- multiple entry points making it difficult for older people to locate the services the need;[27]
- in some locations HACC services are targeting those with high support needs, diverting funding from basic support services such as home maintenance and gardening; and[28]
- a proliferation of new, small programs – whether funded by the Australian Government or by states or local government.[29]

8.37 The Committee also received suggestions for improving integration so that services focus on client needs rather than on funding streams and associated administrative structures: a single national community services program, a single entry point, and coordinated planning of funding and assessment.

8.38 The Myer Foundation suggested establishing a national program integrating the full range of community care services. The Foundation considered that this, together with encouragement of comprehensive care providers, would improve efficiency and help ensure equity of access to similar services based on assessed need across all regions. A single national program was also suggested by the Moreland City Council, but achieved by merging Australian Government programs (including those funded through the Department of Veterans' Affairs) with HACC. The merged national program would target both high and low levels of need and have clearer goals and strategic directions.[30]

8.39 A single point of entry together with case management was suggested to ensure easier access for older people and continuity of care as their needs increase. Ms McClean stated that:

> …we would need service providers to have some form of central point where someone is actively managing a particular person and facilitating the actual levels of care with different service providers. If you like, one organisation is contracted, perhaps on a regional basis, to manage a person's care … guide the client and the family all the way …[31]

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26 Lgov NSW, sub 89, pp 17-18; National Aged Care Alliance, Sub 88, p 6; Moreland City Council, sub 37, p 3;

27 Waddington B, transcript 28/04/2003, p 374; McClean C, transcript 31/03/2003, p 340

28 Lgov NSW, sub 89, pp 17-18.

29 Moreland Council, sub 37, p 4; McGuiness M, sub 60, p 642

30 Myer Foundation, sub 80, p 3; Moreland City Council, sub 37, p 5.

31 McClean C, transcript 31/03/2003, p 340. See also, Waddington B, transcript 28/04/2003, p 374. Waddington B, transcript 28/04/2003, p 374

8.40 Regardless of the structure used to improve integration, Mr Mundy of Aged and Community Services Australia pointed to level of planning involved for CACPs (within the overall 40:50:10 ratio) when those places result in only a small proportion of all community services:

> Most of [the services are] in the HACC program, which of course the states run, and it does not really make sense to spend a lot of time carefully planning the CACPs when the bulk of the system is done separately. It should be looked at slightly more broadly.[32]

8.41 Differing requirements for assessment for CACPs and HACC also make planning less effective than it should be and more confusing for older people needing to access care services.[33]

Quality and safety in community care

8.42 In addition to the negative impacts of fragmentation on older people's experiences of community care services, the Committee heard that greater attention should be paid to the training and qualifications of staff, standards and accountability, and the safety of the environments in which service providers work.

8.43 The Older Women's Network suggested that community care services must have the safeguards of quality management principles, standards and accountability. Mrs Sneesby saw the increase in private provision of community care services as an additional reason for introducing more robust standards. ANHECA drew a sharp contrast between community care and the level of Australian government supervision in residential care where meeting standards is mandatory. Other evidence conveyed the frustration carers feel when the community services providers sent to support them lack the training needed to provided a quality service, or behave in an unprofessional manner.[34]

8.44 Equal importance was placed on ensuring that homes are safe – both for older people receiving care and those providing care.[35] As more older people continue to live at home (and until they become more frail) the issue of safety must become a higher priority especially as many older people live in older homes. Inadequate home safety could

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32 Mundy G, transcript 7/02/2003, p 74.

33 Mundy G, transcript 7/02/2003, p 74.

34 Older Women's Network, sub 58, p 9; See also Sneesby A, transcript 19/05/04, p 468; ANHECA, sub 111, p 7. Halliday G, transcript 3/02/2004, p 768; Foreman R, sub 38, p 4.

35 Australian Nurses Federation, sub 97, p 7; Waddington B, transcript 28/03/03, p 374.

also limit access to Extend Aged Care at Home or to hospital in the home programs (See further, chapter 4, 'Housing and transport').

8.45 The Committee notes that in the 2004-05 Budget, the Government committed $13.7 million over four years for development and implementation of a quality assurance framework. It is intended that framework apply to CACPs, EACH and the National Respite for Carers programs.

The community care review

8.46 The Committee notes that the Department of Health and Ageing conducted a review of community aged care with a view to delivering community care in a more consistent manner across all programs. Input was sought from the community through a consultation paper, *A new strategy for community care*. This paper acknowledged the types of problems identified in evidence to the Committee:

> Many of these Programs provide similar services to similar people but have different administrative arrangements, which can be confusing to care recipients. Additionally, these differing arrangements mean that there is limited continuity of care when care recipient needs change in a way that necessitates a move from one program to another. [36]

8.47 Ms Margrie informed the Committee that the discussion paper:

> …seems to be getting a very good response on the ground. … Quite often the policy comes down from on high … This paper is quite different in that it looks at trying to lead the discussion forward and being interested in what is coming from the ground and in the innovation. So I think that new strategy is a really good first step; it is long overdue and it is very refreshing to see it.[37]

8.48 The consultation paper proposed a set of guiding principles and a National Framework for community care to enable 'Programs, regardless of the funding source, to be planned, funded and delivered in a cohesive and coordinated way and to make the most effective use of finite resources'. The proposed elements for the Framework were:

- The reorganisation of community care service provision to better align with three distinct levels of need, incorporating three service provision tiers:

36 Department of Health and Ageing, *A New Strategy for Community Aged Care*, Consultation paper, March 2003.

37 Margrie L, transcript 4/07/03, pp 677-68.

- ⇒ Access, Information and Support Tier;
- ⇒ Basic Community Care Tier; and
- ⇒ Packaged Community Care Tier;

- The development of a Regional Access Centre network to make it easier for care recipients and carers who require community care information and services;
- The standardisation of assessment and information management mechanisms to reduce unnecessary duplication in assessment and data collection; and
- The streamlining of administrative requirements so that more resources can be redirected into service provision.[38]

8.49 The Committee notes that the Minister for Ageing has recently announced a blueprint for work to be done to move towards greater cooperation and integration in the planing and delivery of community services. The blueprint envisages consistent approaches across Australian Government funded services, and working with the states and territories to extend consistent approaches to HACC services.[39]

8.50 The Committee commends the blueprint's intent to make access easier for people needing care, to enable a continuum of care as care needs increase and to work through a collaborative partnership with the states and territories. The blueprint also indicates that guidance will be sought from a National Reference Group. The Committee notes that funding for the developmental stage will come from within the $47.9 million provided in the 2004-05 Budget. Implementation of common arrangements is envisaged from 2005, once a new HACC agreement with the state and territory governments is in place.[40]

Flexible care

8.51 Evidence to the Committee indicated support for existing flexible care initiatives and stressed that more could be achieved through further realising the potential of flexible care.

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38 Department of Health and Ageing, *A New Strategy for Community Aged Care*, Consultation paper, March 2003, pp 17, 6.

39 Department of Health and Ageing, *A New Strategy for Community Aged Care: The Way Forward, 2004,* pp 7-9, 23-44.

40 Department of Health and Ageing, *A New Strategy for Community Aged Care: The Way Forward, 2004,* pp 11-12.

8.52 The *Aged Care Act 1997*(Part 3.3) enables the provision of flexible care in community or residential settings funded by the flexible care subsidy. (s49-1 to 49-3). Current flexible care initiatives include extended aged care at home packages (EACH), time limited initiatives under the Aged Care Innovative Pool, and multipurpose services. The scope of flexibility enabled by the *Aged Care Principles* (s15.24) is wide-reaching and encourages coordination and integration of care, addressing short term needs such as those following hospitalisation, and exploration of new care arrangements through pilots and projects.

Extended aged care in the home

> People on our [EACH] packages are very pleased to be able to get those added services coming in, delaying their admission to an aged care facility.[41]

8.53 Since the Northern Territory Salvation Army EACH program – 'With Care' – began operation in July 2003 its flexibility has suited the mixed ethnic population in Darwin and the needs of older people without family. There has been a 10% participation rate for both Indigenous older people and for older people without carers. The program has also been successful in maintaining people at home until 24 hours from death. [42] Services provided by With Care include: personal hygiene; domestic assistance; nursing services; meal preparation; medication management; respite care; social contact; transport accompanying to medical consultations; gardening; pet care; provision of mobility equipment; light maintenance; occupational therapy and physiotherapy; and care management.'[43]

8.54 Mrs Poole noted that a lack of set up funding made the first few months difficult:

> One of the difficulties that we experienced with the program was that there was no start-up funding for the program and therefore it was initially difficult to purchase equipment to commence the program.[44]

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41 Poole J, transcript 3/02/2004, p 797-798; NSW Department of Health, sub 160, p 7-8; Community Care Options Inc, part of ASLARC, sub 151, p1; Department of Health and Ageing, sub 119, p 43-45. See also: Community Care Options Inc., part of ASLaRC sub 151, p 1; Australian Nursing Homes and Extended Care Association Ltd (ANHECA), sub 111, p 12-13; Ward J, transcript 25/02/2003, p 143; Anglican Aged Care Services Group, sub 99, p 1

42 Poole J, transcript 3/02/2004, p 797.

43 Poole J, transcript 3/02/2004, p 797.

44 Poole J, transcript 3/02/2004, p 797.

8.55 Since 1998, more than 900 older Australians who would have otherwise had to enter residential care, now receive high level care at home by using the EACH program. As at the 30 June 2003 there were 450 allocated places through 19 service providers, with an additional 550 EACH places to be allocated in 2003. Following increases in provision for CACPs in the 2004-05 Budget, over 3,224 EACH places are expected to be available by 2006.[45]

8.56 Evidence presented to the Committee highlighted growing demand for EACH places and the need for further resources to increase the number of EACH packages to enable people to have the chance of receiving high care at home.[46]

8.57 The Committee considers that while the EACH program must continue to grow, expansion should be timed to proceed within the proposed quality assurance framework for community care programs.

The Aged Care Innovative Pool

8.58 The Aged Care Innovative Pool provides flexible care subsidies to enable the testing of new approaches to aged care, not to provide ongoing aged care services. Projects are operated in partnership with other stakeholders including state and territory governments. At 30 June 2003 there were 865 innovative care places allocated to 30 projects. A further 400 places were to be made available in 2003-04.[47]

8.59 It was suggested to the Committee that innovative service models may provide a future basis for improving access to a range of specialised services for the elderly in rural and remote areas.[48]

8.60 Professor Byles pointed to the worth of these pilots in exploring problems such as how best to ensure older people have enough time to recover following a stay in hospital:

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45 ANHECA, sub 111, p 12-13; Hogan W, Pricing Review of Residential Aged Care, 2004, p 16; Department of Health and Ageing, Extended Aged Care at Home, viewed 19/08/2004, <http://www.health.gov.au/acc/commcare/each.htm>; Minister for Ageing, the Hon Julie Bishop MP, *Investing in Australia's aged care: More places, better care*, May 2004, p 8. Department of Health and Ageing, *A New Strategy for Community Care: The Way Forward,* p 14.

46 NSW Department of Health, sub 160, p 7-8; COTA, sub 157, p 7; Carers Australia, sub 77, p 13; National Aged Care Alliance, sub 88, p 2;

47 Department of Health and Ageing, *Investing in Australia's aged care: more places, better care,* May 2004, p 11; Department of Health and Ageing, *550 aged care places for transitional and dementia care*, media release, 8 July 2002.

48 National Rural Health Alliance Inc, sub 131, p 5.

> Many people are admitted to long-term residential care following acute admission to hospital. There needs to be effective programs for enabling people to rehabilitate and return to their own homes. Transitional Care projects are beginning to shed light on these opportunities and indicate that such approaches can be effective and cost-effective.[49]

8.61 Since 2002, pilot projects to trial transitional care have been jointly funded by the Australian and State/Territory Governments. The pilots combine personal and nursing care and rehabilitation, with the aim of:

- increasing the number of older Australians able to return to their own homes, or to enter residential care from the pilot with a higher level of functional and cognitive ability and independence than would otherwise have been possible;
- reducing the rate or readmission to hospital of recently discharged older people; and
- improving the quality of life of participating frail older people.[50]

8.62 Mrs Thorn informed the Committee of three models of interim/ transitional care being explored in Victoria which 'seem to be working quite well': a hospital based model; a residential care facility model using unfunded beds and hospital projects funding; and a community based model providing extra support to the family.[51]

Transitional care and Pathways Home

8.63 The need for immediate investment in some form of transitional care was raised in evidence to the Committee in relation the importance of services to maintain healthy functioning, the interfaces between acute care and residential and community care, residential care, and older people's experiences of care during a stay in hospital – as is discussed in other sections of this report.

8.64 The Committee notes that the Hogan Review recommended the creation of a strategic pool of up to 3,000 additional places each year for the next four years to be used (among other things) flexibly and to support innovative care models.[52]

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49 Byles, J, sub 103, pp 8-9. See also, National Aged Care Alliance, sub 11, p 6.

50 Department of Health and Ageing, sub 119, p 45-46; Thomann M, transcript 7/02/2003, p 9.

51 Thorn J, transcript 31/02/2003, p 306.

52 Hogan W, Pricing Review of Residential Aged Care, 2004, p 16

8.65 In response, the Australian Government agreed to provide up to 2,000 new transition care places (from within the increased ratio) to:

> … help older people after a stay in hospital. This will allow them to receive rehabilitation services and support to increase their independence and confidence, and give them time to assess whether they can return home with additional support from community services or need to consider the level of care provided in an aged care home.[53]

8.66 The program will continue to be funded via flexible care subsidy, and costs will be shared with the States and Territories.

8.67 The Committee welcomes the intent of this initiative. Giving older people time to regain confidence after acute care and time to make decisions about future care without undue pressure is essential. The details of joint funding and program implementation arrangements are yet to be finalised.

8.68 The Committee is concerned that there is potential for duplication and overlap with the Pathways Home program, funded under the Australian Health Care Agreements 2003-08. A collaborative initiative between the Australian Government and the States and Territories, Pathways Home is designed to increase the rehabilitation and step down (convalescent) services provided to patients leaving hospital, particularly patients who are older or who have some form of mental disability. Projects agreed under State and Territory work plans include home and community based care as well as transitional care in hospital related sub-acute facilities.[54]

The Multipurpose Services Program

8.69 The Multipurpose Services Program (MPS) is a joint Australian and state/territory government funded initiative. It is designed to provide a range of health and aged care services to rural and remote communities. At 30 June 2003, the MPS program consisted of 1,810 flexible aged care places in 83 locations.[55]

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53 Minister for Ageing, the Hon Julie Bishop MP, *Investing in Australia's aged care: more places, better care*, p 17

54 Department of Health and Ageing, 'Pathways Home Projects (Schedule B of the ACHAs)', viewed 24/08/2004, <http://www.health.gov.au/ahca/agreements.htm>. Links at this site lead to lists of projects approved for each State and Territory.

55 Department of Health and Ageing, *Investing in Australia's aged care: more places, better care*. May 2004, p 11.

8.70 Evidence to the Committee affirmed that the MPS program has worked well a in many areas and that the pooling of Australian government and state/territory funds has enabled a greater number and variety of services to be available in rural and regional areas.[56] Mrs Jeffrey from Uniting Church Frontier Services, however, reminded the Committee that the MPS model was not designed – and does not work – for remote areas such as most of the Northern Territory:

> Multipurpose schemes have worked quite well in lots of areas but, because of the spread of our population, it is not the way to go all the time…[57]

8.71 The Committee heard that there is some confusion around the roles of and arrangements for MPSs and Regional Health Services.[58] Both programs are designed to enable flexible and integrated solutions for communities that are too small to support a range of stand-alone services. Because they are funded under the flexible care subsidy provisions of the *Aged Care Act 1997* (Part 3.3) and *Flexible Care Subsidy Principles 1997* (s15.13 – s15.14), MPSs must have the capacity to provide residential care whereas Regional Health Services are not required to do so. Otherwise the services provided can be very similar.

8.72 The Committee questions whether continuing two separate programs is sensible. Perpetuating silos around two programs which both have the goals of encouraging flexibility and integration is not desirable.

8.73 Further, the Committee considers that ongoing consideration must be given to how the flexible care subsidy may be used to better provide care in remote areas.

Care services in diverse settings

8.74 Wide-spread concerns were put to the Committee about the availability and quality of care for people with dementia or mental health problems, and for those needing respite or palliative care. Such care may be provided at home, in the community or in an

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56 Gregory G, transcript 7/03/2003, p 240; Jeffrey R, transcript 3/02/2004, p 777; North R, transcript 23/02/2004, p 814.

57 Jeffrey R, transcript 3/02/2004, p 777.

58 Gregory G, transcript 7/03/2003, pp 240-41.

institutional setting – or a mix of these settings – raising questions about continuity and integration of care.

Care for people with dementia or other mental health problems

> Dementia is an insidious disease and Alzheimer's accounts for up to 70% of all dementia cases. The disease by its very nature changes the lives of those with dementia and their relationship with family members and friends, often to a critical degree.[59]

8.75 Evidence to the Committee suggested that while the impacts of dementia are beginning to be more fully recognised and addressed, the extent of depression and other mental health problems are yet to be acknowledged.

Incidence and costs of dementia

8.76 Alzheimer's Australia suggested to the Committee that a potential impact of the ageing of the Australian population will be a rapid increase in the numbers affected by dementia. Dementia is already the fourth biggest cause of death among older Australians; it is the third largest cause of disability burden among women and the fifth among men. Projections indicate that by 2041 the number of people affected will increase by three and a half time to around 460,000. More recent studies by Access Economics (commissioned by Alzheimer's Australia) and the Australian Institute of Health and Welfare (AIHW) suggest similar increases. However, the AIHW counsels that the figures should be treated with some caution. There are no Australian incidence studies: all estimates have been based on information derived from overseas epidemiological studies.[60]

8.77 Dr Michael Lowe drew the Committee's attention to the fact that in the Northern Territory Aboriginal people with dementia are likely to be just middle-aged. There is also a growing number of people in their thirties with dementia caused by substance abuse, diabetes or vascular disease. People with alcohol related brain damage live longer

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59 Alzheimer's Australia, sub 79, p 6.

60 Alzheimer's Australia, sub 79, p 6; Access Economics, *The Dementia Epidemic*, p 32; AIHW, *The Impact of Dementia*, pp 13-14; NSW Health, sub 160, p 8; Australian Medical Association, sub 86, pp 4-5; The Aged Care Rights Service, sub 87, p 33. The Review of Pricing Arrangements in Residential Aged Care, p 296, recommended that future research should include comprehensive prevalence studies to provide more robust data for future planning and policy development (Recommendation 20).

than an 85 year old with Alzheimer's so that they may spend much longer in residential care.[61]

8.78 Dementia results in a heavy financial burden on individuals and their carers, health and aged care services, and the economy. These direct and indirect costs are summarised in Table 8.1 (below). They are projected to rise from 0.91% of GDP in 2002 to 3.3% by 2051.[62]

8.79 Equally heavy are the non-financial burdens on individuals and their families and carers including loss of income, isolation and poor mental health.[63]

Table 8.1: Summary of direct and indirect financial costs of dementia, 2002

	Real cost $ million	Transfer payments $ million	Total $ million	Per person with dementia	% GDP 2002	% GDP 2051
Direct Health Costs	3,235.9		3,235.9	19,938	0.45	
Including Residential care	2,847.1		2,847.1	17,542*		
Home and community care	174.8		174.8	1,077*		
Indirect financial costs						
Lost earnings (patients)	355.3		355.3			
Morality burden	8.8		8.8			
Tax Foregone (patients)		102.2	102.2			
Value of carers	1713.2	324.4	2,037.6	12,555	0.28	1.0
Tax foregone (carers)		489.7	489.7			
Welfare payments		52.0	52.0			
Aids and modifications	119.8		119.8			
Subtotal indirect financial costs	2,197.2	968.3	3,165.4	19,504	0.44	1.6
Total financial costs	**5,607.9**	**968.3**	**6,576.1**	**40,519**	**0.91**	**3.3**

*Notes: The averages, per person, with dementia is residential care and per person with dementia at home receiving formal services are $36 547 and $2 554, respectively.

Source: Access Economic, Dementia Epidemic, p 50.

Diagnosis and care

8.80 In all cases, dementia is a progressive disease with changing care needs as it progresses:

61 Lowe P, transcript 3/02/2004, pp 787-8; Wintringham, sub 42, pp 6-7.

62 Access Economics, *The Dementia Epidemic*, p 50.

63 Access Economics, *The Dementia Epidemic,* p 24.

> For each of these stages a person moves through with that illness[,] they require a different skill set, possibly even require a different type of environment with various levels of expertise … depending on the level and difficulty of that challenging behaviour.[64]

8.81 Dementia may be accompanied by challenging behaviours – referred to as behavioural and psychological symptoms of dementia (BPSD) – which may range from wandering to episodes of increased anxiety and bouts of aggression. Such behaviours can be disruptive to carers and other residents and may result in physical injury to the individual themselves or to care staff.[65]

8.82 Dr Susan Richardson explained to the Committee that not all people with dementia exhibit challenging behaviours: however, a significant number have moderately challenging behaviour and a few have extreme behaviours. According to Brodaty's model of management of BPSD, only 1% of all dementia sufferers (some 1,700 people) have 'very severe' BPSD, and a very small number have 'extreme' challenging behaviours. Brodaty considers that those with 'very severe' BPSD should be cared for in psychogeriatric facilities and those with 'extreme' behaviours require a high security specialist care unit.[66]

8.83 The Committee heard, however, that it is not always easy to find a place for people with dementia, especially when there are challenging behaviours. The small numbers of people with severe and extreme behaviours means that in many localities there are no facilities suited to their needs.[67]

8.84 The diagnosis of dementia is not straightforward and the Committee heard that many GPs are not well informed about its diagnosis and treatment. As Dr Menzies stated:

> Dementia is a complex health problem, and often GPs do not have the skills to give optimum care to these patients.[68]

8.85 This may result in people receiving inappropriate care, forgetting to take their medications for other conditions, and not being in a

64 Richardson S, AMA, transcript 7/03/2003, p 214.

65 NSW Health, sub 160, p 9.

66 Richardson S, transcript 7/03/2003, p 214; Gegg S, sub 48, p 1; Burfoot C, transcript 19/05/2003, p 470; Henry Brodaty, Brian M Draper and Lee-Fay Low, 'Behavioural and psychological symptoms of dementia', *MJA, 2003* 178 (5): 231-234.

67 Richardson S, transcript 7/03/2003, pp 214-15; The Aged Care Rights Service, sub 87, p 34; K Burfoot, transcript 19/05/2003, p 470; Ward J, transcript 24/02/2003; p 142.

68 Menzies R, transcript 24/02/2004, p 841.

position to start planning for how their care, financial and legal matters will be handled when they can no longer take responsibility.[69] Central Coast Health, NSW, referred the Committee to a CD-ROM called, *Its time to think about dementia,* distributed to GPs to assist them to improve diagnosis. While such products provide useful support, the Federation of Ethnic Communities Councils of Australia emphasised that there is an urgent need to develop culturally and linguistically appropriate assessment tools for the diagnosis of dementia. [70]

8.86 Dr Mahajani stressed that the need to develop dementia skills is an even greater challenge when working with Indigenous people, especially those in remote areas.[71]

8.87 The New South Wales Department of Health suggests the implementation of a strategy that:

> …provides for a coordinated approach to dementia policy, planning and research, workforce development and training, particularly with the Divisions of General Practice to address the lack of GP involvement in the medical care of people with dementia in aged care facilities…[72]

8.88 The need for community care and residential care staff to improve their knowledge and care skills relating to dementia was repeatedly raised. Constant TV, a small fish tank, and a weekly keyboard rendering of WWI songs scarcely constitute appropriate care.[73]

8.89 Views were put that dementia care education and training should be compulsory for all care staff in residential aged care and for management and support staff. This is in keeping with the requirement under the Accreditation Standards that management and staff have appropriate skills to perform their roles effectively. While the assistance of the Psychogeriatric Units in assessing difficult behaviours is valued, these are few and far between so that many areas lack access to their support.[74]

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69 The Aged Care Rights Service, sub 87, p 33; Blackwell J, transcript 24/02/2003, p 90; Council on the Ageing, NSW, sub 157, p 5; Richardson S, transcript 7/03/2003, pp 215, 220; Flecknoe-Brown S, transcript 24/02/2004, p 841.

70 Blackwell J, Central Coast Health, transcript, 24/02/2003, p 90; Federation of Ethnic Communities Councils of Australia, sub 140, p 2.

71 Mahajani S, transcript 3/02/2004, pp 795-796.

72 New South Wales Department of Health, sub 160, p 9.

73 Warn P, sub 26, p 10.

74 Council on the Ageing, NSW, sub 157, p 5; NSW Health, sub 160, p 9; The Aged Care Rights Service, sub 87, p 32; AMA, sub 86, p 2; Accreditation Standards, viewed

8.90 The Committee heard that facility design plays a significant role in successful dementia care. Architects KLCK Woodhead International explained that:

> Designing for people with dementia requires a particular understanding of the impact of the disorder on residents and their families. … it is essential to provide an environment that enables residents to use their remaining cognitive abilities and skills to the highest possible level. To achieve this, we believe key design principles, such as redundant cueing, design for wayfinding and orientation, familiarity, appropriate scale and security, need to be applied.[75]

Australia now has a growing body of experience in design for dementia care.[76]

8.91 To act as an incentive for residential care providers to take dementia care more seriously, the Council on the Ageing, NSW, suggested:

> Making accreditation reports publicly available to potential residents and their families and carers to know whether the facility has the staff and environment to provide quality dementia care.[77]

8.92 The Committee notes that in the 2004-05 Budget, a new supplement for the care for people with dementia and challenging behaviours recognises the more intensive staff time needed for this care. Details of the rates and eligibility for the supplement have yet to be announced.

Depression and other mental health problems

8.93 Evidence to the Committee indicated inadequate provision of mental health services in the community and in residential care, and a lack of access to skilled staff to call on for support. The National Rural Health Alliance pointed to the limited capacity in small towns to provide either effective diagnosis or ongoing care for people with mental

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13/07/2004, <http://www.accreditation.aust.com/accreditation/ standards.html#1>; Ward J, transcript 25/02/2003, p 141.

75 KLCK Woodhead International, sub 96, p 2.

76 Review of Pricing Arrangements in residential aged care, pp 183-84

77 Council on the Ageing, NSW, sub 157, p 6

health disorders (such as schizophrenia, delirium, mood disorders or mania) or to provide respite for their carers. [78]

8.94 Many older migrants who suffered trauma in their earlier lives are in need of mental health services attuned to their particular circumstances. In this context, the importance of careful assessment to distinguish between dementia and other mental health conditions was stressed by the Blacktown Migrant Resource Centre.[79]

8.95 According to the findings of the 'Challenge Depression 'project, approximately 51% of residents in high care homes and 30% in low care homes score above the cut-off point for depression on the Geriatric Depression Scale. Other studies suggest that up to 20% of older people in the community are also subject to depression. [80] The project identified factors that best explained the depression experienced by residents as follows (in order of importance):

- Grief over loss of opportunities and abilities to take part in valued activities
- Described by a relative as being depressed prior to admission
- Not involved in helping others
- Attending but not taking part in activities
- Having problems settling in, particularly with establishing good relationships
- Experiencing chronic pain
- Having had a stroke
- Not having a weekly visit.[81]

8.96 Other research concludes that:

> Depression is commonest among those living in nursing homes or hostels, and is especially prevalent in those who suffer chronic illness or disability, especially conditions that produce pain, urinary incontinence, or significant activity limitation. … depression among the elderly is under-recognised, under-treated, and associated with a poor

78 Australian Nursing Federation (SA Branch), sub 93, p 12; Aged Services Learning and Research Collaboration, sub 151, p 12; National Rural Health Alliance, sub 131, p 32-3; FECCA, sub 140, p 2; Department of Veterans' Affairs, transcript 7/02/2003, p 33.

79 Malak A, transcript 7/03/2003, p 260; Agyepong B, transcript 4/07/2003, p 660.

80 Flemming R, 'Challenging Depression in the Elderly: making a determined start'. A project commissioned by the Department of Health and Ageing, viewed 4/07/2004, <http://www.hammond.com.au/resources/intro.pdf>.

81 Flemming R, 'Challenging Depression in the Elderly: making a determined start', p 3.

prognosis, including being an independent risk factor for premature death.[82]

8.97 The Committee also heard that in part the inadequacy of services stems from poor understanding of mental health disorders in older people, and hence how to best provide support and services. As Professor McCallum stated, 'We do not know what to do at the moment'.[83]

8.98 Building on the 'Challenge Depression' project, the Department of Health and Ageing has developed a resource package and is promoting seminars to assist residential aged care staff to recognise and manage depression in residents.[84]

8.99 The Committee welcomes the assistance that will be provided through the resource package but concludes that there is a long way to go before depression in residential aged care is properly understood and managed.

Respite care

8.100 Alzheimer's Australia, among others, welcomed the expansion of respite services in recent years through the National Respite for Carers Program and the Home and Community Care Program. Australian Government funding subsidised 47,716 admissions to residential respite, (around 985,000 days) in 2002-03. The Committee notes that funding for the National Respite for Carers Program was expected to be almost $99 million in 2003-04.[85]

8.101 Even so, a number of concerns were raised. These were echoed by Mr Chodziesner, of Carers Australia, in light of his personal experiences caring for his wife:

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82 Ritchie C and Ames D, 'Disorders of old age in Australia', in Meadows G and Singh B (eds), *Mental Health in Australia: collaborative community practice*, Oxford University Press, 2001, p 418.

83 McCallum J, transcript 4/07/2003, p 674.

84 Department of Health and Ageing, *Challenge Depression: Reducing Depression in Aged Care Homes,* viewed 4/08/2004, <http://www.ageing.health.gov.au/workforce/chaldepr.htm>

85 Alzheimer's Australia, sub 79, p 13; Lgov NSW, sub 89, p 19; Sneesby A, transcript 19/05/2003, p 468; The Hon Julie Bishop MP, *Investing in Australia's Aged Care: More Places, Better Care,* May 2004, p 10; Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997*, 1 July 2002 to 30 June 2003, p xi.

- insufficient respite places to cover demand, in part because funding incentives for aged care homes to provide respite care are lacking – and quality residential respite care is difficult to find,[86]
- insufficient home respite resulting in long waiting lists or, in some locations, no access at all;
- limited choice in respite arrangements: short term residential care or occasional home care – and in a few locations, day care, but this may cater only for people with relatively low care needs, and not for people with dementia; and
- weekend and overnight respite is very scarce and very hard to organise.[87]

8.102 A further disincentive identified by representatives of the Aged Care Assessment Services in Victoria, is the paperwork burden involved in admitting people to residential care respite, especially for high care. Despite the desperate need to respite care, Mrs Thorn stated that some providers seem willing to not fill respite beds rather than complete the necessary paperwork. She also noted the success of Carer Respite Centres in helping to maximise access:

> We have about 2,500 respite bed days in the north-east region and we use about 500 of those a year. The only ones that are being fully utilised are being managed through the care and respite centre, where they do a lot of the paperwork and provide extra dollars for settling in … If the bed is not filled for some reason, the facility does not miss out.[88]

8.103 Other evidence indicated there are very good respite services operating, including dementia respite services, day care services and innovative approaches similar to family day care for children. Lake Macquarie City Council's single assessment service makes it easier for people seeking respite by referring them to providers that could meet their particular needs. [89]

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86 A further disincentive identified for residential respite was the paperwork burden involved: see Harvey D, transcript 31/03/2003, p 298.

87 Chodziesner B, transcript 7/03/2003, p 246; Burfoot C, transcript 19/05/2003, p 470; Sneesby A, transcript 19/05/2003, p 468; Barrand P, transcript 3/02/2004, p 759; Bogaerts J, transcript 25/02/2003. A further disincentive identified for residential respite was the paperwork burden involved: see Harvey D, transcript 31/03/2003, p 298.

88 Houghton P, Harvey D and Thorn J, transcript 31/03/2003, pp 297-98; Sneesby A, transcript 19/05/2003, p 468.

89 Burfoot C, transcript 19/05/2003, p 470; Iliffe J, transcript 7/03/2002, pp 252-53; Bogaerts J, transcript 25//03/2003, p 153-54

8.104 In addition to more funding for services under the National Respite for Carers Program, proposals put to the Committee included improving funding incentives for offering respite care, and incentives for developing specialisation and diversification of models of respite care to encourage greater flexibility and responsiveness and give carers more choice.[90]

8.105 As part of the allocation of new places, providers nominate the proportion of place days that will be used to provide respite care. Once approved, providers are then limited to their specified allocation of residential respite place days, regardless of the demand and whether they are willing to provide more respite days.[91]

8.106 At present for each respite care resident, aged care homes receive:

- respite care subsidy, paid at RCS level 3 for high care and RCS level 6 for low care; and
- respite care supplement. This supplement was increased in the 2004-05 Budget by $2.75 to $16.25 per day in line with the concessional resident supplement to assist providers with capital requirements.[92]

8.107 The Committee considers that while the increased respite care supplement is welcome it is unlikely to improve access to residential respite care. In the 2004-05 Budget context, the Australian Government announced that the RCS (residential classification scale) will be streamlined from eight categories to three. This provides an opportunity to establish respite care subsidy rates that will provide a better incentive for aged care homes to provide respite care, including care for people with complex high care needs.

8.108 A more comprehensive reassessment of residential respite care arrangements is needed.

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90 Moreland City Council, sub 37, p 3; National Aged Care Alliance, sub 88, p 6.

91 Department of Health and Ageing, *Residential Care Manual,* Appendix 1, Residential Respite Care, viewed 16/07/2004, <http://www.ageing.health.gov.au/manuals/rcm/contents/append1_b.htm>.

92 Department of Health and Ageing, *Residential Care Manual,* Appendix 1, Residential Respite Care, viewed 16/07/2004, <http://www.ageing.health.gov.au/manuals/rcm/contents/ append1_b.htm>; *Budget Measures 2004-05*, Budget Paper No. 2, p 187.

Palliative care

8.109 Quality palliative care is essential to the person and their family in the final stages of an older person's life. Palliative Care must be easily available to people who are terminally ill. Caring staff and adequate resources are necessary to ensure the comfort of those in need of care.[93]

8.110 In evidence to the Committee many organisations and individuals emphasised the importance of access to quality palliative care.[94] Palliative care refers not just to caring for people who are very sick or dying, it involves supporting patients and their families in dealing with the physical, psychological, emotion and spiritual aspects of their condition.[95]

8.111 Palliative care can be provided in community settings, designated palliative care beds in hospices, acute hospitals or living environments such as an aged or supported care facility environment of the patient's choice.[96] Evidence to the Committee showed that people are opting for all of these settings. By the very nature of aged care homes, the incapacity to provide quality palliative care will grow in importance.[97]

8.112 Mrs Sneesby of the Mid North Coast Area Health Service explained that many people wish to remain in their own homes and in the Coffs Harbour area there are approximately 150 patients seeking palliative care each year, with 50 per cent of people electing to die in their homes.[98]

8.113 People in rural and remote areas should also be able to benefit from palliative care. Limited resources in rural and remote areas mean people often miss out or travel long distances to major centres for

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93 Australian Lung Foundation, sub 173, p 36

94 Country Women's Association, sub 121, p 2; Otomancek G, sub 169, p 4; Australian Physiotherapy Association, sub 118, p 18; Anglican Dioceses of Sydney, sub 67, p 3-4; Australian Nursing Foundation, sub 97, pp 1, 14.

95 Palliative Care Australia, sub 139, p 4; Australian Lung Foundation, sub 173, p 36.

96 Palliative Care, *Service Provision in Australia: A Planning Guide*, viewed 28/07/2004, <http://www.pallcare.org.au/publications/Planning%20guide2003.pdf>, p 17; Barrand P, transcript 3/02/2004, p 760.

97 Baptist Community Care Ltd, sub 56, p 2; Maddocks I, Medical Journal of Australia, *Palliative Care in the 21st Century,* 15/09/2003, volume 6, supplement, viewed 28/07/2004, p 1-2, <http://www.mja.com.au/public/issues/179_06_150903/mad10519_fm.html>.

98 Sneesby D, transcript 19/5/2003, p 468.

palliative care.[99] Very few palliative care services are available in Indigenous communities, however, the Central Australian Aboriginal Congress informed the Committee of their innovative primary health care service for older indigenous people including palliative care through its Frail, Aged and Disabled (FAAD) program.[100]

8.114 Australia is earning a high reputation in the development of palliative care. It has been suggested that this is due in part to the increasing focus by governments on palliative care over the past twenty years.[101] This focus is reflected by endorsement in 2000 by the Australian Health Ministers' Advisory Council (AHMC) of the National Palliative Care Strategy. The strategy represents the commitment by governments, together with key stakeholders, to the development and implementation of consistent policies and quality palliative care services across Australia. Under the 2003-08 Australian Health Care Agreements, the Australian Government is providing $201.2 million for palliative care. Of this, $188 million it to be allocated on a per capita basis to states and territories for palliative care provision, and $13.2 million for the implementation of national initiatives.[102]

8.115 Other recent initiatives include: a scoping study to determine palliative research priorities;[103] funding for palliative care in the community;[104] a national study of the palliative needs of Indigenous communities;[105] and funding for the Divisions of General Practice to develop multi-disciplinary palliative care suited to the needs of rural communities.[106] The NHMRC is providing specific funding for palliative care research through PhD scholarships, post-doctoral fellowships and research grants. A recently completed NHMRC

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99 DeBono S, transcript 24/02/2004, p 875; Millman D, transcript 24/02/2004, p 859; Smith M, transcript 2/02/2004, p 743.

100 Central Australian Aboriginal Congress Inc, sub 176, p 5; Boffa J, transcript 2/02/2004, p 730.

101 Maddocks I, Medical Journal of Australia, *Palliative Care in the 21st Century,* 15/09/2003, volume 6, supplement, viewed 28/07/2004, p 1, <http://www.mja.com.au/public/issues/179_06_150903/mad10519_fm.html>

102 Department of Health and Ageing, The National Palliative Care Strategy, viewed 27/07/2004, <http://www.palliativecare.gov.au/strategy.htm>.

103 NHMRC, research, viewed 30/07/2004, <http://www.nhmrc.gov.au/research/srdc/pallcare.htm>

104 Department of Health and Ageing, Budget Measures 2002-03, Budget Paper No. 2, 2002, http://www.health.gov.au/budget2002/fact/hfact2.htm

105 National Indigenous Palliative Care Needs Study, viewed 28/07/2004, <http://member.telpacific.com.au/ksa/>.

106 Australian Divisions of General Practice, Rural Palliative Care Program, viewed 28/07/2004, <http://www.adgp.com.au/site/index.cfm?display=683>.

funded project indicates there is still much work to be done before older people in Indigenous communities can access palliative care that also respects Indigenous cultural practices.[107]

8.116 The 2004-05 Budget saw the introduction of a new care supplement for residents with complex palliative care needs. The supplement recognises that palliative care requires more intense care time. The supplement will help ensure that aged care homes are adequately funded to provide residents with high quality palliative care.[108]

8.117 A further step to national cooperation was taken in July 2004 with the release of guidelines for a palliative approach in residential aged care and an associated framework for education and training.[109]

8.118 The Committee welcomes the increasing focus on palliative care across levels of government. Even so, it is clear that the potential benefits are yet to be widely accessible in the community. Eligibility criteria and access arrangements for the new palliative supplement are yet to be announced by the Australian Government. It is essential that eligibility and the level of funding reflect all facets of a palliative approach, including the person's physical, cultural, psychological, social and spiritual needs.

Residential care

8.119 In 2002-03, 184,095 people received permanent residential care - just 10% of Australians aged 70 or more years. Some 34,025 people received residential respite care, of whom 14,792 were later admitted to permanent care.

8.120 Of residents in care as at 30 June 2003:

- just over 50% were over the age of 85;
- 72% were female;
- 56% of all female residents were over the age of 85;

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107 NHMRC Palliative Care Research, viewed 30/07/2004, <www.nhmrc.gov.au/research/train/ palgrant.htm>, <www.health.gov.au/nhmrc/research/train/ postdoc.htm>, <http://www.nhmrc.gov.au/research/train/palcare.htm>.

108 Department of Health and Ageing, Budget Measures 2004-05, Budget Paper No. 2, 2004, p 190; Department of Health and Ageing, *Investing in Australia's Aged Care*, viewed 29/07/2004, <http://www.health.gov.au/investinginagedcare/q_a>.

109 Australian Palliative Residential Aged Care Project, viewed 30/07/2004, <http://www.apacproject.org/showpage.asp?ButtonID=1>.

- 37% of all male residents were over the age of 85;
- 90% received a full or part pension – 74% received a Centrelink pension and 16% a DVA pension; and
- 6215 residents (4%) were under the age of 65.[110]

8.121 Evidence to the Committee suggested that older people are entering care at a later, frailer stage, increasing the demand for high care.[111] This is borne out by Table 8.2 which shows the proportion of residents in each RCS category between 1999 and 2002.

8.122 The Committee heard wide-ranging evidence about the care currently provided in aged care homes, and about the adequacy of the system to meet future demands for care as the number of older Australians increases. The main concerns identified were as follows:

- access: appropriateness of the planning ratio and allocation processes;
- assessment and the role of Aged Care Assessment Teams;
- quality of care;
- adequacy of care for individuals with special needs;
- the interface with acute care; and
- funding and the viability of aged care facilities.

Table 8.2: Proportion of residents in each RCS category, 1999 to 2002

RCS Category	Unit	June 1999	June 2000	June 2001	June 2002	Change 1999 to 2002
RCS 1	%	14.2	17.2	18.8	19.3	35.9
RCS 2	%	25.7	25.4	25.1	24.9	-3.1
RCS 3	%	16.5	15.4	14.7	14.5	-12.1
RCS 4	%	4.6	4.6	4.6	4.6	0.0
High Care	**%**	**61.0**	**62.6**	**63.2**	**63.3**	**3.8**
RCS 5	%	8.8	9.8	10.5	10.5	19.3
RCS 6	%	10.2	10.5	10.8	10.8	5.9
RCS 7	%	16.9	14.9	13.9	13.8	-18.3
RCS 8	%	3.1	2.2	1.6	1.5	-51.6
Low care	**%**	**39.0**	**37.4**	**36.8**	**36.7**	**-5.9**

Source: WP Hogan, Review of Pricing Arrangements in Residential Aged Care, The Context of the Review, p 7.

110 Hogan WP, *Review of Pricing Arrangements in Residential Aged Care, Final Report*, p 167.

111 Australian Nurses Federation (SA Branch), sub 97, p 5; Young R, transcript 7/03/2003.

8.123 It should be noted that the Committee heard evidence relating to residential care before the Hogan Review report was released. Many of the issues raised with the Committee and discussed here are consistent with those presented to the Hogan Review.

The availability of residential care

8.124 Issues of major concern regarding the availability of residential care included the adequacy of the planning ratio, the bed allocation (licensing) process, and the need for allocated places to become operational much more quickly. Together, these factors were seen as limiting access to care, causing long waiting lists in many areas, and (for one reason or another) jeopardising the viability of aged care homes.

8.125 The planning ratio of 50 low care, 40 high care and 10 CACPs for every 1000 people aged 70 years and over was widely regarded as inadequate. The Committee heard that this ratio failed to keep pace with growth in the older population or the demand for high care and no longer reflected preferences for continuing to live in the community. Further, tying the ratio the over 70 years age group was considered to not acknowledge that users of residential aged care are mostly over 80 years of age.[112]

8.126 A major criticism of the allocation process was its short-term focus, with places being announced and allocated on an annual basis making it difficult for providers to plan ahead, including marshalling finance. Dr Howe summed up the effect as follows:

8.127 [It requires] the sector to gear up and wind down in short cycles rather than continue at a steady rate of development, with effects felt at all stages throughout the development process from land acquisition to engaging architects and builders and finally commissioning and staffing facilities.[113]

8.128 In addition, local governments with rapid increases in their older populations due to retirement migration were concerned that allocations were based on outdated census data.[114]

8.129 Concerns about the lag between allocation of places and the time older people can access the services is consistent with figures in the

112 Anglican Aged Care Services Group, sub 99, pp 1-2; Moreland City Council, sub 37, p 3; Gray R, transcript 17/08/2003, p 699; Lgov NSW, sub 89, pp 15-16; ANHECA, sub 111, p 11; COTA, sub 157, p 2.

113 Howe A, sub 128, p 5.

114 Blackwell J, transcript, 24/02/2003, p 96; Anglican Aged Care Services Group, sub 99, p 4; Lgov NSW, sub 89, p 16; Lipscombe J, transcript 7/03/2003, p 241.

most recent *Report on the Operation of the Aged Care Act 1997.*[115] Suggestions to reduce or offset the lag time included releasing sufficient places to catch up with the planning benchmarks, developing better designed allocation processes including addressing the short term focus of annual releases which makes it difficult to plan ahead.[116] The Committee also heard about the efforts some local governments are making to reduce the lag time by identifying and making available suitable land so that approval processes can be simplified and expedited.[117]

8.130 The Hogan Review also identified these issues as major concerns and made recommendations regarding the planning ratio, introducing more flexibility to the allocations process, and providing incentives for new places to become operational more quickly.[118] In the 2004-05 Budget context the Australian Government announced that:

- The provision ratio will be increased to 108 operational places for every 1000 people aged 70 or over comprising: 20 CACPs, 40 high care places, and 48 low care places.
- An estimated 27,900 new places will be allocated over the next three years, including 13,030 in 2004.
  - ⇒ Up to 2000 transitional care places will be provided over the next three years on a cost-shared basis with the states and territories.
- Indicative numbers of new places will be announced three years in advance so providers have more time to plan ahead and enable beds to in use more quickly.
- A flexible pool of places will be created within each allocation round to address structural and regional requirements.
- The effectiveness of the new planning arrangements will be reviewed in 2007-08.[119]

8.131 The Committee notes that these commitments have the potential to address the concerns presented to it. The Minister for Ageing has

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115 *Report on the Operation of the Aged Care Act 1997*, 1 July 2002 to 30 June 2003, p 5;

116 NSW Health, sub 160, p 6; Anglican Aged Cares Services Group, sub 99, p 2; National Aged Care Alliance, sub 88, p 2; Moreland City Council, sub 37, p 3

117 Moreland City Council, sub 37, p 3; Brady P, transcript 25/06/2003, pp 553-554, Blackwell J, transcript 24/02/2003, p 96.

118 *Review of Pricing Arrangements in Residential Aged Care,* Final Report, pp 276-78.

119 The Hon Julie Bishop, Minister for Ageing, Budget 2004-2005, Fact sheet 1, Summary of Aged Care Measures, p 2, viewed 1/06/2004, <http://www.health.gov.au/budget2004/abudget/afact1.htm>.

already announced indicative places for the coming years. However, the number of places overall falls short of the recommendation made by the Hogan Review. The Committee endorses the need for a thorough and fundamental review of planning arrangements in 2007-08.

8.132 While by far the majority of those who expressed concerns about the process for allocating (licensing) places wanted the process to be fixed, Mrs Cusworth, of the Chamber of Commerce and Industry WA, suggested that licensing should be abandoned in the longer term: 'The idea that you have a bed licence for which there is an informal competitive market in a government funded system is just nonsense'.[120] The Hogan Review considered the implications of the secondary market for bed licences and the value providers accrue from the intangible asset allocated 'free' by the Government. The Hogan Review suggested that the Government should consider progressively replacing the 'free' allocation process with an auction system – however few details of how this might operate were provided. In response, the Australian Government announced that it will consult the community and aged care providers on the appropriateness of this option.[121]

8.133 The Committee considers that such a move is likely to discriminate against small not-for-profit providers, including homes managed by community organisations in rural areas. Any future consideration of an auction system must include safeguards for the provision of aged care in rural and remote areas, and the potential for the auction system to contribute to financing care in those areas.

Assessment for residential aged care

8.134 Although the work of individual Aged Care Assessment Teams (ACATs) was praised, overall a high level of frustration with assessment arrangements was described, including the need for better coordination to streamline assessment and access to services (see above, 'Community care services').

8.135 More specifically in relation to residential care, the Committee heard suggestions that ACATs should play a stronger role in waiting list management and in helping people to make informed choices. The

120 Cusworth N, transcript 29/04/2003, p 433.

121 Cusworth N, transcript 29/04/2003, p 433; *Review of Pricing Arrangements in Residential Aged Care,* Final Report, pp 300-01; Australian Government's Response to the Review of Pricing Arrangements in Residential Aged Care, p 1, viewed 1/06/2004, <http://www.health.gov.au/investinginagedcare/response/response.pdf>.

Aged Services Learning and Research Collaboration also proposed that where ACATs are attached to hospitals, they should control discharge planning and home care services as well as being gatekeepers for residential care.[122]

8.136 Concerns were expressed that pressures on current assessment arrangements mean that people from culturally and linguistically diverse backgrounds do not always receive targeted information to assist them in making informed decisions about their care. Nor may assessment teams have access to the range of skills and cultural knowledge to ensure that people from culturally diverse backgrounds are not disadvantaged by the assessment process.[123]

8.137 ACATs and aged care homes both raised the inconsistency between the assessment of needs under ACAT guidelines and under the RCS categories. While these assessments have different purposes, the inconsistency can impact on the level of funding received. The requirement for ACAT approval to upgrade care from low to high as a resident's care needs increase was also raised as a source of frustration, both in terms of working against the concept of ageing in place and the administrative burden for both the home and ACAT staff. ACATs prioritising heavy workloads and relative urgency at times give lower priority to upgrades than to assessing a person in the community in danger of fractures from falls. In rural areas especially, delays in upgrade assessments can mean that homes may be paid at a lower RCS rate than that for the actual care received.[124]

8.138 While the Committee heard that improving coordination and streamlining requirements are essential, Ms Alanson stressed that change without adequate funding will achieve little:

> My concern is that we keep arguing about and being critical of the aged care assessment teams but they can only be as good as they are funded. … There are some wonderful people in ACAT. As I said, if they are underfunded, they cannot meet the objective of the Aged Care Act.[125]

8.139 Even increased funding may not solve the recruitment problems experienced by some assessment teams, especially the general

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122 Aged Care Assessment Services, Victoria, sub 61, p 2; Aged Services Learning and Research Health Collaboration, sub 151, p 15.

123 Council for Multicultural Australia, sub 74, p 2.

124 Harvey D, transcript, 31/03/2003, p 290; Byron D, transcript 25/02/2003, pp 175, 177; Mahajani S, transcript 3/02/2004, p 794; Fullerton and Allanson V, transcript 25/02/2003, pp 177-78; Phillips C and Jeffrey R, transcript 3/02/2004, pp 782-83

125 Allanson V, transcript 25/02/2003, p 178; Harvey D, transcript 31/03/2003, pp 290-91.

shortage of geriatricians and allied health professionals and the more acute shortages in rural areas.[126]

8.140 In some remote areas, staff shortages have led to pragmatic approaches which incidentally lead to better integration across programs. Ms Gwynne, whose team of four services the entire East Arnhem region, stated that:

> The team leader there also wears the hat of the local area coordinator and the hat of the ACAT assessor. … it is nonsense to separate out those particular functions … when we are going out to remote communities; it is meaningless to them for a white person to say, 'I can only talk to you about disability issues today.'[127]

8.141 Australian Government funding for the Aged Care Assessment Program in 2003-04 was $47.2 million which was distributed according to a new needs-adjusted, population based funding model. Funding included a one-off amount of $2.5 million provided in the 2003-04 Budget which was targeted to under-funded ACATs. The states and territories supplement this with additional funding or access to other resources such as specialist staff to support assessments and access to hospitals and rehabilitation services.

8.142 The Committee notes some changes to funding for the Aged Care Assessment Program and ACAT responsibilities are being implemented following decisions in the 2004-05 Budget context. Funding of $47.9 million over four years (including extension of $2.5 million one-off funding from the 2003-04 Budget) will be provided to increase the capability of ACATs and allow better case management, more timely assessments, and better links between community and residential care. The funding will also enable the development and implementation of common assessment processes, eligibility requirements and standards of provision. In addition, an ACAT assessment is no longer required to upgrade a resident from low to high care within the same aged care home.[128]

Quality and accreditation

8.143 Evidence to the Committee reflected a strong commitment to quality care for people in residential aged care and concerns about factors considered to limit residents receiving such care. It also reflected the

126 O'Donnell G, transcript 31/03/2003, p 292;

127 Gwynne K, transcript 3/02/2004; p 752.

128 *Budget Paper No. 2, 2004-05,* p 188.

fact that gaining a shared understanding of what constitutes quality and how best it may be assessed and rewarded is an ongoing challenge.

8.144 Ms Iliffe identified a set of inter-related factors that can contribute to, or diminish, the quality of care: quality buildings, quality staff, quality funding, quality accreditation and a quality complaints system. As other evidence indicated, quality management should be added to these. [129]

8.145 Concerns were raised about staff competence and shortages, the quality of management, requirements and administrative arrangements that generate paperwork burdens, and the role of the Aged Care Standards and Accreditation Agency.

8.146 The Committee heard that quality care is directly related to the availability and competence of staff. As Ms Iliffe stated: 'To be able to provide quality aged care, providers must be able to attract and retain quality staff'. Others stressed the importance of continuing education for care staff (see further, 'Workforce shortages', below).[130]

8.147 The competence of all staff was seen as critical to quality care, including that of facility managers and boards of management. Mr Kennedy, of Catholic Health Care Services, advised the Committee that his organisation is frequently called on to assist homes establish better management and management systems:

> We … come in and assist them with their RCS classification, with their workers compensation premium and risk management strategies. We often have to assist them with their basic financial management systems and their clinical care systems, to help them with the accreditation process.[131]

8.148 Over reliance on agency nursing staff can diminish the quality of care residents receive. The Committee heard that for many shifts some homes 'are totally dependent on agency staff to provide registered nurse cover'.[132]

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129 Iliffe J, transcript 7/03/2003, p 231; Lewit J, sub 96, for the importance of facility design to support overall service provision, dementia care, carers and other staff, and relatives and other visitors.

130 Iliffe J, transcript 7/03/2003, p 225; Russell C, transcript 4/07/2003, p 671; [others]

131 Kennedy M, transcript 23/02/ 2004, p 825. See also, Lipscombe J, transcript, 7/07/2003, p 243.

132 Holmes B, transcript 4/07/2003, p 650. Se also, Baptist Community Services, sub 172, p 5.

8.149 Ms Warn, for example, warned that by using agency nurses and casual nurses, aged care facilities may not be best serving its residents needs:

> You could not possibly see how somebody's condition had changed from one day to the next. You could read it in the nursing notes if you had time, but you could not actually see it, because you do not know the people. There is little sense of responsibility for someone if you are moving in and out willy-nilly. It makes it very difficult.[133]

8.150 Under the *Aged Care Act* 1997 (Section 96-3(5)), the Aged Care Standards and Accreditation Agency has been delegated responsibility for managing the accreditation process using the Accreditation Standards, and for promoting high quality care.

8.151 At the time submissions to the Inquiry were received, aged care homes had experienced the first round of the accreditation process – a new experience for the Agency and for all the homes. The rough edges of a 'settling in' stage were reflected in evidence to the Committee. As Ms Houghton explained to the Committee:

> I think that was around the time of the first accreditation process for facilities. It was an enormous exercise for those facilities to get all their paperwork up to scratch. That is a good thing because that is a process of being accountable, but it really was at the cost of direct care time of the residents.[134]

8.152 Other evidence also expressed concern that focus on the fundamental issue of quality was in danger of being displaced by a focus on documentation, and the right choice of words.[135] Ms Warn was among those who stressed that documentation tells only part of the quality story:

> …in terms of accreditation, there is not sufficient effort made to talk to carers, to talk to relatives and to interact in any way with residents.[136]

8.153 The importance of involving consumers and their families was seen as particularly important to improving the Agency's capacity to accurately assess evidence of culturally appropriate outcomes.[137]

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133 Warn P, transcript, 3/07/2003, p 611. See also, North R, transcript 23/02/2004, p 814.

134 Houghton P, transcript 31/03/2003, p 301.

135 Millar J and Miller G, transcript 23/02/2004, pp 808-09;

136 Warn P, transcript 3/07/2003, p 604-06; Older Women's Network, sub 58, p 3;

137 NSW Aged Care Alliance, sub 11, p 18.

8.154 Suggestions were put to the Committee that quality (and funding arrangements) could be improved by the introduction of a benchmark of care (see further below, 'Funding and the viability of aged care homes'.

8.155 In the 2004-05 Budget the Australian Government provided the Aged Care Standards and Accreditation Agency with additional funding of $36.3 million over four years. The funding will place the Agency on a more secure financial footing and allow it to maintain its current level of monitoring and accreditation activities, including spot checks. In addition, in response to a Hogan Review recommendation, $3 million is being provided to develop an internet information system and a 'star rating' system. Families and people in the community will be able to more easily access information on the quality of care in aged care homes (including accreditation assessments), together with information on fees and services.[138]

The interface between residential care and acute care

8.156 The transfer of residents between aged care facilities and hospital is common however the circumstances of transfer and the impacts on residents were questioned in evidence to the Committee.

8.157 The Committee heard that aged care providers sometimes shift residents to acute care as a way of removing them from the facility permanently. Mrs Harvey of the Aged Care Assessment Service in Victoria told the Committee that:

> There are also some issues around security of tenure that emerge when someone who is ageing in place in a facility goes into acute care because of an episode of ill health and the facility uses that time to make the decision that they do not want to have them back, that it is time for them to move on. That seems to be fairly commonplace. We see that when we are doing the assessments at the hospital end…it is an issue that acute care often precipitates the transition to a nursing home.[139]

8.158 Residents' security of tenure is protected by the User Rights Principles 1997(s23.4 – s23.6) under the *Aged Care Act 1997* which ensure that residents can not be removed from an aged care facility without sufficient cause. Reasons why a resident may be asked to leave include the facility no longer being able to provide the

138 *Budget Paper No. 2*, pp 189-90.

139 Harvey D, transcript 31/03/2003, p 300.

'accommodation and care suitable for the care of the recipient'. As Mrs Harvey noted, transfer to acute care is a 'fairly common' way of precipitating the issue, and not always in the best interests of the resident. As part of the Australian Government's changes to the aged care assessment scheme there is no longer any requirement for an ACAT assessment to upgrade a resident from low care to high care within the same aged care facility.[140] However, cases such as that raised by Mrs Harvey which would involve a transfer between facilities, should be protected by the user rights principles provided these are adhered to.

8.159 If a resident is being transferred to acute care for the benefit of the aged care facility rather than their own health, it is likely that the move will be detrimental to their wellbeing.

8.160 Transferring a resident into hospital is sometimes motivated by legal reasoning. Aged care staff may wish to avoid any possibility of legal action from family or relatives of the person should the aged care staff or visiting GP not be seen to take action to 'prolong life'.[141]

8.161 Professor Picone, of the New South Wales Department of Health, considered some transfers unnecessary, adding to the pressure on hospitals:

> …what we then do is take an old person out of their home, disrupt them, stick them in the back of an ambulance, send them up to emergency department – which are absolutely flat out at the best of times – and then put them in a queue of other people for services that could be provided in their homes, like a blocked catheter or listening to their chests if they need to start some antibiotics.[142]

Professor Picone attributed unnecessary transfers to poor GP remuneration for visits to aged care homes and/or to inadequate nursing skills. At the same time, such attitudes are consistent with a general perception that older people have 'less right' to hospital care than other people.

8.162 The Committee also heard of strategies being trialled to avoid the stress to residents of unnecessary transfers. Some public hospitals are now sending nurses to aged care facilities to train nurses in administering treatment that residents would normally only receive in hospital. While this may minimise the need for any transfers to

140 Treasury, Budget Paper Number 2, 2004-2005, p .

141 Glover A, sub 5, p 2.

142 Picone D, transcript 3/07/2003, p 569.

hospitals and smooth transfer back to residential care, concerns were put to the Committee that hospitals may be off loading responsibilities onto aged care home – and onto aged care nurses who receive lower pay than acute care nurses. [143]

8.163 The problems of older people being discharged before they are sufficiently recovered was raised by the Coffs Harbour Health Campus, [144] and the by Local Government Association of New South Wales which was:

> …concerned about the repeated incidents of inadequate coordination between hospital discharge planning and residential and support services. Discharge planning is essential to ensure adequate continuity of care for older people, to ensure that they and their carers are prepared for a return to the home or to minimise the wait for residential based care.[145]

8.164 The need for proper discharge planning has already been raised above in relation to transitional care and is also pertinent to the need for more age friendly hospitals (see below).

Ageing with disability

8.165 A further issue brought to the attention of the Committee is that of people with disabilities who are ageing. Around 4% (13,000) of those aged 65 or over with severe or profound core activity restrictions have lived with disability since before the age of 18.[146] However, access to disability funding and associated services ceases at age 65, just when their needs may be increasing because of age. Indeed, the Aged-care Rights Service stated that:

> …people with longstanding disability who are ageing experience an earlier decline in function than others of a similar age … they can also experience 'secondary disability' or health complications which can arise as a result of the long-term effect of the disability itself.[147]

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143 Holmes B, transcript 4/07/2003, p 648.

144 Bartlett K, transcript 19/05/2004, p 473.

145 LGov New South Wales, sub 89, p 22.

146 The Aged-care Rights Service, sub 87, p 37 based on the ABS 1998 Survey of Disability, Ageing and Carers. Preliminary analysis of the ABS 2003 Survey of Disability, Ageing and Carers (Cat. 4446.0) shows very little difference between the 1998 and 2003 rates. See also, Australian Society for Geriatric Medicine, sub 64, p 2; Stockton Hospital Welfare Association Inc., sub 29, pp 1-2.

147 The Aged-care Rights Service, sub 87, p 37.

8.166 The Latrobe Community Health Service Inc. suggested to the Committee that changing eligibility for services at age 65 could constitute a form of age discrimination.[148]

8.167 The Aged-care Rights Services proposed, *inter alia*:

- Challenging perceptions within the disability and aged care sectors to ensure flexible, appropriate and timely services for people with longstanding disability who are ageing.
- Developing responsive, integrated models of service provision that support collaboration and address the transition issues for people who are ageing.

8.168 The Committee notes that the Bilateral Agreements under the third Commonwealth State Disability Agreement 2003-2007, express commitment to collaborative work on improving issues at the interface between disability support and aged care programs. Commitment across states and territories varies from general agreements to begin discussions, to progressing specific policy and service delivery tasks, and recognition that there will be resource implications for both parties.

8.169 The Committee considers that this component of the new agreements is a positive step however all parties must ensure there is real action within the period of the agreement.

Funding and the viability of aged care homes

8.170 Baptist Community Care summarised their concerns about funding and viability as follows:

- Ageing building stock yet inadequate capital funding available to rebuild it, particularly high care.
- Recurrent funding declining significantly in real terms as particularly wage inflation, driven by State awards, acute sector pay differentials and growing nursing shortages, continues to exceed price increases paid by the Federal government to providers. … The focus therefore needs to be on new sources of recurrent funding.
- Consumer resistance to the payment of bonds has been much documented. The increasing trend to high care in residential settings will only exacerbate this concern as stays become increasingly short. In any event, neither accommodation bonds nor charges will satisfy capital needs. Indeed, the latter generate 3.5 times less income

148 Latrobe Community Health Service Inc., sub 39, p 2.

than bonds. Additionally bonds are not uniformly available across city and country.

- A proliferation of aged care providers in both residential and community. This not only spreads competent senior staff very thinly but acts against the creation of regionally based service continuums which consumers can easily navigate.[149]

8.171 Similar concerns were raised in other evidence.

8.172 Difficulties in raising bonds in locations with low property values were seen as a problem for UnitingCare but, as a large operator, less of a problem than for small homes. Further, in light of the trend to later entry into care, some homes feel that high care is no longer viable. Older aged care homes, even those that have passed the new certification requirements, require ongoing capital works which, Mr Millar explained, was difficult with a maximum daily accommodation payment in high care of $13.84.[150]

8.173 The adequacy of the indexation formula (COPO) was questioned, and seen as a contributor to wages gap for nurses (see further, Workforce, below).[151]

8.174 Mrs Jeffery of Uniting Church Frontier Services, informed the Committee that Frontier Services has to top up the funding of their remote homes because of extra costs caused by distance:

> We pay extra freight, we pay extra for everything … We spend a lot of money on recruitment and getting staff into Alice Springs. We have to pay airfares, accommodation, meals and all sorts of things to deliver the same care, the same amount of work…[152]

8.175 The Committee notes, that these concerns are broadly consistent with the issues in evidence to the Hogan Review.

8.176 To better assess the impact of these factors on the viability of residential care providers, the Hogan Review undertook extensive analysis of financial information for the year 2001-02 covering 912 aged care facilities or around 31% of the total number of facilities. Of

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149 Baptist Community Care, sub 56, p 1.

150 Herbert H, transcript 3/07/2003, p 579; Millar J, transcript 23/02/2004, p 807; Baptist Community Care, sub 56, p 2, 18-19; Lgov NSW, sub 89, pp 15-16; COTA, sub 157, p 2.

151 Iliffe J, transcript 7/03/2003, p 248; Miller G, transcript 22/02/2004, p 805, Miller J, transcript 23/02/2004, p 808-9; ANHECA, sub 109, p 4; Baptist Community Services, sub 171, pp 1-2.

152 Jeffrey R, transcript 3/02/2004, p 776; Miller G, transcript 23/02/2004, p 805

these, 224 were for information covering a single facility, and some 83 providers submitted information covering two or three facilities.[153]

8.177 Analysis of earnings before interest, taxes, depreciation and amortisation (EBITDA) was used as this allows analysis and comparison across the for-profit and not-for-profit sectors. Analyses were undertaken by state and locality, sector, and size of facility; and by the top 10% and quartile groups according to EBITDA for each provider.[154]

8.178 Table 8.3 shows that there are high performers and poor performers in all the categories of analysis. There is no pattern of provider characteristics (locality, sector/ownership, size, resident mix) that determines high or poor performance, although services were more likely to fall into the bottom quartile if they were provided by the state government sector, had mainly high care residents, and/or were small facilities with less that 30 residents. The Hogan Review noted that the relatively strong performance of rural providers 'belies much of the folklore about residential aged care'. It also concluded that the quality of facility management probably explains poor performance.[155]

8.179 Comparisons of average EBITDA per bed year for aged care sectors are shown in Table 8.4 for the top 10% of services and for each quartile. These demonstrate that while services in the fourth quartile are struggling, those in the top two quartiles (and especially the top 10%) are well placed for viability.

8.180 The Hogan Review highlighted that within the first quartile services, can be considerably better placed than the average. Services performing well in the top ten percent group include community based services. Victorian community services reported the highest average of $18,790. The religious sector, represented over a third of the top quartile of services, reported an average of $9,149 per bed year. Within those religious services placed in the top ten percent grouping, more than half are located in capital cities and had an average EBITDA of $14 674 while more than 75% of community based services are based in rural areas and had an EBITDA of $16,977 per bed.

153 *Pricing Review of Residential Aged Care,* p 27.

154 *Pricing Review of Residential Aged Care,* pp 34-35.

155 *Pricing Review of Residential Aged Care,* pp 38, 55-56.

8.181 In total rural services made up 39% of the first quartile, with an average of $10 236 per bed year. Rural providers made up 46% of the top ten percent group. Of these Rural services, Victoria and NSW reported EBITDA figures of $18 461 and $12 133 per bed year respectively. These results illustrate that rural services can perform just as well or better than metropolitan and capital city services.[156]

Table 8.3: Numbers of State, Sector, Locality, Size and Resident Mix for Top 10 percent and Quartile Groups according to EBITDA for each provider

State	**Top 10%**	**1st Quartile**	**2nd Quartile**	**3rd Quartile**	**4th Quartile**	**Total**
NSW (ACT)	35	93	63	64	40	260
QLD	6	19	14	9	11	53
SA (NT)	11	27	28	24	11	90
TAS	2	3	5	2	3	13
VIC	22	44	63	64	104	275
WA	2	9	22	32	27	90
Total	**78**	**195**	**195**	**195**	**196**	**781**
Sector	**Top 10%**	**1st Quartile**	**2nd Quartile**	**3rd Quartile**	**4th Quartile**	**Total**
Charitable	6	18	26	22	14	80
Community	21	58	40	45	24	167
Local Govt	5	7	6	6	3	22
Private	11	26	33	30	23	112
Religious	29	74	76	78	79	307
State Govt	6	12	14	14	53	93
Total	**78**	**195**	**195**	**195**	**196**	**781**
Locality	**Top 10%**	**1st Quartile**	**2nd Quartile**	**3rd Quartile**	**4th Quartile**	**Total**
Capital	35	95	120	126	111	452
Other metro	6	22	16	11	6	55
Remote	1	1		3	7	11
Rural	36	77	59	55	72	263
Total	**78**	**195**	**195**	**195**	**196**	**781**
Size	**Top 10%**	**1st Quartile**	**2nd Quartile**	**3rd Quartile**	**4th Quartile**	**Total**
0-30	21	44	41	35	79	199
31-60	42	105	101	113	78	397
61-90	13	32	37	29	23	121
90+	2	14	16	18	16	64

156 *Review of Pricing Arrangements in Residential Aged Care*, p 40, 41, 42.

Total	**78**	**195**	**195**	**195**	**196**	**781**
Resident Mix	**Top 10%**	**1st Quartile**	**2nd Quartile**	**3rd Quartile**	**4th Quartile**	**Total**
High Care	33	83	78	81	118	360
Low Care	30	77	73	83	60	293
Mixed Care	15	35	44	31	18	128
Total	**78**	**195**	**195**	**195**	**196**	**781**

Source: Hogan W, Pricing Review of Residential Aged Care, p 38.

Table 8.4: Average EBITDA per bed year ($) in each Sector

Sector	**Top 10%**	**First Quartile**	**Second Quartile**	**Third Quartile**	**Fourth Quartile**
Charitable	10 292	7 521	3 757	1 040	- 4 204
Community	15 146	9 477	3 443	1 163	-2 941
Local Govt	12 043	10 300	4 438	303	-5 010
Private	10 003	7 992	3 584	928	-2 569
Religious	13 537	9 149	3 640	1 216	-6 186
State Govt	16 444*	11 305	3 983	273	-8 281
Average	**13 350**	**9 116**	**3 655**	**1 044**	**-5 771**

*Notes: Tasmania reported an EBITDA of $4362 per bed year. This was higher than other states and affects the State Government top 10% average.

Source: Hogan W, Pricing Review of Residential Aged Care, pp 40-47.

8.182 The Hogan Review also commissioned the Centre for Efficiency and Productivity Analysis (CEPA) at Queensland University to analyse the efficiency of the residential aged care sector. CEPA indicated that, 'The average level of technical inefficiency is around 17 per cent (on a conservative estimate)'. That is, there is scope for inefficient providers to do more with the resources they receive.[157]

8.183 The issue of COPO indexation was also considered by the Hogan Review which reached the conclusion that other means are available to employers to improve wages than through increasing COPO or changing the basis of indexation.[158]

8.184 The Committee notes that to assist industry efficiency and viability the Hogan Review recommended: streamlining administrative arrangements causing a high paperwork burden; new funding supplements for particular care needs; a new conditional incentive

157 *Review of Pricing Arrangements in Residential Aged Care*, Recommendations

158 Review of Pricing Arrangements in Residential Aged Care, pp 146-480

supplement; increasing the viability supplement for rural and remote services; changes to concessional transitional and assisted resident supplements; abolishing the adjusted subsidy reduction; and changes to accommodation payments.[159]

8.185 The Australian Government's response addressed most of the recommendations although not all precisely as the Review proposed. In addition, to help ensure that all providers meet improved safety and building standards required for 2008 certification, the Government is providing a one-off payment of $3,500 per resident (total funding $513.3 million).[160]

8.186 The Committee notes that responses to the administrative streamlining and increased funding in the Budget have been mixed. The National Aged Care Alliance lobby group considers the measures provide a short-term patch up, leaving the long term underlying problems to still to be addressed. The Alliance continues to push for 'a benchmark of quality care' as a funding mechanism (including a capital component), with changed indexation, and wage parity for nurses.[161]

8.187 A more optimistic outlook was taken by Mark Moran, of Moran Health Care Group, who hopes 'to open at least another 100 beds in NSW alone as a result' of the $13million funding boost received from the $3500 per –resident bonus. The Committee also notes that Ramsay Health continues to look for opportunities to purchase aged care beds, indicating that the industry continues to be regarded as an attractive investment opportunity.[162]

> …a new funding system for aged care based on a defined and properly costed benchmark of care. This benchmark of care must reflect the real costs of providing a quality aged care service in different regions around Australia, and allow for the flexible delivery of aged care services responsive to the needs of the individual.[163]

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159 *Review of Pricing Arrangements in Residential Aged Care* , pp xvii – xxv;

160 The Government's response to the *Review of Pricing Arrangements in Residential Aged Care*, <http://www.health.gov.au/investinginagedcare/response/index.htm>, viewed 20/05/2004.

161 National Aged Care Alliance, *Get Aged Care Right*, <http://www.naca.asn.au/election_2004.pdf>, viewed 2/07/2004.

162 'Cashed-up nursing homes still want bonds', Sydney Morning Herald, 13 May 2004; 'Ramsay tipped to impress', Financial Review, 4 August 2004, p 17.

163 National Aged Care Alliance, sub 88, p 2; McGuiness M, sub 60, p 4.

> The AMA referred to the Productivity Commission's 1999 recommendation for a benchmark – a benchmark that the Commission envisaged could be based on outcomes against the four accreditation standards.[164]

8.188 Evidence also pointed to the challenge involved in designing a benchmark (or benchmarks) combining quality of care and a basis for funding. Mr Gray sketched some of the complexity:

8.189 As noted above, the National Aged Care Alliance called for the introduction of a benchmark of care as a funding tool with emphasis on the real costs of care:

> … Clearly, it is not just one level of a mix of things; it is more complex than that, because you have numbers of residents with individual needs. If we are talking about person centred care as the basis of how the system should be funded, we have to look at what the needs of that individual are in terms of quality care and adequately skilled staff to provide that care, and that becomes the benchmark.[165]

Similarly, Ms Allanson highlighted the challenge in setting prices for benchmarks: '… in principle we would like to see a benchmark of care that is funded. But the scary point there is: who is going to say how much would be funded?'[166]

8.190 A benchmark of care for funding purposes raises the question of the relationships between:

- such a benchmark and the Accreditation Standards – which were designed for the purpose of accreditation;
- such a benchmark and the Quality of Care Principles – which provide a basis for quality care, together with the flexibility to provide the person centred care stressed by Mr Gray and the National Aged Care Alliance.

8.191 A major criticism put to the Committee concerned confusing the purpose of the RCS by using it as a funding tool and care planning tool, resulting in a plethora of documentation more concerned with defending funding than care planning. There is a danger that a benchmark of care which attempts to combine the purposes of quality standards and a funding mechanism may run into similar difficulties.

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164 AMA, sub 86, p 17; see also, sub 104, Uniting Care, pp 3-4. Productivity Commission, *Nursing Home Subsidies* (Report No. 4), 1999, pp 85-86.

165 Gray R, transcript 7/03/2003, p 230.

166 Allanson V, transcript 25/02/2003, p 180.

8.192 The notion of a benchmark of care was also proposed to the Hogan Review. However, the Hogan Review considered that a 'benchmark of care' in regard to quality is already provided by the Quality of Care Principles (s18.9 (2)), and concluded that this should continue to provide the benchmark.[167]

The need for age-friendly hospitals

> But there is always the stigma of old people being bed blockers. No-one wants to admit them…[168]

8.193 Evidence was put to the Committee that the health of older people, particularly those with dementia, can decline during a stay in hospital so that they may end up more dependent than when they entered.[169] Professor Picone explained to the Committee that:

> It increases the person's dependency as well. … we are not experts in long-term residential aged care. It obviously increases their chance of contracting a hospital acquired infection. The longer you are in, the more that can happen. It also results in a deterioration of their functioning and cognitive ability, because they are not in an environment where a model of care has been set up to care for them …[170]

8.194 Early or poorly planned discharge too often results in distress for patients and/or un-planned readmissions:

> We had a lady who was discharged home following massive surgery and was left to go to her own home, which is a two-storey building. The only other person living there is her husband, who is in his late 70s and very frail. That really is a recipe for disaster. …This sort of discharge is unreasonable.[171]

8.195 For older patients, especially those with cognitive difficulties, issuing only verbal instructions for post-discharge care can be confusing and jeopardise recovery.[172] Aged care residents at times return from

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167 *Review of Pricing Arrangements in Residential Aged Care*, Summary of the report, p28

168 Mahajani S, transcript 3/02/2004, p 789.

169 Aged-care Rights Service, sub 87, pp 29-30; Mahajani S, sub 181, p 2; Harvey D, transcript 31/03/2003, p 305.

170 Picone, D, transcript 3/07/2003, p 576

171 Barrand P, transcript 3/02/2004, p 759.

172 The; MacGuiness M, sub 60, pp 2-3; ANHECA, sub 111, p 4; Pollard D, sub 153, p 9.

hospital with problems arising from neglect or oversight of their specialised aged care needs.

8.196 The Committee is concerned that in evidence put to them, the issue of the quality of hospital care for older people often became submerged in arguments about responsibility for shortages of acute and/or residential aged care beds, and the potential of transitional care to 'fix' the bed shortage.

8.197 The Committee appreciates the pressures these issues place on hospitals and agress there is an urgent need for the development and implementation of transitional care (as discussed above). However, this does not remove hospitals' responsibility for improving care for older people and minimising negative impacts such as those identified above.

8.198 Other evidence demonstrated that in some locations action is already being taken to minimise practices that affect the health of older patients. Central Coast Health (NSW) are:

> … trying to have the health services have more age-friendly hospitals for patients and their carers. … if you go to almost any hospital you will find that about 70 or 80 per cent of patients are over 70. … So actually making sure that we run health facilities which are age friendly … understanding the needs of older people on the wards … is extremely important.[173]

8.199 A clinical nurse consultant in gerontology has been appointed, and admission and discharge protocols have been rewritten through a process involving all the agencies affected by the protocols. Extra nurses have been engaged to liaise between the hospitals and community and residential providers – an initiative that is actually smoothing the path between services.

8.200 Professor Nair suggested that there is a need to employ people with broader skills – such as geriatricians – to look after older people in hospital, and to adopt a case management approach to help ensure continuity of care from admission to discharge. [174] A similar approach was put forward by the Australian Medical Association (AMA) which also suggested that general hospitals should improve their services to older people by ensuring they have medical practitioners with expertise in aged care and by providing a designated geriatric

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173 Blackwell J, transcript 24/02/2003, p 90. See also, L Worrall, transcript, 20/05/2003, p [504].

174 Nair K, transcript 3/07/2004, pp 560, 561.

medical service with beds for acute care, assessment and rehabilitation. The AMA also proposed that hospitals should provide multi-disciplinary out-patient services for older people with complex syndromes such as falls, dementia and incontinence.[175]

GPs and the care of older people

> There needs to be much more attention paid to the potential and realising the GP role in encouraging self-management and working with their patients in an earlier, preventative kind of mode…but they are too bogged down in the day-to-day medicine of the traditional kind…[176]

8.201 This evidence from Professor Boldy to the Committee suggests there is a need for change in the role of doctors and the ways they interact with other service providers. Similar evidence was received from physiotherapists, nurses, aged care providers, academics and other health care workers as well as doctors themselves.

8.202 Issues around GP involvement in care of people as they grow older were identified as the shortage of GPs,[177] limited knowledge of the ageing process and care of the aged, especially diagnosing and caring for people with dementia,[178] the reluctance of GPs to visit older people outside their practice (home visits),[179] or to visit aged care homes,[180] and the need for better collaboration between GPs and other health professionals.[181]

175 AMA, sub 86, p 2.

176 Boldy D, transcript 29/04/2003, p 404.

177 Department of Health and Ageing, sub 119, p 39; Australian Medical Association, sub 86, p 23.

178 Nair K, transcript 3/07/2003, p 560; Le Couteur D, transcript 3/07/2003, p 45; Russel C, sub 133, p 1; Ward J, transcript 25/02/2003, pp 141-142; National Rural Health Alliance, sub 131, pp 34-35; Federation of Ethnic Communities Councils of Australia, sub 140, p 2; Council of the Ageing Australia (New South Wales), sub 157, p 7; New South Wales Department of Health, sub 160, p 9; Centre for Ageing and Pastoral Studies Charles Sturt University, sub 167, p 5; National Aged Care Alliance, sub 88, p 3.

179 Waverley Council, sub 73, p 1; Aged Services Learning and Research Collaboration, sub 151, p 10.

180 Ward J, transcript 25/02/2003, p 140; Phillips C, transcript 3/02/2004, p 783.

181 Mersiades N, transcript 7/02/2003, p 2; Pharmacy Guild of Australia, sub 75, p 6.

GP shortages

8.203 A fundamental limiting factor is the overall shortage of doctors and the even greater shortage in rural and remote areas. In recent years substantial efforts have been made to address shortages in the longer term. Making a difference in the short term is still proving a challenge.

8.204 Table 8.5 tracks GP supply over the period 1995-96 to 2002-03, by headcount, full-time equivalents (FTE), and by full-time workload equivalent (FWE). In rural areas the headcount increased by 25% and the full-time workload equivalent also increased appreciably by 15.5%. Urban areas experienced a drop in headcount and a slight increase in FWE. These figures, however, provide no indication of the extent to which supply meets demand.

Table 8.5: GP headcount, FTE and FWE by broad RRMA, 1995-96 to 2002-03

	Urban			Rural and Remote		
Year	Headcount	FTE	FWE	Headcount	FTE	FWE
Number						
1995-96	18,959	10,416	12,501	5,417	3,120	3,551
1996-97	18,937	10,599	12,719	5,589	3,164	3,596
1997-98	18,524	10,659	12,791	5,706	3,216	3,641
1998-99	18,208	10,613	12,754	5,968	3,232	3,635
1999-00	18,024	10,587	12,761	6,210	3,287	3,672
2000-01	17,905	10,555	12,668	6,363	3,417	3,825
2001-02	17,719	10,564	12,731	6,588	3,555	4,005
2002-03	17,521	10,485	12,608	6,739	3,650	4,101
% change on previous year						
1996-97	-0.1%	1.8%	1.7%	3.2%	1.4%	1.3%
1997-98	-2.2%	0.6%	0.6%	2.1%	1.6%	1.2%
1998-99	-1.7%	-0.4%	-0.3%	4.6%	0.5%	-0.2%
1999-00	-1.0%	-0.2%	0.1%	4.1%	1.7%	1.0%
2000-01	-0.7%	-0.3%	-0.7%	2.5%	4.0%	4.2%
2001-02	-1.0%	0.1%	0.5%	3.5%	4.0%	4.7%
2002-03	-1.1%	-0.7%	-1.0%	2.3%	2.7%	2.4%
% change on 1995-96						
2002-03	-7.6%	0.7%	0.9%	24.4%	17.0%	15.5%

GP headcount	A count of all GPs who have provided at least one Medicare Service during the reference period.
FTE	Full-Time Equivalent: measures the number of doctors working full-time and the partial contribution of part time doctors.
FWE	Full-Time Workload Equivalent: a measure of service provision because it takes into account doctors' varying workloads. It is generally considered a good overall indicator of workforce supply.

Rural, Remote and Metropolitan Areas Classification (RRMA) categorises geographic areas into an index of remoteness according to population size based on the 1991 Census. Urban Areas: RRMA1 and RRMA 3. Rural Areas: RRMA3 to RRMA 7.

Source: Department of Health and Ageing.

8.205 Dr North mentioned the importance of the new Rural Clinical Schools including the one in Dubbo in encouraging medical students to practise in rural areas. Ten Rural Clinical Schools have been established since 1999 under the Australian Government's policy to encourage at least 25% of medical students to receive a significant part of their clinical training in rural and remote areas.[182] The rural clinical school in Dubbo, for example, provides medical students with half a year of training in the region, including geriatric medicine. This policy is intended to help address the problem of GP shortages in rural and remote locations however the full effects will not be felt for some years.

8.206 The Committee is aware that the shortage of GPs in some regions is placing an even greater demand on doctors. Older people generally have more complex and time consuming care needs, which is extremely demanding for GPs, as indicated by the Central Coast Division of General Practice:

> Our GPs are telling me that they are busier…their workload has increased exponentially…because of the complexity of care that is required with ageing people…so the demand means that our GPs are busier and dealing with more complex cases. Obviously, with new medications and treatments, they are saying that their day is busier and more mentally exhausting. Our GPs are saying by seven o'clock at night they are mentally exhausted. The issues of after hours care and nursing home care are obviously complicated because of that.[183]

GP skills and knowledge

8.207 Concerns were raised about whether GPs' experience and knowledge best suit them to diagnosing and treating disorders common among older people.[184] Dr Menzies summed up the issues as follows:

182 North R, transcript 23/02/2004, p 817; Department of Health and Ageing, Rural Clinical Schools, viewed 19/08/2004, <www.health.gov.au/workforce/new/rurclinical.htm>.

183 Hanrahan M, transcript 24/02/2003, p 118.

184 Catholic Women's League Australia Inc, sub 65, p3; New South Wales Department of Health, sub 160, p 9; Catholic Health Care Services Ltd, sub 174, p 8.

> Health care of the elderly is a specialty in itself. There are differences when looking after the health of an elderly person, for instance in the use of medications, the care of patients with dementia and the care of patients with very limited mobility.[185]

GPs and care of older people in the community

8.208 The Committee received evidence recommending GPs need to become more flexible in their practice to ensure that the aged receive appropriate care. Of particular concern was about the need for GPs to recognise the value of including carers as part of the care team:

> …about [carers] being included in the medical model somehow. That is about finding a way for GPs to acknowledge that the carers actually are a key component in that and looking at it more holistically so there is more care inclusion there.[186]

8.209 Preventative approaches were identified as one of the keys to ensuring that the diseases associated with ageing are minimised.[187]

8.210 In recent years a range of new MBS items and other initiatives have been introduced to encourage doctors to engage more fully in the care of people as they age, especially in encouraging preventive behaviours (see Box 8.1). Building on the Enhanced Primary Care (EPC) initiative introduced in 1999, they also aim to encourage greater collaboration between GPs and other health care providers.

8.211 Evidence to the Committee indicated that while there is support for the underlying objectives of these initiatives, not surprisingly there is also some resistance to changing ways of working and some concerns about the structure of the items and administrative arrangements. The Committee also heard of practices 'looking at ways of working smarter' and of maximising the opportunities provided by working as a team.[188]

8.212 Department of Health and Ageing statistics for the March quarter 2004 indicate that less than half of all GPs use the EPC items provided through the Medicare Benefits Scheme. Media reports suggest the

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185 Menzies R, transcript 24/02/2004, p 841.

186 McKell J, transcript 3/02/2004, p 774.

187 McCallum J, sub 132, p 20; O'Donoughue R, transcript 7/02/2003, p 4; Complementary Health Care Council of Australia, sub 147, p 2; Boldy D, transcript 29/04/2003, p 404.

188 Haikerwal, transcript 7/03/2003, p 216; NSW Aged Care Alliance, sub 11, p 6; Australian Medical Association, sub 86, p 15; Hanrahan M, transcript 24/02/2003.

national average for the use of EPC items by GPs could be as low as 17% nationally.[189] At the same time it should be noted that use of EPC items generally (and specific EPC items) will in part depend in the patient profile of each GP.

Box 8.1: Measures to increase GPs involvement in the care of older people in the community

- 2004-05 Two new MBS items for certain allied health services for people with chronic conditions and complex care needs who are being managed under an EPC multi-disciplinary care plan. $162.6m over 4 years. Limit of 5 allied health and 3 dental consultations per year.
- 2004-05 Incentives for GPs to bulk-bill concession card holders include a $7.50 payment per consultation, at a cost of $1.131 billion over four years.
- 2003-04 Continued funding ($108.1m over 4 years) for voluntary health assessments for people 75 years and over (55 and over for Indigenous Australians). Introduced under EPC in 1999, assessments may be conducted at GP surgery or at home.
- 2003-04 Continued funding ($5.4m over 4 years) for multi-disciplinary case-conferencing to determine the best treatments for people with chronic or terminal conditions and complex care needs. Introduced under EPC in 1999.
- 2003-04 Continued funding ($69.2m over 4 years) for co-ordinated, multi-disciplinary care planning for patients with chronic conditions and complex health needs. Introduced under EPC in 1999.
- 2003-04 Focus on Prevention $16.4 million over four years to help primary care providers, including pioneer practices and Divisions of General Practice developing evidence based approaches to prevention and early intervention of chronic disease.
- 2001-02 Ongoing funding for Extended Aged Care at Home (EACH) giving older people with high and complex care needs the option of care at home.
- 2001-02 New MBS item to enable doctors and pharmacists and other members of the health care team to make home visits to conduct Domiciliary Medication Reviews. Funding $18.1 m over 4 years.
- 1999-00 Enhanced Primary Care (EPC) items created under MBS to provide health assessments for people aged 70+ (55+ for Indigenous people) multi-disciplinary case planning; multi-disciplinary case conferencing and multi-disciplinary discharge.

Source: Department of Health and Ageing, Budget Fact Sheets

8.213 The Department of Health and Ageing commissioned a review of EPC item use for the years 2001 and 2002, which showed that the free health assessments were used more than any other item, while case

189 http://www.health.gov.au/pcd/programs/epc/epcstats/index.htm, viewed 9/08/2004; The Age, *Red tape hurting Medicare plan*, 2/04/2004.

conferencing is the least used. Of the small number of GPs who claimed for case conferencing, most consider that it is effective. It is notable that most of those who have used case conferencing are younger, more recently qualified doctors. Doctors who do not utilise case conferencing claim it is too complex and remuneration is not sufficient. The evaluation also identified 'a number of positive impacts on practice and systems both within practices and between general practices and allied health service providers' although more needed to be done to enable better management.[190]

8.214 Although little direct evidence on the issue was received, the Committee is aware of concerns expressed about the administrative costs associated with EPC. The EPC program evaluation commissioned by the Department of Health and Ageing identified some complexities, the Productivity Commission estimated that EPC contributed 14.9% of total GP administrative costs in 2001-02, and a recent Senate Select Committee sought evidence on the impact of the burden. It should be noted, however, that questions have been raised about the some aspects of the assumptions and methodology used by the Productivity Commission. For example, estimates of administrative time include time spent providing EPC care planning and health assessment services (ie the clinical services) as well as the time spent on any associated administrative tasks.

8.215 At the same time, the matter was being considered by a Red Tape Taskforce established by the Prime Minister and the then Minister for Health and Ageing.[191]

8.216 Following consultations with doctors, the Minister for Health and Ageing has announced measures to reduce red tape for general practitioners including:

- simplifying administrative requirements and conducting a second stage review of PIP and EPC that may lead to more substantial changes in the future;
- developing a GP communications entry point;
- developing a template for electronic forms; and

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190 Wilkinson D, et al, *Evaluation of the Enhanced Primary Care (EPC), Medicare Benefits Schedule (MBS)items, and the General Practice Education, Support and Community Linkages Program (GPESCL)*, Final report July 2003, pp 18, 20, 24, 26, 39.

191 Wilkinson D, et al, *Evaluation of the Enhanced Primary Care (EPC), Medicare Benefits Schedule (MBS)items, and the General Practice Education, Support and Community Linkages Program (GPESCL)*, Final report July 2003; Productivity Commission, *General practice administrative and compliance costs,* Research Report, 2003, Canberra, p xxi; Senate Select Committee on Medicare, *Medicare – health or welfare?* October 2003, Canberra, pp 24-26;

- improving communications between the Department and GPs.[192]

GPs and residential aged care

8.217 Aged care providers reported to the Committee that it is difficult to obtain regular, reliable GP services in residential care homes. Juninga Aged Care in Darwin, for example, stated that doctors are reluctant to visit as it is not financially viable for them.[193]

8.218 The number of GPs making visits to aged care homes is of concern to the Committee. The Australian Medical Association stated that only 16% of GPs are visiting aged care facilities:

> Even though the number of beds rises each year, we see the number of GP visits each year going down…it is something that GPs are not keen to do.[194]

8.219 Reluctance to visit aged care homes was attributed to remuneration arrangements, time lost travelling, and the disruption to GPs schedules which also diminishes remuneration. GPs often give visits to aged care facilities low priority. Overall, only GPs with a strong interest in the elderly make regular visits to aged care facilities.[195]

8.220 Dr Ward of Hunter Health informed the Committee that GPs consider aged care facilities difficult environments to work in:

> …The patient is not necessarily where you want them at the time you arrive…you have to find a nurse who knows what is going on. … For GPs, usually when the patient comes in, all their equipment is there. That is the environment they like to work in. So aged care facilities are not what you would call GP friendly.[196]

8.221 The Australian Medical Association suggested that aged care homes need appropriate facilities for medical consultations, including computer access.[197] Ensuring that aged care facilities are equipped with computer facilities to enable GPs to access patient records and prescribe electronically would assist GPs and improve patient safety and care.

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192 The Hon Tony Abbott MHR, Minister for Health and Ageing, Media releases: 'Government's response to red tape', 11 May 2004; Government acts to reduce red tape for GPs', 12 July 2004;

193 Phillips C, transcript 3/02/2004, p 783.

194 Rivett D, transcript 7/03/2003, p 217.

195 North R, transcript 23/02/2004, p 814. Aged Services Learning and Research Collaboration, sub 151, p 10; Poole J, transcript 3/02/2004, p 800; AMA, sub 86, p 14.

196 Ward J, transcript 25/02/2003, p 140.

197 Haikerwal M, transcript 7/03/2003, p 219; National Aged Care Alliance, sub 88. p 8.

8.222 The Committee notes that such evidence may also indicate there is a need for GPs to develop more flexible ways of working when making visits to aged care facilities. Mr Hanrahan told the Committee about pilot projects on the Central Coast of New South Wales, to identify better ways of working with aged care homes. He stressed the importance of communication with staff and working as a team to coordinate 'whether the GP goes in, the nursing staff, the pharmacist or the carer', depending on the immediate need. Similarly, the AMA stressed that to ensure older people receive age-friendly care, team work and good communication are essential: 'GPs can not work in isolation: the team must be encouraged to participate'.[198]

8.223 In a Hunter Health initiative the employment of a full time primary care nurse enables smooth team work and maximises care for residents:

> She arrives at work at about 7.30 in the morning. She goes around all the 12 or 15 lodges. She knows exactly what is going on … who needs to be seen urgently, what the issues are for the day. She has practice worked out by the time [the GP] arrives at 9 o'clock. In four hours they can get through 20 or 30 people with no trouble at all. She organises the enhanced primary care items, the case conferences, the care plan reviews. She is working in proactive sense.
>
> We have done primary care plans on everybody, so we are not just reacting to the situation. We are planning their care in the way that they would in a general practice. I believe that is the ideal way to provide good primary care in aged care facilities.[199]

8.224 The Australian Government has recently introduced measures to address the level of remuneration attached to working with residential facilities and to encourage GPs to be more actively involved in the care of the aged residents. A new MBS item will provide a rebate of $150.05 for doctors to undertake comprehensive medical assessments and enable doctors and other health staff to better manage residents' health care. Divisions of General Practice will also receive funding to set up panels of GPs to act as visiting doctors at aged care homes in their area. These GPs will also provide

198 Hanrahan M, transcript 24/02/2004, p 123; Australian Medical Association, sub 86, p 15.

199 Ward J, transcript 25/02/2003, p 140. See also Australian Medical Association, sub 86, p 14., and attachment p100.

advice on strategies to improve the quality of health services for all residents.[200]

8.225 The Committee concludes that there is increasing consideration being given to the implications the ageing of the population has for general practice and general practitioners. The ongoing workforce shortage limits the effectiveness of GP involvement in the care of people as they age and continuing efforts are needed to maximise all avenues for attracting, and keeping GPs in the workforce.

8.226 The Committee concludes that many GPs are accepting the challenges involved in adapting practices to provide age-friendly and age-appropriate care of older people, including adapting to working with allied health providers. At the same time, there are GPs who continue to resist change to the detriment of care for people as they age and for older people in residential care.

Workforce shortages

8.227 Workforce issues were among those most frequently raised with the Committee. Solving the critical shortage of nurses (especially in aged care) and other health professionals topped the list, together with the factors that are seen as contributing to the shortages.

8.228 The critical shortage of nurses is now widely acknowledged and well documented.[201] The impacts of this shortage were reflected in evidence to the Committee.

8.229 Evidence to the Committee also shows that consideration is being given to the wider workforce involved in aged care and health services for older people, whether supply is adequate now and to meet future demand, and the changes in roles and work practices that will be necessary. In part, concerns point to shortages of other health professionals who will become increasingly important in services to assist people maintain health functioning as they grow older.

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200 The Hon Tony Abbott MHR, Minister for Health and Ageing, and The Hon Julie Bishop MP, Minister for Ageing, joint media release, 'Better medical services for residential aged care', 30 June 2004.

201 See, for example, AIHW, *Nursing Labour Force* 2001, AIHW Cat. No HWL 26, 2003; National Review of Nurse Education, *Our Duty of Care, …..*; La Trobe University, *Recruitment and Retention of Nurses in Residential Aged Care – Final Report,* Canberra, 2002; Senate Community Affairs References Committee, Inquiry into Nursing, *The Patient Profession: Time for Action,* AGPS, Canberra, 2003

8.230 The Committee found that the extent of the shortages is difficult to quantify numerically. However, the National Skills Shortage List maintained by DEWR indicates the extent of shortages across the general and specialist areas in which nurses are employed. The majority of these areas are relevant to aged care and health services for older people (Table 8.6, National Skills Shortage List, Nurses and Health Specialists, March 2004).[202]

8.231 Table 8.6 also shows the shortages across eleven health specialist areas. Of the eleven health specialists, seven areas were mentioned in evidence to the Committee as being critical to services for older people, and/or were identified as suffering from workforce shortages: dentists, pharmacists, occupational therapists, physiotherapists, speech pathologists, podiatrists and audiologists.[203]

Table 8.6: National Skills Shortage List, Nurses and Health Specialists, March 2004

Occupation	AUST	NSW	VIC	QLD	SA	WA	TAS	NT
Registered Nurses								
Registered Nurse (general)	N	S	S	S	S	S	S*	S
Accident/Emergency	N	S	S	S	S	S	S	S
Aged Care	N	S	S	S	S	S	S*	S
Cardiothoracic	N	S	S	S	S	S	S	S
Community	N	S		S	S	S	S*	S
Critical/Intensive Care	N	S	S	S	S	S	S	S
Indigenous Health	N	*		S	S	S		S
Neonatal Intensive Care	N	S	S	S	S	S	S	S
Neurological	N	S	S	S	S	S	S	S
Oncology	N	S	S	S	S	S	S	
Operating Theatre	N	S	S	S	S	S	S*	S
Paediatric	N	S	S	S	S	S	S	S
Palliative Care	N	S	S	S	S	S	S	
Perioperative	N	*	S	S	S	S	S	S
Rehabilitation	N	S	S	S	S	S	S*	S
Renal	N	S	S	S	S	S	S	S

202 DEWR bases the National Skill Shortage Lists primarily on surveys of employers who have recently advertised vacancies for selected occupations. Industry and employer intelligence is considered together with statistical information on demand and supply trends for selected occupations.

203 Australian Physiotherapy Association, sub 118, p 14; The Aged Care Rights Service, sub 87, p 35; National Rural Health Alliance, sub 131, p 34; Speech Pathology Australia, sub 52, pp 3-4; The Deafness Forum of Australia, sub 66, p 11.

Registered Midwife	**N**	**S**	**S**	**S**	**S**	**S**	**S**	**S**
Mental Health Nurse	**N**	**S**	**S**	**S**	**S**	**S**	**S**	
Enrolled Nurse	**N**	**S***	**S**	**S**	**S**	**S**	**S**	**S**
Health Specialists								
Dentist	N	S*	R*	S		S*		S*
Pharmacist (Hospital/Retail)	N	S	S*	S	S	R		D
Occupational Therapist	N	S*	S*	S	D	D*	S	R
Physiotherapist	N	S*	S*	S	S	S*	S	S
Speech Pathologist	N	M	S*	S	R		S	D
Podiatrist	N*	*	*	*	*	*	*	*
Diagnostic Radiographer	N	S*		S			S	S
Radiation Therapist	N	S	S	S	S	S	S	
Nuclear Medicine Technologist	N	D		S		S	S	
Sonographer	N	S		S	S	S	S	S
Audiologist			S	S				S

Notes: * Shortages may be restricted to specialist skills

N=National Shortage R=Shortage in regional areas D=Recruitment difficulties

S=State-wide shortage M=Shortage in metropolitan areas

Source: National Skills Shortage List, Nurses and Health Specialists, March 2004, p 3-4.

Nurses

8.232 The Committee heard that difficulties in recruiting and retaining nurses jeopardises the continuity and quality of care in aged care homes. Shortages also affect older people's wishes to continue to live at home, and access to timely assessment by Aged Care Assessment Teams.

8.233 Several factors contributing to the shortage of nurses and other care staff have been consistently identified in evidence to the committee and in recent research:

- ageing of the nursing workforce;
- lack of wage parity;
- working conditions experienced by care staff in aged care homes;
- lack of education and training opportunities; and
- poor public image of caring for the aged.

Ageing of the nursing workforce

8.234 The average age of registered nurses in the public sector is 44 years. In the aged care sector the average age of registered nurses is 54 years with some nurses working over the age of 75 years. As Mr Holmes of the New South Wales Nurses Association stated:

> There are many very dedicated aged care nurses who carry on past 60—some even work to 75, we have found. It is truly amazing that they can carry that workload.[204]

8.235 Table 8.7 shows the proportion of nurses aged over 45 years of age between 1987 and 2001. The proportion of registered nurses aged 45 years or older nearly doubled between 1987 and 2001. The proportion of aged or disability person carers aged 45 years or older increased from 19 per cent in 1987 to 45 per cent in 2001.[205]

Table 8.7: Summary statistics of employment in nursing and carer occupations by age and hours worked per week, Australia, 1987 and 2001.

	Percent 45 years of age and over	
	1987	2001
Directors of nursing	71	71
Nurse managers	22	45
Nurse educators & researchers	26	34
Registered nurses	20	38
Registered midwives	20	25
Enrolled nurses	15	35
Personal care and nursing assistants	26	37
Aged and disability person carers	19	45

Source: *Shah & Burke 2001 as cited in National Review of Nursing 2002*

8.236 As these nurses age and retire, a greater demand will be placed on the health and aged care workforce, impacting upon the quality and quantity of care available.

8.237 Mr Holmes stressed to the Committee:

> …That means that we have less than five years to turn that around to ensure that we actually reduce that average age to ensure there will be a work force.[206]

Lack of wage parity for nurses caring for the aged

> …many employers refuse to negotiate fairly over wages and conditions. This results in a significant wages gap between

204 Holmes B, transcript 4/07/2003, p 650; Australian Nursing Federation, Sub 97, p14; National Review of Nursing Education 2002, *Our duty of* care, viewed 30/8/2004, <http://www.dest.gov.au/archive/highered/nursing/pubs/duty_of_care/doc5.html#8>; New South Wales Nurses' Association, sub 120, p 6-7

205 National Review of Nursing Education 2002, *Our duty of* care, section 2.6 Changing nursing worker profile, viewed 30/8/2004, <http://www.dest.gov.au/archive/highered/nursing/pubs/duty_of_care/doc5.html#8

206 Holmes B, transcript 4/07/2003, p 650.

> the public and private acute sectors and the aged care sector, and less favourable working conditions, making it difficult for aged care providers to recruit and retain nurses in a very competitive employment market.[207]

8.238 The Australian Nurses Federation (ANF) informed the Committee that the wage differential nationally between the acute care sector (private and public) and the aged care sector increased from $92.72 in 2001 to $123.06 in September 2001. By the beginning of July 2004, ANF data showed a gap of $170.50 per week national average. Gaps vary from state to state reflecting differences in State Awards/Enterprise Bargaining Agreements (EBA) for the sectors (see Table 8.8). [208]

Table 8.8: Disparity in pay rates RN (Year 8 or equivalent) across states and territories at June 2004

State/Territory	Public Sector EBA Rate Weekly Earnings $	Aged Care Award Rates Weekly Earnings $	% Difference
Victoria	930.10	784.20	18.6
NSW	1074.20	922.70	16.4
Queensland	950.25	793.90	19.7
WA	942.60	754.60	24.9
SA	929.60	742.60	25.2
Tasmania	896.90	773.70	15.9
NT	970.49	802.00	21.0
ACT	960.94	757.57	26.8

Source: Australian Nursing Federation, Nurses Paycheck, Volume 3 Number 3 June – August 2004.

8.239 According to the ANF the wage disparity between nurses employed in homes where EBAs are in place and those in the public sector is reduced (see Table 8.9).

Table 8.9: Disparity in pay rates RN (Year 8 or equivalent) between Public Sector and Aged care EBAs in selected states and territories as at June 2004

State/Territory	Public Sector EBA Rate Weekly Earnings $	Aged Care Award Rates Weekly Earnings $	% Difference
Victoria - Anglican	930.10	857.17	8.51

207 Australian Nursing Federation (ANF), sub 97, p 11; see also, eg, Anglican Aged Care Services Group, sub 99, p 3; Chamber of Commerce and Industry WA, sub 70, p 7.

208 ANF, sub 97, p 11; ANF, 'The National Aged Care Phone-in', p 1, viewed 20/04/2004, <http://www.anf.org.au/>.

Aged Care Services Group and ANF Certified Agreement			
SA - Nurses – ANF – Flora McDonald Lodge Enterprise Agreement 2001	929.60	874.06	6.35
Tasmania – Tasmanian Aged Care Nursing Enterprise Agreement 2001	896.90	829.35	8.14
ACT – Anglican Retirement Services – Brindabella Gardens, ANF Enterprise Agreement 2002-2004	960.94	793.00	21.18

Source: Australian Nursing Federation, Nurses Paycheck, Volume 3 Number 3 June – August 2004.

8.240 The Hogan Review also expressed concern that the disparity in wages decreases the capacity of the sector to attract and retain nurses. The Review noted that the ANF data indicates the potential of EBAs to improve salary outcomes for employees. However, the aged care sector has been slow to negotiate EBAs at individual workplaces.[209] Analysis by the Review also demonstrated that there are significant differences in pay rates within the residential aged care. These variations depend on whether homes are state government or non-government owned, and whether non-government homes have access to Fringe Benefits Tax (FBT) advantages to offer salary packaging to their staff.[210]

8.241 Proposals were put to the Committee suggesting that the Australian Government should increase funding to address wage parity, either directly or by developing and funding a 'benchmark of care' covering the real costs of providing staff.[211]

8.242 The Committee notes that in the 2004-05 Budget the Australian Government announced funding of $877.8 million over four years for a new conditional adjustment payment, in addition to the usual indexation increases. This payment is designed to enable aged care homes to offer more competitive wages and increased training opportunities to nurses and other staff. The payment will be 1.75% of the basic subsidy amount payable in respect of each eligible resident

209 *Review of Pricing Arrangements in Residential Aged Care, Final Report,* p 224

210 *Review of Pricing Arrangements in Residential Aged Care,* p 223.

211 Australian Nursing Federation, sub 97, pp 11-12; Aged Care Alliance, sub 88, p 6. See also, Sullivan F, transcript 17/08/2003, p 695.

in 2004-05, rising to 7 per cent of the basic subsidy amount by 2007-08. The first payments are being made in July and August 2004.[212]

8.243 The new payment is conditional upon homes meeting certain requirements including encouraging workforce training, making audited accounts publicly available annually, and participating in a periodic workforce census. Details of the conditions are being developed by the Department of Health and Ageing in consultation with the industry. [213]

8.244 The Committee considers that while the intent of the new payment is to improve wages and conditions for nurses and other staff in residential aged care, success in achieving such improvements will depend on the commitment of providers to their staff.

8.245 As indicated above, the ANF has found that many aged care employers are still not willing to negotiate improved conditions to secure and keep good staff. Equally, organisations such as the Kingston City Council are putting significant investment into making working in aged care more attractive. In their HACC services, the Council has recruited a higher number of carers (where possible) to reduce work loads, increased skills training, and at times reduced the number of hours worked to help limit the risk of injury. The comprehensive and innovative approaches the Council is taking to ensure their low care facilities are less likely to face shortages of skilled staff are summarised in Box 8.2, together with the benefits for both staff and the homes.

8.246 The Committee concludes that details of the conditions attached to the new payment will be critical and must provide a strong incentive for aged care employers to ensure that nurses and other care staff do reap the intended benefits of the payment. Residential care employers must also demonstrate commitment to investing in their staff to improve quality of care for residents.

212 *Budget Measures 2004-05*, Budget Paper No. 2, p 185.

213 Department of Health and Ageing, Conditional Adjustment Payment, viewed 28/07/2004, <http://www.ageing.health.gov.au/finance/cap.htm>.

Box 8.2: Kingston City Council: Strategies to invest in staff

Council has made significant investment in the upskilling and career development of the hostel staff to develop and sustain high levels of quality care to the residents.

In 1999, Council made a conscious decision to embark on a range of strategies to improve career development within its hostel staffing structure. Workforce issues of untrained staff were addressed through provision of traineeships that gave staff skills, knowledge, experience, and a qualification. These traineeships covered the full range of occupations in an aged care facility, with nursing traineeships being introduced for the first time. Council also developed an in house training program that focused on the provision of care and introduced a performance management system that was linked to the hostel's quality system. Benefits, apart from increased retention levels, job satisfaction, and the attainment of formal qualifications was the empowerment of staff and an enormous increase in self esteem resulting in a hunger to continue personal development.

There were financial benefits to the organisation of approximately $100,000 in training subsidies and this income was used to create opportunities for this further development to take place. Additional financial benefits were gained through staff knowledge that enabled them to maximise care relating funding. Workcover claims went from extremely high to nil; premiums reduced significantly. This team was recognised by Workcover Victoria, winning the risk minimisation award in 2002.

To consolidate staff satisfaction and retention, and to ensure the future viability of Kingston's staffing structure and delivery of quality care, succession planning and career pathways were developed. Key staff were identified and a tailored internal education program developed and implemented. Staff have progressed from no qualification to Certificate III, Certificate IV Nursing, Diplomas and Advanced Diplomas in Business.

Three managers have been recognised at national level, winning awards for leadership excellence.[214]

Source: Kingston City Council sub 144, p 1

Working conditions

8.247 Evidence indicated that the level of the paper work burden in aged care (compared to that in acute care and other areas of employment) is a major disincentive for nurses to work in aged care. In particular, the work involved in the resident classification scale (RCS) assessments and validations was frequently mentioned together with the stress the 'inspectorial' validation process generates.[215] Claims were made that registered nurses spend an hour a day writing up paperwork just to support the RCS, and that the nature of the documentation required places stress on assistants in nursing and

214 Kingston City Council, sub 144, Case Study 2 Attachment, p 1.

215 ASLARC, sub p 32

other care workers who do not always have high level literacy skills.[216]

8.248 Family friendly conditions were also a matter of concern. The ANF drew the Committee's attention to the fact that aged care is a female dominated profession. Yet too few aged care homes consider introducing flexibilities to attract and retain staff, especially young, newly qualified staff.[217]

8.249 As Mr Otomancek explained to the Committee, the working conditions are leading to many nurses leaving permanent employment to become Agency nurses:

> I queried one Agency RN why she was working for an Agency, the reply was simple but true; 'Great hourly rate. Minimal responsibility. No crap from management or Government Agency for documentation!'[218]

8.250 Occupational health and safety issues, in particular those associated with managing challenging behaviours, the amount of lifting associated with frailty, and longer working hours to cover absences all contribute to shortages. The ANF stated that nursing homes experience higher claims rates made under Commonwealth, state and territory workers' compensation acts than hospitals, including psychiatric hospitals. Other evidence indicated that in part the high injury rate may be due to inadequate skills and training. Kingston City Council, for example, dramatically reduced their Workcover claims as a result of concentrating on skills and career development for their staff.[219]

8.251 Distance and isolation make working in rural and remote areas unattractive, despite the investment aged care homes make to attract staff. As Ms Gwynne reminded the Committee, places like Nhulunbuy and Tennant Creek are:

> … a long way from family and home and you need a very experienced person to work there … So finding the right incentives to encourage people to work here is an enduring challenge.[220]

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216 Bryon D, transcript 25/02/2003, p 169; West K, transcript 24/02/2003, p 130; *[others??]*

217 Australian Nursing Federation, sub 97, p 12;

218 Mr Goran Otomancel, sub 169, p 6

219 Australian Nursing Federation, 97, p 116-17; Nall C, transcript 31/03/2003, p 332; Kingston City Council, sub 144, Case Study 2 Attachment, p 1.

220 Gwynne K, transcript 3/02/2004, p 753. See also, Miles M, transcript 2/02/2004, pp 713-14; Jeffery R, transcript 3/02/2004, p 776.

8.252 The Committee notes that in the context of the 2004-05 Budget, the Australian Government committed to reducing the paperwork burden associated with the RCS and with other time consuming administrative procedures. It plans to streamline the RCS from eight categories to three. An ACAT assessment to upgrade residents from low to high care within the same aged care home will no longer be required. Together these changes should free nurses from a significant paperwork burden and enable them to focus of the care of residents. In addition, homes will no longer be required to assess the assets of new residents, sensibly separating decisions on assessment of needs and future care from a task better performed by Centrelink.[221]

Lack of education and training opportunities

8.253 The Committee heard that while some employers encourage and support nurses involvement in further education and professional activities, a survey in NSW showed that close to 50% of employers fail to do so.[222] Where training and continuing education opportunities are available, they are not necessarily relevant to the needs of age care staff (see further, 'Education and training', below).

8.254 Evidence also highlighted both a lack of access to continuing education opportunities and an urgent need for recognition that aged care has its own care practices and body of knowledge which should underpin education and training. The ongoing care of very frail people with complex co-morbidities (including dementia) combined with periodic acute episodes is different from care in other contexts. Not all nurses have the skills and knowledge to provide such high acuity care or to develop person-centred team work and systems to support it. [223]

Poor public image of caring for the aged

> … young people not wanting to go into nursing, full stop, because it is seen as lackey work…[224]

8.255 It is a well known problem that a major impediment in recruiting people to work in the aged care sector is its poor public image. A key finding in the Department of Education, Science and Training report into Australian Aged Care Nursing was that while:

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221 *Budget Measures 2004-05,* Budget Paper No. 2, p 188.

222 Australian Nursing Federation, sub 97, p 11

223 Australian Nursing Federation, sub 97, p 10; Royal College of Nursing Australia, sub 28, p 3-4; National Aged Care Alliance, submission 88, p 3; Nair B, sub 154, p 1.

224 Emerson F, transcript 7/03/2003, p 209.

> …both aged care and acute care sectors have significant difficulties in recruiting nurses, aged care experiences greater staffing difficulties, as it is often perceived to be the poor cousin of acute care nursing. Aged care is typically viewed as a field that lacks glamour and excitement, and often receives very poor media presentation. [225]

8.256 Evidence to the Committee explained that there are perceptions that aged care is more menial, less skilled, and rewarding than other types of work. Mrs Gregg explained to the Committee that potential aged care workers need to see aged care as a challenging and rewarding career option, '...not an off-the-street job that anyone can do.'[226]

8.257 The Anglican Diocese in evidence to the Committee, stressed that the image of the aged care sector needs to be improved so that potential workers realise that 'what goes on in those places is very socially uplifting'[227]

8.258 The government is addressing the negative perception of aged care through a number of strategies. The Department of Health and Ageing is working in collaboration with the aged care sector and the media to improve the image of aged care in Australia.[228]

Beginning to turn the shortage around

8.259 A range of initiatives is being put in place to address the shortage of nurses but, given the underlying causes, turning the shortages around will take some years. In the 2002-03 Budget, the Australian Government provided $47.5 million over four years to boost aged care nurse numbers. In the first two years:

- Over 400 aged care homes nationally have provided training and education opportunities for more than 4,400 care staff through 38 training and education programs;

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225 Department of Education, Science and Training, *Australian Aged Care Nursing: A Critical Review of Education, Training, Recruitment and Retention in Residential and Community Settings*, Chapter 1, viewed 17/8/2004, <http://www.dest.gov.au/archive/highered/nursing/pubs/aust_aged_care/3.htm>.

226 Gregg S, sub 48, p 3. See also Otomancek G, sub 169, p 9; Anglican Diocese of Sydney, sub 67, p 2; Russell C, transcript 4/7/2004, p 467; Hogan W, *Review of Pricing Arrangements in Residential Aged Care*, 2004, p 225-26.

227 Anglican Diocese of Sydney, sub 67, p 2

228 Department of Education, Science and Training, *Australian Aged Care Nursing: A Critical Review of Education, Training, Recruitment and Retention in Residential and Community Settings*, Chapter 4, viewed 17/8/2004, <http://www.dest.gov.au/archive/highered/nursing/pubs/aust_aged_care/2.htm>.

- Over 990 aged care nursing scholarships have been awarded to encourage more people from riral and regional area to enter or re-enter aged care nursing; and
- Recipients of aged care nursing scholarships have received additional support to maintain their connection with the aged care specific networks, members and quality clinical placements.[229]

8.260 A further package in the 2004-05 Budget provides $101.4 million to assist providers to attract and retain qualified staff and will help the development of a more skilled aged care workforce.

8.261 These funds will underpin a major expansion in training places for aged care workers and nurses. This will allow up to 21,000 aged care workers over four years to obtain and upgrade their qualifications up to Enrolled Nurse, including training in medication management. In addition, up to 8,000 additional aged care workers will be assisted through the Workforce English Language and Literacy (WELL) program to improve their literacy and language skills. The funding will also allow 1,600 more students to commence nursing studies over the next four years.

Other health professionals

8.262 The recruitment of sufficient appropriately qualified staff is becoming an increasing challenge for the care of people as they grow older. As mentioned previously in this chapter, there is a serious shortfall across a range health services and health specialist areas to meet the needs of an ageing population.

8.263 Evidence to the Committee identified workforce shortages in the areas of: geriatrics; orthopaedics; pathology; podiatry; psychiatry; radiology; oncology; mental health; dermatology; ear nose and throat surgery; nutritionist and dieticians; and anaesthetists. This is consistent with analysis undertaken from the Australian Medical Workforce Advisory Committee.[230]

8.264 The Committee also heard about some of the impacts these shortages have on older people: 'Waiting times and waiting lists are ballooning.

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229 Investing in Australia's aged care: More places, better care, p50.

230 The Aged-care Rights Service, sub 87, p 35-36; Department of Health and Ageing, sub 119, p 39-40; Aged Services Learning and Research Collaboration, sub 151, p 32; National Rural Health Alliance Inc, sub 131, p 34-37; Australian Medical Workforce Advisory Committee, *Australian Health Workforce Shortages – January 2004*, p 1, viewed 10/08/2004, <http://amwac.health.nsw.gov.au/amwac/pdf/Austhealth_shortages.pdf.

A large number of residents travel elsewhere for specialist care. This is a significant burden on the aged'.[231]

8.265 While shortages are being experienced across Australia, they are increasingly affecting rural and regional areas. The National Rural Health Alliance Inc explained that health professionals who cater specifically to the needs of elderly people are already in short supply and:

> As the population ages in rural and remote areas more quickly than in urban areas the relative needs in rural and remote areas for the services of all types of health professionals will increase.[232]

8.266 The shortage in rural and remote areas places additional pressure on those who do work there leading to:

> … excessive overtime, inability to get back-up for continuing professional development or leave, increasing demand without additional providers and having to provide services which would in better supplied areas be provided by other types of health professionals. Adverse consequences from this are burnout, leading to rapid turnover and extra stress for those working in circumstances where their skills may be out of date.[233]

8.267 Future supply problems will be exacerbated by the number of older professionals, who will have retired by 2021. The percentages of professionals aged 45 and over in 2001 were 61.8% (general practitioners), 54.5% (pharmacists), 42.2% (registered nurses), 54.9% (psychologists) and 49.0% (dentists).[234]

8.268 The national implications of these shortages have been recognised by the Australian Government and State and Territory Governments. The *National Health Workforce Action Plan* was endorsed by the Australian Health Ministers in July 2004. It is to be supplemented by a range of Australian Government and State and Territory Action plans and health workforce initiatives. The action plan provides a set of

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231 Aged Services Learning and Research Health Collaboration, sub 151, p 10

232 National Rural Health Alliance Inc, sub 131, p 34-37; Department of Health and Ageing, sub 119, p 39-40; Australian Medical Workforce Advisory Committee, *Australian Health Workforce Shortages – January 2004*, p 1, viewed 10/08/2004, <http://amwac.health.nsw.gov.au/amwac/pdf/Austhealth_shortages.pdf>..

233 National Rural Health Alliance Inc, sub 131, p 35.

234 NSW Department of Health, sub 160, p 12; Department of Health and Ageing, sub 119, p 40; National Rural Health Alliance Inc, sub 131, p 34-37; NSW Department of Health, sub 160, p 12.

guiding principles for government and workforce stakeholders to address health workforce issues (See Box 8.3).

Box 8.3: The National Health Workforce Action Plan Principles

Principle 1:
Australia should focus on achieving, at a minimum, national self-sufficiency in health workforce supply, whilst acknowledging it is part of a global market.

Principle 2:
Distribution of the health workforce should optimise equitable access to health care for all Australians, and recognise the specific requirements of people and communities with greatest need.

Principle 3:
All health care environments regardless of role, function, size or location should be places in which people want to work and develop; where the workforce is valued and supported and operates in an environment of mutual collaboration.

Principle 4:
Cohesive action is required among the health, education, vocational training and regulatory sectors to bring about an Australian health workforce that is knowledgeable, skilled, competent, engaged in life long learning and distributed to optimise equitable health outcomes.

Principle 5:
To make optimal use of workforce skills and ensure best health outcomes, it is recognised that a complementary realignment of existing workforce roles or the creation of new roles may be necessary. Any workplace redesign will address health needs, the provision of sustainable quality care and the required competencies to meet service needs.

Principle 6:
Health workforce policy and planning should be population and consumer focused, linked to broader health care and health systems planning and informed by the best available evidence.

Principle 7:
Australian health workforce policy development and planning will be made most effective when undertaken collaboratively involving all stakeholders. It is recognised that this will require: cohesion among stakeholders including governments, consumers, carers, public and private service providers, professionals, and the education, training, regulatory, industrial and research sectors; stakeholder commitment to the vision, principles and strategies outlined in this framework; a nationally consistent approach; best use of resources to respond to the strategies proposed in this framework; and a monitoring, evaluation and reporting process.

Source: Australian Medical Workforce Advisory Committee, National Health Workforce Action Plan, pp 5 – 13.

8.269 The Committee endorses the principles in the National Health Workforce Action Plan and considers that several have particular relevance to increasing the workforce to care for older people:

- all care environments should be places people want to work, where the workforce and their work are valued and they operate in an environment of mutual collaboration;
- cohesive action among broader education, training and regulatory sectors to ensure the workforce is knowledgeable and skilled;
- realigning existing workforce roles or the creation of new roles may be necessary; and

- collaboration involving all stakeholders is essential to developing and planning workforce policy.

8.270 The Australian Health Ministers' Advisory Council (AHMAC) is overseeing further research to examine health workforce shortages in the medium and long term and to provide a sufficient health workforce by 2020, and is investigating recruitment and retention strategies to ensure workforce supply and distribution best meets the needs of all Australians. Both projects are expected to be completed by May 2005.[235]

8.271 The Committee understands that there is no quick fix for solving workforce shortages in the health care sector. It will take considerable time for policies and practices to fully take effect, to ease the strain on the workforce caring for people as they age, and enable holistic approaches to care.

Summing up

8.272 Several broad themes emerged, demonstrating that there are areas of common concern in aged care and health services:

- inadequate focus on services aimed at maintaining healthy functioning: physiotherapy; podiatry; nutrition advice; speech pathology; oral health services; and podiatry.
- *diverse settings* the availability and quality of care for people with dementia or mental health problems, and for those needing respite or palliative care – care which may be provided at home, in the community or in an institutional setting;
- working on it
- confusion caused by multiple community care services, and issues around the quality of community care services;
- the availability, quality and viability of residential care;
- hospitals that are seen as becoming increasingly unfriendly to older people and poorly integrated with other care services for older people;
- the need for changes in general practice and the ways GPs work with other health professionals to provide better care for people as they grow older; and

235 Health Workforce Australia, *2004-05 Health Workforce Program*, viewed 10/08/2004, <http://amwac.health.nsw.gov.au/amwac/projects.html>.

- workforce shortages, especially nurses and other residential care staff.

Conclusion 12

8.273 **The Committee concludes that the Department of Health and Ageing liaise with the state and territory agencies so that:**

- **the new dementia care supplement should be set at two levels, consistent with the rates for the new medium care and high care RCS categories; and**
- **the medium care level supplement should also be made available for the care of people with challenging behaviours who are still living in the community.**

Conclusion 13

8.274 **The Committee concludes that, to provide a better incentive for aged care providers to provide respite care, including for people with complex high care needs, the subsidy for respite care in residential aged care facilities should be set at two levels, consistent with the rates for the new medium care and high care RCS categories.**

8.275 While the care needs of the elderly while in hospital are beginning to receive attention, the Committee concludes that this requires urgent action. The types of initiatives being successfully developed by some hospitals indicate that wider adoption of a safety and quality approach should be pursued. The Committee considers that it would be appropriate for the Australian Council for Safety and Quality in Health Care to promote examine the occurrence of adverse events relating to older people in hospital and recommend ways of improving their clinical governance.

Conclusion 14

8.276 **The Committee concludes that Australian Health Ministers, through the Australian Council for Safety and Quality in Health Care, should identify the care of older people while in hospital as a safety and quality priority and recommend specific actions to improve the standard of their care.**

9

Aged care and health services: Looking to the future

9.1 The Committee received a range of suggestions for putting aged care and health services on a better footing for the longer term. Three overarching matters are seen as critical to addressing these issues, together with related funding issues:

- increased focus on research to gain a better understanding ageing and the care of the aged;
- a workforce more attuned to the needs of older people and more appropriately skilled to provide services for people as they age; and
- better integration of services to provide person centred care: genuine cooperation between the states, territories and the Australian Government, breaking down traditional program and funding barriers, and collaboration and team work by health professionals.

Research to better understand ageing and care of the aged

There is an urgent need for more research to underpin planning and action for the ageing population. Ageing is a complex biological, psychological, and social phenomenon. Research into ageing must necessarily be transdisciplinary, focusing on a variety of biological, clinical and social

> perspectives for greater understanding of issues limiting health in older age and effective means to intervene.[1]

9.2 This need for ageing research was a common theme in evidence to the Committee. There is growing recognition that the processes of ageing are poorly understood and that a better understanding is urgently needed if aged care and health services are to more effectively support older Australians now and in the future.

9.3 Areas identified for health and age care research were comprehensive and wide-ranging, underlining concerns that it is no longer appropriate to assume that the outcomes of research designed for other age groups can be assumed to be valid for older people. Areas for research included: increased knowledge of the physical norms in older age groups, understanding of the mechanisms that enhance ageing in place, healthy ageing, the cultural dimensions of ageing, diagnosis, prevention and management of neurodegenerative diseases, vascular disease, geriatric nutrition, evidence to underpin clinical decision making, better understanding of how to empower older people and respect their individuality, older people's perceptions of their experiences and needs, geriatric pharmacology and adverse drug events, musculoskeletal health, support for carers including older carers looking after people with a disability, the potential for information and communication technology to support care services. [2]

9.4 Changes to funding arrangements and the level of funding available for ageing research were seen as essential to quickly building research capacity and a body of research knowledge.

9.5 Attention was drawn to the fact that by far the majority of NHMRC funding is awarded to biomedical research and that the peer assessment panels are largely drawn from biomedical researchers: only two experts represent geriatrics.

9.6 Professor McLean stated that arrangements for ageing research compare poorly with some overseas countries:

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1 Byles J, Hunter Medical Research Institute, sub 103, p 11.

2 Centre for Education and Research on Learning, sub 63, p 3; Byles J, Hunter Medical Research Institute, sub 103, p 7; Australian Physiotherapy Association, sub 118, p 19; Australian Association of Gerontology, sub 143, p 3; CSIRO, sub 35, pp 6-7; Council for Multicultural Australia, sub 74, p 2; COTA, sub 91, p 14; Alzheimer's Australia, sub 79, pp 7-8; Andrews G, University of South Australia, transcript 28/03/2003, p 355-6.

> Australian contributions [to ageing research] are limited by a small and ageing research work force, funding levels which are relatively trivial, funding award systems which are disorganised and unfocussed compared to the integrated systems in place in the USA, Britain, Scandinavia and the European Union. The US system is pre-eminent in terms of size and organisation with the National Institute on Ageing …[3]

9.7 At the same time, recent initiatives to increase the emphasis on ageing research and establish research priorities were acknowledged as a step in the right direction including: the work of the NHMRC's Strategic Research Development Committee; the Scoping Study on Ageing Research; the Building Ageing Research Capacity (BARC) initiative; and the move by the Australian research Council (ARC) to begin funding applied ageing research.[4]

9.8 The NHMRC noted that since 1997 it has funded over 100 age-related research projects, and that in 2002 an additional $23 million was provided for research into areas such as osteoporosis, arthritis, dementia, Alzheimer's disease and injury.[5]

9.9 The NHMRC also noted that in December 2002, the Prime Minister announced the Government's National Research Priorities including as a priority goal, *Ageing well, ageing productively* under the national priority, *Promoting and maintaining good health*. All Australian Government research and research funding bodies are expected to submit plans to the Government outlining how they propose to support the four priorities. No additional funding will be provided specifically for the National Research Priorities; rather they will be addressed through better coordination of effort.[6]

9.10 A suggestion was put to the Committee that Australia should develop a research infrastructure similar to the US National Institutes of Ageing. However, Professor Le Couteur stressed that Australia has a lot of good researchers and the important thing is to find a

3 McLean A, sub 95, p, 2.

4 Australasian Centre on Ageing, sub 108, pp 2, 4; Byles J, sub 103, pp 12-13; Australasian Centre on Ageing, sub 108, p 2.

5 Australasian Centre on Ageing, sub 108, p 2; Nair K, transcript, 3/07/2003, p 562; Le Couteur D, transcript 3/07/2003, p 599; Bartlett H, transcript 20/05/2003, p 498; NHMRC, sub 130, p 3.

6 NHMRC, sub 130, p 2; 'Research priorities for Australia's future prosperity', media release 5 December 2002, viewed 12 July 2004, <http://www.pm.gov.au/news/media_releases/2002/media_release2018.htm>.

mechanism to draw them into ageing research, possibly through establishing an NHMRC panel on ageing. Such a panel, together with emphasis on multi-disciplinary collaboration, was supported by the Australian Association of Gerontology because they considered it would be unlikely a model such as the US National Institutes of Ageing could be achieved, given Australia's much smaller population.[7]

9.11 The Committee notes that all 21 research agencies and funding bodies have completed their National Research Priorities implementation plans. Those with a major focus on *Ageing well, ageing productively* include, CSIRO, components of the Cooperative Research Centres programme, and the NHMRC. The Australian Institute of Family Studies and the Department of Veterans' Affairs have a lesser focus on *Ageing well, ageing productively.* For the first time, the ARC and the NHMRC will collaborate to jointly fund projects in the fields of medical research and new technologies. Working groups have been established to identify projects.[8]

9.12 In its implementation plan the NHMRC stated that in 2003 around $68 million in funding would be provided for 257 projects ($30.6 million) for research in *Healthy start to life*, 110 projects ($10million) for *Ageing well, ageing productively*, and 199 projects ($27.6 million) for *Preventive healthcare*. This comprises in the order of 23% of NHMRC's total expenditure. NHMRC anticipates that there will be an incremental increase in their funding for National Health Priorities in future rounds and that it would be 'reasonable to expect' that one third of total expenditure (around $105 million) could be directed to priority areas by the end of 2005. [9]

9.13 The NHMRC plans to establish Strategic Research Networks in each of the three health-related sub-priorities to accelerate the development of research capacity in these areas. The Strategic Research Networks are to be informed by the notion of the 'consensus conferences' developed by the US National Institutes of Health. The

7 Centre for Education and Research on Ageing, sub 63, pp 4-5; Le Couteur D, transcript 3/07/2003, p 598-59. See also, Nair K, transcript 3/07/2003, p 562; Australian Association of Gerontology, sub 143, p 3.

8 Department of Education, Science and Training, 'National Research Priorities: Implementation', viewed 14/04/2004, <http://www.dest.gov.au/priorities/implementation.htm>; ARC, *Discovery,* Autumn 2004, p 2; NHMRC, *eNewsletter*, April 2004, p 3, viewed 14/07/2004, <http://www.health.gov.au/nhmrc/new.htm>

9 NHMRC, Implementation plan, pp, 5, 12, 13., viewed 14/07/2004, <http://www.dest.gov.au/priorities/implementation.htm>

networks will bring together research teams from across basic, clinical, population health, and health services research.[10]

9.14 The Committee concludes that all three sub-priorities, *Healthy Start to Life, Ageing well, ageing productively* and *Preventive Healthcare,* and the establishment of Strategic Research Networks have the potential to improve the urgent need for a better understanding of the processes of ageing and how to improve aged care and health services.

9.15 However, on the basis of NHMRC's 2003 funding across the sub-priorities, *Ageing well, ageing productively* is still the poor cousin. This imbalance should be actively addressed in future funding rounds as Strategic Research Networks focussing on this area are established

Conclusion 15

9.16 **The Committee concludes that the Australian Government actively monitors funding for National Health Priorities research to ensure that by the end of 2005, at least one third of the funding priority is directed to research related to Ageing well, and ageing productively.**

9.17 The Committee also concludes that gaining a better understanding of nutrition for people as they age, and for people who are already in their later years, is of critical importance. Immediate priority should be placed on this area of research by the NHMRC.

Conclusion 16

9.18 **The Committee concludes that, in the next funding round, the National Health and Medical Research Council should give priority to research aimed at gaining a better understanding of nutrition for people aged over 65 years.**

10 NHMRC, Implementation plan, viewed 14/07/2004, <http://www.dest.gov.au/priorities/implementation.htm>.

A workforce attuned to the needs of older Australians

9.19 The Committee is concerned by evidence of the inadequacy of education and training to fit health and allied health professionals for working with an ageing population. These concerns relate both to the shortage of professionals with specific geriatrics education or training and to the minimal exposure undergraduates and post-graduates get to understanding and working with older people. Once in the field, many practitioners are exposed only to older people who are sick, disabled or in hospital. As this may not be balanced by exposure to the 'well old', stereotypical impressions that 'old' means 'sick' are reinforced. Nor does this situation encourage a focus on prevention rather than treatment.

9.20 Research considered by the Deans of Australian Schools of Nursing calls for changes in the curriculum for aged care nursing education and training. Provision by the Australian Government of aged care scholarships is also acting as an incentive for universities to provide more appropriate courses. The Committee appreciates that these initiatives will take some years to bring more appropriately qualified staff into aged care in significant numbers.

9.21 At the under-graduate level of medical education, there is still no core component relating to ageing. Some electives in geriatrics are available and in some clinical schools these are proving popular. At the graduate level, various universities offer masters degrees or graduate certificates but these more often attract people already working in the field than new graduates.

9.22 The Committee concludes that current arrangements are insufficient to ensure that health professionals are equipped to meet the demands of working with an ageing population. The Committee of Deans of Australian Medical Schools is best placed to take a leadership role in this matter. The Committee considers that the conference to consider a future vision for Australian medical education being organised by the Committee of Deans provides a timely forum to consider the implications of Australia's ageing population for curriculum development.

Conclusion 17

9.23 **The Committee concludes that the Department of Education, Science and Training should work with the Committee of Deans of Australian Medical Schools to increase the focus of the health of older people in the curriculum for under-graduate medical education.**

Working together

> The key to a robust, efficient and effective health system is improved integration of care services between acute, residential, transitional, mental health and home and community care sectors. … Strategies must be implemented to improve continuity of care across programs and to address any cost shifting, service fragmentation and jurisdictional duplication measures that impede quality care.[11]
>
> One of the major requirements for … holistic care is for health professionals to work together, rather than along side each other. The latter is the norm now.[12]

9.24 The Committee is concerned that a repeated theme in the above sections is fragmentation and lack of cooperation: across levels of government; between GPs and residential aged care homes; between hospitals and residential aged care homes; between community services; between professionals with what should be shared responsibility for the care of people as they age.

9.25 Fragmentation and lack of cooperation are claimed to results in frustration, inconvenience and costs to older people, service providers, and governments at all levels – and to jeopardise the healthy ageing of older people.[13]

9.26 Fragmentation and lack of cooperation may arise from policy and funding arrangements. Equally they may arise from historical professional practices. Mr Malone, of the Australian Physiotherapy Association, highlighted the difficulties of working in an area subject to split policy responsibilities and multiple funding arrangements:

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11 Catholic Health Australia, sub 94, p 9.

12 Nair B, sub 159, p 2.

13 Chamber of Commerce and Industry of WA, sub 70, p 7.

> … physiotherapy services often fall between the cracks of state and federally funded programs. The Commonwealth … would say that physiotherapy is a state responsibility, yet at the same time the Commonwealth has programs, like the enhanced primary care program and the More Allied Health Services Program, which in principle are terrific ideas that we support and which are trying to deliver a multidisciplinary service to people who have conditions that have been shown to respond well to multidisciplinary care.[14]

9.27 Evidence was also received about a lack of cooperation between care professionals and the people and communities they care for. The National Rural Health Alliance, for example, referred to providers who 'resist the efforts of community organisations' to recruit professionals themselves, 'presumably to maintain an effective monopoly' on services and income.[15]

14 Malone D, transcript 31/03/2003, p 332.

15 National Rural Health Alliance, sub 131, p 35.

A

Appendix A – List of submissions[1]

1	Mr John Ray
2	Association of Superannuation Funds of Australia Limited
3	University of the Third Age Inc. (U3A), Hobart
4	Mr Loris Eric Kent Hemlof
5	Ms Alice Glover
6	Mr Alan Nicholson, Macquarie Shores Centre
7	Shop, Distributive & Allied Employees' Association
8	Disability Information Australia Pty Ltd
9	Ms Leone Mills
10	University of the Third Age (U3A) Incorporated, Sydney
11	NSW Aged Care Alliance, Council of Social Service of NSW (NCOSS)
12	Macarthur Care, Campbelltown
13	Third Son Financial Services Pty Limited
14	O'Mara House Aged Facility
15	Ms Clara McCarthy
16	Mr Robert Steadman
17	Mrs Doreen Laing
18	Southern Health Primary Care
19	Macarthur Forum Action Group
20	Industry Funds Forum
21	Ms Fiona Bannister
22	Voluntary Euthanasia Society of Victoria Inc.

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1 In above list (supp) indicates supplementary submission, and submissions from the same author/s are cross referenced

23 Mr Geoff Robson
24 Mr C J Green
25 Mr & Mrs Ken & Jeanette Clifton
26 Ms Patricia Warn *(see also sub 166)*
27 Ms Betty Teltscher OAM
28 Royal College of Nursing, Australia
29 Stockton Hospital Welfare Association Inc
30 Institute of Chartered Accountants in Australia
31 Older Women's Network, Melbourne
32 Mrs Delaune Pollard *(see also sub 153)*
33 Christian Science Committee on Publication, Federal Representative for Australia
34 Ms Jenny Kearney
35 Commonwealth Scientific and Industrial Research Organisation (CSIRO)
36 Right to Life Australia Inc.
37 Moreland City Council, VIC
38 Mr Robert Foreman
39 Latrobe Community Health Service Inc.
40 S Adamantidis
41 Ms Connie Mirabella
42 Wintringham
43 Mr Tom Polich
44 University of the Third Age (U3A), City of Melbourne Incorporated
45 Southern Gold Coast 60 & Better Program Inc
46 Hunter Health, Aged Care and Rehabilitation Services, Hunter Area Health Services
47 City of Nedlands Council, WA
48 Mrs Suanne Merle Gegg
49 Dr Satya Brink
50 ACT Government *(see also sub 158)*
51 Investment & Financial Services Association Ltd
52 Speech Pathology Association of Australia Limited
53 National Private Rehabilitation Group
54 Mr Russell Callister
55 Sustainable Population Australia, Canberra Region
56 Baptist Community Care Ltd, VIC
57 Superannuated Commonwealth Officers' Association (SCOA) Inc
58 Older Women's Network (Australia) Incorporated *(see also sub 59)*
59 Older Women's Network (Australia) Incorporated *(supp to sub 58)*
60 Mrs Moira McGuinness

61 Aged Care Assessment Services (ACAS) Victoria

62 Ms Pam Rey

63 Centre for Education & Research on Ageing (CERA)

64 Australian Society for Geriatric Medicine

65 Catholic Women's League Australia Inc (CWLA)

66 Deafness Forum of Australia

67 Anglican Diocese of Sydney, Social Issues Executive

68 Lake Macquarie City Council, NSW

69 Small Independent Superannuation Funds Association Ltd (SISFA)

70 Chamber of Commerce and Industry, WA

71 Australian Services Union

72 Association of Superannuation Funds of Australia Limited

73 Waverley Council

74 Council for Multicultural Australia (CMA)

75 Pharmacy Guild of Australia

76 Brisbane Water Legacy

77 Carers Australia

78 Centrelink

79 Alzheimer's Australia

80 The Myer Foundation

81 National Seniors Association

82 IBISWorld Pty Ltd

83 Salvation Army Australia, Eastern Territory

84 University of NSW, Research Centre on Ageing & Retirement (RCAR) *(see also sub 161)*

85 Australian Association of Social Workers (AASW)

86 Australian Medical Association Limited

87 The Aged-care Rights Service (TARS)

88 National Aged Care Alliance

89 Lgov NSW (representing the Local Government Association of NSW and the Shires Association of NSW)

90 Department of Family and Community Services *(see also sub 156)*

91 Council on the Ageing (Australia)

92 Dr Katharine Betts, Swinburne University of Technology, VIC *(see also sub 145)*

93 Australian Nursing Federation (SA Branch)

94 Catholic Health Australia

95 National Ageing Research Institute

96 KLCK Woodhead International

97 Australian Nursing Federation

98 Sustainable Population Australia Inc

99 Anglican Aged Care Services Group

100 Adult Learning Australia Inc

101 Aged and Community Services Australia (ACSA)

102 Local Government Association of Tasmania

103 Associate Professor Julie Byles, Hunter Medical Research Institute & the University of Newcastle

104 Uniting*Care* Australia

105 Health & Aged Care Roundtable, Isaacs

106 Trustee Corporations Association of Australia

107 Australian Council of Trade Unions

108 Australasian Centre on Ageing, University of Queensland

109 Municipal Association of Victoria

110 Australian Industry Group (Ai Group)

111 Australian Nursing Homes and Extended Care Association Limited (ANHECA)

112 SAI Group

113 Department of Veterans' Affairs

114 The Treasury *(see also sub 134)*

115 Australian Institute of Family Studies (AIFS)

116 Australian Council of Social Service (ACOSS)

117 Department of Immigration and Multicultural and Indigenous Affairs *(see also sub 136)*

118 Australian Physiotherapy Association

119 Department of Health and Ageing *(see also sub 146)*

120 New South Wales Nurses' Association (NSWNA)

121 Country Women's Association of Australia

122 Disability Support and Housing Alliance (DSHA), *Victoria (see also sub 148)*

123 Local Government Association of Queensland Inc

124 Wyong Shire Council, NSW *(see also sub 149)*

125 Central Coast Area Health

126 Confidential

127 Mrs Laraine Dunn, Well Dunn - Health, Exercise, Lifestyle

128 Dr Anna Howe

129 Queensland Government

130 National Health and Medical Research Council

131 National Rural Health Alliance Inc

132 Professor John McCallum, University of Western Sydney

133 Associate Professor Dr Cherry Russell, University of Sydney

134 The Treasury *(supp to sub 114)*

135 Dr Alan Tapper, Edith Cowan University, WA

136 Department of Immigration and Multicultural and Indigenous Affairs *(supp to sub 117)*

137 Amputees and Associates, Newcastle and Northern Region Inc.

138 Institute of Actuaries of Australia

139 Palliative Care Australia

140 Federation of Ethnic Communities Councils of Australia

141 Aboriginal and Torres Strait Islander Commission (ATSIC)

142 Department of Employment and Workplace Relations *(see also sub 164)*

143 Australian Association of Gerontology

144 Kingston City Council, VIC

145 Dr Katharine Betts, Swinburne University of Technology, VIC *(supp to sub 92)*

146 Department of Health and Ageing *(supp to sub 119)*

147 Complementary Healthcare Council of Australia

148 Disability Support and Housing Alliance (DSHA) *(supp to sub 122)*

149 Wyong Shire Council, NSW *(supp to sub 124)*

150 Professor Duncan Boldy & Dr Ann Clarke, Centre for Research into Aged Care Services, Curtin University of Technology

151 Aged Services Learning and Research Collaboration (ASLaRC), Southern Cross University & the University of New South Wales

152 Local Government Association of Queensland

153 Mrs Delaune Pollard *(supp to sub 32)*

154 Professor Kichu Nair, John Hunter Hospital & the University of Newcastle *(see also sub 159)*

155 Commander John Fielding (Retired)

156 Department of Family and Community Services *(supp to sub 90)*

157 Council of the Ageing (NSW) Inc

158 ACT Government *(supp to sub 50)*

159 Professor Kichu Nair, John Hunter Hospital & the University of Newcastle *(supp to sub 154)*

160 NSW Department of Health

161 Research Centre on Ageing & Retirement (RCAR), University of New South Wales *(supp to sub 84)*

162 Mrs Barbara Veness

163 Human Rights Coalition

164 Department of Employment and Workplace Relations *(supp to sub 142)*

165 Dr Judith Crockett, University of Sydney (Orange, NSW)

166 Ms Patricia Warn *(supp to sub 26)*

167 Rev. Dr Elizabeth MacKinlay, Centre for Ageing and Pastoral Studies, St Mark's Theological Centre & School of Theology, Charles Sturt University

168 Mr Ross Venner

169 Mr Goran Otomancek
170 Confidential
171 Tasmanian Government
172 Baptist Community Services, NSW & ACT
173 Australian Lung Foundation Inc, Lung Cancer Consultative Group
174 Catholic Health Care Services Limited
175 Springvale Indochinese Mutual Assistance Association Inc (SICMAA)
176 Central Australian Aboriginal Congress Inc
177 NT Government, Department of Health & Community Services
178 Council on the Ageing (NT) and National Seniors
179 NT Carers Association Inc
180 Frontier Services (Uniting Church)
181 Dr Sadhana Mahajani
182 Dubbo Clinical School, University of Sydney
183 Catholic Health Care Services Ltd – Lourdes, Dubbo
184 Returned Services League, Broken Hill
185 Menindee Health Advisory Council
186 Confidential
187 Ms Cath Bonnes
188 Mr John McAuley
189 Wellbeing of Older Men, Hunter Retirement Living / UnitingCare
190 Mr Ron Coleman
191 NT Government, Department of Health & Community Services (*supp to sub 177)*
192 Ms L Elbourne
193 ACT Disability, Aged and Carer Advocacy Service (ADACAS)

B

Appendix B – List of exhibits[1]

1 *Adaptable housing – proposed policy initiatives*, Jeff Heath and the Coalition for Adaptable Housing South Australia, 1 p, (Related to: sub 8)

2 *Submission to Senate Select Committee on Superannuation Inquiry into Superannuation and Standards of Living in Retirement*, June 2002, The Association of Superannuation Funds of Australia Ltd, 69 p (Related to: sub 2)

3 Shaw, Stuart, 2002, Letter to the Hon K. Andrews on the aged care system, Unpublished, 8 p (Provided by Mr Stuart Shaw, General Manager, Baptist Village Baxter Limited)

4 Collection of five newspaper articles on the right to die and the right to refuse medical treatment in Victoria, 2002, *Age,* 3 p (Related to: sub 27)

5 *Position paper on access to public and private housing*, July 2001, Coalition for Adaptable Housing South Australia, 2 p (Related to: sub 8)

6 Research capability statement for the Centre for Research into Nursing and Health Care, University of South Australia, 41 p (Provided by Professor Julianne Cheek, Director, Centre for Research into Nursing and Health Care, University of South Australia)

7 Collection of pamphlets, information sheets and reference manual, Southern Gold Coast 60 & Better Program (Related to: sub 45)

8 *Building strong communities through positive ageing*, 2002, Western Suburbs Regional Organisation of Councils; Lee Phillips and Associates, Western Australia, 306 p (Related to: sub 47)

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1 The list of exhibits has been compiled by Kay Richardson, Informed Sources Pty Ltd.

9 Adamson, Linda, 1997, *A picture of wellness: the story of the Bankstown Older Women's Wellness Centre*, Older Women's Network, Sydney, 64 p (Related to: sub 58)

10 *Scoping study on ageing research: draft report*, Centre for Education and Research on Ageing; National Ageing Research Institute, Concord, NSW (Related to: sub 63)

11 Submission to the Senate Select Committee Inquiry into Superannuation and Standards of Living in Retirement, 2002, Australian Institute of Superannuation Trustees, Unpublished, 15 p (Provided by Ms Susan Ryan AO, President, Australian Institute of Superannuation Trustees)

12 Jorm, Anthony, 2001, *Dementia: a major health problem for Australia*, Alzheimer's Association Australia, ACT, 5 p (Related to: sub 79)

13 *2020: a vision for aged care in Australia*, Myer Foundation, Melbourne, 40 p (Related to: sub 80)

14 *Rural and remote briefing*, May 2002, Aged & Community Services Australia, Melbourne, 5 p (Related to: sub 101)

15 *Learning and living in the third age*, 2000, Learning Circles Australia, ACT, Unpublished, 13 p (Related to: sub 100)

16 *Fairness and flexibility: making superannuation work for low and middle income-earners: submission to the Senate Select Committee on Superannuation's Inquiry into Superannuation and Standards of Living in Retirement*, 2002, Australian Council of Social Service, Strawberry Hills, NSW, 56 p (Related to: sub 116)

17 *Proposals for Commonwealth age discrimination legislation: information paper*, December 2002, Attorney-General's Department, Canberra, 74 p (Provided by the Attorney-General's Department)

18 *Review of pricing arrangements in residential aged care: call for submissions*, 2003; [and] *Review of pricing arrangements in residential aged care: the context of the review: background paper no. 1*, 2003, Dept of Health and Ageing, Canberra, 2 v (Provided by Ms Sue McCutcheon, Dept of Health and Ageing)

19 McDonald, T. A., 2001, *What do nurses think about aged care?: a report on nurse perceptions about the aged care sector*, NSW Nurses Association, Camperdown, NSW, 62 p (Related to: sub 120)

20 *Policy options in aged care and ageing: key policy issues and questions*, Federation of Ethnic Communities Council of Australia, Canberra, Unpublished, 11 p (Provided by Mr Conrad Gershevitch, National Co-ordinator, Federation of Ethnic Communities Councils of Australia)

21 Hill, Martin, 1999, *Breaking into adaptable housing: a cost benefit analysis of adaptable homes*, Hill PDA, 11 p (Provided by Mr Bernd Bartl, Disability Support and Housing Alliance)

22 One pamphlet and four information sheets on the safe use of prescription medications, Pharmacy Guild of Australia, Canberra, (Provided by Ms Ann Dalton, Professional Services Officer, Pharmacy Guild of Australia)

23 Richardson, Chris, 2002, *The intergenerational blues*, Pharmacy Guild of Australia, Canberra, Unpublished, 11 p (Provided by Ms Ann Dalton, Professional Services Officer, Pharmacy Guild of Australia)

24 *Physiotherapy research update*, 2002, Australian Physiotherapy Association, St. Kilda, 5 p (Provided by Mr Andrew McCallum, Australian Physiotherapy Association ACT)

25 Submission on the need for a physiotherapy workforce study to the Australian Health Workforce Officials' Committee, 2003, Australian Physiotherapy Association, St. Kilda, Unpublished, 10 p (Provided by Mr Andrew McCallum, Australian Physiotherapy Association ACT)

26 *Changes needed to the Resident Classification Scale and the subsidy for residential aged care facilities: submission to the Hon Kevin Andrews*, 2002, Australian Physiotherapy Association, St. Kilda, Unpublished, 8 p (Provided by Mr Andrew McCallum, Australian Physiotherapy Association ACT)

27 Australian Physiotherapy Association, 2001, *Annual report*, Australian Physiotherapy Association, St. Kilda, 36 p (Provided by Mr Andrew McCallum, Australian Physiotherapy Association ACT)

28 Aged care, service delivery and demographic data for the electorate of Cowper, 2003, 17 p [and] Dunn, Amanda, 2004, 'Victoria: the place to be and be and be', *Age,* 1 p [and] Brodaty, Henry; Draper, Brian M.; Low, Lee-Fay, 2003, 'Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery', *Medical Journal of Australia*, Vol. 178, p. 231-234 (Provided by Dr John O'Callaghan, Geriatrician, Aged Care Services, Cowper)

29 Bartlett, Helen; Findlay, Robyn, 2003, *Linking the ageing research and policy agenda: towards a strategy for Queensland*, Australasian Centre on Ageing; University of Queensland; Dept of the Premier and Cabinet (Qld), Brisbane, 52 p (Provided by Professor Helen Bartlett, Director, Australasian Centre on Ageing)

30 Tapper, Alan, 2003, 'Family change and the ageing welfare state' in Jamieson, Lynn; Cunningham-Burley (eds), *Families and the state:*

conflicts and contradictions, [to be published], 19 p (Provided by Dr Alan Tapper, Edith Cowan University)

31 Tapper, Alan, 2002, 'Fertility free fall – does it make any sort of sense?', *On Line Opinion*, 15 September, 2002, 5 p (Provided by Dr Alan Tapper, Edith Cowan University)

32 Tapper, Alan, 2002, 'The Intergenerational Report is not about intergenerational equity, but about fiscal sustainability', *On Line Opinion*, 15 June 2002, 5 p (Provided by Dr Alan Tapper, Edith Cowan University)

33 Federation of Ethnic Communities' Councils of Australia, 2003, *Art, culture and heritage policy: draft,* Unpublished, 6 p (Provided by Mr R. Alwis, Chairperson, Federation of Ethnic Communities' Councils of Australia)

34 Centre for Research into Aged Care Services, Curtin University of Technology, 2002, *Annual report*, 27 p (Provided by Professor Duncan Boldy, Director, Centre for Research into Aged Care Services, Curtin University of Technology)

35 Niedzwiecki, Yolanta; Pierce, Gill, 2003, *Stepping outside the square: a report on the respite needs of carers of older people in the western metropolitan region*, Carers Victoria, Melbourne, 80 p (Provided by Carers Australia)

36 *Research into the transport needs of older people on the Central Coast of New South Wales*, Prepared for the Central Coast Quality Ageing Transport Working Group by Transport Planning and Management, Marrickville, NSW, 75 p [and] two pamphlets on quality ageing and services provision record book (Provided by Mr Jon Blackwell, Chief Executive Officer, Central Coast Area Health Service)

37 *Strategic directions for an ageing community: City of Salisbury: strategic plan 2001-2004*, City of Salisbury, South Australia, 20 p (Provided by Country Women's Association of Australia)

38 Woodley-Baker, Rochelle, 2002, *Northern Collaborative Project: progress & planning report 2002-2003*, Northern Collaborative Project, Adelaide, 36 p (Provided by Country Women's Association of Australia)

39 *City of Kingston aged care strategy*, November 2002, Viney Consulting Group, 137 p (Provided by the City of Kingston)

40 Merl, Helga; Bauer, Lyndon, 2003, *A dementia care guide for general practitioners: time to think about dementia,* [CD ROM], Dementia Advisory Service; Central Coast Division of General Practice (Provided by Mr Jon Blackwell, Chief Executive Officer, Central Coast Area Health Service)

41 *The dementia epidemic: economic impact and positive solutions for Australia*, March 2003, Prepared for Alzheimer's Australia by Access Economics Pty Limited, Canberra, 100 p (Provided by Mr Glenn Rees, National Executive Director, Alzheimer's Australia)

42 *Australian Capital Territory population projections 2002-2032 and beyond*, June 2003, Demographic Group, Chief Minister's Department, Canberra, 19 p (Provided by Mr Peter Brady, Director, ACT Office for Ageing)

43 Flanagan, Patrick; Stoyles, Megan, 2000, *In their shoes: caring for residents as individuals: a guide for all staff working in residential aged care*, Aged & Community Services Australia, Melbourne, 62 p (Provided by Ms Patricia Warn)

44 Flanagan, Patrick; Stoyles, Megan, 2002, *In their homes: caring for people as individuals: a handbook for home care workers*, Aged & Community Services Australia, Melbourne, 68 p (Provided by Ms Patricia Warn)

45 *Growth pensions proposal: income stream products: characteristics and social security treatment*, [table], 1 p (Provided by Mr Richard Gilbert, Chief Executive Officer, Investment & Financial Services Association)

46 *Commonwealth Approved Aged Care Home Funding Index (1997-2000),* [graph] (Provided by Mr Francis Sullivan, Chief Executive Officer, Catholic Health Australia)

47 Ahamed, M. Syeed, July 2003, *Mature age unemployment in Australia and its socio-economic impact*, [Prepared for Ms Jill Hall, MP], Australian National Internship Program, Australian National University, Canberra, 2 February 2004, Unpublished, 30 p (Provided by Mr M. Syeed Ahamed)

48 Letter dated 2 February 2004 from Masonic Homes Inc. regarding the costs of providing residential aged care services in Darwin, 3 p (Provided by Ms Kylie Gwynne, Director, Aged, Disability and Community Care, Dept of Health and Community Services, Northern Territory)

49 *Residential aged care beds, Darwin 2004*, [Statistics] 1 p (Provided by Dr Mahajani, Aged Care Assessment Team, Dept of Health and Community Services, Northern Territory)

50 Four photographs of the Juninga Centre (Provided by Mrs Caroline Phillips, Director of Nursing, Gwalwa Daraniki Association Inc)

51 *Residential aged care funding: third report*, February 2003, A report by the Australian Institute for Primary Care, La Trobe University for the National Aged Care Alliance, National Aged Care Alliance,

Melbourne, 27 p (Provided by Ms Jill Iliffe, Member, National Aged Care Alliance Secretariat)

52 Stevens, John; Herbert, Jan, 1997, *Ageism and nursing practice in Australia*, Royal College of Nursing, Australia, Deakin ACT, 23 p (Provided by Ms Elizabeth Foley, Director, Policy and Strategic Development, Royal College of Nursing, Australia)

53 Plymat, Kay R., 1998, *Health promotion in nursing practice*, Royal College of Nursing, Australia, Deakin ACT, 14 p (Provided by Ms Elizabeth Foley, Director, Policy and Strategic Development, Royal College of Nursing, Australia)

54 *The best of times, the worst of times: older women's retirement experience: messages for future older women*, 2000, Older Women's Network (Australia), Sydney, 54 p (Related to: sub 58)

55 *Difficult decisions: older women speak about money, life and retirement*, 1996, Older Women's Network (Australia), Sydney, 73 p (Relates to: sub 58)

56 Maller, Jerome; Rees, Glen, 2002, *Research priorities: dementia: a submission to the National Research Priorities Taskforce*, Alzheimer's Australia, 16 p (Related to: sub 79)

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59 *A vision for community care: a discussion paper*, 2002, Aged & Community Services Australia, Melbourne, 10 p (Related to: sub 101)

60 *Bodies matter: the pap test kit: a program for adults to discuss health issues*, 2002, [prepared by Learning Circles Australia], New South Wales Cervical Screening Program, Wentworthville, NSW, 3 v (various pagings) (Related to: sub 100)

61 *Learning and living in the third age*, A project developed with support from the Federal Government as part of International Year of the Older Person, Learning Circles Australia, Canberra, 1 v (various pagings) (Related to: sub 100)

62 Harvey, Roy, 2002, *Options for reforming the Pharmaceutical Benefits Scheme: submission to the Interdepartmental Committee*, Australian Council of Social Service, Strawberry Hills, NSW, 25 p (Related to: 116)

63 *Generating jobs: fifteen strategies for reducing unemployment in Australia,* 2001, ACOSS Paper 118, Australian Council of Social Service, Strawberry Hills, NSW, 30 p (Related to: sub 116)

64 *A framework for Commonwealth/State Housing Agreement negotiations, and beyond*, 2002, Australian Council of Social Service, Strawberry Hills, NSW, 11 p (Related to: sub 116)

65 Yencken, David; Porter Libby, 2001, *A just and sustainable Australia*, ACOSS Paper 115, Australian Council of Social Service, Strawberry Hills, NSW, 104 p (Related to : sub 116)

66 *Case statement on lung cancer*, 2003, The Australian Lung Foundation, Brisbane, 17 p (Related to: sub 173)

67 *Wellbeing of older men project*, [pamphlet], Uniting Care, Uniting Church in Australia, Mayfield, NSW (Related to: sub 189)

68 *The impact of Tasmania's ageing population*, 2003, Tasmanian Government, Hobart, 48 p (Related to: sub 171)

69 *Creating tomorrow's workforce today: how new initiatives in school based vocational education can increase the aged care workforce*, Enterprise & Career Education Foundation, Sydney, 2 p (Provided by Ms Gael Kennedy, Manager, Nursing Initiative, Enterprise & Career Education Foundation)

70 Nelson, Sue, 2001, 'The coming of age', *HR Monthly*, November 2001, p. 38-39 (Provided by Ms Gael Kennedy, Manager, Nursing Initiative, Enterprise & Career Education Foundation)

71 *Creating tomorrow's workforce today: aged care targeted industry project 2000-2001*, [Report by the Industry Advisory Committee], 2002, Enterprise & Career Education Foundation, Sydney, 13 p (Provided by Ms Gael Kennedy, Manager, Nursing Initiative, Enterprise & Career Education Foundation)

72 *A matter of maturity*, [video], Enterprise & Career Education Foundation, Sydney, 7 mins (Provided by Ms Gael Kennedy, Manager, Nursing Initiative, Enterprise & Career Education Foundation)

73 Levy, Linda L, *Information processing and dementia, Part II: Cognitive disability in perspective*, American Occupation Therapy Association, Baltimore, USA, 7 p (Related to: sub 153)

74 Caine, Eric D, 1993, 'Should ageing-associated cognitive decline be included in DSM-IV?', *Journal of Neuropsychiatry and Clinical Neurosciences*, vol. 5, p. 1-5 (Related to: sub 153)

75 Allen, Claudia Kay; Allen, Robert E, 1987, 'Cognitive disabilities: measuring the social consequences of mental disorders', *Journal of Clinical Psychiatry*, vol. 48 no. 5, p. 185-190 (Related to: sub 153)

76 Pollard, Delaune, 2002, *Midlife's challenge: understanding and coping with decline in thinking and behaviour*, 132 p (Related to: sub 153)

77 *Allen Cognition Levels*, [table], 1 p (Related to: sub 153)

78 *Allen Cognitive Levels: differing social abilities*, [tables], 3 p (Related to: sub 153)

79 *Allen Cognitive Levels predict placement for aged care*, 1 p (Related to: sub 153)

80 Three pamphlets, map, Summer 2002-03 issue of the Minymaku News from the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council (Provided by Ms Maggie Kavanagh, Co-ordinator, Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council)

81 Gallagher, Phil, 2002, *Intergenerational change in Australia: economic, fiscal and financial implications*, Retirement and Income Modelling Unit, Dept of Treasury, Canberra, 20 p (Provided by Mr Phillip Gallagher, Manager, Retirement and Income Modelling Unit, Dept of Treasury)

82 Rodger, Stuart, 2003, *Retired market financial products*, 10 p (Related to: sub 138)

83 *Public & community housing: a rescue package needed*, 2002, Australian Council of Social Service, Strawberry Hills, NSW, 7 p (Related to: sub 116)

84 *Ensuring excellence: an investigation of the issues that impact on the registered nurse providing residential care to older Australians: report* [and] *executive summary*, March 2002, Centre for Research into Nursing and Health Care, University of South Australia, Adelaide, 2 v (Provided by Professor Julianne Cheek, Director, Centre for Research into Nursing and Health Care, University of South Australia)

85 Concept plan for integrated retirement village incorporating self-care apartments, villas and aged care facility at The Lakes, Coffs Harbour, 2003, McFadyen Architects, Wagstaffe, NSW, 2 p (Provided by Mr Geoffrey Smith, General Manager, Astoria Developments Pty Ltd)

86 *A home does not need to be a horror chamber*, July 2001, Jeff Heath and the Coalition for Adaptable Housing South Australia, www.adaptablehousing.org/dox/news_sta_020711.pdf, 1 p (Related to: sub 8)

87 *Draft aged care policy*, Federation of Ethnic Communities Council of Australia, Canberra, Unpublished, 10 p (Provided by Mr Conrad Gershevitch, National Co-ordinator, Federation of Ethnic Communities Councils of Australia)

88 O'Brien, Paraig; Blythe, Adrian; McDaid, Shauna, 2002, *Lifetime homes in Northern Ireland*, [abridged version], Joseph Rowntree Foundation; Chartered Institute of Housing in Northern Ireland, Belfast, 4 p (Provided by Mr Bernd Bartl, Disability Support and Housing Alliance)

C

Appendix C – Public hearings, site inspections and community forums

Public Hearings

Friday, 7 February 2003 - Canberra

Aged and Community Services Australia (ACSA)
Mr Gregory Mundy, Chief Executive Officer

Australian National University
Professor Peter McDonald, Professor and Head, School of Demography and Sociology, Research School of Social Sciences

Department of Family and Community Services
Mr Alexander Dolan, Assistant Secretary, Seniors and Means Test Branch
Ms Kerry Flanagan, Executive Director, Strategic and Ageing Cluster

Department of Health and Ageing
Mr Warwick Bruen, Assistant Secretary
Dr David Cullen, Executive Director, Aged Care Price Review Taskforce
Dr Ruth Lopert, Assistant Secretary, Pharmaceutical Benefits Branch, Medical and Pharmaceutical Services Division
Mr Nicolas Mersiades, First Assistant Secretary, Ageing and Aged Care Division
Mr Ross O'Donoughue, First Assistant Secretary, Population Health
Mr Mark Thomann, Assistant Secretary, Office for an Ageing Australia

Department of Immigration and Multicultural and Indigenous Affairs
Ms Claire Cooper, Assistant Director, Economic and Environment Section, Migration Branch
Mr David Doherty, Assistant Secretary, Citizenship and Language Services Branch
Mr Ian Lester, Policy Advisor, Service Delivery and Performance Section, OATSIA

Mr Abul Rizvi, First Assistant Secretary, Migration and Temporary Entry Division
Mr Chris Smith, Assistant Secretary, Migration Branch

Department of Veterans' Affairs
Mr Arthur Edgar, Branch Head, New Compensation Scheme
Mr Wes Kilham, Branch Head, Younger Veterans and Vietnam Veterans' Counselling Service
Mr Barry Telford, Branch Head, Housing and Aged Care

The Treasury
Mr Phillip Gallagher, Manager, Retirement and Income Modelling Unit
Mr Trevor Thomas, Manager, Superannuation, Retirement and Savings Division
Mr David Tune, General Manager, Fiscal and Social Policy Division

Monday, 24 February 2003 – Central Coast

Aged Services Association (Central Coast)
Mrs Jennifer Eddy, Secretary, Central Coast Regional Committee, and General Manager, Woy Woy Community Aged Care
Mr Glen Gillingham, Vice Chair, Central Coast Branch
Mr Kevin West, Vice Chair, Central Coast Branch

Central Coast Area Health
Mr Jon Blackwell, Chief Executive Officer

Central Coast Division of General Practice
Mr Matthew Hanrahan, Chief Executive Officer

Wyong Shire Council
Councillor Greg Best, Mayor
Mr Edward John Burgess, Director, Corporate and Community Services
Ms Nancy Nicholson, Team Leader, Community Services

Tuesday, 25 February 2003 – Lake Macquarie

Individual
Mrs Laraine Dunn

Aged and Community Services of NSW and ACT Inc
Ms Vivienne Allanson, Chief Executive Officer, Maroba
Mr Denis Byron, General Manager, Anglican Care
Mr Andy Fullerton, Regional Chair (Hunter)

Hunter Health
Dr John Ward, Clinical Director, Aged Care and Rehabilitation Services

Lake Macquarie City Council
Ms Jill Bogaerts, Community Planner, Ageing and Disability

Hunter Medical Research Institute and The University of Newcastle
Professor Julie Byles, Director, Centre for Epidemiology and Biostatistics

Friday, 7 March 2003 - Canberra

Aboriginal and Torres Strait Islander Commission

Ms Fran Emerson, Acting Manager, Health and Welfare
Mr Michael Gooda, Acting Executive Coordinator
Mr Geoffrey Gook, Manager, Information Analysis and Research Unit
Mr Glen Hansen, Executive Policy Officer, Education, Social Participation and Gender
Ms Kerrie Nelson, Acting Assistant Manager, Economic and Social Participation Policy Group

Australian Medical Association Limited

Dr Mukesh Haikerwal, Chair, Australian Medical Association Committee on Care of Older People and President, Australian Medical Association, Victoria
Dr Susan Richardson, Member, Australian Medical Association Committee on Care of Older People
Dr David Rivett, Member, Australian Medical Association Committee on Care of Older People and Chair, Australian Medical Association Council of General Practice
Mr Bruce Shaw, Senior Policy Advisor

Australian Nursing Federation

Ms Victoria Gilmore, Federal Professional Officer
Ms Jill Iliffe, Federal Secretary

Carers Australia

Ms Julie Austin, Policy Analyst
Mr Ben Chodziesner, Vice President

Department of Employment and Workplace Relations

Mr Chris Alexandrou, Assistant Director
Mr Graham Carters, Group Manager, Employment Policy Group
Ms Shelley Cooper, Director, Employment Conditions Section, Workplace Relations Policy and Legal Group
Mr Kenneth Douglas, Group Manager, Employment Analysis and Evaluation Group
Mr Scott Matheson, Assistant Secretary, Economic and Labour Market Analysis Branch, Employment Analysis and Evaluation Group

Federation of Ethnic Communities Councils of Australia

Mr Conrad Gershevitch, National Coordinator
Mr Abd Malak, Chair
Mr Serge Voloschenko, Executive Member

National Aged Care Alliance

Mr Richard Gray, Delegate
Dr Mukesh Haikerwal, Australian Medical Association Delegate
Ms Jill Iliffe, Member
Mr Glenn Rees, Member
Ms Patricia Reeve, Council on the Ageing National Seniors Delegate
Mr Rodney Young, Delegate

National Rural Health Alliance

Mr Gordon Gregory, Executive Director

Ms Joan Lipscombe, Consultant
Ms Lexia Smallwood, Executive Assistant

Pharmacy Guild of Australia
Mr Stephen Greenwood, Executive Director
Ms Wendy Phillips, Director, Strategic Policy
Mr Patrick White, Committee Member, ACT Branch

Monday, 31 March 2003 - Melbourne

Individual
Dr Katharine Betts, Swinburne University of Technology, VIC
Ms Raelene West

Aged Care Assessment Services
Mrs Deborah Harvey, Chairperson, Aged Care Assessment Service Victoria and Manger, Kingston Aged Care Assessment Service
Ms Penny Houghton, Manager, North West Aged Care Assessment Service and Access Unit
Ms Gail O'Donnell, Program Manager, Hume Regional Aged Care Assessment Service
Mrs Juliet Thorn, Heidelberg Aged Care Assessment Service

Australian Physiotherapy Association
Mr David Malone, Chief Executive Officer
Ms Catherine Nall, Vice President

Disability Support and Housing Alliance Victoria (PSHA)
Ms Janice Florence, Information Officer, Paraquad Victoria

Kingston City Council
Ms Carolyn McClean, Community Services Manager
Mr Trevor McCullough, General Manager, Resident Services

Municipal Association of Victoria
Mr Troy Edwards, Senior Policy Advisor
Ms Clare Hargreaves, Senior Advisor, Social Policy
Mr Trevor Koops, Senior Economist

Monday, 28 April 2003 - Adelaide

Coalition for Adaptable Housing South Australia
Ms Jill Fowler, Chairperson
Mr Trevor Harrison, Committee Member
Mr Jeff Heath, Public Relations Officer
Dr Barry Seeger, South Australian Representative, Australian Network for Universal Housing Design

Commonwealth Scientific and Industrial Research Organisation (CSIRO)
Dr Mavis Abbey, Scientific Executive, Health Sciences and Nutrition
Affiliate Professor Richard Head, Preventative Health

Country Women's Association of Australia
Mrs Linda Bertram, National Treasurer
Mrs Phoebe Marie Lally, National President

Mrs Elizabeth Waddington, Chairman, South Australian Country Women's Association Social Issues Fact Finding Team

University of South Australia and Flinders University

Professor Gary Andrews, Professor of Ageing, University of South Australia; and Director, Centre for Ageing Studies, Flinders University and University of South Australia

University of the Third Age (U3A), Adelaide

Associate Professor Jack Cross, President

Tuesday, 29 April 2003 - Perth

Individual

Dr Alan Tapper

Australian Services Union

Ms Meredith Hammat, Assistant Branch Secretary
Miss Melissa Mitsikas, Acting Senior Industrial Organiser

Chamber of Commerce and Industry Western Australia

Mrs Nicola Cusworth, Chief Economist
Ms Nicole Roocke, Adviser, Health

Curtin University of Technology

Professor Duncan Boldy, Acting Director, Centre for Research into Aged Care Services
Dr Ann Clarke, Research Fellow, Centre for Research into Aged Care Services

Nedlands City Council

Dr Shayne Silcox, Chief Executive Officer, City of Nedlands
Mrs Deborah Stanton, Manager, Community Access, City of Nedlands
Mrs Susan Turner, Manager, Community Services, City of Subiaco

Monday, 19 May 2003 – Coffs Harbour

Aged Services Learning and Research Collaboration (ASLaRC)

Mr Timothy Allsopp, Chief Executive Officer, Catholic Care for the Aged, Coffs Harbour
Associate Professor James Curran, School of Rural Health, Faculty of Medicine, University of New South Wales
Mr Christopher Foster, Area Director, Nursing and Mental Health, Mid North Coast Area Health Service
Professor Jennifer Graham, Executive Dean, Division of Health and Applied Sciences, Southern Cross University
Mr Warren Grimshaw, Executive Director, Coffs Harbour Education Campus
Dr Richard Hill, Head of Social Sciences, Southern Cross University
Ms Deborah Kuhn, Project Manager, Future of Ageing: Coffs Coast, Coffs Harbour City Council
Ms Karyn O'Reilly, Head Teacher, Nursing Section, North Coast Institute Technical and Further Education
Mr Kevin Rocks, Aged Care Manager, Ramsay Health Care
Mrs Janice Ryan, Manager, Coffs Harbour, Bellingen and Nambucca Community Transport Inc

Associate Professor Shankar Sankaran, Director, College of Action Research, Graduate College of Management, Southern Cross University
Mr Geoffrey Smith, General Manager, Astoria Developments Pty Ltd
Professor Peter Wilson, Professor and Head, School of Psychology, Southern Cross University

Coffs Harbour Health Campus
Mrs Kerry Bartlett, Discharge Planner Clinical Nurse Consultant
Mrs Carol Burfoot, Clinical Nurse Specialist/Dementia Counsellor

Mid North Coast Area Health Service – Aged Care
Mr Peter Caban, Clinical Nurse Consultant, Aged Care Assessment Team, Acting Program Manager, Aged Care
Mrs Dolores (Anne) Sneesby, Clinical Nurse Consultant, Aged Care Assessment Team

Mid North Coast Division of General Practice Ltd
Dr Michael Peck, Chief Executive Officer
Mr Peter Spence, Executive Officer

Tuesday, 20 May 2003 – Brisbane

Individual
Mrs Delaune Pollard

COTA National Seniors Partnership
Mr David Deans, Chief Executive, National Seniors Association
Ms Patricia Reeve, Director, National Policy Secretariat

Local Government Association of Queensland Inc
Ms Natalie Kent, Manager, Finance, Governance and Community
Mr Mark Leyland, Finance and Governance Advisor

University of Queensland
Professor Helen Bartlett, Director, Australasian Centre on Ageing
Associate Professor Linda Worrall, Communication Disability in Ageing Research Unit

Wednesday, 18 June 2003 – Canberra

Royal College of Nursing Australia
Ms Elizabeth Foley, Director, Policy and Strategic Development
Rev. Dr Elizabeth MacKinlay, Director, Centre for Ageing and Pastoral Studies, St Marks Theological Centre & School of Theology, Charles Sturt University

Wednesday, 25 June 2003 – Canberra

Australian Capital Territory Government
Mr Peter Brady, Director, Australian Capital Territory Office for Ageing
Rev. Dr Elizabeth MacKinlay, Chair, Australian Capital Territory Ministerial Advisory Council on Ageing

Thursday, 3 July 2003 – Sydney

Individual
Ms Patricia Warn

Association of Superannuation Funds of Australia Limited
Mr Ross Clare, Principal Researcher
Ms Philippa Smith, Chief Executive Officer

Institute of Actuaries of Australia
Mr Andrew Gale, Vice President
Mr Andrew Kirk, Manager, Policy and Research
Mr John Walsh, Member

Investment & Financial Services Association
Ms Jo-Anne Bloch, Deputy Chief Executive Officer
Mr Richard Gilbert, Chief Executive Officer

New South Wales Department of Health
Ms Christine Foran, Acting Policy Manager, Government Relations Branch
Ms Elizabeth Gallagher, Senior Policy Officer
Ms Catherine Katz, Director, Government Relations Branch
Associate Professor Deborah Picone, Deputy Director-General

UnitingCare NSW/ACT
Reverend Harry Herbert, Executive Director

University of Newcastle
Professor Balakrishnan (Kichu) Nair, Professor of Geriatric Medicine, University of Newcastle & Director of Geriatric Medicine, Hunter Area Health Service

University of New South Wales
Dr Diana Olsberg, Director, Research Centre on Ageing and Retirement

University of Sydney
Professor David Le Couteur, Professor of Medicine, Senior Staff Specialist in Geriatric Medicine, Centre for Education and Research on Ageing

Friday, 4 July 2003 – Western Sydney

Blacktown Migrant Resource Centre
Ms Bernadette Agyepong, Generalist Caseworker
Ms Irene Ross, Manager

Macarthur Aged and Disability Forum
Ms Linda Margrie, Macarthur Home and Community Care Development Officer and Facilitator of Forum

New South Wales Nurses Association
Ms Kathryn Adams, Manager, Professional Services
Mr Brett Holmes, General Secretary

North West Community Care Inc.
Mr Paul Ripamonti, Administration Manager
Pastor Warren Weir, Director

University of Western Sydney
Professor John McCallum, Dean, College of Social and Health Sciences

University of Sydney
Associate Professor Cherry Russell, School of Behavioural and Community Health Sciences

Wednesday, 17 September 2003 – Canberra

Catholic Health Australia
Mr Richard Gray, Director, Aged Care Services
Mr Francis Sullivan, Chief Executive Officer

Monday, 2 February 2004 – Alice Springs

Individual
Mrs Rosalie Kunoth-Monks
Ms June Noble

Central Australian Aboriginal Congress Inc
Ms Stephanie Bell, Director
Dr John Boffa, Public Health Medical Officer
Dr Koen De Decker, Acting Medical Officer Coordinator
Ms Louise Dennis, Aboriginal Health Worker, Frail, Aged and Disabled Program

Frontier Services (Uniting Church)
Ms Ellie Lusty, Coordinator, Frontier Services Carer Respite Centre
Mrs Mary Miles, Director of Nursing, Frontier Services Old Timers Aged Care

Mampu Maninja-kurlangu Jarlu Patu-ku Aboriginal Corporation
Ms Maxine Kay Smith, Aged Care Project Officer, Yuendumu Old People's Program

Tuesday, 3 February 2004 – Darwin

Individual
Dr Michael Lowe
Dr Sadhara Mahajani

Council on the Ageing (NT)
Dr Leila Valerie Asche, AM, Board Member and President, Country Women's Association (NT)
Mrs Phyllis Barrand, President
Ms Carole Miller, OAM, Executive Director

Northern Territory Carers Association Inc
Mr Garry Halliday, Executive Director
Miss Janelle McKell, Team Leader, Carers Services Information
Mrs Leonie Simmons, Respite Manager

Northern Territory Department of Health and Community Services
Ms Philippa Cotter, Senior Aged Care Policy Officer, Aged and Disability Program
Ms Kylie Gwynne, Director, Aged and Disability Program

Salvation Army With Care Program
Mrs Jane Poole, Care Coordinator

Frontier Services (Uniting Church)
Mrs Rosemary Jeffery, Director of Nursing, Terrace Gardens
Mrs Caroline Phillips, Director of Nursing, Juninga Centre and Manager, Tracy Aged Care
Mrs Judy Ratajec, Coordinator, Territory Older Persons Support Services

Monday, 23 February 2004 – Dubbo

Baptist Community Services, NSW & ACT
Ms Vicki Cheah, Manager, Community Aged Care Program

Catholic Health Care Services Ltd – Lourdes, Dubbo
Mr Michael Kennedy, Non-Executive Director

Dubbo Clinical School
Dr Robert North, Sub-Dean

Returned Services League Aged Care Association Ltd, Dubbo
Mr John Millar, General Manager

Society of St Vincent de Paul
Ms Janice Pateman, Manager, Ozanam Villa

United Protestant Association of New South Wales Ltd
Mr Gregory Miller, District Manager Dubbo

Tuesday, 24 February 2004 – Broken Hill

Medical Practitioners

Barrier Division of General Practice
Dr Rosalind Menzies, Director

Broken Hill Health Services
Dr Stephen Flecknoe-Brown, Consultant Physician, and Chairman, Medical Staff Council, and Director of Clinical Training

Aged Care Providers

Aruma Lodge
Mrs Dallice Robins, Chairman

Shorty O'Neil Village, Broken Hill City Council
Mr Andrew Colbert, Manager

Southern Cross Care (Broken Hill) Inc and Aged Care Focus Group, Broken Hill
Mr Allan Carter, Chief Executive Officer

Local, State and Federal Government Organisations

Broken Hill City Council
Mrs Donna Millman, Community Programs Manager

Far West Area Health Service
Ms Debra Jones, Manager, Aged Care Services

Home Care Service of New South Wales
Mr Anthony Trebilcock, Branch Manager, Far West Area

Returned Services League, Broken Hill
Mr William Vickers, Pension-Welfare Officer and Vice-President, RSL, and Legacy Pension-Welfare Officer

Indigenous Organisations
Individual
Mrs Nyoli Bell
Maari Ma Health Aboriginal Corporation
Mr Stephen DeBono, General Manager, Lower Western Sector, Far West Area Health Service
Maari Ma Primary Health Care Service
Mr Terence Dwyer, Manager
Menindee Health Advisory Council
Mr Ricky Doyle, Facilitator

Site inspections

Friday, 12 July 2002 – Melbourne
Atkins Terrace, Kensington Banks
Gilgunya Village, Coburg
Port Melbourne Hostel, Port Melbourne
University of the Third Age, City of Melbourne Inc, Melbourne

Friday, 6 September 2002, 4 – Gold Coast
"501", Biggera Waters
Lions Haven for the Aged Ltd, Hope Island
RSL War Veterans Home, Currumbin
St Vincent's Community Services Respite Centre, Burleigh Heads

Monday 10 February 2003 – Canberra
Haptic Workbench and associated technology at the CSIRO Research premises at the Australian National University, Canberra

Monday 2 February 2004 – Alice Springs
Hetti Perkins Home for the Aged, Alice Springs

Tuesday 3 February 2004 – Darwin
Tracy Aged Care, Darwin
Juninga Centre, Nightcliff

Monday, 23 February 2004 – Dubbo
Kooringle Apex Nursing Home Association, Tullamore
Dr Rupert Newton, Medical Practitioner, Tullamore
Tullamore Central School
Tullamore District Hospital

Community forums

Friday, 6 September 2002, Gold Coast, 20 participants
Monday, 24 February 2003, Norah Head, 9 participants
Tuesday, 25 February 2003, Charlestown, 16 participants
Monday, 19 May 2003, Coffs Harbour, 17 participants
Monday, 2 February 2004, Alice Springs, 23 participants
Tuesday, 24 February 2004, Broken Hill, 42 participants

Briefings

Wednesday, 15 May 2002, Canberra

Department of Health and Aged Care
Dr David Graham, First Assistant Secretary, Aged and Community Care Division
Mr James Jordan, Assistant Secretary, Information Research Branch
Ms Lana Racic, Acting Assistant Secretary, Office for Older Australians

Wednesday, 29 May 2002, Canberra

Australian National Audit Office, Performance Audit Services Group
Ms Deborah Jackson, Audit Manager, Department of Health and Ageing and Department of Veterans' Affairs
Mr John Meert, Group Executive Director
Dr Paul Nicoll, Executive Director, Department of Health and Ageing and Department of Veterans' Affairs

Wednesday, 19 June 2002, Canberra

The Treasury
Mr Phil Gallagher, Manager, Retirement and Income Modelling Unit
Ms Lynne Thompson, Manager, Public Finance Unit, Budget Policy Division

Wednesday, 26 June 2002, Canberra

Australian Pensioners and Superannuants Federation
Mrs Edna Russell, National Secretary

The Council on the Aging
Ms Veronica Sheen, Deputy Executive Director

Pharmacy Guild of Australia
Mr John Bronger, National President
Mr Stephen Greenwood, Executive Director

Wednesday, 18 September 2002, Canberra
The Minister for Ageing, Hon. Kevin Andrews MP

Wednesday, 16 October 2002, Canberra

Commonwealth Scientific and Industrial Research Organisation
Dr Graham Harris, Chair, SCIRO Flagship Programs

Wednesday, 13 November 2002, Canberra

Australian Bureau of Statistics
Ms Barabara Dunlop, First Assustant Statistician, Social and Labour Force Statistics Division
Mr David Martyn, Assistant Director, National Ageing Statistical Unit

Wednesday, 4 December 2002, Canberra

Australian National University, National Centre for Epidemiology and Public Health
Dr Jim Butler, Senior Fellow (Health and Economics) and Deputy Director, NCEPH
Dr Judith Healy, Visiting Fellow, NCEPH
Professor Tony Jorm, Director, Centre for Mental Health Research

New Zealand Select Committee on Health
Members of the NZ Committee on Health

Wednesday, 5 February 2003, Canberra

Department of Health and Ageing
Mr Mark Thomann, Assistant Secretary, Office for Ageing

Australian Institute of Health and Welfare
Dr Diane Gibson, Head of Welfare Division

Wednesday, 14 May 2003, Canberra

Australian National Audit Office, Performance Audit Services Group, Department of Heath and Ageing and Department of Veterans' Affairs
Ms Deborah Jackson, Audit Manager
Dr Paul Nicoll, Executive Director
Ms Ee-Ling Then, Auditor

Wednesday, 28 May 2003, Canberra
Professor Kichu Nair, Professor of Medicine, University of Newcastle and Director, Geriatric Medicine, John Hunter Hospital

Wednesday, 5 November 2003, Canberra
Mr Syeed Ahamed, Parliamentary Intern to Deputy Chair, Australian National Internships Program, Australian National University

Wednesday, 31 March 2004, Canberra

Wellbeing of Older Men, Hunter Retirement Living/UnitingCare
Mr Richard Morrison, Project Coordinator

Conferences attended by Committee members

3 September 2002, Adelaide, Aged and Community Services Australia National Conference 2002
27-30 October 2002, Perth, the International Federation on Ageing 6th Global Conference and Expo